REPORT OF THE PANEL

TO REVIEW THE CARE AND TREATMENT
PROVIDED FOR

JONATHAN NEALE

BETWEEN
OCTOBER 1995 AND SEPTEMBER 1999

APPOINTED BY
NORTH ESSEX HEALTH AUTHORITY

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SECTION 1

The Members of the Review Panel, Introduction and Terms of Reference

1. The Review Panel consisted of :-

Dr John Bradley, FRCP FRCPsych, Emeritus Consultant Psychiatrist, Camden & Islington CMHS NHS Trust and Honorary Senior Lecturer, University College, London, a Member of the Parole Board 1992-1998 and a Member of the Mental Health Review Tribunal since 1971. Chairman of the Panel.

Miss Bridget Ledbury, Registered Mental Nurse, Diploma in Health Service Management, Senior Clinical Operations Manager in Mental Health and who has acted on several public inquiries.

Mr Mike Lindsey, has long experience as a Mental Welfare Officer and Approved Social Worker and is a former Deputy Director of Social Services, now acting as an independent Consultant, mainly on formal inquiries. He was for several years a member of the Home Secretary's Advisory Board on Restricted Patients and of the NHS Drug Advisory Service. He participated in the Reed Review of Services for Mentally Disordered Offenders as a member of the Psychopathic Disorder Working Party. He chairs Rural Minds, a national network for improving mental health services in the countryside.

2. Introduction

We were appointed by the North Essex Health Authority in May 2000 to review the care and treatment of Jonathan Neale between October 1995 and September 1999. The need for this review arose from the fact that on the 9 February 2000 at Chelmsford Crown Court Jonathan had been found guilty, on grounds of diminished responsibility, of the manslaughter of his mother, Mrs Rosemary Neale of 17 The Bourne, Colchester, Essex at Plowright House, St Peter's Street, Colchester on the 2 September 1999 and had been committed to Runwell Hospital, The Chase, Wickford, Essex under the provisions of Sections 37 and 41 of the Mental Health Act 1983.

At the outset, we should point out that the major part of our inquiries was completed by about March 2001 but that matters beyond our control resulted in a delay of about 10 months thereafter before we could deal with one aspect of the Review. With the agreement of the commissioning Authority, there will have been a delay of about one year, before this Report is ultimately delivered. That is as much a matter of regret to us as it may be to others, particularly as we are conscious not only that organizational change in the set-up of Mental Health services in Essex has occurred in the meantime, but also

that some of our conclusions and recommendations may already have become out-dated through action taken during that intervening year.

We were asked to carry out the Review under the provisions of the National Health Service Executive's Guidelines HSG (94) 27.

Our terms of reference are set out in full below. They encompass the main topics for review set out in HSG (94) 27, which are:-

The care Jonathan was receiving at the time of the killing of his mother;

The suitability of that care in the light of his history and his assessed health and social care needs;

The extent to which the care corresponded with statutory obligations, guidance from the Department of Health and local operational policies;

The exercise of professional judgment; and

The adequacy of the Care Plan and its monitoring by Jonathan's key-worker.

3. Terms of Reference

" To conduct an independent inquiry into the circumstances surrounding the care and treatment of Jonathan Neale.

1. To examine all the circumstances surrounding the care and treatment of Jonathan Neale, in particular :

    - ❖ The quality and scope of health and social care
    - ❖ The assessment and management of risk
    - ❖ The appropriateness of the treatment, care and supervision in respect of
        - his assessed health and social care needs
        - his risk assessment in terms of harm to self and others
        - any previous psychiatric history including drug or alcohol abuse
        - the nature of any previous involvement with the criminal justice system including outcomes

- ❖ The appropriateness of the professional and in-service training of those involved in the care of Jonathan Neale or in the provision of services to him

- ❖ The extent to which statutory obligations were met in care plans HC(90)23/LASSL(90)11, HSG(94)5 and HSG(94)27

- ❖ The extent to which local policies were adhered to

- ❖ The extent to which the care plan was effectively drawn up, delivered and complied with by the patient

- ❖ The details of any medication including retrospective information and the patient's compliance.

2. To examine the adequacy of collaboration and communication between

   - ❖ the agencies involved in the care and treatment of Jonathan Neale

   - ❖ the agencies and Jonathan Neale's family

3. To prepare a report and make recommendations to North Essex Health Authority"

Note: As part of NHS reorganisation, North Essex Health Authority was succeeded by Essex Health Authority on 1st April 2002.

SECTION 2

Definitions and Abbreviations

"Abberton"	The Day Hospital at the Lakes
"the Authority"	The North Essex Health Authority
"the Act"	The Mental Health Act 1983
"CAC"	Colchester Assessment Centre
"CHAC"	Colchester Housing and Care Project, a voluntary organisation providing supported housing for the disadvantaged, including those suffering from mental illness
"CMHT"	Community Mental Health Team
"CJMHT"	The Criminal Justice Mental Health Team, Colchester
"CQHA"	The Colchester Quaker Housing Association
"FME"	Forensic (or Force) Medical Examiner, being a Doctor in contract with the Police to provide them with medical services
"the Lakes"	The Lakes Mental Health Centre, Turner Road, Colchester comprising of Ardleigh and Gosfield Wards (two in-patient wards) and Abberton, situated on the Colchester District General Hospital site
"Needas"	North East Essex Drug and Alcohol Service, an integral part of the Mental Health Services provided by the Trust in Colchester
"Open Road"	A voluntary organization operating in both Clacton and Colchester and offering complementary therapy to persons suffering from drug problems
"Oxford Road"	A mental health day-care project and alcohol day-care project
"Penfold Lodge"	A private residential home in Clacton-on-Sea run by Arc Healthcare Ltd and registered with Essex County Council
"Plowright House"	Plowright House, St Peter's Road, Colchester set up in

	March 1999 by the CQHA to provide temporary, supported housing for vulnerable single, homeless people with mental health, drug or alcohol problems and a chaotic lifestyle
"Northgate Centre"	A day hospital at North Station Road, Colchester
"Shannon House"	A psychiatric intensive care unit at the Princess Alexandra Hospital, Harlow managed by the Essex & Herts Community NHS Trust
"The Trust"	The North East Essex Mental Health NHS Trust [N.B. It should be noted that the North Essex Mental Health Partnership NHS Trust has assumed responsibility for Mental Health Services in Colchester with effect from the 1 April 2001, as part of a reorganization of such services in Essex.]
"Willow House"	Willow House, 2 Boxted Road, Colchester comprising Almond Ward (a low secure in-patient ward) and Aspen Ward (an intensive rehabilitation ward)
"Work On"	A sheltered employment service run by the Trust for people recovering from Mental Illness

SECTION 3

How We Approached Our Task

We have been provided with copies of:-

- Jonathan's psychiatric records;
- The Essex Social Services Department's papers relating to him;
- His General Practitioner records;
- The Essex Police's records relating to several "Missing Persons" incidents when Jonathan absconded from hospital and to the various events in 1999 which put Jonathan into contact with the Police;
- The Log from Plowright House where Jonathan lived from 22 March 1999 to the 21 April 1999 and from 22 June 1999 to the 2 September 1999 and certain other letters and documents relevant to his residence there;
- The local policy documents and organisational papers of the Authority and the Trust, listed in Appendix B to this report; and

Jonathan's psychiatric records were sent to us at the outset, along with a chronology of his illness which has proved to be very useful to us as our inquiries have proceeded.

From these documents, a history of Jonathan's mental illness and the care and treatment provided for him up to the 2 September 1999 has been prepared and is set out in Section 4 of this Report.

Following our consideration of his records and the chronology, at an initial meeting held in London on the 25 July 2000 we agreed the issues and events which seemed likely at that stage to be most significant in our inquiries, and we agreed a list of the people most closely involved with Jonathan, his care and treatment and the organisation and management of the Services responsible for providing that care and treatment, whom we wished to meet to discuss the case.

It was obviously right that Jonathan's family should be invited to give us their views on the matter at an early stage and our Secretary contacted James, Rosemary Neale's elder son (and Jonathan's half-brother), and the family member in closest contact with the Authority when we were appointed, to invite him to the first meeting in Colchester on the 18 October 2000. Accordingly, he and his wife were the first people whom we met to discuss the case. In addition to the comments which they gave to us in person, they left a paper with us setting out their concerns about Jonathan's case. We list their main concerns and our responses to them in Section 6 below.

When arrangements for our first series of meetings were being made, it was not anticipated by James that any other family members would wish to meet us, particularly as Jonathan's father was living in Hong Kong. However, James kindly provided our Secretary with Mr Neale's address there and although a letter was sent to Mr Neale on the 4 September 2000, inviting him to put in writing any comments on Jonathan's care and treatment which he wished to make if he could not meet us personally, no reply to that letter has been received.

As we say, it was not anticipated initially that any of Jonathan's other relatives apart from James and his wife would wish to meet us. However, on the 12 December 2000, James informed our Secretary that Jonathan's aunt, Carol, did wish to have the opportunity of giving us her views. As, at that time, arrangements could not conveniently be made for Carol to meet the full Panel, she was happy to meet our Secretary and to put her comments to us through him. Accordingly, our Secretary met Carol on the 9 January 2001 and obtained her comments on the case. Those comments have been included in a note approved by Carol and that note has been put before us during our consideration of the facts of the case and the formulation of our conclusions and recommendations.

From the start, we had decided that our meetings with the people involved in the case would be held in a relatively informal setting and without examination and cross-examination in a legal sense. We sought to bring out the information and opinions, which we wanted to obtain, by the appropriate Panel member leading the discussion. We believed that by proceeding in that way, we would enable the witnesses to discuss both Jonathan's individual case and questions concerning the general provision of services for the mentally ill in North East Essex in a more frank and meaningful way. We believe this expectation to have been fully justified by the positive responses which we have received in all our meetings to date.

Where possible, our Secretary gave advance written notice to the witnesses of the matters which we were likely to want to discuss and we offered to all of them the opportunity to be accompanied by a legal representative or other adviser. No-one attended with a legal representative. Three of them attended with a colleague or manager to provide support, and in all those cases the colleague or manager concerned was able to help us with his or her own contribution to a number of the matters under discussion.

One individual, who was a potential witness, declined to attend a meeting with us and he provided us with written reports instead.

The Essex Police needed to make further, internal inquiries before meeting us but we are pleased to say that a meeting was held on the 16 January 2002, which greatly assisted us in relation to the contacts between Jonathan and the Police, with which we deal in Part 5.c of Section 5 below.

It was decided by the Health Authority at the outset that witnesses and others would not be identified and that was the basis on which evidence was given to us.

The people whom we have met are:-

James, Rosemary Neale's elder son (also Jonathan's half-brother), and his wife;

The 1st General Practitioner, Jonathan's and Mrs Neale's General Practitioner;

The 2nd Community Psychiatric Nurse, CPN and Jonathan's Care Co-ordinator from the 22 June 1999 (accompanied by the 2nd Nurse, Senior Nurse, the Youth Offending Team and previously a CPN in the CJMHT in Colchester, who discussed with us both aspects of Jonathan's case within his own knowledge and general questions about Mental Health Services in North Essex);

The Service Manager (Mental Health), Essex Social Services;

The 2nd Consultant Psychiatrist, Consultant Psychiatrist;

The Director of Mental Health Joint Commissioning, North Essex Health Authority, the Trust's Director of Planning and Information with a part-time secondment to the Authority as its Director of Mental Health;

The 1st Community Psychiatric Nurse, CPN and Jonathan's Care- Co-ordinator until the 21 June 1999;

The Trust's Director of Nursing;

The Registered Mental Nurse and on the staff of Needas at the material times (accompanied by the Team Manager at Needas);

The Manager of Plowright House at the time Jonathan was living there
(accompanied by a Director of the CQHA); and

The Essex Police Solicitor; the 1st Chief Inspector; the 1st Inspector and the 2nd Inspector of the Essex Police.

A verbatim record was made of all our meetings with witnesses (except the meeting with the Police) and transcripts have been available to us for our subsequent consideration of the case.

From 1995 to April 1999, the 1st Consultant Psychiatrist was Jonathan's Consultant Psychiatrist and Responsible Medical Officer for the purposes of the Act. She has now retired from the National Health Service and was abroad during the interview stage of our review. Accordingly, we did not have an opportunity of discussing the case with her at the time when we met with the others primarily responsible for Jonathan's care up to the end of August 1999, but we feel able to complete our report without meeting her personally, for four reasons, namely;-

- ❖ Jonathan's history and treatment are well documented in the psychiatric records for the period of the 1st Consultant Psychiatrist's involvement;

- ❖ We have the benefit of having heard personally from the 1st Community Psychiatric Nurse about Jonathan and his care and treatment at the material times;

- ❖ We have not read or heard of any evidence which might have been given, or reported, to the 1st Consultant Psychiatrist and suggested to her that Jonathan was a risk to the physical safety or well-being of anyone else; and

- ❖ No issues arise in relation to the 1st Consultant Psychiatrist's treatment of Jonathan, which we feel we need to discuss with her personally, and she had formally transferred responsibility for Jonathan's treatment to the 2nd Consultant Psychiatrist approximately five months prior to Mrs Neale's death.

Consequently, to a large degree we have concentrated, both in our inquiries and in this Report, on the events which occurred in 1999, particularly the period from April 1999 onwards.

We also received a number of written communications about the case, which we have considered. A full list of those communications is set out in Appendix A to this Report.

Our Chairman, Dr John Bradley, made a psychiatric examination of Jonathan on the 28 September 2000 and has provided a report for the purposes of this Review.

Having read the documentation and discussed the matter with the witnesses, we have held further meetings first to agree a list of key events and issues with which we must deal in Section 5 of this Report and then to formulate this report. Those key events and issues are:-

1 The diagnosis of Jonathan's mental illness:

2 Risk Assessment and Risk Management, including

   a. The nature of the risk which Jonathan presented;
   b. The steps taken to assess that risk;
   c. Jonathan's tendency to abscond whilst an in-patient subject to compulsory detention under the Act, and the position of the nursing staff in relation to that absconding; and
   d. Jonathan's non-compliance with his treatment regime while in the Community.

3. Clinical Management, particularly

   a. The provision of more secure accommodation for Jonathan;

b. The decisions as to Jonathan's future care and treatment taken on the 21 June 1999 and the 4 August 1999;
c. The Care Programme Approach and its application in Jonathan's case; and
d. Other options which might have been considered and used.

4. Operational Systems

a. the 2nd Consultant Psychiatrist's leave and provision for cover;
b. Record systems within the Trust;
c. The support and supervision of Community Nursing Staff within the Trust; and
d. The 72-hour assessment procedure.

5. Inter-agency Co-operation and Contacts with Jonathan's Family

a. Social Service's involvement in Jonathan's care;
b. Links between the CQHA (1) and the Trust and the Authority (2);
c. The Involvement of the Police in the case; and
d. Contacts with Jonathan's family

SECTION 4

Jonathan Neale's Psychiatric History and Background

1 Jonathan was born on the 11 February 1978. His father, James Neale, was a Solicitor until he was removed from the Roll of Solicitors. He was also an international hockey player. Jonathan's mother, Mrs Rosemary Neale, whose marriage to Mr Neale was her second marriage, was a model. Mrs Neale had a son and a daughter by her first marriage and we met her son, James, at the very start of our review. Mr and Mrs Neale separated in the mid-1990's and subsequently were divorced. When they first separated, Jonathan lived with his father for a time but when Mr Neale was sentenced to a term of imprisonment, Jonathan returned to live with his mother in 1995.

James told us that Jonathan was a happy boy who enjoyed an entirely normal childhood. As a young teen-ager, he was interested in sports. However, when he was about 14 or 15 years of age, he became quieter and spent less time with friends and more on individual activities, such as his computer. The friends that he did have were not the kind of friends that the family wanted him to have.

2 James also told us that he was not aware of Jonathan having preoccupations in his youth with religious or pseudo-religious thoughts. However, while living with his father, as he progressed into his teens and in common with some of his friends, he began to take drugs.

3 The first consultation relating to Jonathan's mental state was with his General Practitioner, the 1st General Practitioner, of Colchester, on the 24 October 1995.

4 According to the records of that consultation, for some months Jonathan had felt as though everyone could read his thoughts; he was confused and occasionally tearful; and he apparently felt that he had to go and do good in the world and spread love. He had taken an overdose 4 days previously. He was said to be sleeping and eating normally, but to have no concentration. He was described as being "distressed +" and as having some, but not full, insight. The 1st General Practitioner asked the 1st Consultant Psychiatrist, Consultant Psychiatrist at the Lakes, to see Jonathan in an urgent domiciliary visit.

5 The 1st General Practitioner's referral letter to the 1st Consultant Psychiatrist dated 24 October 1995 described Jonathan's family background and his current condition. Jonathan was said to be a 17 year old boy who had had a very stormy adolescence due to the break-up of his parents' marriage, precipitated by his father's illegal financial dealings and consequent committal to prison for 4 years. Jonathan was said to have admitted using illicit drugs for 6 to 9 months and to date the start of his symptoms from that time. Jonathan thought that cameras were watching him and that people knew his thoughts. As stated, he wanted to do good

and spread love in the world. He had stated that his minor overdose was aimed at enabling him to return to live with God.

6 The 1st General Practitioner was of the opinion that Jonathan had no overtly depressive symptoms, though she suspected that his mood was low. The 1st General Practitioner's conclusion was that Jonathan had abnormal thoughts secondary to a depressive illness, with his past drug-taking being a possible influence. She said that Jonathan had only minimal insight and that he accepted, somewhat unwillingly, the need to take pills in order to reduce the confusion and distress that he felt. Finally, Jonathan's mother was described as being an extremely supportive and sensible mother.

7 The 1st Consultant Psychiatrist saw Jonathan on a domiciliary visit on the 25 October 1995. She advised the 1st General Practitioner of her conclusions by a letter dated the 26 October 1995. The 1st Consultant Psychiatrist's opinion was that although Jonathan's problem could be a drug-induced psychosis, he could be suffering from the onset of a schizophrenic illness. She referred to an occasion some three years previously when Jonathan was taken to the Accident and Emergency Department after taking too much LSD and thought that the cameras there had been set to watch him, since which time he had vague ideas of being watched and under surveillance.

8 Jonathan had told the 1st Consultant Psychiatrist that he did not agree with modern society and because he loved God, he wanted to live in medieval days and had, therefore, taken the recent overdose to get back to God.

9 The 1st Consultant Psychiatrist concluded that there was no evidence of any depressive symptoms and said that Jonathan denied passivity phenomena (i.e. being controlled by outside influences) and auditory hallucinations. She said that she would have liked Jonathan to have started a small dose of Trifluoperazine (Stelazine), the inference being that Jonathan declined to accept this medication, though he did agree to attend Abberton for further assessment. Indeed, the 1st Consultant Psychiatrist arranged for Jonathan to start his assessment immediately and the intention was that it should last five days.

10 Jonathan's assessment proceeded with him maintaining his unwillingness to take any medication. Then, on the 1 November 1995 the 1st General Practitioner telephoned the hospital to say that both she and Mrs Neale were both very concerned with Jonathan's mental state and to request an assessment to see if he should be compulsorily detained under the Act or if he would take his medication. Indeed, the 1st General Practitioner saw Jonathan that day and recorded in her notes that Jonathan was "Worse ++, incoherent, (experiencing) religious thoughts and paranoid".

11 The Associate Specialist at Abberton who had been assessing Jonathan, spoke to the 1st General Practitioner and was told that Mrs Neale was concerned because

Jonathan was talking rubbish at home. Jonathan's refusal to accept medication or voluntary admission, his gross thought disorder and restlessness were all mentioned. The doctors discussed Jonathan's case with a view to his being admitted under Section 2 of the Act.

12 Jonathan ran away two or three times on the 1 November 1995, but was finally admitted to the Lakes in the morning of the 2 November 1995.

13 Jonathan's compulsory admission was based on medical recommendations to the effect that he was suffering from a psychotic illness, gross thought disorder and paranoid delusions. He lacked insight and refused both medication and voluntary admission. Accordingly, compulsory admission was necessary in the interests of his own health and safety, though not with a view to the protection of others.

14 The Approved Social Worker who made the application for Jonathan's admission, expressed the view in her (unsigned and undated) report that Jonathan was obviously very psychotic. Amongst other things, she recorded his thought disorder, the fact that he was talking in biblical terms and language and his refusal to take medication or to agree to admission.

15 From his admission on the 2 November 1995 until the 8 November, Jonathan continued to be affected by his religious concerns. He did not settle. He did not take food, nor did he communicate with the nursing staff to any great extent. On the day of his admission he was observed to be responding to auditory and visual hallucinations. Later that day, after he appeared to be more settled momentarily, he climbed out of a window and had to be restrained and brought back to the ward, being very thought-disordered. Jonathan appeared to sleep a lot during the first four days of his hospitalization, and he remained uncommunicative.

16 Jonathan settled gradually, which enabled the level of nursing observation to be reduced from "close" to "intermittent monitoring" on the 6 November. By the evening of the 8 November Jonathan was described as being "a little settled", but on the 9 and 10 November 1995 he absconded from hospital twice, remaining absent on the second occasion until the 16 November.

17 On the 17 November, Jonathan was assessed by the 3rd Consultant Psychiatrist, Consultant Psychiatrist at Willow House, a low secure unit, with a view to a transfer there, though lack of beds made this an unlikely option. Runwell Hospital, a medium secure unit, was considered as another possibility. The 3rd Consultant Psychiatrist diagnosed psychotic illness, probably schizophrenia, with acute onset of religious preoccupation in the last few weeks but with more gradual change over nine months to a year. He suggested that Jonathan needed nursing on a one-to-one or a two-to-one basis in view of the severity of his illness, the risk of absconding and the risk of self-neglect and self-harm. The 3rd Consultant Psychiatrist recorded that Jonathan had not been violent and suggested that Jonathan would not be managed any better on a locked ward at that time, though

he acknowledged that that possibility would have to be considered again if Jonathan did not respond to treatment. The 3rd Consultant Psychiatrist confirmed that there were no vacancies at Willow House at that time. Jonathan continued to be nursed on a one-to-one basis for some days.

18 On the 21 November, he was described as having a very settled morning and even when he absconded again on the 25 November, whilst a nurse was momentarily distracted by another incident on the ward, he returned of his own volition about 30 minutes later, saying that he wanted to show that he could be trusted. His speech was less "religious"; he maintained a reasonable conversation during a visit from his mother; and he seemed calm and rational.

19 Jonathan continued to be observed on a one-to-one basis without further incident. Then, on the 29 November the statutory basis for his compulsory detention in hospital was changed from Section 2 of the Act to Section 3, because the 1st Consultant Psychiatrist concluded that he was still psychotic and required further in-patient treatment, as opposed to observation.

20 On the 1 December the 1st Consultant Psychiatrist found that Jonathan was much more rational and showing more insight. She set out a treatment plan which provided for Jonathan to have a two hours visit with his father on the 2 December, week-end leave the following week-end if he continued to improve, and a reduced level of observation to 15 minute checks.

21 Jonathan's improvement continued and when the 1st Consultant Psychiatrist reviewed him further on the 6 December, she changed Jonathan's supervision to routine observations and kept him on his depot medication of Depixol (Flupenthixol) only. The 1st Consultant Psychiatrist also authorised a long weekend's leave, discharge at the end of the following week if all was well and follow-up at Abberton. She found that Jonathan was no longer psychotic and was quite rational, cheerful and relaxed.

22 That plan was implemented. Jonathan attended Abberton on the 7 December. He had his weekend leave on the 9 and 10 December; he spent most of the afternoon of the 13 December with his mother; and he had day-leave with his father on the 15 December. Throughout this period, he maintained his improvement and was, therefore, discharged on the 18 December.

23 A meeting was held that morning to make provision for his after-care under Section 117 of the Act. This was to be provided first through Abberton, commencing the following Wednesday, and then by the 1st Community Psychiatric Nurse, when Jonathan was discharged from Abberton. Jonathan was to have 40mg of the anti-psychotic drug, Depixol (Flupenthixol), intra-muscularly monthly at Abberton commencing on the 29 December 1995. In addition, his mental state and his acceptance of his medication, while he was in the community, were to be monitored.

24 Almost immediately, problems were experienced in Jonathan attending Abberton and when he was reminded in a telephone call on the 29 December 1995, that the intention was that he should attend Abberton both for his injections and for a continuing treatment programme, his answer was that he was all right and not in need of medication, as his problem was religious in nature. He did, however, attend that afternoon for his injection.

25 On the 22 January 1996 Jonathan attended with his mother and both of them confirmed that he was mentally well, but also said that he could not attend Abberton because of his work commitments.

26 Following his in-patient discharge, Jonathan was also seen by the 1st Community Psychiatric Nurse on the 26 January 1996. The 1st Community Psychiatric Nurse had already made inquiries after Jonathan's previous failure to attend Abberton on the 20 and 27 December 1995, but as he was told that Jonathan was well, the matter was left on the basis that Abberton would seek his further help if Jonathan did not attend on the 2 January 1996. Jonathan was due for his next depot injection on the 26 January 1996 and although the intention had been that it should be given to him at Abberton, the 1st Community Psychiatric Nurse in fact visited Jonathan at home on that day and administered it. Mrs Neale told the 1st Community Psychiatric Nurse that Jonathan remained well mentally; that there was no evidence of psychotic features; and that Jonathan seemed to have his religious ideas in perspective. The 1st Community Psychiatric Nurse also noted that Jonathan was taking oral Procyclidine on a regular basis to prevent acute dystonic reactions to the Depixol (Flupenthixol).

27 The 1st Community Psychiatric Nurse visited Jonathan again on the 23 February 1996. On this visit, Jonathan declined to have his depot injection. He said that he was seeing the 1st Consultant Psychiatrist on the 27 March and would discuss medication with her before he decided whether or not he would continue with it. The 1st Community Psychiatric Nurse informed the 1st Consultant Psychiatrist of the position.

28 The 1st Community Psychiatric Nurse's next visit was on the 1 March 1996, when Jonathan's mother told him that she had seen the 1st Consultant Psychiatrist with Jonathan three days previously and that Jonathan had then agreed to continue taking the depot injections. There seems to have been some suggestion that the injections should now only be administered six-weekly instead of at monthly intervals, but this concerned Mrs Neale because she feared that a recent incident, when Jonathan came home at about 11 p.m. and sat outside on a very cold night with a cup of tea, might be an early sign of a possible relapse. However, the 1st Community Psychiatric Nurse saw no evidence of psychosis.

29 On the 1 April 1996 the 1st Community Psychiatric Nurse visited again and saw both Jonathan and his mother. Apart from Jonathan's reluctance to agree to taking

medication for more than a couple of months, there was no cause for concern. The 1st Community Psychiatric Nurse observed no abnormalities and Mrs Neale said that Jonathan had been well mentally. The 1st Community Psychiatric Nurse's plan was that Jonathan should be given his next depot injection after a further five weeks, with the following one to be given after another six weeks. Jonathan would then see the 1st Consultant Psychiatrist for a review.

30 On the 21 May 1996 Jonathan's half-sister, Rebecca, expressed concern to the 1st Community Psychiatric Nurse that Jonathan had not been so well over the past few days and she queried whether this was a result of altering the frequency of the depot medication. Jonathan failed to keep an appointment with the 1st Community Psychiatric Nurse on the 28 May, so he was not seen again until he was reviewed by the 1st Consultant Psychiatrist on the 3 June 1996, in accordance with arrangements made on the 13 May.

31 At that review, Jonathan is said to have reluctantly agreed to his medication regime and to attending Abberton and "Work On", an employment scheme. The other aspects of the plan for Jonathan's ongoing treatment were continued depot injections of 40mg Depixol (Flupenthixol) at four-weekly intervals and support and monitoring.

32 At the 1st Community Psychiatric Nurse's next visit on the 12 June 1996, he concluded that Jonathan appeared stable mentally, though still preoccupied with religious ideas, and in the face of further reluctance on Jonathan's part to continue the medication, the 1st Community Psychiatric Nurse agreed to injections of 20mg Depixol (Flupenthixol) every fortnight instead of 40mg monthly. Jonathan's father was present and was worried that the 1st Consultant Psychiatrist had labelled Jonathan as a schizophrenic, whereas Jonathan's condition was really drug-induced. Jonathan admitted to having taken LSD and "Speed" (amphetamine), but only Cannabis in the six months prior to October 1995.

33 Jonathan's condition then gave no overriding cause for concern through June, July and August 1996. On the 2 September 1996, there was a further review of his case. Jonathan's own view of his condition at the meeting was that he felt well and wanted to discontinue the medication. His father was still not convinced about the diagnosis of schizophrenia and was advised that if he wanted a second opinion, he should seek it via the 1st General Practitioner, though we have seen no evidence to suggest that he actually did so. The conclusions reached at this Review were that Jonathan's Depixol (Flupenthixol) should be reduced to 20mg every three weeks; that he should be discharged from the Day Hospital; and that the 1st Community Psychiatric Nurse should continue to visit to provide support/monitoring and to continue the injections.

34 Jonathan then started college to study computing and philosophy. The 1st Community Psychiatric Nurse had some difficulty in meeting Jonathan to give him his injections, but apart from that, there was no cause for concern until

Jonathan refused to continue with the injections on the 27 November 1996. He said that he did not need them and that they clouded his thoughts. Apparently this decision had caused a disagreement with his father and Jonathan was moving back to live with his mother. The 1st Community Psychiatric Nurse arranged a further review for the 16 December 1996.

35 At that Review, Jonathan was adamant that he did not want to continue the depot injections and that he would not accept alternative oral medication. He was preoccupied with religious ideas. He was living with his mother, who was unable to persuade him to accept medication. It was decided to discontinue these reviews; to make an out-patient clinic appointment for Jonathan to see the 1st Consultant Psychiatrist in three months time; and for Mrs Neale to contact the 1st Community Psychiatric Nurse if Jonathan's mental state deteriorated. Future liaison was to be with Mrs Neale because Jonathan did not want any more monitoring visits.

36 On the 2 January 1997 Mrs Neale left a message for the 1st Community Psychiatric Nurse to the effect that she was concerned about the recent deterioration in Jonathan's mental state and his preoccupation with religious ideas and beliefs. Jonathan had run off and the 1st Community Psychiatric Nurse left a message for the 1st General Practitioner to warn her that Jonathan may need to be assessed by an Approved Social Worker with a view to possible compulsory admission under the Act, when he returned.

37 Jonathan was then interviewed at the Lakes on the 3 January 1997 while visiting the Chaplain there. In the course of the interview, Jonathan tried to leave the room but was prevented from doing so. He was found to be suffering from schizophrenic illness, which needed treatment in hospital, and lack of awareness and insight. It was thought that he could quickly be at severe risk, particularly given the very cold weather at that time, if he were not detained. An emergency application for Jonathan's immediate detention in hospital under Section 4 of the Act was made and he was kept in hospital.

38 In passing, we would comment that on the face of the various statutory forms relating to this admission, there is some confusion regarding the dates of these events. However, as such confusion is not unknown over a Christmas/New Year period, we do not propose to go into details in this report.

39 A second medical recommendation to support Jonathan's compulsory detention on this occasion was duly provided by the 1st General Practitioner and it did, of course, operate to "convert" the legal basis for Jonathan's compulsory detention from Section 4 of the Act to Section 2.

40 After initially requiring close observation, Jonathan settled gradually and on the 8 January 1997, although he was still psychotic and lacking in insight, the supervision level was reduced to 15 minute checks and permission was given for

him to go out with his parents. Jonathan's mental state continued to improve, with the result that a referral back to Abberton and leave with his parents began to be considered as possibilities. Indeed, weekend leave with his parents was authorized on the 22 January 1997.

41 Generally, Jonathan's settled state continued until on review on the 29 January 1997 there was no evidence of psychosis; his parents were happy with his progress; and he was prepared to accept depot medication. Accordingly, he was discharged, to be followed up by the 1st Community Psychiatric Nurse.

42 The 1st Community Psychiatric Nurse visited Jonathan at his mother's house on the 3 February 1997. Jonathan was still reluctant to accept medication but agreed to accept depot medication (Depixol (Flupenthixol)) in a dose of 30 mg every two weeks, and the prescription was changed accordingly.

43 Apart from comparatively minor concerns, Jonathan remained well mentally for the next seven months. Indeed, there were occasions when he initiated contacts when his depot medication was due. During this period, for example, Jonathan was found to be very well mentally on the 9 April 1997; on the 7 May 1997 there were no psychotic symptoms; and on the 13 August 1997 Jonathan's psychotic symptoms were described as being well controlled with medication. The only concerns during this period were Jonathan's reluctance to develop social contacts and the possibility that he might be taking alcohol and cannabis under the influence of friends.

44 On the 8 October 1997 Mrs Neale reported to the 1st Community Psychiatric Nurse that she was anxious that Jonathan might be having a relapse, because he had been smoking cannabis and had been seen laughing to himself. Although Jonathan was well again by the 5 November, the risk of a relapse was raised again on the 18 November, when Mrs Neale telephoned the 1st Community Psychiatric Nurse and advised him that Jonathan had been forgetful, hallucinating, giggling to himself, smoking imaginary cigarettes and speaking oddly at times.

45 The 1st Community Psychiatric Nurse arranged an urgent Out-Patient Clinic review for the 19 November 1997. Jonathan was said to have been "high", hallucinating, paranoid and suffering from grandiose delusions. An immediate injection of 40mg Depixol (Flupenthixol) was given, to be followed by similar injections fortnightly, 20mg Droperidol daily for one week and Procyclidine as necessary. A further review was scheduled for one month ahead.

46 Mrs Neale continued to be concerned and on the 21 November, the 1st Community Psychiatric Nurse visited and discussed Jonathan's condition with her when Jonathan was asleep. By this time an injection of Droperidol administered on the previous day on the prescription of the 1st General Practitioner, had taken effect and Mrs Neale felt more in control. Over the next two days Mrs Neale thought that the improvement was continuing, and when the 1st Community

Psychiatric Nurse visited on the 24 November he found no evidence of psychotic symptoms, though Jonathan admitted to hearing voices and having thoughts about his friends wanting to kill him. Mrs Neale expressed confidence that Jonathan's recent episode had subsided and she felt able to manage him at home.

47 On the 3 December 1997 the 1st Community Psychiatric Nurse found that Jonathan was better mentally but was still expressing unrealistic ideas. Mrs Neale was concerned that Jonathan was regularly abusing cannabis and Jonathan was adamant that he would not stop smoking it.

48 On the 14 January 1998 Jonathan was planning to move out of his mother's house and to share a flat with a friend. Mrs Neale was understandably anxious about his ability to care for himself away from home. Throughout this period, Jonathan continued to take his depot medication and by the 28 January 1998 he was described by the 1st Community Psychiatric Nurse as remaining well mentally. Jonathan had also abandoned the idea of moving out of his mother's home.

49 On the 11 February 1998, Mrs Neale was still concerned with Jonathan's unwillingness to take responsibility for himself. He stayed in bed during the day, but went out at night until the early hours. He was spending money recklessly, perhaps on alcohol and drugs. This situation was jeopardising their relationship. The 1st Community Psychiatric Nurse suggested the possibility of Jonathan moving to sheltered accommodation to increase his independence and arranged a Care Programme Approach review for the 26 March 1998.

50 Two weeks later on the 25 February 1998, Mrs Neale was concerned that Jonathan's abuse of cannabis and alcohol had increased, and the 1st Community Psychiatric Nurse saw that Jonathan's general irresponsibility was causing friction with her. In spite of this friction, it must be repeated that Mrs Neale was consistently supportive of Jonathan.

51 The 1st Community Psychiatric Nurse saw Jonathan on the 27 February, when Jonathan said that he refused to accept any more injections, not even a reduced dose of Depixol (Flupenthixol). He admitted to taking cannabis and alcohol, but denied that they caused any adverse effects. Jonathan was slightly more excitable; his concentration was patchy and he was talking in a grandiose manner about possibly having healing powers. The 1st Community Psychiatric Nurse discussed with him the possibility of independent living at CHAC, though Jonathan was talking unrealistically about going to India to do missionary work. The 1st Community Psychiatric Nurse's plan was to continue to monitor Jonathan's mental state; to advise him that he would administer the Depixol (Flupenthixol) injection, if Jonathan would agree to take it; to continue to support, and liaise with, Mrs Neale; and to proceed with the scheduled review on the 26 March 1998. He also wrote to the lst Consultant Psychiatrist and the 1st General Practitioner on the 2 March 1998 to advise them of the position.

52 In spite of the current difficulties, Mrs Neale believed that the situation was manageable at home at present, when the 1st Community Psychiatric Nurse spoke to her on the 3 March 1998, and she agreed to contact him again if she felt that Jonathan needed further hospital admission.

53 On the 5 March 1998, Mrs Neale informed the 1st Community Psychiatric Nurse that one of Jonathan's friends had told her that he was taking amphetamines in addition to cannabis. She had spoken to the 1st Consultant Psychiatrist and the 1st General Practitioner, in case Jonathan needed to be admitted to hospital again. The 1st Community Psychiatric Nurse was due to be on annual leave in the following week, but he arranged for a colleague to make contact and try to persuade Jonathan to accept medication. He also advised Mrs Neale to contact his colleague or the Duty Team, if an assessment for possible admission was required.

54 Jonathan's mental state remained reasonably stable until the next Care Programme Approach review on the 26 March 1998. At that review, Jonathan's current problems (lack of insight, his refusal to accept depot injections for the last six weeks or alternative oral medication, his refusal to accept day-care, his drink and drug abuse, irresponsible behaviour, an unwillingness to engage in useful structured activities and his impaired concentration) were identified. The plan for his on-going treatment was the continued monitoring of his mental state and encouragement to him to accept medication, the suggestion that he might take Olanzapine 10mg daily as an oral alternative to injections, encouragement for him to attend "Work-On" or Oxford Road, the possibility of alternative accommodation at CHAC and the offer of further sessions with the Chaplain at the Lakes, with whom Jonathan had been discussing religious questions for some time. However, Jonathan refused to accept these suggestions.

55 On the 14 April 1998, Mrs Neale was concerned that Jonathan's mental state had deteriorated to the point where she felt that he needed re-admission to hospital. The 1st Community Psychiatric Nurse made arrangements for the necessary assessment for compulsory admission, as it was unlikely that Jonathan would agree to be admitted voluntarily.

56 Jonathan was examined on the 15 April 1998. He was found to be in need of compulsory admission in the interests of his own health and safety, because of his lack of insight, his refusal to accept medication or voluntary admission, his self-neglect and his severe and florid psychotic condition, and was admitted to the Lakes compulsorily under Section 3 of the Act that same day.

57 On admission, Jonathan was placed on 15-minute observations due to the possible risk of his absconding. Drug and alcohol abuse was seen as the main cause of his relapse. Jonathan was said to have taken cannabis and ecstasy regularly, to have experimented with "speed" (amphetamine) and heroin, and to have indulged in a "few pints" every second day though without exhibiting any features of

dependency. The immediate plan for his treatment was to re-commence Depixol (Flupenthixol), to administer Lorezepam 2 – 4 mg for Jonathan's severely aroused state and to take blood and urine samples for drug screening. The case would then be discussed with the 1st Consultant Psychiatrist the following day.

58 The 1st Consultant Psychiatrist described Jonathan's re-admission as being a "typical picture" for him, with the addition of an accommodation problem due to his unwillingness to return to live with his mother in due course. She prescribed the continued administration of Depixol (Flupenthixol) 40 mg intra-muscularly fortnightly as soon as possible.

59 Jonathan did not pose any significant management problem for some days. On the 21 April 1998 he was described as being "settled in mood, behaviour" though some laughing to himself was observed.

60 The 1st Consultant Psychiatrist saw Jonathan with Mrs Neale on the 22 April. The 1st Consultant Psychiatrist's plan was that Jonathan should continue treatment with Depixol (Flupenthixol), with his accommodation problem being tackled by the 1st Community Psychiatric Nurse in conjunction with CHAC. Apart from one incident when Jonathan left the ward without reference to the staff, no problems were experienced with him over the following few days. The 1st Community Psychiatric Nurse saw him with Mrs Neale on the 28 April 1998 and discussed the possibility of his taking accommodation with CHAC. Jonathan agreed to this, but the 1st Community Psychiatric Nurse noted that he still lacked insight and was unable to give a commitment to continuing with his medication after eventual discharge.

61 On the 29 April 1998 the 1st Consultant Psychiatrist reviewed Jonathan's case, in his absence. She noted that there was no management problem with him, though he went out a lot. In fact, it became necessary to cancel his leave almost immediately, following his admission that he was taking alcohol and smoking a "few pipes" of cannabis.

62 On the 1 May 1998, Jonathan and another resident on the ward acted suspiciously and gave the staff cause to believe that cannabis was being smoked on the ward. Indeed, cannabis was found in the other resident's room. A search of Jonathan's room revealed a piece of tinfoil and Jonathan admitted using it to smoke heroin, though he maintained that he did not do it on the unit. Jonathan was reminded of the detrimental effect of drug abuse on his mental health, and his mood changed from one of amusement to being sullen and angry later.

63 Jonathan's problems then continued for about one week. He was described as showing some bizarre behaviour on the 1 May. A urine test was positive for opiates on the 2 May. For some days he was generally withdrawn in his room. His bizarre behaviour continued and on the 4 May he was rather sullen with the staff and preoccupied with his own thoughts.

64 On the 6 May 1998 Jonathan's care programme was reviewed. His mental state had not improved. Test results showed that he was still taking opiates and cannabis, and he was warned that the Police might have to be involved, if his drug abuse continued. Jonathan showed no insight into his illness or the adverse effects of his drug abuse and he was in need of education about the harmful effects of that abuse, when his mental state improved. A referral to Needas was proposed. It was also noted that CHAC would provide Jonathan with accommodation, when he was eventually discharged. In the meantime, the care plan provided for the cancellation of all leave, limited visits by his mother only, spot checks for illicit drugs with possible Police involvement (if necessary) and increased Depixol (Flupenthixol) medication.

65 After some improvement from the 9 May 1998, on the 13 May Jonathan's care programme was reviewed again. He did not think that he was in need of medication but he agreed to take it, and his Depixol (Flupenthixol) was increased to 80 mg every two weeks. Although his behaviour was described as pleasant and appropriate in the two days prior to the review, Jonathan was unhappy at the outcome and further leave had to be cancelled. He also became very "uptight" when the staff refused to let him have money, which he apparently wanted in order to buy drugs. He did, however, improve by the 17 May1998 and he went to CHAC's premises at 14 Creffield Road, Colchester on leave on the 18 May 1998.

66 Jonathan's case was reviewed again on the 27 May 1998. CHAC's representative said that he was fine and that although he was taking drugs, they could cope with him and wanted him discharged from hospital. Accordingly, Jonathan was discharged on the 27 May 1998, with the 1st Community Psychiatric Nurse to be responsible for his follow-up, possibly involving "Work-On" (if Jonathan would agree), the Northgate Centre, or the MIND Centre. 80mg Depixol (Flupenthixol) was to be administered fortnightly and the 1st Community Psychiatric Nurse was to monitor Jonathan's mental state and any drug abuse, and liaise with Mrs Neale.

67 The 1st Community Psychiatric Nurse saw him at 14 Creffield Road on the 28 May 1998, when Jonathan reluctantly agreed to take the Depixol (Flupenthixol). Already, drug abuse was suspected by the staff there, though Jonathan would not admit it.

68 On the 1 June 1998 Mrs Neale told the CHAC staff at 14 Creffield Road that Jonathan had been asking her for money to buy illegal substances. Other tenants at the property complained of Jonathan asking them for cigarettes, or even stealing cigarettes from them. He also upset them by playing loud music and being noisy at night. Problems of this nature continued and in addition Jonathan broke the terms of his agreement by allowing friends to stay overnight in the house.

69 The 1st Community Psychiatric Nurse saw Jonathan again on the 11 June, when he refused his depot injection. The 1st Community Psychiatric Nurse warned him of the risk of a relapse and the dangers of drug abuse, but Jonathan showed no insight. Jonathan was rejecting help from the CHAC staff. He had failed to keep an appointment with Needas and was refusing to attend "Open Road" and "Work On". Although the 1st Community Psychiatric Nurse did not detect any psychotic symptoms, he noted that Jonathan was unable to engage in meaningful conversation, had glazed eyes and had little contact with his mother.

70 On the 17 June 1998 Mrs Neale told the 1st Community Psychiatric Nurse of her worries about Jonathan's failure to conform to the advice offered to him by CHAC or to co-operate with them.

71 More evidence of Jonathan's drug and alcohol abuse appeared, and on the 6 July the 1st Community Psychiatric Nurse was of the view that Jonathan's mental state was steadily deteriorating because of his refusal to take his depot medication and his increased use of illegal drugs. The 1st Community Psychiatric Nurse's warnings and the arrangements which he made for Jonathan to see Needas were all ignored and his only course of action was to liaise closely with the CHAC staff and to monitor Jonathan's deteriorating mental state, recognizing that he may need screening and assessment under the Act again in the near future.

72 On the 12 July Jonathan's problems with the other tenants increased when he was attacked by friends of another resident at 14 Creffield Road and needed out-patient hospital treatment. The assault was reported to the Police and Jonathan was moved by CHAC to alternative premises temporarily, returning to 14 Creffield Road on the following day.

73 On the 17 July 1998 Jonathan's care programme was reviewed. He was absent but Mrs Neale was present. The main features of his condition were his refusal to accept his depot medication and other treatment, continuing drug abuse, a steady deterioration in his mental state, disjointed speech, bizarre thoughts and lack of insight. The possibility that Jonathan may need admission to hospital by the time of the next review was considered and with that possibility in mind, an assessment was arranged for the 20 July.

74 That assessment showed that Jonathan had clearly relapsed into a partially psychotic state, and admission to the Lakes under Section 3 of the Act was recommended. The reasons were Jonathan's deterioration, the risk that he would deteriorate even further and his refusal to accept treatment in the Community.

75 The Approved Social Worker who made the application for Jonathan's compulsory detention on this occasion, concurred with the medical recommendations and was also concerned that Jonathan was at risk from others.

He also emphasized Jonathan's concerns about Depixol (Flupenthixol) and commented that he could not stress highly enough the need to look at alternatives in partnership with Jonathan, to secure long-term compliance with his medication.

76 Jonathan was then admitted to the Lakes on the 20 July 1998, when no evidence of paranoid ideation was found. He remained subject to compulsory detention under the Act until the 16 September 1998 and then continued as an informal patient until the 5 November 1998. Generally during this period Jonathan was difficult to manage because of his absconding and overstaying periods of authorised leave. When Jonathan was away from the ward, he did, of course have free access to drugs and alcohol. The Ward records show that Jonathan absconded or overstayed authorised leave on about twenty-three occasions between the 22 July and the 8 September 1998, though between the 2 and 15 August, when his possible transfer to the more secure environment of Shannon House or Willow House was under consideration, no incidents of absconding occurred.

77 Jonathan was assessed for Willow House on the 10 August 1998 by a Charge Nurse and another member of staff from Willow House, though it is not clear from the records whether a member of the medical staff at Willow House was involved. It was then decided on the 17 August that he was not a suitable candidate for transfer there, because of his lack of motivation to abstain from drugs and because of the fact that he had not been placed under close observation on Ardleigh Ward in the Lakes.

78 In the period between the 2 and 15 August 1998 Jonathan was more co-operative with the staff. However, the decision not to accept him at Willow House was immediately followed by a recurrence of absconding.

79 Out of the 23 incidents of absconding or overstaying leave mentioned in paragraph 77 above, Jonathan admitted taking alcohol or drugs, or other evidence of drug or alcohol abuse by him was found, on about 6 occasions.

80 At a review of Jonathan's case on the 26 August 1998 the 1st Consultant Psychiatrist concluded that he was less psychotic and hostile but was still thought-disordered. Jonathan's leave plan was altered to permit unescorted leave of up to 3 hours per day at the discretion of the Nurse in charge of the ward. Discretionary, unescorted leave overnight was then permitted from the 2 September 1998 and on the next day the 1st Consultant Psychiatrist reviewed the case again and was told that Jonathan was improving. Apparently he had not been accepted by Shannon House.

81 Apart from one incident of absence without leave on the night of the 8/9 September, Jonathan's condition remained satisfactory and on the 9 September, on review, the 1st Consultant Psychiatrist approved overnight leave for him on a Thursday and week-end leave if the overnight leave went well. She recorded that Jonathan wanted to attend "Open Road" and that he was not thought-disordered.

82 Jonathan took his overnight leave on the 10/11 September at CHAC's premises at 14 Creffield Road, Colchester and returned in the afternoon of the 11 September 1998.

83 On the 16 September Jonathan was reviewed by the 1st Consultant Psychiatrist whose opinion was that he was not then psychotic and that he was compliant with his medication. Jonathan was re-graded to the status of informal patient. He was referred to "Oxford Road" and was given an appointment with Needas during the following week.

84 Jonathan's mental state remained settled and so he went on leave to CHAC on the 21 September. However, on review on the 23 September the CHAC staff reported that Jonathan had been drinking every night. The 1st Consultant Psychiatrist suggested a referral to CAC, if the placement with CHAC failed.

85 Jonathan then had periods of absence from his CHAC accommodation, which made it difficult for the 1st Community Psychiatric Nurse to monitor him and ensure that Jonathan had his depot medication, but on the 7 October he was brought to the Lakes and given his injection of Depixol (Flupenthixol) and 10 mg Procyclidine. The 1st Community Psychiatric Nurse expressed his concerns that it had not been possible to monitor Jonathan over the past two weeks, and it was decided that Jonathan should remain with CHAC for another week and then be reviewed again.

86 On the 12 October the 1st Community Psychiatric Nurse reported that CHAC might evict Jonathan from their premises, due to his failure to abide by the terms of his tenancy agreement, the fact that he had not made himself available for the 1st Community Psychiatric Nurse to monitor him, his failure to spend time at CHAC so they could assess him, the discovery of drug-taking equipment (burnt spoons) in his flat and the fact that he left a candle burning and unattended in the flat.

87 Jonathan's case was reviewed again on the 14 October 1998. CHAC's representative mentioned that syringes had been found in Jonathan's flat and it came to light that he had been in contact with his General Practitioner in an endeavour to obtain Methadone. In the light of CHAC's intention to evict him, Jonathan was eventually persuaded to remain on the ward for detoxification with Loflexidine. However, only the first dose of Loflexidine seems to have been given to Jonathan, because he showed no signs of withdrawal from heroin during the night of the 14/15 October 1998 and on the following day he said that he had not taken heroin for a month.

88 An assessment carried out on the 16 October 1998 noted that Jonathan was not a risk to himself or to others and this was followed by a note on the 19 October that he had no ideas of doing any harm to himself or to others and displayed no

evidence of psychosis. That opinion was confirmed by the 1st Consultant Psychiatrist on the 21 October 1998.

89 The next significant review was carried out by the 1st Consultant Psychiatrist on the 4 November 1998 in Jonathan's absence. It was noted that he had sabotaged all attempts to make arrangements for his assessment at CAC, and that he lacked motivation to refer himself to Penfold Lodge. Jonathan's taking of illegal substances while off the ward and his inability or unwillingness to take responsibility for himself were mentioned. After some doubt whether CHAC would have him back at 14 Creffield Road, Jonathan did, in fact, return there on the following day.

90 On the 5 November Jonathan refused his depot medication before leaving the Hospital to go to 14 Creffield Road. The responsibility for Jonathan's future care passed back to the 1st Community Psychiatric Nurse.

91 Jonathan's stay at 14 Creffield Road was short-lived. He was given notice to quit the property by letter dated the 9 November 1998 because of his lack of co-operation with the measures agreed for his on-going treatment and his breaches of several of the terms and conditions of his licence from CHAC. Jonathan was required to move out by the 16 November.

92 Jonathan opted to go to stay with friends when he moved out of 14 Creffield Road. He was adamant that he did not need medication, believing that praying was sufficient to prevent further relapses. The 1st Community Psychiatric Nurse confirmed that he would continue to provide support for Jonathan and Mrs Neale, though he personally would be away for some weeks and he had alerted the Duty Team to respond to any crises that occurred.

93 On the 2 January 1999 Mrs Neale went on holiday. She returned home on the 10 January and on the following day she noticed that some items were missing from her house, including two giro cheques in her favour. Her inquiries of the local Post Office revealed that Jonathan had cashed the cheques. She reported the matter to the Police. Jonathan was arrested on suspicion of burglary and released on bail. The case was ultimately disposed of by a formal caution from the Police given on the 5 February 1999.

94 In the meantime Jonathan had moved from his friends' accommodation to bed and breakfast accommodation in a hotel, because of fears for his safety. The 1st Community Psychiatric Nurse visited him there on the 12 January 1999 and Jonathan expressed regret for the theft of the giro-cheques, said that he would agree to take his depot medication and to refer himself to Needas for help with his drug problem. The 1st Community Psychiatric Nurse gave him a dose of 40 mg Depixol (Flupenthixol), which was the dose which Jonathan would accept. The plan was for the 1st Community Psychiatric Nurse to see Jonathan weekly at the hotel; for Jonathan to accept 40 mg Depixol (Flupenthixol) fortnightly; for

Jonathan to refer himself to Needas; and for the position to be reviewed at a meeting to be held on the 25 January 1999.

95 After an abortive appointment on the 19 January, the 1st Community Psychiatric Nurse next saw Jonathan on the 26 January. Mrs Neale was present. Jonathan was hostile in manner, blaming his mother for trying to "control his life". His concentration was poor and he lacked any insight. Jonathan refused his depot medication. Mrs Neale's attempts to help Jonathan with his finances and housing were not welcomed by him.

96 Jonathan then failed to keep several appointments with the 1st Community Psychiatric Nurse and no depot medication had been given since the 26 January. The 1st Community Psychiatric Nurse reported the position to the 1st General Practitioner and the 1st Consultant Psychiatrist by letter dated the 11 February 1999, but pending the next Review meeting fixed for the 25 February, felt unable to do anything more than respond to crises as and when they might occur.

97 Jonathan's condition was next reviewed on the 25 February 1999. Mrs Neale explained that since the incident with the giro cheques, she had had little contact with Jonathan, although she still occasionally provided him with food and a bath. His non-compliance with his medication regime and his drug abuse had had a negative effect on their relationship. Jonathan was said possibly to have some psychotic symptoms and his non-compliance with his treatment and his drug abuse were also noted. It was agreed that the 1st Community Psychiatric Nurse should discuss with Jonathan and the Housing Department the possibility of his being given supported accommodation. Apart from that, the 1st Community Psychiatric Nurse would continue to liaise with Mrs Neale and Jonathan, if he was agreeable. It was noted that the 2nd Consultant Psychiatrist would take over from the 1st Consultant Psychiatrist as Jonathan's Consultant Psychiatrist or, in the context of the Act, the Responsible Medical Officer as from April 1999, because of changes in the catchment areas of the Mental Health Teams in Colchester.

98 The 1st Community Psychiatric Nurse then saw Jonathan on the 5 March. It appeared that accommodation at Plowright House might be made available for Jonathan shortly. At this meeting, Jonathan was unkempt and dishevelled. He complained of having no money and admitted to regular heroin abuse. He was encouraged to attend Needas for help/support and to consider depot medication, but he stormed out of the meeting, refusing any further discussion.

99 On the 8 March 1999 the Manager of Plowright House of the CQHA was able to confirm that a place would be available for Jonathan at Plowright House from the following week.

100 On the 17 March 1999 Jonathan was robbed of £120 in the street at St John's Street, Colchester on the 17 March 1999. The difficulties which would have been

experienced if Jonathan had to give evidence and the lack of any other available evidence prevented this matter being pursued by the Police.

101 On the 5 April 1999, Jonathan was arrested in connection with an alleged offence of criminal damage but we now understand that he was released due to insufficient evidence.

102 On or about the 14 April Mrs Neale reported that Jonathan's behaviour was bizarre in that she thought that he might be hearing voices and was gesticulating with his arms, but the 1st Community Psychiatric Nurse's conclusion was that Jonathan was not liable to be detained under the Act at that time and that he would never go into hospital voluntarily. However, one week later Jonathan turned up at the Peter Bruff Unit in Clacton, behaving oddly and gesticulating with his hands and was thought to be drunk. On the following day, he was seen behaving bizarrely on a piece of waste ground in Clacton. He was in the company of someone who was said to be known to the Police as a drug dealer. When spoken to, Jonathan talked gibberish and the Police detained him under Section 136 of the Act, prior to his admission to the Lakes under Section 3.

103 On this occasion Jonathan was found to be suffering from a relapse in his schizophrenia, with evidence of thought disorder and delusional ideas. He lacked insight, had not been compliant with his medication and would not co-operate with out-patient care or voluntary admission. There was no alternative to compulsory admission as Jonathan was a risk to himself through neglect or self-neglect. He was not thought to be a risk to others.

104 On admission to the Lakes on the 22 April 1999, Jonathan was very agitated and a course of rapid tranquilisation was given with good effect. That same day Jonathan absconded at 4 p m and was brought back by the Police at 8.45 p m. He was suffering from acutely disturbed and bizarre behaviour and he accused the ward staff of using black magic against him and said that if they did not stop, he would become very angry. He continued to be verbally abusive on the 23 and 24 April and on the second of those two days was angry at being compulsorily detained under the Act.

105 Over the next two or three days Jonathan absconded and was chaotic, unkempt and bizarre. He did not feel that there was anything wrong with him. The 2nd Consultant Psychiatrist saw Jonathan on the 26 April 1999 and recorded that he was abusive when challenged, although there had been no physical aggression. Jonathan did not accept that he suffered from any form of mental disorder. The 2nd Consultant Psychiatrist contacted Willow House about Jonathan's possible transfer there. Jonathan continued to express anger and frustration at being in hospital and showed little or no insight into his condition. **This was the 2nd Consultant Psychiatrist's first contact with Jonathan.**

106 Jonathan was assessed for possible transfer to Willow House on the 27 April. Pending a decision on a possible transfer, the Willow House team advised on Jonathan's ongoing medication and the need for drug screening. At the same time the possibility of transferring Jonathan to Shannon House was raised, but there were no vacancies there and the 2nd Consultant Psychiatrist suggested that that idea be put on hold.

107 The next morning Jonathan agreed to accept his compulsory admission under the Act and appeared to be coming out of his drug and alcohol induced state.

108 On the 29 April the level of supervision was reduced further to general observation and in a one-to-one session with a Staff Nurse, he gave some slight acknowledgement that his substance misuse had contributed significantly to his mental health problems and his numerous admissions. In this conversation, Jonathan admitted to using amphetamines, but said that this was for his personal growth and enlightenment.

109 Further instances of absconding occurred on the 30 April and 1 May, and Jonathan's mental state seemed to vary day-to-day. On the 4 May 1999, the 2nd Consultant Psychiatrist saw him and noted that he had no real intention of attempting to reduce or stop his illegal drug abuse. However, as he had not then absconded for some days, the 2nd Consultant Psychiatrist agreed to Jonathan having Section 17 leave at the coming week-end, if the week went well in the meantime.

110 In the afternoon of the 12 May 1999 Jonathan was seen walking up Turner Road, gesticulating and grinning. He admitted to having smoked heroin costing £10, at midday. Whilst a search revealed no drugs in his possession, in his room ten syringes were found, which he said he had used previously to inject amphetamines. Drug screening revealed that he had taken morphine, but no cannabis, amphetamines or cocaine. Jonathan's behaviour was not acutely disturbed at that time and the care plan was to give him no medication that day, but to restart it on the following day; not to grant any further leave at present; to search his room, if he absconded again; and to send a urine sample for drug screening.

111 Over the next week or so, Jonathan absconded almost on a daily basis. After two of these occasions Jonathan admitted taking cannabis or heroin. The incidents occurred in spite of Jonathan having been put on 15 minute observations and the institution of drug screening measures. His refusal to contemplate giving up illicit drugs was illustrated by his missing an appointment at Needas on the 17 May and his remarks to a Staff Nurse on the 23 May to the effect that he refused to give up amphetamines and rejected any factual information about them and heroin. The possibility of a transfer to Willow House was raised again.

112 Jonathan was reviewed again on the 24 May. In addition to his recent history of absconding and drug taking, Mrs Neale expressed her concern that his condition was deteriorating. Apparently, Willow House was unable to provide any further support at that moment, apart from advising that he be placed on close observation. The 3rd Consultant Psychiatrist, the Consultant Psychiatrist at Willow House, said that he would be happy to discuss the case. Jonathan was kept on his current medication and under close observation.

113 On the 25 May Jonathan accepted his depot medication and for several days there were no incidents of absconding.

114 He was seen again on the 28 May. He wanted further leave, at the same time maintaining that he would probably take drugs again as they were part of his life. A referral to Shannon House was considered again as a possibility, because of the need for long term care to evaluate his mental state after a significant period free from illicit drugs and the significant risk that he would abscond again.

115 On the 1 June 1999, Jonathan's supervision level was eased to 15 minute checks, but he remained adamant that he would not give up using illicit drugs in a conversation with a member of the Needas staff. Jonathan then went missing from the ward between 3.45 p m and 6.30 p m when the Police returned him in an intoxicated state.

116 The 2nd Consultant Psychiatrist reviewed the case on the 2 June and agreed to allow Jonathan one hour's escorted leave per day at the nurses' discretion, subject to the warning that it would be stopped if he absconded again. Jonathan absconded the very next day and leave was stopped. A close observation regime was reintroduced. "Close observation" means a constant and continuous observation of one client by a designated nurse practitioner. The only variable between that level of observation and 1:1 observation is that the practitioner does not need to be in such close proximity; it is sufficient that the client is within eyesight. All other guidelines are the same for close and 1:1 observation.

117 Jonathan absconded again on the following day from about 11 am until 5 p m, but he then returned of his own accord. He readily admitted to having injected amphetamines and showed the injection site to the nursing staff. He went absent again on the 4/5 June from 9.45 p m until 2.30 am when again he had to be returned to the ward by the Police. Although initially settled on his return, he later started shouting that he was angry with God and continued with loud shouting so that he required sedation with 10mg Droperidol and 2 mg Lorazepam. Even then he made another attempt to leave the ward.

118 On the 6 June 1999 Jonathan was assessed by the Shannon House staff for possible admission there. However, he was not thought to be either a significant danger to others or at significant risk of suffering harm from others or from his self-neglect and so Shannon House would not accept him.

119 On the 8 June the case was discussed by the 2nd Consultant Psychiatrist and the ward staff. A policy of continuous observation for weeks on end was said by the ward staff to be impractical, because on an open ward it would antagonise Jonathan and would not stop him from absconding. Observation at that level was said to be inhuman and intrusive, given the comparatively low level of risk. In these circumstances, it was decided to put him on close observation only if he appeared to be acutely disturbed and to continue that level of supervision only until he became settled again. At that stage observation would be reduced to 15 minute checks or even general observation, depending on his behaviour. The need to hold a case conference involving Mrs Neale and the Community staff was recognized, as was the need to treat Jonathan's schizophrenia as well as his substance abuse. The 2nd Consultant Psychiatrist spoke to Jonathan about these conclusions; he had no great objections to the plan, but clearly disagreed with the proposition that there was anything wrong with him.

120 Apart from one incident of absconding on the 10 June and a continuing refusal to change his life style, because (in his view) it was not affecting his mental state, Jonathan enjoyed a relatively settled period for several days. He was reviewed on the 14 June, and the plan for his care was to continue with the current medication; to allow him leave for 2 to 3 hours per day; and to continue with the drug screening. Further instances of absconding or failing to return from authorized leave in time occurred on the 15, 16 and 17 June and on each occasion tests for illicit drugs proved positive on Jonathan's return. **The 2nd Consultant Psychiatrist instructed that close nursing observation be resumed.**

121 On review on the 21 June 1999, after a reasonably settled period of three days, Jonathan was agreeable to trying alternative therapy offered by different groups in the community. The alternative therapy at "Open Road" was said to give Jonathan the opportunity of taking precautions against any further admissions. It was, therefore, decided to discharge him on the following day, after an injection of 80mg Depixol (Flupenthixol). Accommodation was available for him at Plowright House and he would be followed up by the 2nd Community Psychiatric Nurse, within 72 hours and at an out-patient appointment with the 2nd Consultant Psychiatrist in six weeks. The 2nd Community Psychiatric Nurse was taking over from the 1st Community Psychiatric Nurse as Jonathan's Care Co-ordinator and key-worker, because of the same change in catchment areas as had led to the 2nd Consultant Psychiatrist succeeding the 1st Consultant Psychiatrist as Jonathan's Consultant Psychiatrist and Responsible Medical Officer. Present at this review were the 2nd Consultant Psychiatrist, the Senior House Officer, Mrs Neale, the Manager of Plowright House of CQHA, two Nurses from Gosfield Ward, the 1st Community Psychiatric Nurse and the 2nd Community Psychiatric Nurse. Jonathan was not present, but he had written a letter to the 2nd Consultant Psychiatrist in the following terms:-

"I have no longer any reason to be under section. I am requesting that I be totally discharged. My problem is not a mental health act but rather one of the life style with drugs. I do not wish (?) harm to any one when taking such substances, I just like to get my senses stimulated is the truth. I am willing to keep in contact with [the 1st Community Psychiatric Nurse] and also willing to make contact with Open Road and Needas to further my knowledge on the effects of the substances I take. I hope you really understand I am not mentally ill! I'm.....(?)"

122 Subsequent to this review meeting, the 2nd Consultant Psychiatrist was on study leave on the 30 June and 1 July and on annual leave from Monday, the 5 July, until Friday, the 30 July.

123 The 2nd Community Psychiatric Nurse spoke to Jonathan by telephone on the 25 June and arranged to see him on the 28 June. That meeting did take place but Jonathan was very reluctant to agree to any further meeting, though in the event he did agree to one on the 12 July. The 2nd Community Psychiatric Nurse's plan was to see Jonathan on a two-weekly basis and to liaise regularly with Mrs Neale and the Manager of Plowright House.

124 The next contact between the 2nd Community Psychiatric Nurse and Jonathan was on the 12 July 1999, but that meeting was very brief, as Jonathan was rushing off to sort out some money matter.

125 There was no further contact between them until the 2 August, when Jonathan was again asked to consider having his depot injection, which had been due on the 5 July. He still said that he did not want it, as he was not ill. The 2nd Community Psychiatric Nurse found signs in Jonathan's flat that he was continuing to inject illegal substances and smoke cannabis. At this meeting, Jonathan was also vague; he was having difficulty in concentrating; and was rambling about mystical spirits and having control of his own spirit. A meeting with the 2nd Consultant Psychiatrist to review Jonathan's care programme was fixed for the 4 August, along with a further meeting between the 2nd Community Psychiatric Nurse and Jonathan for the 16 August.

126 The review meeting took place on the 4 August between the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse. Jonathan did not attend. The 2nd Community Psychiatric Nurse brought the 2nd Consultant Psychiatrist up-to-date with Jonathan's condition, including the belief that there had been no aggressive episodes. It was decided that there was no point in sending Jonathan another appointment and that a further review meeting should be held in six months.

127 Jonathan was then arrested on the 10 August 1999 on suspicion of having assaulted a man in Guildford Street, Colchester on the 2 August, causing him actual bodily harm. The alleged assault consisted of a single blow with the hand to the back of the victim's head. Jonathan told the Custody Sergeant that he had

suffered from schizophrenia in the past and the FME was asked to examine him to see whether he was fit to be detained or whether he required assessment under the Act. The 2nd General Practitioner (who was both the FME and a local General Practitioner), examined Jonathan and found that he was fit to be detained and was not liable for compulsory detention under the Act. The 2nd General Practitioner did, however, think that Jonathan should be accompanied by an appropriate adult at interview. An "appropriate adult" is someone independent of the Police (such as a relative, guardian or other person responsible for the care of a mentally disordered or mentally handicapped person or someone with experience of dealing with a mentally disordered or mentally handicapped person) who is advised by the Police that a mentally disordered or mentally handicapped person is in custody, who visits the person and advises him or her about obtaining legal advice. The attendance of an appropriate adult is required under the Codes of Practice laid down under the Police and Criminal Evidence Act 1984.

128 Difficulties were, however, experienced in securing the attendance of both the duty solicitor and an appropriate adult to accompany Jonathan at an interview. The Custody Sergeant decided, therefore, to release Jonathan on police bail until the 16 August 1999.

129 Jonathan did not return to the Police Station on the 16 August as he should have done, but his name was not put on the Police National Computer as a bail absconder, as the police knew where he lived. However, in spite of a number of visits to Jonathan's address by a Police Officer, Jonathan was not taken back into custody in connection with the alleged assault, because he was never found at home. No direct contact with the Criminal Justice Mental Health Team was initiated by the Police or made by the 2nd General Practitioner. The 2nd General Practitioner did, however, send a Fax to the 2nd Community Psychiatric Nurse on the following day and the 2nd Community Psychiatric Nurse spoke in turn to the 2nd Nurse of the CJHMT about the matter.

130 The allegation that Jonathan had committed an assault, which was the first indication to the Police that he might be physically violent, was therefore known to the 2nd Community Psychiatric Nurse, his key-worker. The alleged assault was not pursued by the Police thereafter, because within just over two weeks Jonathan was arrested and charged with the murder of his mother.

131 On the 16 August the 2nd Community Psychiatric Nurse saw Jonathan again. Used needles around Jonathan's bedroom suggested that he was still injecting illegal drugs. Also the Manager of Plowright House reported that Jonathan was still causing concern through his noisy behaviour at night, about which other residents were complaining. In addition, Jonathan continued to refuse his depot medication.

132 On the 18 August Jonathan was charged with begging in the High Street, Colchester and was bailed to appear at Colchester Magistrates Court on the 28 September 1999.

133 Then, early in the morning of the 26 August 1999, the Police were called to Plowright House because Jonathan had been creating a disturbance in his room by screaming. The door of his room had to be forced to gain entry and he was arrested for committing a breach of the peace. While Jonathan was in custody, the Custody Sergeant assessed him and concluded that compulsory detention under the Act was not appropriate. The Sergeant also spoke to a member of the staff of Plowright House, who apparently agreed that there was little risk of Jonathan committing any further breach of the peace and so the matter was resolved by Jonathan being strongly warned by the Police as to his future behaviour and then being released.

134 The 2nd Community Psychiatric Nurse was asked by the Manager of Plowright House to visit Plowright House on the 26 August, because of Jonathan's noisy and bizarre behaviour the previous night. He did visit and was told by the Manager of Plowright House that Jonathan was facing criminal charges for begging and causing actual bodily harm respectively and was due in Court on the 29 September. The Manager of Plowright House had obtained this information from a fax or letter from the Police found in Jonathan's flat. However, when the 2nd Community Psychiatric Nurse tried to speak to Jonathan, he refused to open his door, jumped through the bedroom window and ran off.

135 The 2nd Community Psychiatric Nurse's final visit to Jonathan before the sad events of the 2 September 1999 was on the 31 August, when Jonathan again refused to open the door to him. He was told by the Manager of Plowright House that Jonathan was a lot more settled and that Mrs Neale had visited him. Accordingly, the 2nd Community Psychiatric Nurse left matters on the basis that the staff at Plowright House would inform him of any further developments.

136 Mrs Neale then went to Jonathan's flat at Plowright House in the morning of the 2 September 1999. At about 12.30 p m, the resident living in the flat opposite saw the door to Jonathan's flat open and Mrs Neale lying there apparently with serious head injuries. The Police and an ambulance were called. Jonathan was arrested at the railway station at about 1.30 p m on suspicion of having assaulted his mother, causing her grievous bodily harm. Very regrettably, Mrs Neale died later in hospital and Jonathan was charged with her murder.

137 The Police tried to contact the Colchester Mental Health Team at about 3.55 p m to obtain someone who could act as an appropriate adult when Jonathan was interviewed. However, there seems to have been no positive response until the case was allocated to the Service Manager (Mental Health) Essex Social Services acting as a member of the Social Services Emergency Duty Team at about 7.25 p m. The Service Manager (Mental Health) attended the Police Station immediately

and ascertained the position at that time. Jonathan had already been seen by the 3rd General Practitioner, an FME, though there seems to have been some misunderstanding about the 3rd General Practitioner's opinion as to Jonathan's fitness to be interviewed. However, Jonathan was seen by the Service Manager (Mental Health), the 3rd General Practitioner and the 4th Consultant Psychiatrist, and there was common agreement between them that Jonathan needed to be detained in hospital under Section 3 of the Act because he was clearly psychotic and showed no insight into his condition. Apart from one incident of verbal aggression, Jonathan had shown no signs of aggressive behaviour.

138 It was not possible to find a bed in an appropriate secure unit for Jonathan that evening and so the only alternative was for him to remain in Police custody over night. During the morning of the 3 September 1999, Jonathan was admitted to Willow House and remained there until he was transferred to the medium secure unit at Runwell Hospital, Wickford, Essex on the 7 September 1999 under the care of the 5th Consultant Psychiatrist, Consultant Forensic Psychiatrist.

SECTION 5

Key Events and Issues

We need to preface the remainder of this Report by commenting that although we have adopted the normal practice of offering to those whom we were provisionally minded to criticize (including the 2nd Community Psychiatric Nurse) the opportunity of commenting on the relevant parts of the draft Report affecting them before finalising it, for personal reasons the 2nd Community Psychiatric Nurse has been unable to take the opportunity of commenting on the draft and for that reason our conclusions and recommendations affecting him have to be regarded with some reservation.

1. THE DIAGNOSIS OF JONATHAN'S MENTAL ILLNESS

The 1st Consultant Psychiatrist's initial diagnosis was that Jonathan could have been suffering from a drug-induced psychosis or from the onset of schizophrenic illness. By his second admission under the Act on the 3 January 1997 the diagnosis had crystallised as one of schizophrenic illness, and later it became exacerbated by Jonathan's ingestion of illicit drugs and alcohol. At different times he was tested positive for cannabinoids, amphetamines and heroin. Jonathan adamantly refused to accept help and treatment to deal with his drug problem and he expressed his intention to continue taking drugs following his release from in-patient care on numerous occasions.

He also suffered frequently from delusions and/or hallucinations, often of a religious nature. Indeed, he says that the Devil deceived him into killing his mother, in that a Spirit made out that it was God and showed him things that his mother was doing around the World. In this way he was led to believe that his mother was inspiring rapes and murders around the World and that if he killed her, God would bring paradise to Earth.

Occasionally some question has arisen about Jonathan's condition being primarily caused by his illicit drug-taking, but schizophrenic illness remains the preferred – and in our view correct – diagnosis. The 2nd Consultant Psychiatrist confirmed Jonathan's condition as being schizophrenic illness and added that even if he were suffering from a drug-induced condition, that should not have made any difference to his management in practice.

We considered whether the 2nd Consultant Psychiatrist might usefully have referred Jonathan to a Consultant Psychiatrist specialising in Substance Abuse, but our inquiries revealed that such a Consultant only took up his post with the Trust on the 9 August 1999 and we do not believe it to be reasonable to expect the 2nd Consultant Psychiatrist to have referred Jonathan to him during the period between the 9 August 1999 and the 2 September 1999. We do, however, think it important that General Psychiatrists should normally have access to a Consultant specialising in Substance Abuse in cases involving the dual diagnosis of both mental illness and substance abuse.

2. RISK ASSESSMENT AND RISK MANAGEMENT

a. The nature of the risks presented by, or to, Jonathan

Our inquiries have revealed that from his first admission on the 2 November 1995 until the end of 1998 Jonathan was a risk **to** himself from self-harm or self-neglect or was at risk **from** others, **without there being any reason to suggest that he was a physical threat to others.** All of his compulsory admissions to hospital under the Act were based on psychiatric opinions to that effect.

Also, at no time during any of his periods as an in-patient was there any record or indication that he posed a physical threat to the ward staff or other patients.

The 2nd Community Psychiatric Nurse confirmed that Jonathan certainly did not present as someone who was aggressive or would harm anyone in any way: on the contrary, there was a high risk of vulnerability to Jonathan himself.

As far as Mrs Neale was concerned, the 2nd Community Psychiatric Nurse gave us his opinion that she was not intimidated by Jonathan in any way. The 2nd Consultant Psychiatrist told us that Jonathan "did not have much of a history of aggression really" and although he (the 2nd Consultant Psychiatrist) was aware that Jonathan had had heated arguments with his mother, he took this to mean that the heated arguments had only taken the form of verbal aggression and gesticulating, without any suggestion that Jonathan would attack her.

The 1st Community Psychiatric Nurse, too, confirmed that Jonathan displayed no violence to his mother "as such". He said that relations between them were good early on, but that Jonathan changed as time went on, his drug abuse escalated and his behaviour became more devious. The 1st Community Psychiatric Nurse added that tensions between Jonathan and his mother began to rise a bit, as Mrs Neale – entirely understandably in our view – tried to get Jonathan to budget his finances and refused to permit him to bring illicit drugs into her house. An example of the increasing tension between Jonathan and his mother is seen at paragraph 96 of Section 4 above, where on the 26 January 1999 in an incident of high expressed emotion Jonathan was blaming his mother for trying to "control his life". Even so, although Jonathan clearly disliked what he saw as his mother's attempts to control his life, the 1st Community Psychiatric Nurse saw no evidence of Jonathan posing a physical threat to Mrs Neale.

The Manager of Plowright House confirmed to us that they had carried out a risk assessment of Jonathan, without identifying any risk that he would become violent towards anyone else, and that she had never felt threatened by him.

James, Rosemary's elder son, and his wife, did, however, tell us of the first occasion when Jonathan posed any physical threat to anyone. It was about the time of the incident

in early January 1999 when Jonathan stole items and cheques from his mother's house whilst she was on holiday (see paragraph 94 of Section 4 above). Jonathan made a serious attempt to hit Mrs Neale, when she was seeking an explanation from him for his actions. There had been previous incidents of verbal aggression and posturing, but this was the first time Jonathan had tried to strike his mother. However, that incident was not reported to either the Police in the course of their investigations of the theft or to the 1st Community Psychiatric Nurse.

There is no further evidence of Jonathan committing violence, until the alleged assault by him on a man on the 2 August 1999. We have already dealt in paragraphs 127 to 130 of Section 4 of this report with the fact that Jonathan was arrested on the 10 August 1999 on suspicion of having committed this assault and subsequently released on bail. Insofar as the Police are concerned, we deal with this point further in Part 5.c of Section 5 below.

In any event the incident was drawn to the attention of the 2nd Community Psychiatric Nurse in a Fax fom the FME, on the 11 August 1999. We record in paragraph 129 of Section 4 that on receipt of this Fax the 2nd Community Psychiatric Nurse spoke to the Senior Nurse of the CJMHT, though the Senior Nurse was not the 2nd Community Psychiatric Nurse's line manager. Apart from that, the 2nd Community Psychiatric Nurse took no action to re-assess Jonathan's mental state at that time. The only explanation from the 2nd Community Psychiatric Nurse for not taking any such action was that he was waiting to see if anything developed from the Fax in terms of the Police contacting the 2nd Nurse at the CJMHT. In our opinion the report of this incident should have been followed up by the 2nd Community Psychiatric Nurse and the 2nd Consultant Psychiatrist should have been informed of it by him.

We were also told by James and his wife that two days prior to Mrs Neale's death she telephoned James and asked him to go to her house to keep an eye on Jonathan while she did his washing and he had a bath. James said that Mrs Neale found Jonathan outside her house when she returned home at 5.30 to 6.00 p.m., and when she rang James she was panicking. He went to Mrs Neale's house and, in short, there was an argument about Jonathan wanting to take some of his best shirts with him and Jonathan then threatened to kill Mrs Neale. There is no record that this incident came to the notice of any of the agencies in contact with Jonathan.

For the sake of completeness, we would add that we have also considered the risks to Jonathan from the violence of others. On the 12 July 1998, Jonathan was attacked by friends of a fellow resident at 14 Creffield Road. There had been earlier complaints in June 1998 by Jonathan's fellow residents about his behaviour (see paragraph 69 in Section 4 above). Shortly after the attack on him, Jonathan's deteriorating condition required his further admission to hospital under the Act on the 20 July 1998 anyway. After this isolated incident in the earlier part of his treatment, we believe that the risk to Jonathan of suffering harm from others increased steadily. After his discharge from hospital on the 5 November 1998, he had to be moved from friends' accommodation to bed and breakfast accommodation because of fears for his safety. Then, the period of his residence in Plowright House was consistently marked by chaotic, anti-social behaviour

on Jonathan's part and in our view that it is to the credit of the carers at Plowright House that the potential problems which Jonathan's conduct might have caused were held in check.

There is, however, little evidence that from March 1999 onwards Jonathan's conduct was recognized as an indication of the deterioration in his condition that was then occurring and of the increased danger to him of physical violence from others. Unfortunately, that situation coincided with Jonathan's transfer to a new Consultant Psychiatrist and CPN.

Conclusion: **We can but conclude, therefore, that although Jonathan posed no threat of physical violence to anyone else up to the end of 1998, thereafter a deterioration in his condition, in part attributable to his drug and alcohol abuse, began to give rise to a degree of risk of violence to others, which manifested itself most clearly in the incident of alleged assault on the 2 August 1999.**

We also believe that during 1999 the risk that Jonathan might suffer violence became greater and that the reasons for that greater risk, particularly his increasingly chaotic and anti-social lifestyle, were not recognized as signs of the deterioration in his underlying condition, which was gaining momentum as 1999 progressed.

b. The Steps taken to assess the Risk which Jonathan presented or faced

Risk assessment is, of course, an intrinsic part of the process of deciding whether or not a person requires compulsory admission to hospital under the Act, in that it is one of the pre-conditions to such an admission that he or she requires it in the interests of his or her own health or safety or with a view to the protection of other persons. The statutory forms of medical recommendation required to support an application for compulsory admission deal with this element of risk assessment in outline form, and the forms were all duly completed on each occasion when Jonathan was taken into hospital compulsorily.

The assessment forms used by Approved Social Workers in connection with the actual applications for compulsory admission of persons in Essex do not appear to have included a specific section on risk assessment until, in Jonathan's case, the form completed on the 15 April 1998, and even then the relevant section of the form is in outline terms only.

Indeed, the first **detailed** Risk Assessment form completed in respect of Jonathan was that completed by the Service Manager (Mental Health) of the Essex Social Services Department, who saw Jonathan as a member of the Social Services Emergency Duty Team when Jonathan was in Police custody in connection with his mother's death during the evening of the 2 September 1999.

In the same way, the in-patient nursing records contained no specific provision for risk assessment, though no doubt the general, daily record forms would have referred to any

problems with Jonathan suggesting that he was a physical threat to others, if any such problems had occurred.

A Care Programme Approach appears to have been first used in Jonathan's case on the 15 April 1998 and the review form used then did not contain any Risk Assessment section. Such a section was introduced by the time Jonathan was reviewed on the 20 July 1998, but during the remainder of 1998, the only occasion when Risk was expressly addressed was on the 16 October 1998 when Jonathan was said to be a risk to neither himself nor to others.

We have taken some time to review the documentation in relation to Risk Assessment, as at first glance it seemed to us that it was a discipline or technique which was still in its relative infancy in North East Essex in 1999. Accordingly, we considered its use in Jonathan's case at some length with the 2nd Community Psychiatric Nurse and the Director of Mental Health Joint Commissioning, North Essex Health Authority.

The Director of Mental Health Joint Commissioning, North Essex Health Authority told us that the Trust had issued guidance on Risk Assessment tools in 1997 and that the 1997 CPA policy document had included quite a full statement on the subject, but that discussions about which Risk Assessment tool should be used in the Trust are still ongoing.

The 2nd Community Psychiatric Nurse agreed that no formal, written Risk Assessment was carried out in respect of Jonathan when he became Jonathan's key-worker in June 1999. He told us that the reason for this was that Jonathan had agreed to establish contact with him, but we do not see why that obviated the need for a Risk Assessment.

We asked the 2nd Community Psychiatric Nurse about his training in Risk Assessment techniques. He told us that when new written policies are being introduced within the Trust, time is made for the staff concerned to consider them and to make comments. A team is then identified to carry out training in the form of workshops, which are available to everyone. However, he also told us that attendance at these workshops is not mandatory, " though the message is that everybody will attend....". The 2nd Nurse explained to us that the Trust's training was more concerned with using the booklet dealing with the use of the forms, rather than how to conduct a risk assessment. Certainly, when we met the 2nd Community Psychiatric Nurse., he could not remember whether he had attended a workshop.

The Trust's Director of Nursing confirmed that the 2nd Community Psychiatric Nurse had attended a Risk Assessment course, though he could not give us the date. We have subsequently been told that the 2nd Community Psychiatric Nurse received some post-qualification training, in Beck's Depression Inventory, on the 9 July 1999, but that training relates specifically to the assessment of depression and would not be adequate, in itself, to enable a CPN to carry out an effective and comprehensive assessment of the risks presented by a client, particularly where, as in Jonathan's case, the client suffered from both mental illness and addiction problems.

As to training within the Trust generally, the Trust's Director of Nursing said that there was a tremendous amount of training in the Trust, with all individuals undergoing a performance review. That review identifies an individual's training requirements and his interests, and tries to strike a balance within a Team, so that people with a range of skills are available across the whole of the Service.

Although we have now been told about the 2nd Community Psychiatric Nurse's training in one element of Risk Assessment, his inability to recall the training seems to us to indicate that Risk Assessment, as an important technique or discipline, was not foremost in his mind in this case.

It is also relevant that the Risk Assessment process should contain a default action plan, specifying the action to be considered and, if necessary, implemented if the Client fails to observe the arrangements made for his care and treatment. We consider this point in more detail in Item 4 in the Table in Section 3.c below.

In any event, the introduction of a policy on Risk Assessment and training in the subject did not have the result of ensuring that a detailed Risk Assessment was actually carried out in Jonathan Neale's case.

Conclusion: **We have already concluded in Section 2.a above that Jonathan's deteriorating condition during 1999 gave rise to a degree of risk of violence to others. The omission to carry out any formal risk assessments in June/July 1999 – and even more particularly in August 1999 when the allegation that Jonathan had assaulted a man arose – must in our view have contributed to the lack of pro-active management of Jonathan's mental illness when problems arose at those times.**

It now appears that the 2nd Community Psychiatric Nurse had not received sufficient training in Risk Assessment techniques to enable him to carry out an effective risk assessment in Jonathan's case, and we can but conclude that the lack of full training was a major cause of the omission to carry out an effective and formal risk assessment in Jonathan's case in the period from June to early-September 1999. Accordingly, we have reservations about the pace of the introduction of Risk Assessment within the Trust and serious concerns about the training of the Trust's staff in Risk Assessment techniques. Our inquiries have been limited to this particular case and, therefore, we cannot make a final judgment as to whether these reservations are applicable only to Jonathan's case or whether they may be of wider concern. It is clear to us, however, that the arrangements for training the Trust's staff in Risk Assessment need to be urgently reviewed to ensure that all appropriate staff are competent, both now and on an on-going basis, in the techniques and are able to apply them effectively in their day-to-day practice.

This is more necessary still in complex cases where the clients present with dual diagnosis (both mental illness and drug/alcohol problems).

c. Jonathan's tendency to abscond whilst an in-patient subject to compulsory detention under the Act and the position of the nursing staff in relation to his absconding.

Jonathan showed a tendency to abscond and/or to overstay leave from the start of his in-patient treatment on the 2 November 1995. On that day he climbed out of a window and had to be restrained and brought back into the ward. This tendency posed a management problem for the Ward staff at the Lakes at various times throughout all of Jonathan's periods as an in-patient. It was a problem which increased in frequency as his condition deteriorated. We have already quoted the example in paragraph 77 in Section 4 above of there being about 23 incidents of absconding or over-staying leave between the 22 July 1998 and the 8 September 1998. His "escapes" did, of course, provide Jonathan with access to illicit drugs and alcohol, which in turn removed or reduced the opportunities for him to benefit from his medication in an environment free from such substances.

We were told by the 2nd Consultant Psychiatrist that it was not possible to keep Jonathan on an unlocked ward, unless he was under observation by three or four nurses, which was impossible in practice, given the level of nursing staff available. The 2nd Consultant Psychiatrist also told us that the nursing staff could not actually prevent a patient leaving; all that they could do is to inform the ward manager, who then informed the Police.

We took the first of these points up with the Trust's Director of Nursing. He provided us with the establishment record for the Lakes and advised us that there had been no vacancies at the material times. The Trust's Director of Nursing was also able to confirm that generally staffing levels were, or should have been, adequate to cope with the demands imposed on the nurses in providing the requisite levels of observation of patients, with additional staff being available from the "Bank" at the Lakes and/or an agency. In general, therefore, lack of staff would not seem to have been a reason for the failures to contain Jonathan on the wards at the Lakes.

When we come to the period from April to June 1999, we find the view being expressed that close observation was not practicable in an open ward because it antagonised Jonathan, without stopping him absconding. Also, continuous observation was said to be inhuman and intrusive, given the low level of risk which Jonathan posed. The plan, therefore, was to put him on close observation if he appeared to become acutely disturbed and to continue that level of observation only until he settled again. That plan did nothing to reduce the degree of absconding and therefore it failed to achieve the object of giving Jonathan the opportunity of recovering in a drug and alcohol-free environment. Indeed, the plan was itself an acknowledgement that Jonathan could not be contained in an open ward.

We find the adjective "inhuman" to be a curious description of continuous observation, which may well be necessary in certain cases for carefully defined periods, if the relevant patient is to receive the care and treatment which he requires. We accept, however, that it can be distressing for both patient and a nurse, though we also feel that it can form the basis of a therapeutic relationship between patient and nurse.

On the second of the issues raised by the 2nd Consultant Psychiatrist, namely the inability of the nursing staff to prevent a patient subject to compulsory detention under the Act from leaving, all that we can say is that Section 6 of the Act provides authority for a properly committed patient to be compulsory detained and in our view it is self-evident that reasonable steps should be taken by the ward staff to stop such a patient from absconding.

We recognise that difficulties will be experienced from time to time on an open ward in dealing with a patient who is set upon absconding, but that consideration does not relieve ward staff from their obligation to take reasonable steps to detain a patient who is subject to compulsory detention.

One incidental point arose in relation to the observation of patients by nurses. The records show that on occasions Jonathan was put on close observation for one week in advance. This is not acceptable, as the level of nursing observation should be reviewed and fixed every shift.

We asked the 2nd Consultant Psychiatrist for his comments on this point. His view was that nurses can increase the level of observation without reference to the Psychiatric staff, but they cannot properly reduce it below the level specified by the Consultant. The 2nd Consultant Psychiatrist agreed that the level of observation should be reviewed every shift, with the additional requirement that it should be reviewed with the Consultant every 48 hours, but this did not occur.

The Trust's Director of Nursing also agreed that the level of observation should be reviewed shift-by-shift and indeed he told us that was the policy and the practice. He added that if close observation is ordered one week in advance and is not reviewed shift-by-shift, then there are clear implications for nurse staffing levels and for the patient, as a prolonged period of close observation may well become so intrusive that it becomes counter-productive.

If there are any doubts about the policy and practice in this respect among any sections of staff, then nurse managers should dispel them.

Conclusion: **Lack of ward staff was not a reason why Jonathan was able to abscond so frequently from the Lakes.**
The reason seems to have been a feeling on the part of the Ward staff that they were limited as to the action which they could take to stop Jonathan absconding. In that regard, the staff's understanding of the position was wrong and

Senior Clinicians, Nurse management and Ward staff need to resolve that issue urgently.

d. Jonathan's non-compliance with treatment while in the Community

Jonathan's history shows that from the start of his mental illness he was very reluctant to comply with his treatment regime while he was in the Community.

His first compulsory admission was necessitated in part by his refusal to take medication and after his discharge from that admission he failed to attend Abberton as a voluntary patient.

The 1st Community Psychiatric Nurse managed to achieve considerable success in persuading Jonathan to accept his depot medication, whilst he was in the Community throughout 1996 and between February and December 1997, but thereafter Jonathan's resistance to taking medication increased in early 1998 and was one of the reasons for his further admission in April 1998. That resistance continued in May to July 1998 and during the period when Jonathan was in the Community between November 1998 and April 1999.

Jonathan's opposition to depot medication culminated in a total refusal to accept it after his discharge on the 22 June 1999.

His opposition to taking medication was accompanied by a consistent refusal to stop taking illicit drugs and/or alcohol and by a failure or inability to improve his chaotic life style. In that latter regard, the Plowright House log shows that from the 22 June 1999 onwards Jonathan's anti-social behaviour was a constant cause of problems with his neighbours at the property.

Conclusion: **Jonathan's refusal to abide by a treatment regime in the Community after the 22 June 1999 should have been considered as a cogent reason for a further review of his mental state, certainly by the end of August 1999 and even by the Out-patient appointment on the 4 August 1999 which Jonathan failed to attend.**

The 2nd Community Psychiatric Nurse told us that he was hoping that the depot medication given to Jonathan before his discharge on the 22 June 1999 would have a continued effect on his condition, but with Jonathan's continued use of illicit drugs we feel that that expectation was unrealistic.

3. THE CLINICAL MANAGEMENT OF JONATHAN'S CASE

a. The provision of more secure accommodation for Jonathan

Jonathan's transfer to more secure accommodation than was available at the Lakes was considered during his first period as an in-patient, twice during his fourth compulsory admission and twice during his final in-patient spell. We do not intend to review the first of these occasions, but we think it necessary to spend some time on the remainder of them.

One of the problems seems to have been that Jonathan was not considered to meet the criteria for a transfer even to low secure accommodation, notwithstanding his record of absconding and the consequent effect which his increased access to illicit drugs and alcohol had on his treatment.

The units to which Jonathan's transfer was considered at different times were Willow House and Shannon House. Penfold Lodge was also considered but no referral there was actually made. Willow House is a unit at Boxted Road, Colchester managed by the Trust. It comprises two wards, of which Almond Ward is a minimum secure short-stay facility for the assessment and treatment of detained patients who cannot be successfully or safely managed in an open ward. It has seven beds.

An operational policy dated August 2000 is the only document produced to us, which sets out criteria for the admission of patients to the unit. We have assumed that those criteria also applied substantially in 1998 and 1999.

The criteria permit admission to Almond Ward of patients between the ages of 17 and 70, who are detained under the Mental Health Act and who are suffering from a severe mental illness or mental disorder which seriously compromises the physical and psychological well-being of the patients themselves or others, where the requisite security level is not greater than minimal. Insofar as the failure to obtain a bed for Jonathan in Willow House in April/June 1999 may have rested, at least in part, on the conclusion that he did not meet the admission criteria for Willow House, we would find that difficult to understand, as in our view at that time Jonathan was suffering from severe mental illness, which compromised his physical and psychological well-being and which might well have been more amenable to treatment within a more secure environment.

Shannon House is a psychiatric intensive-care unit managed by the Essex & Herts Community NHS Trust and located at Harlow, Essex. Penfold Lodge is managed and run by Arc Healthcare Limited and is in Clacton-on-Sea.

Leaving aside the referral for a place at Willow House in November 1995, the first occasion when a place for Jonathan was sought there was in late July/early August 1998.

At that time Jonathan was absconding frequently. Nevertheless, on the 17 August 1998 it was decided that he was not a suitable candidate for Willow House, partly because of his lack of motivation to abstain from drugs and partly because he had not been under close observation at the Lakes.

The 1st Consultant Psychiatrist apparently remained of the opinion that Jonathan needed secure accommodation and so a referral was sent to Shannon House on or about the 20 August 1998. He was assessed by Shannon House representatives on the 1 or 2 September 1998 but was not accepted for that unit either, though the grounds for their refusal to accept him are not recorded in Jonathan's records. In fact, Shannon House's rejection of Jonathan coincided with an improvement in his condition which led to his being re-graded as a voluntary patient on the 16 September 1998.

Within four days of the start of Jonathan's next period of compulsory detention at the Lakes as an in-patient on the 22 April 1999, it was necessary to refer him to Willow House again. The Willow House team assessed Jonathan on the 27 April 1999 and his case was to be discussed at a meeting in the following week. In the meantime, the Willow House representatives advised that his depot medication of Depixol (Flupenthixol) should be recommenced, as he would not comply with oral medication; that 5mg Trifluoperazine should be continued twice-daily; that Droperidol should be increased from its then current level of 10mg, administered as necessary, to as much as might be required; that Jonathan's agreement to giving urine samples for drug screening should be obtained; and that Flupenthixol 40mg and Procyclidine 5mg should be started immediately, with the Flupenthixol being continued at 40mg weekly and increased, if required.

A possible transfer to Shannon House was raised, but they had no vacancies and the 2nd Consultant Psychiatrist suggested that that idea be put on hold.

In commenting on this aspect of the case in response to our submission to him of the parts of the draft Report affecting him, the 2nd Consultant Psychiatrist explained that it was very important that Jonathan should stop taking illegal drugs, to provide a drug-free period in which he might be treated properly. The 2nd Consultant Psychiatrist accepts that it was very difficult to manage Jonathan on an open ward at the Lakes, but there were no vacancies at either Willow House or Shannon House at the material time in April 1999 and he was left with no alternative but to wait for a place to arise.

Jonathan was discussed at Willow House's Referrals meeting on the 4 May 1999, though the only details of the discussion available to us are contained in a letter dated that same day, in which Jonathan was said to be "not appropriate for placement at Willow House at this time." Thereafter, a Ward review note of the 24 May 1999 states that Willow House had been contacted (again ?) and they felt that they could not provide any further support at the moment, except to advise that Jonathan be placed on close observation and to say that the 3rd Consultant Psychiatrist, the Consultant Psychiatrist at Willow House, was happy to discuss the case further, as was the Clinical Manager.

Over the next month or so Jonathan's condition was variable, with some periods when he gave no cause for concern. For example, it was possible to reduce his supervision to general observation on the 29 April 1999 and on that same day in a one-to-one session with a Staff Nurse he gave some slight acknowledgement that his substance abuse had contributed to his mental health problems and his admissions to hospital.

However, on the 24 May 1999, following several episodes of absconding over the previous week and concerns by Mrs Neale that Jonathan's condition was deteriorating, the 2nd Consultant Psychiatrist reviewed the case again. As already mentioned, at the Review, Willow House's inability to provide any further support at that time and the willingness of the 3rd Consultant Psychiatrist or the Clinical Manager at Willow house to discuss the case with the 2nd Consultant Psychiatrist were noted.

On the 28 May 1999, the treatment plan for Jonathan included a referral to Shannon House. An acting Ward Manager from Shannon House assessed Jonathan on the 6 June 1999. She found that Shannon House would not be an appropriate unit for him as the short-term goal of keeping him drug-free for a period should be achievable at the Lakes and in the longer term he was adamant that he would continue with his drug-taking anyway. In our opinion Shannon House's view that the short-term goal of keeping Jonathan drug-free should be achievable in the Lakes was optimistic, given that they were apparently told that since admission Jonathan had absconded on a number of occasions; that he was assessed by the Lakes as still being a significant absconding risk and that he was already "due to be nursed on close observations".

We asked the 2nd Consultant Psychiatrist whether he would have liked to have had some kind of facility such as a locked ward where Jonathan could have received more observation and/or have been restricted more and the 2nd Consultant Psychiatrist answered that question in the affirmative. He said that he could have "banged the table and made a big fuss and got Jonathan transferred", but in June 1999, with a long period of study and annual leave rapidly approaching, he was running out of time to do that, though he felt that it was something which would have to be done on Jonathan's next admission, which might be expected very soon.

As there had been difficulties in obtaining a secure place for Jonathan, we asked the Director of Mental Health Joint Commissioning, North Essex Health Authority about the ways in which suitable secure places can be found, if necessary. He explained to us that the available facilities which provide a low level of security for North Essex, are primarily Willow House and Shannon House. Overall, there are 18 psychiatric intensive care beds, about 12 low secure beds and 20/22 medium secure beds available to Mental Health Services in North Essex, with a new psychiatric intensive care unit being built in Chelmsford and due to open in mid-2001.

Director of Mental Health Joint Commissioning, North Essex Health Authority also told us that there is a secure service liaison group in North Essex to ensure that patients who really need to do so, can get into the available facilities in the area, and that if there is difficulty in placing a patient in a secure unit, an approach can be made to the Authority and there should not then be a problem in securing a bed, if a case is made out. The 2nd Consultant Psychiatrist has now informed us that his understanding of the role of this group is that it is a strategy group and does not deal with the placement of specific patients in secure units. He adds that his inquiries of his Consultant colleagues in general adult psychiatry reveal that none of them has ever used this group to obtain an intensive

care bed. If the group really does have a role to play in finding secure beds for individual clients, no doubt the Consultants can be so advised.

A placement in a private facility was another possibility which Director of Mental Health Joint Commissioning, North Essex Health Authority mentioned, though he knew of no request having been made to place Jonathan in private, secure care. Again, there is no evidence that the 2nd Consultant Psychiatrist pursued this possibility.

Conclusion: **We believe that the possibility of a transfer to Shannon House should have been more actively pursued in late April 1999. We note the 2nd Consultant Psychiatrist's comment that he had no alternative but to wait for a place to arise, but we remain firmly of the view that the 2nd Consultant Psychiatrist should at least have started to make much firmer representations to obtain a secure place for Jonathan at that time.**

Then in June 1999, when the possibility of Jonathan being moved to Willow House arose again, the 2nd Consultant Psychiatrist now tells us that he did have a brief discussion with the 3rd Consultant Psychiatrist over the telephone, only to be told that there were no vacancies there and were unlikely to be for some considerable time. However, the 2nd Consultant Psychiatrist accepts that there was no real discussion of any substance with the 3rd Consultant Psychiatrist regarding Jonathan's management and that the 3rd Consultant Psychiatrist was not in a position to discuss Jonathan's case because he had not assessed him personally. If anything, these comments reinforce us in the view that the 2nd Consultant Psychiatrist should have initiated a much more detailed discussion with the 3rd Consultant Psychiatrist about Jonathan, with a view to obtaining a place at Willow House for him.

If, for whatever reason, Willow House had still been unable or unwilling to accept Jonathan, then irrespective of the correct role of the secure service liaison group, we feel that the help of senior management within the Trust should have been sought to obtain a low secure place for Jonathan. The reasons for our conclusions are that certainly by June 1999 the inability of the Lakes to cope with Jonathan had been well established; the periods of time in which he was well enough to be treated in the Community were decreasing; his abuse of drugs and alcohol was well recognised; his life-style was chaotic; and the extent of his illness was, or should have been, demonstrable not only by direct observation and assessment but also by supporting material such as the letters which he wrote to those responsible for his care.

Whether or not treatment in a secure environment would actually have been of benefit to Jonathan is a question which no-one can answer with certainty. The 1st Community Psychiatric Nurse, who probably knew Jonathan as well as any of his carers, pointed out to us that any improvement in Jonathan's condition deriving from a secure environment would have been dependent on Jonathan being in such a unit for a long enough period to receive treatment and to regain insight into his illness and appreciation of the adverse effects of the substances which he was taking, and Jonathan's constant enjoyment in taking illicit drugs and his lack of any desire or motivation to give them up may well have made that difficult.

However, in our opinion the chance of Jonathan improving after treatment in a secure environment in which his access to illicit drugs and alcohol was more closely controlled, was never explored as fully as it should have been.

b. The decisions as to Jonathan's future care and treatment taken on the 21 June 1999 and the 4 August 1999

We are very concerned about the decision taken on the 21 June 1999 to discharge Jonathan the following day.

In his comments on the parts of the draft Report concerning him, the 2nd Consultant Psychiatrist explains his reasons for discharging Jonathan on the 21 June 1999. He says that Jonathan was not acutely disturbed and he had shown some sign of improvement, albeit intermittent. There was no evidence that he was a risk to himself or to others save for the fact that he was taking illegal drugs. There were serious difficulties in managing Jonathan on an open ward where, through his propensity for absconding, he was spending a fairly large amount of time in the Community in any event. He had accepted depot medication and therefore a trial of further depot medication was considered to be worthwhile. On discharge, he would be monitored in the Community and would be subject to Out-patient review, and finally, it was made clear to those present at the meeting on the 21 June that should, following discharge, Jonathan develop aggressive behaviour or should there be a deterioration in his mental state, then he should be re-admitted.

We have to say that the 2nd Consultant Psychiatrist's comments do not ease our concerns about the decision to discharge Jonathan taken on the 21 June 1999. Only five days or so earlier Jonathan had been absconding regularly and had been in need of close observation and within the previous month the 2nd Consultant Psychiatrist had been trying to place him in low secure accommodation.

It is true that the nursing team's recommendation was that Jonathan appeared stable at that moment and that discharge from hospital was appropriate, but that recommendation seems to us to be open to serious challenge. In their summary preceding the recommendation, the nursing team acknowledged that Jonathan's mental health deteriorated when he misused drugs and that he had very little insight into the effect of illicit drugs on his life. They also acknowledged that during that admission he had remained drug-free only for short periods, when he was managed on close observation. Admission is then said by the team to be beneficial only in the short term because Jonathan remains drug-free only in the short term. The conclusion that we draw from the nursing team's view of the case is that it would have been well worth-while trying to reduce his access to illicit drugs for a longer period by placing him in more secure accommodation. Instead, the nursing team suggests that admission is counter-therapeutic in the long term because Jonathan is more at risk if kept drug-free, due to reduced tolerance and greater vulnerability to an overdose.

That reasoning seems to us to be tantamount to abandoning any hope of achieving any longer term solution to Jonathan's problems and to an acceptance of a future involving a series of short term admissions to hospital interspersed between periods in the Community in which his condition would rapidly (and progressively) deteriorate due to his access to illicit drugs and alcohol - and this position was being reached without Jonathan actually being placed in a more secure unit to see if he would benefit from a period in a more controlled environment.

The medical note of the Review meeting records that:-

- Jonathan's mental state fluctuated with his use of amphetamines;
- He was agreeable to be followed up by his CPN, though we would comment that it surely was readily apparent that he would not keep to that agreement after he had actually been discharged;
- He was unlikely to take his depot medication of 80 mg Depixol (Flupenthixol) every two weeks; and
- He will "take precautions from further admissions by taking part with Alternative Therapy at Open Road", which we take to mean that Jonathan would utilize the help available from Open Road in order to obviate the need for any future admissions. Again, we would suggest that his history casts grave doubt on that intention being realised.

The decision taken was that Jonathan should be discharged from hospital the following day, thus ending his status as a patient liable to be compulsorily detained under Section 3 of the Act. Instead:-

- Jonathan was to go into accommodation at Plowright House;
- He was to be given 80 mg Depixol (Flupenthixol) that day and to be offered this as on-going medication by the 2nd Community Psychiatric Nurse;
- An out-patient appointment with the 2nd Consultant Psychiatrist was to be made in six weeks time; and

- A 72 hour assessment was to be made by the 2nd Community Psychiatric Nurse, who was also " to continue to offer patient care when necessary, i.e. acute episodes."

We would comment that these arrangements contained no Default Action Plan, nor were they specific in the Note as to the steps to be taken, and by whom, if and when Jonathan failed or declined to engage with his CPN and/or refused to accept his depot medication. Also, there was no express agreement with CQHA as to the precise role which its staff at Plowright House, who are not psychiatrically trained, were expected to play in Jonathan's care and treatment, nor any long-term plan for that care and treatment.

It is clear that after Jonathan's discharge the 2nd Community Psychiatric Nurse experienced great difficulty in engaging with him. He telephoned Jonathan on the 25 June 1999 and arranged to see him on the 28 June and immediately Jonathan said that he would not be accepting depot medication and that he did not want to see the 2nd Community Psychiatric Nurse, though he then agreed that he would see him every two weeks.

On the 12 July the 2nd Community Psychiatric Nurse's meeting with Jonathan was very brief, as Jonathan had to rush off and sort out some financial matter.

On the 2 August Jonathan again refused his depot injection, saying that he did not need it as he was not ill. There was evidence in his flat that he was continuing to inject illicit substances and smoke cannabis. Also, Jonathan was vague, seemed to be in difficulty in concentrating and was rambling on about mystical spirits and having control of his own spirit.

The nursing team's report to the Review meeting on the 21 June 1999 had suggested that a contingency plan for his management in crisis would have been useful. We asked both the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse how they expected the case to develop. The 2nd Community Psychiatric Nurse felt that there would be some sort of stability in Jonathan's condition between his discharge and the out-patient appointment on the 4 August 1999, due to the medication taken while Jonathan had been on the ward, but both he and the 2nd Consultant Psychiatrist felt that Jonathan would need to be re-admitted within a fairly short time.

In the light of their expectations, we feel that the decision taken on the 21 June 1999 should have included a definite statement that Jonathan should be re-admitted as soon as he refused to co-operate with the arrangements for his care in the Community and his mental state began to deteriorate again. Such a statement may well have been a positive indication to the 2nd Community Psychiatric Nurse in July and August that Jonathan required further compulsory admission as an in-patient as soon as the problems which the 2nd Community Psychiatric Nurse then faced, began to arise.

The period between Jonathan's discharge on the 22 June 1999 and his out-patient appointment with the 2nd Consultant Psychiatrist on the 4 August 1999, was a time

throughout which Jonathan failed completely to co-operate with the arrangements for his on-going treatment. He took no medication. He did not engage with the 2nd Community Psychiatric Nurse in any meaningful way. There was evidence of further drug abuse, and his behaviour at Plowright House was consistently disruptive.

Jonathan failed to attend the out-patient appointment on the 4 August which, according to the 2nd Consultant Psychiatrist's note, proceeded as a CPA meeting between him and the 2nd Community Psychiatric Nurse. The 2nd Consultant Psychiatrist noted that "[the 2nd Community Psychiatric Nurse] sees him (Jonathan) at home fortnightly", which really fails to reflect the lack of success which the 2nd Community Psychiatric Nurse had experienced in establishing any sort of rapport with Jonathan. The 2nd Consultant Psychiatrist also noted Jonathan's continuing drug abuse, his refusal to accept his depot medication, his disordered lifestyle, the problems he caused with his noise and "the usual.....(?).....speel about spirits etc." Even if the 2nd Consultant Psychiatrist's reasons for discharging Jonathan on the 21 June were sound – something which we do not accept – it is quite clear to us that they had ceased to be sufficient to justify Jonathan's continued care in the Community on the 4 August. To us, the matters raised in the meeting of the 4 August clearly indicated a compelling need to take some further action. However, the decision taken at that meeting was that there was no point in sending Jonathan another appointment and that his case should be reviewed at a CPA meeting to be held six months hence in February 2000.

We would also comment at this point that we cannot accept that this appointment on the 4 August can have proceeded as a CPA meeting. A number of people who should have been invited to a proper CPA meeting, such as a representative of Plowright House and Mrs Neale, had not been invited to this meeting and thus the expectation that it would function as a CPA meeting was totally unjustified. The 2nd Consultant Psychiatrist has accepted this point.

Conclusion:

The decisions taken at both of these meetings were inconsistent with the salient facts of the case, as known at the time, and resulted in a level of care and treatment being provided for Jonathan which fell short of the optimum that should have been sought.

We also reiterate that the Note of the Review meeting held on the 21 June 1999 omitted to record expressly that Jonathan should be re-admitted if he developed aggressive behaviour or if there was any deterioration in his mental state.

We appreciate that we have the advantage of hindsight in making this judgment, but we believe that our conclusion is fully justified by the information set out in the contemporaneous documentation. We also note that the Carebase entry for the meeting of the 4 August 1999, which we assume would normally

have been completed by the 2nd Community Psychiatric Nurse, was not actually completed.

c. The Care Programme Approach system and its application in Jonathan's case.

The CPA process was first introduced nationally in 1991 and we have been advised that in North Essex it was first implemented locally in 1993, after certain problems had been resolved.

In North Essex the CPA process then evolved during the period through to April 1997, when a new local policy document was produced. The policy continued to develop and the April 1997 document continued to be amended until it was republished in April 1999. That process of on-going development of the CPA in North Essex and continued amendment of the policy document no doubt accounts for the fact that the document which was initially produced to us as the Trust's policy document on the CPA was one containing sections bearing different dates, mainly in 1997 but continuing through to September 1999.

We have also been advised that the re-evaluation of the original 1997 document later that year resulted in the provision of on-going education and training in the CPA process for staff of all disciplines involved in the delivery of that process to clients. The trainers (a team manager, nurse and social worker) have also been responsible for the revisions to the April 1997 document during the two years from April 1997 to April 1999.

Another document, produced in October 1998, was also given to us. It stated that the previous practice differed from the CPA process in two main ways. The first was that one practitioner (the CPA Care Co-ordinator) assumed overall responsibility for a client's assessment and care. The second was that the whole process of referral, assessment, development of the Care Programme and the regular review of the programme became more structured and systematic.

The earlier part of the history of the implementation of the CPA in North Essex is not of any immediate concern to us in the particular context of Jonathan Neale's care and treatment up to the end of 1998 as we are satisfied overall that his care in the Community then was properly planned and implemented. The 1st Community Psychiatric Nurse told us that while Jonathan was an in-patient, he (the 1st Community Psychiatric Nurse) would attend ward rounds and reviews, as it was crucial to maintain contact with Jonathan. Then, when Jonathan was discharged, we are satisfied both from the records and from our meeting with the 1st Community Psychiatric Nurse that he responded quickly to any expressions of concern from Mrs Neale; saw Jonathan regularly; and rapidly took steps to deal with any deterioration in Jonathan's condition as it occurred. The 1st Community Psychiatric Nurse said that there was a strategy in place to re-admit Jonathan whenever he was failing to adhere to his care-plan. As an example of this, we refer to the events of June and July 1998 summarised in paragraphs 70 to 77 of Section 4 of this report.

Also, as stated, we find that no credible evidence to suggest that Jonathan might have been a threat to the safety of others existed before the end of 1998.

However, we are concerned that the CPA process was not fully or adequately applied in Jonathan's case from April 1999 onwards, and we set out in the Table below (a) in the centre column, the main aspects of the Trust's CPA policy, and (b) opposite each such entry in the right-hand column, our comments on the implementation in Jonathan's case of that aspect of the Policy between April 1999 and August 1999.

Before doing that, however, it is right that we should deal with one further point regarding the timing of the various changes or developments in the Trust's policy. We are told that the last relevant publication of the Trust's policy on the CPA took place in April 1999. That, of course, was very close to the start of the period of Jonathan's care with which we are most concerned (April to September 1999). It naturally occurred to us that the individuals with prime responsibility for Jonathan's care in the Community after April 1999 might say that the version of the policy republished in April 1999 was not brought to their attention in time for them to have regard to it.

We raised this point with the relevant officer of the Trust who confirmed to us that once the new April 1999 documentation was ready for circulation, every Mental Health Team and Consultant was contacted and that as the new folders went out, the previous ones were collected to avoid confusion. The officer also confirmed that by the beginning of April 1999 all of the new documentation was in place throughout the Trust, including Consultant Psychiatrists, all clinical areas (Community Mental Health Teams, Day Hospitals and in-patient areas) and managers. Therefore, the likelihood was that the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse, who were primarily responsible for Jonathan's care from April 1999 onwards, saw this documentation during April or May 1999.

We felt obliged also to canvass this point with both the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse, when we invited their comments on the provisional findings affecting them, set out in the draft of this Report. The 2nd Consultant Psychiatrist did not suggest that he had not seen the Policy document and, as we say, personal circumstances have prevented the 2nd Community Psychiatric Nurse from commenting on the provisional findings affecting him.

Had it been necessary for us to do so, we would, of course, also have considered the point that compliance with the main features of the Trust's policy on the CPA may reasonably have been expected as a matter of good professional practice, even in the absence of a policy document.

We now set out the Table listing to the main aspects of the Trust's CPA policy and our comments on their implementation in Jonathan's case.

	ASPECTS OF THE APRIL 1999 POLICY ON THE CPA	HOW THE ASPECT OF THE APRIL 1999 POLICY SET OPPOSITE WAS IMPLEMENTED IN JONATHAN'S CASE
1	The primary purpose of CPA is to ensure that every client being treated in the community receives the care and treatment that they need.	We can but comment that subsequent events show that this purpose was not achieved, though we do, of course, make that comment with the benefit of hindsight.
2	Where a new CPA Care Co-ordinator is to be appointed, then there should be an effective handover, which should include a detailed discussion about the client's needs.	The need to appoint a new Care Co-ordinator arose from organisational changes in the catchment areas in Colchester on the 1 April 1999. The 1st Community Psychiatric Nurse told us that at that stage a referral was sent to the CMHT in Herrick House, for them to appoint a new Care Co-ordinator. The Herrick House team works with the 2nd Consultant Psychiatrist and is a different team from the 1st Community Psychiatric Nurse's team at Holmer Court. The record of the Review meeting held on the 24 May 1999 then shows "the 3rd Community Psychiatric Nurse /the 2nd Community Psychiatric Nurse" as Care Co-ordinator. In the event, that responsibility actually passed to the 2nd Community Psychiatric Nurse, though the transfer from the 1st Community Psychiatric Nurse to him was not formally completed until the Review meeting on the 21 June 1999. The 2nd Community Psychiatric Nurse told us that it would be ideal to engage a new client in advance of the formal transfer and that it was the practice to do so. It may have been the general practice, but it did not occur in this case. Whether this was because of delay in the decision whether the 2nd Community Psychiatric Nurse or the 3rd Community Psychiatric Nurse would

		actually take over Jonathan's case or the other demands on the 2nd Community Psychiatric Nurse's time or because he expected to have some further opportunity to engage Jonathan after the Review on the 21 June and before Jonathan was discharged, we do not know. In any event, the 2nd Community Psychiatric Nurse told us that he did have an opportunity to discuss the case with the 1st Community Psychiatric Nurse after the meeting on the 21 June, and the 1st Community Psychiatric Nurse both confirmed that and told us that the discussion went into Jonathan's case in some detail, covering the difficulties which he presented in accepting his medication and in being traceable, as well as the benefit which came from Mrs Neale's support. Nevertheless, we cannot help but wonder whether the decision taken at that meeting to discharge Jonathan the very next day really allowed the 2nd Community Psychiatric Nurse the opportunity of coming fully to terms with the problems inherent in Jonathan's case from that very next day. The records of the meeting do not, however, make any mention of there being any dissent on the question of discharge the next day. We asked the 1st Community Psychiatric Nurse whether it was usual practice for a CPA review meeting to be held on the day before discharge and in his experience it was not. We can but conclude, therefore, that the 2nd Community Psychiatric Nurse was satisfied with the handover. For our part, we simply cannot see

		that one day's notice of discharge of a patient such as Jonathan back into the Community can possibly be sufficient to ensure that all the requisite and detailed arrangements for his care and treatment are in place and fully understood by all concerned before he leaves hospital. We wish to make one further point regarding a handover of a client to a new CPN. We note that in Jonathan's letter to the 2nd Consultant Psychiatrist, presumably written shortly before the CPA Review on the 21 June 1999 and to avoid an attendance at that meeting, he said that "I am willing to keep in contact with the 1st Community Psychiatric Nurse...." Whilst that phrase might have more than one meaning, it seems to us that the most likely interpretation is that Jonathan was saying that he would keep in contact with the 1st Community Psychiatric Nurse, in the belief that the 1st Community Psychiatric Nurse would still be his CPN after discharge. That suggests that Jonathan did not know of, or remember, the change in his CPN prior to the 21 June 1999 and if that is right, then it reinforces the need for teams to decide well in advance of the actual handover who the new Care Co-ordinator will be, so that the practice of assertive in-reach can occur and the basis of an on-going therapeutic relationship can be established.
3	A care programme will need to be drawn up – clients and carers must be consulted and as far as possible there should be agreement about the content of the Care Programme.	A care programme was drawn up. It provided for the 2nd Consultant Psychiatrist to see Jonathan in an Out-patients' clinic following discharge; for in-patient care to be offered when necessary, namely when acute episodes of Jonathan's illness occurred; for 80mg Depixol

		(Flupenthixol) fortnightly to be offered and administered by the 2nd Community Psychiatric Nurse; and for the order under Section 3 of the Act to be rescinded. Again, we have to acknowledge that there is no suggestion that anyone disagreed with the programme at the meeting. However, we were told by the Manager of Plowright House that she did not recall being asked for her view on Jonathan's return to Plowright House and also that she has a "crystal-clear" recollection that when she and Mrs Neale came out of the meeting they looked at each other and Mrs Neale said "It's back to you and I, then, isn't it!" the Manager of Plowright House went on to tell us that she remembers feeling really just terrible for Mrs Neale, because she thought that Mrs Neale realized that they were back to the situation which had existed previously and which was so bad. We must also say that the 1st Community Psychiatric Nurse told us that after the meeting he and the 2nd Community Psychiatric Nurse spent some time with Mrs Neale, discussing the arrangements for follow-up, and he thanked her for her support throughout all the time he had been Jonathan's CPN. Certainly all the other evidence which we have heard suggests that the relationship between Mrs Neale and the 1st Community Psychiatric Nurse had been consistently good and we would have expected that Mrs Neale would have felt free to have voiced to the 1st Community Psychiatric Nurse any substantial reservations which she may have felt about the programme for Jonathan's future care on the 21 June 1999. Although we

		can but speculate at her exact concerns, it could be that Mrs Neale's comment to the Manager of Plowright House was more in the nature of an understandably disappointed reaction to the fact that no lasting improvement was apparently being achieved in Jonathan's case. We have already commented on the decision taken on the 21 June 1999 to discharge Jonathan in the preceding Part 3.b of this Section.
4	The plan must include agreement as to what action will be taken, should there be a deterioration in the mental state of the client or there is evidence of non-compliance with the care plan, particularly if violence, self harm or substance misuse is involved.	Given the particular problems which Jonathan presented in relation to the taking of his medication, his drug and alcohol abuse and his reluctance to engage with his carers, and given also the fact that both his Consultant Psychiatrist and his CPN/Care Co-ordinator had limited knowledge about the case, we feel that the plan made on the 21 June 1999 should have contained a clear statement of the action to be taken if any of the events set out opposite occurred. Whilst both the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse told us that they expected that Jonathan would have to go back into hospital, a specific statement of the circumstances which would have triggered that action, even within a short time after discharge, should have been expressly included in the plan. In our meeting with him, the 2nd Consultant Psychiatrist accepted that in retrospect he had left the 2nd Community Psychiatric Nurse "at a little bit of a loose end" after the 4 August 1999.
5	Where the Care Programme is in danger of breaking down or contact with the client becomes difficult, arrangements for an urgent review should be put in place	The programme was threatened almost immediately after Jonathan's discharge through his refusal to take his medication, and the 2nd

	and .....contingency plans to prevent a breakdown of the Care Programme should be documented and available to all involved, including the General Practitioner.	Community Psychiatric Nurse's attempts to keep in contact with him became increasingly more difficult. Even though we were told that it was expected that Jonathan would have to return to hospital, no steps were taken to arrange a further assessment of his mental state nor were any other active steps in the nature of a contingency plan put into operation.
6	Carers who are providing substantial and regular support for clients should have their needs assessed annually and have a Care Programme developed.	By this requirement the Trust's CPA guidance recognized the need to provide support for carers who have a substantial involvement in the care of a client who is on the CPA. That requirement is also reflected in the National Service Framework for Mental Health, which provides for an assessment of a carer's needs. There is no indication in Jonathan's records that any formal assessment of Mrs Neale's needs, as a carer, was carried out, though the contacts between her and the 1st Community Psychiatric Nurse up to April 1999 lead us to believe that if Mrs Neale had sought any help from the Trust in connection with Jonathan's care, her request would have been properly addressed. When the 2nd Community Psychiatric Nurse took over as Jonathan's care Co-Ordinator actively in June 1999, he had very little time in which to make any assessment of Mrs Neale's needs as a carer and we would not criticise him for not making any such assessment in the available time, though it is, of course, apparent from other parts of this Table that we feel that other matters did require more active responses from him. However, the Trust must review its obligations to carers to ensure that proper attention is given to their needs at all times.

7	Where a client either refuses treatment or deliberately loses touch with his/her CPA Care Co-ordinator, all reasonable attempts should be made to locate the client and determine an appropriate course of action.	As stated, Jonathan was both refusing his medication immediately after his discharge and deliberately avoiding contact with the 2nd Community Psychiatric Nurse within a short time after discharge. The only action taken to address the lack of contact was for the 2nd Community Psychiatric Nurse to rely on the staff at Plowright House to keep him informed about Jonathan's whereabouts and condition. The Plowright House staff were not, however, qualified to deal with psychiatric issues and there were no agreed protocols defining and agreeing their precise role. Accordingly, we have to say that in our judgment, the situation merited more robust remedial action on the 2nd Community Psychiatric Nurse's part.
8	Where the CJMHT is not providing the Care Co-ordination role, the CPA Care Co-ordinator will need to ensure that the various parts of the Criminal Justice mental health system are kept fully informed.....Close links and good communication between the CJMHT and CPA Care Co-ordinators are essential.	We comment on liaison with the Police in Part 5.c of Section 5 below. In so doing, we raise a query whether the CJMHT's Operational Policy dated October 1998 is really aimed at a suspect before charge. In any event, the salient point is that the 2nd Community Psychiatric Nurse was aware of Jonathan's arrests on both the 10 and 26 August 1999, without considering that either or both of them justified a report to the 2nd Consultant Psychiatrist or action by the 2nd Community Psychiatric Nurse to arrange a further assessment of Jonathan's condition.
9	CPA reviews for clients involved in the criminal justice system will be incorporated into the Mentally Disordered Panel System and will normally be facilitated by the CJMHT.	No comment.
10	It is essential that this CPA policy is linked to the policy on discharging patients from in-patient care and Section 117.	See Items 2 and 3 of this table.

11	The policy on discharge from in-patient care which we have seen, is dated October 1999 and its relevance to Jonathan's case is, therefore, in some doubt. However, it provides that no client should be discharged without an agreed discharge plan, which should be accepted by all relevant parties.	Ditto.
12	The skills and expectations required of a Care Co-ordinator are also spelled out. He or she has to have good communication skills and must monitor the effectiveness of the Care programme to ensure that it is meeting the client's requirements. This monitoring process is said to necessitate regular meetings with the client, possibly his carers, and other key workers. It requires sufficient clinical competence to monitor (amongst other things) mental state, social functioning, compliance with treatment regimes, risk assessment and any practical support needed.	We are satisfied that with clear guidance, support and supervision, the 2nd Community Psychiatric Nurse can function as a conscientious CPN and Care Co-ordinator. **However, from his own evidence to us there is some doubt in our minds as to whether his experience in dealing with dual-diagnosis cases in April to June 1999 was sufficient really to permit him to take over a case as difficult and complex as Jonathan's at minimal notice and to handle it effectively from the very start.** As we have already stated, the 2nd Community Psychiatric Nurse's active involvement with Jonathan in practice started with one day's notice, in a case which had a number of serious complications. The 1st Community Psychiatric Nurse summed this point up when he told us that by June 1999, Jonathan's drug abuse had escalated, his compliance with his medication had become poorer and hence engagement with him had become increasingly difficult. We believe, therefore, that the 2nd Community Psychiatric Nurse found it difficult to come to grips with this case and that fact, coupled with some other factors peculiar to this case, made it difficult for him to initiate a more pro-active response as problems materialised and indeed increased.

		The other complicating factors were, of course, the changes in Jonathan's Consultant and CPN, both occurring within a short time, the 2nd Community Psychiatric Nurse's workload, the absence of a more definite plan and the 2nd Consultant Psychiatrist's leave for a period of about five weeks almost immediately after the 2nd Community Psychiatric Nurse took the case over.
13	Where there is a handover after the assessment stage, the Care Co-ordinator who carried out the assessment must fully brief the new Care Co-ordinator to ensure that the latter is fully aware of the client's needs.	We have dealt with this point in Item No. 2 in this table.
14	The Care Co-ordinator also needs to ensure that any other agencies involved in the Care Programme (voluntary and statutory) are clear about their responsibilities and what is expected of them.	The only other agency which we need to consider in this context is the CQHA, as the managers of Plowright House, and as we wish to comment on other aspects of the relationship between them on the one hand and the NHS bodies on the other, we deal with this matter in Part 5.b of this Section below.
15	The Policy provides for regular meetings of all relevant parties, but in addition it also provides for ad hoc meetings where there is a crisis or imminent crisis or where essential aspects of the care programme are not being followed and deterioration in the client's condition may result.	Certainly the 2nd Community Psychiatric Nurse and the staff at Plowright House kept in close communication in the period from the 22 June 1999 to the 2 September 1999. Indeed, the 2nd Community Psychiatric Nurse tried to solve the problem of Jonathan's unwillingness to meet him by liaison with the staff there to keep informed of Jonathan's whereabouts and mental state. However, communications between the 2nd Community Psychiatric Nurse and the 2nd Consultant Psychiatrist were far less effective, particularly insofar as the 2nd Community Psychiatric Nurse did not inform the 2nd Consultant

		Psychiatrist of any of the major events which occurred after the 4 August 1999, such as Jonathan's arrest on suspicion of causing actual bodily harm to a stranger and the need for the Police to be called to arrest him on the night of the 25/26 August 1999. The 2nd Consultant Psychiatrist told us that these events would probably have resulted in a further assessment of Jonathan's condition under the Mental health Act. Indeed, we feel that the information given to the 2nd Community Psychiatric Nurse by the Plowright House staff between the 22 June 1999 and the 26 August 1999 and the 2nd Community Psychiatric Nurse's own contacts with Jonathan during that period were sufficient grounds for the 2nd Community Psychiatric Nurse to have arranged a fresh assessment of Jonathan's mental state on his own initiative.
16	The policy incorporates a paper dated August 1998 on the role of Consultant Psychiatrists, Specialist Clinical and other medical staff. It states as a paramount requirement that necessary decisions, however difficult, must be taken with effective communication. It also provides that where a client is in the Community and a Consultant is involved, there is a need for close co-operation between the CPA Care Co-ordinator and the Consultant.	These principles are, of course, central to the efficient implementation of the CPA process. Our grave reservations about the extent to which they were adopted in Jonathan's case are apparent from the other items in this table and the other parts of this report. Moreover, the 2nd Consultant Psychiatrist effectively left Jonathan's care to the 2nd Community Psychiatric Nurse after the 21 June 1999, which was an entirely inadequate response in the circumstances.

17 and 18	The policy goes on to deal with the tasks and responsibilities of Team Managers, and particularly where a practitioner is care co-ordinating a client who is non-	The difficulties which the 2nd Community Psychiatric Nurse faced when he became Jonathan's Care Co-ordinator led us to inquire about his

	compliant with treatment and is a risk to himself or others. In such a case, support of the practitioner should be achieved by regular audit of the CPA documentation, face-to-face supervision and appropriate net-working with other agencies and senior Trust management; AND Team Managers are also given the responsibility of ensuring compatibility between practitioners' caseload numbers and the degree of risk and complexity the clients in question present.	experience and the supervision and support available to him. He qualified in 1988 and after about 4 to 4 ½ years as a staff nurse on the wards at Severalls Hospital, Colchester he transferred to a post in Community nursing. He undertook a degree course in Community Psychiatric Nursing and then took up a post as a CPN at Herrick House, Colchester in late 1995/early 1996. The 2nd Community Psychiatric Nurse agreed that Jonathan was an extraordinarily difficult patient. He first said that he had very little experience of working with dual-diagnosis patients presenting with both mental illness and problems induced by drugs and/or alcohol, though he later clarified this statement by distinguishing between those who suffer from mental illness and some substance abuse, with whom he said he has considerable experience, and actual drug addicts, where his experience is less. He also told us that expert advice on substance abuse was readily available from his colleagues in Needas, who are also located in Herrick House. On the subject of supervision and support, the 2nd Community Psychiatric Nurse told us that the Trust's policy was that everyone should be supervised and that, in effect, an officer can choose his supervisor from a register kept by the Trust. Discussions with the supervisor then take place on a monthly or six-weekly basis. The system seemed to us to be aimed much more at providing a means by which an officer can obtain advice for his own professional benefit, rather than providing a system for regularly checking the standard of care provided for clients or for providing support for staff. We took that point up with the Trust's

		Director of Nursing, who told us that the trust had two types of supervision. He described the first of them as individual clinical supervision from someone on the register of supervisors, which all individuals in the organization are encouraged to seek. He told us that this is "a reflective kind of supervision", which enables staff "to take time out to reflect on their professional approach, their educational needs (and) where they explore where they are in terms of their review of patients and discuss any type of difficulty in relation to their scope of practice." This seemed to be the supervision system described by the 2nd Community Psychiatric Nurse. The Trust's Director of Nursing went on to describe the second type of supervision, which was "managerial supervision, particularly in relation to the way in which individuals work." Whilst the 2nd Community Psychiatric Nurse did not say that he had requested, or received, this second type of supervision in Jonathan's case, the Trust's Director of Nursing told us that he had personally offered the 2nd Community Psychiatric Nurse advice on the case on one occasion, which would seem to have been around the 4 August 1999. The Trust's Director of Nursing' advice was to ensure that the Consultant was notified of anything that was important enough to put on the Carebase records system. However, although the Trust's Director of Nursing thought that the 2nd Community Psychiatric Nurse was vulnerable he did not take any further action in the case. We also discussed the 2nd Community Psychiatric Nurse's caseload with both him and the Trust's Director of Nursing. The 2nd Community Psychiatric Nurse told us that he had a caseload of 40 plus

		and that the number depended on how many clients were in the Level 1 (now Standard) CPA category and how many were in the Level 2 (now Enhanced) category. He told us that although allocation and feedback meetings in the team are held weekly, there is no standard procedure for the allocation of new cases. A lot of the responsibility is left to the CPN's and much depends on the urgency of a case. The 2nd Nurse amplified the 2nd Community Psychiatric Nurse's comments, saying that the allocation of cases depends on who has the space to take a new case and whether a CPN has a particular interest in a new client's needs. The Trust's Director of Nursing told us that there is case load supervision, but that management leaves "what happens to individual case loads to the professional judgment of the CPN's, for them to say when one of their clients should be discharged or when there are questions about the mix of their case loads or when they have problems." Both types of supervision described by the Trust's Director of Nursing are optional and in our view supervision of that nature does not help a Mental Health Team to handle its collective case load effectively as a team. On the contrary, the "optional" approach to supervision seems to have left one member of the team isolated in his endeavours to provide a difficult and complex client with a proper service. Whilst management methods vary, it does not seem to us that the methods described to us enable an objective view to be taken of the capacity of an individual CPN to provide, and maintain, an effective service for his clients. In Jonathan's case, for example, his reluctance to engage with the 2nd Community Psychiatric Nurse from the

		22 June 1999 onwards seems to us to have required a more assertive response from the 2nd Community Psychiatric Nurse than his case load of 40 plus and experience allowed him to give. Indeed, the Trust's Director of Nursing told us that when he was offering advice to the 2nd Community Psychiatric Nurse, he was thinking about how vulnerable he (the 2nd Community Psychiatric Nurse) was at that time with the number of patients that he had. In addition, we have seen nothing to indicate that cases are effectively and consciously matched to the skills of the CPN's who may have to handle them. The formulation of a protocol for the joint assessment of clients with both mental illness and addiction problems may help in a case such as this.
19	The Policy also gives guidance on assessing dangerousness. It stresses that this is a multi-disciplinary and multi-agency function, which needs to be undertaken in accordance with the Trust's approved Risk Assessment tools and to be translated into a Risk Assessment plan. The Policy emphasizes that risks may change with different circumstances and, therefore, that risk assessment is " a dynamic process", requiring constant re-evaluation.	We have already commented on this question in Parts 2.a and 2.b of this Section, preceding this table.
20	The Guidelines for reviewing a Care Programme provide that clients engaging in proven risk-heightening behaviour (such as illicit drug use) require more regular reviews. They also state that if a client is arrested in relation to a violent incident, the Care Co-ordinator and the consultant should consult about the action (including calling a review) that needs to be taken.	Both illicit drug use and an allegation that Jonathan was involved in a violent incident were factors in this case. Illicit drug use was, of course, a regular feature during almost the whole of Jonathan's treatment and the allegation of the violent incident was known to the 2nd Community Psychiatric Nurse from the 11 August 1999, **though the 2nd Consultant Psychiatrist was not informed of the incident allegedly involving violence at any time before Mrs Neale's death.**

		Unfortunately, neither of these factors directly resulted in a review after the 22 June 1999. In this regard, we would repeat that we do not accept that the Out-patient appointment on the 4 August 1999 can have constituted a CPA review.
21	The Policy makes detailed provision for a client leaving the Service, without actually announcing his intention to do so. "Leaving the Service" is defined in this context as failing to keep appointments in any caring environment or with a care worker and without making contact to arrange alternatives. The Policy specifies the steps to be taken to establish the facts; requires a visit within five days; and makes final provision for a notice to be sent to all participants in the Care Programme advising them of the withdrawal and calling for a review.	Whilst Jonathan may have "left the Service", according to the definition set out opposite, there was no recognition by his Consultant or CPN that he had done so. The 1st General Practitioner was not informed and there were no discussions with Plowright House on the basis that he had left the Service. The position was that his Consultant and more particularly his CPN were merely waiting for another crisis to occur; but again the steps set out in the Policy, particularly the need for a review, were not taken.

Conclusion: **It will be readily apparent from the preceding table that in Jonathan's case the Trust's CPA policy was not applied in several crucial respects, without there being any adequate explanation for the omissions, a number of which were of a basic nature.**

d. Other courses of action which might have been considered or used.

Section 17 of the Act empowers the responsible medical officer to grant to a patient who is liable for the time being to be detained compulsorily in hospital under Part II of the Act, leave of absence from the hospital. Such leave can be subject to any conditions which the responsible medical officer considers necessary in the interests of the patient or for the protection of other persons.

The "responsible medical officer" is defined by Section 34(1) of the Act as meaning the registered medical practitioner in charge of the treatment of the patient, which in this case would have been the 1st Consultant Psychiatrist and then the 2nd Consultant Psychiatrist, as the Consultant Psychiatrists with responsibility at the respective times for Jonathan's treatment, as long as they were not on leave or otherwise unavailable.

It is proper and recognized practice for leave to be granted to a patient under Section 17 as a trial for his subsequent discharge from hospital.

In fact, Jonathan's admission to the Lakes under Section 3 of the Act from the 15 April 1998 to the 27 May 1998 came to an end by his first being given leave on the 18 May 1998 to take up accommodation with CHAC at 14 Creffield Road, Colchester on a trial basis and then by the 1st Consultant Psychiatrist discharging him after CHAC had decided not only that they could cope with him but wanted him discharged.

In contrast, the decision to discharge Jonathan on the 22 June 1999 was an immediate decision.

On the 15, 16 and 17 June 1999 Jonathan had absconded or overstayed leave on a daily basis, resulting in the 2nd Consultant Psychiatrist ordering that he be placed on close observation. Nevertheless, Jonathan was thought to be suitable for immediate discharge five days later. We asked the 2nd Consultant Psychiatrist whether he considered allowing Jonathan to go to Plowright House on leave under Section 17 for a period prior to discharge. **His reason for not using that section was that he was about to go on a period of study and annual leave for nearly five weeks and that he would have to have asked the Consultant covering him to see Jonathan while he was away.**

The 2nd Consultant Psychiatrist also faced the problem that for the first two and a half weeks of his leave cover for him was being provided by another Consultant, who was newly appointed and who was still getting to know her own case load. Accordingly, he did not want to impose any additional burden on her, unless it was absolutely necessary to do so, and he did not see it as absolutely necessary that Jonathan should see another Consultant whilst he was away. **Nevertheless, the 2nd Consultant Psychiatrist acknowledged to us that in retrospect the use of Section 17 at that time might have been a good thing.**

Sections 25A to 25 J were inserted into the Act by the Mental Health (Patients in the Community) Act 1995. In effect, they confer power on the relevant Health Authority, in consultation with the local Social Services Authority, to secure that a patient who is liable to be detained in hospital, actually accepts the after-care services provided for him in the Community under supervision, under the ultimate sanction – if he refuses to do so – of a fresh application being made for his return to hospital as an in-patient.

We asked the 2nd Consultant Psychiatrist whether he had considered using those powers in Jonathan's case. In reply, he told us that he uses these powers very little, because with someone like Jonathan they simply would not have any effect. He was so set against treatment, that he would have ignored it in the Community, and the use of the supervision powers would have been an unnecessary complication which would have achieved nothing.

Conclusion: **We believe that Section 17 leave would have been a better alternative than discharge on the 22 June 1999. Certainly it would have provided a more effective means of recalling Jonathan to hospital when problems occurred, as they did immediately after his discharge.**

The option available under Sections 25A to 25J could have been considered at a Care Programme Approach review at a later date, if necessary.

We would also repeat the point that to discharge a patient such as Jonathan one day after the decision to discharge him is taken is not good practice.

4. OPERATIONAL SYSTEMS

a. The 2nd Consultant Psychiatrist's leave

Jonathan was discharged as an in-patient under the Act on Tuesday, the 22 June 1999, in accordance with the decision to that effect taken at the Review meeting held on the previous day.

The 2nd Consultant Psychiatrist was on study leave on Wednesday, the 30 June 1999 and Thursday, the 1 July 1999, and then went on annual leave from Monday, the 5 July until Friday, the 30 July.

We have been told that within the Trust the arrangements for covering a Consultant on leave are that a locum is not employed if the period of leave is two weeks or less, and if the period of leave is more than two weeks, then a locum is engaged only for the balance of the period after the first two weeks have elapsed. So, for a period of leave of up to two weeks another Consultant or other Consultants within the Trust are expected to provide Consultant cover.

The medical staff establishment and numbers in post in Adult Acute Psychiatry within the Trust on the 30 September 1998 and 1999 respectively and expressed in Whole-time Equivalents were :-

Establishment 30.9.98		In Post 30.9.98		Establishment 30.9.99		In Post 30.9.99	
Senior	Junior	Senior	Junior	Senior	Junior	Senior	Junior
13.99	7.50	11.93	8.23	18.93	6.27	13.43	6.82

In the above table, senior staff include Consultants, Associate Specialists, Specialist Registrars and Staff Grade doctors, and junior staff include Senior House Officers and Clinical Assistants. The 2nd Consultant Psychiatrist told us that he has one Senior House Officer under his personal supervision and that in addition there are two Staff Grade doctors, who provide assistance to all the Consultants in Adult Acute Psychiatry.

The 2nd Consultant Psychiatrist, who was appointed as a Consultant Psychiatrist in the Trust on the 15 February 1999, draws his patients from a catchment area with a population of 47,000 (including the elderly, whose mental health needs are covered by other members of the medical staff). His duties include the treatment of an average of

around 12 in-patients at any one time at the Lakes, attendances at clinics, reviews and meetings (at the Lakes for acute patients, Northgate House for chronically mentally disordered patients, Jackson House, a long-stay unit in the Community sector, and Herrick House where a Community Mental Health Team and certain other services such as Needas are based). In addition, his programme includes one day per week at Addenbrooke's Hospital, Cambridge for research.

Reverting to the question of the 2nd Consultant Psychiatrist's leave cover, we can but assume that if the 2nd Community Psychiatric Nurse had felt that he really needed a Consultant's intervention while the 2nd Consultant Psychiatrist was away, then either the 2nd Consultant Psychiatrist's colleague or his locum could have been approached. Indeed, even when the 2nd Community Psychiatric Nurse and the 2nd Consultant Psychiatrist met on the 4 August 1999 on the 2nd Consultant Psychiatrist's return from leave, the information which the 2nd Community Psychiatric Nurse passed on to the 2nd Consultant Psychiatrist did not merit any active intervention from the 2nd Consultant Psychiatrist at that stage.

Conclusions: **Whilst a clear understanding of who is deputising for an absent Consultant is absolutely necessary, it is a fact of life that Consultants take leave and are away for other, legitimate reasons from time to time and although, exceptionally, the 2nd Consultant Psychiatrist was away for a longer than usual time in June/July 1999, that clearly cannot be a matter of criticism, save insofar as it was a factor which rendered it even more necessary for a clear and definite contingency plan to have been put in place when Jonathan was discharged on the 22 June 1999 and before the 2nd Consultant Psychiatrist went on leave.**

b. Record Systems within the Trust

The Community nursing records relating to Jonathan from June 1999 onwards were partly in manuscript form and partly computerised on the Carebase system. We wondered whether this dual system of record keeping allowed all the information about a client to be readily available to all the professionals involved in his care, when they needed it. Our concerns on that score were confirmed by some of the comments of the 2nd Community Psychiatric Nurse, the 2nd Nurse and the 2nd Consultant Psychiatrist.

The 2nd Nurse told us that the use of Carebase was very erratic, with some Teams using it and others not. He also told us that the "message" from the Trust was that in the end there was no need for a written record, if an entry was made on Carebase.

That last point surprised us somewhat on medico-legal grounds, as if a manuscript note of an attendance on a client is made but then destroyed when that attendance is also recorded on Carebase, there is a continuing duty to retain the manuscript note, as well as the Carebase entry, in case there is any subsequent legal action regarding the client's care and treatment. If both forms of record are made, it would not be surprising for lawyers to

demand to see the manuscript note as well as the Carebase entry, in order to check the accuracy of the latter.

In addition, there is the practical point that an accurate manuscript note may be made more easily immediately after the meeting with the client, when the subject matter is fresh in the CPN's mind, compared to making a Carebase entry on returning to the office later in the day.

These are the reasons for our surprise that a "message" is said to have emerged from the Trust, which might be interpreted as indicating either that there is no need to make a contemporaneous, manuscript note or that such a note can be discarded once a corresponding Carebase entry has been made.

We were also told that Carebase had certain technical problems, which made it erratic to use at times and difficult and slow to access.

Our consideration of Jonathan's records revealed that in August 1999 certain significant events occurred, which the 2nd Consultant Psychiatrist said would probably have resulted in a fresh assessment of Jonathan's mental state being made, if they had come to his attention. We, therefore, discussed the Records position with the 2nd Consultant Psychiatrist at some length.

He told us that he would only get to know of an entry on Carebase by a CPN, if either he had a reason to look for it or his secretary scanned the system daily for new information about all of his clients. Such daily scanning was clearly not routine practice for the 2nd Consultant Psychiatrist in 1999. Whether or not it should be introduced is not a matter on which we feel able to comment further, as the introduction of such a system would, no doubt, have implications for Consultants and their secretaries' workloads.

We also asked the 2nd Consultant Psychiatrist about the use of the manual records as a system of passing client information quickly between professionals. He told us that there is a "green file", which is the main manuscript record folder for a client. It is meant to contain all the information relating to the client and is usually held by the Care Co-ordinator. The 2nd Consultant Psychiatrist told us that this means that if he sees a client in an out-patient clinic, he has to keep a subsidiary "white file", as the green file will not be available to him. Apparently, this problem was only meant to exist during the transitional phase of the introduction of Carebase, but the 2nd Consultant Psychiatrist told us that that phase had lasted for 18 months and is still continuing.

The 2nd Consultant Psychiatrist gave us further examples of the problems which can and do arise from the present record system, but the net result is that there are continuing risks that members of the medical or nursing staff may well not have all the relevant information available to them from the record system, either when they see clients or when they need to be reviewing cases.

We asked the Director of Mental Health Joint Commissioning, North Essex Health Authority about the records system, in his capacity as Director of Planning and Information. He outlined to us the difficulties which the Trust had experienced, in starting in 1994/5 from a situation in which there had been separate, stand-alone systems for in-patients and for each of the CMHT's. A decision was taken in 1995 to introduce the Carebase system, which the Director of Mental Health Joint Commissioning, North Essex Health Authority described as a fairly complicated system. In-patients were put on the system first, followed by out-patients, the CMHT's and more recently the day hospitals.

The introduction of the system has been a slow process because of the varying degrees of computer literacy of the staff and "attitude problems" to its introduction. Consequently, a degree of tolerance has been necessary in regard to the use of Carebase and/or manuscript records, because of members of the Trust's staff being at various stages of enthusiasm for, or ability and competence in, the use of the computerized system. The Director of Mental Health Joint Commissioning, North Essex Health Authority thought that this explained the 2nd Community Psychiatric Nurse's point that some freedom of choice existed between using Carebase or manuscript records.

The Director of Mental Health Joint Commissioning, North Essex Health Authority told us of the efforts being made to audit the use of Carebase, which are still on-going. He accepted that Carebase might not contain all the information about a particular client, though it should show if a client is on the Supervision Register or otherwise at risk. He did not know whether Jonathan was shown on it as being at risk, though there is no indication in the records which we have seen to suggest that he was.

Matters such as the full integration of the system with the Social Services' system and with Primary Care apparently give rise to complicated issues and questions of cost and are still under consideration.

On the matter of the manuscript records, the Director of Mental Health Joint Commissioning, North Essex Health Authority told us that the Trust had started from a position of almost each individual practitioner having his own set of records for a client and of those records being totally unstructured. A system of a single record for each client had been tried but had failed because it could not be circulated quickly enough to the various units/teams, whenever it was needed. The alternative was the system of a main and subsidiary records mentioned above.

Notwithstanding the problems identified to us by members of the staff of the Trust, we have been advised that the policy of the Trust was to have an up-to-date, unified patient record at all times, so that where patient information was held in Carebase, it would be printed out and also be included in the manual record, until a unified, electronic system is put in place.

In spite of that policy, the Trust continues to have two parallel records systems, Carebase and the unintegrated manuscript system mentioned above, with the continuing risk that

not all material client information will necessarily be available to each clinician or practitioner at the time when it is needed.

Conclusion: **Our review has revealed both a duality (or even multiplicity) of records systems and varied practices by staff as how they actually use the available systems.**

We believe that it should be a priority for the Trust actively to implement its policy of having a single, unified, electronic patient record system, which would be comprehensive, consistent and robust and which should then be uniformly used by all staff. All necessary training to ensure that all staff members can, and do, use the system effectively and consistently must be provided.

Otherwise, patients will be provided with care and treatment, without clinicians and practitioners having all the current information on patients which they need to practice effectively.

c. The support and supervision of Community Nursing Staff within the Trust

We have already commented on aspects of the training, support and supervision available to nursing staff within the Trust in the context of risk assessment, stopping patients from absconding and case loads.

We discussed support and supervision with the Trust's Director of Nursing and were told by him that there were two types of supervision within the Trust, namely individual, non-hierarchical, clinical supervision and secondly managerial supervision.

The first type seems to be aimed at professional development.

With regard to the second type, the Trust's Director of Nursing told us that it was "sporadic", "different within each team " and "It will be about what individuals feel about the complexities of the case loads in those teams."

Conclusion: **The skills and competencies of all staff-members must be formally recorded by Management, so that a data base exists from which the training needs of individuals can be accurately identified and then addressed. In our view, the necessary training programmes must then be implemented on a compulsory basis, so that it is clearly demonstrable that all employees have acquired the core competencies which they need to perform their respective roles properly.**

d. The 72-hour Assessment

There are references in Jonathan's records to the practice within the Trust of requiring CPNs to visit patients discharged from hospital within 72 hours of discharge, as during that time recently discharged patients are perceived to be highly vulnerable. Following Jonathan's discharge on the 22 June 1999 and after an intervening weekend, he was seen by the 2nd Community Psychiatric Nurse on the 28 June 1999 "as part of the 72 hour follow-up". Although Jonathan told the 2nd Community Psychiatric Nurse that he would not be accepting depot medication and initially expressed his reluctance to see the 2nd Community Psychiatric Nurse again, no positive action was taken by the 2nd Community Psychiatric Nurse, thus negating the object of the 72-Hour assessment.

Conclusion: **Whilst we understand the reason behind this practice, we would comment that a visit by a CPN within that period is only effective if the practice then requires the CPN to take appropriate action if there are serious concerns that the patient will not comply with his or her treatment regime in the Community or there are other indications that the patient's return to the Community will prove to be unsuccessful. That action would necessarily include immediate feedback to the Consultant and/or clinical team.**

We have commented above at some length on the handover arrangements when a CPN becomes the new Care Co-Ordinator for a client. In this regard, we would also suggest that the successor Trust should consider making the 72-hour assessment a joint one by both the out-going and new CPNs, if the handover does not take place until the CPA meeting.

5. INTER-AGENCY RELATIONS AND CO-OPERATION AND CONTACTS WITH JONATHAN'S FAMILY

a. The level of involvement of Social Services in Jonathan's care.

We note that with the exception of Approved Social Workers being consulted for the statutory purposes of applications to detain Jonathan compulsorily under the Act, Essex County Council's Social Services Department had no input into Jonathan's care from the time of the first diagnosis in October 1995 until Mrs Neale's death.

We were told that the Community Mental Health Teams include both Community Psychiatric Nurses and Social Work Practitioners and provide a unified service. However, the County Manager for Mental Health and Drug & Alcohol Services in the Essex Social Services Department, advised us in a letter dated the 13 November 2000, that the CPA Care Co-Ordinator for a particular client is the officer responsible for establishing, co-ordinating, monitoring and reviewing the care plan and ensuring that the appropriate arrangements are in place to meet both the health and social work needs of that client. The 1st Community Psychiatric Nurse and the 2nd Community Psychiatric Nurse, were Jonathan's Care Co-ordinators successively and they no doubt concluded

that no resources from Social Services were needed in order to provide for Jonathan's needs.

Indeed, the 2nd Community Psychiatric Nurse told us that whilst generally a Social Worker should be involved at the Section 117 stage (i.e. when an in-patient's care in the Community is being planned for his discharge from hospital), even that is dependent on there being social issues with which a CPN Care Co-ordinator cannot deal. The 2nd Community Psychiatric Nurse added that in the current climate, the Nurse Care Co-ordinator is able to deal with social issues as well as psychiatric ones and that Social Services' involvement really depends on the number of resources that may be necessary for the patient's after-care in the Community.

Conclusion: **Whilst respecting the 2nd Community Psychiatric Nurse's opinion, we nevertheless feel that there were factors in Jonathan's case, such as his chaotic life-style his housing difficulties and his drug abuse, which might have benefited from the involvement of a Social Worker in his case. Clearly there can be no certainty that any such benefit would have been achieved, but by July/August 1999 the psychiatric team seem to have been running out of ideas for Jonathan's future care and that fact in itself would seem to have made a request to a Social Worker to look at the case worthwhile, thus maximising the potential of multi-disciplinary teams and utilising their different professional backgrounds, expertise and skills to the full.**

b. Links between the CQHA, as managers of Plowright House (1) and the Trust and the Authority (2)

We have, of course, seen that when Jonathan was discharged on the 22 June 1999, he went to live at Plowright House, following a short period of residence there in March/April 1999.

The staff at Plowright House largely come from a Housing background and the CQHA's literature on the role of the project states specifically that they are not nursing staff or social workers and have no specialist knowledge.

A Risk Assessment of Jonathan was carried out by the Plowright House staff before he took up his accommodation there and although that assessment was primarily aimed at identifying any risks which Jonathan presented to the staff there, it also indicated the difficulties which were likely to appear as a result of Jonathan's mental illness, his drug and alcohol abuse, his delusions and his reluctance to accept medication.

The Log kept at Plowright House shows that although certain difficulties were experienced during Jonathan's first period there, matters did not reach such a pitch that the 1st Community Psychiatric Nurse had to be called in.

When Jonathan returned to Plowright House, although there were episodes of his being noisy at night early in July, his behaviour became worse from the 12 July onwards.

During the night of the 11/12 July, Jonathan had been screaming obscenities and the Manager of Plowright House telephoned the 2nd Community Psychiatric Nurse to come and see him. He visited, but was not able to spend any time with Jonathan as he (Jonathan) was rushing out to sort out some financial matter.

The problems, largely in the form of disturbances at night, continued. Also, evidence of drug abuse became apparent. The 2nd Community Psychiatric Nurse visited again on the 2 August 1999, when Jonathan was very vague, lacking concentration, rambling in his speech and talking about mystical spirits. Also on this occasion, used needles and a plastic bottle thought to be used for smoking cannabis were on the floor of Jonathan's flat. We believe that these factors were indications of deterioration in Jonathan's mental state, similar to those which had resulted in Mental Health Act assessments previously.

This visit was followed closely by the out-patient appointment with the 2nd Consultant Psychiatrist on the 4 August 1999, which Jonathan did not attend. The 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse did, however, discuss his case and decided not only that no action needed to be taken but also that there was no point in giving Jonathan another Out-patient appointment as he would not attend. Therefore, his next scheduled attendance would be his next CPA review in six months time.

The difficulties of managing Jonathan continued in much the same vein and without the 2nd Community Psychiatric Nurse being able to engage with him to any meaningful extent.

The Plowright House Log for the 23 August 1999 contains an entry to the effect that Jonathan was due in Court on the 29 September 1999 in connection with an alleged assault on a woman. We have to say that we find this entry somewhat baffling as we have heard no other evidence to suggest that such an assault occurred. The only assault which we have found documented in the Police records released to us, is the alleged attack on a man on the 2 August 1999, for which Jonathan was arrested on the 10 August. Moreover, the only matter of which we are aware and for which he was required to attend Court was the begging offence said to have been committed on the 18 August 1999, and even then the correct date of the Court attendance was the 28, and not the 29, September 1999.

As any incident alleging violence by Jonathan would obviously be of the greatest significance to our review, we pursued the suggestion that Jonathan might also have assaulted a woman with the staff at Plowright House and have been told that the basis for this suggestion was that other residents at Plowright House had been discussing the incident before the events of the 25/26 August 1999, which are mentioned below, and also that one of the Police Officers who attended at Plowright House on the night of the 25/26 August seemed to know of it. Further enquiries of the Police revealed no other record of this incident, and thus we feel that there could have been some misunderstanding about it, so that it is not something to be taken into account in our

consideration of the case. In general terms, however, it exemplifies the ease with which care and treatment might be affected by any breakdown of communication or even a simple misunderstanding

Next, on the night of the 25/26 August 1999, Jonathan created such a disturbance that the Police had to be called. They had to break into his flat, handcuff him and take him into custody for causing a breach of the peace. On the following morning they released him after deciding that he was not liable to compulsory detention under the Act and after a discussion with the staff at Plowright House to the effect that he was unlikely to create such a disturbance again.

The 2nd Community Psychiatric Nurse went to see Jonathan on the 26 August, but Jonathan jumped from the window and ran away. The 2nd Community Psychiatric Nurse advised the Plowright House staff that if the Police picked Jonathan up again, they would seek an assessment of his mental state under the Act. We are not sure from the evidence that there was a common understanding about the exact nature of the 2nd Community Psychiatric Nurse's advice. The evidence reveals a number of versions of that advice, ranging from the suggestion that if the Police picked Jonathan up again, they **"will"** ask for an assessment, through advice that the Plowright House staff should say to the Police that they think that there was a need to have Jonathan assessed, to the view that the Plowright House staff could insist on the Police arranging an assessment.

We have set out the events occurring at Plowright House in some detail, as we thought it necessary to discuss with a Director of CQHA, the Manager of Plowright House and the 2nd Community Psychiatric Nurse, the degree of assistance given by Plowright House to the 2nd Community Psychiatric Nurse and vice versa.

The overall picture that we have from the 2nd Community Psychiatric Nurse is that, particularly in the light of the difficulties which he was having in engaging directly with Jonathan, he was relying on the staff at Plowright House, particularly the Manager of Plowright House, to let him know about Jonathan's whereabouts and his condition.

Did that expectation give rise to any difficulties for the Manager of Plowright House and her colleagues? The answer to that question seems to have been "No", and indeed the Manager of Plowright House said that the staff at Plowright House were very pleased to have the sort of relationship with the 2nd Community Psychiatric Nurse which enabled them to pass on to him information about Jonathan's behaviour, because in the event of a deterioration in Jonathan's condition, they would have an established relationship with the 2nd Community Psychiatric Nurse and would know him to be the right person to talk to.

Even so, it seems to us that by late-August 1999 Jonathan's care was not as effective as it should have been, for two reasons:-

- firstly, as already mentioned in Item 15 of the Table included in Part 3.c of Section 5 above, there were sufficient indications between the 22 June 1999 and

- the 26 August 1999 for the 2nd Community Psychiatric Nurse to have made arrangements for a fresh assessment of Jonathan's mental state on his own initiative, but that was not done; and

- secondly, the procedures for initiating a mental health assessment were not clearly formulated.

Conclusion: **Although both Plowright House and the 2nd Community Psychiatric Nurse were satisfied that communications between them were good in this case, those communications were informal and in our view informal communications cannot replace formal arrangements and protocols for proper patient care and treatment which have been agreed between the relevant agencies.**

It emerged from our meeting with the Director of CQHA and the Manager of Plowright House that in relation to both their staff training and their sources of advice on aspects of Jonathan's case, they relied on voluntary organisations rather than the statutory NHS bodies. Also, we understood that there had been no contact with the Trust, the Colchester CMHT or the Lakes either before Plowright House was opened or before Jonathan's case arose, though the Association did have good links with the CMHT in Clacton.

If it is not already their policy to do so, the NHS bodies will, no doubt, wish to consider establishing formal contact with voluntary agencies, who may be asked to provide services to their clients particularly in new projects, in advance of clients being placed with them, and thus to establish whether any assistance with matters of common interest such as training can be given and whether any operational issues need to be resolved.

c. The involvement of the Police in the case

It will be seen from Jonathan's history (Section 4) that in 1999 he was involved with the Essex Police on 5 occasions as a suspect or offender prior to his arrest in connection with the attack on his mother.

Before commenting on those individual matters, we should make one general observation about the position of the Police in dealing with suspects or offenders who suffer from mental disorder. The role of the police is somewhat different from that of other agencies for three reasons. First, they often have to treat a suspect or offender on the basis of the medical or psychiatric history which the person himself gives to them, and he may well deny any history of mental disorder. Second, their primary task is merely to decide whether the person is fit to be interviewed and/or detained in connection with the offence

for which he has been arrested and they can only take that decision on the basis of the person's conduct at the time of assessment, which may well be lucid or reasonable, if only for a temporary period. Third, they have to deal with suspects or offenders strictly in accordance with the Criminal Law and in the absence of valid grounds for dealing with someone under the express powers of the Mental Health Act, they are bound to release a person whose continued detention cannot be justified by the available evidence or who is otherwise entitled to be released as a matter of law.

Jonathan's first relevant contact with the Police was for the theft from his mother during her absence on holiday in early January 1999 of some items and two giro cheques for income benefit, for which matter he was arrested on suspicion of burglary and then formally cautioned for the offence on the 5 February 1999.

Then, on the 5 April 1999, he was arrested for an alleged offence of criminal damage, but released for lack of evidence.

Third, Jonathan was arrested on the 10 August 1999 on suspicion of having assaulted a man, causing him actual bodily harm, in the street in Colchester on the 2 August 1999. The Police Duty Report dated the 16 September 1999 shows that the arresting officer requested that Jonathan be examined by an FME to see whether he was fit to be detained or whether he required assessment under the Act. The FME found that Jonathan was fit to be detained and was not suitable for compulsory detention under the Act, though he did think that Jonathan should be only be interviewed if accompanied by an appropriate adult. Because of difficulties in securing the attendance of an appropriate adult and a solicitor to advise Jonathan, the Police decided to release him on Police bail until the 16 August 1999. Jonathan did not return to the Police station on the 16 August in accordance with his bail conditions, but his name was not put on the Police National Computer as a bail absconder. The reason was that the Police Officer dealing with the offence had an address for Jonathan in Colchester and believed that he could take him back into custody, when necessary. The adequacy of this reason is an operational, Police matter. Another consideration is, of course, the fact that Jonathan was arrested in connection with the attack on his mother just over two weeks later.

On the 18 August Jonathan was charged with begging in the High Street, Colchester and was bailed to appear at Colchester Magistrates Court on the 28 September 1999 and during the night of the 25/26 August 1999, the Police were called to Plowright House because Jonathan had been causing a disturbance there. On this occasion the door of his room had to be forced to gain entry and he was arrested for committing a breach of the peace.

On this occasion Jonathan was arrested at 0120 hours. At 0615 hours a Custody Sergeant assessed him and concluded that at that time he was "not sectionable". We were told by the Police that the term "not sectionable" was used to mean that at the time of the assessment Jonathan was not exhibiting any signs or behaviour to indicate any mental disorder. The Sergeant also spoke to a member of staff at Plowright House and according to the Police note of the discussion there was little risk of Jonathan committing any

further breach of the peace and so the matter was resolved with a strong warning to him as to his future behaviour and his release.

It seems that the Officers dealing with the case on the 18 August did not recognize that Jonathan was a bail absconder. We understand that the relevant Police records are filed by date and not by the name of the detained person and so earlier records will not be available to an Officer on a subsequent occasion, unless he personally recognizes the detainee in question as, for example, a bail absconder and can trace or recall the date of the previous detention. We can but comment that this records system may not permit Police Officers to deal with a detainee such as Jonathan, who comes in contact with them several times in quick succession, in the light of his full, known history. The implications of this situation are, of course, for the Police to consider.

We have been supplied with copies of several policy documents concerning the detention of mentally-disordered suspects or offenders and relations between the Police and mental health services, including particularly the North East Essex Criminal Justice Team Operational Policy dated October 1998. It was something of a surprise to us that this paper was not known to the 2nd Inspector, the Officer from Colchester present when we met the Police.

However, 2 ½years have now passed since the death of Mrs Neale and the content of the policy documents may have changed in the meantime. Accordingly, we do not think that it would be useful for us to embark upon a critique of these documents in this Report, save to say, for example, that North East Essex Criminal Justice Team Operational Policy of October 1998 seems to us to concentrate on the action to be taken after a mentally-disordered detainee is actually charged with an offence, leaving something of a gap in relation to such detainees in the period before charge.

In our meeting with the Police we were told of the arrangements now in place for the training of Custody Sergeants and detention officers in relation to mentally disordered detainees. This takes the form of 2½hours training during the five-day Custody Sergeants' course and some input during the detention officers' two-day course.

One further point was made to us, namely that although previously members of the Criminal Justice Mental Health Team in Colchester had made visits to the Police station, no visits had been made over the past two years.

Before we met the Police representatives there was some suggestion made to us that Jonathan was well known to the Police locally in Colchester, with the possible inference that they should have been more alert to his mental condition. The officers whom we met told us, however, that Jonathan was known to the Police in Colchester for his absconding from the Lakes rather than for constituting any threat around the town. Indeed, the 2nd Inspector, who is based at Colchester, could not recall Jonathan's name or any reference to him, before we approached the Police in connection with this Review.

Conclusion: **Whilst it may be superfluous for us to urge that the new Trust, the Police and any other relevant agencies liaise closely on matters of mutual concern in the Criminal Justice/Mental Health fields in the spirit of Partnership working, when arrangements may already be in place for that purpose, nevertheless we feel that there may well be some reason to suggest that such liaison should be reviewed by the new Trust with a view to ensuring that the procedures for dealing with mentally-disordered detainees are fully understood and agreed by the Trust's staff and the Police and are operated in practice.**

d. Contacts with Jonathan's Family

In our meeting with James, Rosemary's elder son, and his wife, James' wife said that in her opinion Mrs Neale was not given enough support or feed-back from the health professionals and that there was no support network for her as a carer. She added that Mrs Neale needed someone to speak to in an emergency, when Jonathan was really bad.

James' wife added that while the 1st Community Psychiatric Nurse was quite involved in the early days, as the situation progressed, it was more and more difficult to speak to him. She went so far as to say that the 1st Community Psychiatric Nurse's willingness to help Jonathan decreased as time went on and James said that this happened to every one because Jonathan was just so difficult to control.

Naturally, these views were put to the 1st Community Psychiatric Nurse. He certainly would not agree with the proposition that the fact that a CPN might be caring for a client for a prolonged period will adversely affect the standard of care provided. Indeed, he said that prolonged contact and continuity of care actually enhanced the rapport between carer and client, and in Jonathan's case the 1st Community Psychiatric Nurse said that he was sure that there were times when he managed to get Jonathan to accept an injection of depot medication because of the length of time over which he had been involved. The 1st Community Psychiatric Nurse spoke with the experience of a CPN who has cared for patients for considerably longer periods than he cared for Jonathan.

In our view, Jonathan's records demonstrate quite clearly that the 1st Community Psychiatric Nurse provided a good level of support to Mrs Neale as well as a good level of service to Jonathan. Our conclusion in this regard is confirmed by the 1st General Practitioner, Mrs Neale's and Jonathan's General Practitioner, who told us that the 1st Community Psychiatric Nurse got on very well with Jonathan and said that he (the 1st Community Psychiatric Nurse) had done a fantastic job.

Of course, the relationship between the 1st Community Psychiatric Nurse and both Jonathan and his mother grew up over a period of about 3 ½years and it would not be reasonable to expect the 2nd Community Psychiatric Nurse to have achieved the same level of rapport within the limited time that he spent as Jonathan's CPN. In addition, Jonathan was then living at Plowright House, rather than at home with Mrs Neale, and so

the 2nd Community Psychiatric Nurse's primary contacts were with the staff at Plowright House. Nevertheless, we have dealt in paragraph 6 of the Table in Part 3.c above with the requirement for the Trust to ensure that carers' needs are properly assessed.

Conclusion: **Although we do not accept the criticisms advanced by James' wife, we recognise that there is merit in the suggestion made by her and her husband that family members and other individuals who are involved in the domestic care of patients such as Jonathan may well benefit from forms of support which supplement the professional service available from CPN's. This is consistent with the Trust's obligations to carers under both the National Framework on Mental Health, the Carers and Disabled Children Act 2000 and the Trust's own CPA guidance**

SECTION 6

James and his wife's main questions and our responses to them

Question 1

How can a patient, who is known to be non-compliant with his medication, be allowed to be in the Community, especially when so little is known about schizophrenia and too many people have lost their lives already?

Answer

This question assumes that there is a simple choice between compulsorily detaining a person suffering from schizophrenia in secure accommodation or allowing him to live as normal a life as his mental illness will allow in the Community. In practice, the choice is not as straightforward as that, as the illness may be well controlled in many cases but may be progressive in others. This is why a person's schizophrenia may well be treated in different ways at varying times. For that very reason, treatment has to be a matter of judgment for the professionals responsible for the particular patient's care. The only way of providing absolute security against the risk of incidents like this one occurring is by compulsorily detaining everyone who suffers from schizophrenia, and Society clearly finds that to be an unacceptable and disproportionate solution.

The alternative, therefore, is to continue to try to ensure (as far as one can) that the professionals concerned have all the knowledge and skills necessary to enable them to exercise their judgment in the treatment of a schizophrenic patient effectively at all times. This review is part of that process.

Question 2

How is it that when we knew that Jonathan's mental state would always decline after missing his depot medication for six weeks, additional efforts were not made to ensure that his medication was taken?

Answer

Whilst Jonathan was reluctant from the start of his illness to accept his depot medication, considerable success was achieved until the 21 June 1999 in securing that he took this medication. We would, however, agree that after that date his refusal to accept his Depixol (Flupenthixol) injections was one indication, among others, that a further review of his mental state was necessary.

Question 3

How can a patient be deemed to be not a danger to himself or others when it is known that he is taking illegal, addictive substances such as heroin? The Lakes refused point

blank to help Jonathan any further until he voluntarily stopped taking illegal drugs. How can you expect anyone who has schizophrenia to voluntarily give up drugs?

Answer

We have not seen any evidence to support the suggestion that the Lakes refused point blank to help Jonathan any further until he voluntarily stopped taking illegal drugs. Indeed, whilst he was an in-patient, it was known that he was obtaining access to illicit drugs on numerous occasions, but his treatment continued, even though his illicit drug-taking made him unpredictable.

Taking illicit drugs does not necessarily make someone a danger to others. Indeed, Jonathan was taking drugs and alcohol between 1995 and the end of 1998, without there being any reason to believe that he was a physical danger to others.

Certainly, Jonathan's condition was greatly complicated by his refusal to try to give up illicit drugs and we have commented in his report on the part which a period or periods in more secure accommodation, when his access to illicit drugs would have been reduced, **might** have played in his treatment. We would stress, however, that even if Jonathan had been treated in a more secure environment, it may still have been impossible to get him to give up the use of illicit drugs, given his consistent refusal to accept expert advice on drug abuse and the adamant desire to use illicit drugs which he expressed throughout the period which we have reviewed.

Question 4

Why does it say on the release forms from the Lakes that the conditions of Jonathan's discharge was that there be adequate supervision in the Community, when the only person looking after him was his mother?

Answer

From the start of his mental illness, Jonathan was supervised in the Community by a CPN, who acted as his Care Co-ordinator. Moreover, the evidence available to us suggests quite clearly that his first CPN, the 1st Community Psychiatric Nurse, enjoyed a good relationship with Mrs Neale in monitoring Jonathan's condition while he was in the Community, liaising with others involved in Jonathan's care in the Community and ensuring that hospital in-patient treatment was available to Jonathan when the need for it arose.

We have commented in this report on several aspects of the level of care available to Jonathan in the Community from June 1999 onwards, but even from June 1999 onwards it does not seem to us to be right to suggest that Mrs Neale was Jonathan's sole carer, as the staff at Plowright House also provided him with a very considerable level of support. However, we do, of course, accept unreservedly that Mrs Neale made a tremendous contribution to Jonathan's care at all material times.

Question 5

If the taking of medication by a patient in the Community cannot be enforced, why release people into the Community, if it is already known that they will refuse to take medication as soon as they are released?

Answer

Ensuring that a patient takes his medication in the Community can be a difficult task for a CPN, as the good relationship which the CPN is naturally trying to establish and maintain with the patient, can easily be adversely affected if the CPN has to rely on authoritarian measures to achieve that objective. The legal framework for dealing with any problems which may arise in this regard is considered in Part 3.d of Section 5 of this report.

In general terms, once an in-patient's condition has improved to a level which suggests that it may be appropriate to give him the opportunity of returning to the Community, then it will be right to give him that chance, as the only alternative is long-term detention.

His return to the Community should, of course, be properly supervised and monitored, and the way in which that supervision and monitoring was implemented in Jonathan's case from June 1999 onwards is considered in detail above.

Question 6

What action did the mental health authority or social workers take after Jonathan attacked a stranger in the street? Were they made aware of this incident by the Police? Should there not be a mechanism that flags mental health patients to the notice of the Police?

Answer

The first two parts of this question are dealt with in paragraphs 127 to 130 of Section 4 and in Part 2a of Section 5 of this report. We do not consider that the mere fact that someone is suffering from mental illness requires that such a patient be brought to the notice of the Police. Such a proposal would have serious implications for Civil Liberties.

We do, however, feel that where the actions of someone, who suffers from mental illness, have brought him to the attention of the Police as a potential suspect or offender, then there needs to be close liaison between the Police, Mental Health Services, Social Services and any other relevant agencies to ensure that all necessary action is taken both in the interests of public protection and to ensure suitable treatment for the person concerned.

Question 7

What grounds did Willow House have for refusing Jonathan low secure accommodation?

Answer

This aspect of our review is dealt with in Part 3.a of Section 5 above.

Question 8

What action did the Police take when Jonathan was arrested for ABH? If he was found by a doctor to be unfit to answer questions, why was he released on normal Police bail, particularly as he had previously been cautioned for theft?

Answer

We have deal with these points (so far as it is within our terms of reference to do so) in paragraphs 127 to 130 of Section 4 and in Part 5.c of Section 5 of the Report.

Question 9

Care in the Community is responsible for the tragic events in this case. Surely those who are not compliant (with their medication) and cannot take responsibility for their own actions, should not be allowed in the Community?

Answer

This question does, of course, open up the whole issue of criminal responsibility of people suffering from mental illness (particularly schizophrenia), while in the Community. It is a question which goes well beyond our remit and we do not think that we can usefully add very much to our answers to the preceding questions.

Question 10

What is the point of having review after review and recommendations made, if they are not (implemented)?

Answer

The implementation of recommendations made by a panel such as this one is essentially a matter for the management of the bodies concerned, who are inevitably faced with conflicting demands for resources, both human and financial.

Nevertheless, we strongly believe that such reviews play a worth-while part in the acquisition of knowledge about cases of this most unfortunate type and thus in improving the exercise of professional judgments which are an intrinsic element in achieving the best balance between public protection on the one hand and the proper care and treatment of patients on the other.

SECTION 7

The Recommendations of the Review Panel

In the light of the conclusions reached in Section 5 of this Report, we make the following recommendations.

1 We are concerned that significant omissions occurred in the provision of care and treatment for Jonathan. Accordingly, we recommend that with a view to supporting them in the future, the 2nd Consultant Psychiatrist and the 2nd Community Psychiatric Nurse should undergo a period of continuing professional education to ensure that they have the core competencies of a Consultant Psychiatrist and CPN respectively and thus are fully equipped to deal with difficult and complex cases in the future, without any risk that the omissions which in our view occurred in Jonathan's case, may be repeated.

2 We have already highlighted in this report the serious omissions in the application of the CPA process, which occurred in Jonathan's case, and that process should be completely reviewed by the Trust's successor with its partner agencies and non-statutory bodies, with the aim of ensuring that it is adequately applied, audited and supervised in the future.

3 Whilst we accept that the 2nd Consultant Psychiatrist's comparatively long period of study and annual leave in June and July 1999 was an exceptional event, we nevertheless recommend that the successor Trust must ensure that cover for an absent Consultant, whether by an existing colleague or by a locum, must be provided and that the covering psychiatrist must actually be advised of all material events and developments in relation to patients, and be actively consulted, by other team members in all circumstances in which the absent Consultant should or would have been involved in the care of a patient, if he had been present.

4 The successor Trust should urgently review the training of staff in Risk Assessment to ensure that all relevant staff are, and continue to be, properly trained in the subject and focused on the active practice of its techniques. This review needs to be carried out, and any further training given, as a matter of the greatest urgency, as by definition Risk Assessment is of crucial importance in trying to avoid further cases like this one. This recommendation is of even greater relevance in relation to complex cases such as that of Jonathan Neale. The successor Trust also needs to ensure that Risk Assessments are reinforced by regular audit and support by management.

5 The successor Trust should ensure that Ward nursing staff understand their powers and responsibilities under the Act in preventing patients subject to compulsory detention from absconding, and a policy for the active

implementation of those powers should be agreed (including the appropriate use of restraint).

6 The successor Trust and the Authority should together review the provision and availability of secure accommodation for North East Essex. Also, as we are told that some doubt exists as to the procedures available to obtain such accommodation for a patient who requires it, if an initial referral is unsuccessful ostensibly because of a lack of a suitable place, the successor Trust and the Authority should ensure that such procedures are in place and mutually known to and understood by clinicians and managers. An operational manager should take responsibility for obtaining a secure place from within the successor Trust's facilities or from another provider, once the clinical need is established.

7 The successor Trust needs to establish as a priority a pro-active system of nursing management, supervision and support, aimed at facilitating the provision of high quality care to patients, so that staff responsible for the first-hand provision of that care (a) will be clearly aware of the sources available to them for obtaining effective advice and guidance on any patient-orientated problems that may arise, and (b) will be confident that their training and professional development needs have been identified and met.

8 The successor Trust should urgently address the matter of its records systems. The diverse picture which we have been given, in terms of both the available systems and the apparent freedom given to staff as to how they individually keep their records is unacceptable and inevitably increases the risk of decisions about patients being taken without all the current and relevant information being available. Robust and comprehensive records systems should be introduced, meeting the requirements of current best practice and they must then be consistently used by all staff.

9 Jonathan's case also highlights, in relation to the decisions taken at the CPA Review on the 21 June 1999, the need for such decisions to be accurately and fully recorded at all times in order to ensure that all practitioners have a clear and consistent understanding of the future action to be taken in any particular case, and this should include the roles and responsibilities of the respective practitioners involved.

The successor Trust should review the range of services available from the various statutory and non-statutory agencies to provide optimum care and treatment, particularly in cases involving dual diagnosis and chaotic life-styles. In particular, the successor Trust and the Authority should enter into a dialogue with CQHA with a view to exploring whether the NHS bodies can usefully assist CQHA with its training needs and to ensure that working practices for the care of patients accommodated in CQHA's properties are agreed in detail and to both sides' satisfaction.

10 The successor Trust must ensure that policies and liaison arrangements with the Police in Colchester in the field of Mental Health are really agreed in a form which both sides understand and accept, and which meets the current expectation that all agencies involved in Mental Health services will combine effectively in the interests of public protection. Those arrangements must cover all people with known or suspected Mental Health problems, both those who are taken into Police custody but not subsequently prosecuted and suspects and offenders who are actually referred to the Criminal Courts.

11 The successor Trust and the Authority, in conjunction with Essex Social Services, should consider their relationships with carers to ensure that the needs of carers are assessed and addressed in accordance with the provisions of the National Framework on Mental Health and now the Carers and Disabled Children Act 2000.

12 It is evident to us that a gap existed in some respects between senior management at the Trust and those of its staff who are engaged in the first-hand provision of services to patients and clients. For example, we feel that such a gap existed in relation to supervision and support and that it has affected the efficiency of the Carebase records system. We can but draw attention to the existence of such a gap, in the firm belief that the successor Trust's management, at all levels, will wish to close it as a matter of urgency.

APPENDIX A

List of written communications submitted to the Panel in the course of the Review

Number	Description	Date
1	Leaflet on the CQHA Single Homeless Action Project	
2	CQHA Risk Assessment Document on Jonathan	
3	Letter from the Chief Executive of the Trust, to the Secretary to the Review Panel (with accompanying paper)	27 September 2000
4	Written comments of the Service Manager (Mental Health), Essex Social Services, on the case and accompanying Client Observation Summary	
5	Letters from the County Manager (Mental Health), Essex Social Services to the Panel's Secretary	17 October 2000 and 13 November 2000
6	Letters from the 2nd General Practitioner (FME) to the Panel's Secretary	16 and 30 November 2000
7	Paper by James, Rosemary's elder son and his wife presented to the Panel on 18 October 2000	18 October 2000
8	Summary of Medical Staffing (Psychiatry) in the Trust	
9	Letter from the Director of CQHA, to the Panel's Secretary	14 December 2000

10	Letters from Essex Police Solicitor, to the Panel's Secretary	13 December 2000 and 14 March 2001
11	Note of the discussion between Carol, Jonathan Neale's Aunt, and the Panel's Secretary	9 January 2001 (Date of Meeting)
12	Statement by the Project Worker, CQHA	1 February 2001
13	Letter from Director of Mental Health Joint Commissioning, North Essex Health Authority to the Secretary to the Review Panel (with accompanying copies of the records from Willow House relating to the referrals for Jonathan Neale's possible admission there)	30 August 2001
14	Letter from the Head of Corporate Administration, the North Essex Mental Health Partnership NHS Trust, to the Secretary to the Review Panel, with a copy of the North East Essex Mental Health Trust's Risk Assessment Tools Handbook (Volume 1, October 1997)	30 August 2001
15	Letter from Director of Mental Health Joint Commissioning, North Essex Health Authority to the Secretary to the Review Panel	14 September 2001
16	Letter from Director of Mental Health Joint Commissioning, North Essex Health Authority to the Secretary to the Review Panel	30 November 2001
17	Letter from the Medical Protection Society representing the 2nd Consultant Psychiatrist, setting out his comments on the parts of the draft Report affecting him.	3 December 2001
18	Documents provided by the Essex Police at the Review Panel's meeting with them on the 16 January 2002, namely:- a. Note of Instructions from the Trust dated 23 February 1999 re: Mental Health Services for Adults in Police Stations; b. Colchester Police Reminder Note to Custody Sergeants re faxes to the Criminal Justice Mental Health Team; c. Draft Joint Policy and Plan for Developing Services for Mentally Disordered Persons; d. Draft Strategy of the Essex Mentally Disordered Offenders Strategy Group, 2000 – 2003; e. Excerpt from the Codes of Practice issued under the Police and Criminal Evidence Act 1984; f. Essex Police Policy re: Vulnerable Persons in Custody; and	

	g. Essex Police Policy re: Mentally Disordered Persons. N.B. The above list does not include documents which formed part of the total documentation provided by the Police for the meeting but which have already been referred to in this Report.	
19	Letter from the Essex Police Solicitor, to the Secretary to the Review Panel, enclosing copies of:- 124 Home Office Circular 32/2000 relating to Detainee Risk Assessment; 125 The Mid-Essex CJMHT paper "Working for Mentally Disordered Offenders, Policy and Procedures Document"; and 126 A paper detailing the aims and objectives of the detention officer and the custody attendant's course.	

APPENDIX B

List of Policy Documents and Guidance Papers supplied to us by the North Essex Health Authority and the North East Essex Mental Health NHS Trust

1 Document entitled "Joint Care Programme Approach" including the following papers :-

a. CPA Policy (Ver 6 – April 1999)
b. General Guidance – Supplementary Points (Ver 1 – October 1998)
c. Glossary of Terms (Ver 3 – April 1999)
d. CPA Care Co-ordinators (Ver 2 – April 1999)
e. The Role of Consultant Psychiatrists, Specialist Clinical and other Medical staff (Ver 2 – August 1998)
f. The Role of Key Workers (Ver 1 – Sept. 1998)
g. The Role, Key Tasks & Responsibilities of Team Managers (Ver 1 – April 1999)
h. CPA Administration and Management (Ver 1 – June 1999) and
i. Administration/Clinician/Manager Responsibilities for the CPA/Carebase Process.

2 Joint Care Programme Approach Policy, comprising:-

a. Guidance for the completion of CPA2 Assessment Form and
b. Guidance on Assessing Dangerousness

3 Procedure note 206 of the Trust on Discharging Patients (dated August 1991 but apparently superceded)

4 Document entitled "Joint Care Programme Approach" and comprising:-

a. The Care Programme (Ver 2 – June 1999)
b. Guidelines for Reviewing the Care Programme (Ver 2 – June 1999)
c. Guidance when Clients leave the Service (Ver 2 – June 1999)
d. Guidance on the Mental Health Act 1983 (Ver 2 – June 1999)
e. Guidance relating to Section 117 of the Mental Health Act (undated) and
f. Supervision Register – Guidance Notes (Ver 2 – June 1999)

5 The following appendices to the Essex Care Programme Approach:-

a. Appendix 1 – Practice Level Audit Tool (Ver 1 – April 1999)
b. Appendix 2 - Assessing Dangerousness (ver 1 – June 1999)
c. Appendix 3(a) – Policy for Discharge from In-patient Care (October 1999)

[This document is, of course, dated after the events which we have had to review.]

d. Appendix 3(b) – Process for the Purchase of Private Nursing Home Care (September 1999)

[This document, too, is subsequent to the material events]

e. Appendix 4 – Eligibility Criteria for health and Social care in Essex: Notes for Practitioners.
f. Appendix 5 – Principles of Joint Management of Resources
g. Appendix (also numbered) 5 – Review of the 72 hour (3 working days) post-discharge follow-up (1999)

6 "Examples of the CPA Process for Joe Public"

7 "Next of Kin and Nearest Relative"

8 Willow House Operational Policy (August 2000)

9 North East Essex CJHMT Operational Policy (October 1998)

10 Joint Policy and Plan for Developing Services for Mentally Disordered Offenders, produced by various bodies in Essex (revised version – January 2000).