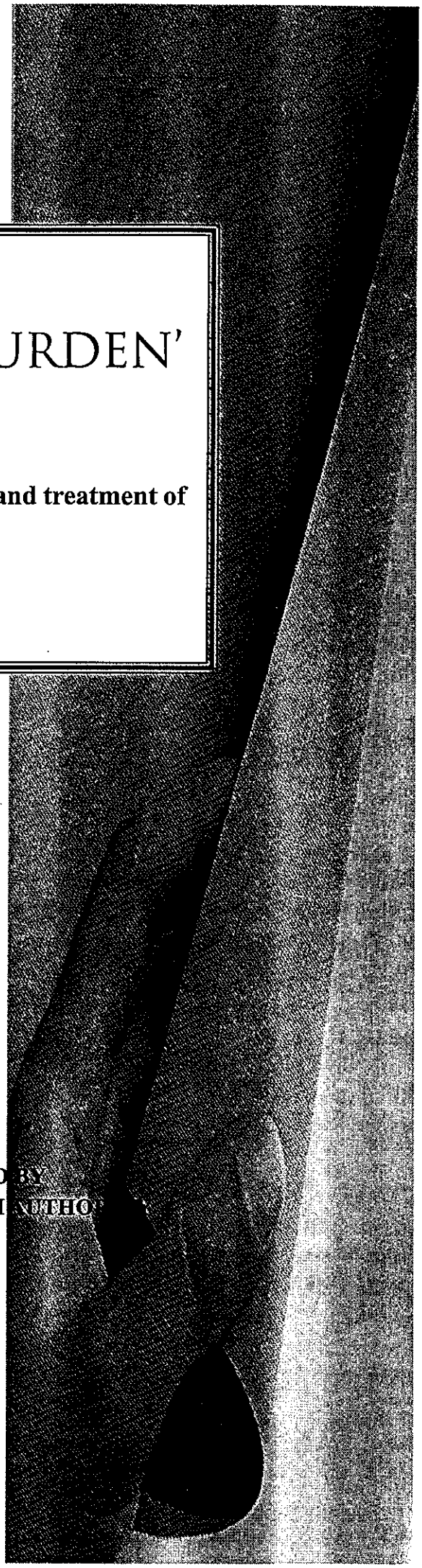
'SHARING THE BURDEN'

An independent inquiry into the care and treatment of Desmond Ledgester



A REPORT COMMISSIONED BY
CALDERDALE & KIRKLEES HEALTH AUTHO

1997

"It cannot be concluded that errors of judgement led to the killing of Malcolm Hodgson by Desmond Ledgester. It is our opinion that the killing could not have been predicted. It is clear that services failed Desmond Ledgester and his family by failing to 'SHARE THE BURDEN' of caring for a severely ill young man"

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PREFACE

I was commissioned in May 1997, by Calderdale and Kirklees Health Authority, to Chair an Independent Inquiry into the care and treatment of Desmond Ledgester whilst he was a patient in the care of Calderdale Healthcare NHS Trust.

I now present the Inquiry Panel's report, having followed the Terms of Reference under which we were commissioned.

We believe it is only when it can be seen that the concerns which we highlight in this report are being addressed and acted upon that it will be possible for the family of Malcolm Hodgson to begin to make some sense of his death.

Signed

V J Double (Mrs)

ACKNOWLEDGEMENTS

The Committee's very grateful thanks go to all the witnesses who gave evidence. Their frankness and willingness to cooperate undoubtedly considerably aided our inquiries.

In particular we would like to thank Mrs Eccles, Desmond's mother, for her willingness to talk openly and frankly to us. She raised many important questions which the Panel have considered during their deliberations.

We are also grateful to Desmond Ledgester for giving us the opportunity of hearing his account of the events.

My colleagues and I wish to record our gratitude to Gillian Longbottom who, as secretary to our Inquiry, liaised with everyone involved, organised all the meetings and interviews, the results of which were always very quickly turned into typed documents.

Our thanks also go to Sharon Holleworth, Assistant Chief Executive of Calderdale and Kirklees Health Authority, who gave us invaluable help and advice.

Finally, my personal thanks go to my three colleagues, Peter McGinnis (Director of Nursing and Quality, Leeds Community Mental Health Services), Terry Nelson (Retired Consultant Psychiatrist) and Jeremy Pritlove (Development Officer Mental Health, Leeds Social Services), whose professional input has been essential. Their very different areas of expertise and ability to elicit information from those interviewed has been invaluable and determines for me the need to involve professional expertise from broadly differing backgrounds in independent inquiries.

TERMS OF REFERENCE

Our Terms of Reference were as follows:

Independent inquiry under HSG(94)27 into the circumstances surrounding the care and treatment of Desmond Ledgester.

1 To examine all the circumstances surrounding the care and treatment of Desmond Ledgester by the mental health services of Calderdale Healthcare NHS Trust, in particular:

- the quality and scope of the health and social care
- the assessment and management of risk
- the appropriateness of the treatment, care and supervision in respect of:
  - his assessed health and social care needs
  - his risk assessment (in terms of the risk of harm to himself and/or others)
  - any previous psychiatric history, including drug or alcohol abuse
  - the nature of any previous involvement with the criminal justice system including the outcomes
- the appropriateness of the professional and in-service training of those involved in the care of Desmond Ledgester or in the provision of services to him
- the extent to which statutory obligations were met in care plans (including Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers HSG(94)5 and the discharge guidance HSG(94)27
- the extent to which local policies were adhered to in the care plan
- the extent to which the care plan was:
  - effectively drawn up
  - effectively delivered
  - complied with by the patient
- the details of any medication including retrospective information and the patient's compliance.

2 To examine the adequacy of collaboration and communication between:

- the agencies involved in the care and treatment of Desmond Ledgester
- the agencies and Desmond Ledgester's family.

3 To prepare a report and make recommendations to Calderdale and Kirklees Health Authority.

4 To publish those recommendations.

METHOD OF WORKING

The Panel held its first meeting on 6 May 1997 and met on twelve further occasions during which the interviews were carried out, the final interview being held on 23 October 1997.

We then held four further meetings to write our report which was presented to the members of the Health Authority on 8 January 1998.

Desmond Ledgester will be referred to as DL throughout the report.

SHARING THE BURDEN

An inquiry into the care and treatment of Desmond Legester

THE INCIDENT

Around 1.10 am, on the morning of Wednesday 21 June 1995, DL's step-father was asleep at his home when he was disturbed by a noise and, on investigation, found DL lying on a bedroom floor in the house. He escorted him from the house and on doing so noticed the body of a man lying on the ground, face upwards, a few yards from his own house. Police officers were called and discovered the body of Malcolm Hodgson. He had a cut across his neck, his mouth was open and it was apparent that a necktie had been forced into it with just the tip showing through the man's lips.

DL was arrested soon afterwards and interviewed about his entry into his step-father's house and the attack upon Malcolm Hodgson. He denied any involvement but it was noted that the palms of his hands were heavily stained with black paint which, following detailed forensic evidence, was also found on Mr Hodgson's body.

Following an examination by the police surgeon, Dr Lord, DL was interviewed at length but denied any involvement in Malcolm Hodgson's death. Eventually the police were left with no option but to release him from custody having ascertained from Dr Prince, Locum Consultant Psychiatrist, that DL could not be compulsorily detained under the Mental Health Act 1983.

Mrs Eccles, DL's mother, told us that after his release from custody he kept asking her *'What if I have done it?'* and she would reply *'They've let you go so you can't have done it'*. When asked if she thought DL was upset at the thought he might have done it, she replied that he didn't know if he had or not.

Around 9.48 am, on the morning of Thursday 6 July 1995, DL was re-arrested. Because of concerns about his mental state and the consequent reliance which could be placed on his answers to questions, arrangements were made for DL to be examined by Dr Lord and Dr Prince.

Both doctors and Mr Mark Haigh, a solicitor representing DL, were briefed by Detective Superintendent Whittle about the need to differentiate between fitness for detention and fitness for interview. It was stressed that the latter involved an assessment about the reliance which could be placed on DL's responses to police questions. He was duly examined by Drs Lord and Prince in the presence of his solicitor and deemed by the medical practitioners as fit to be interviewed.

In the subsequent interview DL admitted responsibility for Malcolm Hodgson's death but declined to go into any detail about the circumstances leading up to it or the act itself. He said that he had heard voices in his head urging him to *'do him, do him in'*.

After being charged with the offence of murder, DL appeared before Halifax Magistrates Court and was remanded in custody to Leeds Prison. His violent behaviour there resulted in him being examined by Dr Alexander Shubsachs, a consultant forensic psychiatrist and clinical director at Rampton Hospital, who was of the opinion that DL was suffering from a mental illness (Schizophrenia) of a nature and degree warranting his detention in hospital for medical treatment for his own health and safety and for the protection of others.

Dr Subsachs was also of the opinion that DL was unfit to plead and was currently a grave and immediate danger, following which DL was transferred to Rampton Hospital on 26 July 1995 under the terms and conditions of Section 48/49 of the Mental Health Act 1983.

DL appeared before His Honour Judge Coles at Bradford Crown Court on 21 December 1995. He pleaded guilty to the manslaughter of Malcolm Hodgson on the grounds of diminished responsibility. In his evidence to the court Dr Shubsachs expressed the view that DL was now fit to plead and not under any disability regarding his trial. He, however, went on to express the opinion that in an unmedicated state DL represented grave and immediate danger to the general public and required to be treated in conditions of maximum security.

His Honour Judge Coles told DL that it was clear he was suffering from a mental illness involving delusions and persecution complex and he was still a danger to the public and himself and committed him to be detained in a secure unit under section 37/41 of the Mental Health Act 1983 without time limit.

MALCOLM HODGSON

It was not in our remit to look into the circumstances of the victim, but we were informed that he was a 60 year old bachelor who had lived in Halifax all his life. He had worked for the Yorkshire Water Authority until his retirement some six years prior to his death. He had lived with his parents up to their deaths, following which he lived on his own.

DESMOND LEDGESTER SEPTEMBER 1969 TO NOVEMBER 1993

DL was born in Huddersfield on 13 September 1969. His mother is English, his father Jamaican and his brother was born some two years later than DL. His parents separated when DL was a young child although he kept in contact with his father. DL now has a half sister who was born in 1989. His birth, early development and childhood were all normal. He suffered from the usual childhood ailments and in 1975 he was diagnosed as having non-specific toxic arthritis which resolved itself spontaneously.

DL is reported as saying that he enjoyed all school subjects and particularly sport. During his fourth year at secondary school, due to one of the family's frequent house moves, he transferred to another school. At this stage he lost interest and started to play truant. He felt that the teachers at this school were ignoring him and that he was always getting into trouble and being caned.

From the age of twelve DL became involved in crime as follows:-

Calderdale Juvenile Court

21.10.81	Burglary and theft - 12 months conditional discharge
14.12.83	Theft from a vehicle - Attendance Centre 24 hours and £1 compensation
28.3.84	Theft/Shoplifting - Supervision Order 12 months
20.6.84	Robbery - Supervision Order 2 years
12.2.86	Burglary with intent to steal and a non-dwelling theft - Supervision Order 2 years

DL left school at 17 years and then entered various types of employment including some associated with training schemes which were in connection with various trades, ie. motor vehicle mechanic, bricklaying and catering. He went on to gain an NVQ in bricklaying.

His criminal activities continued into adult life as follows:-

Calderdale Magistrates Court

23.12.86	Criminal damage - Community Service Order 180 hours. Compensation £229
	Theft from dwelling - Community Service Order 120 hours, concurrent. Costs of £7
	Handling - Community Service Order 120 hours, concurrent
20.10.89	Criminal damage - fined £40 plus compensation £17
	Assault - Occasioning Actual Bodily Harm - Community Service Order 180 hours
	Assault on police officer - Community Service Order 180 hours

On 1 April 1992, at the age of 22, he was charged at Manchester Crown Court with possessing a controlled drug with intent to supply and was sentenced to 6 months imprisonment suspended for 12 months.

DL enjoyed relationships and had several girlfriends of which 2 seemed to be 'serious'. The second of these 2 relationships resulted in the birth of his daughter in April 1993. His mother informed us that 2 days after the birth of his daughter his girlfriend finished with him and it was at that stage that DL's mother first noticed he was changing. She thought this was due to depression.

DL's mother told us that as the months went by she felt his mood and personality were changing and she used to advise him to get an appointment with the doctor. She said that although DL had his own flat he used to return home almost every day and started to say that people were going into his house. He believed that people were trying to poison him and he put padlocks on his fridge. She commented to us that the number of times he changed his locks *'was unbelievable'*.

During this period DL had been involved in a fight which resulted in part of his ear being bitten off. After this he always maintained that he had a microchip in his head. His mother described how it was difficult to get DL involved in any

activities as he mistrusted everyone. He would not listen to the radio or watch television as he felt all the programmes were directed at him personally. The only person he visited was her and he cut himself off from what had been a fairly large circle of friends. He was out of work and would not 'sign on'. His mother said she would sometimes take him to Woolworths for his breakfast.

Eventually, Mrs Eccles took DL to see his general practitioner, Dr Ormerod, in November 1993. This was the commencement of DL's contact with formal mental health services.

PSYCHIATRIC CARE
NOVEMBER 1993 - NOVEMBER 1994

25.11.93

Mrs Eccles took DL to see his GP, Dr Ormerod. DL was complaining of feeling lousy and wanting to *'do himself in'* to escape from everything. He said that he had felt like this for 12 months. Dr Ormerod told us that, following examination and discussion with DL, he did not appear to be suffering from any biological symptoms of depression but was deluded and paranoid. He was complaining of being controlled by his friends and that people were devising plans against him. He also said that he had switched the television off as he felt the programmes always related to him personally. DL told Dr Ormerod that he was not taking any other form of drugs, although Dr Ormerod found out later that this was not true. Dr Ormerod referred DL to Dr S Garbett, Consultant Psychiatrist, as he felt DL was psychotic.

16.12.93

Dr Garbett saw DL in her outpatient clinic and following a period of discussion with him she wrote in the case notes, *'that unless this man is a total fraud, I am sure he is suffering from schizophrenia'*. She also stated that he had a degree of insight into his problems and appeared to be trying to adjust himself to the fact that he was quite severely mentally ill. She recorded in the notes that one of DL's worries was that medication produced side-effects and, after some discussion with him, she prescribed Risperidone[1] 1 mg increasing to 3 mg twice daily, and arranged to see him in one weeks time.

23.12.93

DL was seen again by Dr Garbett in her outpatient clinic. He said that he was taking his Risperidone and appeared calmer. Arrangements were made to see him again the following week.

This pattern of regular outpatient consultations continued.

30.12.93

Dr Garbett's entry on this visit stated that DL was improving but as he still had a weeks supply of tablets left, compliance with his medication was not so good. He also complained of not sleeping and was given a further prescription of Risperidone 3 mg twice daily for four weeks, to which was added Zimovane[2] 7.5 mg at night together with an appointment to be seen again the next week.

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[1] A newer anti-psychotic drug used in the treatment of major mental illness—BNF catagory 4.2.1.

[2] Hypnotic drug used to aid sleep—BNF catagory 4.1.1.

6.1.94

DL was reviewed again by Dr Garbett who felt he was still improving and gave him a further prescription of Zimovane and a further appointment for 2 weeks time.

20.1.94

At this appointment DL said he was feeling better and able to talk to people although he still felt people were interfering with his brain. Dr Garbett made a note that she felt DL became paranoid easily.

He was given a further 4 weeks supply of Risperidone 3 mg twice daily and Zimovane 7.5 mg at night and it was agreed that DL would be seen again in 6 weeks time.

Dr Garbett's letter to Dr Ormerod following this visit stated *'condition continues to improve and although he is apparently unaware of it, many of his ideas of reference and passivity feelings are now drifting into the background of his consciousness. He has started socialising and his confidence has subsequently improved'.*

17.3.94

At this outpatient appointment DL told Dr Garbett that his ideas had gone away but he was no better. The entry in the case notes stated *'refer to CPN for assessment'*. This does not appear to have happened on this occasion and there is no mention of it in the letter Dr Garbett wrote to Dr Ormerod on 30 March 1994. She informed him in this letter that although she felt DL was much better and that most of his paranoid symptoms had gone away, DL himself had said that he wanted his tablets changing as he said he felt occasionally restless and edgy. She suggested that he continue with his current medication and added Procyclidine[3] 5 mg when necessary and Thioridazine[4] 50 mg when required for insomnia. She agreed to see him again in 4 weeks time.

14.4.94

At this appointment DL said he was not eating and sleeping properly and was asking for Temazepam[5]. This was declined by Dr Garbett and she suggested that he stop taking his Risperidone and increase his Thioridazine to 75 mg at night. She also said that she would refer him to the Community Psychiatric Nurse (CPN) for further assessment.

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[3] A drug used in the treatment of Parkinsons Disease and in Parkinsonian side-effects produced by anti-psychotic drugs—BNF catagory 4.9.2.

[4] Anti-psychotic drug with some sedative properties—BNF catagory 4.2.1.

[5] Hypnotic drug used to aid sleep—BNF catagory 4.1.1.

4.5.94

Dr Garbett wrote to CPN Terry Dutchburn asking him to help in further assessing the problems of DL. Her letter stated:-

> *'Mr Ledgester always seems very cheerful when I see him in clinic but complains of paranoia, with ideas of reference when he watches the television as well as anorexia and insomnia.*
>
> *I have treated him with Risperidone which has made little difference, although he does get some help from Thioridazine and is now being prescribed 75 mg of this each night.*
>
> *He sees one of his main problems as a worry over whether or not his girlfriend's child is his own, as he thinks the child's colouring is different from his.*
>
> *Mr Ledgester lives alone and attends a training programme where he is learning to be a builder'.*

She finishes by saying that she will continue to monitor DL's progress in her outpatient clinic.

7.5.94

Terry Dutchburn and a newly appointed CPN, Nick Sellers, went to DL's house to undertake a first assessment[6]. When they arrived at DL's house on 7 May 1994 they found it was dark, the curtains drawn and there was subdued lighting. They felt, very quickly, that this atmosphere was linked to his state of mind. He referred to numerous ideas of reference to music he was listening to, or had stopped listening to, because he felt they were referring to him specifically. He told them that he felt his girlfriend had some sort of malevolent intent towards him.

Nick Sellers informed us that for someone who was so unwell DL was very willing to share his thoughts with himself and Terry Dutchburn. Nevertheless, they came to the conclusion that DL was a very ill young man. Terry Dutchburn's discussion with us confirmed Nick Sellers' account.

DL told them that he had been involved with the mental health services before and that his medication didn't seem to help. He got the feeling that if they could help relieve his stress he (DL) would do all he could to help them.

Having made their initial assessment they discussed with DL further therapy consisting of Depixol[7] injections on a regular basis. This, they recalled, DL readily agreed to.

During their visit neither CPN saw any evidence of substance misuse although, when asked, DL volunteered that up until 2 years previously he had been misusing substances. He admitted using LSD, ecstasy and marijuana but they did not feel he was under the influence of substances at that time.

Terry Dutchburn then allocated DL to Nick Sellers as his very first client. He monitored his case during a weekly supervision meeting, during which they went through each of his allocated cases.

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[6] Initial assessments are usually undertaken by F or G grade CPNs but as Nick Sellers was a newly qualified E grade he was, on this occasion, supervised by Terry Dutchburn.

[7] Anti-psychotic drug administered by long acting depot injection—BNF catagory 4.2.2.

19.5.94

Terry Dutchburn wrote to Dr Garbett outlining the result of their assessment of DL and suggesting that he be prescribed Depixol injections on a regular basis. This she agreed to.

16.5.94

DL was seen again in Dr Garbett's outpatient department. He said he was not feeling very good but found it hard to elaborate. He stated that he was not sleeping very well, claiming that he went to bed around midnight to 1.00 am and was waking at 3.00 am. He said that he dozed during the day but was still going to work.

Dr Garbett felt that he appeared low in mood, that he was *'flat and subdued'*, worrying about how he was going to pay his debts. He also talked about his child and the Child Support Agency.

She changed his medication to Paroxetine[8], 20 mg daily and, in Dr Garbett's records, there appears to be no mention by DL of the visit on 7 May 1994 by the CPNs.

27.5.94

DL commenced on Depixol, his initial dose was 10 mg. Having tolerated this he was prescribed depot injections of 20 mg every 2 weeks.

Nick Sellers continued to pay regular visits to DL but did not have any involvement with any of DL's friends or relatives. He told us *'I think his mother did a bit of cooking but apart from that nothing. He was a young man living on his own rather than heavy involvement with his family'.*

7.6.94

Nick Sellers wrote to Dr Ormerod (with a copy to Dr Garbett) bringing him up-to-date with DL's progress. In his letter he informed him that DL had commenced on his Depixol 20 mg every 2 weeks, as well as continuing to take the Paroxetine as prescribed in the last outpatient session by Dr Garbett.

Nick Sellers stated that he felt that DL's mood appeared to have lifted considerably since he first saw him and that he was verbalising an overall improvement in his situation, although he was still aware of experiencing ideas of reference primarily from the radio but also from the television. He was able to identify them as symptoms of his illness and the real belief he had had in them had reduced dramatically. He also noted that he had no further feelings of passivity.

In his letter he went on to say that DL felt his sleep was still impaired, although he described an average of about 6 to 8 hours sleep each night, which seemed to be sufficient for him. His appetite was still described as rather poor, but that appeared to have as much to do with DL's limited desire to cook for himself as limited interest in food.

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[8] A anti-depressant of SSRI type used in the treatment of depression—BNF catagory 4.3.3.

Nick Sellers reported that he had described the side-effects of Depixol to DL and that he was advised to see Dr Ormerod if he experienced any of these side-effects. DL was quite happy to continue his treatment with Nick Sellers, as it was at that time, which involved fortnightly injections and, exploring coping mechanisms for him to deal with any residual symptoms that may not be suppressed by the depot injection.

June 1994 to August 1994

During the period 27 May to 12 August 1994 Nick Sellers saw DL fairly regularly and gave him his depot injections of Depixol 20 mg.

Nick Sellers reported that DL appeared quite happy for him to continue giving him his injections. The somewhat irregular fortnightly pattern was due to DL not arriving or not being able to be found when his medication was due. DL was working on a building site over the road from the health centre where Nick Sellers was based and, for a few sessions, DL went to the health centre in his lunch break for his injections. He was predicting that the site was nearing completion and spoke of going to London to start building work down there. Nick Sellers told us that he had tried to dissuade him from doing this because he was not sure that he was consolidated enough in his recovery to undertake such a change in life style.

During this period, whenever DL missed his appointment for his Depixol, Nick Sellers made efforts to locate him. He informed us that on one occasion he called at DL's house unannounced and DL asked if, rather than letting him in, he could have his injection at the health centre. Nick Sellers told us that he felt this was DL's way of not having his injection. Much to his surprise, however, DL followed him straight away and said he had friends in the flat whom he did not trust and told him something on the lines of *'if I don't get back soon they will have sold everything!!'*.

In response to our questions regarding DL's mental state during this time, Nick Sellers told of the 2 occasions when his depot was overdue. One time he was suspicious and he felt DL was experiencing ill health. On the second occasion he did not feel there were any symptoms for him to be concerned about.

DL appeared to have received his last depot injection on 12 August 1994. He then stopped going to the health centre. Nick Sellers told us that he visited his house but he was never in. He did see him around the Halifax area on 2 or 3 occasions but he was never close enough for him to speak to. He said that DL did not appear overtly ill as he had been when the initial assessment was undertaken.

When asked if he had any reason why he felt DL had stopped attending for his medication, Nick Sellers told us that he suspected that he had started misusing substances again. On one of his visits it had been apparent that DL was smoking cannabis. As soon as he had been challenged, DL admitted this and described what Nick Sellers called a moderate level of one smoke a day. DL said he used it for its sedative substances and Nick Sellers had counselled him about taking mind altering substances.

Nick Sellers told us that he had then lost contact with DL and wondered if he had gone to work in London as he had not seen him around. He also told us that he mentioned to his GP, Dr Ormerod, that he was concerned that DL had gone. He wrote to Dr Ormerod (with copy to Dr Garbett) on 6 September 1994

informing him that he had been seeing DL on a regular basis to administer his depot injection and during this period his condition had appeared to improve markedly and that he was verbalising and had insight into his illness. He went on to say that he felt DL's return to good health coincided with his successful completion of the building trades course he was on. As a result of this he had been able to start work on a local building site. He went on to explain that the building site was over the road from the health centre where he was based and therefore DL would attend there for his injections. He further explained that this situation had worked well until a month prior to the letter after which DL had not turned up, and that he had caught up with him at his home a few days later. DL had repeated his desire to continue the treatment. Nick Sellers then stated that he had to report that since 12 August DL had not attended for his depot, despite his making 3 visits to DL's house and having offered a number of alternative appointments at the health centre. Nick Sellers concluded from the lack of response to his numerous visits and offers of appointments, that DL no longer wished to continue treatment and although *'saddened by this I had to accept that this was his prerogative'*. He finished by saying that he had left details with DL of how to get back in touch with himself if he felt that would be of help, and that he would be happy to re-engage DL.

DL's next engagement with the service was on 11 December 1994.

PSYCHIATRIC CARE
DECEMBER 1994 - APRIL 1995

Mrs Eccles told us that she felt the period from May 1994 to September 1994 was the best time for DL. After that he seemed to deteriorate again and she told us that on:-

11.12.94

She was talking to DL on the phone when he had told her he was taking an overdose as he was fed up with society. Mrs Eccles went down to his home and got him into hospital, the Royal Halifax Infirmary, where it was confirmed that he had taken 25 Paracetamol tablets. He admitted to not taking his previously prescribed medication, stating it did not work.

The medical records confirm that DL was admitted at 9.35 pm and had taken the Paracetamol at approximately 8.15 pm. He was very unsteady and distressed. He was seen at 10.00 pm by Dr Redman, SHO in A&E, and was found to be aggressive, distressed and suicidal. Following the administration of Ipecacuanha[9] he was admitted to Appleyard ward at Halifax Royal Infirmary, where he was reported to be very depressed and not willing to talk about his problems, but stated that he wanted to take his own life. He eventually settled and enjoyed a restful night.

[9] An emetic readily used in the treatment of self-poisoning

12.12.94

Due to a bed shortage it was decided to transfer DL to Kitchenman/Simpson ward at Halifax Royal Infirmary. This was completed at 10.15 am when DL was referred to the psychiatrist.

12.05 pm DL appeared anxious to be discharged as he wanted to go and 'sign on' for his benefit. He was advised to wait and see the psychiatrist. DL said that he wished to see the psychiatrist and the DSS were contacted and they agreed that DL could 'sign on' a day late if he was in hospital. This was relayed to DL and he said he was happy to stay and 'sign on' the next day.

12.40 pm DL decided that he wanted to take his own discharge. According to the nursing records the Medical House Officer was informed but would not visit the ward, stating that it was up to DL if he wished to take his own discharge.

1.05 pm DL took his own discharge and left the ward despite being advised to stay and see the psychiatrist.

The nursing staff notified the psychiatrist that DL had taken his own discharge and stated that they would post an appointment on to him.

2.00 pm Mrs Eccles phoned the ward and requested an appointment for DL to see a psychiatrist. She was told that he was known to the psychiatric department and that they would send him an appointment through the post.

23.12.94

DL did not attend for his psychiatric outpatient appointment. There is no indication of which consultant was involved or whether any follow-up arrangements were made to try and contact DL—we suspect not.

Our discussions with DL's mother revealed that during the next few weeks DL continued in a downward spiral. His mother further told us that he would not do anything, he was unkempt and, in her words, dressed *'like a tramp'*. He had previously been smartly dressed but with his declining mental state this disappeared. He would not let her into his house and he would not listen to the radio or watch television. He would not 'sign on' and she again said that she sometimes took him to Woolworths for his breakfast but he was always looking around. He spent most of his time in his house. She said that she had to force contact with herself on him and he would only come to see her when he needed something. He felt his food was being poisoned and he went back to painting the wallpaper in his house with a tiny paintbrush. The fridges were locked and he even got to the stage of questioning whether or not she was his mother.

10.3.95

Dr Ormerod told us that he remembered seeing a member of DL's family who gave him a history of him having delusions and psychosis. He had been aggressive and was pushing his mother about. He arranged that he himself or a CPN would visit DL and would recommend depot injections or compulsory detention under the Mental Health Act 1983. Dr Ormerod said he did not think

that the family felt it was an emergency situation. His feeling was that he had stopped having the depot injections and was beginning to relapse.

15.3.95

DL arrived at Dr Ormerod's surgery. He felt DL was quite anxious and psychotic, telling him that a microchip had been put in his bloodstream and he wanted tests. He mentioned the fact that he was having some violent feelings but these were mainly in order to protect himself. DL then left the surgery.

Dr Ormerod said that he made a note to contact Terry Dutchburn to see how he had got on with seeing DL and, in the meantime, he arranged to try to find DL with a view to admission to hospital. He said that DL was living above a curtain shop at the bottom of Pellon Lane. He could not gain entry and on his return to the surgery he telephoned Terry Dutchburn to see if he could find DL with a view to getting him admitted to hospital.

We spoke with an approved social worker, Brian Smith, who had had no direct involvement with DL. He worked at the Laura Mitchell Health Centre with 2 CPNs in March 1995, one of the CPNs being Terry Dutchburn. He remembered Terry Dutchburn being asked to see DL in respect of a rapid response team request from his GP over the previous two days. He told us that there was talk about a warrant to get into his premises. He contacted Dr Ormerod to try to find DL's mother's address but he did not have it. (He subsequently telephoned the psychiatric unit to find that DL had been admitted the night before).

At 7.50 pm DL was arrested for being in breach of the peace. The police had been called because DL was outside his mother's house wielding a baseball bat. On that evening he did not hit her with the bat, although on a previous occasion he had done so. The police were not too concerned about the offensive weapon but more concerned for DL's own safety and that of others. He was arrested and taken to the police station and, because of his mental state, Dr Lord, the police surgeon, was called to see DL and this he duly did.

Dr Lord felt that everyone wanted DL admitted to hospital and he said he had a long chat with him. DL told Dr Lord that he wasn't sure that his mother was his mother and he thought he was being victimised but he was unable to give Dr Lord an example of how.

DL told Dr Lord that he had been seen several times before and remembered Dr Garbett's name. He thought it was 2 years since he was last admitted (in fact, it was 11 December 1994). Dr Lord went on to tell us that DL was quite orientated in time and space and knew why he had been arrested. He answered all Dr Lord's questions directly and Dr Lord did not think there were any problems with thought disorder apart from paranoia.

DL told Dr Lord that he could not get a job and said his landlord was a policeman and he thought he was setting him up to get him into trouble. He continued to say that he thought his home was bugged and people were moving ornaments, messing around with his food, and that he was injected with a microchip.

As DL wanted to go into hospital, Dr Lord said he would arrange this.

When asked by us if the idea of a compulsory detention under the Mental Health Act 1983 ever arose, Dr Lord replied that, as DL had been agreeable to go into hospital voluntarily, this was not appropriate at that stage.

DL was informally admitted to ward F[10] at Halifax General Hospital during the late evening/night of 15 March 1995. The admitting nurse was Staff Nurse Julie Duckworth. He was placed under the care of locum consultant psychiatrist Dr Prince[11] who served the geographical sector which DL resided in.

In her admission notes, Julie Duckworth stated that DL was very willing to talk about his problems. He had paranoid ideas to a very great extent and found all aspects of his life were involved in these ideas. He felt his whole life was affected by a conspiracy and he thought he was being poisoned, his house was not safe, people could get in, the whole world was controlled by police and that he was part of an experiment which he could not get out of. DL seemed to have become totally isolated by his paranoia as everyone he came into contact with was either involved or laughed in disbelief.

Julie Duckworth found that at times DL seemed to be on the verge of tears and was unable to decide whether to fight or give in. Giving in, however, meant to him that he must die/kill himself. She noted that he had previously taken an overdose. Her records state that DL did not lack insight and was aware that he was probably mentally ill and wanted treatment, but was not able to trust a system that was controlled by the police.

His personality appeared to have remained intact and he was able to pursue activities of daily living, although cooking and eating had become a problem due to his belief that he was being poisoned.

DL was examined by Dr Sahota, the admitting doctor, and gave the same information as he had to Julie Duckworth. He also said that he had tried all illegal drugs and last took some cannabis on 13 March 1995. Dr Sahota recorded *'impressions - drug induced schizophrenia'* and he prescribed Chlorpromazine[12] 75 mg QDS.

Julie Duckworth produced a care plan copied overleaf.

She recorded that DL retired to bed at 1.45 am and at 7.15 am he had remained in bed apparently asleep all night.

16.3.95

Julie Duckworth then handed over to the day staff who recorded that he accepted his morning medication and ate some breakfast. He was still freely speaking of paranoid ideas and requested to visit his flat to check its security. He agreed to wait to see a doctor, following which there was a further request to visit home. He promised to return and left the ward around 10.15 am.

Dr Pool, Locum Senior House Officer, was contacted when DL had not returned. He said he was an informal patient and to contact his mother. This the ward staff did and she said that she had seen DL and that he was no longer aggressive.

At 8.15 pm DL returned to the ward. He spoke kindly of his mother and said he had been to his flat and seen to a few things. From his records he appeared to go to bed in a contented frame of mind and slept all night.

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[10] Ward F was an acute psychiatric ward.

[11] DL's Responsible Medical Officer changed due to sectorisation of the Mental Health Services in Calderdale.

[12] A traditional anti-psychotic used in the treatment of severe mental illness—BNF catagory 4.2.1.

Care Plan produced by Julie Duckworth

'Care Plan		
Problems	**Aims**	**Nursing Care**
1 Thought Disorder		
Extensive paranoid delusions	To reduce the paranoid ideas	a Observe and report any changes in mood up or down
		b Ensure DL takes his medication as prescribed
Victim of conspiracy	That DL will take regular medication	c Reassessment and sympathetic listening
		d Encourage DL to trust staff
Suspicious of authority - mainly police	To assess and observe	e Give DL time to ventilate his anxieties
2 Suicidal ideas		
	To prevent self-harm	a See 1a
Feels the need to die to end his problems		b To be aware of DL's ambivalence towards death
OR		c Encourage him to be positive about his future
needs to fight the conspirators		d Assess on a daily basis to decide on levels of close watch
3 Poor appetite		
Weight loss	That DL should eat an adequate diet and fluids	a Observe and record dietary intake
		b Ascertain weight loss if any
Believes food is poisoned		c Reassure DL that food is not poisoned
4 Regular user of drugs - LSD - Speed and ?Heroin and Methadone (in the past)	That DL shall continue to abstain from drug use	a Refer to Dashline
		b Supportive counselling re. drug use
Perceptual problems 'Flash Backs' Drug induced psychosis'		c Non-judgemental approach

17.3.95

DL was reported to have woken in a reasonable humour but declined to take his medication in syrup form. He was advised that this was the same as the tablets to which he replied *'I haven't taken any of them yet'*. DL then said he wanted to discuss the matter with the doctor and became increasingly agitated as the morning wore on due to the non-appearance of the doctor, who was in the outpatient department. He left the ward and returned on three occasions.

During the afternoon DL's mother and aunt came to visit him, during which the three of them were seen by Dr Pool. His mother said how his behaviour had improved since the day before, although it was noted that DL was still demanding a brain scan, was argumentative, and refused to stay in his room. DL left the ward after this. At 5.00 pm he returned to the ward with no signs of aggressive behaviour, accepted his medication and sat and watched television for most of the evening. He later appeared a little restless, pacing up and down the ward.

DL spent the early part of the night staff's shift listening to records and dancing up and down the ward. He accepted his 10.00 pm medication and retired to bed and slept until 1.15 am when he said he could not sleep. He was given Zopiclone[13] 7.5 mg, following which he returned to bed and settled.

18.3.95

DL accepted his morning medication and breakfast. At 10.00 am he went home to do some physical exercise and to go out shopping with his mother.

Staff Nurse Frank Kelly returned from his days off and was allocated to DL as his key worker. He then reviewed DL's care plan, as drawn up by Julie Duckworth on his admission on 15 March 1995. He initially confirmed that there were only 2 main elements regarding the care plan - that the patient was deluded and felt persecuted and had expressed suicidal ideas in the past. He immediately discounted the second element because over the previous 48 hours DL had shown a rapid improvement and had been off the ward on a number of occasions. Frank Kelly told us that *'it didn't seem to be relevant'*.

There was no indication from Frank Kelly of the two additional elements that Julie Duckworth had identified, namely adequate diet and fluids and continued abstinence from elicit drug use.

DL returned from visiting home at 12.30 pm. He was very accusatory of others, saying that his notice on his bedroom door had been altered and his things in his bedroom had been tampered with. He then became involved in a heated argument with another patient following which he was allowed to ventilate his feelings and an explanation was given to diffuse the situation by Staff Nurse Gough. He was encouraged to go out for a short walk and he seemed to be calm on his return to the ward. DL spent a very quiet afternoon and evening mostly on his bed, leaving the ward at 8.00 pm and returning at 9.40 pm.

He accepted his medication, went to his bedroom, and settled.

[13] Hypnotic drug used to aid sleep—BNF catagory 4.1.1.

19.3.95

Records show that DL spent all morning in his room, and staff report that there was no opportunity to assess his mood.

At 8.00 pm he refused his evening meal because he thought he was being poisoned but accepted a 'take away' meal brought in by his mother.

He accepted his prescribed medication but did not swallow it in the presence of the staff. He was reported to be very bad tempered and easily provoked. He spent a lot of time in his bedroom in an agitated state, appearing to have taken illicit substances and was now socialising readily with a known drug dealer from ward G[14] at Halifax General Hospital.

DL spent a quiet night in his room and accepted his medication.

20.3.95

The nursing and medical case note entries for this day are somewhat confusing.

Staff Nurse Frank Kelly made an entry in the nursing notes as follows -

'WARD ROUND - not seen in ward round. He had left the ward before we could obtain a urine sample, continue with present regime.'

Dr Pool records in the medical notes -

> *'WR To discuss with police any record. Reported to be paranoid last night, expressing that food may be poisoned, has left ward this am, D/W Dr Prince may need to have a section applied, not to leave the ward without permission if he returns. W/e kept quite contained his paranoia, able to engage in reasonable discussions.'*

Staff Nurse Gough records in the nursing notes -

> *'Seen in the ward round, placed himself with his back to the door, behind 3 chairs. Wants a CT scan to show a computer chip in his brain, blamed S/N Cavanagh and her colleagues for going into his room and moving things around just to upset him. Very hostile - says half of him is good and half is bad. Prescribed Clopixol[15] depot 100 mg Clopixol 20 mg orally on day one, 20 mg TDS after. Clopixol accuphase 150 mg I/M Lorezapam[16] 4 mg if he will take it.'*

She also records that DL said *'if anyone tried to do anything against his will they will have to fight him.'*

Dr Pool further records in the medical notes on 20 March 95 - *'SB Dr Prince Clopixol test due.'*

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[14] Ward G was an acute psychiatric ward adjacent to Ward F.

[15] Anti-psychotic drug used in major psychiatric disorders, which is used in:

a) tablet form

b) a long acting depot injectin vis Depixol—BNF category 4.2.2 and

c) a shorter acting depot—Clopixol Accuphase, which is used in the treatment of acute episodes of psychotic disturbances—BNF category 4.2.1..

[16] Anxiolytic preparation used for anxiety, and by injection, for acute anxiety and disturbance—BNF catagory 4.1.2.

The later nursing records of that day show that DL had been very settled, apologising for his previous outburst and had slept without night medication.

21.3.95

DL remained in bed until lunchtime. At 2.10 pm he took a telephone call from his mother, then became very irate and said that the staff were trying to poison him, and said that he was going to the general hospital to find the result of an HIV test which had been taken when he had part of his ear bitten off.

The nursing records show that Dr Prince contacted nursing staff and advised over the telephone that they should *'wait and see'* what happened regarding a compulsory detention under the Mental Health Act 1983.

At 6.00 pm DL returned to the ward, he went straight to his room and declined his medication. During the night he was found smoking in his room and was told that this was not allowed. He became very rude, saying he would go home and smoke, spat out his medication, then settled for the night.

22.3.95

DL appeared to follow his normal pattern during the morning and left the ward without acknowledging anyone and took his possessions with him. Staff felt that he would probably return during the afternoon.

A case note entry was made to indicate that he had left the ward.

At 7.35 pm the nursing record entry states that DL was still missing from the ward, with no communication received as to his whereabouts.

Neither the nursing nor medical records indicate any contact having been made with his mother about the fact that DL had left the ward.

23.3.95

A further entry in the nursing records made by the night staff at 4.30 am reports that DL was still missing with no communication being received as to his whereabouts. Dr Pool wrote in the medical notes that *'DL is AWOL. If he returns to the ward to be reviewed by Dr Prince re ? section'.*

A final entry in the nursing records for this admission is made by Staff Nurse L Eastwood - *'Dr Prince was advised re Des being AWOL - If he has not returned by 5.00 pm he is to be discharged. 5.00 pm still no news of Des therefore discharged in his absence'.*

24.3.95

The entry in DL's medical notes reads *'has been discharged in his absence'.*

3.4.95

DL went to see his GP but saw another doctor in the practice, Dr Ellwood. Dr Ormerod told us that he had spoken to Dr Ellwood about this visit who had informed him that DL was concerned about his ear since it had been bitten and he was concerned that he had AIDS and Hepatitis and wanted tests. Dr Ellwood

said that DL had told him he was not on any treatment and had discharged himself from hospital. He said he was using drugs and was heterosexual. Dr Ellwood told Dr Ormerod that he had not felt that DL had come across as being unduly deluded.

7.4.95

DL attended the Accident and Emergency department at the Royal Halifax Infirmary complaining of pain in his right foot but departed before treatment.

Brian Smith met DL when he was attending Dr Prince in the outpatient department with another client. A telephone message came through saying that DL was wanting to see a doctor. He remembered that Dr Prince said there was no one else available and he therefore had to see him. He was asked to stay until a junior doctor arrived as Dr Prince said he was nervous to be on his own with DL. He remembered DL coming into the room and was surprised at his size and demeanour, as he had expected someone much larger and aggressive from the way Dr Prince had acted. He told us that DL was very apologetic about leaving the ward and that Dr Prince was querying his use of drugs. He was then readmitted to F ward at Halifax General Hospital under the care of Dr Prince.

Dr Pool assessed DL on admission. He found that he wished to return to the ward voluntarily and agreed to take his medication. He felt he was generally the same, with thoughts that his body was not balanced. His mother who was with him said he had been managing at home. DL stated that he believed that his flat had been bugged and also believed that there was special significance in the colour of his clothes and sexuality, although he did not enlarge upon this.

He was found to be well dressed and well mannered.

Dr Pool found his mood to be distressed objectively and normal subjectively. His speech together with his thoughts were of normal rate and volume but of delusional content. DL refused to have any blood and urine tests performed.

The plan was to admit him as an informal patient with medication of Clopixol 20 mg by mouth four times per day.

The admitting nurse on that day was Staff Nurse Frank Kelly, who had been his key worker during his previous in-patient stay. He told us that he saw DL on this occasion for about 5 minutes. DL came onto the ward and went straight to bed. Frank Kelly told us that it was mentioned to him that because of DL's previous record they were not going to rush him and he therefore left him to settle - especially as he was on duty until 9.00 pm that evening.

He told us that at 7.00 pm DL was visited by his family and there followed what appeared to be a heated argument but not severe enough for him to intervene. At 7.15 pm DL left the ward with his family without speaking to any of the ward staff. Staff Nurse Frank Kelly told us that he did not feel it necessary to contact any of DL's relatives to tell them he had left the ward as he had left with them.

Mrs Eccles told us that when she visited DL on F ward that night he was just sitting in the room on his own and had said there was nothing to do. She said he might as well go home.

Mrs Eccles also told us that during both admissions to F ward she was never approached by the nursing staff. She once met Dr Prince and he had mentioned schizophrenia and paranoia.

In response to our questions she said she was never given any support or information about schizophrenia. She contacted MIND and they sent her leaflets. She also said that she had learnt more about schizophrenia from watching Eastenders recently than she had ever learnt from the hospital.

The night staff made an entry in the nursing records that there was no word from DL and that the duty doctor, Dr Chaudley, had been informed.

10.4.95

Staff Nurse Julie Duckworth told us that she arrived on duty that morning to be told that DL was AWOL having been on the ward for approximately 2-3 hours on Friday 7 April 1995.

She wrote a limited care plan copied as follows:-

	Problems	**Aims**	**Nursing Care**
10.04.95 12.00 md	DL is AWOL AWOL from 7.30 pm on day of admission	That DL return to the WARD Needs to be assessed ? Discharge or Section'	- To await his arrival back on the ward - Evaluate on DL's return - Discharge in his absence from ward round

She told us that, at the ward round, there was a view to discharge him whilst AWOL. This she said was not her view, but Dr Prince was adamant if he didn't come back for the ward round he would be discharged. When asked if there was any plan to talk to Dr Ormerod, Staff Nurse Duckworth told us 'no' but there would be a discharge letter which would be sent to him. This Dr Pool dictated on 21 April 1995 and it was typed on 15 May 1995. The letter was sent to Dr Ullah of the same practice.

THE INTERNAL INQUIRY

An internal inquiry was undertaken by Calderdale Healthcare NHS Trust in November 1995, the Panel consisting of internal and external personnel.

The Terms of Reference were as follows:-

1 To determine the facts concerning the relevant contacts between DL and the care providing services.

2 In relation to (1):

   a) to determine if the appropriate policies and operational procedures were in place in Calderdale Healthcare NHS Trust

   b) to determine if the appropriate policies and operational procedures were followed

   c) to determine what lessons can be learned, to report to the Trust Board and to make recommendations.

3 In fulfilling these terms of reference the Inquiry will need to consider:

   a) the policies and operational procedures in place at the time in relation to statutory requirements, to guidance and good practice and whether HSG(94)27 was complied with

   b) the medical history of DL, the diagnosis, the risk assessment and the circumstances of discharge.

They made seven recommendations:

1 That paragraph 2(f) in the document 'Procedure To Be Undertaken For Patients Absent Without Leave of Calderdale Care Programme Approach', should be expanded. Where it relates to informal patients, it should include a documented risk assessment by the RMO and the multi-disciplinary team as well as the assessment of any appropriate community support. It was appreciated that this goes beyond the current policy of assessment by the consultant and ward team and the implications of this recommendation on the Social Services Department would need to be considered.

2 That the CPA policy should have provisions explicitly requesting a patient risk assessment for patients with complex needs by a multi-disciplinary team before discharge. The medical records should document the factors taken into account in reaching risk assessment conclusion. Guidance should also be offered on a non-prescriptive basis of the factors which a risk assessment should consider.

3 All staff, including psychiatrists, must make it a priority to attend training sessions provided for CPA and this must be reinforced by management action.

4 Procedures for outpatient appointments should be reviewed to ensure that it is the responsibility of an identified member of staff to make outpatient appointments following the patient's discharge.

5 That secretarial support for psychiatrists is adequate to ensure that discharge letters to GPs are despatched in a timely manner. It is noted that Consultant Psychiatrists are now each provided with a secretary.

6 It should be noted that the implementation of major new policies takes time and it is not realistic to expect that the production of a novel complex formal policy will be automatically followed from implementation date by staff without considerable training and monitoring effort.

7 That procedures are reviewed in the case of patients admitted with self-harm to A&E department with a view to ensuring that patients previous contacts with mental health services are known to A&E staff.

POLICIES/PROCEDURES

During the period November 1993 to April 1995 there were a number of policies and procedures in the Trust which were pertinent to the treatment and care of DL.

POLICIES

The following were in operation:-

CPA Guidance for staff in Calderdale Healthcare NHS Trust and Calderdale Social Services, this included:

- Documentation for Hospital Discharge
- Guidance for Community Staff and CPA Key worker
- Information for Patients/Clients
- Information for Staff
- Observation Policy

PROCEDURES

- Hospital Discharge Procedures
- Clinical Risk
- CPN Quick Response/Deliberate Self Harm
- Patients AWOL

We unfortunately could find no evidence of comprehensive written policies/ procedures on the following:-

- Transfer of Information between Community and Hospital
- Communications between Staff of all Disciplines and Sectors
- Guidance on Working with Carers.

STATUTORY SERVICES FOR MENTAL HEALTH IN CALDERDALE 1993-1995

a) Calderdale Healthcare NHS Trust

The Trust at this time worked in partnership with the West Yorkshire Health Authority and the Calderdale Metropolitan Council in providing comprehensive mental health services.

The Trust operated its acute in-patient beds on 2 hospital sites at Halifax General Hospital and Northowram Hospital. F ward and G ward, both acute psychiatry wards, were based at Halifax General Hospital. DL had spent both of his in-patient stays at F ward. 53 acute beds were available at Halifax General Hospital while 48 beds at Northowram provide acute and rehabilitation facilities.

Plans were in place to reduce the Trust dependency on the Halifax General Hospital site by transferring services to Northowram. Plans additionally identified the development of a new 96 bedded facility for mental health services replacing services at Northowram by the year 2000.

Since 1987, community services had been sectorised and were coterminous with Social Services boundaries. There were 4 geographical areas, namely Upper Valley and Lower Valley, North and South Halifax. At the time the community services were being aligned with GP practices. Community mental health teams were in an embryonic stage with some social worker and CPN joint-working evident. A quick response/deliberate self-harm team was in its pilot form in January 1995 offering a limited out of hours service.

A 'street based agency' called DASHLINE provided a drug and alcohol service, based in the centre of Halifax addressing issues of assessment, counselling, advice, needle exchange and outreach. One consultant psychiatrist with a special interest in substance misuse devoted 3 sessions a week to this work. Additionally, the Trust had developed a court diversion scheme with a consultant psychiatrist attending court one session per week and a CPN 5 sessions per week.

Sessions for older people, children and adolescents and rehabilitation were available from the Trust but are not linked and therefore not covered by this inquiry.

At an operational level, mental health services were managed by a team headed by a clinical director, Dr Patsy Chapman, and a service manager, Mrs Kate Kilshaw. Mrs Kilshaw was also, as Director of Nursing, the Executive Director responsible at Board level. An assistant service manager, Mr S McDonnell, worked with several nurse managers covering day to day services. Mr G Nichols provided day to day management to adult mental health services which included in-patient services at Halifax General Hospital. John Ketteringham complimented that work by managing the community teams as well as taking a lead role in the implementation of the CPA.

A service management team and strategic implementation groups offered strategic direction for mental health services through a number of working groups.

DL's in-patient stay predominantly applied to F ward which had a nursing staff establishment of 21.79 WTE. The total nursing staff establishment available to mental health at the time was 260.95 WTEs. By 1997 this had been significantly increased to 302.49 WTEs.

b) Calderdale Social Services

Evidence submitted to us suggested that during the period we are concerned with, integration of Social Services and the Trust mental health services had some long way to go.

There was an approved social worker based in Halifax General Hospital who had clearly built up extensive and close links with the mental health medical and nursing services. Social workers were not however directly linked to Community Mental Health Teams and the system was complicated by Social Services having different management arrangements for social workers in mental health.

We understand that, from late 1996 onwards, a number of steps have been taken by Social Services to improve co-ordination with the Trust, especially in terms of developing Community Mental Health Teams.

Despite this apparent lower level of integration in 1994/95, Social Services were clearly readily available to help with care if and when they were contacted.

CORRESPONDENCE WITH DR PRINCE

Dr Prince, as the most recent consultant in charge of DL's care, was the senior medical member of both the community and multi-disciplinary teams and therefore someone we felt it was essential to interview. At the time of the Inquiry he no longer worked for Calderdale Healthcare NHS Trust and much time was spent in trying to make suitable times for us and him to meet, either in Yorkshire or where he currently worked.

An appointment was made for 19 August 1997 and we were informed on 18 August 1997 that Dr Prince had had to go home to Sri Lanka on urgent business and would not be attending.

The following two letters are self-explanatory:-

'*Dear Dr Prince*

INDEPENDENT INQUIRY - DL

I was sorry to learn that due to your sudden departure from Rampton Hospital, to attend to urgent business at home, you were unable to keep your appointment with the Panel of Inquiry.

You will appreciate that considerable time has been spent on contacting you and making appointments that were convenient to you and all to no avail.

I feel I should remind you that we have received a copy of the internal inquiry by Calderdale Healthcare NHS Trust which, of course, includes your statement. In our inquiry we have received oral evidence from all staff involved in DL's care and it would be most unfortunate if we did not have the opportunity of receiving your account of your involvement.

The inquiry has no powers to compel anyone to appear and therefore the Panel will have to come to its findings on the basis of the information available and the evidence from those who have appeared. They may of course have given us accounts which are at variance from your recollection of events and it seems

If we are not able to see you, the inquiry will have to base its findings on the evidence on those who have appeared before us, and we may have to reach findings about your involvement in the case based upon what others tell us.

May I urge you to make contact with us, our inquiry will cease taking evidence on Friday 25 September 1997. After this date we will, as previously stated, have to rely upon what other staff have told us about your involvement with DL.

I am sending this letter to your secretary at Rampton Hospital as she has your forwarding address and I am also sending a copy to the medical agency that you use.

Yours sincerely
V J DOUBLE
INDEPENDENT INQUIRY CHAIRMAN

Dear Mrs Double

INDEPENDENT INQUIRY - DL

Thank you for your letter of 19th August 1997, which was redirected to me in Sri Lanka. I am sorry that I was unable to attend the inquiry as arranged as I had to leave UK unexpectedly in order to attend to a very urgent personal matter.

You must admit that I have to give priority to see to urgent personal matters which affect my life.

The tone of your letter appears to me that you are holding an inquiry regarding my management of DL.

I have gone on record and given precise and clear reports on all matters pertaining to this case and there is nothing further that could be added to this.

As to what conclusions you draw from the statement of others is of no concern to me. My involvement with this patient lasted only a few weeks.

Yours sincerely

DR PRINCE KODITUWAKKU'

ISSUES/COMMENTS/CONCLUSIONS ON DL's CARE

1 DIAGNOSIS AND ASSESSMENT

a) Psychiatric Diagnosis

The initial diagnosis made by Dr Garbett was that of Schizophrenia. This seems to be in accord with the information available at the time. DL was treated accordingly and with good results, especially when oral medication was replaced by a depot injection. The diagnosis on admission in March 1995 was modified to that of Schizophrenia worsened through recent drug misuse. After having been interviewed by Dr Prince when DL was detained in police custody, Dr Prince diagnosed that he was suffering from a drug induced psychosis and not schizophrenia and felt therefore that it was not appropriate to admit him to hospital under the Mental Health Act. However, Dr Wood's (Consultant Forensic Psychiatrist) view on 3 February 1997, and the doctors and staff at Rampton Hospital when they were interviewed, was that the diagnosis was schizophrenia. The Rampton staff also emphasised the extensive drug abuse which started with glue sniffing from the age of 14.

Our concern is that the effects of widespread and severe drug abuse do not seem to have been appreciated in the early stages of DL's illness but seemed to become over emphasised during his admission and on his detention in custody. This emphasis unfortunately seemed to have excessively coloured the management of DL.

The concept of dual diagnosis, that is the combination of mental illness and drug abuse giving rise to particular problems in presentation and management, particularly violence, does not seem to have been understood by those responsible for the care of DL. At the time this would have been a fairly recent concept in the UK but there was a comprehensive review article in the British Journal of Psychiatry in July 1994.

b) Multi-disciplinary Assessment

There is limited evidence throughout DL's case of the range of multi-disciplinary contributions to his care and treatment.

Assessments carried out throughout DL's care should have sought to understand DL's views of the world, and explored his feelings, behaviours, and aspirations more thoroughly.

It remains open whether DL could have engaged in productive therapeutic work, but any further knowledge gained from such attempts would have been available to inform the clinical team managing his care. A real and meaningful assessment did not take place, particularly during his in-patient episodes.

In the cases of patients presenting with dual diagnosis who additionally are difficult to engage, and have a history of violence, a second opinion from differing professionals may have been an appropriate course of action.

2 COMPULSORY DETENTION UNDER THE MENTAL HEALTH ACT 1983

There is no doubt that compulsory admission to hospital was not indicated on either occasion DL was admitted to hospital, as it is clear that admission was agreed by the patient who was willing to enter hospital.

The issue is, of course, whether compulsory powers should have been used to give staff authority to prevent DL's frequency of leaving the ward without permission, and to insist that he took medication which had been prescribed, and whether the criteria for assessment and compulsory detention under the Mental Health Act 1983 were met.

Another reason for compulsory detention was to keep him on the ward. There is strong suspicion that he was abusing illicit drugs whilst on the ward, with a constant worsening of his mental state which would make him more inaccessible to offers of help and so a vicious circle would be established. Also had he spent more time on the ward he would have been more available for ward based therapies which may have had a beneficial effect on his condition, particularly as we know that he could respond to nursing staff input.

Although it is an important principle that treatment is best given with the patient's co-operation, statute does nevertheless allow for the fact that this is not always possible. DL had responded the previous year to a depot injection and there would have been a reasonable expectation that he would have responded again. It is therefore unfortunate that compulsory medication was not tried. This of course does not minimise the practical problems of administration.

The Act is quite clear that one of the reasons for detention in hospital is 'for the protection of others'. DL had assaulted his mother prior to his admission and was found to be paranoid and highly suspicious when assessed on the ward.

It certainly seems reasonable to assume, therefore, that active consideration should have been given to detaining him for the protection of other persons. Although there is evidence that nursing and junior medical staff raised the issue of detention under the Mental Health Act 1983, there is no evidence that this was pursued by Dr Prince.

Discussion with staff suggests that there was a common view that in order to impose treatment, detention would have been necessary. There were differing thoughts as to whether DL should have been detained compulsorily. This difference of view cut across all disciplines. The view was expressed that, at the time of his admission, the prevailing ideology of the ward would not have been to restrict DL's freedom by the imposition of a compulsory order under the Mental Health Act 1983. The preference would have been to try and work with him and to obtain trust and persuade him to have the treatment he needed.

It is difficult to escape the conclusion that DL met the basic requirements for assessment and detention under the Mental Health Act 1983 and that the clinical team, led by Dr Prince, on this occasion dragged their feet and should have intervened more forcibly in the treatment of DL.

Again, there was considerable evidence in the assessment on DL on the ward that he was suicidal. This would have been backed up by the fact that he had been admitted to hospital in December following an overdose, had this information been available on the ward.

3 CONSULTANT RESPONSIBILITY

It was unfortunate that Dr Prince was unable to be interviewed, and our impressions of his involvement in the matter of DL must perforce be derived from his evidence to the internal inquiry, from impressions gained from the views of others, and such views as we obtained from case notes and similar sources. Dr Prince was a locum consultant psychiatrist employed through a reputable locum agency. There are obvious problems in using locum consultants, particularly concerning their level of expertise and their lack of knowledge both of services and of the local population and their characteristics. There can also be issues surrounding team working, with differences in philosophy of care existing between the team and the newly appointed locum whose post is, by definition, temporary.

Dr Prince was, at the time of DL's admission, familiar with the locality, having held a locum post in another part of the district working with the same consultant colleagues and for the same managers. His performance in this post was acceptable and gave no cause for concern. As a clinician he was regarded as cautious, indeed if there was any cause for notice it was that he tended to place a greater emphasis on in-patient care, as indicated by increased bed usage and greater length of stay than his colleagues. Other comments suggested he was rather autocratic and not easily suited to multi-disciplinary working.

With respect to the case of DL Dr Prince's evidence to the Internal Committee of Inquiry suggests that his judgement in the diagnosis and management of the case was heavily influenced by DL's involvement in substance abuse and his criminal antecedents, although accepting that he was experiencing symptoms of severe mental illness (whatever the cause). He did not seem to give enough consideration to the problems of management that can be created by the disease process itself, preferring to regard many of the problems in this case to be caused by a personality disorder. Evidence from the Internal Inquiry, which was all we had available to us, indicated that he seemed to have been swayed by his perception of the combination of DL's ethnic origin, drug misuse, criminal behaviour and what he deemed to be a menacing manner exhibited by DL in this case.

It is clear that Dr Prince did not consider the effective use of the Mental Health Act 1983. It would seem that he had a poor understanding of legislation fundamental to clinical practice and hence it affected his use of the Mental Health Act which he did not in fact use to the best advantage. In retrospect the patient himself feels he should have been treated against his wishes, and should have been made to engage with the service in order to comply with treatment.

The above shows to us a lack of use of the therapeutic aspects of the Mental Health Act 1983.

4 CARE IN THE COMMUNITY

a) Pre Admission

Having reviewed various views and opinions reached by the clinicians involved in this case, we were impressed by Dr Garbett's initial care and treatment of DL. She, in fact, did start to treat his schizophrenia with some success.

The involvement and commitment shown by DL's GP, Dr Ormerod, is commendable, in that he offered regular review, tried to stay in contact with the patient, and communicated well to the statutory agencies.

It has got to be questioned whether every reasonable effort was made to maintain contact with DL. The importance of continuity of care and staying in touch are central to caring effectively for the seriously mentally ill. Whilst Nick Sellers did play a part with Terry Dutchburn in engaging DL they were equally quick to discharge him from their care when they thought he was either in London or not available to be treated.

Whilst the care they gave was exemplary, their continuing responsibility to maintain contact with somebody who had a schizophrenic illness is under some question. Of particular concern is the decision not to contact DL's mother on the occasion when he lost contact with the service. It is reasonable to assume, for example, that his mother would have known whether or not he had gone to London at the time.

b) Care Programme Approach and Discharge Procedures

The CPA circular (HC/90/23) required Health Authorities and Trusts to implement care programme policies by 1 April 1991. In view of this it was surprising to learn from evidence given to us that the first serious attempt to set up the CPA in the district started in 1994.

There was, however, a comprehensive approach to the issues of CPA and discharge planning. A senior manager was put in charge of implementing the CPA and a charge nurse was appointed in June 1994 to follow up every discharge and check that an adequate care package had been put in place. A procedure guidance document was produced for staff and multi-disciplinary training for all relevant staff was organised, although two staff nurses on F ward told us that they did not receive any training in CPA. The discharge procedure had three elements - initial screening assessment (ISA), care programming and the discharge planning meeting. The initial screening assessment determined a patient's eligibility for the CPA. Five criteria provided access to the complex CPA (tier 3). Two of these could potentially have been applicable to DL - *'severe and enduring mental illness; and complex needs and likely to require complex packages of care'*. If the patient was not eligible for the complex CPA the Simple Discharge Procedure was to be implemented.

Perhaps, because of the late implementation of the CPA, the view was expressed to us that it was sometimes only working 'in theory' in 1994/5, and that clinicians were not aware of its importance.

c) Application of CPA to DL

It appears that no initial screening assessment of DL was carried out (other than the initial care planning by Julie Duckworth immediately on admission) on his first admission to F ward early in 1995. There was no way therefore, in which his eligibility for the CPA could be assessed. This was a major omission. The allocation of a key worker some two days after admission clearly affected the provision of the ISA.

Despite evidence in the notes of discrete areas of care planning, these did not culminate in any specific discharge plan for DL following his two admissions. The only note states that he was discharged in his absence. The point was made to us by several interviewees that because DL was so often absent from the ward, discharge planning was impossible. In this connection, the letter to Dr Prince from Mr Smith, the Social Services Social Care Assessor who

interviewed DL at the police station following his arrest in June 1995, is highly relevant. Mr Smith concludes: *'I am writing to you to express my concern that while Mr Ledgester apparently has a history of hospital admissions, with (I understand) a diagnosis of schizophrenia, and while he appears to have a track record of substance abuse, which is likely to reinforce his disturbed thoughts/ actions, he does not appear to receive any kind of supervision, whereas I would have thought that he could be considered for both the Care Programme Approach and the Supervision Register, and that these possibilities would have been discussed at the time of Mr Ledgester's last discharge from hospital'*. This offers support to our previous comments about the need for an assessment under the Mental Health Act.

The conclusion must be, therefore, that the relevant procedures as laid down in the guidance for staff were not carried out in respect of DL.

d) Aftercare for the patient

When a patient discharges himself or is absent without leave as occurred in this case, it is not easy to comply with the usual discharge and Care Programme Approach requirements. However, the only positive measure taken to engage DL in this was the suggestion of an out-patient appointment (which in the event was not instituted) and a letter sent to the GP. There was no mention of a referral to the CPN service which had known him before, or to Social Services to try and organise treatment in the community. Another grave omission was the failure to contact DL's family who could have proved an important ally in trying to obtain help for him.

e) Aftercare for the family

Following tragic events such as this, families grieve and are generally in need of support and guidance. DL's mother clearly received no such help and was left without explanations. One of the only times that she got to explain her story and hear the facts was when interviewed by us.

5 INFORMATION TRANSFER

One of the more disturbing aspects of this case was the failure to pass information about DL from one part of the service to another. This meant that valuable information was lacking. A knowledge of his involvement with the CPN service and his successful response to the CPN on a personal level, as well as his response to his medication, would have been helpful to staff looking after him following admission. One might even speculate that a visit to him in hospital by the CPN might have aided his co-operation. The absence of his case notes from the ward we find puzzling. We were assured that case notes were available at any time, yet Dr Prince says he never saw any old notes. It seems clear that failure to appreciate his previous diagnosis and response to treatment were crucial.

There was a clear failure to share appropriate information between the elements of the service in the best interest of the patient. The community team and in-patient teams did not exchange information as they should have done. There appears not to have been a clear communication channel between the in-patient team and the on-site social worker. Equally DL's family and their information was not really conveyed to the team and vice versa. This whole issue of sharing

information in the best interests of the patient is paramount and is consistently raised within all Inquiries. In this case it plays a major part.

There seemed, at the time, a lack of knowledge of services for drug abusers and no ready way of introducing an in-patient to such services. In view of DL's abuse of illicit drugs, it is unfortunate that during the course of his contact with the services this could not have been available to him.

6 WORKING WITH SOCIAL SERVICES

The Calderdale Social Services Department was not involved in any of the care and treatment given to DL in 1994/95. This was due to the fact that DL's case was not referred to Social Services at any time apart from a possible assessment for admission under the Mental Health Act in early 1995, which never took place because DL entered hospital voluntarily.

It is an open question as to whether such a referral should have been made. Undoubtedly, DL could have been offered further help with his living situation, including housing, daytime occupation and general ability to cope in the community, and this should have been within the remit of Social Services. It is difficult to know if he would have accepted this, but it could certainly be seen as an appropriate part of a holistic care plan for someone with a serious ongoing mental illness, and the need to deal with the social effects of this.

There is concern in our minds about the jointness of working with Social Service colleagues. At a senior level there does not appear to have been sufficient liaison and certainly there are no written policies of statement of joint arrangements and joint working. No formally agreed joint strategy existed and the direction of travel for the mental health services was not clear at that time. While this did not impact specifically on DL's case it does show a background in which co-ordination and co-operation was not being fully utilised.

7 CLINICAL RISK MANAGEMENT

There appears to be no evidence that there was a consistent and comprehensive risk assessment being carried out at any point in DL's care and treatment. During his care and treatment with the Trust it was clear that during his in-patient stay this factor became paramount in deciding his treatment and there is yet again limited evidence to suggest any risk factors were taken into account.

DL demonstrated many risk factors for both potential violence and serious harm to self and others which were augmented by his chaotic lifestyle and drug misuse.

Attempts were made to assess DL but staff constantly reminded us that he was never available or on the ward long enough for a rigorous and thorough assessment to take place. Nevertheless his previous behaviour, both on the ward and in the community, clearly demonstrated high levels of risk which were disregarded by the clinical team.

DL exhibited both hostility for the service offered and regularly disregarded conventions of hospital treatment by absconding or not accepting treatment. We believe it was the staff's responsibility to engage this man by use of the Mental Health Act 1983 to detain him, in order for the risk assessment to take place so that treatment could be considered.

At the time of DL's care there had been an increased emphasis on the importance of formal assessment and risk management. We are of the opinion that in DL's case there is little evidence, apart from initial assessment on his admission, of such an approach to his care.

An important aspect of risk management is considering previous behaviour. It is our opinion that previous predictors were available, both in his care in the community and around his overdosing, that would have helped the clinical team in their management of DL. If the clinical team had taken this long-term view to his risk and behaviours then it may have affected significantly the way he was treated.

There is considerable research evidence for the link between schizophrenia, substance abuse and violence (Smith and Hucker (1994)). The importance of the link between violence, major mental disorder and drug misuse was further emphasised in the Department of Health Guidance on the Discharge of Mentally Disordered People (HSG(94)27).

There is evidence that DL had assaulted his mother in the context of delusional ideas. This was very important, as 'the best predictor of future violence is past evidence'

In considering the level of discharge planning generally which was agreed whilst DL was AWOL, it is clear that very few risk factors or predictors were considered.

During DL's care he exhibited risk of self-harm with previous suicide attempts, including an overdose. Whilst his care plan on his first admission identified such suicidal risk, no subsequent action was taken.

8 CONTACT WITH DL'S FAMILY

a) The Importance of Working the with Family

Working with the patient's family is an essential part of caring and treating someone with mental illness. There are two main reasons for this. Firstly, the families of people with mental illness undergo a high level of stress and burden, and need help in their own right (Lavender and Holloway (1988), Chapter 11). Secondly, and very importantly, supporting the family helps to support the patient. Families should be seen as colleagues in the work of caring for mentally ill people, and this is specifically recognised in the Care Programme Circular (HC/90/23).

The importance of this is reinforced by the Inquiry into the Care and Treatment of Christopher Clunis, which made the point that professionals failed to involve Mr Clunis' family in his care, despite their close contact with him ('Building Bridges' (1995), Chapter 2).

Working with the family has been further emphasised in recent years by the recognition of the role of carers in general in community care.

Work with the patient's family can take four forms:

1 Providing general information about mental illness and the services available.

2 Providing information about the patient's condition and needs, always of course with their consent.

3 Working with the family about the patient's condition and needs, again always if possible with the patient's consent.

4 Understanding that families' contact with the services will be constrained by lack of knowledge and embarrassment or shame. The service must therefore be proactive in helping families.

To what extent did the service working with DL carry out these four ways of working with his family?

b) The Family's Attitude

DL's main carer while he was ill and in the community was his mother. It is clear from her account and those of others that she made considerable efforts to cope with the effects of his illness and to seek help for him. She was virtually his only support for most of 1993 when he was apparently ill but not in touch with the services, and for the periods later when he lost touch with the services. One witness described her as *'very caring and supportive'*.

It is also clear that she suffered considerable distress and burden from his illness. At its most extreme, this included his expressing the idea that she was not his mother at all, and his attacking her with a baseball bat. Throughout her caring role, she had to cope with his paranoia and very disruptive lifestyle.

c) Provision of General Information about Mental Illness and the Services Available

This seems not to have happened to any noticeable extent. During the whole time that DL was being cared for in the community, no contact was made by the service with his family. There is no evidence that while he was in hospital, the service tried to explain about mental illness or the services to his family.

DL's mother commented that she learnt more about schizophrenia from a recent episode of 'Eastenders' than she ever did from the mental health services. This comment in itself speaks volumes.

d) Provision of Information about the Patient's Condition and Needs

DL's mother felt that she was given inadequate information about her son, for example not being told that he had left the ward when he had, and not receiving any information about care plans. It seems that she was not involved in discharge planning.

DL's mother specifically asked us 'Why weren't we, his family, told more about his illness and sectioning discussed more?'. The question about sectioning is related to DL's assault on his mother.

The CPN service did not contact the family at all during the course of their work with DL.

We were given a number of reasons for this apparent lack of contact with DL's family:

1 The service only dealt with the patient, and confidentiality prevented any contact with the family without his consent.

2 DL did not have much involvement with his family.

3 There was no need to contact his family because he responded to treatment (whilst being cared for by the CPN service).

e) Working with the Family for the Patient

It was clear from DL's mother's account to us that she had a wealth of knowledge about his behaviour and problems while he was ill. The service seems to have made very little use of this, probably for the reasons given above. Had this been done, however, a much fuller picture of the extent and depth of DL's illness would have become apparent to the service.

Of particular concern is the decision not to contact the family on the occasions when DL lost contact with the service, especially when he lost contact with the CPN service. It is reasonable to assume, for example, that his mother would have known that he had not gone to London at that time.

DL's mother's question to us sums this up. *'Since his condition resulted in him not co-operating wasn't it important to you that we, his family, knew the position and were able to assist with his treatment?'.*

f) A Proactive Approach to Working with the Family

For reasons of lack of knowledge or stigma, families are usually not able to make the first move with the service. It is up to the service to contact them, It was a matter of concern therefore that we were told that families had to 'come forward' and 'identify needs' before the service would have offered help.

The general consensus amongst those interviewed by ourselves was that there was no policy in 1994/5 for working with the family and carers, either at Trust Board level or elsewhere, and that there were no meetings between the Trust and the Carers Project. We were told that things had improved since then, but this view was not shared by some of those interviewed.

9 ETHNIC MINORITY ISSUES

DL is of mixed ethnic origin, his father is Jamaican and his mother white British.

Concern nationally about the treatment of African-Caribbean people by the mental health service is extensive. Studies show that black people are more likely than white people to be diagnosed as suffering from schizophrenia and to be detained under the Mental Health Act (Association Metropolitan Authorities 1993). The Reed Committee - 1992 Department of Health/Home Office looked in particular at the relationship between ethnic grouping and mentally disordered offenders.

One additional aspect of this can be an assumed association between African-Caribbean people, schizophrenia and substance misuse, especially cannabis. The ethnic minority population of Halifax is predominantly Asian, with people of African-Caribbean origin being of a comparatively small group. For all the above reasons, it is especially important that the mental health services treat patients sensitively in terms of ethnic origin.

No one interviewed by us felt that DL's treatment by the service was adversely affected by his ethnic origin (this included DL himself and his family). However, concern does arise from certain comments by Dr Prince to the Internal Inquiry, in which he appeared to suggest that DL himself made staff uneasy because *'he was Afro-Caribbean'* and linking this with his being dangerous. We were not able to check these comments with Dr Prince, but they do suggest a certain stereotypical approach to African-Caribbean patients, which could, in certain circumstances, be prejudicial.

This is unfortunate as DL himself is recorded in the police records as feeling racially victimised at one point.

10 WARD F

The quality of psychiatric care and attention given to DL was generally lacking and did not meet expected standards.

The ward culture in F ward was clearly dysfunctional. It seems that this was based on the patient agreeing to stay to have treatment, and was certainly not needs based. Had the ward been functioning on a needs based culture, then it would have been obvious that DL had needs that would have been treated. Instead, because DL did not want to engage with the service and, therefore did not want to stay and have treatment, it was felt that he must be allowed to leave on a regular basis, and therefore no treatment was effective. DL was certainly a difficult management case. It concerned us to find nurses particularly not engaging people who demonstrate difficult behaviour. This tended to suggest to us that there was an attitude problem, which was probably due to lack of training, development and socialisation of nurses. In acute psychiatry today it would be irresponsible to take the attitude that you do not engage with the acute mentally ill person. The level of dependency in in-patient psychiatry today is such that staff have no option but to engage this type of person. Equally, it can be shown that had they engaged DL and treated him, probably with depot medication, it was likely that he would have improved in the short term. This in itself may have resulted in a better mental state.

On a broader issue of culture it is fair to say that a treatment culture did not exist in F ward. It could equally be argued that if we look across the whole of his treatment there is potential that DL did not really get active, consistent treatment. He got intermittent interventions which again suggest that the culture was all wrong.

The review of this case highlights areas in which professional education and development might generally be enhanced. Risk management and dealing with patients who have a dual diagnosis are two such areas.

There has been an increasing emphasis on the importance of assessment and containment of risk. Three aspects of clinical risk management, in this case, might have been given more prominence, namely:-

- Monitoring the possible reccurrence of thoughts relating to harming others
- Consideration of future harm to himself or others
- Seeking an understanding of the interplay between drug misuse and symptoms of schizophrenia.

A Clinical Risk Policy was not available in the Trust until April 1996.

Ward records, both nursing and medical, were not without ambiguities, and did not seem to capture previous events that were of paramount importance in DL's case.

Care planning details, actions and changes were poorly recorded.

The allocation of key workers to patients was somewhat chaotic. On one occasion DL did not see his key worker for 2 days following admission, due to a system that allocated such duties even though a member of staff is actually on days off and not due to be on duty for 2 days.

A provisional care plan was drawn up by Julie Duckworth. Nothing further seems to have happened to this plan until 18 March 1995 when Staff Nurse Frank Kelly, a newly qualified and temporary appointment to ward F, returned from his days off, became DL's key worker and he, with little knowledge of DL,

reviewed his care plan. He discontinued the section which dealt with DL's suicidal and psychotic ideas. The key worker did not start or complete the ISA.

Frank Kelly, as DL's key worker, seems to have made little effort to get to know him or his family.

It is known that previous and past behaviour is a good predictor for future behaviour. The ward team in particular did not seem to take note of any previous behaviour or previous patterns of behaviour in formulating their initial care plan. Their lack of definition of risk and their lack of understanding of how risk plays its part is evidenced within the nursing records.

11 MANAGEMENT ARRANGEMENTS

From the evidence given to us, we can only conclude that managers did not really know what was going on at ward level, particularly in F ward. All the evidence suggests a light influence from managers, even though the manager was based on site. Recent evidence from senior managers suggest that the local manager was not drawn away on reprovision matters and should have been providing a very good day to day service. Clearly this was not evidenced from ward staff.

It is also clear that the Assistant Service Manager was not driving the changes as such that were occurring in the move to Northowram. The management emphasis was towards locality services and community care. It could be suggested that the move to Northowram and the community development left F ward and G ward at Halifax General Hospital isolated. In such isolated times we know that people rarely start changing behaviour. It could be argued therefore that the charge nurse and one or two other key staff had transferred their behaviours from large hospitals and retained that type of culture on F ward.

12 POLICIES AND PROCEDURES

An Absent Without Leave Policy existed within the Trust. While it was followed on those occasions that warranted its use, we are concerned at the discharge of DL so soon after being AWOL. This is particularly relevant to a man exhibiting the risk factors which DL exhibited.

An absence of a Clinical Risk Management Policy at the time of DL's care may have allowed for the variation in practice in this case.

RECOMMENDATIONS

1 For patients presenting with both substance misuse and serious mental illness it is important that:

   a) the importance of the interplay between these 2 conditions should be made aware to all Trust staff who are likely to come into contact with mentally ill people

   b) a clear plan should be evident to deal with this issue with regard to the training and eduction of clinical staff

   c) those who manage day to day services should be aware and consider more fully management and resource implications raised by these patients and their needs.

2 We would re-emphasise the need for a comprehensive multi-disciplinary assessment in the care and treatment of people with serious mental illness and, furthermore, an assessment should be undertaken even if the patient has discharged himself from hospital and the information is limited.

3 We would further emphasise that even when a patient is AWOL or discharges himself a multi-disciplinary assessment should still be undertaken to consider further action which needs to be taken in that case.

4 Even in the most ill, all assessments should include an understanding from the patient's point of view, their feelings, behaviours and aspirations.

5 In the recruitment of locum consultant psychiatrists, the Trust should ensure that those appointed clearly understand Trust procedures concerning risk management, multi-disciplinary working and the use of the Mental Health Act 1983.

6 When using an Initial Screening Assessment tool we recommend that it should be carried out on all patients whatever their level of compliance.

7 No patient should be discharged without a discharge plan which fully considers the involvement of all appropriate agencies and, in particular, Community Mental Health Teams.

8 In complex mental health cases it is imperative that social worker services should be immediately and fully involved to aid in the assessment and treatment of patients.

9 The Trust and Local Authority should work towards developing, as soon as possible, a fully integrated and prioritised plan for providing services to the severely mentally ill.

10 The Trust and its managers should be fully aware of the importance of clinical risk management in the day to day management of patients and treatment.

11 Specific guidance should be made available, if necessary facilitated by an educational programme, to deal effectively with clinical risk.

12 Where patients have shown significant risk factors including violence or self-harm, they should be positively considered for a full care programme.

13 The service should develop and implement a comprehensive policy about working with carers and the patient's family, and back this up with multi-agency training for all staff working with severely mentally ill people.

14 The service should consider the good practice models that are available around carer development workers and, if possible, should seek to appoint a Carer's Development Worker within the next 6 months.

15 Information resources should be produced and made available for carers, explaining about the service and about mental illness. These should be given to the carer by the patient's Key worker on the patient's first contact with the service, and made available throughout the patient's involvement with the service.

16 Carers should be routinely invited to all Care Programme and care planning meetings about the patient (with the patient's consent).

17 Carer's knowledge about the patient and wishes concerning the patient should always be taken very seriously by the service, even where there is disagreement between them and the care team or patient about the care plan.

18 If the patient does not consent to the service being in contact with their carer, the service should nevertheless ensure that the carer has access to general information about the service and about mental illness, and that they are aware of services for carers generally within the district.

19 The Trust should take steps to involve local carer projects and national agencies eg NSF and SANE in the development of services for carers of mentally ill people.

20 The service should develop and implement a policy for working with patients from ethnic minority communities. This should ensure that the service takes all appropriate steps to provide care and treatment that is sensitive to these patients' cultural and other needs. The policy should be discussed with representatives of the relevant ethnic minority communities. Multi-agency training should be provided to support the policy.

21 The use of the key worker system within acute in-patient settings requires urgent review and refinement. For the system to operate safely it is recommended that key workers should be available immediately on admission.

22 Management should ensure that the clinical supervision is effective and fully implemented for all professionals.

23 Professionals involved in the care of the severely mentally ill should have access to relevant updates and training. Managers should ensure that such is afforded to staff, particularly those working in acute in-patient settings.

24 Management should ensure that appropriate levels of supervision by them on a day to day basis are available, particularly to acute in-patient wards.

25 The Trust should clarify, as soon as is practicable, the lines of accountability between day to day management and the development of the service. The roles and functions of the Clinical Director and Service Manager need further clarity.

26 As a matter of some urgency the Trust needs to consider ways and means of integrating services within a locality model. The link between in-patient services and community services requires attention in order to improve their effectiveness.

27 Managers need to ensure that systems for information capture and usage are optimal and are focused towards the best interests of the patient.