MISSED OPPORTUNITIES

FULL REPORT OF THE

INDEPENDENT INQUIRY

INTO THE CARE AND TREATMENT

OF SAHEEDA KAPDE

JULY 22nd 2002

COMMISSIONED BY
CALDERDALE AND KIRKLEES HEALTH AUTHORITY

THE INCIDENT

On the 6th June 2000 Nihaal Ahmed Kapde died, he was six years old. His death was caused by inhaling toxic gases from a fire in his bedroom started by his mother Saheeda.

Five days earlier, on the 1st of June, Saheeda Kapde telephoned an interpreter who had previously worked within her mental health team, she was in a very distressed state requesting help. Saheeda had been under the care of the mental health team, periodically, since 1994. Despite the fact that the interpreter no longer worked there, she was so concerned about Saheeda's emotional state that she immediately visited the outreach team at Ravensleigh Resource Unit to voice her concerns. In less than one hour, Saheeda's previous mental health key-worker, along with a community psychiatric nurse and the interpreter visited Saheeda at home.

They found her very distressed, she had stopped taking her medication, and her mental health had deteriorated. She had feelings of worthlessness and she felt her children would be better off without her. The key-worker assessed the state of her mental health as similar to that four years earlier when she had attempted to commit suicide. She had also threatened to kill one of her children at that time but this fact had been forgotten in the intervening years.

An outpatient's appointment was brought forward to the 7th of June and arrangements were put in place for the key-worker to take her to the hospital. In the meantime the community psychiatric nurse was to visit on Monday the 5th of June and the health visitor was telephoned and advised of the situation. It was reported that Saheeda appeared calmer when the team left. Saheeda's husband was at home during the visit and the key-worker discussed Saheeda's situation with him. The team felt there was no reason to suspect that either Saheeda or the children were at risk, therefore she remained at home with her children over the following five days. Her medication was not resumed at this time.

She was visited at home by the community psychiatric nurse on Monday the 5th of June and was found to be calmer than she had been on the first visit, though her mood was low and flat and she had feelings of low self-esteem. Saheeda was convinced that if she were detained in hospital on the 7th June she would never be allowed to see her children again.

She was visited at home on Tuesday morning, the 6th of June, by the health visitor who found her very distressed, she was finding life very difficult and was adamant she would never be allowed to see the children again if she was admitted the following day.

That evening Saheeda and her three children were at home. When the children were asleep in bed, Saheeda set fire to the bottom of Nihaal's bed using matches. Her eldest daughter woke up due to the heat and she, the youngest son and Saheeda were able to escape downstairs. Saheeda called the fire brigade. Nihaal was found by the fire brigade unconscious in the bedroom and tragically died at the scene. His death was caused by smoke inhalation.

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PREFACE

I was commissioned by Calderdale and Kirklees Health Authority in May 2001 to chair an Independent Inquiry into the care and treatment of Saheeda Kapde by local statutory services.

A panel of four, listed below, conducted the Inquiry:

• Mrs Karen Smoult-Hawtree	Barrister at Law, York Chambers. Formerly Chairman East Yorkshire Community and Mental Health NHS Trust.
• Mrs Ann McKenzie	Formerly Director of Operations Newcastle City Health NHS Trust.
• Mrs Indrani Sircar	Formerly Senior Care Manager Disability and Community Health Division, Bradford Social Services Department.
• Dr Andrew Easton	Consultant Psychiatrist, Leeds Mental Health NHS Trust

I now present the report on behalf of the panel, having had regard to the Terms of Reference and having adopted the procedure set out at appendix A.

KAREN SMOULT-HAWTREE
BARRISTER AT LAW
YORK CHAMBERS

INDEPENDENT INQUIRY CHAIRMAN

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the care and treatment of Saheeda Kapde by mental health services in Dewsbury (Dewsbury Health Care NHS Trust and Kirklees Social Services) in particular:

   - the quality and scope of the health and social care
   - the assessment of management of risk
   - the appropriateness of the treatment, care and supervision in respect of:

     - her assessed health and social care needs

     - her risk assessment (in terms of the risk to harm herself and/or others)

     - any previous psychiatric history, including drug, substance 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 Saheeda Kapde or in the provision of service to her

   - The extent to which statutory obligations were met in care plans (including Care Programme Approach (HC(90)23/LASSL(90)11 and subsequent updates of this legislation. Supervision Registers HSG(94)5 and any subsequent updates of this legislation and discharge guidance provided in HSG (94)27.

   - The extent to which local policies were adhered to in the care and planning process

   - The extent to which the care plan:

     - addressed her needs

     - was effectively drawn-up

     - was effectively delivered

     - was complied with by Saheeda Kapde

   - The details of any medication, including retrospective information and compliance issues

2. To examine the adequacy of collaboration and communication between:

- The agencies involved in the care and treatment of Saheeda Kapde
- The agencies above, Saheeda Kapde and her family, advocates

3. To examine the Area Child Protection Committee Report on the care and treatment of her children and identify any relevant issues.

4. To prepare a report for Calderdale and Kirklees Health Authority and make recommendations for all agencies involved where policy or practice issues need to be addressed.

5. To publish the report's recommendations.

ACKNOWLEDGEMENTS

The panel's gratitude goes to all the witnesses who gave evidence. Their willingness to co-operate and frankness when answering questions undoubtedly aided our inquiries.

In particular we would like to thank Saheeda's husband for his honesty and frankness and his parents for their willingness to talk to us at length in their own home. They raised many concerns and questions, which the panel has considered throughout the inquiry process.

We are also grateful to Saheeda Kapde for giving us the opportunity, on two separate occasions, to hear her account of the events, which led to the death of her son.

The panel would like to thank those members of the ethnic community who met with panel members, in particular, the religious leaders, K.A.F.A.S. (Kirklees Asian Family Advice Service) and the user and carer group. The information and advice they gave greatly assisted the Inquiry.

My colleagues and I wish to record our particular gratitude to Ann and Peter Johnson of the APMJ Partnership for their invaluable assistance in leading the administration of the Inquiry and liaising with senior personnel of the agencies involved. We would also like to thank Janice Doherty from Calderdale and Kirklees Health Authority for scheduling the interviews, arranging for relevant documents to be forwarded to panel members and dealing with the general day to day administrative duties, which an Inquiry such as this inevitably involves.

Finally, my personal thanks go to my three colleagues, Ann Mckenzie, Indrani Sircar and Dr Andrew Easton, their professional input has been invaluable. Their varied professional backgrounds were essential in enabling the panel to elicit information and draw findings and recommendations from this multi-faceted and often complicated, Inquiry.

BACKGROUND TO SERVICE PROVISION

At the time of Saheeda Kapde's illness, services for people with mental health problems in the North Kirklees area (including Batley where Saheeda lived) were provided by Dewsbury Health Care NHS Trust and by Kirklees Metropolitan Council Social Services Department (which also provided children and families services).

The community mental health service was provided by integrated health and Social Services teams and was jointly managed by a manager from Kirklees Social Services Department and a manager from Dewsbury Health Care NHS Trust. A mental health board made up of senior managers from both organisations, a GP, a consultant psychiatrist and a consultant clinical psychologist oversaw the community mental health service. This board reported to Dewsbury Health Care NHS Trust Board and to Kirklees Social Services Committee. Community mental health services included:

- Community Assessment and Short-term Therapy Team (C.A.S.T.) who received all the service referrals and whose role was to provide assessment, including ASW (Approved Social Worker) and rapid response and short to medium term therapeutic services.

- Community Support Team, (C.S.T.) who provided support for people with enduring mental illness.

- Assertive Outreach Team (introduced in 1998) who provided intensive care management for more complex and challenging needs.

- Day services providing skills training and social and leisure activities.

The C.A.S.T. team was based at Ravensleigh Resource Unit and was the team providing care to Saheeda.

Inpatient mental health services were provided by Dewsbury Health Care NHS Trust at Dewsbury and District Hospital. Outpatient clinics were also held at the hospital.

Dewsbury Health Care NHS Trust was a 'whole district Trust' providing the full range of acute services, community health, mental health and learning disabilities services. It therefore also provided the health visiting service to Saheeda and her family. Out of its total annual budget in 1999/2000 of £62 million, it spent £5million on mental health services. Its main commissioner of mental health services was Calderdale and Kirklees Health Authority, who spent 8.3% of its total allocation on mental health services.

In 1991, in the Kirklees Metropolitan Council area, 10.7% of the population were from ethnic minority backgrounds. In January 2000 17% of school children in Kirklees were of South Asian origin and a further 2.2% were black. In July 2001 approximately 10.5% of residents of Calderdale and Kirklees Health Authority area had a South Asian name, with a rate of 17% in the North Kirklees area of the Health Authority.

SAHEEDA KAPDE'S LIFE

1969 TO 1994

1. Saheeda was born on the 4th December 1969 into a Muslim family in Bombay, India. She was the fourth of five children, having two elder brothers, an elder sister and a younger brother. Her father died in 1994 from a heart attack just after the birth of Saheeda's eldest son Nihaal. One of her elder brothers died of a heart attack in 1999. Her mother and the remaining extended family all live in Bombay.

2. There is no record of any psychiatric disorder in the family, although one brother had learning difficulties and epilepsy following a head injury. Saheeda's childhood is described as happy and normal, her father was a captain in the merchant navy, her mother didn't work. Saheeda was raised as a Muslim.

3. She was an outgoing, intelligent, bright young woman who studied for a degree in commerce at the University of Bombay with a view to pursuing a career in commerce in India. The end of her studies coincided with her arranged marriage and she failed her final examinations by a narrow margin. She did not re-sit them as it was assumed, by her family and In-laws that she would not work following marriage.

4. She was 20 years old in May 1989 when she married. She had not had any boyfriends prior to this relationship. Her mother and mother-in law are related.

> ***Saheeda states she did not wish to marry at that time but was given no choice in the matter. She had met her husband only once prior to the marriage but was not given any say in choosing him.***

5. She came to England in 1990 and felt isolated without her family and friends. She and her husband lived with his parents. There were difficulties in the marriage and Saheeda complained of a number of incidents of domestic violence over the following years. He worked very long hours as a taxi driver, leaving Saheeda at the home of his parents each day, where she was expected to help with day to day housework, cooking and the care of an elderly relative.

6. On 21 February 1991 their first child was born; a daughter. There was little input from health services at this stage other than normal health visiting appointments. Saheeda felt her in-laws were interfering in the upbringing of her daughter and giving her conflicting advice, although she tended to avoid confrontation with the family, sharing her problems only with the health visitor.

7. During 1993 Saheeda, her husband and their daughter moved into their own home two doors away from his parents.

8. It was not until 1994 and the birth of her second child Nihaal that Saheeda became involved with mental health services.

INVOLVEMENT WITH STATUTORY AGENCIES

1994 TO 2000

9. 14.04.94 Saheeda's second child Nihaal was born at Dewsbury and District Hospital following a relatively uncomplicated delivery; mother and baby were discharged home the following day.

10. 21.04.94 Saheeda was visited by the midwife who recorded a potential problem with postnatal /puerperal psychosis and made a note to contact the GP.

11. 22.04.94 Saheeda was taken to A&E by her husband having taken an overdose of prothiadin (an antidepressant). She was admitted to ward 5 (General and Medical ward) expressing a wish to die. A suicide note was brought in with her, dated 20.04.94.

> ***This is the first recorded suicide attempt. There is no record of her being prescribed prothiadin at the time and therefore it is unknown how she accessed it.***

12. 23.04.94 Saheeda was found to be acting strangely, she was seen by a locum consultant psychiatrist and diagnosed with postnatal depression. Her nursing and medical notes state she felt her in-laws had been interfering since her marriage and she felt powerless to do anything. She also felt she had an incurable disease in her blood and the baby was infected. She was seen by a member of C.A.S.T. (Community Assessment and Therapy Team)

> ***This is the first mention, in her notes, of problems within the family.***

13. 24.04.94 Saheeda was transferred to the Mental Health Ward 28, the Priestley Unit. A staff psychiatrist made a thorough assessment at this time. At some point during her in-patient stay the staff psychiatrist fully explained to Saheeda and her husband the nature of postnatal depression. The baby Nihaal was brought into the hospital by his father, at the hospital's request, so that Saheeda could care for him. The Midwife recorded in the case notes that the in-laws were interfering and had taken over the care of Nihaal.

> ***This was the introduction of Saheeda to psychiatric services. There was a thorough assessment made by the staff psychiatrist. At this early stage there were already indications of a family lacking in understanding of her mental health problems and perhaps being overly interfering. The diagnosis of puerperal depression made at the time was entirely consistent with the presentation.***
>
> ***Saheeda's husband says the explanation by the staff psychiatrist is the only time Saheeda's mental health problems and the risk they posed to herself and the children have ever been 'fully' explained to him***

14. 25.04.94 Saheeda continued to express the belief that she would die from poison in her body. Nursing notes questioned whether this was a sign of early psychosis (postnatal) She cared for the baby extremely well on the ward but continued to complain about the in-laws' interference. She wanted to name the baby but the family overruled her choice and chose Nihaal.

15. 26.04.94 Saheeda seemed better in herself but became distressed following a visit from her husband. She communicated well with staff and stated she didn't get time to talk to anyone at home and was not in contact with her family in India. Saheeda was visited by her husband and family most days. She was prescribed temazepam (hypnotic) 10mg nocte and paroxetine (antidepressant) 20mg daily by an associate specialist.

16. 28.04.94 Seen by a consultant psychiatrist, prescribed thiorizadine (antipsychotic) 25mg tds

17. 03.05.94 Seen by an associate specialist, prescribed thioridazine (antipsychotic) 10mg bd.

18. 07.05.94 Saheeda was still very depressed wanted to go home to do housework. Prescribed procyclidine (antimuscarinic)

19. 11.05.94 An approved social worker was to work with the family, regarding problems at home

20. 14.05.94 Saheeda still felt she would die of poisoning but her care of the baby was good. Agreement was given for weekend leave 14th &15th.

21. 16.05.94 Saheeda was discharged from hospital. An outpatient's appointment was arranged for 07.06.94, which she subsequently did not attend.

22. 03.06.94 Saheeda complained to a health visitor that the family had spoiled Nihaal.

23. 06.06.94 Saheeda was visited by her social worker from the Ravensleigh team; she was frightened, hearing voices, she thought a telephone had been planted under her carpet. She said her in-laws were interfering. Her paranoid symptoms were returning. At this stage her support workers were informed that Saheeda's father had died in India but the family had decided not to inform her until her arrival in India, for fear she would become ill on the flight. She was told she was leaving the next day. The health visitor expressed her concern at this but the consultant, GP and social worker were reported to be happy about the situation. Saheeda was given 3 months prescription of anti-depressants.

24. 07.06.94 to end July 94 in India. Saheeda had not been back to Bombay since leaving in 1990. The panel was informed, by Saheeda and her husband that during the time spent in India there were arguments between Saheeda's family and her husband, as they felt he should have brought her home earlier than 1994. There were arguments between Saheeda and her family as they criticised her and blamed her for giving birth to Nihaal because just after his birth their father had died. They saw this as a bad omen and called the baby a Manhoos (ill/bad omen) During one of these arguments Saheeda ran upstairs and tried to kill herself by throwing herself off the balcony, she was only prevented from doing so by the quick reactions of an uncle. She was taken to a psychiatrist in Bombay and given medication.

Her husband later confirmed to the panel that Saheeda had called Nihaal a 'Manhoos' on a number of occasions over the years.

25. 03.08.94 On her return from India Saheeda received a home visit from her social worker, Saheeda told her she was feeling fine and did not need any further sessions, she was therefore discharged.

There is no mention in the notes relating to the visit to India or how she coped with her father's death. None of the details outlined in the above paragraph are contained in any of her records following her return from India. The only reason given for the decision to discharge was that Saheeda said she felt well and didn't need further involvement.

26. 17.08.94 Saheeda informed a health visitor that she and the family had moved back in with the in-laws and that she was helping care for an elderly relative.

27. 08.11.94 Saheeda was seen in the health visitor's clinic, she appeared tearful and requested a telephone number for support. There was no subsequent contact made by Saheeda.

28. 20.06.95 Saheeda was referred for counselling by her GP due to her depression.

29. 03.07.95 Saheeda rang her social worker requesting an urgent visit. A meeting had been arranged between the community elders, her in-laws, two elderly couples, Saheeda and her husband. The social worker went to support Saheeda. She describes the meeting as chaotic with only herself supporting Saheeda.

This is a common method of solving family disputes in the ethnic community but would require the mental health professional to have knowledge of how the system works in order to achieve the most beneficial outcome for the client.

30. 01.08.95 Ravensleigh referred Saheeda to K.A.F.A.S. (Kirklees Asian Family Advice Service) she visited their offices that same day. There is a letter on file written by Saheeda describing her treatment by her husband including incidents of domestic violence and requesting her rights. There was a lengthy meeting and a compromise was found between Saheeda and her husband.

There were concerns raised by Saheeda about domestic violence. It appears no attempt was made by the services to discuss these allegations with Saheeda and her husband.

31. 16.10.95 The social worker discharged Saheeda from her caseload once again, stating that her circumstances had improved.

There is no mention of domestic violence in the social worker's notes.

32. 24.01.96 A K.A.F.A.S. member visited Saheeda at home, she seemed happier; her in-laws were in India. K.A.F.A.S. agreed to keep in touch with a monthly card should she need them in future.

33. 13.05.97 Saheeda's third child, a son, was born at Dewsbury and District Hospital, delivery was normal.

34. 14.05.97 She was transferred to ward 2 (Obstetrics) and found to be depressed and paranoid. She was seen the next day by the locum consultant psychiatrist and prescribed thioridazine (antipsychotic) 25mg tds. She was described by staff as having hallucinations and talking irrationally. On the 16.05.97 she was assessed by the locum consultant psychiatrist for transfer to Priestley Mental Health Unit. The nurses were concerned because she was caring for the baby inappropriately, trying to bath him in water that was too hot**.** Mention is made in the locum's notes of her psychopathology being more severe than post partum blues. The discharge summary, which accompanied her transfer, stated, 'mum developed psychosis.'

35. 17.05.97 Saheeda was transferred to the Priestley Unit. She was seen by a staff psychiatrist. There is mention in her notes of depression, dizziness, bad dreams, careless in caring for baby, mood slightly down**.** Prescribed thioridazine (antipsychotic) 10mg bd and Zopiclone (hypnotic) 7.5mg nocte by a locum consultant.

The staff psychiatrist makes no mention of the psychosis suggested by the locum consultant

36. 18.05.97 Saheeda was convinced the delivery of the baby had not been performed correctly and that she had been taken advantage of by the midwives and doctors. She spoke at length to the nurses about her unhappiness with her home life, the background to her marriage, her in-laws and domestic violence from her husband. She told the nurses she had considered divorcing him in the past but didn't feel strong enough to do so with three children. She was caring well for the baby at this time. The family was visiting every day.

37. 21.05.97 Clinical review meeting held which stated she was on priority CPA at the time but may go down to basic. The health visitor was contacted and confirmed the situation Saheeda had expressed about difficulties at home, she confirmed the children were living with the in-laws. The family were unwilling to discuss anything in detail with the health visitor but confirmed the children were fine. The interpreter

spoke to Saheeda and confirmed she would try to talk to the family. The midwife also discussed the family background problems with Saheeda.

38. 23.05.97 Saheeda was allowed home on leave for what appears to be 4 days, the midwife was informed, the ward could not contact the health visitor.

It does not appear that C.M.H.S. (Community Mental Health Services) were advised of home leave although she was still on CPA priority.

39. 27.05.97 Clinical review meeting held, Saheeda was to be referred to CMHS (Community Mental Health Services) if any further leave periods were approved. She remained on priority CPA.

40. 29.05.97 She was referred to C.A.S.T. with a request to see her as soon as possible; she was discharged the same day. Discharge summary by a senior house officer stated postnatal depression. Her medication on discharge was thioridazine (antipsychotic) 10 mg BD; zopiclone (hypnotic) 7.5 mg nocte; ferrous sulphate (iron) 200mg BD. Aftercare agreement was completed with identified risk of relapse and identified needs as requiring community support.

This is the first time a risk of relapse is mentioned.

41. 10.06.97 The key-worker from Ravensleigh Resource Unit assessed Saheeda. The assessment detailed all her problems within the family, how she perceived her life to have been ruined by her marriage, how the in-laws interfered and how Nihaal, then aged three, was a 'bit of a handful.'

It appears a case conference was planned for the 16.06.97 but was cancelled.

42. 23.06.97 The key-worker and the interpreter visited Saheeda again, Saheeda told the key-worker that her husband had agreed she could go home to India but she was adamant she wouldn't leave the children as she wanted to be a good mother to them.

43. 30.06.97 The health visitor visited Saheeda at home and discovered Saheeda was having 'dreams' and hearing voices. She telephoned the key-worker and stressed the need for him to visit that day. The key-worker and the interpreter visited that day and shared the health visitor's concerns but did not feel Saheeda needed to be admitted. Saheeda and the key-worker discussed many issues/problems including suicidal thoughts she had, which had been caused by a letter about her case conference and her fear she would be re-admitted. She didn't feel her blood was Muslim any more she felt she was already dead. The conversation was full of catastrophic thinking. The key-worker agreed to arrange for an Islamic teacher to visit.

Outpatient's appointment organised for 01.07.97 Saheeda did not attend.

44. 2.07.97 The key-worker and the interpreter visited Saheeda at home again; the conversation was not so catastrophic. Her husband was present, the key-worker explained postnatal depression to him and how he could help by being more sensitive to her needs. Her husband explained she has been like this after birth of all children. A case conference was planned for 07.07.97.

45. 07.07.97 Case conference. Saheeda was to remain on CPA, her key-worker was confirmed. Visits from C.A.S.T. weekly and health visitor fortnightly.

46. 11.07.97 Saheeda missed her outpatient's appointment; there was no apparent communication of this to C.A.S.T.

47. 22.07.97 Saheeda was seen by a locum consultant psychiatrist in outpatients, she was very tearful, feeling guilty about the baby's delivery, had been suspicious on occasions, had problems with her appetite, had interrupted sleep and felt she had lost all interest. The locum started her on the antidepressant paroxetine 20mg. He scheduled a review in 6 weeks.

48. 22.07.97 She was visited at home by the health visitor, she was tearful, confused over religion, she said her husband was going to get a new wife, she reported his tendency to be violent at times. The health visitor discussed the women's refuge with her.

49. 25.07.97 Saheeda rang the health visitor, she was upset and confused and complained about problems. A meeting was held later that day between the health visitor Saheeda's husband and the GP where there was also a long discussion about Saheeda's mental health condition and the need for support.

50. 14.08.97 She was seen at home by the health visitor, she was confused, lucid at times then became confused again.

51. 27.08.97 Saheeda was visited by the health visitor at home she was extremely confused, unsure about her future, talked about the after life, thought she would be better off there. She felt if she were admitted to hospital she would be transformed into a male. She was very tearful and had not been taking her medication. the health visitor ordered a repeat prescription and contacted the key-worker.

52. The key-worker and the interpreter visited that day and found Saheeda had stopped her medication, she had feelings of hopelessness and helplessness, felt her children were cursing her for bringing them into the world, felt she would be better off dead. Her interaction with the children seemed appropriate with no suggestion of any neglect. Saheeda didn't feel she would get better so there was no point in taking her medication.

53. The key-worker reported these issues to the CPA review the same day. The senior nurse manager, who chaired the review, records in the minutes that the relapse coincided with her stopping medication, and strained family relationships meant there was no-one to give her medication, therefore she was heading for readmission. A locum consultant psychiatrist was consulted re a flexible outpatient's appointment.

This is the second mention of her condition relapsing, coinciding with the cessation of medication.

54. 28.08.97 The key-worker and the interpreter visited Saheeda, she told of her fears that her blood had been diluted and she was part Christian part Muslim and if she went into hospital she would be turned into a man. She said she wanted to separate from her husband but was not sure which, if any, of her children would be allowed to go with her.

55. 03.09.97 The health visitor telephoned Saheeda who seemed brighter on the phone but was talking in riddles. The key-worker saw Saheeda and her husband that day and reported that a frank discussion took place about Saheeda's mental health and the marriage problems.

56. 04.09.97 Saheeda was seen in outpatients by a locum consultant psychiatrist who notes she was crying, talking about suicide, she was markedly depressed, her depression was combined with irrelevant talk. He prescribed an increase in paratoxetine (antidepressant) to 40mg daily plus introduced the anti-psychotic drug sulpiride 200mg bd. He stated that Nihaal, aged 3, who was at the clinic with Saheeda, was hyperactive and suggested a nursery placement for him.

There is no indication of a further outpatient's appointment; she was sent home without any increased community follow up. Saheeda went home and took an overdose of her prescription and was admitted to Accident and Emergency later that day.

57. 04.09.97 Saheeda was transferred to Ward 9 (medical ward) from Accident and Emergency.

58. 05.09.97 The health visitor visited the family at home and Saheeda's husband showed her a number of suicide letters written by Saheeda. One to her GPs, two to the key-worker, the interpreter and the health visitor and a declaration of what she wanted to happen to the children after her death. The letters clearly indicate she intended to kill herself and the baby. She stated she didn't have the courage to kill all three children so she was leaving two behind and "making the courage to kill one". Her husband was advised by the health visitor to take the letters to the psychiatrist.

59. The health visitor telephoned the Sister on ward 9 and told her of the contents of the letter, she confirmed Saheeda's husband would bring them into the hospital. He requested support in the manner of nursery places for his two younger children. Accident and Emergency notes show a call was received from a social worker

confirming that suicide notes were found with homicide threat to one of the children (it is believed this was the health visitor, not a social worker) Saheeda was transferred to ward 18 Priestley Unit

60. 05.09.97 Saheeda was seen on the ward by a locum consultant psychiatrist, then later by the senior house officer. The medical notes state that Saheeda's husband brought in suicide notes written by Saheeda which had detailed plans for looking after the children following her death. There is a note in the nursing records, which mentioned the plans to kill one of the children. The nursing notes stated she had had suicidal intentions for the previous two weeks and had considered burning herself. Ward staff telephoned the key-worker to advise of admission.

There is no mention in the clinical (medical) records of the threat, to kill one of the children, contained in the suicide letters.

61. 08.09.97 Ward round by a consultant psychiatrist. Saheeda was advised to have ECT. the health visitor visited her. The health visitor told ward staff she was worried about the threat to kill one of the children and asked that the matter be referred to the Batley Child and Family Unit of Kirklees Social Services Department. Saheeda refused to tell the health visitor how she planned to kill the baby.

62. 08.09.97 Visit to Saheeda on the ward by the key-worker, Saheeda told him she had considered burning herself prior to the overdose because she viewed the situation as hopeless. He made a note that she believed herself to be very ill and would not get better, hence she is a liability to the children. He notes she had written a suicide letter to him but not sent it. The key-worker noted he would feed his concerns into the CPA review process and liaise with ward staff and the clinical review process throughout duration of Saheeda's admission.

The key-worker made no mention of reading the suicide letters himself, which were held with the clinical notes, or of reading the nursing notes relating to the threat to kill one of the children

63. 09.09.97 Ward staff referred the case to the Batley Child and Family Unit, informing the duty officer of the Child and Family Team of the suicide notes and threats to kill one of the children. They outlined her mental health history. The health visitor received a phone call from the duty officer of the Child and Family Team to say they would attend her discharge review and assess the risk at that stage. He stated there was no risk to the children whilst she remained an in-patient. He suggested the health visitor contact nursery placements for the two youngest children.

A referral form, from the nursing staff to the Child and Family Team, should have been filled in and filed with the nursing notes, no form has been found.

64. 10.09.97 Clinical Review meeting was held; the notes of the meeting are very brief but identify the risk as one of suicide, noting the patient wanted to set herself alight and postnatal depression. Priority CPA level. The health visitor, the key-worker and the named nurse were not present at the review.

No mention of the suicide notes. No mention of the homicide threat to one of the children. None of the key people in her care were at the clinical review meeting other than the interpreter who usually accompanied the key-worker on home visits to Saheeda. The interpreter had not been made aware of the suicide/homicide notes.

Later that day the key-worker attended CPA review meeting and fed back on the situation. Saheeda was confirmed as a high suicide risk. There was no mention in his notes of the threat to kill a child. The minutes of the CPA meeting highlighted the details of her suicide attempt and noted that she wrote "a convincing suicide note, which has now been seen and is with her notes." The minutes state that the key-worker was very worried about her comments, her mental state, being suicidal and the risk of burning herself. The minutes suggest her problems may be more than just a bad marriage. The staff are noted to be greatly concerned.

There is no mention that the suicide note also contained clear threats to kill one of the children. The minutes do not clarify who has 'seen' the suicide note.

65. 11.09.97 Saheeda informed nursing staff that the family wanted her home, as the children were proving very demanding. Following discussion with the nursing staff, Saheeda agreed to stay as an informal patient and agreed to ECT treatment.

66. 11.09.97 to 18.09.97 a number of telephone calls took place between the key-worker, a Community Care officer at Batley Child and Family Team and Saheeda's husband regarding help and nursery places for the two younger children.

67. 15.09.97 The Batley Child and Family Team suggest closing the case.

68. ECT given to Saheeda on the 16th, 19th,23rd,26th 30th September.

69. 17.09.97 A suicide risk assessment was done on the ward by nursing staff; Saheeda was assessed as high risk. The health visitor expressed her concern to the ward staff that there needed to be a risk assessment done on the children before Saheeda was allowed home on leave. On this day the Child and Family Team decided to close the case.

70. A clinical review meeting held, apart from the interpreter, none of Saheeda's main care workers were present. Risk was assessed as suicide; mention is made of the involvement of Child and Family Team because of suicide note.

There is no mention of threat to kill child

71. 17.09.97 The health visitor had a telephone discussion with the manager of the Child and Family Team; the health visitor explained her unhappiness with the decision to close the case. She explained the home situation, the suicide threat, they discussed the threat to kill the baby and that inappropriate home leave was being

granted by the ward staff. They discussed nursery places for the youngest child and the health visitor was told the community care officer from the Child and Family Team would visit the grandmother to see what help he could offer. The team manager of the Child and Family Team notes on her file that she would discuss the matter with the officer.

72. 18.09.97 A senior house officer visited Saheeda on the ward, he said she was feeling well and could have time out over the weekend at home with family but not overnight. Home leave given on the 20th until 8pm.

73. 24.09.97 Saheeda was given day leave to look after children. A clinical review meeting was held, apart from the interpreter, none of her main care workers were present.

Risk still identified as suicide, no mention of threats to kill a child.

74. 26.09.97 The health visitor had a meeting with the Child Protection lead nurse to discuss the Kapde problems and the referral to Child and Family Team and how to deal with the concerns the health visitor had.

75. 28.09.97 Family wanted Saheeda home to care for the children.

It is clear from the records that during her stay on the ward Saheeda felt it was her duty to go home and look after the children.

76. 1.10.97 A case conference arranged for the 13.10.97

77. 06.10.97 Saheeda was discharged this day. The nursing staff left a message regarding discharge for the health visitor (who was on annual leave) then left message for the community care officer (who was on annual leave) then contacted the interpreter. The discharge summary mentioned suicide notes, however, there was no mention of threat to kill the child. Outpatient's appointment was made for the 16.10.97, the discharge case conference was moved to 20.10.97.

No risk assessment was carried out by Child and Family Team prior to discharge.

There was no mention in the nursing notes that a risk assessment had not been carried out prior to discharge.

A member of the nursing staff filled in a child protection contact sheet on the ward. It noted that she had been contacted by a health visitor who said the team manager from the Child and Family Team had sent a letter stating there were no resources to allocate to the family so she would send K.A.F.A.S. in to see if they could support the family.

There is no record either in the Child and Family notes or K.A.F.A.S. files that a referral was ever made by the team manager.

K.A.F.A.S. is a voluntary support organisation that has no trained mental health workers or risk assessors.

78. Between 06.10.97 and 17.10.97 whilst the health visitor was on annual leave, another health visitor apparently wrote to the Child and Family Team with a referral form expressing concerns that nothing had been done about assessing the risk to the children.

No copy of the letter exists on the Child and Family Team or health visitor's file. The Child and Family Team deny receiving it, the health visitors are adamant it was sent.

79. 08.10.97 Clinical review meeting was held following discharge. Suicide still down as the only risk. None of the main care workers were present apart from the interpreter.

This was the fourth and final clinical review meeting. The key-worker had attended none, nor had the health visitor, the named nurse or the nurse who referred the matter to the Child and Families Team. The issue of the threat to kill a child was now lost from future records.

80. 17.10.97 A health visitor received a telephone call from the community care officer to check how the family were doing, to confirm he would attend the case conference on the 20th and to confirm he would arrange a visit to the Kapde's to carry out an assessment.

No home visit, for the purpose of risk assessment, ever took place.

81. Between the 8th October 97 and 20th October Saheeda was seen and spoken to at home by the health visitor. She appeared well in herself but was having problems with Nihaal, as he was very active. She continued to complain of problems with her vision which she had first mentioned whilst an in-patient.

82. 20.10.97 Case conference held. This was effectively the discharge conference, some two weeks following discharge. The minutes to this meeting are extremely brief. It appears the key-worker, the health visitor and the community care officer were present along with other staff. Saheeda was coping with her childcare responsibilities, she felt fine in herself apart from vision disturbance. It was felt her vision problems could be due to side effects from the medication. She was to remain on priority CPA and be visited twice weekly by the key-worker and by the health visitor as required. It was reported that Saheeda could not remember the suicide attempt or the notes she had written.

There was no note of any contingency plan for possible future risk to her or the children. The health visitor remains adamant that she expressed her concerns at this meeting and others she attended, over the lack of risk assessment on the children. There is no reference in the minutes noting her concerns.

The decision was taken that there was no further need for the Child and Family Team to be involved, there is no indication of why this decision was taken in the absence of any risk assessment.

The only person from the Child and Family Team to attend the meeting was the community care officer who was not qualified to assess risk to the children.

83. 05.11.97 A CPA review meeting was held. The key-worker was on annual leave so submitted a written report; neither the health visitor nor the interpreter were present. It was decided to continue monitoring Saheeda. There is a note of this meeting on a Care Plan Review form, received by Saheeda's GP on 07.11.97 and by the Mental Health Team on the 12.11.97, following the meeting on 05.11.97. This form identifies that the children are at risk.

This is the only instance, following the referral to Child and Families Team by nursing staff on the 09.09.97 that the issue of risk to the children appears on any CPA review or clinical record of Saheeda's. There is no indication given as to why the children were at risk. The key-worker did not follow it up on his return. The issue is never raised again.

84. 17.11.97 Child and Family Team notes, signed by the community care officer, suggested no further action should be taken on the case, this was confirmed and signed by his manager on the 19. 11.97.

85. 03.12.97 CPA review meeting. The key-worker reported that he had seen Saheeda the day before and had no concerns about her mental health although she was unhappy and alluded to domestic problems. She interacted well with the children. There is also a note that the Child and Family Team was happy, but no indication of where that message came from.

There was no one from the Child and Family Team at the meeting as they had closed the case over two weeks earlier.

86. Between 14th October 97 and February 98 Saheeda was seen by the key-worker and the interpreter on six occasions, the health visitor on eight occasions and in outpatients on three occasions where she appeared to be mentally stable. Although when she was seen by the health visitor on the 21.01.98. she admitted she hadn't taken her medication the previous week and had become depressed, so started taking it again. There was a CPA review meeting on the 28.01.98 which was attended by the key-worker but not the health visitor, the issue of her stopping medication was not raised.

This is the third mention in her notes, of her condition relapsing, coinciding with a cessation of medication.

87. 3.03.98 The health visitor saw Saheeda at home at Saheeda's request. She had stopped taking her medication again, there was a long discussion about the need for medication and she was advised to discuss the matter with an associate specialist.

88. 05.03.98 Saheeda was seen by the key-worker and the interpreter at home, they found she had relapsed due to not taking medication. She was experiencing vivid dreams, she discussed her marriage problems and ended by saying she was better off dead. The key-worker discussed her need to restart medication.

This is the fourth mention of her condition relapsing, coinciding with the cessation of medication.

89. 12.03.98 A staff psychiatrist saw her in outpatients where he notes she had stopped taking her medication with a resulting reoccurrence of her symptoms. Depot injections were discussed and Saheeda said she would think about it. Her prescription at this time was continued as, paroxetine (antidepressant) 40mg each morning; sulpiride (antipsychotic) 200mg at night; procyclidine (antimuscarinic) 5mg at night. The staff psychiatrist confirmed the need for her to be on medication for the foreseeable future. She was to be seen at the next available outpatient's clinic, this turned out to be 11th June 98, some three months later.

Given the relapsing nature of her condition and her propensity to stop taking medication this was felt to be an inappropriate gap between appointments.

She was seen by the key-worker and the interpreter, the same day, following her outpatient's appointment. She had resumed medication, was not now experiencing vivid dreams as she had been the previous week but she said her marital situation was not good. The key-worker noted she was socially isolated with no social contacts other than her husband and sister-in-law.

There is no mention of the fact that Saheeda spent every day with the children at her in-laws' house, usually until early evening.

90. 30.03.98 The health visitor visited Saheeda at home. She complained that her husband did not offer her any support. She told the health visitor that he had started going out to nightclubs and threatened to beat her if she told his mother. There was a long discussion on domestic violence and zero tolerance. The health visitor tried to persuade Saheeda to join a mother and toddler group.

Saheeda said she had started her medication again and felt well, she said she felt quite different when not taking it.

91. Between March and July 98 Saheeda appeared to be coping well. A CPA review meeting was held on the 22.04.98 where it was noted that Saheeda was mentally well but had low self-esteem and experienced vivid dreams when she had stopped her medication a few weeks earlier. She was seen in outpatients on the 11th June and reported to be well, her medication remained the same.

92. 29.07.98 CPA review meeting. The key-worker reported that Saheeda was doing well and accepting her medication with no suicidal ideation. All her HONOS ratings were below 3 and if she continued with medication her mental state would remain stable. He wrote the question, how will this be monitored? and then wrote, monitoring through outpatients. It was agreed to de-register her from priority CPA to

basic level, monitoring her through outpatients. It was noted there were still some minor domestic problems, she was limited to home because of the children but when her son Nihaal eventually went to school she could use the crèche facilities at the Indian Muslim Welfare Society and the College.

> ***The risks outlined were stated as "ceasing her medication prematurely could cause serious problems". The key-worker makes a note in his files that the main issue is compliance with medication. CPA basic level had no facility to monitor patients in the community other than outpatient appointments.***

93. 17.09.98 The key-worker and the interpreter visit Saheeda at home and inform her and her husband that she has been de-registered from priority CPA. The key-worker reassured them they could contact him or the locum consultant if they had any concerns about her mental health. He closed the case the same day in accordance with the decision to de-register. He confirmed this in a letter to her GP on the 23.09.98.

94. Between July 98 and February 2000 Saheeda appeared well in herself. She was seen by the health visitor on five occasions relating to the children's healthcare between July 98 and September 99. She was seen in outpatients for her mental health appointments on 4 occasions by two different consultant psychiatrists, no concerns were raised. Saheeda had previously been under the care of one consultant and his team but in October 99 she moved into the care of another consultant and his team due to sectorisation. She was seen by a locum Associate Specialist, on the 14th October, this was the first time they had met. He reported her as fine and he left her prescription the same. Her medication, at that time, prescribed by the pre October 99 consultant on 12.01.99, was paroxetine (antidepressant) 20mg daily, sulpiride (antipsychotic) 200mg daily, procyclidine (antimuscarinic) 5mg daily.

> ***Although Saheeda received her repeat prescriptions from her GP during this time and saw him on a number of occasions for other matters, he was not actively involved in monitoring her mental health care.***

95. 03.02.2000 Saheeda was seen in outpatients by an associate specialist in psychiatry. This was the first time they had met. He noted there were no psychotic symptoms, she was eating and sleeping well but was tired during the day. The associate specialist decided to stop the prescription for sulpiride (antipsychotic) and procyclidine (antimuscarinic) at Saheeda's request but continued with paroextine (antidepressant) in the mornings. Due to sectorisation Saheeda was transferred again, for follow up by the Batley team.

> ***There is no reference in the associate specialist's notes to any risk of relapse when ceasing medication. The CPA review notes of the 29.07.98 highlighting the risk were pasted into the clinical notes some two pages prior to associate specialist's entry.***

96. 29.03.2000 Saheeda was seen in outpatients by a locum consultant psychiatrist. This was the first time they had met. The locum's notes state Saheeda appeared fine, quite well, symptom free, she was doing courses at the Al-hikmah Centre, had started

a computer course and was learning to sew. Saheeda felt she was ready to come off medication, the locum was uncomfortable with this as she did not know Saheeda but agreed after Saheeda pressured her. She advised Saheeda to reduce her medication gradually. Saheeda was advised to continue with her Paroxetine (Antidepressant) for another month and come off very, very slowly. There is no indication as to what very, very slowly meant. The locum wrote to Saheeda's GP informing him of the same advice. An appointment was made for Saheeda to be seen at outpatients again in a further 5 months.

> ***The risk of relapse due to prematurely stopping medication, highlighted in the notes, had been noticed by the locum. No community monitoring was put in place. As it transpired, Saheeda stopped taking her medication immediately.***

THE FINAL DAYS LEADING UP TO THE INCIDENT

JUNE 1ST TO 6TH 20000

AND SUBSEQUENT OUTCOME

97. 01.06.2000 (Thursday) 08.50am Saheeda telephoned the interpreter in a terribly distressed state. She was very tearful and difficult to calm down. She had argued with a shopkeeper at a local grocery store calling him a cheat, she said no one liked her, she wanted the interpreter to go and apologise on her behalf. She repeatedly said, "please look after my children." The interpreter was no longer working as an interpreter in mental health services at this time. She tried to calm Saheeda down and explained she was working that day and may not be able to get there but she would try. Saheeda rang her back a few minutes later still very distressed. The interpreter called her employer, explained the situation and was allowed to deal with the problem. She went to the Ravensleigh Resource Unit where she had worked in the past and spoke to a senior ASW (approved social worker) and then to the person who had been Saheeda's last key-worker.

98. A decision was taken almost immediately for a home visit by the key-worker and the interpreter along with a community psychiatric nurse as an observer. The community psychiatric nurse had been a registered mental nurse for five years; she had joined the service at Ravensleigh four weeks earlier and was on her induction period. The car journey took between five and ten minutes, during which time there was a brief discussion on the previous problems with Saheeda.

> ***At this stage the key-worker had not been in contact with Saheeda for 20 months.***

99. On arrival at the house Saheeda was found to be in a distressed state. The incident at the shop, which had upset her, was discussed. Saheeda told the key-worker she had stopped taking her medication in March following her appointment with a locum consultant. She told him that the children would be better off without her, that she would be better with Allah and expressed concerns about her in-laws saying they were trying to take the children away from her. She told him that if she was admitted to hospital again the family would take the children away from her and she would never see them again. She felt worthless and everyone was against her. She had considered leaving the family home with and without the children. She no longer went out because she was convinced everyone was talking about her. When he asked her directly whether she had considered harming herself she said she felt she would be better off with Allah.

> ***This was the fifth mention of her condition relapsing coinciding with the cessation of medication.***

100. Her husband had been asleep in bed at the start of the meeting but later came downstairs. The key-worker explained the situation to him. Her husband said he had

observed his wife talking to herself for a few days and crying. The key-worker telephoned to make an appointment for the next available outpatients which was Wednesday the 7th June and arranged his diary so he could take her himself. He telephoned the health visitor informing her of the situation and said he felt Saheeda might appreciate another friendly face. He then completed a risk assessment which resulted in Saheeda being assessed as having relapsed and a clear note on that assessment that she was previously considered a high suicide risk when presenting similarly (in 1997) The child protection score was 2/3. There is no acknowledgement of the threat to kill one of the children, written in her suicide notes of 1997

> ***Policy at that time dictated that a score of 2 should be reported to the specialist nurse child protection and a score of 3 should be reported to Social Services Child and Family Team; neither were informed.***
>
> ***The same day the key-worker sent a letter to a Psychiatrist re the outpatients appointment on the 7.th He detailed Saheeda's presentation and informed the psychiatrist that she was previously perceived as a high suicide risk when presenting similarly.***
>
> ***There was no mention of the threat to kill one of the children when presenting similarly. He stated that there was no evidence of her acting on her suicidal ideation or putting the children at risk.***
>
> ***He stated that he had fully discussed his concerns with her husband who would monitor the situation and was aware he could contact Ravensleigh at any time.***
>
> ***The key-worker was aware that her husband spent most of the time out of the family home running his taxi business.***
>
> ***No attempt was made to restart medication immediately.***

101. It was reported that Saheeda had calmed down by the time the team left some 1hr later. The key-worker organised for the community psychiatric nurse to visit on Monday the 5th June, as he did not work on Mondays or Tuesdays at that time. He told her husband he could call Ravensleigh at any time.

> ***Based on his previous knowledge of her, the contingency arrangements he had made, her history of interacting well with the children and her presentation that day, the key-worker felt the potential crisis had been "nipped in the bud" and the situation was now in hand.***

102. 05.06.2000 (Monday) The community psychiatric nurse visited Saheeda at home. Saheeda told her she had been OK over the weekend and had taken her daughter to school that morning, she hadn't wanted to but did. Nihaal was not at school because Saheeda said he was unwell, the youngest child was also at home. Saheeda appeared low in mood with a sad facial expression, she was tearful, not eating well and had no appetite. She had no motivation to do housework and had no energy. She told the community psychiatric nurse that her husband had been alright over the weekend because she had been giving him some attention and it had been difficult for him. She asked if she could take the children with her to the outpatients

appointment on the 7th She said her husband told her to take them to his parents but she was reluctant to because she was afraid they would be taken away from her. They discussed the situation and Saheeda agreed it would be better to talk to the doctor without the children there, so she would take them to her in-laws.

> ***Whilst the community psychiatric nurse was a qualified Registered Mental Nurse with five years experience, she was still in her induction period at Ravensleigh; she had not carried a case load as a CPN before, and had not been assessed by her managers at Ravensleigh on her own cases.***
>
> ***She did not read the file prior to visiting Saheeda, she was not aware that the key-worker had scored the risk to the children as 2/3 or that, in his letter to the psychiatrist, he stated that when presenting similarly Saheeda was considered a high suicide risk. Nor was she aware that there had been a previous threat to one of the children.***
>
> ***The only knowledge she had of Saheeda was the 5 to 10 minute briefing the key-worker had given her in the car on the 1st June and her observation of the meeting that followed.***

103. 06.06.2000 The health visitor visited Saheeda at her in-laws. She found Saheeda extremely depressed and very tearful. The health visitor noted that in the past, she and Saheeda had always been able to talk things through, but she felt Saheeda was holding back this time. Saheeda kept saying that there was nothing wrong and that the health visitor couldn't help, which was something she hadn't done before. She spent two hours with Saheeda, during which time Saheeda cried most of the time and eventually told her she was finding life very difficult. She wanted to leave her husband and take the children with her. She was afraid of going to the outpatient's appointment the following day because she was adamant she would not be allowed to see the children again. The health visitor tried to ring the key-worker as she was very concerned about Saheeda's mental state, she felt this was the worst she had ever seen her, she left a message, as he was unavailable that day. The health visitor left the house and was asked by Saheeda's sister-in-law what was wrong, the health visitor chose not to discuss Saheeda's problems with her sister-in-law.

> ***The health visitor felt the family didn't understand her mental illness, they felt she was putting it on or that she was mad. She did not discuss Saheeda's problems with the family that day because she felt they were not supportive of her mental health problems and there was also an issue of confidentiality.***

104. Saheeda left her in-laws and went to her own home around 7.30pm that evening. Her husband was out working. The children went to bed sometime later, they were all in the same bedroom. Nihaal was sleeping in the bed under the window; his sister and younger brother were in the double bed. When the children were asleep Saheeda took some matches upstairs and lit a bundle of clothes at the end of Nihaal's bed, starting a fire in the room. The daughter woke because of the heat and managed to get herself out of the room. The youngest child and Saheeda also managed to go downstairs. Saheeda called to Nihaal to wake up and she called the fire brigade but hung up before giving the address. The first call was received at 11.57pm. When the firemen

arrived they could not find Nihaal at first, as he was making no noise, when they eventually found him he was still lying in his bed. He died at the scene.

105. When the police attended, Saheeda was sitting on the doormat just inside the doorway holding onto her two children, when she was touched by anyone she became hysterical, hugging the children tighter. Her daughter had to be forcibly removed from her. They were all moved to the garden where Saheeda grabbed the children again and continued to scream uncontrollably saying many times, "they are not taking my children." Saheeda struggled violently and was panicking and had to be forced into the ambulance. She shouted, "I meant to kill myself not them".

106. 07.06.2000 In the early hours of the morning at Dewsbury & District Hospital, the daughter heard Saheeda say "I wanted the children to die and when we die everything will get better again, back to normal, like it was before and we will live happy." When her husband saw her she admitted she had thrown matches around and when she was told Nihaal had died in the fire she said "we are all going to die." She asked for some poison so she could kill the other children.

107. A staff psychiatrist saw her at 1.30am. The transcript of the criminal proceedings record that the staff psychiatrist's diagnosis was one of acute psychosis. Saheeda had told him she was surprised she was still alive, she had been trying to burn herself. She was aware Nihaal had died and she thought he would be at great peace as he was with God. She felt she should have died after taking sleeping tablets with him. She claimed to hear muffled voices from a bag. She thought her bath had moved when she was in the bathroom. The staff psychiatrist felt she was profoundly disturbed.

108. There was a discussion as to whether she should be admitted to the Priestley Unit but the staff at the unit felt this was not appropriate for fear of reprisals by the community; the unit was an open one, not secure, with minimum staff and she ought to be forensically assessed.

109. At 2am Saheeda was taken into custody at Dewsbury Police station. The duty social worker was called to attend her. Saheeda was extremely upset and a police sergeant was not sure that she understood where she was or what was happening. She told the social worker that she seemed to realise where she was; she had no friends in Batley and no family. She wanted the key-worker and the health visitor to be called. She explained that she was due at outpatients later that day and she feared she would be admitted to hospital and her children would be removed from her care and that is why she started the fire. She said her husband worked all the time and her in-laws interfered in her life. She said people were laughing at her and she felt as though someone was grabbing her and holding her tightly. She discussed the domestic violence she had suffered in the past.

110. Saheeda was later seen by the police surgeon who felt she should be in hospital under section 3 of the Mental Health Act. He contacted the on-call consultant who

agreed she should be in hospital. He felt she could go to Priestley Unit but the ward manager disagreed. The consultant said he would discuss it with the senior nurse manager after 8am. The social worker believed she should be sent to the Castle Hill Unit at St Luke's Hospital.

111. Saheeda was eventually transferred to New Hall prison. She was assessed some short time later by a consultant forensic psychiatrist who found her to be acutely mentally ill and arranged for her to be transferred to a secure unit under section 48 of the Mental Health Act. He reported that Saheeda had some very abnormal ideas, she believed she had black magic put on her in India. She had abnormal ideas about Nihaal, she felt he came into the world without any intention and that he was an ectopic delivery. She felt his delivery was not normal, she felt he had an hereditary condition that meant he couldn't die. She believed Nihaal was not a normal child.

112. The consultant outlined Saheeda's condition as a relapsing mental illness since 1994, which was diagnosed as post natal depression but on closer examination reveals that she was not only depressed on each occasion, she lost touch with reality and became very seriously mentally ill with symptoms of psychosis, such as delusions and hallucinations. He felt the nature of these symptoms suggested that she probably had an illness which was schizophrenic in nature. He stated there was a wealth of evidence to suggest Saheeda was acutely mentally ill before and at the material time of the offence.

113. 07.11.2000 At Leeds Crown Court before The Honourable Mr. Justice Harrison, Saheeda pleaded guilty to manslaughter on the grounds of diminished responsibility and was ordered to be detained pursuant to section 37 of the Mental Health Act, with a restriction order without limit of time pursuant to section 41 of the same Act. At the time of writing this report, she remains detained.

MEDICAL AND SOCIAL CARE IN THE CONTEXT OF RISK MANAGEMENT

This section looks in detail at the care received by Saheeda, both from Health and Social Services and considers it in the context of the management of risk. The findings show that the panel had some serious concerns over the way in which poor risk management impacted on the care given to Saheeda.

Clinical risk management is described within all of the guidance from national strategy documents to be the cornerstone of effective care management for people with mental ill health.

The Health of the Nation document, Building Bridges, identifies risk assessment as a key skill and refers readers to HSG(94)27 Guidance on the discharge of mentally disordered people and their continuing care in the community. Both documents set out to describe good practice that should be followed in relation to care planning and place particular emphasis on risk assessment prior to discharge.

There is of course agreement that the assessment of risk remains an inexact science. However, it is accepted that the key principle of risk assessment is to use all available sources of information as part of any assessment. Essential information collected should include:

- The patient's background
- Their present mental state
- Social functioning
- Past behaviours

The patient, staff observations, relatives, carers, or any significant other can provide this information.

The panel therefore, considered the care given by the Trust, Social Services and her GP, considered within the context of risk, in relation to (1) Saheeda (2) the children

Risks to Saheeda

The panel considered Saheeda's care and treatment against the baseline already described which identifies the parameters of accepted good practice in risk management at that time. The panel found, in particular, the holistic assessment to be lacking. Saheeda does not appear to have been viewed within the context of the whole family within their specific cultural norms.

Findings

1. The cultural norms in which Saheeda lived were not highlighted by her key-worker. Her husband described their life as one family with two homes, with his parent's house being the main residence. The hugely influential role of the

grandparents in the lives of the Saheeda and the children was not apparent in the key-worker's notes, although their interference and Saheeda's problems with them were. They were heavily involved in decisions relating to the children. Saheeda's husband describes his parents as loving his children so much, Nihaal in particular, that they treated them like their own children. He also admitted that Saheeda would be challenged by him or his parents for chastising the children, particularly Nihaal.

2. It is clear from most clinical notes, that Saheeda deeply resented the role her in-laws played and her husband's attitude towards her. What is not apparent in the notes, but became very clear once the panel had received evidence from a number of witnesses, including the family, is that Saheeda rarely, if ever, argued or voiced her discontent to her in-laws or husband. It is clear to see why the family was not fully aware of her deep unhappiness. It appears she kept her feelings to herself, only venting her frustration and despair to the professionals who met her. Her feelings of helplessness are well documented.

3. Whilst there were constant references to her presenting mental state on four separate occasions over the years when it was noted that she had relapsed due to stopping medication, there is no 'easily identifiable picture' of her repeated relapsing condition. None of the notes highlighted her tendency to relapse with psychotic symptoms when untreated.

4. In 1998 despite the recognised risk of relapse and what was a fairly recent relapse, due to medication non-compliance, Saheeda was de-registered from priority CPA with no effective monitoring in place other than outpatient appointments.

5. Furthermore the case was closed by the CAST team (Community Assessment and Treatment Team) as they were ostensibly set up to offer short-term interventions and her condition did not fit the criteria for the Community Support Team for the chronically unwell. She thus received only outpatient review on a fairly infrequent basis.

6. Her key-worker never accurately described or understood Saheeda's social activity/functioning. He was unaware for example that she and the children spent every day at her in-laws home, where Saheeda was expected to help with household chores, cooking and other family commitments and she spent every evening in her own house on her own with the children whilst her husband worked. Nowhere in her notes is there an accurate description of her activities of daily living and therefore no proper assessment could have been made of her ability to cope at home or identify the potential support or otherwise, the family could provide.

7. Throughout her contact with services Saheeda's diagnosis/illness changed, in terms of the treatment she was receiving, although postnatal depression did appear to continue as the perceived diagnosis for some time after. It was unclear from the case notes at what point the diagnosis shifted and therefore unclear for any one of the many consultant psychiatrists involved in her care, to know exactly what they were treating.

8. Saheeda was subjected to a number of changes of consultant involvement, which increased the risk of lack of continuity of care. There were problems with the number of doctors involved; their awareness of Saheeda's needs and problems, and, from the way the information was contained in the notes, there was difficulty accessing them in a busy outpatient clinic.

9. The risk of relapse was well documented and appeared in her clinical notes. The associate specialist in psychiatry saw her on the 04.02.2000 and agreed to stop her prescription for Sulpiride and Procyclidine. This was the first time he had met her. He had not read the note, identifying the risk of relapse, which appeared two pages prior to his entry and he was aware she would not be seen by him again as she was being transferred to another team due to sectorisation.

10. A locum consultant saw her on the 29.03.2000 and agreed she could stop her medication altogether. Saheeda had begged her to stop the medication. The locum consultant was not happy with the situation, as she did not know Saheeda at all, but agreed, providing Saheeda reduced it very gradually. She made an appointment for five months hence, which she accepts, with hindsight, was too long if she was to monitor Saheeda's withdrawal from medication. She accepted that four or five weeks would have been more appropriate. She thought the GP would be assessing Saheeda's mental health when she went for her prescriptions. This was not the case, nor had it ever been. The locum consultant also accepted she did see the note highlighting the risk of relapse if medication was stopped prematurely, and was aware that Saheeda had become depressed once before when she stopped. However, she pointed out to the panel that in 15 minutes it is impossible to assess a patient's full history and that if she'd had more time or a brief history she would have known Saheeda had a tendency to stop medication. She had asked for longer slots, as she was new to the hospital, but because of the number of patients and the shortage of doctors, this was not possible

11. The Kapde family feels particularly aggrieved that they were not well informed or included in decision formulation around her care, particularly around the events of the 1st to 6th June 2000. They firmly believe if they had been made aware of the risks, they would have been able to prevent the tragedy that followed. In the past, when she had been mentally unstable, she had been forced to stay at her in-laws by her husband so that she could be monitored.

12. The key-worker states he left Saheeda's husband monitoring the situation, however, he also accepts that he was aware her husband was out at work most of the time and was no real support to Saheeda and that his understanding of her mental health problems was limited.

13. The key-worker had made a detailed risk assessment on Saheeda. However, no attempt was made by him to alert the extended family to the obvious risk he assessed (at that stage suicide) The panel felt that given the fact that Saheeda and the children spent every day with the in-laws who were always the main carers for the children when her health deteriorated, this was an inappropriate omission. Although the panel recognised that the key-worker did not know her daily routine, it felt, as her key-worker, he ought to have known.

14. There was no attempt to obtain a further supply of medication for Saheeda, despite the fact that she had ceased taking it sometime previously and there were acknowledged risks around the cessation of medication.

15. The action that was carried out was the arrangement of an early outpatient appointment some 6 days later and an interim visit by the community psychiatric nurse. This might have been entirely appropriate if the family had been made fully cognisant of the level of risk, the degree to which workers felt her illness had relapsed and the level of monitoring this situation required. There was however an assumption made, by the key-worker, about the degree of family involvement, which was wholly incorrect. There appears to have been a total failure to appreciate the family dynamics partly in a desire to "keep the family out of it." The key-worker said that in the past Saheeda had not wanted her in-laws involved therefore he didn't feel it appropriate to involve them.

16. The community psychiatric nurse did not know Saheeda, had no knowledge of the wider family and was not aware of the suicide risk assessment carried out by the key-worker. It is understandable therefore, that she didn't involve them. The health visitor did not feel able to tell the family that Saheeda was unwell again as they had not been emotionally supportive of her in the past. As Saheeda was being visited by the mental health team and was attending outpatients the following day, she felt it was better not to involve them.

17. Following the assessment visit, despite writing a letter which indicated major concerns to the psychiatrist, the key-worker failed to pass on sufficient information to the rest of the community team and specifically to a new community psychiatric nurse who was to make the assessment visits after the weekend. The community psychiatric nurse unfortunately did not look at the file and therefore was unaware of the content of the risk assessment.

18. The panel members accept that they have the benefit of hindsight, however, the following information was well documented over many years:

    - her suicide attempts
    - her despair with her life
    - her anger with her in-laws
    - her belief she would be better off with Allah
    - the domestic violence within the marriage
    - her relapses if she stopped her medication
    - the lack of family understanding and therefore support, with her mental health deterioration
    - the fact her husband worked very long hours and she was left alone every night with the children

- her isolation from the community, she had no outside interests or friends

19. Given the knowledge of the real absence of any emotional support and the fact she would be at home alone with three young children, the panel felt the contingency plans put in place by the key-worker were simply not robust enough, especially as he had not seen Saheeda for some 20 months prior to this relapse.

Risks to the Children

Findings

1. Throughout Saheeda's contact with mental health services her children have been a major contributor to her overall presentation. However, the panel feels that the psychiatric services did not exercise their responsibility (under guidance set for risk assessment) in ensuring that the whole picture of her needs and problems in relation to the children were clearly identified or acted upon.

2. The main focus of their work was Saheeda or helping the husband/extended family deal with practical childcare arrangements.

3. No risk assessment was ever carried out on the children despite a referral to Social Services by nursing staff, and the health visitor regularly voicing her concerns to both Mental Health and Social Services staff.

4. During interviews with the extended family and the professionals it became obvious that Nihaal as the first-born male, was the favourite of his father and grandparents. Saheeda said he was 'spoilt' and difficult for her to manage at times. He was also described by Saheeda and clinicians, as hyperactive. Saheeda had called him 'Manhoos' on a number of occasions (which means bad omen) as he was born just before the death of her father. Her family in India blamed her for the bad luck of her father's death coinciding with Nihaal's birth.

5. Despite the fact that, on questioning, the family were quite open in giving this information, none of the clinicians involved in her care were aware of a number of these factors, and therefore their focus centred around the physical well being of the children when considering potential risk.

6. The overriding view of the clinicians involved in Saheeda's care, was that the children were always well cared for, clean, well fed and loved, and that Saheeda's interaction with them was 'appropriate.'

7. When she was an in-patient, the grandparents took over the main role as carers and once again the children were well cared for and loved. They wanted for nothing. However, all of the professionals involved, with the exception of the health visitor, did not appear to appreciate the risk her mental state posed to them.

8. As highlighted above, the following information was well documented over many years and posed a threat to the children as well as Saheeda herself:

    - her suicide attempts
    - her despair with her life
    - her anger with her in-laws
    - her belief she would be better off with Allah
    - the domestic violence within the marriage
    - her relapses if she stopped her medication
    - the lack of family understanding and therefore support, with her mental health deterioration
    - the fact her husband worked very long hours and she was left alone every night with the children
    - her isolation from the community, she had no outside interests or friends
    - and finally, the most significant indicator, her threat to kill one of the children in 1997

9. These indicators, some clearly suggesting that the children could be at risk, seem to have been discounted because the children were well cared for and loved.

10. After reading the records and hearing evidence, it became clear to the panel that there was no-one raising concerns on behalf of the children other than the health visitor. She felt other professionals were not really appreciating her concerns about risk to the children. She raised concerns with the following people:

    - the nursing staff on the ward in September 97 and urged them to refer the matter to Social Services when Saheeda threatened to kill one of the children.
    - three different people at Social Services Child and Family Team, including the manager, regarding the referral because of the threat to kill a child and the risks associated with home leave and discharge.
    - the Senior Nurse Child Protection in the Trust.
    - CPA review meetings.

11. The most significant incident in failing to address the risks to the children, was without doubt, the failure of Social Services to carry out an assessment on the children following the referral by nursing staff on 09.09.1997.

12. The chronology details the exact involvement of Social Services. The panel has concluded there were a number of failings within Social Services, which left the children at risk.

13. The initial referral from the ward should have been acted on whilst Saheeda was still an in-patient. There was a clear threat to kill a child; Saheeda had a history of mental illness and relapse. The fact that she posed no immediate risk whilst she was in hospital was not a valid excuse to delay some form of assessment of the situation. The referral was clearly of the type envisaged in section 47 of The Children Act 1989 (child at risk of harm) as opposed to a section 17 referral (child in need)

14. The case was not referred to a qualified social worker, it should have been. It was referred to a community care officer because the family were requesting practical support at the same time (section 17 support). His evidence to the panel was that it was never part of his job to assess risk to children, he was simply asked to offer the family practical support whilst Saheeda was in hospital. From comments made to the panel, it seems one of the reasons for allocating it to the community care officer appears to be his ethnicity. Whilst it is always useful to have someone with knowledge of the culture of the patient, it should never be a reason for allocating an unqualified worker in a case which clearly required qualified input.

15. The manager of the Child and Family Team, told the panel that in her experience a lot of parents, with psychiatric problems, threaten to kill their children. She said it was not an uncommon threat, and that Social Services had a number of referrals regarding mental health issues, social isolation and threats to children from mothers in the Asian community and therefore this referral was not considered unusual. The perceived commonness of threats to kill, was clearly refuted by the other professionals questioned by the panel and therefore, showed a marked lack of understanding of risk by the manager of the team, especially in relation to written threats.

16. It became clear to the panel, that Social Services expected the Mental Health Team to do a risk assessment on Saheeda to see whether she remained a threat to the children, before the Child and Family Team would involve themselves further. The fact that Saheeda was allowed home on leave and then discharged, seems to have been sufficient for Social Services to decide they were no longer required as, they pointed out, "mental health would not have let her home if she posed a threat to the children." This was an inappropriate assumption to make; they had a duty to follow up the referral, to reassure themselves, on behalf of the children, that there was no current or future threat.

17. Despite no assessment having taken place and when Saheeda was still an in-patient on the 15.09.97, Social Services first suggested closing the case. The panel could find no logic in that action whatsoever, save for the fact the service was under-resourced and over-stretched, a fact later confirmed by the team manager.

18. Despite the concerns voiced to the manager, by the health visitor on the 17.09.97 regarding her fears about the risk to the children and concern over their decision to close the case, the case was still not referred to a qualified worker to assess the situation. This was a failure, brought about by a marked lack of understanding of the risks involved.

19. Social Services accept that as a multi-disciplinary conference had not taken place prior to Saheeda's discharge, it would have been appropriate for them to call a child protection conference to assess whether any risk remained. They do however, point out that a large part of that assessment would have required the mental health team to have assessed Saheeda's mental state.

20. The only person from Social Services to attend the case conference/ discharge meeting on the 20.10.97 was the community care officer who as we know, was not qualified to assess the risk to children, he simply attended to confirm the practical support he was offering. The panel feel that, because there was no qualified worker from the Child and Family Team present at the meeting, the homicide threat to the child completely disappeared from the overall picture of Saheeda's care, the issue was never referred to again.

21. The panel feels very strongly that had an assessment of risk been undertaken at that time, then many of the family circumstances, from the aspect of risk to the children, would have become an integral part of a much more holistic view of the care Saheeda required. It is also felt that a child protection risk assessment would have ensured that the threat to kill one of the children would not have been 'lost' from the records.

22. It seems clear that Social Services responded to a section 47 referral of a child at risk, with a section 17 response to Saheeda's husband's need for assistance, which was wholly inappropriate in relation to the referral by nursing staff.

    We are pleased to hear that procedures are now in place to prevent that type of response in the future.

23. It was not only Social Services' failings that led to the threat to kill a child being omitted from subsequent records. Nursing staff made a thorough detailed entry about the concerns surrounding Saheeda, the suicide notes, the threat to kill, the concerns of the health visitor and the referral to Social Services. They correctly informed the lead nurse Child Protection, the health visitor and Social Services. However, it is clear from evidence given to the panel, that the nursing staff, following their referral, expected Social Services to act thereafter. A referral form should have been filled in by nursing staff, with a copy retained on file. There is no record of the form in nursing or child protection files.

24. There are concerns over the fact that once the referral had been made, there is no mention of it again in the nursing notes. Neither the key-worker, the health visitor, nor Social Services were informed when Saheeda was given weekend leave. They were all informed when she was discharged but no check was made by the nursing staff as to whether any assessment had taken place. Whilst the panel acknowledge that the onus passed to Social Services to take the matter

further, it feels there should have been some mechanism whereby nursing staff had to raise the issue of the referral before discharge. There is no suggestion in the nursing notes or clinical review meeting that this was the case.

25. The key-worker also failed to appreciate the complete picture of Saheeda's admission and the threat to the children.

26. He was informed of her admission on 05.09.97. He visited her on the ward on 08.09.97. He was aware of the suicide notes addressed to him but not sent. He wrote in his notes "she perceives herself to be very ill, will not get better and hence is a liability to the children." The suicide notes were with the clinical notes, he did not access them, and he told the panel he had never seen them and did not know there was a threat to kill one of the children. The threat to kill was clearly written in the nursing notes, as was the referral to Child and Family Team; he did not access those notes.

27. There was a CPA review meeting on the 10.09.97, which the key-worker attended. He reported to the meeting that he was very worried about her mental state and that a convincing suicide note had been written by her, had been seen and was now with her notes. He does not say who saw them, nor does he refer to the threat to kill a child. He informed the Inquiry panel he never saw the suicide notes.

28. He did not appear to be aware that a referral had been made to the Child and Family Team by the nursing staff because of the threat to kill a child. Ironically, he was aware that a referral had been made to Social Services from Saheeda's husband for family assistance and indeed he was very involved with the community care officer in trying to help the family with this assistance.

29. He received copies of a CPA review meeting dated 05.11.97 which he did not attend, which identifies the risks involved as 'risk to the children' When questioned about it he admitted he did not know why it highlighted the children at risk. He did not refer back to those present at the meeting to ascertain why.

30. As her key-worker, then panel felt it was a great failing on his part not to seek out the letters to assess their content. He appears to have made no attempt to read them, even though he was aware at least one was addressed to him and they were easily accessible. He knew her better than most people, it is difficult to see how he could have made reasoned decisions on how her care should progress, when he was not fully conversant with her thoughts at the time she decided to kill herself.

The panel believes this failure, on his part, in 1997 was to prove fundamental to his failure to recognise any risk to the children on the 1st June 2000. He realised Saheeda had deteriorated to a similar state to that when she was considered a serious suicide threat in 1997, but failed to appreciate she had also threatened to kill a child at the same time. He told the panel that had Child and Families been involved in doing a risk assessment in 1997 and found any risk to the children at that time, he would have involved them immediately in June 2000 when she relapsed.

31. The clinical review process was also of concern to the panel. The first clinical review was held on the 10.09.97 the day after there had been a referral to Social Services. The minutes are extremely brief but make no mention whatsoever of her threat to kill one of the children. The perceived risk is one of suicide only. The named nurse, the key-worker and the health visitor were not present at the meeting.

32. The following week the clinical review meeting minutes suggest that the Child and Families Team were involved due to suicide letter but again there is no mention of threat to kill a child and the perceived risk remains highlighted as one of suicide. All future clinical review meetings refer only to a suicide risk. None of the people involved in Saheeda's care at that time, i.e. the named nurse, the key-worker nor the health visitor, were present at any of the four Clinical Review meetings.

33. The medical notes for the 05.09.97 show that Saheeda was seen by a staff psychiatrist and then later by a senior house officer. The senior house officer noted that her husband brought in the suicide notes and that there were detailed plans for taking care of the children after her death. There is no reference to the threat to kill the child, yet it was clearly there. The panel can only conclude from this that either the very detailed suicide notes were not fully read, or the senior house officer did not take the threat seriously. We feel the former is clearly the most likely, given the knowledge in the profession that written threats like this are to be taken very seriously.

34. It appears that, apart from the health visitor, the senior house officer was the only person to read the notes. Unfortunately his omission to recognise and highlight the threat to the child meant that it never appeared in any of her subsequent clinical notes and therefore psychiatrists who assessed her thereafter were completely unaware of the fact.

35. The service response to Saheeda's initial phone call on the 1st June was quick and appropriate. The assessment made by the key-worker, who had not been in contact with Saheeda since 1998, appeared highly accurate and led to completion of a risk assessment, which clearly highlighted the main areas of risk. The assessment made clear mention of symptoms being identical to that leading up to her admission in 1997 and also included actions such as a letter to the GP and informing the health visitor.

36. There was however, no mention of previous threats to the children, which had clearly been completely lost from the picture in 1997. There was however a clear breach of a policy in that the scores attained in the risk assessment on the children, indicated that, at the very least, the senior nurse in Child Protection should have been informed. This policy was a draft policy that was being piloted and had been in active use for several months.

37. Every clinician who saw Saheeda between the 1st and 6th of June 2000 was fully aware that she firmly believed she would be prevented from ever seeing her children again if she was admitted to hospital on the 7th June. They all accept that her belief was absolutely real to her at that time. It was recognised that her

condition had deteriorated to a similar state as that in 1997. It was known her husband worked all the time and that he had little support for or appreciation of, her mental state. It was known she was socially isolated with no friends outside the family, yet it was still felt the children were not at risk because Saheeda had never hurt them in the past and had always interacted well with them.

The panel felt that the emphasis on the children's upbringing and well being meant other risks to the children were effectively ignored.

The GP's role in managing risk.

1. Saheeda's GP acknowledged the fact that he played a very small part in her mental health care as he assumed that secondary care services would actively follow-up and monitor all matters related to her care.

2. There was an unfortunate assumption by secondary care that at least some of this monitoring would be undertaken in primary care.

3. There were a number of missed opportunities where her primary care physician could have taken a more active role in Saheeda's mental health management.

Recommendations

1. The new Trust and all partner organisations must identify a named individual who is responsible for executing the clinical risk strategy. This should be a board level post.

2. Where a mental health client raises issues of domestic violence, especially where there are children involved, professionals must assess the situation effectively following agreed policy.

3. Social Services must deliver a more robust system, whereby the Child and Family Team must carry out an assessment of risk where threats to children have been raised. Such a system should not allow for individuals to make decisions on such issues until an initial assessment under Section 47 has been carried out.

4. Adequate training is required for staff within the Child and Family Team relating to risk to children and carers suffering from mental health problems.

5. Once a referral to Social Services for a child protection risk assessment has been made, involving an in-patient, systems should be set up within wards to ensure that the referral and its progress should always be taken into account in any subsequent decisions related to home leave or discharge.

6. The significance of the extended family and family dynamics must be addressed more effectively by all professionals involved in a client's care. Where child protection issues are involved this must be addressed by Social Services.

7. The key-worker should be central to the entire risk process from the beginning.

8. All main care workers should be present at clinical review meetings wherever possible. At the very least the named nurse and key-worker should be present at the first meeting to ensure no important details, relating to the state of health on admission, are missed.

9. A detailed discharge summary, pointing out the cardinal features of a patient's condition, treatment and risk of relapse, should always be completed.

10. The process of de-registering from Priority CPA must have an effective backup process identified at the time.

11. An appropriate structure should be agreed in terms of follow up needs of individuals, especially during a period of cessation of medication in vulnerable cases.

12. Clients must not be allowed to fall between the two elements of the service, Priority CPA and Standard CPA. A system capable of catering for the needs of an individual with a relapsing condition, that is not chronic, must be instigated with immediate effect.

13. The CPA process needs to be much clearer in terms of allocating roles and responsibilities and the paperwork needs to reflect those roles and responsibilities more effectively.

14. Consideration should be given to more flexible outpatient appointments, both in terms of length of appointment and ability to see patients earlier if necessary.

15. Greater focus on the role of primary care in the management and treatment of mental disorder in concert with secondary care should be achieved as part of the development of protocols under the National Service Framework.

THE EXTENDED FAMILY

It became apparent, very early on in the Inquiry process, that the extended family plays a central role in ethnic minority culture. Time and time again the panel received evidence of this fact. With that in mind this section looks at the extended family and its involvement in Saheeda's care. It also looks at the role of the professionals in working with the family. The findings are as follows:

Extended family's support.

Findings:

1. The panel commends Saheeda's family for the very extensive practical support they provided to her. They took very good care of the children whenever she was ill or was admitted to hospital and visited her daily.

2. Saheeda lived two doors away from her in-laws. She spent most of her day at their house watching TV and helping with the household chores and cooking. The in-laws and her husband took her shopping and felt that they were offering her support in coping with her illness.

3. Saheeda's husband and his parents were never fully aware of the nature of the illness from which she suffered. A staff psychiatrist explained postnatal depression to them in 1994. However, it is clear from conversations with her husband and his family and indeed from the practitioners caring for Saheeda, that the family simply couldn't understand the western concept of mental illness or the nature of Saheeda's relapsing condition. The panel therefore feels that it would be somewhat unfair to criticise the family for not offering emotional/psychological support to Saheeda.

4. They trusted the practitioners and believed that everything was being done to treat Saheeda's illness. The key-worker and other members of the team had tried to explain to her husband how he could help Saheeda to deal with her illness, but the extended family were never involved in these discussions.

Role of professionals in working with the family

Findings:

1. Evidence suggests that the mental health practitioners had no contact with Saheeda's extended family.

2. The key-worker used to have discussions with Saheeda's husband regarding her illness and treatment, however he told the panel he felt her husband didn't fully appreciate her mental health problems. Her husband says the key-worker did not discuss with him the possible risks involved if Saheeda stopped taking her medication or any perceived threat to the children. The key-worker gave evidence

that he never believed the children were at risk because of Saheeda's interaction with them.

3. Apart from the health visitor, no member of the team visited Saheeda's in-laws to assess the family circumstances. The panel feels this was an unwise decision given that Saheeda had discussed, at length, with many professionals over the years, her unhappy relationship with her extended family.

Service provision

Findings

The panel is of the opinion that the professionals did not provide an appropriate level of service to Saheeda and her family. Some of the failures could be considered as failing to provide statutory service to her and her children. The following are indicators of shortcomings in service provision.

1. On 6 June 2000, when Saheeda's sister-in-law asked the health visitor the reason for her visit, she was not given any indication about Saheeda's relapse, or the serious nature of her illness. The family felt that they would have supported Saheeda and looked after the children had they been told about the serious concerns of the practitioners.

2. The team didn't appear to support Saheeda with the problems she was experiencing within the family and which were clearly affecting her mental health. Except on one meeting between the family, Saheeda and community elders on 03.07.95, little attempt was made to help her to resolve her difficulties.

3. There is lack of documentation relating to the family environment and background. The case notes do not reflect the family's lifestyle or the different views held by the family members regarding Saheeda and her children's relationship with them.

4. Failing to take appropriate action regarding incidents of domestic violence, which were known to the services.

5. Although it was known Saheeda's husband had little appreciation of Saheeda's mental health and was out of the house most of time, the key-worker and the team were quite happy to leave him in charge of caring for Saheeda and monitoring her mental health when she was considered, at times, a high suicide risk.

6. Good practice dictates that practitioners should explain, to the nearest relative, the nature of the illness and any risk issues. Her husband, as the 'nearest relative' lacked understanding of Saheeda's mental health problems and apart from an explanation of postnatal depression in 1994, he felt he was never given a proper explanation as to the nature of her illness.

> ***The panel appreciate that this may be down to her husband's lack of comprehension, however, this fact was known to the practitioners and it is***

felt that more effort should have been made to involve him and the family in more detailed discussions on the current state of her mental health, particularly on the 1st June 2000. Saheeda's husband accepted that the key-worker had told him why they were there and what was going to be done. However, he had no idea she had relapsed to a state similar to that in 1997 when she was a suicide risk nor was he told she had stopped her medication.

7. It appears her husband was never informed about the change in Saheeda's diagnosis. He believed that she was suffering from post-natal depression, from which she would recover. He was never informed, or never understood, about the psychotic nature of her illness.

Recommendations:

1. Practitioners should recognise the extended family culture in ethnic minority families and consider involving them in the care and treatment of an individual, if a holistic approach would benefit the person.

2. It should not be taken for granted that members of the ethnic community understand or do not understand the Western European concept of mental illness. The onus should be on the professionals to assess the situation and to fully explain to those concerned.

3. If it is recognised that the family has little understanding of the psychological difficulties of their relative and that little or no emotional support is forthcoming, this MUST form part of the risk assessment process. It must not be assumed that, because a mentally ill patient has practical family support, the risk factors are low. If that family does not appreciate the concept of mental illness and feels, as in this case, the patient is "putting it on" then the situation can be made far worse.

4. Statutory responsibilities should not be overlooked because of cultural factors. Practitioners should not be afraid to carry out their duties, by perhaps involving themselves in family matters, for fear of being seen as racist.

5. Clinical managers should take responsibility for supervising and monitoring complex cases, so that any failure of provision of services is identified at an early stage.

ETHNICITY AND CULTURAL DYNAMICS

It became clear to the panel that there were many problems in delivering an 'appropriate' service to the ethnic minority community and this had a distinct bearing on the care received by Saheeda. The problems lay in areas such as training, risk management and communication in the context of ethnic minority services. It was therefore felt that this report should contain a separate section covering these difficulties.

The panel appreciates that some progress is being made in delivering services to the ethnic minority community both by Health and Social Services. The service has become more positive in recent years, in respecting cultures, individuals and individual needs. A transcultural team was established in 1999 and was made up of representatives of each locality. Its role was to look at the needs of teams, in terms of working with ethnic minority groups and to provide training about culture and mental health issues.

However, the transcultural service suffers badly from a lack of resources and staff, this has had the effect of dampening enthusiasm within the team and creating a feeling that the service is little more than a token gesture. However, on a positive note, it is felt that Dewsbury has better services than many other areas. Apart from the transcultural team, there are a number of other services available, including, outreach workers, community assessment, Muslim chaplains, Pakistani and Kashmiri Welfare Association, the Al Hikma Centre, user and carer groups, Clover Leaf, K.A.F.A.S. and respite care for the elderly. There is however, no respite care for adults who will not use a mixed sex home because of religious reasons, and there are no real services for younger people. The users and carer group lacks crèche facilities, which is proving a big disadvantage.

It was reported that many of the younger members of the ethnic community now accept the concept of mental illness, however, the older generation does not. This not only causes problems for the older generation itself but also for young people living within the group culture. If the extended family do not accept the illness, they are of little support to the younger generation.

All those spoken to confirm the fact that working with ethnic minority families takes more time than usual.

The main issues, which the panel identified as being of major significance and concern, undoubtedly effected the care and treatment given to Saheeda Kapde, they are as follows:

Was the service provided culturally sensitive, acceptable and did it address her needs?

Findings

1. Health and Social Services were made aware, 9 years ago, through Zaffer Iqbal's report, that service provision to the ethnic minority population was inadequate,

since then the percentage of ethnic minority families in the area has vastly increased yet the service, according to the evidence given to the panel, remains inadequate.

2. The professionals interviewed stated that they were not equipped to deal with the different cultural 'nuances' of these communities without proper training and knowledge.

3. The panel does not wish to be critical or lay blame on any individual's doorstep for the failures in providing a sensitive and supportive service to Saheeda and her family, however, the panel feels that, except for those GPs and psychiatrists who came from 'similar' ethnic background, the mainstream professionals had little understanding of the different cultures 'within' the ethnic community itself. For example they were unable to identify that Saheeda's Asian culture from Bombay differed from the Asian culture of her in-laws and the local community who were mainly from Pakistan and that this may be one of the reasons she was socially isolated.

4. Saheeda was provided with interpreters who spoke Gujarati and Urdu while her mother tongue is actually Konkani. The explanation for this may be that there was no one who actually spoke her mother tongue and a third language was used, however, there is no record of that in her notes. Nuances of languages can be lost when translators are using a 'core' language for example Urdu, rather than a local language. Having said that, the panel members' own experience with Saheeda was that she speaks good English and is able to understand and express herself quite well in English.

5. Prior to her marriage and subsequent life in England, she was studying for a Bachelor of Commerce Degree at Bombay University in India. She was a bright articulate woman, looking forward to a brighter, better future. This was well recorded in all of her notes and recognised by the professionals involved, however, there is no suggestion in the notes that this formed any part of the evaluation of her life within the extended family.

6. The panel feels that the basic code of practice in mental health and core professional judgements, were perhaps unduly overshadowed by concerns about 'dabbling' in race and ethnic issues. Saheeda and her husband were therefore offered more support on practical issues as opposed to emotional and psychological intervention, both by Social Services and Health Services**.**

7. The professionals did not address the emotional and relationship issues, which were major contributory factors in Saheeda's mental health difficulties. The panel felt that the key-worker in particular did not have a proper understanding of the dynamics of the extended family and therefore limited the remit of his work and involvement to Saheeda and her husband.

This criticism is levelled at the lack of training of the professional and not the professional himself.

8. The panel recognises the difficulties involved because of patient confidentiality, however, it feels the services should find a way of including the extended family into the care plan without breaching patient confidentiality, especially when there are issues involving suicide risk or there are children in the family.

Training on cultural dynamics.

This has been covered in detail in the section on training, however, to reiterate, it is the panel's belief that given the size and diversity of the ethnic population in the area, training was inadequate, should have been far more detailed and, without question, should have been ongoing and mandatory at all levels.

Educating and informing the ethnic community in Mental Health issues.

Findings

1. The evidence given by the professionals clearly indicate they are aware of the fact that, in general, the Asian community in the area lacks proper understanding of the concept of mental illness.

2. Mental health problems are either perceived or presented in a somatic context or they form a part of superstitious and spiritual beliefs. Somatisation of depressive illness is a common practice in the ethnic community. Hallucination and delusions are rationalised as spiritual experiences. It is not unusual for families to pay substantial sums to Muftis (religious men) to drive out the evil spirits. The concept of "mind" and mental illness is very difficult for them to comprehend, because of their beliefs. Mentally ill people can be termed 'pagaal' which is a derogatory word similar to the English' Loony.' They fail to access the services due to their lack of knowledge of mental illness, which is compounded by the stigma attached.

3. Evidence indicates that not enough effort has been made to educate the community in recognising mental health problems, in a manner that would help them to accept it as any other form of illness. A religious leader emphasised to the panel members the importance of describing mental illness in a way that is seen as acceptable to the community, perhaps as a chemical imbalance and therefore a medical problem.

4. Whilst it is acknowledged that interpreters are available within Health and Social Services, it was made clear to the panel that there are simply not enough.

5. It was noted that there is still distrust between some professionals and interpreters, generally due to the lack of confidence in whether conversations are fully and completely translated. If more interpreters were available and were used regularly enough to become part of a team, this problem should be eased somewhat. It was also noted that professionals can find it difficult to work through interpreters as the main relationship develops between the client and the interpreter and the key-

worker feels like a third party. These issues will have to be dealt with if the system is to work for the benefit of the client.

6. However, interpreters were seen as vital to the delivery of services whilst there remains a deficit of ethnic minority staff. It was stressed that translators must be trained and valued as part of the team, irrespective of whether they are salaried or volunteers. Interpreters have to pass a language test but do not have any compulsory training in mental health.

7. It was also considered essential that interpreters are fluent in English as well as the chosen language. Nuances of languages can be lost when translators are using a 'core' rather than a local language. It was welcomed that more Punjabi translators were becoming available.

8. One of the areas highlighted as an essential vehicle for educating the community and encouraging young people into the profession, was the Careers Service. At present, NHS posts, other than doctors, are not seen as desirable to the ethnic community. Encouraging more people to have a career in social or mental health services will have a double benefit. It will solve some of the ethnic minority staff shortages and create more 'messengers' in the community. It was also emphasised that career paths should be available for 'good' ethnic minority staff. This was not said in the terms of positive discrimination, but in the context that some very good ethnic minority staff were not finding their way up the ladder very easily.

Financial commitment to Ethnic Minority Services.

Findings

1. The panel was concerned at the lack of sufficient financial commitment by Social Services, the Health Authority and the Trust towards providing more 'appropriate' resources and training.

2. Whilst it was not made specifically clear, it appears, from evidence given to the panel, that Social Services' training commitment towards race and ethnic minority issues appears to be limited to the Approved Social Workers training programme. This cannot be considered adequate for ongoing practice.

3. In giving evidence, the managers expressed their inability to allocate more funding and acknowledged that the percentage of money spent on mental health in Dewsbury district is less than the average amount spent in the Yorkshire region

4. The lack of sufficient Muslim Chaplains was highlighted as a problem. Services need to recognise that ethnic minorities, more often than not, pay more attention to their religious leaders than to their doctors. The panel was told that there had been occasions when lives had been put at risk because there was not a Muslim Chaplain available to confirm that a particular treatment was acceptable to Islam.

5. The panel was informed there was no marriage guidance services available which was specifically designed to deal with the particular problems experienced by the ethnic community.

6. There appears to be a distinct lack of funding for schemes to help the ethnic community understand mental health issues.

7. The most disappointing aspect in relation to financing ethnically sensitive services was the fact that in 1993 Zaffer Iqbal produced a report on developing a Transcultural Mental Health Service in North Kirklees. Many of the observations and recommendations were not acted upon. Some 9 years later this report is outlining the same problems highlighted then. The panel makes no apologies for repeating some of Zaffer Iqbal's findings here, as they are clearly relevant in light of this report.

   "Research has shown the extent to which, in many cases, local Asian patients are given practical and emotional support by their immediate family. However, in many cases, the lack of understanding with respect to the patient's illness has been known to exacerbate the situation, resulting in the regression of the users mental health"

   "Family systems have been shown to be causal factors in the maintenance and outcome of psychiatric disorder, and intervention at a family therapy level will curb potential relapse, help enhance well being, and give the patient and her family a constructive insight into psychiatric health"

   "The majority of support to the patient was provided by the immediate family. Local community support was regarded by many as undesirable"

   "complex issues have to be understood with regard to community politics, socially accepted norms and group behaviour, which effect the users decision to use a service or not"

   "The insular nature of many family systems along with community/peer group pressure, result in many families trying to cope with a mentally ill relative"

   "The need for information about their illness for themselves and their family as well as assistance with practical issues was seen as the main areas that services should try to improve"

   "Overcome the taboo associated with mental illness….provide the Asian community with a concept of mental illness they can recognise"

   "Non-conformity to long term use of medication is possibly more prevalent in the Asian community…if no concept of mental illness exists and none has been explained to the patient in a language they will understand, expecting stringent conformity to long term drug therapy is implausible"

"In order to incorporate the needs of the local Asian community into the psychiatric service structure, the first step will require the education of the community with regard to mental illness and, following on from that, their feedback as to the exact needs of this community will have to be integrated into the present service"

The import of ethnic minority culture into the formulation and development of procedures and policies

Findings

1. Nearly all the practitioners we spoke to said ethnic minorities do not understand the Western European concept of mental health. Asian and Eastern cultures are group cultures, Western cultures are individual cultures. Delivering individual based services to a person living within in an ethnic group/extended family culture, is like trying to complete a jigsaw puzzle with central pieces missing, the whole picture is impossible to comprehend. The panel did not find any concrete evidence to suggest that this issue had been properly addressed or given consideration when policies and procedures were being formulated or revised.

2. The panel did not see any documented evidence to indicate that, prior to the incident, either Health or Social Services had any planned strategy or implementation plan for the delivery of culturally sensitive services to the ethnic community.

3. The panel got the impression that ethnic minority issues were unfortunately always at the 'bottom' of the agenda whenever any 'action' or 'financial' commitment was necessary.

Recommendations:

1. The Western European model of mental health and social services, currently being delivered to the ethnic communities, be urgently reviewed and reconsidered in recognition of the findings of this report.

2. The service deficits raised by Zaffer Iqbal in 1993 and repeated in this report be reviewed and acted upon without delay. A structured plan of educating and involving the community be considered a priority and financed appropriately.

3. A much greater commitment to inter-faith chaplaincy should be provided within the newly reconfigured Health Services.

4. More interpreters, both salaried and voluntary be recruited and appropriately trained in mental health issues.

5. Health and Social Services should consider commissioning, in conjunction with the voluntary sector, a family guidance service appropriate to the ethnic minority community.

6. All policies and procedures should reflect that minority issues have been given proper consideration.

7. Practitioners from ethnic minority backgrounds and or professionals with experience in working with the community should always be involved at policy making stage so that the policies reflect and address the actual service requirements of the community.

POLICIES AND PROCEDURES

On reviewing various policies and procedures the panel was presented with many different presentations of information. They were extremely difficult to follow and it was difficult to ascertain which policy/procedure was in force at the relevant time. The way in which they appeared to have been formulated was confused with no clear expectation of presentation to an agreed standard.

Policies in General

Findings

1. The information provided by Directors to the panel, was that there was indeed no agreed standard (apart from statutory responsibility with policies that pertained to the whole trust) and that wards / departments wrote their own. This was certainly true of the examples considered by the panel.

   The policy/procedures were generally confusing, not dated or signed with no apparent system of introduction, training or review.

Record keeping and related procedures

Findings

1. The panel had access to the original files pertaining to Saheeda. These are listed in Appendix D The standard of record and record keeping within the mental health and health visiting services was generally of a good standard. Regular notes were kept of all interviews with Saheeda. However signatures were not always present. When they were present they were often indecipherable and rarely indicated the person's position within the organisation.

2. The Social Services file carried very little information. In particular the panel was keen to establish the rationale for no risk assessment having been completed on the children in September 1997 when the referral from nursing staff on the in-patient ward was completed. That referral identified very clearly the threat to the children. There is no indication in the records of how the decision to allocate the case to an unqualified worker, who was neither appropriate nor able to carry out any such risk assessment, was made. There is indeed an entry in the Social Services notes on the 17.9.97 regarding a discussion that had taken place between the health visitor and the manager where it is acknowledged that Saheeda had threatened to kill herself and a baby. No action was taken.

3. There were reported missing letters written by the health visitor to Social Services. No letters pertaining to the concerns of the health visitor regarding closure of the case in 1997 were found either in the Social Services file or the health visitor's records.

4. There was one letter in the clinical records, to Saheeda's GP from a consultant psychiatrist following an outpatient appointment. The letter was very detailed and highlighted the fact that she had stopped taking her medication and there had been a reoccurrence of her symptoms. This bore no relation to the account he wrote in the clinical file, which consisted of the words, "satisfied, no change." The consultant has no recollection of this or how it could have happened, but the danger of such an oversight is clear, given Saheeda's propensity to stop taking medication.

5. There was important information in the case notes that members of staff appear not to have read or remember anything about. These were letters written by Saheeda in 1997, which contained crucial information regarding her thoughts and feelings about herself and children at the time. From within the system that existed, there appeared to be no system in operation that could clearly indicate these letters could be crucially important as risk factors for both Saheeda and her children at that time or any time in the future.

6. The clinical notes did not facilitate quick or easy recognition of crucial information. This was particularly important in this case as Saheeda had a number of changes in her consultant care.

Care Programme Approach Policy and Procedure

Findings

1. The C.P.A. was required to be introduced in England during 1991. Dewsbury Healthcare NHS Trust, like many other organisations nationally was slow in implementing policy but by 1994 had appointed a C.P.A. co-ordinator whose background was in social work.

2. The most recent documentation provided to the panel was dated 21.8.95. This agreed document was therefore in operation at the time of the incident. On reviewing the document the panel found it extremely basic with little reference to process, or outcome.

3. Dewsbury had chosen two categories of the C.P.A., basic and priority. Basic C.P.A. is classed as not being 'registered ' whereas priority describes multi-disciplinary involvement and on an active case register.

4. There was no interim level of CPA registration for those clients who needed more than basic level but less than priority.

5. The panel acknowledges that those people interviewed were very 'comfortable' with the CPA system that had been in operation for a number of years. However, it is the view of the panel that it is cumbersome system for a number of reasons.

6. A number of meetings exist and operate. They are:

- Clinical reviews: attended by the full multi-disciplinary team on a weekly basis.

- C.P.A. Review/Case Conference between the professionals and the user/carer/advocate.

- Monitoring panel meeting. Monitors how the client's care is progressing, attended by the CPA co-ordinator a doctor and the key-worker

7. Each of these meetings has an independent chair and note taker. The chair will be either the C.P.A. co-ordinator or the senior nurse manager mental health. Neither of these people are clinicians involved in the care of patients although they may build up knowledge over time.

8. The clinical review meetings are held weekly for in-patients and are separate from the ward rounds. As can be seen by the example of this case, potentially major issues can be missed if the right people do not attend the meetings.

9. CPA review/case conference meetings are held for outpatients and should be attended by all clinicians as deemed necessary. However, there were a number of instances where the main care workers were not present at the meetings and it was rare for the health visitor to be present at Saheeda's meetings, which was unfortunate as she was the one who kept raising the concern about risk to the children.

10. Monitoring meetings were held between the CPA co-ordinator who would chair it, one of the doctors and the key-worker. Their purpose being to monitor the patient's care and how things had progressed since the last CPA review. These meetings appear to be a much shorter 'mini' version of the CPA review meeting.

11. Detailed minutes are not made in any of the meetings. In particular, anyone not present at the clinical review meeting would find the minutes of no use in clarifying either the content or the decision making process.

12. Summary notes exist but as can be seen in this case, important information can be lost. Both a clinical review meeting and a CPA meeting were held on the 10.09.97 neither highlights the threat to kill a child, only the CPA meeting mentions Saheeda's suicide notes, neither detail the summary of discussion sufficiently.

It is the opinion of the panel that so many different meetings, albeit they are described as having different functions, seems repetitive. It appears to be a bureaucratic system. There are different files, kept separate from case notes, for some meetings. Others result in communication to all people involved in that person's care and some are reduced in size to be stuck on pages in the medical case notes.

The panel was concerned that on a number of occasions important information was lost. Clinicians acting as key-workers need to feel

ownership of the process and when reviews are 'managed' and chaired by others, it may relieve them of their responsibility in real terms.

13. It is clear from the evidence given to the panel, that the key-worker takes somewhat of a back seat when the client becomes an in-patient. Whilst the panel recognise this will happen to some extent, nevertheless the key-worker should retain responsibility for patients when admitted, according to the principles of 'in-reach' as opposed to handing over total responsibility to the in-patient staff.

14. Because of the findings outlined above, the panel felt the care planning process was not as effective as it could have been.

- It did not address all of her needs as information was missing.
- The plethora of meetings, the fact that important 'players' did not always attend the meetings, and the limited effectiveness of the paperwork, meant the plan was not drawn up as effectively as it could have been.
- Professionals always effectively delivered the planned services, however, as the plan was defective in areas, this meant the most appropriate service was not delivered.
- Saheeda did not always comply with her care plan as can be seen from the chronology. Her relapses were caused by her ceasing medication inappropriately and she failed to attend some outpatient appointments.

Recommendations

Policies in general

1. The panel recommends that through the clinical governance system in the NHS and allied systems within the Local Authority, guidance be given on a standard to be achieved on the production of any new or revised policy. It should include:

- The involvement of 'appropriate' key staff in the production of the policy or procedure. Appropriate, in this context, meaning those with specialist knowledge in that particular area.
- Drafts agreed, should be presented through a clinical governance and/or Local Authority equivalent sub-group to check and endorse the education and or training planned for all staff affected, prior to its formal introduction.
- Policies/procedures that are then introduced should be piloted and reviewed.
- Agreed policies should be dated and compiled centrally as well as being available on all wards and departments.

Record keeping and related policies in Mental Health Services

1. The Trust should ensure that in line with the national standards on records and record keeping all staff within health services should be required to date, sign and identify their profession/position legibly.

2. The Trust should ensure that case notes carry a summary sheet, which is easily accessible, that indicates past and present indicators of risk to self and or others.

3. Medical notes should contain clear summaries of in-patient admissions that are in a different colour to the ordinary correspondence and easily identifiable.

4. Important issues, such as suicide notes, should be fully read by the professionals involved, including the key-worker, recorded and highlighted in the notes for future reference.

5. The Trust should, as a priority, embark on an audit of records and record keeping that scrutinises on the basis of the above recommendations.

Care Programme Approach Policies and Procedures

1. The C.P.A. policy and procedure should be reviewed urgently.

2. The new system should place the client and key-worker at the centre of the process

3. The CPA policy should describe, in detail, a streamlined system that does not separate responsibilities of good clinical practice from documentation.

4. The system must identify roles, responsibilities and time-scales for actions and the documentation should reflect this.

5. The key-worker should chair the meetings related to their clients, 'assisted' by the administrator.

6. The care plans, produced at these meetings, should be periodically reviewed by a clinical supervisor.

7. The key-worker should be recognised as retaining responsibility for patients when admitted, according to the principles of 'in-reach' as opposed to handing over total responsibility to the in-patient staff.

COMMUNICATION

The details on page 8, Background to Services, describe how mental health services were managed in the area. The panel found that whilst much communication took place between the services and internally within each service, there were many shortcomings in relation to the quality of that communication. The panel's findings and recommendations, in relation to this incident and in general, are as follows:

Communication within the management structure of the Trust

Findings

1. The link between mental health services and the Trust Board was through the Director of Primary Care. The Director of Primary Care had no background or training in mental health and his contact with services was through a general manager responsible for the mental health directorate.

2. The Director of Primary Care is a full member of the Trust Board. There is a mental health committee, which is a sub-committee of the Trust Board that fulfils the Non-executive responsibilities as 'managers' under the Mental Health Act '83.

3. Feedback to the Trust Board from the mental health directorate was through reports on a range of issues relating to quality, practice development, financial performance and clinical effectiveness.

4. Reporting to the Trust Board would only take place on a two or three monthly basis with the exception of specific reporting, when necessary. Not all serious incidents were reported to the board although the Chief Executive and the Regional office of the NHS Executive were informed.

5. This particular incident was reported to the Trust Board but not until some time after the incident (August 2000). At no time did the board receive formal documentation on this incident; various directors gave only verbal feedback.

6. As part of a Whole District Trust, the mental health directorate is managed as one of many competing specialities. It appears to have been difficult for the Trust Board to provide guidance and focus to mental health because of so many competing demands and particular pressures for the Trust, as for many others, around waiting lists, operating lists and a constantly changing agenda. The mental health service felt marginalized by the board's apparent lack of understanding or interest in the pressures and policy driven changes in mental health.

7. The mental health directorate has a mental health board made up of Health and Social Services staff. There is also an operational management group. The board is supposed to meet bi-monthly but the panel notes, for various reasons, usually diary restrictions, it has not been meeting regularly, this was a real concern to the panel.

Communication between professionals

Findings

1. Clinical Review and CPA review meetings were often held without key-members of the care team present. This will have hindered communication within the team and distorted the complete picture.

2. The panel appreciated that the administrator of the CPA review system always sent out copies of the minutes and care plans to members of the care team, whether they were present at the meetings or not, however, very few of these were actually found in the professional's notes on the patient, with the exception of the clinical notes, which did contain copies.

3. The referral by nursing staff to the Child and Family Team does not appear to have been communicated to the key-worker.

4. Saheeda's home leaves, other than her final discharge, were not communicated to other members of the care team. There was no community team support for her, during these times, because of this.

5. The health visitor's numerous verbal concerns, regarding risk to the children, were not heeded.

6. When Saheeda's care was transferred between consultants, there was no communication, other than clinical notes, on handover.

Recommendations

Communication within the management structure

1. In Trusts where mental health services are managed, the Board must find a way of having appropriate representation at board level.

2. The panel recommends that, apart from the Chief Executive and the Regional Office, serious incidents should always be reported to the Chair and Non-Executive Directors of Trust Boards. The appropriate Child and Family process, within the serious case review procedure in Social Services, should also be informed.

3. The joint agency procedure "When Things Go Wrong"(97) should be updated to include the Trust Board's involvement. This involvement should be the incident reporting, subsequent action and an account of lessons learned.

The panel is aware of the proposal to establish a new specialist NHS Mental Health Trust across Calderdale, Kirklees and Wakefield. The panel strongly endorses this.

Communication between Professionals

1. All key members of a client's care team must be present at review meetings, except in exceptional circumstances. Where children are involved, this should always include the health visitor.

2. If a worker cannot attend a meeting, a written report outlining their assessment of the situation, as at the date of the meeting, should be submitted.

3. Minutes of review meetings should be as detailed as possible and in any event, should identify why specific decisions have been taken.

4. All members of the care team should receive a copy of the minutes and care plans and file them with their papers.

5. The key-worker should always be informed of any referral to child and families team and receive a copy of the paperwork.

6. If any professional within the care team (care team in the widest sense, meaning hospital and community staff at all levels) has concerns about a client's care or risk management, they should inform the key-worker and follow it up in written form (no matter how brief) to all members of the care team.

7. Concerns raised by any professional involved with the family, should be discussed at review meetings, minuted and reasons given for any subsequent decision taken.

8. Those members of the care team who need to be informed when a client is discharged from hospital, should also be informed when interim leave is given.

9. Communication between clinicians when a patient is transferring needs to be by provision of detailed summaries and meaningful hand-over notes.

TRAINING ISSUES

The panel received confirmation of training opportunities available, which relate to areas of concern contained in this report. They are:

- Race Ethnicity and Health Strategy Action Plan 2000
- Risk Management Training
- Mentally Ill Parents and their Children
- Transcultural Awareness Training
- Race Ethnicity and Health Workshops
- Honos Plus Training
- Race and Mental Health (joint training health and Social Services)
- Good Practice in Mental Health Assessments
- Children and Domestic Violence
- Supervising Child Protection
- Managing cases where parental illness has an impact on the child's development needs.

Our terms of reference require that we examine the appropriateness of the training of those involved in Saheeda's care. Clearly some initiatives have been put in place to attempt to address the needs of the ethnic minority community since the incident, although the panel has been told it is still not meeting the training needs outlined in this section. However, it is clear there was very little training available prior to June 2000. The panel found many shortcomings in the training strategies of both the Trust and Social Services, not least the fact that no courses were mandatory, many lacked the specific detail required to facilitate appropriate services to the community and they were generally under resourced. The most redeeming and positive fact that came out of the Inquiry process was that all professionals and managers interviewed, agreed that training in ethnic minority issues should be mandatory for all.

Our findings are set out below.

Training in Ethnic and Cultural Issues.

Findings

1. The panel specifically wishes to recognise and acknowledge the efforts of the Transcultural Co-ordinator who is involved in structuring a training programme and facilitating and co-ordinating the interpreter service within the elderly mental health service. He should be commended for his interest and input into training, as this work was in addition to his job as a full time community psychiatric nurse, carrying a caseload of 20 to 30 patients. 20% of his time is committed to training. Although he informed the panel that to do the job effectively it would require a full time post.

2. There are also a number of other staff who dedicate much of their time to improving and developing ethnic services. The panel had an overall impression of

many practitioners trying to improve services with extremely limited budgets and very little 'real' support or understanding from senior managers.

3. One of the most significant developments in relation to training appears to be a report from Roland Self (Consultant Clinical Psychologist) In 2001 he produced a proposed Transcultural Network Project as a response to the problems of providing high quality, accessible mental health services to the ethnic population. The aims of the Network are

    - To reduce inequalities of access and delivery of mental health services to ethnic minorities by making the mainstream service more effective and accessible to these groups.

    - To provide specialist transcultural services to people who cannot use mainstream services because of barriers of language, culture and other special needs.

4. The aims are to be met, in part, by specific extended training to selected workers in transcultural working, plus all mental health staff are to receive 3 days training over a period of one year, in ethnic sensitivity, race and mental health and transcultural working.

    Whilst the aims of the Transcultural Network are to be applauded concerns have been raised to the panel that, despite its good intentions, the training expectations are unrealistic. No separate training funds have been allocated to the project. To release all mental health workers from their posts, for three separate days over one year, would be impossible, as there would be insufficient funds or staff to backfill the posts.

    Also the transcultural network does not address the more specific issues of training staff, in the nuances of ethnic group cultures and extended family dynamics, which this report is more concerned with.

5. From the witness statements and documents/reports available to the panel, the Health Trust and Social Services did not provide 'adequate' on-going training to their employees in the area of race, culture and mental health. The training that was given was limited in quantity and quality.

6. The meeting attended by the social worker in 1995, which she described as chaotic, is a common way of resolving family disputes in the ethnic community. If professionals do not understand how the system works they will not be able to support the client effectively. A religious leader advised us that any professionals attending a family 'meeting' to resolve disputes, should always take an Asian worker with them.

7. It was commented upon that some white workers feel uncomfortable 'dabbling' in family affairs, for fear of appearing racist. However this is the way the ethnic community resolve their family problems. It was deemed essential that workers develop good contacts in the community in order to seek help on these issues.

8. It was acknowledged by almost all the managers and practitioners that the training provided was insufficient to deal with the complexity which surrounds mental health issues in the ethnic community and the concept of a group culture within the community.

9. The practitioners have received only basic training in cultural issues and most of the senior managers have received none. The content of the training course dealt largely with issues like language, religion, diet, names and dress code etc, rather than with race, ethnicity, cultural barriers which effect perception and acceptance of mental illness as an illness.

10. The Trust accepts it has a difficulty in recruiting and retaining ethnic minority staff, which is of course a problem throughout the NHS. However, there was feedback from at least one ethnic member of staff who felt that the failure to prioritise ethnic minority service issues was leading to low moral amongst all those staff who are trying to improve the service. The Trust should recognise the effect these concerns may have on staff recruitment.

11. It appears that since training in ethnic and cultural issues is not mandatory many of the managers and professionals do not feel obliged to acquire knowledge in the area to enable them to provide the service.

12. The panel felt that there was a general appreciation of the fact that the Western European concept and treatment model of mental illness does not always fit the ethnic minority needs. However, there was little evidence to suggest that efforts were made to modify Saheeda's care and treatment plans to suit her individual needs given her specific cultural background.

The health visitor's training

Findings

1. The health visitor's role is to check on the well being of the children and to advise where appropriate. Whilst she clearly has a duty to alert other services if she feels there is a risk to the children, she is not trained to assess that risk.

2. She was the lone voice in trying to push the matter of risk of harm to the children, onto the agenda after Saheeda had threatened to kill one of them in 1997. However, she was not trained in assessing that sort of risk, which is perhaps why her concerns appeared to have carried little weight with other professionals.

3. She had never undertaken, or been offered, any training on dealing with mentally ill main carers of children. She felt that better, ongoing training in this area would benefit health visitors and patients. The panel agrees.

4. Despite the fact that her caseload was 95% ethnic minority clients, her training on cultural issues was virtually non-existent. She did a cultural awareness study day on her arrival at Dewsbury, which she describes as not very useful and a week on a mental health ward some 19 years earlier. Most of what she knew she had gleaned from working with the women themselves and ethnic minority GPs.

The G P's training.

Findings

1. The information to the panel was that there is very little mental health training for GPs and as such GPs had minimal involvement in their patients' mental health care and tended to leave the matter in the hands of the specialist mental health services.

Supervision and Support to professionals on Cultural and Ethnic issues

Findings

1. The panel acknowledges and appreciates the efforts made by the key professionals to provide a service to Saheeda and her family despite the lack of extensive knowledge of ethnic issues. However the lack of supervision and support on ethnic issues made it doubly difficult for them to provide a good service.

2. The evidence given indicates that the practitioners had to depend on inadequate training, peer group supervision, and/or on their personal effort to "educate" themselves on ethnic issues. The impact of the lack of 'proper' supervision in ethnic minority issues was clearly felt by those involved in delivering services to the users.

   The panel is of the opinion that the senior managers and in particular the Trust Board, did not focus sufficiently on the service requirements of the ethnic community and therefore failed to take the necessary actions, which would have provided more appropriate and effective training.

   The panel felt it was difficult to see how managers and directors could involve themselves in supervision, policy-making decisions and allocation of resources, effectively, if they had no training on the cultural dynamics of the community they serve

Training Recommendations

1. Training in ethnic minority issues should be tailored to extend beyond its current composition, be ongoing and mandatory for <u>all</u> staff involved in the delivery of services (including supervisors, managers and board directors)

2. Lack of appropriate in-house trainers should neither delay nor prevent the above recommendation from being implemented. Appropriate trainers should be seconded in or staff seconded out wherever necessary.

3. Wherever possible, when services are delivered jointly between Health and Social Services, there should be joint training.

4. Appropriate funds should be allocated to implement the Transcultural Network Project without delay.

5. There should be joint training between primary and secondary care in mental health and cultural norms, with protocols for the treatment of specific illnesses.

6. There should be appropriate training for health visitors on ethnic issues, community mental health, and an introduction to risk assessment training.

7. All interpreters working within the service should receive mandatory, appropriate training on social and mental health care issues, as a pre-requisite to working with professionals and clients.

8. Books and other literature on mental health issues in the ethnic minority community, should be made available to staff for personal study, either on site or accessible from other venues.

9. Health and Social Services should identify a full time training officer who has a lead on ethnic minority issues.

10. Voluntary organisations such as K.A.F.A.S. which are relied upon by the statutory services for supporting clients, should be given the opportunity to access Health and Social Service training facilities in the areas they feel deficient in.

11. Health and Social Services should ensure that a training needs analysis is completed.

THE PANEL'S RESPONSE TO THE FINDINGS AND RECOMMENDATIONS OF BOTH INTERNAL INVESTIGATIONS AND THE CHILD PROTECTION PART 8 REVIEW

In 1994, the NHS Executive issued guidance as part of the Secretary of State ten-point plan announced in August 1993. The guidance framed the HSG 94(27), which set out good practice to be followed for all patients who are discharged following referral to the specialist mental health services. It also urges that when any violent incident occurs, it is important to respond to that incident but instigate an investigation to identify and rectify possible shortcomings in operational procedures, as well as investigate in detail that person's clinical care.

In this instance three investigations were conducted prior to this Independent Inquiry, these were an internal multi-disciplinary audit, an internal management review and a Part 8 child protection review.

Internal multi disciplinary audit

The panel read the internal audit and agreed with the recommendations contained within it, however, great concern was felt over the absence of some crucial information. The internal audit failed to highlight, or misinterpreted the following issues, which the panel felt were important:

Findings

1. There was no mention of the threat to kill one of her children, which was contained in her detailed suicide note, plus her nursing and Social Services notes of September 1997.

2. There was no mention of a child protection referral from the nurse.

3. There was no mention of the Child and Family Team's failure to act on the referral.

4. There was no mention of the health visitor's concerns over risk to the children.

5. The audit team assessed the CPA system as being very effective with documentation being consistent and well recorded.

> ***However, the panel feels the CPA arrangements are somewhat bureaucratic, not as effective as they could be, key-workers were often absent and the minutes were poor in reflecting why decisions were being taken.***

6. The audit team felt the arrangements the key-worker made on the 1st of June were robust and sufficient and stated that he had felt it was imperative to re-establish medication.

> ***The panel felt the arrangements were not robust enough and all the evidence shows that the key-worker did nothing to re-establish medication.***

7. The audit team referred to Saheeda making passing references to the family wanting to take the children away and her not wanting the in-laws to look after the children and that was why she wanted them at the outpatients clinic with her.

> ***The panel found overwhelming evidence that Saheeda was convinced she would never be allowed to see the children again if she were admitted the following day. She admitted to staff in the hospital, immediately after the fire, that this was why she had set fire to the house. (The professionals who saw her accepted that her belief was genuine)***

8. The audit found there was an attempt to have a holistic approach to Saheeda's care.

> ***The panel found no evidence to support this opinion.***

9. The audit recognised that the key-worker had done a comprehensive risk assessment on the 1st of June.

> ***What it failed to recognise was the very important fact that he breached child protection policy by failing to notify child protection staff based on the score that his assessment provided.***

Internal management review

In line with guidance, Calderdale and Kirklees "When Things Go Wrong" policy completed a detailed review of the case. A consultant psychiatrist/clinical co-ordinator and the general manger for mental health conducted the review.

The policy dictates the review should take the form of:

- Statements collected from those involved in the case.
- All case notes reviewed by both the clinician and manager.
- A formal meeting is convened that is attended by all those involved in the case, across agencies. Presentation of the case and a question and answers session is undertaken.
- The general manager then writes up the review, it is recorded and recommendations made.

Findings

1. The panel became aware that, although this process had been followed, the internal review failed to recognise important issues.

2. The management review mentions an appropriate referral was made to Child and Family Team in 1997 but does not give any indication that this was because of a threat to kill one of the children.

3. The review does not mention the failure by nursing staff to complete a written referral form following the verbal referral to Child and Families.

4. The review failed to recognise a contravention of policy and clinical practice by the key-worker. On the 01.06.00 he completed a detailed risk assessment, which included a referral form, a HONOS score sheet, a child protection mental health assessment and a summary of that assessment including risk. The child protection risk assessment policy, in place at the time, dictated an action commensurate with a scoring system. The form completed by the key-worker on 1.6.00 identified a risk assessment score, regarding the children, of 2/3, which instructed the assessor to, at the very least, notify senior nurse child protection, or refer to Social Services Child and Family Team. Neither of these options was followed. This was a clear breach of the Child Protection policy.

> ***The lead nurse Child Protection informed the panel that this assessment process has now been updated and improved.***
>
> ***The key-worker informed the panel he had not followed the dictated policy as he had telephoned the health visitor and in all the previous dealings with Saheeda, he had never had any concerns about her parenting, or interaction with the children.***

5. In general the panel considered the standard of the internal reviews to be relatively poor, although the management review was somewhat better than the multi-disciplinary audit. The complexity of the case required far closer scrutiny by both managers and clinical staff.

Child protection part 8 review

Findings

1. The panel felt the child protection, Part 8 review was thorough and appropriate. As with the internal reviews however, there is no reference to the key-worker breaching Child Protection policy, in not referring the matter to Child and Family specialists, based on his risk assessment score on the 1st June.

Recommendations

1 We endorse the recommendations of the Multi-Disciplinary Audit and those which have not already been implemented should be implemented without delay.

2 A more formal, rigorous review of major incidents should be undertaken. The Trust may want to consider a separate, more independent, management review where areas such as policies and procedures, standards of care, and conduct of staff are considered.

3 The panel endorses the recommendations from the Part 8 Review and recommends that those not already implemented be implemented with immediate effect.

CONCLUSION

1. The panel makes no apologies for the total number of recommendations contained in the report. Many of the recommendations are common sense, promote good practice and could be implemented immediately without difficulty. The panel recognises that many may have already been implemented since this incident, nevertheless our recommendations are based on what we know to have been the practice in June 2000.

2. Many of the recommendations may appear minor and unimportant to some; however, we would urge caution to those who view them in this way. The care given to Saheeda Kapde from both Health and Social Services, between 1994 and 2000 had many minor as well as major instances of poor practice. Some down to individual failings, most down to system failures, poor procedures and a lack of training and resources. Added together, these instances led to the delivery of a service that did not address Saheeda's needs.

3. The panel has never lost sight of the fact that we had the benefit of hindsight whilst conducting this Inquiry. However, we have based our findings on the information that was available to the services as a whole and practitioners as individuals, throughout the 7 years of Saheeda's care.

4. The services had been alerted in 1993 to the problems inherent in delivering a Western European model of mental health to the ethnic minority community. Resources were not forthcoming to address the issue. Training deficits were not addressed in any meaningful way. Staff were ill equipped to deal with the difficult task of delivering this service to the ethnic minority community.

5. There was never a shortage of professionals trying to help Saheeda. The speed of the initial response to her relapse on the 1st June 2000 was highly commendable. However, the overall management of risk in Saheeda's care was poor, for the following reasons.

    - The service delivered was not sufficiently holistic in its approach.
    - Information, readily available, was not acted upon.
    - Risk assessment procedures were not adhered to.
    - Individual decision making by some health professionals was questionable.
    - Some individual decision making within the Social Services Child and Family Team, based on unwarranted assumptions, was dangerous.
    - Vital information was lost through highly inefficient systems and poor personal practice.
    - Poor communication between professionals.
    - Poor communication between services.
    - Poor transfer documentation.

6. Sadly, this panel has come to the conclusion that the tragic incident on the 6th June 2000 may possibly have been avoided if information, that was available during the period Saheeda received services, had been acted upon in a more appropriate manner.

SUMMARY OF ALL THE PANEL'S

RECOMMENDATIONS

Recommendations related to Medical and Social Care in the context of Risk Management. (Findings pages 32 to 43)

1. The new Trust and all partner organisations must identify a named individual who is responsible for executing the clinical risk strategy. This should be a board level post.

2. Where a mental health client raises issues of domestic violence, especially where there are children involved, professionals must assess the situation effectively following agreed policy.

3. Social Services must deliver a more robust system, whereby the Child and Family Team must carry out an assessment of risk where threats to children have been raised. Such a system should not allow for individuals to make decisions on such issues until an initial assessment under Section 47 has been carried out.

4. Adequate training is required for staff within Child and Family Team relating to risk to children and carers suffering from mental health problems.

5. Once a referral to Social Services for a child protection risk assessment has been made, involving an inpatient, systems should be set up within wards to ensure that the referral and its progress should always be taken into account in any subsequent decisions related to home leave or discharge.

6. The significance of the extended family and family dynamics must be addressed more effectively by all professionals involved in a client's care. Where child protection issues are involved, this must be addressed by Social Services.

7. The key-worker should be central to the entire risk process from the beginning.

8. All main care workers should be present at clinical review meetings wherever possible. At the very least the named nurse and care co-ordinator should be present at the first meeting to ensure no important details, relating to the state of health on admission, are missed.

9. A detailed discharge summary, pointing out the cardinal features of a patient's condition, treatment and risk of relapse, should always be completed.

10. The process of de-registering from Priority CPA must have an effective backup process identified at the time.

11. An appropriate structure should be agreed in terms of follow up needs of individuals, especially during a period of cessation of medication in vulnerable cases.

12. Clients must not be allowed to fall between the two elements of the service, Priority CPA and Standard CPA. A system capable of catering for the needs of an individual with a relapsing condition, that is not chronic, must be instigated with immediate effect.

13. The CPA process needs to be much clearer in terms of allocating roles and responsibilities and the paperwork needs to reflect those roles and responsibilities more effectively.

14. Consideration should be given to more flexible outpatient appointments, both in terms of length of appointment and ability to see patients earlier if necessary.

15. Greater focus on the role of primary care in the management and treatment of mental disorder in concert with secondary care should be achieved as part of the development of protocols under the National Service Framework.

Recommendations relating to the Extended Family (Findings pages 44 to 46)

16. Practitioners should recognise the extended family culture in ethnic minority families and consider involving them in the care and treatment of an individual, if a holistic approach would benefit the person.

17. It should not be taken for granted that members of the ethnic minority community understand or do not understand the Western European concept of mental illness. The onus should be on the professionals to assess the situation and to fully explain to those concerned.

18. If it is recognised that the family has little understanding of the psychological difficulties of their relative and that little or no emotional support is forthcoming, this MUST form part of the risk assessment process. It must not be assumed that, because a mentally ill patient has practical family support, the risk factors are low. If that family does not appreciate the concept of mental illness and feels, as in this case, the patient is “putting it on” then the situation can be made far worse.

19. Statutory responsibilities should not be overlooked because of cultural factors. Practitioners should not be afraid to carry out their duties, by perhaps involving themselves in family matters, for fear of being seen as racist.

20. Clinical managers should take responsibility for supervising and monitoring complex cases, so that failure of provision of services is identified at an early stage.

Recommendations relating to Ethnicity and Cultural Dynamics (Findings pages47 to 53)

21. The Western European model of mental health and social services, currently being delivered to the ethnic communities, be urgently reviewed and reconsidered in recognition of the findings of this report.

22. The service deficits raised in a Transcultural Report in 1993 and repeated in this report be reviewed and acted upon without delay. A structured plan of educating and involving the community be considered a priority and financed appropriately.

23. Greater commitment to inter-faith chaplaincy should be provided within the newly reconfigured health services.

24. More interpreters both salaried and voluntary be recruited and appropriately trained in mental health issues.

25. Health and Social Services should consider commissioning, in conjunction with the voluntary sector, a family guidance service appropriate to the ethnic minority community.

26. All policies and procedures should reflect that ethnic minority issues have been given proper consideration.

27. Practitioners from ethnic minority backgrounds and or professionals with experience in working with the community should always be involved at policy making stage so that the policies reflect and address the actual service requirements of the community.

Recommendations relating to Policies and Procedures Findings pages 54 to 58)

Policies in general

28. The panel recommends that through the clinical governance system in the NHS and allied systems within the Local Authority, guidance be given on a standard to be achieved on the production of any new or revised policy. It should include:

    - The involvement of 'appropriate' key staff in the production of the policy or procedure. Appropriate, in this context, meaning those with specialist knowledge in that particular area.

    - Drafts agreed, should be presented through a clinical governance and/or Local Authority equivalent sub-group to check and endorse the education and or training planned for all staff affected, prior to its formal introduction.

    - Policies/procedures that are then introduced should be piloted and reviewed.

- Agreed policies should be dated and compiled centrally as well as being available on all wards and departments.

Record keeping and related policies in Mental Health Services

29. The Trust should ensure that in line with the national standards on records and record keeping all staff within health services should be required to date, sign and identify their profession/position legibly.

30. The Trust should ensure that case notes carry a summary sheet, which is easily accessible, that indicates past and present indicators of risk to self and or others.

31. Medical notes should contain clear summaries of in-patient admissions that are in a different colour to the ordinary correspondence and easily identifiable.

32. Important issues, such as suicide notes, should be fully read by the professionals involved, including the key-worker, recorded and highlighted in the notes for future reference.

33. The Trust should, as a priority, embark on an audit of records and record keeping that scrutinises on the basis of the above recommendations.

Care Programme Approach Policies and Procedures

34. The C.P.A. policy and procedure should be reviewed urgently.

35. The new system should place the client and key-worker at the centre of the process

36. The CPA policy should describe, in detail, a streamlined system that does not separate responsibilities of good clinical practice from documentation.

37. The system must identify roles, responsibilities and time-scales for actions and the documentation should reflect this.

38. The key-worker should chair the meetings related to their clients, ‘assisted’ by the administrator.

39. The care plans, produced at these meetings, should be periodically reviewed by a clinical supervisor.

40. The key-worker should be recognised as retaining responsibility for patients when admitted, according to the principles of ‘in-reach’ as opposed to handing over total responsibility to the in-patient staff.

Recommendations relating to Communication (Findings pages 59 to 61)

Communication within the management structure

41. In Trusts where mental health services are managed, the Board must find a way of having appropriate representation at board level.

42. The panel recommends that, apart from the Chief Executive and the Regional Office, serious incidents should always be reported to the Chair and Non-Executive Directors of Trust Boards. The appropriate Child and Family process, within the serious case review procedure in Social Services, should also be informed.

43. The joint agency procedure "When Things Go Wrong"(97) should be updated to include the Trust Board's involvement. This involvement should be the incident reporting, subsequent action and an account of lessons learned.

The panel is aware of the proposal to establish a new specialist NHS Mental Health Trust across Calderdale, Kirklees and Wakefield. The panel strongly endorses this.

Communication between Professionals

44. All key members of a client's care team must be present at review meetings, except in exceptional circumstances. Where children are involved, this should always include the health visitor.

45. If a worker cannot attend a meeting, a written report outlining their assessment of the situation, as at the date of the meeting, should be submitted.

46. Minutes of review meetings should be as detailed as possible and, in any event, should identify why specific decisions have been taken.

47. All members of the care team should receive a copy of the minutes and care plans and file them with their papers.

48. The key-worker should <u>always</u> be informed of any referral to child and families team and receive a copy of the paperwork.

49. If <u>any</u> professional within the care team (care team in the widest sense, meaning hospital and community staff at all levels) has concerns about a client's care or risk management, they should inform the key-worker and follow it up in written form (no matter how brief) to all members of the care team.

50. Concerns raised by <u>any</u> professional involved with the family should be discussed at review meetings, minuted and reasons given for any subsequent decision taken.

51. Those members of the care team who need to be informed when a client is discharged from hospital, should also be informed when interim leave is given.

52. Communication between clinicians when a patient is transferring needs to be by provision of detailed summaries and meaningful hand-over notes.

Recommendations relating to Training (Findings pages 62 to 66)

53. Training in ethnic minority issues should be tailored to extend beyond its current composition, be ongoing and mandatory for all staff involved in the delivery of services (including supervisors, managers and board directors)

54. Lack of appropriate in-house trainers should neither delay nor prevent the above recommendation from being implemented. Appropriate trainers should be seconded in or staff seconded out wherever necessary.

55. Wherever possible, when services are delivered jointly between Health and Social Services, there should be joint training.

56. Appropriate funds should be allocated to implement the Transcultural Network Project without delay.

57. There should be joint training between primary and secondary care in mental health and cultural norms, with protocols for the treatment of specific illnesses.

58. There should be appropriate training for health visitors on ethnic minority issues, community mental health, and an introduction to risk assessment training.

59. All interpreters working within the service should receive mandatory, appropriate training on social and mental healthcare issues, as a pre-requisite to working with professionals and clients.

60. Books and other literature on mental health issues in the ethnic community, should be made available to staff for personal study, either on site or accessible from other venues.

61. Health and Social Services should identify a full time training officer who has a lead on ethnic minority issues.

62. Voluntary organisations such as K.A.F.A.S. which are relied on by the statutory services should be given the opportunity to access Health and Social Service training facilities in the areas they feel deficient in.

63. Health and Social Services should ensure that a training needs analysis is completed.

Recommendations relating to the previous investigations into this incident (Findings pages 67 to 70)

64. We endorse the recommendations of the Multi-Disciplinary Audit and those, which have not already been implemented, should be implemented without delay.

65. A more formal, rigorous review of major incidents should be undertaken. The Trust may want to consider a separate, more independent, management review where areas such as policies and procedures, standards of care, and conduct of staff are considered.

66. The panel endorses the recommendations from the Part 8 Review and recommends that those not already implemented should be implemented with immediate effect.

Recommendations to West Yorkshire Health Authority

67. In view of the recent reconfiguration of health services locally, the Health Authority should receive this report and ensure that all of the appropriate organisations formally acknowledge its content and deliver an action plan to ensure that the recommendations are actioned.

APPENDIX A

The procedure adopted by the panel in conducting this Inquiry was as follows:

The Inquiry Chairman, Mrs Smoult-Hawtree and administrative manager Ann Johnson, visited Saheeda Kapde at Newton Lodge (Regional Secure Unit at Wakefield) to inform her of the decision to conduct the Inquiry. Mrs Smoult-Hawtree, Mrs Johnson and an interpreter then visited Saheeda's husband and his parents at their home to inform them of the decision and to obtain evidence from the grandparents. Dr Easton, Mrs Sircar and Ann Johnson visited Saheeda for a second time on the 21st September 2001 to obtain her evidence.

The panel first met on 7th September 2001 then on another 6 occasions at the Health Authority Headquarters.

Each member was given a full set of the documents outlined in Appendix D these were read in detail over a period of 4 months.

The list of potential interviewees (see Appendix B) was decided upon and a letter was sent (see Appendix C) to all people on the list requesting their attendance at interview week commencing 26th November 2001. The interviews took five days to complete. Court stenographers recorded all interviews and a copy of the transcript of each interview was sent to the interviewee for verification, signature and return to the panel.

The panel met again on the 14th January 2002 to discuss the proposed format and content of the report.

The Chairman then wrote the report with input from the other panel members who contributed in areas of which they had specialist knowledge.

Because the recommendations of the report would not be implemented until after the dissolution of the Calderdale and Kirklees Health Authority and the reconfiguration of Mental Health Services in Calderdale and North Kirklees, the panel met 4 senior members of the Health Authority, Trust and Social Services to discuss the panel's 'draft' recommendations.

The Chairman met with senior members of all the agencies involved on the 31st May to outline the main recommendations of the final report in order that an action plan for implementation could be prepared prior to the report's publication.

The Chairman and Mrs Sircar visited Saheeda's husband and his parents at their home on the 10th of July to explain the main findings and recommendations of the report. The Chairman then visited Saheeda Kapde on the 12th July 2002 to explain the main findings and recommendations to her.

The report was presented to West Yorkshire Health Authority at its board meeting on the 22nd July 2002.

APPENDIX B

Persons formally interviewed by the panel

Staff Psychiatrist – Dewsbury Health Care NHS Trust

Health Visitor – Dewsbury Health Care NHS Trust

Senior Nurse Manager, Mental Health – Dewsbury Health Care NHS Trust

Team Manager, Batley Community Support Team, and KIRKLEES SSD

Service Manager – Adult services, Kirklees SSD

Husband of Saheeda Kapde

Team Manager, Batley Children and Family Team, Kirklees SSD

Forensic Psychiatrist – Newton Lodge Medium Secure Unit

Transcultural Co-ordinator and (Elderly Services) Dewsbury Health Care NHS Trust

Interpreter, Ravensleigh Resource Unit

Key-Worker, Ravensleigh Resource Unit, (Social Worker)

GP

Social Worker, Emergency Duty Team, Kirklees SSD

Senior Nurse Child Protection – Dewsbury Health Care NHS Trust

Director of Nursing, Quality and Practice Development, Dewsbury Health Care

Community psychiatric nurse Ravensleigh Resource Unit

Associate Specialist in Psychiatry, Dewsbury Health Care NHS Trust

Locum Consultant Psychiatrist

General Manager – Dewsbury Health Care NHS Trust

Community Care Officer – Kirklees SSD

Manager – Ravensleigh Resource Unit

Consultant Psychiatrist

CPA Co-ordinator and Care Manager, Kirklees SSD

Director, Dewsbury Health Care NHS Trust with responsibility for mental health

Note: The titles shown above are those that applied at the time of the incident

The following people were seen by panel members on a less formal basis:

K.A.F.A.S. Volunteer

Saheeda Kapde

Paternal grandparents

User and carer co-ordinator Dewsbury Health Care NHS Trust

Religious Leader

A written report was received from Saheeda's first Approved Social Worker.

APPENDIX C

Dear

Independent Inquiry into the care and treatment of Saheeda Kapade

Calderdale and Kirklees Health Authority has set up this inquiry as required by Health Service Guideline HSG (94) 27 after discussion with the NHS Executive Regional Office. The HSG requires the Health Authority to hold an Independent Inquiry in the case of a homicide committed by a mentally ill person. Saheeda Kapade who was under the care of the mental health services was convicted of manslaughter following the death of her son in June 2000.

I am chairing the Inquiry Panel, I am a barrister from York. The other members of the panel are Dr Andrew Easton, a consultant psychiatrist from Leeds, Ms Ann McKenzie, a recently retired senior manager of mental health services and registered mental health nurse from Newcastle, and Mrs Indrani Sircar, a recently retired senior care manager from Bradford.

A copy of the terms of reference set for the inquiry is attached for your information together with a copy of the authorisation signed by Saheeda Kapade for the disclosure of the records relating to her care and treatment.

[We are aware that you gave evidence at the internal inquiry set up by Dewsbury Health Care NHS Trust and we have been given a copy of your report to that inquiry.] We consider [however] that you can provide [further] evidence to assist this independent inquiry and would therefore request you to attend a hearing on [date] at [time]. If this date is not possible for you please discuss alternative dates to attend with Janice Doherty, Inquiry Administrator, on [phone number]. Your reasonable travelling expenses and subsistence costs arising from your attendance at the inquiry will be reimbursed. The hearing will be held at the offices of Calderdale and Kirklees Health Authority at the address shown above. [A map is attached for your information.]

When giving your evidence you may be accompanied by a friend or relative, trade union representative, lawyer or anyone else with the exception of another inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. A transcript of your oral evidence will be made and a copy will be sent to you afterwards, which you will be asked to sign and return.

In order to shorten time on oral evidence, and to help clarify issues before the hearing, we may ask you to provide a written statement in advance of the hearing. You will be advised prior to the hearing if this will be necessary and told about the topics / issues the statement should cover.

I would like to thank you for your co-operation and assistance. If there is any matter in addition to the above on which I can give further explanation, please let me know.

I look forward to meeting you.

Yours sincerely

Karen Smoult-Hawtree
Independent Inquiry Chairman

APPENDIX D

List of documents seen by the inquiry panel

Records

- SK medical records – Dewsbury and District Hospital (Mental Health Unit)
- SK GP records
- Health Visitor records – Kapde family
- SK records – Ravensleigh Resource Unit
- SK Nursing records – Dewsbury and District Hospital (Mental Health Unit)
- Kapde family records – Children and Families Team, Kirklees SSD
- SK records – Emergency Team, Kirklees SSD

Criminal proceedings transcript/medical evidence

- Transcript of Court Proceedings – Regina v Saheeda Kapde – 7.11.2000
- Independent psychiatric reports on SK submitted to Leeds Crown Court – October 2000

Previous inquiries into the case

- Dewsbury Health Care NHS Trust – SK Internal Review and reports received by the Review Panel
- Dewsbury Health Care NHS Trust – SK Management Review
- Dewsbury Health Care NHS Trust – Action Plan following Serious Case Review on SK
- Kirklees ACPC – Part 8 Review on Nihaal Kapde

Local trust polices

- Calderdale and Kirklees Health Authority – details of ethnic health projects
- Dewsbury Health Care NHS Trust – Transcultural awareness training programme for staff
- Dewsbury Health Care NHS Trust – Primary Care Services, Mental Health Directorate and Priestley Unit - Audit of Interpreters Service – January 2001
- Audit of transcultural communication services, Priestley Unit, Dewsbury District Hospital – February to May 2000

- Assessment of Risk to Children – Operational policy – Dewsbury Health Care NHS Trust inpatient mental health unit
- Mental Health of the Nation Scale – HONOS PLUS manual and risk management workshop details
- Dewsbury Health Care NHS Trust – Clinical Risk Management policy – December 2001
- North Kirklees Mental Health – Clinical Governance Newsletter October 2001
- North Kirklees Mental Health Services – Annual Clinical Governance Report 2000 and draft report for 2001
- Dewsbury Health Care NHS Trust – policies / statements validated by the Clinical Governance Group – Mental Health Directorate
- Confidentiality guidelines for staff
- DNA policy
- Clinical risk management
- Supervision
- Quality and monitoring
- Clinical audit
- Continuing professional development / learning and development
- Multidisciplinary / agency working
- Protocol for 7-day post discharge
- Dewsbury Health Care NHS Trust Priestley Unit – Care Programme Approach Policy and Procedure September 2001
- Dewsbury Health Care NHS Trust - Mental Health Inpatient Collaborative Update - May 2001
- Dewsbury Health Care HHS trust – Mental Health Directorate – policies and procedures – 1st Draft – July 2001
- Priestley Unit - List of policies, protocols, procedures and guidelines.
- Suicide Audits – North Kirklees, 1997 – 2000

Social Services policies

- Kirklees ACPC Child protection procedures – April 1999
- Change to child protection review process – June 2000
- Social Services Practice Guidelines – November 1995 North Kirklees SSD – Information on resources specifically allocated to address problems amongst its ethnic minority communities
- Mental Health / Children and Families Joint Working Protocol – September 1999

Joint health and Social Services policies

- 'When things go wrong' – Joint agency procedures for dealing with untoward incidents in local mental health services – Calderdale and Kirklees NHS and LA organisations – February 1997
- Dewsbury Health Care NHS Trust / Kirklees SSD – Mental Health Services – Procedure when the main carer of children has deliberately self Harmed
- North Kirklees – Local Implementation Team (LIT) submission – October 2001 on NSF implementation
- North Kirklees NSF LIT – Workforce Training and Education Plan – October 2001
- Ravensleigh Resource Unit – Risk and Safety Procedure – April 1999
- Ravensleigh Resource Unit – Induction Pack – October 2000
- Ravensleigh Resource Unit – List of policies, protocols, procedures and guidelines
- CPA / Care Management approach in North Kirklees – August 1995
- The Development of North Kirklees Community Mental Health Service – November 1998
- North Kirklees Mental Health service – Service Report – March 2000
- North Kirklees Mental Health – Risk Training Programme
- Mental Health Service User Involvement – draft proposal for development – March 2001
- Dewsbury Health Care NHS Trust / North Kirklees SSD – A report outlining the development of a transcultural mental health service in the North Kirklees area – September 1993
- Mental Health Services to People from Ethnic Minorities in North Kirklees – a proposed transcultural network – July 2001
- Kirklees Racial Equality Council – Race, ethnicity and health project – Audit analysis 2000

Health authority documents

- Calderdale and Kirklees HA – Race and Ethnicity Strategy – Action Plan 2000

National guidance publications

- National Service Framework (NSF) for Mental Health
- Health of the Nation- Building Bridges – a guide to interagency working for the care and protection of severely mentally ill people
- Care Programme Approach (HC(90)23/LASSL(90)11 and subsequent updates of this legislation.
- Supervision Registers HSG(94)5 and subsequent updates of this legislation and discharge guidance provided in HSG (94)27.