REPORT TO TEES HEALTH AUTHORITY OF THE INDEPENDENT INQUIRY TEAM INTO THE CARE AND TREATMENT OF JONATHAN CRISP

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GLOSSARY

A and E	Accident and Emergency Department
B P D	Borderline Personality Disorder
C P A	Care Programme Approach
C P N	Community Psychiatric Nurse
D O H	Department of Health
ECR	Extra Contractual Referral
G P	General Practitioner
H C	Health Circular
H S C	Health Service Circular
H S G	Health Service Guidance
RMN	Registered Mental Nurse
S H O	Senior House Officer
U K C C	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Y T S	Youth Training Scheme

TEES HEALTH AUTHORITY

Independent Inquiry into the Care and Treatment of Jonathan Crisp

To the Chairman and Members of Tees Health Authority

SECTION 1 – INTRODUCTION

OUR TERMS OF REFERENCE

We were appointed by Tees Health Authority on 13 May 1998 to enquire into the Care and Treatment of Jonathan Crisp and to report to the Authority in due course with our Report Findings and Recommendations.

The establishment of the enquiry was under the terms of Health Service Guidance Circular HSG (94) 27 following the killing of a young Stockton man, Peter McNamee, at his home in Stockton in the early hours of Sunday 22 June 1997. Police discovering the body later that morning found that his house had been broken into and that Peter McNamee had been killed in a savage attack and that the body had been grossly mutilated after the killing. Meantime, Jonathan Crisp, a 21 year old single man from Stockton, had been making claims that he was responsible for McNamee's death, and in the course of the morning, he was taken into police custody, made a full admission as to the commission of the offence and was charged with the murder.

The trial of Jonathan Crisp took place at Newcastle Crown Court on 12 May 1998 when (in circumstances which we detail more fully later) he pleaded guilty to the murder of Peter McNamee and was sentenced to life imprisonment. Following the conclusion of the court proceedings, Tees Health Authority, in furtherance of the requirements of the Circular HSG (94) 27, established this Independent Inquiry to examine the health and social care and treatment of Jonathan Crisp and thus the circumstances leading to the death of Peter McNamee at his hand.

Following our appointment we held a series of briefing meetings at Teesside in the course of which we considered in detail, the many papers, files, reports and records which had been made available for use by the Inquiry and which we summarise in Appendix D to this report.

We are grateful to all of those who made papers and documents available to us including the Hartlepool and East Durham and the North Tees Health NHS Trusts, Stockton Social Services Department, the Primary Health Services and other agencies, and for the full co-operation we received from all of these bodies and their Officers. We would also wish to record our thanks and appreciation for the secretarial support and assistance which has been made available to us throughout these lengthy proceedings.

THE INQUIRY

Having considered all the detailed documentation referred to above, the Inquiry Panel met together at Middlesbrough on the 7th, 8th, 9th, 10th, 11th, 15th, 16th and 29th September to hear and take evidence from the very many witnesses whose information and assistance was necessary for a full examination and consideration of the issues arising in this case. We were grateful for the assistance of Jonathan Crisp's wider family members who made their views and concerns known to us at the outset of our Investigation and so assisted us in formulating some of the issues which were going to require our examination. Details of the many witnesses we heard are set out in Appendix C to this Report. We also wished to give Jonathan Crisp the opportunity of expressing to us his own account and views about the matters the subject of our Inquiry, and accordingly with co-operation of the authorities at the HM Prison Holme House, two of the members of our panel travelled there to visit Jonathan Crisp to hear and record his views.

Following the conclusion of our Oral Hearings, we met together on a number of occasions to consider in greater detail, the evidence we had heard and the documents we had read and to draft and consider our Findings, Report and Recommendations, which we now submit to Tees Health Authority in accordance with the Terms of Reference given to us, and which we set out in Appendix B. Those Terms of Reference are very wide ranging, and we have therefore concentrated in this Report on those issues which have particular relevance to the case of Jonathan Crisp in the context in which he had been a Hospital Patient of the NHS and had been diagnosed and receiving treatment for the condition of "Borderline Personality Disorder" and his later period of Care in the Community under a CPA Programme. We found this to be a complex and difficult issue and one which has exercised us very considerably, and in the course of this Report we will seek to identify the many problems which it raised, the manner in which they were addressed, and the effectiveness or otherwise of the approach to the treatment of a patient with such a condition.

Our review of all the documents and evidence relating to the case of Jonathan Crisp has underlined to us the desirability of having some clear focus on the appropriate treatment and care of patients in this category, and in the later Sections of this Report, we address ourselves particularly to those areas in which

wider care and treatment facilities might properly be considered for patients diagnosed as having Personality Disorders.

Having seen and heard all relevant witnesses and considered the files, papers, documents and records made available to us – and especially the Internal Inquiry Reports carried out immediately after the event by the appropriate Trust and other Authorities (and upon which we comment and commend later in this Report), we now submit to the Health Authority our Views, Conclusions and Recommendations for their consideration.

SECTION 2 – THE BACKGROUND & REVIEW OF JONATHAN CRISP

BACKGROUND

1 Jonathan Crisp was born on 8 February 1976, and at the time of the killing of Peter McNamee he was just over 21 years of age. Jonathan Crisp was an only child and was born and brought up in Stockton on Tees. He was something of a slow developer and required assistance from a Speech Therapist until he was 3½ years old. More importantly, Crisp's parents separated when he was 2 years old and this undoubtedly had a substantial impact upon him because, we were told, he would idolise his absent father, whereas it is clear that he had a very poor relationship with his step-father when his mother subsequently remarried when Crisp was about 8 years of age. He attended mainstream infant and junior schools but encountered problems there, and he was at one stage assessed by the Child Psychology Service. At this point in time, it is not clear what guidance or assistance was then made available to him, but his problems seem to have escalated and at the age of 12 years, following an incident of violence in the classroom, he was suspended from mainstream school and was then referred to a Child Psychiatrist. He was at the same time placed in a Special School – there he settled reasonably well, and left school at 15 years but without any formal qualifications. Since leaving school, Crisp has not had any consistent employment, and from the age of 16 years has lived apart from his former family home because of problems arising there. He has lived in various bed and breakfast and bedsit accommodation, but has also been able to visit regularly with his paternal grandmother with whom he maintained a close relationship.

2 In May 1995 Crisp met and commenced a very close association with a lady we will refer to as "Miss Y" (because she has children and we must protect their anonymity). This became a dramatic and most eventful development in his life, because Miss Y was the mother of two children whose father was Peter McNamee. Crisp began cohabiting with Miss Y a month after their first meeting, and during the course of their association two further children were born to Miss Y and Crisp, so that the family then comprised four young children, two of whom (boys) were Peter McNamee's and the other two (girls) were Jonathan Crisp's. This became the catalyst for resentment, some mutual antagonism and a degree of confrontation between these two men, and we will consider and examine later the extent to which this led to the killing on 22 June 1997 of Peter McNamee.

During the course of this cohabitation with Miss Y incidents arose concerning Jonathan Crisp and her two sons which led, at the instigation of Peter McNamee, to the involvement of the Child Protection Services at

Stockton in the family situation, and although that referral was later discharged because of acceptable and satisfactory reports, nevertheless, that involvement at the instigation of McNamee may well have had a profound effect on Crisp.

3 Throughout the involvement of the Child Protection Services, Crisp and Miss Y continued, mainly, to live together, but by the end of 1996 their relationship had deteriorated to such an extent that Crisp went to live in his own accommodation in Stockton on a regular basis and during that period, on 25 February 1997, he cut his wrists with a pair of scissors in an incident of deliberate self harm and was admitted to Hartlepool General Hospital for care and treatment. He was discharged a week later with a view to follow-up from North Tees Mental Health Services. A key worker CPN and a social worker were assigned but before any arrangements there could be made for him, he again lacerated his wrists and was admitted as an emergency for a second time on 10 March 1997, this time to North Tees General Hospital. After a period of some 17 days hospitalisation and further period of partial hospitalisation in North Tees, he was then discharged for Community Care under a Care Programme established under the CPA arrangements and the Key Worker CPN and a Social Worker who had been assigned to him at the beginning of March 1997 were allocated their Roles. Part of that Care Programme was to arrange for assessment by a Consultant Psychologist. After some delay he saw the Consultant Psychologist on 16 June 1997, but by the time the Psychologist's Report had been prepared and submitted he had already committed the offence on the night of 22 June 1997.

4 As we previously indicated, Crisp made no secret whatsoever of his commission of the offence and indeed, to some extent, was boastful about it. He was readily apprehended and taken into custody where he admitted the offence in detail, and was charged that same day. At his trial at Newcastle Crown Court on 12 May 1998 (when full Forensic Psychiatric Reports were before the Court) he pleaded guilty to the charge of murder of Peter McNamee and was sentenced to life imprisonment.

REVIEW

Against this brief background of the chronology of Jonathan Crisp's case, we propose in the subsequent Sections of this Report to consider and deal, stage by stage, with each relevant period of his history and circumstances, and to review and examine these under the following headings:

a His early history

b His liaison with Miss Y – in so far as it is relevant to and affected his care and treatment and the link thereby to Peter McNamee;

c The first incident of " deliberate self harm" and his admission to Hartlepool General Hospital and his discharge therefrom;

d The second "deliberate self harm" incident and his admission to North Tees General Hospital and his discharge therefrom;

e Subsequent to his discharge from hospital, the "Care in the Community" and CPA

f His connection with his GP Practice;

g His connection and involvement with the Psychology Services; and

h The background to the commission of the Offence and his Trial, and the Forensic assessment, plea and sentence.

A common theme dictating our examination and approach to all these stages in relation to the history, events and care and treatment of Jonathan Crisp throughout, will be to examine and consider in later Sections and in relation to each of the above stages:

i The question of and the approach to the issues of "Risk Assessment" throughout, as an essential continuing element;

ii. The issue of "preventability" in relation to the eventual offence and outcome;

iii The application of the CPA Programme ("Care in the Community") at each stage, and its effectiveness in implementation and enforcement;

iv The question of records, information and communication and the interchange of this between the various agencies;

v Finally, in the light of the comments we made in the opening Sections of this Report, an examination of the facilities available for the care and treatment of patients with Borderline and other Personality Disorders, and the role of the National Health Service in such provision.

SECTION 3 – THE EARLY HISTORY

1 In considering and reviewing the early history of Jonathan Crisp, through childhood and adolescence, the Panel had limited information available and had, mainly, to rely upon Jonathan Crisp's own account of events (as related by him on the occasions of his later hospital admissions), information given to us by the paternal grandmother, and finally and substantially the GP records of his involvement with the Primary Care Services.

2 In the short background outlined in the previous Section, we have given some outline of those early days and we do not intend to dwell on this period in much greater detail save in so far as it seems to us to be relevant or significant or to be helpful to the understanding of later events. The GP records show a not unusual pattern of involvement with the Primary Care Services as a youngster; attendances through the GP and the school medical service for eyesight assessments and hearing problems which required treatment, and at the Accident and Emergency departments of local hospitals for typical playground and sporting injuries – a fractured wrist when he was aged 9 and a shoulder injury when he was 15.

3 The main themes, running through accounts of these early years, are his allegations that as a child he had been "abused and ill-treated" within the family setting – this during the period after his natural parents had parted and his mother had remarried. There is no firm evidence either way in respect of these allegations and certain it is that his parents denied that this was so. His parents were described in later reports (to which we refer below) as being "caring and attentive", although it emerges that his step-father was something of a disciplinarian within the family setting. It does, however, clearly emerge from the background information, that Jonathan Crisp resented his step-father because he viewed him as having replaced his natural father to whom he had been very devoted and attached, to the extent that the mother was often cast in the role of mediator in seeking to keep the peace between them. There was certainly discipline on the one hand and resentment on the other, but we saw no clear evidence of the "abuse and ill-treatment" to which Jonathan Crisp referred in seeking to explain his own background. However, one established fact is that at the age of 16 he left home and thereafter had to fend on his own; – his being "put out" in this way is some confirmation to us of the history of a troubled and unsettled childhood at that time – a circumstance which may well be relevant in so far as this type of background in childhood and adolescence may well be a factor giving rise to the kind of Personality Disorder from which Crisp was later diagnosed as suffering.

4 This troubled and unsettled childhood is certainly reflected in his schooling. His mother's view (expressed in earlier medical reports) was that "he had always had problems at school" and this came to a head at senior school when he was eventually suspended from mainstream schooling. He had been behaving in a disruptive fashion and expressed a dislike of teachers and discipline and "acted up" in the school setting.

As a result of his suspension from school he was eventually admitted to a local special school where in fact he settled down quickly and well, and appeared to like school there because of the more relaxed atmosphere and discipline and the range of subjects which was more to his aptitude and liking, and where, at last, he was expressing some interest and enthusiasm.

5. The background troubles at home and at school resulted in two significant involvements of the Medical Services. In the summer of 1986 and because of "disturbing behaviour" both at school and at home, which was giving his mother concern, he was referred to the Child Psychological Services at North Tees and was seen in June 1986 by a Principal Child Psychologist at her clinic. In her Report later that month she considered that Jonathan Crisp presented as a quiet and sensitive child who had a strong relationship and tie with his natural father, but that the step-father, although very keen to be a good parent to the boy, was finding it very hard to deal with the degree of rejection he encountered from him. In short, there was "a lot of pain in the family" and work was needed to help this "re-constituted family". We see later reference in documentation to a continued contact with the Child Psychologist, but we cannot see any detailed implementation or development work which may then have taken place.

6 The second involvement with the Health Services came in a referral to the Children and Family Psychiatry Services in September 1988, after his mother again saw the boy's GP to express her concerns about his behaviour at school. She was looking for help from the Psychiatry Department because all the teachers had reported that he was a "very difficult child"; he apparently got up to all sorts of tricks to try to disrupt lessons and had very poor concentration. The Consultant Child Psychiatrist reported in a detailed report of September 1988 which we have seen (when Jonathan Crisp was then 12 years of age) on the history and problems of his mainstream schooling, both at junior and senior level, his suspension from school and his then recent admission to a Special School where it appeared that he was progressing well, attending regularly and expressing interest and enthusiasm for that school. The Psychiatrist reviewed the background history and development in some detail and on his examination found Jonathan Crisp to be "slow and inarticulate, but friendly, and of limited intelligence and ability, but not

seriously so". Most importantly, the Psychiatrist felt that Crisp "did not come across as being emotionally disturbed, but rather somewhat immature". He felt that his behaviour was a reaction to limited academic ability based on personality "without there being anything very sinister in it". It was felt that his move to the Special School would be helpful towards addressing the problems, and the parents were to keep in touch with the Service if they felt it necessary to do so.

7 There is no further relevant medical history during the period of childhood or adolescence, and the next significant stage in this chronology was Crisp's "leaving home" at 16 and thereafter seeking to fend for himself – albeit with regular contact with his paternal grandmother and with continuing contact, less regularly, with his own mother. Records available to us show periodic attendances upon the Social Services to seek help with accommodation, including suitable bed and breakfast accommodation and also, later, with housing when he eventually obtained, with the assistance of the Social Service and Housing Departments, his own single flat accommodation in Stockton. He was not at any stage able to obtain employment, but did use the facilities of a Youth Training Scheme (YTS) at one limited period and otherwise had to rely upon the unemployment and social security benefits available to him.

8 Nothing other of special relevance or significance appears to have happened during this chronology until in 1995 he met and commenced his association and cohabitation with Miss Y – circumstances to which we refer to in more detail in the next Section.

9 **REVIEW**

One particular concern that we have about this period is in connection with the reference to the Psychological and Psychiatry Services in respect of Jonathan Crisp in 1986 and in 1988, because although there are on the GP's file full and detailed reports of the then circumstances and the opinions and advice of the Consultants, these Reports and this information do not appear to have been made known to, or indeed sought out by, the Hospital Psychiatric Services or the Social Services at the time of Crisp's admission to and treatment in hospital, both at Hartlepool and at North Tees in 1997 yet all relevant details and reports were clearly contained in the GP's record file. The GP tells us that he assumed because the earlier Reports had emanated from the local hospitals, that they would have been researched when Crisp was admitted to hospital in February and again in March 1997. In fact this had not proved to be the case, and the Hospital Psychiatric Services were not aware of these specialist attendances or early Reports until a much later stage. We considered that it must certainly have been of help and assistance in understanding Crisp's background if the Hospital and Social Services had had these available at

the initial stages, and in our view, consideration must be given to ensuring that cross-referencing and accessing of all relevant information for a single patient is more specifically targeted. Whether the absence of these earlier Reports may have had any substantial bearing on the later Hospital assessments can only be a matter of speculation, but it is unlikely.

SECTION 4 – CRISP'S LIAISON WITH "MISS Y"

Publication of this section is being withheld to prevent more distress to "Miss Y" and her family

SECTION 5 – THE FIRST ADMISSION AND HARTLEPOOL GENERAL HOSPITAL

1 On the 25 February 1997, quite unexpectedly, Crisp presented himself to a Social Worker at the Children and Families Team in Stockton where he knew the Officer. Crisp later referred to him as "his" Social Worker but in fact, this was not the case. The Social Worker's responsibilities had been in respect of the children. Crisp was remorseful and generally very upset – the more particularly so because, of course, he was at that time not cohabiting with Miss Y having separated from her at the end of 1996 because she was not prepared to tolerate any longer the problems and stress of their relationship. The Social Services Officer was very concerned about him and concerned that he might well harm himself because of what he was saying "there is nothing, no way I can go on. I've done everything wrong, I have lost everything in my life". The Officer spent time talking to him and with him and by the time he'd left to go back to his home Crisp was more settled, and as the Officer told us, "a bit more chirpy". However, the Officer immediately rang up the Social Services Duty Team and made a referral to the Mental Health Services there because of this concern. He also immediately wrote to Crisp's GP reporting the incident in detail, relating some of the background and asking for the GP's assistance in accessing Crisp to the services he needed. The relevant documentation shows indeed a record of the referral to Community Mental Health Team by Social Services Department for social work assessments and the GP's receipt of the letter from the Social Worker – this on the 28 February 1997, because of the intervening weekend. However, by the time the GP had received the letter or the Mental Health Team had the opportunity of implementing any action on the referral, Crisp had already precipitated his admission to hospital by cutting his wrists in an act of deliberate self- harm on the evening of the 25 February 1997.

2 This first became known to his paternal grandmother. She had seen Crisp at her home on the previous day when because of his depressed condition she urged that he should go to the doctors and promised that she would accompany him if he wished, intending that they should meet up on one of the following days and go on together. However, it was the next day at about 6.30pm that he arrived at her flat, standing in the doorway holding his hands, having cut both his wrists whilst alone in his flat and then walked to his grandmother's to seek help. She dealt with emergency care and with the assistance of a friend took him by car to the Accident and Emergency Department at North Tees General Hospital. He was there seen by the Senior House Officer on duty who took what we considered to be a most detailed and careful history, not only of the event of self-injury itself, but also of the psychiatric background relating to his mental health.

The SHO in question was an SHO in Psychiatry who noted Crisp's disturbed and depressed condition; his statements of an abusive childhood; that he thought himself "to be evil" and that he "could hear voices" telling him to kill his step-father and, later telling him to kill the father of the two boys. He was depressed and upset because he had split up with his girlfriend about six weeks previously and he thought he was acting out his abusive childhood again.

The symptom "hearing voices" is often associated with severe mental illness such as schizophrenia. However all assessments of Crisp both before and after the murder concluded that he was not suffering from mental illness. Some individuals with personality disorders complain of this symptom and it is possible that Crisp falls into this group.

It should be noted at once that the question of his "hearing voices" was thoroughly examined at later stages and was then discounted both by the Forensic Psychiatry Services concerned and by his family who had heard of it but had dismissed any such ideas, - and later by Crisp himself who accepted that he had not been "hearing voices". What he was "hearing" was in fact the reflection of his own thoughts and therefore he had been thinking these things but not hearing them.

3 The SHO at North Tees took the view that Crisp should be admitted to a bed in the Psychiatric Unit, but as there were no psychiatric beds available at North Tees at the time, he was immediately transferred for admission to the Psychiatric Unit at Hartlepool General Hospital. There, again, a full and careful history was then taken by the admitting Staff Grade Psychiatrist and the duty nurse, and Crisp was then clearly sufficiently composed to provide a full and detailed account of his current history and background and although he again referred to "hearing voices" he went on to say that "they are his own thoughts and that he is not hearing strange unrecognisable voices as such."

4 However, it remains important to note his recorded admissions of having been violent towards his girlfriend and her two sons, and of the voices/thoughts to kill his step-father and also the father of the boys. He was depressed and tearful and exhibiting feelings of self-blame and unworthiness, and the initial medical diagnosis was that of "adjustment disorder and depression and borderline personality disorder". His wounded wrists (which had been dealt with in the Accident and Emergency Department) were attended to and he was prescribed medication and admitted to the ward. His grandmother had accompanied him from North Tees Accident and Emergency Department by ambulance to Hartlepool General Hospital but, although she took the opportunity to give some information to staff, she felt she was not sufficiently involved in the admission interviews and was not invited to contribute further – as she

certainly could have done – to the background and information gathered on admission and therefore to the contents of the Medical Notes at Hartlepool.

5 Those Notes contained a particular entry which caused us some concern during the course of the Inquiry, and which was underlined in the evidence we heard. That entry was an introductory sentence to a personal history sheet which reads "Urgent; ECR from A/E Department North Tees Hospital of a 21 year old male (arising from) deliberate self-harm". The words "ECR" refer to the procedural term of "extra contractual referral" meaning a patient who is coming from outside the area served by the Hospital, ie because Crisp came from Stockton, outside the district (and not from Hartlepool). This led to the hospital ward staff considering that Crisp would be at Hartlepool only on a temporary basis and that he was effectively "boarded out" at Hartlepool until he could be returned to North Tees Hospital when a bed was found for him there. It was made clear to us later by Management that this was a total misconception on the Ward because of the "joint admission policy" which was operated in the area where arrangements were very properly in force for patients to be admitted to either Hospitals at North Tees or Hartlepool in the event of any bed shortages, and that a patient so admitted was certainly not "boarded out or in transit", but was a patient to be dealt with in the full and normal way at either Hospital. We however, believe that this misconception led to Crisp's stay at Hartlepool being treated as that of a "boarded out" patient whose ultimate responsibility would be that of another hospital, and that this may have affected the depth of the assessment and treatment (or lack of treatment) that he received whilst at Hartlepool.

6 It is right, however, that we should add immediately that we do not consider that the Hartlepool episode and the treatment of Crisp at Hartlepool had any substantial bearing on the eventual outcome which would probably have been the same – but since one of the purposes of such an Inquiry as this is to examine all aspects of care and treatment and to consider where improvements might be made, it is right that we should express a number of views about the Hartlepool episode and aspects of his treatment there until he was discharged back to his home some 8 days later on the 5 March 1997. Because a number of matters were causing us concern, we took the opportunity of interviewing a great many witnesses from the Hartlepool Hospital, both medical, nursing and management, and they will be aware that in the course of our questioning we voiced a number of concerns which mainly centred on:

a The treatment offered to Crisp whilst an inpatient;

b The continuity of medical care and attention;

c The continuity of nursing care;

d The approach to the question of "risk assessment" in Crisp's case;

e The circumstances of his discharge and the discharge letter; and

f The question of the Care Programme Approach in respect of a patient who was "non-resident".

To enlarge on these:

a We were unable to detect any treatment whatsoever being prescribed for Crisp to address the problems which had been seen and recorded at the time of his admittance – save for the continuance of medication as prescribed and attention to dressings as appropriate. We are aware of views expressed to the Panel as to the appropriate treatment (if any) for a patient suffering from Borderline Personality Disorder, but we feel that a major factor in not addressing these problems in any way was the belief that Crisp would be at short notice transferred back to North Tees Hospital and was therefore only in short stay transit at Hartlepool. We hope that the assurances given to us by Management witnesses to whom we expressed these concerns will ensure that the myth of "boarded out" patients has immediately been dealt with and that this misunderstanding does not continue. We are ourselves quite confident that the matter will now have been resolved.

b Crisp was seen most carefully and attentively by Medical Staff on the night of his admission both in Accident and Emergency and on the ward in Hartlepool. However, although he was seen on the ward the following day by another doctor there was no record or note of any medical staff attention thereafter until the day of his proposed discharge on the 4 March 1997 when the Consultant attended. We were confidently assured that medical attention and supervision would have been available at all times if required and that the absence of positive medical indications reflected an uneventful stay in hospital, and was of no significance. However, we did feel that the observations we have made in (a) above about "boarded out" status may well have affected this area also. The evidence before us indicated that the consultant at the time was a Locum Consultant appointed at a time of medical staffing difficulties. Our concern here was that his qualification and expertise would not have warranted him being appointed to a substantive Consultant post, and management were unaware of this. We consider that where a Locum Consultant is appointed who

is not qualified to hold a substantive post appropriate supervision should be provided.

c Nursing care and attention was regular and recorded throughout, but we felt that the "Named Nurse" concept was being observed rather more in the letter than in practice. Therefore if the nurse who was designated Named Nurse was on night duty at the time of admission and not likely to be present during the next week, he or she was therefore not appropriate to hold that role. This meant that a change in "Named Nurse" the following day became necessary but gave rise to uncertainties . Although it appeared to us from the evidence that nursing was very much on a "team" rather than on an individual basis, the question of applying the "Named Nurse" principle and how it should be effected was one which might well be addressed and reviewed.

d We had a number of concerns about the approach to "Risk Assessment" in the case of Crisp and to the manner in which this very important role was discharged. We propose to deal with the issue in more detail later, but note here that Risk Assessment is an essential process to ensure the identification of any risks associated with the patient and the taking of steps to address them. The Patient Admission and Assessment Form provides special documentation for this purpose and indicates within the form the need for proper and careful assessment, both at the date and time of admission and the need for discussion of the assessment within the community mental health team. It was readily acknowledged to us in evidence that the risk assessment form completed in the case of Crisp was inadequate in many respects and had not been properly completed, assessed or discussed, had no "input" other than that of a single nurse on duty on the day following admission, and omitted to refer in any way to the major matters of concern about Crisp indicated in the detailed Admission Notes and Records. There was reference to the obvious area of deliberate self-harm but in relation to risk areas for others the only observation was "became quite violent towards common-law wife" and nothing more. It is to the credit of all those on the Ward and in Management to whom we spoke that they did not seek to justify the shortcomings of this documentation and we received comprehensive assurances that the system then in force was being reviewed and substantially overhauled – and this indeed before the events of June 1997 – and new protocols were in force to provide for multi-disciplinary assessment and Risk Assessment training. We were pleased to hear this and commend the initiatives involved; we hope we can be assured that these shortcomings highlighted in the Crisp case will be a thing of the past.

e When Jonathan Crisp was discussed at the weekly Ward Round by the Locum Consultant on the 4 March 1997, the decision was then made to discharge him home. This appears to have been somewhat unexpected at the time, and both the family and Crisp expressed views to us (Crisp in his diary) that it was "too soon". However, this appears to have been a medical decision and not prompted by any bed situation – because although the ward diary indicates inquiries over the previous days to ascertain if there was a bed available for transfer "back to North Tees", we were told and given figures to demonstrate that there was no pressure on beds at Hartlepool and that was therefore not a factor. The Staff Grade Psychiatrist was asked to prepare and issue a Discharge Letter that day, and this he did. However, because Jonathan Crisp himself thought that it was "too soon", he was able to arrange on the Ward that he should stay another day; (although therefore the Discharge Letter showed the date of discharge as the 4 March 1997 he did not leave hospital until 5 March 1997 which was very unusual in the circumstances). We were unhappy about the discharge arrangements because we were unable to discover any evidence at all – either in the documentation or in oral evidence – that adequate enquiries had been made either as to his home circumstances or his arrangements for getting home – and in fact he simply left the hospital carrying his personal belongings and was left to find his way home to Stockton, partly on foot and partly by public transport. There was clearly, in our view, a breakdown in proper discharge arrangements in this case. Management accepted that there should be a full review of what had occurred.

f The Discharge Letter recited briefly the facts of the admission "following an act of deliberate self-harm" and reviewed his medication, and the Discharge Letter identified the diagnosis/impression as "adjustment disorder/secondary depression". It was significant, however, in our view that the Discharge Letter made no reference whatsoever to the diagnosis of Borderline Personality Disorder or to the admissions of violence and violent thoughts and the "urges to kill" reported and recorded at the time of his admission. Since copies of the admission documents were to be passed to the receiving clinicians, we considered that a properly constructed Discharge Letter should have been careful to draw specific attention to these matters for the benefit of those who were to treat Crisp in the future.

It is nevertheless important to note, that although Crisp was discharged to his home in the circumstances outlined above, steps were in fact taken by the Hartlepool Hospital to ensure that the GP

received a copy of the Discharge Letter and that a copy was also sent to the Consultant Psychiatrist at North Tees General Hospital with a note "to arrange follow up at North Tees General Hospital". North Tees had already been notified by Hartlepool of the proposed discharge, and Hartlepool had arranged to send copies of the Discharge Letter and relevant notes to the Fairfield Clinic where the North Tees Mental Health Team were based. On the 3 March 1997 the Sector Team within North Tees discussed Crisp's imminent discharge from Hartlepool (of which they had been informed) and decided to jointly assess him.

On the 7 March 1997 the allocated CPN and Social Worker called at Crisp's home to see him but as there was no reply left a message for him. Crisp responded by telephone and an appointment was made for the officers to call and see him on the 12 March 1997. From the above we were satisfied, that although we have highlighted a number of concerns about the Hartlepool episode and Crisp's treatment there, that at the time of discharge adequate arrangements were made to ensure that his home area of North Tees received sufficient information to enable them to "pick up" his future care and supervision.

g A final matter of our concern was that we were told by both ward staff and management at Hartlepool that the Care Programme Approach was not applied at Hartlepool to "non-resident" patients, because they felt that this was something which had to be dealt with in the patient's "resident area". As a result of this, Crisp's name was not entered on the CPA register in accordance with this policy. Although the question of the application of the CPA to Crisp was quickly overtaken by events (because of his admission to North Tees General Hospital as an emergency following the second "self-harming" incident to which we refer to below), nevertheless this is an issue which must be addressed to ensure that simply because a patient is "non-resident" in the Hartlepool area he does not fall through the net of "care programme" because of this. In our discussion with Management at the Inquiry this point was highlighted and they are satisfied they have now taken it on board. We must also record that during the course of the Inquiry – and having received full co-operation from all levels of staff and management – we were also shown considerable review documentation and new procedure protocols and training programmes which had been under review in 1997 and onwards, and which were now either in force or in the process of implementation and which Management were sure would address the points we had highlighted. This we commend.

SECTION 6 – THE SECOND ADMISSION & NORTH TEES GENERAL HOSPITAL

1 After his discharge from Hartlepool on the 5 March 1997, Jonathan Crisp returned briefly to his own flat in Stockton, but was immediately in contact both with his grandmother and with Miss Y. Both expressed surprise to us that he had been discharged back home at that stage and felt he was still "very unwell and unable to cope". His grandmother saw to him settling back into his flat and was aware from him that he was due to go to North Tees Hospital as part of the follow-up. However, we learnt that almost immediately he went back to Miss Y's home where cohabitation was substantially resumed – although it appears that in the interests of the boys they arranged that he should not be there when the boys were around and to that extent, therefore, his daily life and routine became even more unsettled.

2 At Miss Y's home on the 10 March 1997 he again cut both wrists – more severely it would appear than on the previous occasion – and she had to call an ambulance to take him to hospital as an emergency. Although this was manifestly deliberate self-harm it did not appear to have been an intentional attempt at suicide, but rather – like the first occasion a fortnight earlier – more a call to draw attention to his condition of moroseness, self guilt and severe depression. At North Tees Hospital his wounds were immediately attended to and dressed but the principal issue was to address his mental state and to deal with it. It was the same Psychiatric SHO on duty at the hospital who had seen and admitted him on the previous "Hartlepool" incident, and she was able to refer to and link with her previous notes which she had available – although she had not at that time had the opportunity of seeing any documentation from Hartlepool relating to his discharge from there earlier that week. He was admitted during the night to the Cook Centre without any documentation being transferred from Accident & Emergency and was not seen further by the medical staff that night. Later that day he was transferred to the Stephenson Centre. Crisp was then seen by the Consultant Psychiatrist at North Tees who noted in her admission notes that, whilst there was notification of Discharge from Hartlepool, she had seen no Care Plan or other direct communication. As with the SHO, she noted the previous admission history but without the previous North Tees hospital notes and the Hartlepool documentation she was not aware of the concerns then expressed and recorded relating to his behaviour to and threats against other people. She noted in conclusion that he was "in an acute social crisis with a background of two episodes of self-harm in the past week and an alleged victim of physical abuse". The plan was that he be hospitalised, with a note that he would be "detained if necessary as he is quite unstable". Formal "detention" was not in fact necessary as Crisp was agreeable to be admitted to hospital.

3 Because of the imminent birth of their second child Crisp was granted leave on the 12 March 1997 to spend time with Miss Y and did so, quite regularly, over the whole of his period of hospital admission. Crisp had shown himself very anxious to be with Miss Y whilst she was expecting the baby and immediately thereafter, and it was seen at North Tees Hospital to be in the best interests of everyone concerned to make this possible. Additionally, we learnt from Miss Y of Crisp's ability to recover very quickly from such an episode and to be able to convince people who saw him "that he was well and capable and should be allowed his own wishes." This was specifically confirmed in the evidence of the Consultant Psychiatrist who saw Crisp as very quickly presenting himself as "I'm alright – I'm through this now. Can I go home and see my girlfriend, I'm not suicidal you know, and I was in a bit of a crisis". However, his mood and presentation fluctuated, and his period as an inpatient (albeit with regular leave periods) continued until the 25 March 1997 when he was transferred within the Ward to the Partial Hospitalisation Programme which was in effect a day attendance procedure providing for Ward accommodation during the day, with no overnight accommodation except in very special circumstances. The intention of such a programme was to enable patients to attend on a daily basis to receive any continued assessment necessary, but where the reservation of a bed for a patient was unnecessary.

4 Hospital records show a continuation of a very unsettled pattern with Crisp having both "good days" and "bad days" both during the Inpatient period and the Partial Hospitalisation Programme. We saw no evidence, however, of his being involved in any way at all in Ward activities or any other therapeutic process, and it appeared to us that he used – and was allowed to use – the service when it was convenient to him. Indeed, during interviews it became apparent that there was confusion amongst the ward staff at that time, relating to their respective roles with regard to full in-patient versus partial hospitalisation schemes. It was confirmed during interviews with senior managers that there had been changes to the organisation of the care scheme which appeared to have taken place with very little preparation of the the staff for these changes. This allowed Crisp to drift throughout his stay within the hospital system with no apparent treatment being provided.

5 Following a multi-disciplinary review of his case it was decided that he should be discharged into Community Care on the 16 April 1997 under the CPA Programme. Prior to his discharge an appropriate CPA meeting took place and a Care Programme was prepared; he was placed on full CPA but not on the Supervision Register. We deal in more detail with the Care Programme and its application and implementation in a subsequent Section of this Report.

6 So it was that between the 10 March 1997 and the 16 April 1997 Jonathan Crisp was a patient at North Tees General Hospital either as an Inpatient or under the Partial Hospitalisation scheme – a period of some five weeks – and there are a number of aspects of this hospital period upon which we must comment specifically:

a Whilst there are comprehensive and helpful notes and records of the circumstances, background and history at the time of admission on the 10 March 1997, for reasons which are not entirely clear to us, there was no adequate linking of the second incident of that day with the previous incident on the 25 February 1997, and the hospital admission to Hartlepool – and particularly to the Notes then recorded of previous episodes of violence and the thoughts directed against the step-father and Peter McNamee. Although the admitting SHO was aware of the background (because of her contact with both admissions) the Consultant Psychiatrist in charge of Crisp's case at North Tees told us she had not seen these very important and relevant papers until after the events of June 1997. This is surprising because the Consultant Psychiatrist's own notes of admission on the 10 March 1997 showed that she was aware of the earlier incident and that a report ought to have been available on the Ward in respect of it – and if not there it would have been for her to seek it out. The absence of this earlier vital information must have made it impossible to complete a full assessment.

b We addressed in evidence the question of Assessment and Diagnosis, and the Consultant Psychiatrist at North Tees told us that her assessment was that of "Borderline Personality Disorder", a condition which she recognised as being difficult to treat on any conventional basis. Although we recognised that the diagnosis matched the similar diagnosis made at the time of the Hartlepool admission and was subsequently fully endorsed and confirmed in the later Forensic Psychiatric Reports after the events, there was no such specific diagnosis we could trace in the documentation and it differed from the diagnosis given in the Discharge Letter to which we refer below. We do not consider that this had any material effect on the outcome, but a more focused comprehensive assessment might well have assisted in a more active and positive approach in the ultimate Care Programme.

c Undoubtedly Jonathan Crisp presented a complex and confusing picture, with substantial mood swings and the clear ability to demonstrate (and to persuade staff accordingly) that he had recovered from any crisis and was well and capable of managing his own affairs and going his own way. This – perhaps coupled

with the view that he was not suffering from any treatable illness – led to a very "relaxed" attitude being adopted towards his Inpatient and Partial Hospitalisation period. We have noted above the extent of "leave" during the Inpatient period and the "come and go" attitude he was able to adopt during the period of Partial Hospitalisation, and whilst we recognise the good sense of avoiding any unnecessary or additional stress and tension by enabling him to be as much in the company of Miss Y as possible around the time of the birth of their second child, we do consider that insufficient, if any, attention was given during the hospitalisation period towards a constructive and pro-active programme to address his problems as indeed there was effectively no therapeutic input apart from prescribed medication.

d When Jonathan Crisp was discharged from Hospital care on the 16 April 1997 a full and detailed Discharge Letter and Summary was dispatched to all concerned, including the GP, the Fairfield Clinic (base of the mental health team) and the Psychology Department at North Tees. The Discharge Letter fully addressed the North Tees hospitalisation and linked with the previous Hartlepool admission and some of the issues then identified, but it did not refer to Crisp's earlier adverse expressed thoughts about Peter McNamee, and we consider this was an omission which must have reflected on the Risk Assessment issue which we address below. The diagnosis given in the Discharge Letter which was written by the SHO was that of "depression; adjustment; reaction". This did not accord with the diagnosis of the Consultant Psychiatrist as given to us in her evidence. We were given to understand that she had not in fact seen and agreed it beforehand. This we are told is general practice but we consider this is an issue which must be addressed in respect of all Discharge Letters at whatever Hospital in respect of inexperienced Doctors, where prior confirmation by or counter signature by the Consultant is clearly desirable The Management at North Tees assured us that this was already in hand and being implemented.

e We have similar comments to make about the inadequacy of the Risk Assessment in Jonathan Crisp's case at North Tees as we had in respect of the Hartlepool admission. Because this assessment was completed at the time of admission by the nurse in charge of the ward who did not have the medical admission notes and who, after admission, had very little contact with the case, it addressed only the issue of self-harm and nothing else. This Risk Assessment appears never to have been reviewed again or considered on a multi-disciplinary basis. We refer to the issue of Risk Assessment more fully in a subsequent Section, but it is safer

that we should record that at our oral hearings we were assured by North Tees Management that a new and improved Risk Assessment Protocol was already in practice and we saw the new form of assessment now in use.

f We refer to the Community Care and the CPA in some detail in a subsequent Section of this Report. The Care Programme content was quite brief, involving the allocation of a CPN and a Social Worker to arrange follow-up, together with a renewal of the reference to the Psychology Services for a psychological assessment and report and a follow-up outpatient appointment with the Consultant Psychiatrist. This seemingly limited approach to Community Care Programmes in cases such as Jonathan Crisp's inevitably raises the difficult question of how you treat and deal with a person suffering from Personality Disorder – an issue which we review and address in full later in this Report.

SECTION 7 – CPA AND CARE IN THE COMMUNITY

1 Following a ward round at North Tees on 16 April 1997, which had a multi-disciplinary content, it was decided that Jonathan Crisp should be completely discharged from hospitalisation and made the subject of a Care Programme in the Community under the CPA scheme. A Care Programme was thereupon promulgated which had input in its preparation from the Consultant Psychiatrist and the SHO in Hospital, the CPN of the Community Mental Health Team and the Social Worker. The Care Programme was very simple and basic in its terms and in essence provided as follows:

Medical – to be reviewed by the Consultant Psychiatrist through outpatient appointments.

Nursing – the CPN to see Crisp at fortnightly intervals to monitor emotional state and offer support and to liaise with the Psychological Therapy Department regarding the outstanding referral.

Social Work – the Social Worker to organise the referral to Day Services and liaise with the Children and Families Social Work team as necessary.

Psychology Plan – referred to Psychological Therapy Department for assessment with a view to counselling.

2 A CPN and a Social Worker from the Community Mental Health Team were allocated to Crisp's case and the CPN was nominated as the "Key Worker". In fact, the Social Worker and the CPN were at the time of Crisp's discharge into the community already involved in his case. This was because when on the 24 February 1997 the Children and Families Social Worker had been visited by Jonathan Crisp and had referred him (by letter) to his GP, he had also taken the sensible step of making a referral of the case to the Community Mental Health Team via the Social Services Department in order that they could take Crisp "on board" for assessment and any necessary follow up. However, before any action could be initiated, at that time events had been precipitated by Crisp's first incident of self-harm and his admission to Hartlepool General Hospital. Being aware (as a result of information passed from Hartlepool General Hospital) that Crisp was about to be discharged, arrangements were made for a joint assessment by the Social Worker and the CPN and to that end both, together, visited Crisp's home on the 7 March 1997, but were unable to make contact with him there and left a message for him to contact the Team. He did in fact on that occasion respond and make contact and arrangements for a joint visit to see him at home were made by the Social Worker and CPN for the 12 March 1997.

3 Again, however, these arrangements were overtaken by events because on the 10 March 1997, Crisp was involved in the second incident of self-harm and was admitted to the Cook Centre, North Tees General Hospital. Although it may have appeared to the members of the Mental Health Team that there was a confusing pattern of arrangements which followed, with full hospitalisation punctuated by regular leave intervals and then partial hospitalisation seemingly pursued by Crisp on an intermittent and irregular basis, the Social Worker and the CPN were during this period – which covered the remainder of March and the first half of April 1997 – able to keep in touch with him, talk to him and discuss his problems and to develop some background picture – all of this before he was eventually discharged into the Community. Although differing views have been expressed as to the benefit or otherwise of the partial hospitalisation scheme, it is right to record that the CPN in question felt that "it enabled him to maintain contact with the services and close contact, the idea being that he should come into hospital frequently, have contact, have monitoring and have support and was then able to go to his own home at night". During this period, therefore, of hospitalisation and partial hospitalisation the allocated CPN and Social Worker had contact with Crisp in the ward situation on some half a dozen occasions and also were able to see him (on leave periods) once at his flat and once at Miss Y's home.

4 We were impressed by the detailed recording in the Contact Sheets and Summaries of both officers of their meetings and contacts with Crisp, and later of their continued efforts to keep and progress contact – although seemingly receiving little support and backing from their patient.

The assigned Social Worker who was appointed as the Social Worker to Crisp was not qualified as a Social Worker and was holding a temporary position with only some few months experience. Nevertheless, she was described to us by her managers as "highly thought of" and brought "skills and experience from other posts". She received regular supervision and sought advice from her Team Leader whenever appropriate. We were satisfied that despite the issue of qualification and experience she applied herself conscientiously to the role given to her in the Care Plan. The assigned CPN was qualified with an RMN qualification and background and some eight years experience in that role. We were provided with detailed records and summaries of her contacts and interventions in the Crisp case, and we were satisfied that she had made efforts to fill the limited role assigned to her in the Care Plan.

5 However, once Crisp was discharged from hospital and into the community on 16 April 1997 difficulties of contact, intervention and involvement were manifest. During the period from his discharge from hospital on the 16 April 1997 until the 21 June 1997 – a period of some

nine weeks – during which he was in the Community under the Care Plan, there was undoubtedly only fragmentary contact by the Officers with Crisp due to continued difficulties in meeting him and his failure to respond to appointments, calls and letters. The records show some four or five abortive calls at his home by one or other members of the Team, a similar number of letters written to make appointments and attempts at telephone contact. Contact was not made any easier by the fact that Crisp divided his time between his own flat and Miss Y's home – but seeking not to be at Miss Y's home when the older boys were there.

The last meeting at Crisp's flat during the partial hospitalisation period was by the Social Worker shortly before the formal discharge, when she was able to raise the question of Day Services available to him so that he could consider this in advance. Both Team members were in fact able to see and visit Crisp at his own flat on two occasions during the last week in April and found him "calmer and more in control" and willing to think about attending Day Services. These services would either be at the Norton Road Centre or at Parkside (where day facilities and training were available) and the Social Worker undertook to make contact and facilitate this. This was immediately followed up by the Social Worker who in fact took Crisp to the Day Services at Norton Road on the 1 May 1997 to enable him to explore his interest in the project, and having introduced him there and let him see the facilities at Norton Road, she then took onboard making similar arrangements for Parkside. In fact, she made an appointment with him to visit Parkside, but he later cancelled this by telephone and thereafter neither the Social Worker nor the CPN were able to make personal contact with Crisp before the events of the 22 June 1997 occurred.

6 The records – as we have indicated above – show house calls without success; follow-up letters to make appointments and telephone calls to try and progress arrangements, but all without response or success – and one appreciates the difficulties, and indeed the frustration, of Team members in seeking to make progress with the patient in the face of such an apparently negative attitude. The Team, nevertheless, sought to keep in touch with the situation as best they could by telephone calls and by third party contacts. On the 14 May 1997 when he telephoned to cancel the appointment to view Parkside, Crisp left a message for the Social Worker that he would in fact make an appointment with her to view the Day Services in the following week. On the 27 May 1977 when the CPN failed to make telephone contact with Crisp at Miss Y's home, she did in fact speak to Miss Y who informed her that Crisp was "okay" and arranged to pass on to Crisp a message that he should contact both the CPN and the Social Worker. He did not in fact do so. On the 8 June 1997 the Social Worker – having failed in attempts to contact Crisp – was able to speak to the Health Visitor who was attending Miss Y and the family and

using this as a means of "third party contact" by someone who was in regular touch, learnt from her that "there were currently no major concerns". On the 17 June 1997 the CPN was in fact able to contact Crisp by telephone at Miss Y's home; he informed her that he was "fine" and that "things had been going well for him". He apologised for not responding to previous requests for contact and said that he had in the meantime visited 70 Norton Road on a chance visit (and this has been confirmed by the Norton Road staff) and that he had kept his appointment the previous day to see the Consultant Psychologist for assessment. He told the CPN that the Psychologist was to arrange counselling for him, "that he was pleased with this" and that he was continuing to take his medication. A specific appointment was then made with Crisp that the CPN and Social Worker would visit him on the 23 June 1997 to see him and to re-assess the Care Programme. The Psychology Department was contacted in order to confirm the assessment had indeed taken place and Norton Road Day Centre was contacted so that his further attendance there could be monitored.

7 The situation, therefore, as at the 17 June 1997 was that although contact during the latter part of the Care Programme had been fragmentary and difficult, the situation was then looking much improved; Crisp was indicating interest and co-operation, was enthusiastic about participating in Counselling Services, was expressing positive interest in Day Centre attendance and expressed his feeling that "things had been going well for him". The next contact between all three was for the 23 June 1997 to review the CPA Programme. It can therefore be understood that against that recent background the events of the 22 June 1997 came as a great shock to both Officers to whom it was totally unexpected and who had no reason to believe that such an event was to be foreseen.

We were anxious to learn from both members of the Team what they saw as their specific roles in the Care Programme, and we talked to them about this when they gave their oral evidence before us. The Social Worker was quite clear that her role was to arrange Day Services and social issues, and she also indicated that she had researched information from the Children and Families Team as to earlier background. The reason for the specific role as to Day Services was that Crisp, during the hospitalisation period, had demonstrated little interest in anything other than staying with Miss Y and her family and it was thought essential to interest him in other fields. The Social Worker made strenuous efforts to involve him in either the Norton Road Day Centre or in Parkside Day Centre, or both, but we have indicated above how difficult this proved to be and at the end of the day little of practical value was achieved, although towards the end of the period Crisp was promising to show more interest.

8 So far as the CPN was concerned under the Nursing Plan, she regarded herself very much as the "co-ordinator" of Crisp's care which meant giving general support and liaising with the Psychological Therapy Department; she would seek there to accelerate his appointment with the Consultant Psychologist following which, it was hoped, that a more positive therapy of Counselling would be introduced. She saw it "as very much a co-ordinating role, but at the same time as a supportive and monitoring role". When one refers to the Care Programme promulgated on the Discharge from North Tees hospitalisation, the views expressed by the Social Worker and the CPN as to their roles matched what the Care Programme required. If, therefore, it was felt that the period of the Care Programme in the Community was lacking in any positive input or therapeutic approach, it appears to us that this was a deficiency in the care plan itself rather than in those who were seeking to implement it.

9 We were also concerned to examine the data and information which the Care Team had available to them considering their management of Crisp's case. They had, of course, the Care Programme itself (but which contained no background history or narrative) and they also had their copies of the Discharge Letters from Hartlepool General Hospital and North Tees Hospital – but, of course, as we have already noted, neither of those referred to any substantial extent to the issues involving Peter McNamee and Crisp's possible antagonism towards him which appeared in the Hospital Admission Notes, whilst any question of violence to others was only peripherally addressed. The Team had access – because the Care Programme referred to this – to the Children and Families Team whose records had more detailed reference to the period of cohabitation with Miss Y and the problems it presented, and although the Social Worker researched the background to some extent, she did not there find any substantial reference to the McNamee issue. Details of the childhood referrals to Psychiatric and Psychological Services had not at that time been identified. In discussing these issues of data and information with the Officer who was the Team Manager Adult Mental Health Service at the time, she was forceful in her comments to us on the question of incomplete information and particularly the absence of prior information about the "McNamee situation". She commented "so we did not know everything, and not everybody in the system knew everything, and I think that is a huge failure". She felt there was no grounds upon which the Care Team could have known that there was any risk to another individual. Such comments emphasised our concerns that grew throughout the hearing of evidence at the Inquiry, that no one agency, no one person, had the full information about Jonathan Crisp, and that the whole picture had therefore never been presented or seen before; all the relevant pieces of information on Crisp were available in and from different sources, but had never appropriately been brought together before the events of the 22 June 1997 occurred. Whether this in any way affected the outcome or

whether the outcome might have been different if there had been a greater co-ordination of information and sources must remain a matter of conjecture, but our main concerns are that:-

a a complete and comprehensive assessment of Jonathan Crisp and his problems was made the more difficult because total information had not been gathered together in one agency or shared at any multi agency meeting;

b this led to the possibility that the problems which Jonathan Crisp presented had not been taken as seriously as might otherwise have been the case; and

c the approach to dealing with such problems as were perceived, and addressing the issue of appropriate therapy and treatment was in the circumstances minimal – and so, as outlined above, the provisions of the Care Programme were perhaps equally minimal and could be likened largely to a "holding exercise".

10 An attempt to bring available sources of information and contact together was indeed made whilst Crisp was in hospital (under partial hospitalisation) and before arrangements were made for his Discharge. Social Services Department at Stockton convened a "Strategy Meeting" on the 2 April 1997 "regarding Jonathan Crisp". Members of the Children and Families Child Protection Team were present, together with the family's Health Visitor and the Social Worker's Team Leader. Crisp's CPN was invited to attend but because of other commitments was unable to do so. The meeting received from the Officers present a full account of Crisp's then current situation (at the Stephenson Centre) and the inter-relationship with the Child Protection situation and Miss Y's home. However, in our view an opportunity was missed in that the Strategy Meeting was viewed from the Child Protection aspect only and did not address the issue of Jonathan Crisp himself.

Of course, it must be remembered that at that stage, although there had been a referral of Crisp's situation to the Mental Health Team and the allocated CPN and Social Worker were effectively "in post", nevertheless Crisp was at the time (and indeed for the next fortnight) a patient at North Tees and neither a Discharge Plan nor a Care Programme had yet been promulgated.

11 Although, as we indicate above, the Team did their best to overcome the frustrating difficulties created by an inability to contact Crisp, his failure to keep appointments, his obvious reluctance to attend the Day Centre facilities offered him and his general lack of co-operation, nevertheless our view is that a more positive approach ought to be directed to cases in

which this lack of co-operation arises in the case of patients the subject of a Care Programme. It would appear that the seemingly over-tolerant approach of the Team members arose from the fact that they had no reason to understand that there was any urgency in the Crisp case, and certainly no reason to believe that his case carried any risks in the community (other than perhaps a repetition of a " deliberate self-harm" incident). However, a programme and protocol ought to be in place to deal effectively with the "did not attend" situation, and we learn that this is now being addressed.

SECTION 8 – GP AND PRIMARY CARE SERVICES

1 As part of our remit to examine the role, responsibilities and actions of all the professionals involved in the care of Jonathan Crisp, the Panel considered Jonathan Crisp's involvement with the Primary Care Services and his GP practice. We were wholly assisted by the full co-operation we received, and are grateful to the two General Practitioners at the Stockton practice at which Jonathan Crisp was registered as a patient for taking time to see us and giving evidence at Middlesbrough, and for making their Files and Records available for our consideration.

2 Jonathan Crisp was registered throughout his life with the same practice and the same General Practitioner, who also had contact with other family members - although the GP's professional contact with Crisp himself was limited and somewhat sporadic. The Practice confirmed the pattern of childhood incidents, ailments and attendances as outlined briefly in our Background History above, which was seen by the GPs as being of no particular significance in the context of this Inquiry. They did, however, confirm the two referrals to the Clinical Child Psychologist and the Department of Child and Family Psychiatry in 1986 and again in 1988 which the Practice saw as being of some importance. We have already noted the views expressed in the Clinical Reports of both referrals – which were initiated at the instigation of Jonathan Crisp's mother because she was concerned about his conduct and was looking for help and guidance. The GP, who knew the whole family well, told us that the picture at that time "was one that you would not infrequently see of a broken marriage where a lot of adjustment is needed by a child who obviously felt that he did not belong there and who therefore started to show disturbed behaviour". These are matters which are recognised and addressed in the Clinical Reports.

3 The second of these Reports was in 1988 when Crisp was 12 years of age and there was effectively no further reference to the GP practice after that stage except for the minor incidents and ailments which we have noted above. The GP did, however, consider that the Reports by the Child Psychologist and the Child Psychiatric Department were important and relevant and should have been researched and reviewed on Crisp's later hospital presentations and in connection with the Assessments then made. Although he was aware, through the Admission Letters and later Discharge Letters, of the Hartlepool and North Tees incidents and admissions, there was never at that time any request to him for Reports and Papers and it was his assumption that the earlier Reports, coming from Hospital Clinical Departments, would have been accessed and provided to the appropriate Hospital Departments on admission. This, of course, was not the case, and we would not have expected earlier Reports to be linked after that lapse of time, a request, therefore, from the

Hospital for a report from the GP or for his notes and records would have been extremely helpful in bridging the gap.

4 The Panel also noted the GP's own view of the family setting when Crisp was a child (since he had been in contact with most family members at the time) as being "supportive and reliable". He indicated that he had had no concerns at all about the care that the mother and stepfather were giving Crisp, and saw them as caring parents from a respectable background. He felt that in assessing the repeated allegations of earlier child abuse made by Crisp at the time of the later hospital admissions and subsequently, that either the full facts and information were not at the time being provided, or alternatively that the accounts now being given were not entirely reliable or substantiated. This is clearly a view which must be taken into account in assessing the background history in so far as it is relevant.

5 The GP's files showed, and the GPs confirmed, receipt of the Hospital Admission and Discharge Letters and copies of the Care Plans, but advised us that they were treated as being for information only, as Crisp was then in the care of a full Management Team which was not inviting GP intervention. This did mean, however, that the GP's Practice was throughout aware of the continuing background and problems. The GP was also made aware of the referral to the Psychology Department in 1995 and the appointments then made and Crisp's failure – indeed refusal – to take up the opportunities offered. There was, of course, no basis for compelling Crisp as a patient to accept advice and treatment and all the Practice could do was to receive the information and record it on the patient's files. The GP who confirmed the receipt of the letter dated 24 February 1997, written by the Children & Family Social Worker following Crisp's call on him, took the view that this was for information only as the letter reported that Crisp had been advised to call and see the GP. It is felt that in view of the contents of that letter, the GP practice ought perhaps to have been more pro-active at that stage in pursuing an appointment – but it must be recalled that within days of the letter being received Crisp was back in Hospital again following the second self-harming incident.

6 Crisp failed to attend an outpatient appointment made for him to see the Consultant Psychiatrist at North Tees on 9 June 1997 and the GP was so informed – but Crisp in fact then made an appointment to see his GP on 11 June 1997 – no particular reason for the appointment being given by him. However, he turned up at the Surgery about an hour late after his GP had left for other duties, and therefore the GP's partner, who also gave evidence to us, offered nevertheless to see him outside of the appointment time. We commend the flexibility of the GP practice arrangements which made this possible. Because this was the last

occasion when he was seen by any Doctor prior to the events of the 22 June 1997 we looked at this interview in full detail.

7 The Doctor's Clinical Note recalls that Crisp did not think that his medication was helping – although the Doctor noted his own doubts as to whether Crisp was fully complying with the medication bearing in mind the timed intervals between the prescriptions that he sought. Crisp also told him that he had not seen his CPN recently and was not attending the Norton Road Day Centre; he had further forgotten about the Psychiatrist's interview appointment, nor was there any reason given for his failure to keep an earlier appointment he had made to see his GP at the Surgery. After a general discussion he agreed with the GP that he would contact his CPN and would also attend the Day Centre. He made an admission that he had thrown a brick through the window of McNamee's house on an earlier occasion (although at the time Crisp had denied responsibility) and the GP decided after this interview to make contact with the CPN at the Fairfield Clinic in order to pass on the information that had been given to him. The Doctor also insisted that Crisp should make a follow-up appointment with his own GP – and this was then arranged at Reception for the following week. We were told by the Doctor that his assessment of the position as it then appeared to him was that "he did not feel Crisp was a danger to himself and was certainly not deluded or agitated". He got no impression of any menace or threat or any urgency and had the feeling that this was somebody who was "falling out of his Care Plan rather than somebody who needed something new or urgent doing there and then". In short, there was no new or urgent issue arising or something new that needed to be done save (as he felt) for the wise and sensible precaution of passing the information on to the CPN service and to insist on a further appointment being made with his own GP for the following week.

8 In fact the appointment was made and recorded for the 18 June 1997 but – and unfortunately but not untypically – Crisp failed to attend. The attendance on the 11 June 1997 at the GP practice was therefore the last contact with the Practice. Because of his long association with the Crisp family and the general family background - although recently less with Jonathan Crisp himself – we were anxious to learn the GPs reaction to the events which occurred as against the background which he knew. He told us that he felt that there had been no indication at all that such an event would possibly occur and endorsed the view that he had already expressed in writing to an Internal Inquiry that he felt "that several highly qualified and competent people were involved in looking after and assessing Jonathan. The input from all of these agencies was well planned, but the execution of the plan was obviously hindered by Jonathan's unco-operativeness and failure to attend for appointments".

9 If we have any issues to raise or concerns to voice in connection with GP services in Crisp's case, it is to repeat again our view that it might well have been useful for the Hospital Authorities to make greater use of the availability of information which a GP Practice might well have about a patient's background and previous attendances, and if, therefore, at the Hospital's request the GP's files and documents and early Reports had been made available to the Hospitals, this may well have been of assistance in a fuller understanding of the background of Crisp and in considering this additional information in their Assessment. Further than this we also note that the involvement of the GP Practice in the Care Plan and Programme was minimal – which effectively left it to the patient to contact the GP if he wished to do so; although this limited involvement was at a level which the GP Practice expected because of the range of Hospital and other agencies already involved, nevertheless we think that this is an aspect which ought to be considered and reviewed because (and we understand that this is a view which has been expressed elsewhere) a GP's Practice is usually the first point of contact for a patient and his family, and the Practice may well be able to contribute more positively to a Care Plan if it had the opportunity and invitation so to do.

Additionally we consider that it is desirable that GP practices should routinely receive information in Child Protection cases where any patient of theirs is involved.

SECTION 9 – THE PSYCHOLOGY SERVICES

1 1995

We have already referred in an earlier part of this Report (Section 4 paragraph f) to the attempts by Social Services and the Psychology Services to persuade Jonathan Crisp to take advantage of assessment and probably subsequent counselling through the Psychological Therapy Services at North Tees. During the Child Protection proceedings of 1996 Crisp was referred to the Clinical Psychology Services at North Tees by the Child and Family Social Services. They understood from their contact with him in connection with Miss Y and her family that he was "very keen to take on board any therapeutic work" which would help prevent him from behaving inappropriately with Miss Y's children. He was therefore offered an appointment for assessment seven weeks after the initial referral, but did not attend. He did subsequently return a form to indicate that he wished to have a further appointment – but when this was made he then again did not attend for interview. A third letter was sent to him, asking him to telephone if another appointment was wanted, but yet again he did not respond and he was then discharged, as he had been warned, from the psychology caseload, and his GP and the other agencies were informed. As indicated in our comment in Section 4, against his refusal to be involved in the process, it was difficult to see that the Psychology Services or the Social Services could have done any more at that time. Miss Y recognised Crisp had been offered counselling at that time but told us that he had refused because "he was stubborn about that because he said he could sort himself out",

2 1997

Following Crisp's admission to the Stephenson Centre at North Tees General Hospital in March 1997, he was again referred for assessment to the Psychological Therapy Service and this referral is recorded in their records as having been received on the 26 March 1997. Whilst there is no section in the referral report proforma to indicate whether the referral is or is not urgent, interviews with clinicians at North Tees indicated that they were not aware of the availability of urgent psychological assessments on the ward within a few days, if a case was made for this – despite the fact that we were assured by the Psychological Therapy Service that such a system was in force and at all times available if requested.

The interview with Crisp by Inquiry Panel members, and his diary entries, indicate that at this time in 1997 he appeared enthusiastic about the prospect of a psychological assessment, and his CPN confirmed that he often asked when he was to be seen. One of the roles of the CPN in the

Care Programme was to pursue the question of the psychology assessment appointment, and whilst she advised us that there had been several telephone calls to find out when this would be, there is only one actual record of contact having been made to pursue this. There was no indication at any stage that the referral was to be treated as "urgent" and it was not until the 22 May 1997 that the service was able to send a letter to Crisp offering an appointment for the 16 June 1997. We heard that the time waited by Crisp for a psychology assessment was due to unusual circumstances in terms of shortage as at that time the Psychologist who was initially to assess Crisp was moving to another post and her caseload and appointments were "running down" at that stage.

3 On the 16 June 1997 Crisp did in fact attend the appointment which had been made for him, and the later Report from the Consultant Psychologist confirmed that he used the opportunity to talk relatively openly about his past, and it is recorded in the hand-written notes that he had "angry feelings towards his stepfather and the father of the two elder children". However, it is also noted that he had "no desire to behave in a way which would harm others". The assessing Psychologist was also made aware that he had an interest in reading about crimes of violence and during this assessment session of some 30-40 minutes she formed the opinion that this interest was "morbid curiosity".

At the conclusion of the psychology assessment it was considered that Crisp's core problem was Borderline Personality Disorder (BPD), confirming the Hospital assessment already made, and the initial therapy plan was to refer him to a GP practice based counselling service in order "to examine his abuse history" and also to ask the Psychiatrist to review the question of drug treatment. The report letter also states that Crisp was made aware of a likely delay in starting therapy and he said that he had found the preliminary assessment helpful, and that he was pleased to be making plans for help for his emotional problems.

The Psychologist's Report (which was addressed to the Consultant Psychiatrist at North Tees) expressed the view "there was no evidence from the interview to suggest urgency in the case". We heard in evidence that the Psychologist on further reflection considered that Jonathan Crisp required psychological therapy with a skilled psychotherapist for his condition of Borderline Personality Disorder, but that an appropriate resource had not been identified nor was such a service available locally in the short or medium term because of current waiting problems.

4 The Consultant Psychologist made her detailed notes after the assessment interview, and prepared and issued her detailed report to the Consultant Psychiatrist at the Department of Mental Health at North Tees

General Hospital on the 24 June 1997 – by which time Peter McNamee's homicide had already occurred.

REVIEW

a The referral in 1995 from the Children and Families service and an appropriate response from the Psychology Services in terms of offering and seeking to pursue an appointment and the attempts made to encourage Jonathan Crisp to engage with the service at that time are to be commended.

b It is regrettable that there was no clear understanding between the Hospital professionals and the Psychology Service as to availability of urgent hospital assessments for psychiatric inpatients. This may be symptomatic of the difficulties the service was undergoing at that time, and we understand that the position has now been clarified with all who would be concerned.

c The delay of three months between the 1997 referral and the first assessment appointment was, we were told, unusual, and given that Psychological Therapy has been identified and included in the Care Programme as the appropriate treatment for Jonathan Crisp, a wait of two months before the patient was given an appointment date was regrettable. Despite the delay for assessment, however, we find no evidence that this factor was material to the events of the 22 June 1997.

SECTION 10 – THE OFFENCE, TRIAL AND SENTENCE

1 The killing of Peter McNamee occurred in the early hours of Sunday 22 June 1997. There was never any issue as to the person responsible – Jonathan Crisp fully and readily admitted that he had killed McNamee. In the following account, it must be remembered that for an initial period – around the time of the killing, our only source of information has been Jonathan Crisp. We are therefore reliant on his honesty in understanding his motivation for his actions.

Before looking in more detail at the facts as they then occurred, it may first be useful to reflect upon the contact which Crisp had had with the medical services during that month. His Care Plan was, of course, that he should be in regular contact with his Mental Health Team of Social Worker and CPN, but that was not occurring. Neither the Social Worker nor the CPN had been able to contact Crisp personally at all during June and indeed the Social Worker had not been able to see him since the 1 May 1997 despite personal calls, letters and telephone calls. On the 8 June 1997, seeking to pursue contact, the Social Worker had been able to speak to the Health Visitor who was attending Miss Y's home and from her she learnt that while Crisp had not moved to live openly at Miss Y's home, he was attending there regularly (but not when the two eldest children were in the house) and there were "no major concerns currently".

On the 9 June 1997 Crisp had an outpatient appointment to see the Consultant Psychiatrist at North Tees, but did not attend and the Consultant Psychiatrist informed the Mental Health Team and the GP accordingly. On the 11 June 1997, however, Crisp attended to keep an appointment he had made at his GP Surgery and although he arrived an hour late, he was nevertheless seen by his GP's partner who had the full consultation with him to which we have previously referred. However, because of the admission that he had broken a window at McNamee's home and because he did not appear to be following his Care Plan, the GP got in touch with the Mental Health Services to make contact with the CPN so that she could be informed of the position. Since the contact with the GP on 11 June 1997 was the last medical contact before the event of the 22 June 1997, we sought a full account of what had then occurred and were told in evidence by the GP ... "I did not feel at the time that he was a danger to himself. He certainly wasn't deluded or agitated. I didn't get the impression of a menace or a threat or an urgency, and reading between the lines my feeling was that this was somebody who was falling out of his Care Plan rather than somebody who needed something urgent doing there and then". The action therefore was to "update" the CPN as to the visit. On the 16 June 1997 Crisp kept the appointment which had been made with the Consultant Psychologist for a full review and assessment. All details of this are referred to in a previous Section and we know from

the evidence of Miss Y and from Crisp's diary notes that although he was pleased at the appointment, and felt counselling would be a benefit and was looking forward to it, he was somewhat disappointed that he was offered no immediate solution. Of course, the Psychologist's full Report was not finalised and sent out until the 24 June 1997, by which time the events had occurred. Crisp had made a follow up appointment to see his GP on the 18 June 1997 but did not attend to keep that appointment. Nor indeed had he responded to an appointment made by the Social Worker to meet him at his home on the 17 June 1997 and because of this the Team made efforts to contact him in some way that day; In fact, the CPN was able to find him by telephone at Miss Ys home. Crisp then apologised to her for not contacting either of them previously, said that he was "fine" and that "things had been going well for him". He explained he had in fact made a visit to the Day Centre at Norton Road by himself and that he had attended the appointment with the Consultant Psychologist for assessment on the 16 June 1997. He told the CPN that the Psychologist was going to arrange counselling for him with which he was "very pleased" and he confirmed that he was still taking his anti-depressant medication. The Team decided to review the case in a joint visit with Crisp on the 23 June 1997 and to re-assess him, and Crisp was advised accordingly.

2 It was against this immediate background that all those involved in the care of Jonathan Crisp during that period expressed to us their shock at learning what had occurred on the 22 June 1997 and their view that it was totally unexpected. The last personal contact with Jonathan Crisp had been by the Consultant Psychologist less than a week earlier – on the 16 June 1997 – and we have reviewed her evidence fully in the previous Section. When we asked her to reflect in some detail on the person she saw and assessed on the 16 June 1997 and the circumstances of the offence committed on the 22 June 1997, she told us "I have struggled to see the link between the person I met on the Monday and what happened at the weekend, and I have not been able to do that. I really have found it very bewildering that this could have occurred and then particularly ..... the very fact that the mutilation happened is very very difficult for me to understand, I am afraid". She said it was very difficult to relate the 16 June 1997 and the man she saw then with what happened on the 22 June 1997 and that she was astonished when she heard the news.

3 None of the Team, of course, had seen Crisp's diary or indeed had had any opportunity of seeing it, but after the event it was possible to look at the diary which had then been discovered and to recognise that during June Crisp was still harbouring a resentment against and some antagonism towards McNamee including, indeed, as the Crown Court was advised at his Trial, one chilling thought of positive violence against McNamee. However, his expressed views remained ambivalent and

confused throughout; whilst in one or more entries he is expressing his "hate for McNamee" there are other references about putting these matters behind him and "moving forward". Indeed the very last entry which appears for the page of Saturday 21 June 1997 reads "I felt very depressed today I just want things to be right all round really. I want things to be right with everyone, me, - and - (the two boys), and their Dad and – and – (the two girls). I wish we could all have the perfect world, I really do I want us to just move forward and be happy". Against this confusing and often uncertain and conflicting pattern we were nevertheless able to learn with some certainty the facts of what had occurred on the night of the 21/22 June 1997 from the accounts available at the Trial, from Crisp's own statement to the Police on his arrest and from the subsequent accounts given to the Forensic Psychiatrists.

4 Jonathan Crisp often followed the practice of going "out with his friends" on Saturday nights. On the 21 June 1997 he met them at Stockton "to have a night out". Apparently he drank between 6 and 8 pints of lager during the course of the evening. He admitted that before going out he had taken a bread knife with him as he had it in mind to break into McNamee's flat to recover the Social Service Reports previously referred to and took the knife "for protection", he said, because he understood that McNamee carried a knife on him. The friends he was with became aware of this and they persuaded him to discard the knife before he entered a night club and this he did (the knife being later found by the Police). Crisp had insisted that he had no intention of harming McNamee and believed that McNamee would be out of the house at the time of the break-in as McNamee was in the habit of visiting friends on Saturdays.

About 2am Crisp and three of his friends returned to Stockton by taxi and Crisp was the last to be dropped off. He then, in the early hours of the Sunday morning, decided to go to McNamee's house to try and recover the Social Services Reports, taking a brick with him to smash glass in the front door to gain entry – knowing that McNamee would be out of the house at this time. He then used the brick to break the glass panel in the door and effected entry this way, going upstairs into the living area. He began to search the flat to try to find the Reports but couldn't find them. While he was doing this McNamee arrived home, saw the break-in, ran upstairs and confronted Crisp. A fight started between them and in the course of the struggle McNamee ran to a window and started shouting for help; Crisp picked up the brick and threw it at McNamee. It missed and McNamee picked it up and threw it back; the brick hit Crisp on the head, and at this Crisp "lost control", ran at McNamee, knocked him to the ground and picked up the brick and hit him violently a number of times on the head and face – Crisp says he then became aware that McNamee was dead but added "I didn't intend killing him".

5 It was then that the mutilation of McNamee's body occurred and later forensic examination and reports confirmed that this had taken place after McNamee was already dead. This is the most disturbing and alarming aspect of the case and one which has caused the greatest concern to all who had contact with Crisp in general and this matter in particular. There is no need in this Report for us to detail the full circumstances and it is simply sufficient to record that Crisp got a knife out of the kitchen and used it on McNamee's abdomen and genitals and head and added other offensive behaviour. He then searched the body, and finding some cannabis smoked it; he found some ice cream in the fridge and ate it, whilst playing a record on the hi-fi. He then took some records, books and videos belonging to McNamee and left the house. He returned back to his own home and there telephoned Miss Y to tell her what he had done, and later to prove it took his bloodstained tee-shirt to show her. He left her and went to see another friend to tell him what he had done and then went to a local public house where eventually he was located and arrested by the Police.

6 It has been explained to us from Crisp's own account and from Forensic Reports that Crisp's behaviour and conduct to McNamee's body followed from a morbid fascination which he had developed over some months (at least) into the crimes and behaviour of notorious serial and other killers which was fed by his regular reading of a monthly magazine which was available on bookstalls called "Murder in Mind". Miss Y knew of his reading this sort of material – and indeed his grandmother had seen it on at least one occasion and complained to him about it – but we were told by those who had attended Crisp in both Hospitals that they had no knowledge of this at all nor had the Social Worker or the CPN, and we heard no evidence to the contrary. All told us that if they had known of this at all then although it was something that they could not prevent (since the magazine was openly available in bookstalls) they would have reported and made sure it was known to all concerned in Crisp's care. Crisp's explanation in his statement to the Police was "Dennis Neilson had mutilated his victim and Peter Sutcliffe had stabbed a victim in the eye and I wondered what it would be like to do the same thing".

7 We ourselves can make no comments and express no conclusions on these appalling facts and can only look to the Forensic Psychiatric Reports to place this violent and alarming behaviour in some sort of context. Those Reports advise us that Crisp's description of the sequence of events leading up to the killing of Peter McNamee and Crisp's feelings towards his victim at the time make it likely that the killing took place more out of anger and resentment. Crisp intended to break into McNamee's house that night and his description of events preceding the killing and his efforts to avoid any direct confrontation with McNamee accord with the Borderline Personality Disorder structure. Crisp bitterly resented

McNamee because of the family situation; McNamee's informing Social Services and promoting their involvement; McNamee laughing at him for having "bared his soul" in an earlier attempt to apologise; and this anger and resentment peaked that night when he was struck on the head with the brick which McNamee threw back at him thus leading to an explosion of anger and extreme violence towards McNamee which led to the battering to death.

The second phase of the event, as the Reports suggest to us, followed when Crisp found a dead body on his hands and then proceeded to coolly and methodically carry out various mutilations which he had read in books and fantasised in his mind.

8 All the Consultant Forensic Psychiatrists who examined Crisp supported the view that he fitted into the category of Borderline Personality Disorder – which is described "as a pervasive pattern of instability of inter-personal relationships, self-image and affects" and which carries a number of particular indicators which include "inappropriate intense anger or difficulty controlling anger and displays of temper". In connection with Crisp's then forthcoming trial on a charge of murder the Forensic Psychiatric Reports concluded:

a That his attention and concentration remained unimpaired, he was able to understand the Charge against him and to instruct Counsel and follow the progress of the Trial and to give evidence if necessary, and was therefore "fit to plead".

b Because of the diagnosed Personality Disorder he was, however, suffering from an abnormality of the mind arising from inherent causes. However, their view was that on the balance of probability Crisp's abnormality of mind did not "substantially impair his mental responsibilities at the time of the offence and that accordingly a plea of manslaughter on the grounds of "diminished responsibility" could not be supported.

9 At his subsequent trial at Newcastle Crown Court the issue of "diminished responsibility" was fully argued and examined and upon the Court ruling (on a preliminary point) that the evidence available to the Trial could not support a plea of "diminished responsibility" Crisp tendered a plea of "Guilty" to the charge of murder and was then, as the law required, sentenced to a term of life imprisonment. Finally, we should note that the Forensic Reports concluded that there was no evidence that Crisp suffers from a serious mental illness which needs treatment in a hospital setting. He is, of course, now imprisoned under the terms of the sentence imposed upon him, and a view is expressed in the Forensic Reports that his

personality problems could be considered to be untreatable at the present time.

10 Whilst, as we say, the Panel do not consider it to be part of their role to examine and analyse the circumstances of the killing and its aftermath and to examine and pronounce upon intent and motivation, nevertheless, detailed examination and consideration of all the circumstances and their detailed subsequent examination and consideration at Forensic Psychiatry level can lead to a view – in our opinion the most likely - that the events of the 21/22 June 1997 be seen as containing three stages, namely:

i A "night out" with a fair amount to drink and heightened emotional state,

ii A burglary which "went wrong" with Crisp reacting violently to discovery and confrontation and killing in a mood of pent up anger and resentment.

iii The stage, after the killing, of morbid deranged and bizarre behaviour arising from his readings and fantasising, and rooted in his disordered personality.

The first stage is by no means an uncommon circumstance. The second stage was a dreadful event but one which could occur in a wider range of circumstances not involving mental illness, but the third stage must be one of alarm and concern which remains to be considered and addressed.

SECTION 11 – ISSUES AND CONCERNS

1 In the previous Sections of this report we have reviewed, chronologically, the background and history of Jonathan Crisp up to the tragic events of June 1997 and the killing of Peter McNamee, and have particularly examined and considered his contact and involvement with the Health Service during that period and expressed some views upon it. In our Terms of Reference we are particularly required to consider the appropriateness of Jonathan Crisp's treatment care and supervision in certain particular fields including:

- The assessment of his health and social care needs;
- The assessment of risks;
- Decisions relating to the Care Programme and the extent to which Care Plans were effectively drawn up and delivered;
- The adequacy of collaboration and communication between professionals and agencies involved

We now wish to address each of these issues in more particular detail and we express any concerns we may have about them.

A RISK ASSESSMENT

1 The Assessment and Clinical Management of the risk of a psychiatric patient causing harm to another person is an integral part of psychiatric practice. (Royal College of Psychiatrists Council report CR 53 1996)
Other advice and guidance appear in a number of other references:

In 1990 the Dept of Health issued guidance HC (90) 23 on an approach "to provide a network of care in the community," for people with severe mental illness, which would minimise the risk that they lose contact with services, known as the Care Programme Approach (CPA)."

The Health of the Nation Key Area Handbook for mental illness refined the original guidance, stating that the CPA involves:

- Systematic assessment of the health and social care needs of the patient
- Drawing up a package of care agreed with members of the multi-disciplinary team, GPs', service users and their carers
- Nomination of a key worker
- Regular review and monitoring of the patient's needs and progress and of the delivery of the care programme

In February 1989 the Department of Health published "Discharge of patients from Hospital" and at the same time HC (89) 5, emphasising the importance of ensuring that, before patients are discharged from hospital, proper arrangements are made for their return and for any continuing care which may be necessary.

2 Jonathan Crisp was admitted to Ward 16 at Hartlepool General Hospital on the 25 February 1997 following referral from North Tees General Hospital after having been seen in their Accident and Emergency Department following an act of deliberate self harm. The Psychiatric Senior House Officer at North Tees who saw Jonathan Crisp initially, recorded that he had tried to kill himself, he was hearing voices possibly that of God, he expressed paranoid ideation and that the voices were telling him to kill the father of his girlfriend's children. She formed an opinion of psychiatric depression and schizophrenia and this information was forwarded to Hartlepool General Hospital when the patient was transferred there. On admission to Ward 16 he was seen by the Staff Nurse and Duty Psychiatrist and although the medical examination there of the patient was fairly comprehensively documented the mental health assessment provided to the Inquiry Panel members was inadequate in many sections. In particular, although part H of the assessment form relating to Risk Assessment was partially completed and identified issues of self neglect and self harm and violence towards his common law partner, it did not reflect or record the issues and concerns noted on admission as to the "hearing of voices" and the message to kill. There were manifest shortcomings in the extent and quality of the information contained in the Risk Assessment form which may – as we have already indicated in our review of the Hartlepool situation – have been contributed to by the erroneous view that he was an "in transit" patient and also because of his short stay there. We note particularly that the Risk Assessment form was completed by a nurse coming on duty the following day who appears to us to have little contact with the patient, was not dated and countersigned and does not appear to have been reviewed at any later stage and did not involve any other disciplines. Because, as we have already noted, Jonathan Crisp was back in hospital again less than a week later because of the second incident of self harm, and then was hospitalised for a much longer period the shortcomings of Risk Assessment at Hartlepool do not assume a major role in the picture, but we must note that certain cardinal principles underlined in the report of the Royal College of Psychiatrists to which we have referred did not appear to have been observed in any way:

i "An adequate Risk Assessment can rarely be done by one person alone. Wider information is needed and it is almost always helpful to discuss the assessment and the management plan with a peer or a supervisor".

ii "Risk Assessment needs a predominantly short term perspective and must be subject to frequent review".

3 On 10 March 1997 Jonathan Crisp was admitted to the Cook Centre at North Tees General Hospital from their Accident and Emergency Department having slashed both wrists superficially in an episode very similar to that of 25 February 1997. At that point he became subject to the North Tees Care Programme Approach Policy.

He was admitted to the Cook Centre during the night due to there being no male beds on the Stephenson Centre. This was a temporary placement and he was to be transferred to the Stephenson Centre later that morning.

The Registered Mental Nurse on duty on the Cook Centre began completion of a Specialist Assessment Form, although it being approximately 3am, and the patient being tired and having consumed alcohol, the completion of this document was not comprehensive.

No multi-disciplinary Risk Assessment was carried out though individual members of the clinical team were aware that abuse of the patient's partner and children had taken place. Threats made known to the admitting SHO were not repeated on the ward assessment. Important information obtained by the SHO including "voices in the mind telling me to kill" and recorded in the Accident and Emergency Department were not delivered to the admitting nurse. Instead the admission was arranged by telephone, vital information was not passed on and therefore not included in the Nursing Assessment. The Risk Assessment completed by the admitting nurse was therefore inadequate in many respects, especially in relation to the patient's history of violence and the potential harm to others (already expressed to the admitting doctor).

4 The Panel have similar concerns and reservations to note in respect of this Risk Assessment at North Tees as they have in respect of the Risk Assessment at Hartlepool. The two general principles we have outlined above relating to the review of a Risk Assessment and also to the need for a multi-disciplinary involvement had not been observed, nor did the Risk Assessment (or indeed the Discharge Letter issued at the end of hospitalisation) address the possibility of any specific risk to a third party. Here again, therefore, the Risk Assessment failed to meet proper clear general principles underlined in the Royal College's report namely:-

i "Some risks are general while other risks are more specific, with identified potential victims"

ii "The outcome of the assessment and the management plan must be shared with others as appropriate." – This was something that did not

happen because neither the Risk Assessment or the Discharge Letter contained the necessary information.

5 Whilst the Royal College's report emphasises that "risk cannot be eliminated; it can be rigorously assessed and managed but outcomes cannot be guaranteed" – we are aware that our concerns about Risk Assessments in the Jonathan Crisp case are shared by other professionals who had already carefully examined and reviewed some of the issues arising here. The Internal Inquiry into the care of Jonathan Crisp concluded that the process of Risk Assessment was poor, was inadequately communicated within the clinical team and was not in line with current guidance. There was no evidence that the medical notes were read by the Consultant as part of her assessment and in particular there was no mention in the assessment of any "threat to kill". If the notes were indeed read, there is no evidence that the information contained in them was acted upon for Risk Assessment or in any subsequent formulated plan. We are bound to conclude on all we read and heard on this issue that the Risk Assessment was never adequate, and this may well have been because no risk to others (as opposed to self-harm) was ever perceived. In the events therefore, there was no apparent approach in the Care Programme towards the evaluation of risk.

The Director of Nursing and Quality in her evidence to the Inquiry Panel acknowledged the many deficiencies in the Risk Assessment procedures, and we were encouraged from the oral and documentary evidence placed before us that revised and strengthened procedures are now in place and that the shortcomings that has been highlighted are now being vigorously addressed.

B RECORDS AND COMMUNICATION

1 A great deal of our examination and consideration of the issues arising in the Jonathan Crisp case rested upon our receipt and examination of the records maintained at various stages of his treatment and his involvement with the Health Service and, including in particular, the extent to which information and detail available to one sector or agency was made available to others.

2 The need for keeping accurate records is universally acknowledged and is particularly identified in the report of the United Kingdom Central Council (UKCC) in relation to "Standards for Records and Record Keeping". It is there pointed out that:-

a records provide accurate, current comprehensive and concise information concerning the condition and care of the patient and associated observation;

b they provide a record of any problems that arise and action taken in response to them;

c they will include a record of any factors (physical, psychological or social) that appear to affect the patient;

d there are means of communicating with others and describing what has been observed or done

3 We have considered the Hartlepool and North Tees documentation in the light of these standards and have a number of observations to make.

a **The Hartlepool Admission**

The notes taken during the initial admission assessment were very thorough particularly considering that this took place in the early hours of the morning. However, ongoing clinical records did not address many of the issues raised in the initial assessment, and particularly threats of violence were not followed through. The Mental Health Assessment Record provided to the Inquiry Panel members was deficient in a number of sections. Although the sections incorporating personal/family history, physical health, central nervous system, physical examination and psychiatric help recorded by the admitting officer are comprehensively completed, the section relating to social function in its many aspects of employment/occupation physical well being etc are totally blank and had they been completed could well have produced later valuable information especially in relation to suitability for psychological treatment. The reasons for this poor quality of recording were not adequately explained but the admitting nurse volunteered that this might well have been due in some part to the timing of the admission (about midnight), and Crisp's anxiety to retire to bed after having been subjected already to two sets of interviewing at both North Tees and Hartlepool before the admission procedures commenced. This is perhaps understandable but does not explain why further completion of the necessary documentation in the days following admission and during the continued hospitalisation did not take place. Contact was made with Fairfield Clinic prior to the discharge from Hartlepool and copies of discharge information were faxed through in advance, which was indeed good practice; there appeared, however to be a longer delay in forwarding information to the Consultant Psychiatrist at North Tees.

We have already referred in a previous Section of this Report to the issue at Hartlepool as to Crisp being "boarded out" and his stay of being a temporary nature. In the opinion of the Panel this affected the quality of the assessment that was being carried out and the timing and the apparent lack of preparation surrounding Crisp"s eventual discharge. The Clinical Nurse Manager and the Speciality General Manager for the Directorate at

Hartlepool clarified that the suggestion of a "boarded out" or "in transit" patient are wholly inappropriate in the circumstances that there was a reciprocal arrangement between North Tees and Hartlepool. Our concern was that this reciprocal arrangement did not appear to be communicated effectively to staff at ward level who saw their role as being to facilitate the move of Jonathan Crisp back to North Tees at the earliest opportunity.

b **The North Tees Admission**

Once again, the initial admission assessment records were satisfactory considering the admission was again made in the early hours of the morning and that Crisp was not in a co-operative frame of mind. There was, however, some lack of clarity as to whether all professionals concerned were contributing to the admission assessment process. Between them they had a lot of information from different sources which was omitted from the assessment document. Nobody appeared to be taking the lead in co-ordinating this information and accordingly there was no evidence that a full sharing of information was taking place either then or during subsequent ward rounds.

On the question of inter-communication, very limited contact was made with Jonathan Crisp's partner, and no information was obtained from his grandmother with whom he had regular contact. As a result of this they were not involved in advance in the development of the discharge Care Plan and this was a shortcoming. Communicating of information between the members of the medical team came across as being poor and there was no evidence that past medical records were obtained or considered. As already pointed out, the patient's GP, who had known him since birth, was an obvious source of background information but this was not explored by the Hospital staff.

During interviews it became apparent that there was confusion amongst the ward staff at the time relating to their respective roles with regard to the full hospitalisation scheme and the partial hospitalisation scheme and that no detailed care plan was drawn up to address Crisp's partial hospitalisation needs. This allowed Crisp to drift throughout his stay within the hospital system with no apparent pro-active care being targeted or provided.

Nurses interviewed by the Inquiry Panel accepted, with hindsight, that some of the quality of recording was inadequate and did not reach the standards laid down by the UKCC. This was also accepted by the Management witnesses and we had firm undertakings and assurances that any shortcomings highlighted were being rigorously addressed.

c Social Services and Child Protection Committee Information

Previous contact with Crisp by the Social Services Department (prior to his hospitalisation) was primarily around the role he played in the Child Protection concerns relating to the children of his partner. The information therefore available to the Children and Family Section included valuable information regarding Crisp's past violence to his partner and the difficult relationship he had with the father of her two children (Peter McNamee). Although the Children and Families file was made available to the Social Worker assigned to Crisp, it is not clear how much this information was shared with other mental health team members, although Crisp himself related his past abuse of the children to both medical and nursing staff on both admissions to hospital and during subsequent hospitalisation. Although the CPN was made aware of the background situation between Crisp, the children and Miss Y, Miss Y had stated that she no longer considered him to be a risk within the family setting. Although the Children and Family information was eventually made available to the Social Worker involved with Jonathan Crisp, there was no database available to the Team which would have identified that Jonathan Crisp had previous contact with other Social Services areas and this, we were assured by Management was an issue being currently addressed. More importantly, of course, we have already observed that because of the deficiencies in Risk Assessment and the Discharge Letters, the Community Mental Health team whilst aware of the Jonathan Crisp/Peter McNamee relationship, were not informed through any records or reports of any specific threat. The communication between the two professionals involved in the Community Care of Jonathan Crisp between April and June 1997 appeared positive on a majority of occasions, but difficulties arose when there was a lack of compliance by Jonathan Crisp. Records of contact made or attempted were kept by both parties, although there were some gaps in the written CPN records and some valuable information obtained from the GP's partner (regarding Crisp's attendance upon him) did not appear. Although both workers were involved in ward rounds at North Tees prior to the patient's discharge and there were notes of attendance accordingly, there was no indication as to what information was shared with whom, and to what extent they had been involved in the decision making process regarding both discharge and after care. It is evident from records that when problems began to occur the Social Worker discussed this with her line Manager for guidance as to the action to be taken but there appeared to be no mutually agreed plan drawn up between the two workers in the team as to how to deal with the "no contact" situation and both appeared to be taking a different approach to the lack of contact.

C CARE IN THE COMMUNITY

1 The Discharge Process

Discharge from hospital will precede arrangements for Care in the Community under the CPA and it is appropriate therefore, to reflect upon the discharge arrangements at both hospitals before looking at the Care Programmes then prepared and promulgated for Jonathan Crisp's Care in the Community. Guidance on discharge procedures is set out in the Department of Health publication "Discharge of Patients from Hospital, and HC (89) 5 emphasised the importance of ensuring that before patients are discharged from Hospital proper arrangements are made for their return and for any continuing care which may be necessary.

1.1 Hartlepool

The panel was unable to elicit any information from the medical and nursing notes as to how the decision to discharge Jonathan Crisp from hospital had been made. The areas of possible risk were not identified or examined and the decision to discharge appeared to be quite sudden. Witnesses told the Inquiry that the decision to discharge would have been multi-disciplinary, but there was no documentary evidence either to support this or to indicate any prior in-depth discussion. Jonathan Crisp told Inquiry members that on the 4 March 1997 a doctor simply told him that he was being discharged with no further arrangements being made and that he (Crisp) thought it was "too early" and negotiated with staff a deferment of the discharge by twenty four hours. The following day he did in fact have to make his own arrangements to get back from Hospital, and managed to get a lift to Hartlepool Town Centre and from there he got a bus to Stockton and walked to his grandmothers home. In the Panels view this was wholly inadequate, especially since no contact had been made with any relatives and no attempt had been made to verify social history and daily living arrangements prior to discharge.

The Discharge Letter had been hastily written and did not include information about the threats of violence which Crisp had made during his initial medical assessment. The letter was written by the recently appointed Staff Grade Psychiatrist and did not appear to have been verified by the Consultant. However, it is, important to record that prior to Crisp's discharge from Hartlepool, contact had been made by the Hospital authorities there with the Mental Health Team for North Tees based at Fairfield Clinic, and information concerning the proposed discharge and the later relevant documentation was faxed to them. This was good practice and in turn alerted the Mental Health Team at Fairfield of Crisp's return home and enabled them to initiate the first steps for case contact.

1.2 **North Tees**

There was no written evidence in the case of this discharge that the discharge decision had been based upon any reassessment of Crisp's mental state at that time, bearing in mind he had then been subject to a lengthy previous period of a rather irregular partial hospitalisation programme. Equally the records do not reflect that a multi-disciplinary assessment had been carried out prior to discharge, although the evidence we heard indicated that various disciplines had been present during the ward rounds. Once again family members were not involved in the discharge process and this could well have been a particular assistance bearing in mind the length of time which Crisp had spent at Miss Y's home during the hospital leave periods and the partial hospitalisation programme.

The Discharge Letter which was written by the Senior House Officer Psychiatry covered most relevant areas but importantly did not include any reference to Jonathan Crisp's previous threats against the ex partner of his girlfriend, or that his girlfriend had expressed concern about his obsession with this issue in the past nor was a diagnosis of Borderline Personality Disorder recorded. Again the Discharge Letter did not appear to have been verified in advance by the Consultant despite the fact that the contents of the Discharge Letter would have an important role in conveying to those subsequently concerned with Crisp's Care in the Community all particular and relevant issues. The failure to provide this information in the Discharge Letter is something upon which we have already commented adversely in connection with the implementation of the Care Programme by the Community Team and their criticisms of it.

2 **Content of the Care Programme**

2.1 **Hartlepool**

A full Care Programme Approach was not put in place upon Crisp's discharge from Hartlepool because he was then a North Tees patient and the CPA was not applied to him at Hartlepool. The Discharge Care Plan contained very little information and was based on an incomplete assessment of Jonathan Crisp's situation, and was therefore of limited value with regard to ongoing treatment. Of course as far as Hartlepool was concerned the issue of ongoing treatment was almost immediately overtaken by the second incident and Crisp's admission to hospital at North Tees as a further emergency some few days later.

2.2 **North Tees**

The Care Plan format in place at that time in North Tees was completed on a form CPA/1. This was a very limited Plan consisting of a single page only,

and gave an extremely brief description of the role of the professionals to be involved in carrying out the Plan. The contents of the Plan, as we have already indicated in the previous section, included very little action other than encouraging Crisp to attend for day care and the monitoring of his mental state whilst awaiting the expected appointment with the Psychologist. There was no family involvement in the development of the Care Plan and there is no indication that Crisp had been involved in any way preparing the Plan or had given any prior commitment to its content.

The Care Plan contained no treatment element, and did not provide any guidance as to what the ultimate aim was to be in providing on going support and care in the Community. It did not appear to be linked to an assessment of risk (no doubt because the Risk Assessment and Discharge Letter were markedly deficient in this area) and no guidance was given to the Key Worker as to the action to be taken should there be problems in maintaining contact. The concern of the Panel was that this Care Programme formulated on Crisp's discharge from hospitalisation in April did not address the issues in sufficient depth, and did not sufficiently guide the Community Team in any specific direction or give any sufficient indication of what they were aiming to achieve. We viewed it as being very much a case of "marking time" until the psychology appointment was available. However a much more pro-active Care Plan ought to have addressed in some ways the problems underlying the Personality Disorder and the stresses and distress to which it gave rise.

3 Ongoing contact and communication with Jonathan Crisp

3.1 During the first three weeks following Crisp's discharge from Hospital, contact was made with him in accordance with the Care Plan by the appointed Social Worker and CPN. After the initial visit, this arrangement began to fall down with Crisp missing appointments and not being in for home visit – this happening on at least four occasions when the Social Worker visited. One initial accompanied visit to the Day Centre in Norton Centre was effected but an appointment for a like visit to Parkside was cancelled by him. This resulted in no face to face contact with Jonathan Crisp by either the CPN or the social worker from the 6 May 1997 onwards, some period of seven weeks, until the events of the 22 June 1997 occurred. The maximum contact managed was a telephone call to Miss Y in May 1997, a telephone discussion with the Health Visitor at the beginning of June 1997 and a telephone conversation with Jonathan Crisp himself by the CPN on the 17 June 1997 – which was referred to in full detail in the previous section of this Report.

3.2 The attitude of Jonathan Crisp

The reluctance of Jonathan Crisp to co-operate with the attempts of the CPN and Social Worker to contact him, making no response to cards and

telephone messages which were left for him, and his ambivalent approach to participating in the Day Centre programme made it extremely difficult for the Care Programme to be actioned. In the opinion of the Panel, a more pro-active approach to reinstating contact could have been made and was, we think, possible in the circumstances. Although it was known Crisp made almost daily visits to Miss Y's house no attempt appears to have been made to call and visit him there and no contact was made at any time with the Grandmother. Attempts to contact Crisp at his own home were generally fruitless – this no doubt because he was spending very little time there.

4 **Application of the Care Programme**

The Care Plan contained no clear aim for the workers concerned to work towards, and did not include any treatment element. This resulted in Jonathan Crisp drifting on a week to week basis with no one taking responsibility for exploring in depth, or indeed in any way monitoring, his mental health. Other than the Social Worker being responsible for managing day care, the respective roles of the two workers were blurred. We have already commented on the qualifications and experience of these two workers and an issue arises as to whether these workers had the extent of skills and experience to help Jonathan Crisp to explore his own feelings at any given time, particularly with regard to his personal relationships. Although this type of intervention may have had a very limited impact on the eventual outcome, there is certainly the possibility that it would have enabled him to talk through his problems with someone and for those problems to be better identified.

D PREVENTABILITY OF THE OUTCOME

1 A question which inevitably but understandably arises when events such as those of the 22 June 1997 have occurred is "could this have been prevented?". The Panel have given anxious and careful consideration to this question and have re-examined all the background and evidence leading up to the homicide.

Although in previous Sections we have been critical of some events during the period of Crisp's hospitalisation both at Hartlepool and North Tees it is a matter of conjecture – but doubtful – whether the limited treatment then given to Crisp had any bearing on the eventual outcome.
We have also been critical of the quality of the Risk Asessment procedures which were followed and the Discharge Letters which were written at the end of each inpatient period. They all fell short of the standard which ought to be expected and achieved, and certainly contributed to the failure to provide full information and communication to all concerned and to enable "the full picture" of Jonathan Crisp's problems to be seen and recognised. His Care Plan was basic and minimal, but even at that level Crisp showed no

inclination to co-operate or support it. At the end of the day the diagnosis "Borderline Personality Disorder", identified at Hartlepool and North Tees was supported and endorsed by all the Consultant Forensic Psychiatrists later involved, and also in the Expert evidence we heard. Jonathan Crisp was a very complex person and because of the abnormality from which he was diagnosed as suffering this was a complex situation – but not assisted by the inadequacies in assessment and Risk Assessment procedure to which we have referred.

The Expert evidence which we heard at the Inquiry (and which we detail fully in the next Section of this Report) highlighted the need in such a patient for:-

a hospitalisation and close support and treatment in periods of crisis (such as the two self harming incidents);

b long term Care in the Community with monitoring psychotherapy and counselling;

c but that committing to and long term detention in Hospital or an Institution was not an option.

We have set out above in some detail the events and circumstances as viewed by the GP, the Consultant Psychologist, the Social Worker and the CPN in the fortnight or so preceding the offence and their shock, bordering on disbelief, when they heard of it. They considered this to be contrary to all the improving indications, which they then saw.

In all these circumstances the Panel find it impossible to give a clear answer, one way or another, to the question "could this have been prevented" bearing in mind particularly the outline in the previous Section as to how the offence became to be committed and why – and that it was Crisp's behaviour after the homicide which must give rise to the major questions of his mental state and motivation. The expert advice we have received confirms the view of those who dealt with his treatment at North Tees that his discharge into the Community under a Care Programme was an appropriate course, and therefore it must be a matter of seeking to assess whether the availability and use of a Psychotherapy Service (which would have required full support and co-operation of Crisp) would have assisted in managing the "McNamee" obsession and situation and thereby defused it. This must remain a matter of conjecture. In all the circumstances we do not think it possible to identify and point to any particular problem or shortcoming in the care and treatment of Jonathan Crisp which caused or contributed to the event of the 22 June 1997 – but in the following Section of this Report we seek to review what might best be done to address the problems of patients diagnosed as suffering from this condition of Borderline Personality Disorder and thereby addressing the needs of the larger community.

SECTION 12 – THE TREATMENT OF PERSONALITY DISORDERS

1 Jonathan Crisp was diagnosed as suffering from Borderline Personality Disorder – one of a number of conditions described and defined as disorders of personality. Terminology within psychiatry is at times inconsistent, and although a minority of practitioners may consider that Borderline Personality Disorder is a mental illness, it would more generally be accepted that this, along with the other personality disorders, comes within the umbrella term of Mental Disorder.

We also learned of views that Borderline Personality Disorders are conditions which maybe are "untreatable" – and also of other views that indeed it should be considered to be treatable. We were aware of other similar issues being raised, or concerns being expressed elsewhere, in connection with the diagnosis of personality disorder and of issues in trial and appeal courts where it was considered to be relevant and we are aware of the current debate as to the appropriate treatment and management of such cases, both within the community and within a prison environment. Accordingly, in the light of the issues raised in the case of Jonathan Crisp it was clearly appropriate that we should address ourselves to the issue of Personality Disorder and its treatment within the Mental Health services – or, if not treatable, then to the issues of reducing any risk that behaviours arising from it may raise. If it is believed that Personality Disorders are treatable, then this gives rise to questions of where, how and by whom?

2 We accordingly took the opportunity of seeking expert evidence on the many aspects of this issue and were grateful to Dr Peter John Whewell of the Regional Department of Psychotherapy at Newcastle upon Tyne for agreeing to come to give evidence before us. Dr Whewell is, amongst his many qualifications, a Consultant Psychiatrist and a member of the British Psychoanalytic Society and is presently leading a team in Newcastle which specialises in the treatment of Borderline Personality Disorder. The Panel were seeking advice from Dr Whewell accordingly, on this condition, and were in effect raising with him the question as to how Health Authorities and other providers might want to consider reconfiguring services to deal more appropriately with patients within their care suffering from Borderline Personality Disorder. In what we report below we reflect the evidence and advice that Dr Whewell gave to us, and also other views expressed on this issue during the course of all the evidence we heard relating to the care and management of Jonathan Crisp.

3 Although other diagnoses were at times entertained, the most consistent diagnosis made in respect of Jonathan Crisp was that of Borderline Personality Disorder and Dr Whewell with his particular expertise in this field agreed this diagnosis from his reading of the relevant case papers and pre

trial reports prepared on Jonathan Crisp. He did however point out that it is not uncommon for other maladaptive personality traits to be present in a person with Borderline Personality Disorder, and considered that this was the case with Jonathan Crisp also. Nonetheless, the prominent features of the disorder were present in Jonathan Crisp, and maybe listed as follows:

Firstly, disturbance of affect (mood), with dramatic changes over very short periods of time.

Secondly, impulsive behaviour is seen as sufferers have a very low threshold for tolerating frustration.

And finally, persons with Borderline Personality Disorder lack a solid self identity so that they develop split representations both of themselves and of other people.

4 It is our understanding that to some extent secondary care health services have not been encouraged to develop assessment and management strategies or to take on patients with Personality Disorders in recent years because, perhaps, of a national priority to provide treatment for those individuals with "severe and enduring mental illness". Comments made following recent high profile court cases would appear to be consistent with this approach. Many psychiatric professionals feel uncomfortable with the resulting neglect of those suffering conditions not described as "severe and enduring mental illness", and those who work with patients suffering from Personality Disorders become aware of the extreme and long lasting suffering which is endured by such individuals and those whose lives are affected by them. Every aspect of their lives (relationships, employment, and leisure pursuits) may be blighted by their disorder. Those suffering from this condition are more likely to harm, or even kill themselves than cause serious physical harm to other people. Personality Disorder has consistently been the most frequent diagnosis made in studies of psychiatric morbidity in sentenced prisoners. This is therefore, we consider, a substantial issue of some importance, and one in which society in general and those charged with the provision and management of Health Services in particular, ought properly to address.

5 Our reflection from the range of evidence which we heard is that there is an understandable temptation for some mental health professionals to respond to difficulties of treating patients with severe Personality Disorder by claiming that there is nothing to be offered, and that management should be purely social rather than through Health Services. With this model, sufferers would be assisted with matters such as accommodation and employment but any anti-social or self harming behaviours would be deemed to be the responsibility of the sufferer, and health personnel would only deal with the consequences such as the provision of treatment for the self inflicted

laceration and leave it to the individual to decide whether or not to repeat such an action. In our view from what we have heard that there is sufficient evidence of available treatments improving the quality of life with severe Personality Disorder, to render such arguments unsustainable. Thus even without an aim of reducing serious offending, there is sufficient reason to look critically at the services provided for such patients.

6 During the course of our preparing this report the Government's White Paper on "Modernising Mental Health Services" was published and we were anxious, accordingly, to consider any particular relevance that the paper might have to this Inquiry and particularly to the question of patients with Personality Disorders. We recognised immediately that in its criticism of the past policy of Care in the Community the paper highlights one of the concerns that we express, namely "The Mental Health Act has failed to provide an adequate framework for dealing with a quite different group of people (i.e. other than those with severe mental illness) namely those with severe anti-social personality disorder who present a risk to the public". The more detailed proposals in Paragraphs 4.31 to 4.34 of the paper and the Home Secretary's recent proposals of detention orders address the problem by proposing a new form of "Reviewable Detention Order" for those with such a condition who are considered to propose a grave risk to the public. Whilst we recognise the force and merit of such plans, we do not consider that such additional measures for detention would have proved to have been applicable in the case of Jonathan Crisp. He experienced two periods of "crisis" in the first half of 1997 and on both occasions as soon as his problems were recognised, following incidents of deliberate self harm, he was admitted to hospital in the first instance for a period of more than a week, and in the second instance for more than three weeks. Although we have expressed our concern with regard to the inadequacy of clinical risk assessments, he was never in the case of either hospital admission or subsequent discharge into community care recognised as posing a significant risk to the public.

7 Apart from the consideration of the White Paper and the recent report of the Committee of Inquiry in to the Personality Disorder Unit, Ashworth Hospital (sometimes known as the "Fallon Inquiry") there is currently much debate about the future shape of services for those who have committed serious offences, and who have been diagnosed as suffering from Personality Disorder. It appears to us that cases such as that of Jonathan Crisp and another Teesside resident * whose case has also been the subject of a homicide inquiry make a strong argument for developing services in the community in the expectation that some serious offences can be prevented.

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* Shaun Anthony Armstrong - Report

Not all patients with severe Personality Disorders will realise that they have a disorder and may not accept offers of help. The clinical picture of a patient not attending for assessment and treatment as demonstrated by Jonathan Crisp in 1995 is therefore not unusual. However, we have heard from Dr Whewell that when a patient does accept treatment, there have been significant developments in management techniques over the past fifteen years.

We were anxious to learn from Dr Whewell his views as to the question of "containment" of a patient with this condition and whether it was an option in the treatment of Borderline Personality Disorder. He agreed that it could be relevant at a time when a patient was not safe to be in the community and they should be admitted to hospital "on a very temporary basis". Such patients "need a safe place to go where they can be contained for short periods and then when they have calmed down and are under control again they can move out. Not that they have a long hospital admission – but to have some sort of asylum, and that is one possibility". It seems to us that this pattern matched what occurred in the case of Jonathan Crisp – and therefore the principal and most concerning issues is "What should happen next?"

8 CONCLUSIONS

In the short term, drug treatments are being recognised as being of value in improving mood, and dealing with periods of anxiety and other symptoms of increased arousal. Secondly, there are a number of brief treatments to deal with particular behaviours such as deliberate self-harm. (This was the way in which Jonathan Crisp presented to psychiatric services). These tend to use a mixture of psychological techniques including:

1 Behavioural (focusing on shaping behaviour through measures such as rewards or punishments)
2 Cognitive (encouraging the patient to question automatic thoughts, and consider alternative ways of reacting to situations)
3 Analytic (using the relationship between the therapist and patient as a valid area for exploration in order to understand the patient's problems.)

Although the above are skills that would be present in many mental health teams, or as a part of a district wide service, there exists an additional challenge in working with patients who have Borderline Personality Disorder. The patient needs to form a therapeutic alliance with his or her therapist, as the relationship is very important. These patients, by virtue of their core problems, are amongst the most difficult to work with in the mental health field and require very experienced staff. They also, of course, require staff

who are readily available in a service which is not subject to extensive waiting times – as the Consultant Psychologist who gave evidence before us told us was the case in the Teesside service.

9 In the longer term the only treatment that is generally agreed to have a good chance of bringing about permanent change in the underlying personality that causes the patient problems is psychodynamic analytic therapy. We heard that typically this would involve weekly fifty-minute sessions over a five year period. Such a programme carries obvious resource implications for the NHS if all whom might benefit were to receive such treatment. This explains, at least in part, why Jonathan Crisp did not – and in the light of the service availability at the time could not – rapidly receive optimal treatment once the diagnosis had been made.

It would be unrealistic to expect all professionals of all disciplines in mental health to develop the necessary skills to deal with such patients, and as an alternative, we would suggest that dedicated specialist teams be formed. On Teesside, a service covering more than one health district (as currently organised) might be appropriate and would accept referrals of patients who did not suffer from mental illness (such as schizophrenia or depression) but who would be deemed to pose some risk of violent behaviour as a result of their Personality Disorder. It would seem reasonable to develop such a service for patients who are at risk of harming themselves as well as other persons.

Such a community service would probably involve work by professionals who have been trained in the areas of Forensic Psychiatry and Psychotherapy. The primary role would be in providing training and supervision for professionals dealing with Personality Disorders in the course of their work.

As the Health Service now exists, we believe that the primary responsibility in terms of developing a more appropriate service for such patients lies with Health Service Commissioners. The currently evolving health service structures, with an increase in financial responsibility moving towards primary care means that monitoring arrangements through district Health Authorities and Regional Offices of the NHS Executive may have to take on the role of setting targets and monitoring if such services are to be set up. The "specialist programmes" referred to in the recent White Paper will be charged with providing interventions designed to reduce and manage risk in appropriate security. We consider that professionals working in such settings should also be available to use their expertise in community settings for those individuals with severe Personality Disorders who are not deemed to pose such high risk as to need incarceration, but who like Jonathan Crisp have sufficient evidence of risky thoughts and behaviours so as to warrant expert treatment.

SECTION 13 – CONCLUSIONS AND RECOMMENDATIONS

1 In the earlier Sections of this Report – particularly in Section 11 – we have already given an indication of the views which we have reached on the major issues arising in this case. We have there been critical of various aspects of Jonathan Crisp's care and treatment both in hospital at Hartlepool and North Tees and also under his period of Community Care but we repeat the observations we made earlier, that it is a matter of conjecture – but doubtful – whether these matters had any bearing on the eventual outcome. We are satisfied on all the evidence we have heard that the remedy of committal to and long term detention in a Hospital or Institution was not an option in this case, and also that a programme of Care in the Community with monitoring, psychotherapy and counselling was an appropriate course to adopt and an appropriate objective to seek to achieve. There were, of course, a number of shortcomings along the way, and we identify these particularly below. The condition from which he suffered of Borderline Personality Disorder, made Jonathan Crisp a very complex person and we have highlighted the extent of the contact with Crisp by his GP, the Consultant Psychologist, the Social Worker and the CPN in the fortnight or so preceding the offence and their shock, bordering on disbelief, when they learned of the offence which they considered to be contrary to all the improving indications.

2 In all the circumstances we have concluded that it is impossible to give a clear answer, one way or the other, to the question " could this outcome have been prevented?" and in all circumstances we do not think it possible to identify and point to any particular problem or shortcoming in the care and treatment of Jonathan Crisp which in any substantial way caused or contributed to the events of the 22 June 1997.

3 Nevertheless, we have identified as our major concern the question whether or not the availability of an appropriate local Psychotherapy Service would have assisted in managing and controlling Crisp's Personality Disorder and for this reason we have spent some time in the previous Section considering how such a Psychotherapy Service might be established. Our principal **recommendation** is, accordingly, that there should be a full review of the services available to persons diagnosed as suffering from Borderline and other Personality Disorders with a view to an appropriate regional service being provided, and generally for the more structured treatment and management of patients diagnosed with Personality Disorders who are not otherwise categorised in most cases as suffering from a "mental illness". We accordingly urge that the appropriate authorities give early consideration to the views and proposals we have thought it appropriate to express in Section 12 and to developing appropriate services within the National Health Service accordingly.

4 Our Terms of Reference are wide ranging and ask us to consider all aspects of Jonathan Crisp's care and treatment. Inevitably therefore, in a long ranging examination such as this we have identified and highlighted a number of areas where – and although not necessarily bearing directly upon our principal conclusions – "things might have been done better". It is appropriate, therefore, in order that lessons may be learned and benefits and improvements follow from the tragic events that we have had to consider, that we should identify such matters in this Report and make recommendations accordingly.

5 Before dealing with any of these matters in detail, it is right that we should recognise that as soon as possible after the events of the 22 June 1997, North Tees Health NHS Trust and Stockton Social Services each initiated their own Internal Inquiries at management level to look into the case of Jonathan Crisp and their service involvement, and to identify immediately any lessons which ought to be learned. We were willingly supplied with copies of the Findings and Recommendations of both Internal Inquiries and were impressed by the thoroughness which both displayed and the detail and depth of the investigation which both bodies had carried out. We commend and endorse their recommendations, many of which are indeed reflected in our own conclusions and recommendations and we were pleased to learn in the course of evidence that many – if not all – of the findings and recommendations in those Internal Reports were already in the course of implementation. Our own views will, we hope, serve to underline and emphasise all of these issues in the future.

6 The following are the findings and **Recommendations** upon which we wish to report :

1 **Communication**

We have drawn attention in a number of places throughout our Report to the failure to ensure there was full and complete exchange of information about Jonathan Crisp between the various agencies involved throughout his care and treatment. The result was that although each of the agencies – Hospitals, Social Services, Child Protection Services, GP etc – had their own knowledge and information about Crisp, inadequate exchange of information meant that no-one "had the complete picture". This obviously made risk assessment and a care plan and CPA procedures the more difficult. It is essential in our view therefore, that :-

a) procedures are set in place to ensure that where there is multi-disciplinary involvement in the care of a patient there is full exchange of information between all the professionals involved and that all are able to share in full their knowledge and information about the patient.

b) where it is considered that any such exchange could breach the principles of confidentiality then these must not be allowed to prevent exchange of information which might be relevant to the safety of others, and that therefore if appropriate any consent (including consent of the patient) should be sought as a matter of urgency.

c) consideration should be given to the integration of Care Records to ensure that all disciplines have access to the comprehensive information that they contain, and that where at all possible, joint or shared records should be introduced to display a comprehensive picture of a patients care and treatment. We would wish to add that the introduction of an Integrated Mental Health Service between North Tees Trust and Stockton Social Services of which we were advised, will support and achieve this objective and it is to be much commended.

2 **Records and Record Keeping**

An essential tool in preparing, sharing and communicating information is, of course, the keeping of complete and proper records at all stages. In the course of this Report we have in a number of places referred to the inadequacy of written records and the failure to complete reports and proformas in the detail required. In our view all the protocols for the keeping of full and acceptable records are already in place and all necessary guidance for staff at all levels already exists. Accordingly **We commend** and endorse the recommendation of the Internal Inquiry

a) that all staff should undertake record keeping updates and this could be by means of training workshops to look at the purpose of record keeping and the standards required.

b) This review in training emphasises the need to ensure that records contain all relevant information on the patient and that all hospital records fully record all medical treatment and consultations throughout in-patient stay.

c) That all established Assessment or Report forms used by staff are completed in full – or the reasons for non completion of any section are made clear on the form. Simply leaving a section "in blank" is not acceptable, and only serves to raise unanswered questions for those who follow.

3 **Risk Assessment**

We have already in this Report concluded that the Risk Assessments undertaken at both Hartlepool and North Tees hospitals were inadequate to a serious extent. A properly structured and soundly based Risk Assessment is essential to the proper planning and implementation of any care treatment programme and **we recommend**: -

a) That the Risk Assessment processes at both Hartlepool and North Tees Hospitals be reviewed and in so saying we recognise the weight of the evidence given to us in in the case of both Hospitals that new protocols and new formats and new processes had been introduced and are now in force and we urge and commend their full implementation

b) That Risk Assessment must not be considered as a "one off" process at the time of admission into hospital or care. It must be seen as a continuing process and be reviewed at regular intervals to ensure that any revision and updating of care and treatment programmes can be implemented appropriately.

c) That Risk Assessment must be carried out on a multidisciplinary basis to ensure that all professionals have the fullest possible level of input.

d) That all Risk Assessments are carried out in accordance with procedures recommended by the Royal College of Psychiatrists and as laid out in the appropriate Care Programme Approach.

4 **Treatment Plans**

We have already indicated our view as far as Jonathan Crisp was concerned both at Hartlepool and at North Tees there was no coherent Treatment Plan in force – indeed there appeared to be little or no "plan" as to how his care and treatment whilst in hospital should be oriented. Whilst recognising the problems that a Personality Disorder case poses we nevertheless **recommend**: -

That in the case of all patients whatever their condition or prospective diagnosis, a Treatment Plan should be in force to give a focus and objective for his hospital care.

5 **Discharge procedures**

We have already expressed our concern at the discharge arrangements – or lack of discharge arrangements – made for Crisp on his leaving Hartlepool General Hospital, and in the case of both Hartlepool and North Tees Hospitals on the inadequacies which appear in the Discharge Letters issued from both hospitals. We reiterate the **recommendations**, which we have made accordingly:-

a) That the procedures which no doubt exist at Hartlepool General Hospital relating to patient discharge arrangements should be revisited, and any necessary staff training renewed to ensure that all the requisite discharge arrangements are in force before a patient is discharged, to include all necessary travel and domestic arrangements.

b) That hospital Discharge Letters should be fully comprehensive in their coverage of diagnosis and treatment so that all professionals and agencies receiving and acting upon Discharge Letters are made fully aware of all relevant circumstances relating to the patient.

c) That where Discharge Letters are written by a junior doctor, they should in the case of a previously inexperienced doctor be either checked or countersigned by the Consultant concerned.

6 **CPA Policy**

We have already observed in this Report that the CPA policy was not applied to Crisp on discharge from Hartlepool (because of the "non resident" view) and the care programme under CPA established on his discharge from North Tees hospital did not, on our evidence, follow a full multidisciplinary assessment. **We recommend**: -

a) That all staff members receive ongoing training in the application of CPA and that it is applied to all patients whether or not they are coming from one or returning to another District. We accept this latter issue in respect of Hartlepool has now been fully addressed.

b) That the Care Programmes are prepared on a multi-disciplinary basis with all relevant professionals fully involved

7 **General Practitioner Services**

We have already indicated in this Report our view on the extent of support and involvement that GP services can offer and provide when their own patient is involved with other agencies. In particularly **we recommend**: -

a) That the patient's GP practice should be involved in the fullest exchange of information with all other agencies and be routinely kept in touch with the patient's progress.

b) That all agencies should recognise that the GP records may contain important relevant information about the patients background and history, and access should be sought whenever appropriate.

c) That consideration should be given to enhancing the level of involvement of GPs in CPAs and CPA reviews of their patients.

8 **Personnel and Training**

In connection with the respective roles of the Social Worker and CPN in the implementation of the Care Programme and as to personel matters generally, **we recommend**:-

a) Now that there is a joint Management of the Mental Health services in North Tees, it would be appropriate for Management to review the respective and specific roles of CPN and Social Worker involvement in Care Programmes in order to improve and clarify these roles as far as possible, and to ensure that the appropriate skills and experience are applied to the relevant case by appropriate qualified workers.

b) That the appointment process for Locum Consultants is reviewed to ensure that management are aware whether or not appointees would be entitled to hold a substantive post under prevailing guidelines (particularly from the Royal College of Psychiatrists). In the event of that the appointee is not so entitled, timetable supervision must be provided with an appropriate consultant.

9 The Named Nurse

Whilst we accept the concept of the allocation of a "Named Nurse" to each patient, we believe the concept must be applied in a practical way which ensures the continuity of contact and care which it is designed to achieve and **we recommend**: -

a) That the allocating of a Named Nurse be carried out in such a way that it reflects the continuity of care that the patient requires and actually receives;

b) That a review of the implementation of the improvements regarding the Named Nurse concept, which we were assured in evidence had taken place in both hospitals, should be carried out to assess it's effectiveness.

10 Psychology Services

Whilst we have in the previous Section expressed our views on the possible development of Psychotherapy Services to deal with the condition of Personality Disorder, we have some **recommendations** to make in respect of the existing Psychology Services applying in North Tees namely: -

a) That all relevant professionals are made aware of the availability of urgent psychology referrals in hospital in appropriate cases so that any unnecessary delay in urgent cases can be avoided

b) That the service should consider the possibility of establishing some "fast track" service in appropriate cases to minimise delays in times of staff shortage.

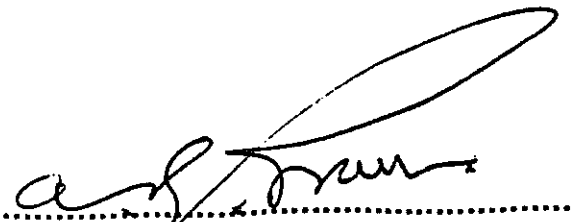
11 Failure to Attend (DNA) protocol

We have expressed our concern at the failure of Jonathan Crisp to maintain appointments, keep contact or respond to approaches by the care team and the apparent uncertainty as to how this should be dealt with. We would **recommend**: -

That North Tees should ensure that a good "DNA" procedure is set in place in conjunction with Social Services so that a joint policy is established to deal with and respond promptly to all cases where there is apparent risk "of losing contact" with a patient so that agreed remedial action can be taken.

It would be appropriate, in concluding the Report, to express our appreciation again to all who have assisted in our examination and consideration of this case and also to all who have given evidence before us. We accordingly submit the Report and our recommendations for the consideration of Tees Health Authority.

DATED THIS TWENTY SIXTH DAY OF MARCH 1999



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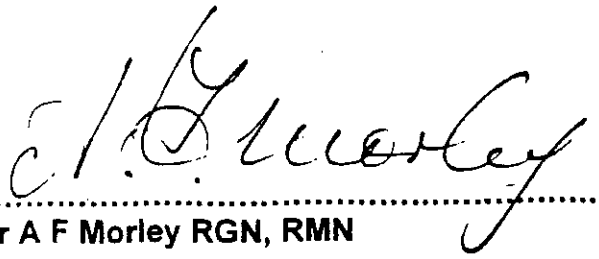
Mr A G Brown, Solicitor and former Chairman, South Tyneside Family Health Services Authority



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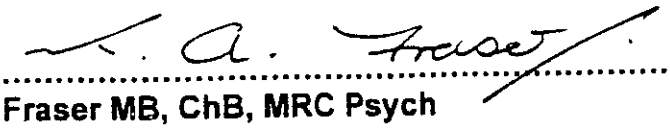

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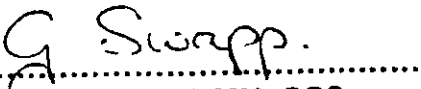
Dr K A Fraser MB, ChB, MRC Psych



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Mrs G Swapp RGN, RMN, CSS

Appendix A

Composition of the Panel

Mr A G Brown	Solicitor and former Chairman, South Tyneside Family Health Services Authority
Dr K A Fraser	MB, ChB, MRC Psych, M Med Sci, Dip Crim Consultant Forensic Psychiatrist, Newcastle City Health NHS Trust
Mr A F Morley	RGN RMN, Inspector, Newcastle & North Tyneside Health Authority Former Director of Nursing Services
Mrs G Swapp	RGN, RMN, CSS, Manager Rotherham Joint Health & Social Services Registration and Inspection Unit

APPENDIX B

TERMS OF REFERENCE FOR INDEPENDENT INQUIRY

To examine all the circumstances surrounding the quality and scope of the health and social care and treatment of Jonathan Crisp in relation to his needs and in particular:

- the extent to which statutory obligations of the agencies involved in his care were met

- the extent to which local policies and procedures relevant to his case existed and were followed

- whether documentation was adequately completed in accordance with organisational policies and procedures

- whether information was adequately and timely communicated to relevant others

- the appropriateness of Jonathan Crisp's treatment, care and supervision in respect of:

  - the assessment of health and social care needs
  - the assessment of risk (in terms of the risk of harm to himself and/or others)
  - decisions relating to the Care Programme and Supervision Register
  - the extent to which care plans were effectively drawn up, delivered, monitored and complied with
  - any previous psychiatric history including drug or alcohol abuse
  - the nature and previous involvement with the criminal justice system including the outcome

- whether adequate continuity of care was maintained during inpatient and community care treatment spells

- the role, responsibilities and actions of all the professionals involved in the care of Jonathan Crisp and the exercise of professional judgement

- the appropriateness and adequacy of professional and in service training of those involved in the care of Jonathan Crisp

- the adequacy of collaboration and communication between professionals within and between the agencies involved in the care of Jonathan Crisp and his family
- to determine whether any changes in policy, procedure, training and monitoring need to take place

- to prepare a report and make recommendations to the Health Authority about actions to be taken relevant to local mental health services

Appendix C

DOCUMENTS CONSIDERED BY THE INQUIRY PANEL

Case Records

Hartlepool & East Durham NHS Trust

- Hospital inpatient notes
- Extract from Ward 16 diary (26 February to 5 March 1997)

North Tees Health NHS Trust

- Hospital inpatient and partial hospitalisation notes
- Community Mental Health and Care Programme records
- Psychological Therapy Service records
- Extract from Stephenson Centre Ward Round Book (Section B – 19 March 1997 – 2 April 1997)
- Stephenson Centre Nursing Duty record (w/c 10 March to w/c 10 April 1997)
- Cook Centre Nursing Duty record (w/c 17 March, 31 March, 7 April and 14 April 1997)

Stockton on Tees Borough Council – Social Services Department

- Adult Mental Health Services Care Management Notes
- Adult Mental Health Services Contact Records

Drs Sagoo & McKenna

- General Practice Records

Ashworth Hospital Authority

- Relevant Hospital Inpatient Notes

Other documents

Jonathan Crisp

- Diary and statement
- Trial papers

Transcripts

- Record of interviews with witnesses

Trial

- The trial depositions and papers (by arrangement with Jonathan Crisps solicitors)

Psychiatric reports

- Dr P R Coorey – Consultant Forensic Psychiatrist – Ashworth Hospital Authority
- Dr J H Kent – Consultant Forensic Psychiatrist – Yorkshire Centre for Forensic Psychiatry, Wakefield
- Dr P Brown – Consultant Forensic Psychiatrist – South Tees Community & Mental Health Trust

Reports

- North Tees Health NHS Trust report of the Inquiry Team into the Care of Jonathan Crisp

- Stockton on Tees Area Child Protection Committee – Inter Agency Chronology Part 8 Overview Report

- Tees Health Authority – The Report of the Inquiry into the Care and Treatment of Shaun Anthony Armstrong (C J Freeman, A Brown, Dr Dunleavy, F Graham)

- County Durham Health Commission – The Report of the Independent Inquiry into the Care and Treatment of Adrian Jones and Douglas Heathwaite (A C Taylor, P McGinnis, Dr S Baugh, M Tuckwell)

Policies & Procedures

Tees Health Authority

- Contract specifications for Adult Mental Health Services 1996/97, 1997/98 and 1998/2000

Hartlepool Community Care NHS Trust

- Care Programme Approach / Related policies and procedures

Hartlepool & East Durham NHS Trust

- Directorate of Mental Health & Learning Disabilities observation policy
- Care Assessment documentation
- Full Assessment documentation
- Care Programme Plan
- Copy of Board Presentation May 1998
- Organisational Structure, Role Of Management Team & Communication Structure
- Departmental Induction Programme – Checklist Jan 1998
- Critical Incident Strategy, MDT reviews completed retrospectively for suicides from April 1997
- Training Participation Jan 1997 – Jan 1998
- Case Note Audit – Nursing
- Case Note Audit – Medical
- Initial guidance notes and new joint assessment documentation due for relaunch October 1998
- Inpatient Core Care plans
- Fail to Attend protocol (additional reporting mechanisms) to be read in conjunction with CPA policy

North Tees Health NHS Trust

- Cook Centre Operational Policy & profile of the service
- Stephenson Centre Nursing Model
- Stephenson Centre Philosophy & Procedures
- Care Programme Approach & Supervision Register Policy
- Operational Policy for Adult Mental Health Service September 1997
- Revised Risk Assessment documentation (September 1998)

GUIDANCE

- Tees Health Authority – Terms of Reference for the Independent Inquiry
- HSG(94)27 – Guidance on the discharge of mentally disordered people and their continuing care in the community
- HSG(85)5 – Discharge of patients from hospital (and booklet)
- HC(90)23/LA55L (90) 11 – Care Programme Approach
- HSG(94)5 – Introduction of Supervision Registers
- HSG(95)56 – Building Bridges: Arrangements for Inter-Agency Working for the care and protection of severely mentally ill people
- Executive Summary and Chapter 5 "If things go wrong: audit and inquiries
- HSG(96)6 – The Spectrum of Care – a summary of comprehensive local services for people with mental health problems
- An audit pack for the Care Programme Approach
- DOH (Welsh office) – February 1996 Guidance on supervised discharge
- UKCC for Nursing, Midwifery & Health Visitors – Standards of Records and Record Keeping
- The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk CR 53 April 1996 "Assessment and clinical management of risk of harm to other people"
- Personality Disorders – Extract from Diagnostic & Statistical Manual (DSM) Fourth edition. American Psychiatric Association 1994
- Mental and Behavioural Disorders – Extract from International Classification of Mental and Behavioural Disorders. World Health Organisation 1992
- HSC 1998/233 Modernising Mental Health Services – Dept Of Health. Dec 1998

PUBLICATIONS

- Clinical Risk (1997) 3 171 – 177

  Review of 11 independent inquiries into homicide by psychiatric patients. Lipsedge M & Bland S.R

- Health Service Journal – 31.10.96 – "Deadly Serious"

- Selection of press cuttings related to Mental Health Inquiries

APPENDIX D

LIST OF WITNESSES / INTERVIEWEES

Publication of names of witnesses withheld