REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF ADRIAN JONES AND DOUGLAS HEATHWAITE

A report commissioned by County Durham Health Authority

AUGUST 1998

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PREFACE

We were commissioned by the then County Durham Health Commission in January 1996 to undertake this Inquiry.

We now present our report having followed the Terms of Reference which were laid down by the Commission and adopted the Procedure suggested to us by the Commission.

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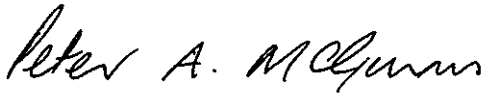
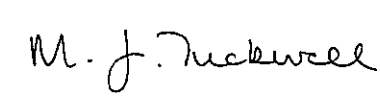


Peter McGinnis



Martyn Tuckwell

SECTION 1

THE PANEL'S REPORT

INTRODUCTION

This Inquiry was commissioned by the County Durham Health Commission in pursuance of the guidance contained in the NHS Management Executive document HSG(94)27 which requires such inquiries to be held where there has been a homicide committed by a person known to the mental health services. As is recounted later in our Report Adrian Jones and Douglas Heathwaite were involved in an incident at a bus stop in Newton Aycliffe, County Durham on 19 June 1995. Adrian Jones inflicted injuries on Douglas Heathwaite as a result of which Douglas Heathwaite died on 22 June 1995. That is the homicide which gave rise to the commissioning of this Inquiry.

As is normal in such cases, the work of the Inquiry could not commence until any necessary criminal proceedings had been concluded. Because of the mental state of Adrian Jones the proceedings were delayed but eventually on 14 July 1997 at the Crown Court at Teesside the Prosecution accepted a plea of guilty to a charge of manslaughter and Adrian Jones was made the subject of an Order under Sections 37 and 41 of the Mental Health Act 1983.

By this time the Panel for this Inquiry had been appointed and accordingly it became possible for the work of the Panel to commence. The task of collecting records, documents, publications, and reports of other such Inquiries had commenced thanks to the good offices of David Baggott, Secretary to the County Durham Health Authority. An approach was made to the family of Douglas Heathwaite and to Adrian Jones for the necessary consents for the use of medical and other records. The Heathwaite family co-operated and gave the necessary consent immediately. There was some delay in obtaining the consent of Adrian Jones but eventually and with the assistance of his solicitor, Mr Michael Clarke, the consent became available and the Inquiry could then proceed.

It was necessary to approach all the relevant agencies for records and documents in respect of both men and this eventually produced a very substantial quantity of paper which was skilfully put into order by David Baggott and his colleagues and read by the Panel. The Panel held three meetings at Durham to consider the written evidence as it came in, to decide what further evidence was needed and to plan the formal hearing. In this process it was helpful to have copies of Reports of previous similar Inquiries, notably the Christopher Clunis Report, the Jason Mitchell Report and the Darren Carr Report.

WITNESSES

We approached over 40 witnesses who had been concerned with the two men either as members of their families, as witnesses of the incident, as carers or as people concerned directly or indirectly with the two men and their problems. The vast majority of those approached were very helpful and most of them were ready to attend the Inquiry and to give oral evidence. Only three of those who gave written statements did not attend the Inquiry, two of them for health reasons.

We were very grateful to the members of the families and friends of the two men who were ready to co-operate with us and both to give written statements and attend the Inquiry to give oral evidence. We appreciated that approaching them was a sensitive matter in the light of the tragic circumstances surrounding the death of Douglas Heathwaite but we felt it was right to give them the opportunity of expressing their views to us as well as giving us information with regard to the housing and treatment given to the men.

EXPERT WITNESSES

In view of the terms of reference of the Inquiry set out in Appendix I of this report we felt it appropriate to approach three expert witnesses representing the fields of psychiatry, nursing and social services. We made available the appropriate written evidence including hospital records, nursing records and social service records to enable them to assess the treatment and medication made available to the two men and to give their opinions on those matters including the appropriateness and delivery of the treatment. This advice was invaluable to us in reaching our conclusions.

ADRIAN JONES

After receiving advice from his solicitor, Mr Michael Clarke, Adrian Jones was prepared to co-operate with the Inquiry, to give consent for his records to be made available and to meet members of the Panel. David Baggott, accompanied by the solicitor, Mr Clarke, attended at the Hutton Centre, the Medium Secure Unit at St Luke's Hospital in Middlesbrough and obtained the written consent of Adrian Jones to the release of the documents. In addition two members of our Panel, Dr Simon Baugh and Mr Peter McGinnis, interviewed Adrian Jones at the Hutton Centre on the morning of the first day of our Inquiry sessions.

OUR REMIT

The Terms of Reference are clearly set out in Appendix I of this Report. In commencing our work we had the benefit of access to the Internal Inquiry Reports prepared by the then South West Durham Mental Health NHS Trust in respect of each of the two men in November 1995. We saw no point in re-writing the background history and relevant chronology relating to the two men since these had already been researched and are factual. We, therefore, adopted them as part of this report and they appear in Appendix V of this Report.

THE HEARING

We held eight days of oral hearings in Durham. Witnesses had been approached beforehand in the terms of the draft letter set out in Appendix III of this report which in turn adopted the main thrust of the extract from the Report of the Christopher Clunis Inquiry which is set out in Appendix II. We had decided that it was not necessary or appropriate to appoint Counsel to the Inquiry and accordingly the witnesses were questioned by the Panel each member taking special responsibility for questioning the witnesses in relation to their particular areas of expertise as well as on general matters. Some witnesses were accompanied by friends or colleagues but most did not find it necessary. All witnesses were invited to raise any issues which they felt needed to be discussed. All the evidence was fully transcribed and each witness was sent a copy of his or her evidence and offered the opportunity to comment on or correct the text.

ACKNOWLEDGEMENTS

No Inquiry of this nature could take place without an enormous amount of work being done beforehand. In this Inquiry there was a need to investigate the history of the two men involved, in one case going back nearly 20 years and in the other 11 years. The evidence had to be obtained from many sources in respect of each of the men and then assembled and presented in such a way as would make it accessible and digestible for the Panel, forming the basis for identifying the relevant witnesses and then conducting the Inquiry. We could not have done it without the skilled and conscientious work of David Baggott and his team of workers in County Durham Health Authority. When it came to the Hearing itself we had the advantage of the very willing help of Janet Donnison who attended instantly to the needs of the Panel and the support of the witnesses. After the hearing we had enormous help from Angela Fleming in putting together the transcribed witness statements and the report of the Inquiry, a substantial task. Finally we pay tribute to Caroline Armstrong whose responsibility it was to transcribe the proceedings of the hearings from the tapes which were used. This involved tasks of voice recognition, technical knowledge of the subject matter and patience without which the task could not have been achieved. We are deeply grateful to her.

SECTION 2

THE OFFENCE

On 19 June 1995 Adrian Jones and Douglas Heathwaite, both men with long histories of mental health illness and both known to the health and social services agencies in County Durham, met by chance in the Acorn public house in Newton Aycliffe at about 12.30 pm. Although they were in no way friends they were known to each other having met, it is believed, both in Winterton Hospital and in various public houses and clubs in the area. On this occasion Douglas Heathwaite was accompanied by his friend Yvonne Slater.

Whilst they were in the Acorn remarks were exchanged between the men but they kept their distance from each other. They left separately. Douglas Heathwaite and Yvonne Slater left first and called at two other places before heading for the bus-stop to catch a bus. In the meantime, Adrian Jones had stayed a while in the Acorn, then called at a fish and chip shop to buy some chips and headed for the bus-stop at about 3.15 pm. At the bus-stop the two men exchanged remarks which led to an exchange of blows. Eventually Adrian Jones who was substantially taller and heavier than Douglas Heathwaite struck a blow to Douglas Heathwaite's chin which pushed him down causing him to bang his head on the pavement. Adrian Jones followed this up by delivering some kicks to Douglas Heathwaite's head. Douglas Heathwaite suffered a fracture of the skull. At this stage Adrian Jones left the scene and took a taxi to his parents' home where he was later apprehended by the Police. In the meantime an ambulance was summoned for Douglas Heathwaite and he was taken unconscious to Bishop Auckland General Hospital. He was eventually placed on a life support machine at that hospital but was diagnosed to have suffered irreversible brain damage. The machine was switched off on Thursday 22 June, three days after his admission.

SECTION 3

THE OUTCOME

Following the death of Douglas Heathwaite, Adrian Jones was charged with his murder and remanded in custody at Holme House Prison. Thereafter a number of dates were fixed for the trial of the charge against Adrian Jones but on each occasion he was found to be unfit to plead and the case was adjourned. Eventually another Hearing was listed at the Crown Court at Teesside for 14 July 1997 and on this occasion he was found to be fit to plead, a finding which was agreed by consultant psychiatrists instructed respectively by the Prosecution and the Defence.

Adrian Jones denied the charge of murder but indicated willingness to plead guilty to a charge of manslaughter. The Prosecution agreed to accept this plea and accordingly after a short hearing the Judge, Mr Justice Ognall, made an Order under Sections 37 and 41 of the Mental Health Act 1983. It was a term of the Order that Adrian Jones should be detained in the Hutton Centre, the Medium Secure Unit at St Luke's Hospital in Middlesbrough, with an interim Order limited to 28 days that he be returned to Ashworth Hospital and detained there pending the availability of a place at the Hutton Centre.

SECTION 4

THE CARE OF ADRIAN JONES

4.1 Adrian Jones' first contact with the Mental Health Services goes back to January 1984, with his GP, Dr Wood, referring him to John Lyons, Clinical Psychologist, at Winterton Hospital. He was then at the age of 19, and was described as 'a degenerate youth'. He was referred to as having developed symptoms of agoraphobia and had become sexually inhibited, but also impotent. He is described as rather naive and gullible, still living at home with his mother.

4.2 Dr Rutter, Consultant Psychiatrist, became involved in his care in February 1985, following a referral from the GP. At this time schizophrenia was the diagnosis and in view of his disturbed state and undoubted tension in the household admission was offered, but declined. Both Adrian Jones and his parents felt that it would make him worse, hence the plan then was to medicate at home. At this time links had already started with the Community Nursing Service under the auspices of Alan Davies, then a Nursing Officer. Adrian Jones was unwilling to come to outpatient clinics at this time and the plan was to leave the management with Alan Davies unless the situation deteriorated further and Adrian Jones was willing to be considered either for hospital admission or out patient attendance.

During this period Adrian Jones was also well known to Social Services and would often be in contact with them. However, because of his failure to co-operate he was usually seen by a duty officer and given access to advice, information, and a telephone. Because of changes in the Social Services his records for this period could not be traced.

4.3 Early attempts at treatment in 1985 by John Lyons, Senior Clinical Psychologist, appear not to have been successful. He was attempting to improve Adrian Jones' self concept, reduce his anxiety and help him to cope. There was a note that his psychotic features were indeed inhibiting any improvement. Adrian Jones valued psychological input if only to help him adjust to certain circumstances. At this time he was rather suspicious and some paranoid ideas were evident in that he tended to feel that people were significantly involved in his life and that it was necessary for him to avoid being dominated by others.

4.4 During 1985, following an admission in August, he came under the care of Alan Coyle, Community Psychiatric Nurse. Regular visits took place during 1985, and at the time Adrian Jones was attending a local day centre. He was causing problems with other people at the day centre, making threats of violence to people if they did not do as he said, and was generally frightening people. Even in the September of 1985 Dr Rutter, Consultant Psychiatrist, was unhappy at having Adrian Jones back into hospital, as he continually discharged himself against medical advice and was not prepared to accept treatment offered to him.

4.5 A gap of some six months then followed when Adrian Jones was out of contact

with services, but was re-referred by Dr Adams his GP in March 1986. He was prescribed Flupenthixol[1] 20 mg every two weeks. At this time he was presenting as overactive, both in terms of speech and movement, very suspicious, unwilling to answer questions, verbally hostile and threatening in manner.

4.6 In April 1986 Adrian Jones accepted admission to Ward 3 at Winterton Hospital after having threatened his father with a knife, which was indeed a real threat, resulting in his father jumping through a glass door to escape and his father had to go to hospital for treatment to numerous cuts.

4.7 Following a period of leave during May 1986 Adrian Jones refused to return to the ward, remaining very uncompliant and he was discharged.

4.8 He was re-referred again in 1987 by Dr Anderson, Locum GP for Dr Adams. The parents explained that at that time he was causing lots of problems and they felt unable to cope with him. Adrian Jones presented as very excited, believing that local 'hoods' and the police were against him, and there was some link at that time to the running of prostitution in Spennymoor. He did refuse to come into hospital at this time. The General Practitioner, Duty Consultant Psychiatrist and Social Services reviewed Adrian Jones at this time and he was admitted to Winterton Hospital under Section 3 on or around 5 November. By 5 May 1988 the Section had run its complete six months, and his Section was extended until 16 September, 1988.

4.9 During 1988 he continued to receive Depot medication, and following discharge from hospital went back to live with his parents in Spennymoor.

4.10 His behaviour at this time got steadily worse, with Adrian Jones becoming violent and intimidating. He was freely admitting at this time to constantly getting into fights while drunk, and that this was really just part of a night out drinking. It appears that during the latter part of 1988 he was actually receiving Haloperidol Decanoate[2] injections, and he had moved into the Wear Valley Hotel, but due to his unreasonable conduct this was due to end. In the latter part of 1988 Alan Coyle took up his care again as CPN, he was referred to the DRO to assist in gaining employment, or purposeful activity, and he was thrown out of the Wear Valley Hotel, going back to live with his parents. A move to Darlington in January 1989 meant the case was referred from Alan Coyle on to Peter Boycott, a CPN in that area.

4.11 In spite of the duty placed on agencies for after care under Section 117, very little appears to have happened that was planned and agreed.

4.12 1990 and 1991 saw a repetition of previous years, with presentation to GPs and to hospital services, for either admission or help.

4.13 In 1990 he was banned from the Waddington Street Day Centre and the opinion at

[1] A Depot drug given by injection, commonly known as Depixol, used in the treatment of schizophrenia.
[2] A Depot drug given by injection, commonly known as Haldol, used in the treatment of schizophrenia.

that time was that this was a personality disorder, with an underlying psychotic illness. Haloperidol was being prescribed at this time, and he was starting to see Dr White, Psychiatrist, in out patient appointments regularly. Interestingly during one occasion in 1990 Dr White indicates no evidence of mental illness, no indication for admission and that the plan for care at this time was supportive review in one week's time. He continued to show no improvement during 1990 and some counselling was occurring from Dr White regarding his behaviour.

4.14 He was regularly followed up by medical staff during 1990, with sessions in August, September and December. His compliance at this time was a little poor, with 'did not attends' in both the October and December of 1990.

4.15 In July 1991 we see Adrian Jones presenting himself at the ward in Winterton Hospital looking for admission, and requesting Diazepam[3] for his "anxiety". He was a known patient then of Dr Fisher, Consultant, who had raised an impression of a psychopathic personality, with schizophreni-form psychosis in the past, secondary to drug abuse and with also a history of alcohol abuse. His attitude to treatment was described as chaotic.

4.16 In August 1991 he had several brief admissions, lasting two to three days, under Dr Bray, both at Ward 37 in Winterton Hospital and also in Harding Ward at the County Hospital. One of these admissions was via the Police surgeon, who made a diagnosis of hypomania. His history at this time was well known, from the point of view both of his schizophrenic illness and of his social anxieties and his abuse of substances.

On 20 August 1991 Adrian Jones was arrested having broken into his parents' home. He had had to leave his previous accommodation and had been homeless for a few days. He was also charged with being in possession of an offensive weapon. He was assessed and detention in hospital was not seen as appropriate. He was detained in custody and his parents were reported as being "terrified" of him. He was remanded to Durham Prison until 9 September 1991.

Adrian Jones then appeared before Sedgefield Magistrates Court on 16 September 1991 and Dr Martin, Consultant Psychiatrist from the County Hospital, Durham , recommended that Adrian Jones be dealt with by way of Section 37 of the Mental Health Act, 1983. This was not possible as the offences for which he was charged did not carry custodial sentences. He was remanded to Durham Prison for a further three days and on 19 September Adrian Jones was discharged from custody and detained in hospital under Section 3 of the Mental Health Act.

He was allocated to Kay Parker, Social Worker, who arranged for him to attend a Drop-in Centre in Durham City. His parents were offered support through the Northern Schizophrenia Fellowship's Carers Support Group in Durham.

4.17 Following the court proceedings Adrian Jones was admitted under Section 3 of the Mental Health Act under the care of Dr White. His mood was described as elevated and "high" and again he was assessed as being hypomanic and was

[3] a "minor" tranquilliser commonly known as Valium.

treated with neuroleptic medication. During this admission to Winterton Hospital there were episodes of violence towards his Consultant Dr Martin and towards another patient.

4.18 The latter part of 1991 still saw Adrian Jones attending outpatients at the County Hospital and some attendance still at the Waddington Street Day Centre until he was banned from the premises for drunken behaviour. His history over the next two years was to continue drinking at home, but continuing to show a history of violence and aggression. He repeatedly presented for admission, suggesting that he had a few problems and he could not socialise and needed something for his anxiety. His compliance at this time is 'hit and miss', with some acceptance of Haloperidol[4], plus his Depot, yet some refusal of any help.

Social Services ceased their formal involvement with Adrian Jones in December, 1991, having offered him support with his benefits claim and accommodation. He was also interviewed in connection with a Mental Health Act Review Tribunal Report. He was eventually discharged back to his parents' home in December, 1991 by Dr White at the request of Mr and Mrs Jones as they believed that hospital treatment was detrimental to his health. As this report was made in their capacity as Nearest Relative and main carers Dr White concurred with their request. He refused contact with Social Services. There is no evidence of a Section 117 meeting prior to his discharge.

Adrian Jones continued to be difficult to engage, apparently threatened staff and service users at the drop-in centre and was reported to the Police for driving under the influence of alcohol. At this time he appeared to be living with a woman in the Durham area. It is difficult to be precise about this because the Social Services records pertaining to this period have not been traced.

4.19 It is clear from the medical notes at this time that he was presenting as a difficult patient, with an unstable lifestyle, heavy alcohol consumption, difficult behaviour when in hospital and even demanding treatment with "atypical antipsychotic medication" (Clozapine[5]) in 1992.

4.20 In 1993 some presentation of lowered mood became apparent, with Paroxetine[6] 20 mg three times daily being prescribed by Dr White.

4.21 In July 1993, following admission to Winterton Hospital under Dr Bray this time, Adrian Jones was homeless. He was discharged only four days later, with a diagnosis of personality disorder, and alcohol abuse, and he was accommodated at the Plawsworth Hostel. At that time he was referred onto the CPNs at the Barnfield Day Centre, as no other psychiatric follow up had been arranged. During this admission he was seen by Social Services with a view to assessment for admission to a residential home. He refused to consider this.

Adrian Jones probably absconded from hospital on 9 July and entered an unoccupied house in Sedgefield. He had a bath and, on the occupier's return,

[4] A drug used in the treatment of schizophrenia.
[5] Clozaril, a new drug used in the treatment of treatment resistant schizophrenia.
[6] An antidepressant of the new SSRI type, commonly known as Seroxat.

demanded food, drink, and money with menaces. The Police were called and Adrian Jones was charged with theft and released on bail. He then hired a taxi, for which he refused to pay, and as a result he was arrested and remanded in Holme House Prison.

4.22 He was due to be seen in outpatients, but did not attend, on the 12 August 1993, as he was then in Holme House Prison. He was later admitted, under Section 48, from Holme House Prison under the care of Dr Cantlay and following an assessment by Dr Martin. He was admitted to a secure ward at Winterton Hospital and Section 48 was converted to Section 37 on 11 October. He was elated, grandiose; some notion of aggression and some questions about his psychosis existed. He was allocated to a Social Worker but the records for this period have not been traced.

A multi-disciplinary meeting was held on 25 January 1994. It was agreed that it was unlikely that Adrian Jones would comply with his medication on discharge and that "follow-up may be difficult". He was to be referred to Social Services Customer Support Team on 27 January for assistance with accommodation. The Customer Support Team does not appear to have been notified of this referral, nor were they warned that Adrian Jones had a history of aggression. The notes of the meeting indicate that Adrian Jones was "not completely well". Adrian Jones was given an accommodation address and a telephone number. There was no follow up despite the fact that Adrian Jones was cursorily allocated to Richard Lamb, Social Worker.

4.23 He was discharged on extended leave in February 1994, and subsequently discharged from Section on 8 March 1994, and continued to reside with his mother.

4.24 He was then allocated back to Alan Coyle, CPN, and his part in the plan at this time was to administer a Depot injection. His medication had now been moved to Fluphenazine Decanoate[7], and he continued to be excitable and garrulous at home, and showing very little insight.

4.25 The main activity following his hospital discharge appears to have been medication supervision only. During 1994 outpatient visits with Dr Cantlay continued on a two weekly, or monthly, basis.

4.26 In May 1994 his parents reported Adrian Jones as being quite well within himself and not creating any problems for them. His shaking and restlessness had improved greatly, and he was continuing to attend outpatients with Dr Cantlay.

Adrian Jones became homeless again in June 1994 and saw Dr Roy his GP. She referred him to the Social Services Department who in turn checked with the CPN Alan Coyle. Dr Roy suggested that Adrian Jones would probably "stage a crisis to get attention" and this comment appears to have enabled various professionals to label Adrian Jones as "attention-seeking" and so offer minimal support.

[7] A Depot drug, given by intramuscular injection, commonly known as Modecate, used in the treatment of schizophrenia.

4.27 Adrian Jones moved to the Plawsworth Centre in July 1994. At this time he had gone back to drinking, and some of his old behaviours were reappearing.

4.28 Unfortunately during the August of 1994, while he was settled with some reduction in restlessness, he stopped taking his medication. Interestingly enough at this time the Community Psychiatric Nurse's opinion was that he should not be visited by a female alone. This was not shared fully with other professionals involved.

4.29 On 14 October 1994 a Section 117 review meeting was held at the Day Unit, Winterton Hospital, with Dr Cantlay, Alan Coyle and Alan Davies being present. There was no social work involvement in that meeting. This meeting was held seven months after Adrian Jones was discharged from hospital. There is no record of a CPA meeting. It was clear from that review that since his discharge earlier in the year Adrian Jones had refused to comply with his medication, with the exception of Procyclidine[8], which he wanted to continue due to some side effects. He had been seeing Dr Cantlay at outpatients on a reasonably regular basis, and was now behaving reasonably at home, and his medication was changed by Dr Roy, now his GP, to Paroxetine 40 mg mornings and 20 mg at night and Flupenthixol[9] 0.5 mg twice a day. Interestingly Dr Roy was not aware of any of the concerns raised by the CPN in regard to a female being alone in the presence of Adrian Jones. Dr Roy in fact appears to have started to confront Adrian Jones with some of his specific deficits and behaviours and actually draw some boundaries around what was acceptable and unacceptable. This appeared to be one of the only times when some level of constructive structure was being applied to Adrian Jones. It could be seen that in most other cases people were going along with him, trying to support his medication and work with him when he was feeling able to be involved.

4.30 At this Section 117 review the care plan was to continue outpatient appointments with Dr Cantlay, to review his mental state, to offer support to his parents on an 'as required' basis and to continue with monthly CPN visits to monitor the situation. Clearly this was not an aggressive or assertive treatment approach to somebody with a dual diagnosis of schizophrenia and substance misuse nor was there any clear care plan involving Mr and Mrs Jones.

4.31 Through the latter part of 1994 CPN visits continued with the same key worker, namely Alan Coyle. His GP changed his medication to Pimozide[10] 2 mg twice a day stopping the Paroxetine.

4.32 Again the visits during late 1994 were purely monitoring visits and support visits, with no indication of actual treatment given, or any framework to deal with both

[8] A drug commonly known as Kemadrin used for the treatment of side effects from some anti psychotic drugs.
[9] Fluanxol, (see footnote 1) a drug used in a lower dose range and for the short term for the treatment of anxiety and mild depression.
[10] Orap, a drug used in the treatment of schizophrenia.

his personality problems and his behavioural responses to situations. There is no indication here of any work regarding his anxiety or relationship problems, or anything to do with anger management.

4.33 During attendance at out patients with Dr Cantlay in January and February of 1995, Adrian Jones became less happy with the treatment Dr Cantlay was pursuing and asked for referral to a Psychologist or a Psychotherapist.

4.34 Adrian Jones was seen by Richard Marshall, Clinical Psychologist, in both February and March 1995. Two other appointments during April and June resulted in Adrian Jones not attending. Richard Marshall confirmed the misuse of drugs and alcohol, along with Adrian Jones' feelings of insecurity. He intimated a somewhat paranoid state and was extremely concerned about his violent potential especially toward women.

4.35 Dr Cantlay had in fact on 23 January confirmed that he was no longer providing care to Adrian Jones, passing him in essence back to the GP, but intimating in his correspondence that if the GP did not find another Consultant he would indeed still be sent an appointment in three months time to see Dr Cantlay.

4.36 Adrian Jones was at this time attempting to move his case to Dr Bray, Consultant Psychiatrist.

4.37 In March 1995 monthly visits were still occurring from Alan Coyle, CPN, and on 15 March Adrian Jones had received a letter from the housing department saying that he was second on the list for a flat in Newton Aycliffe. At this point in time he was not taking his prescribed medication, but was still using illegal substances occasionally. On 28 March he was allocated 242 Tanfield Place and secured a Social Fund Loan. An enquiry from Mrs Jones was dealt with by the Customer Services Team by directing her to the Furniture Scheme

4.38 On 12 April, during a CPN visit, Alan Coyle was informed that Adrian Jones had now moved. Staff at the Phoenix Centre, who represented the local Community Mental Health Team, which was supported by Dr Bray, were informed of the move into their area by Adrian Jones and a brief verbal account of his health status currently was passed on. At this point in time Russell Wyatt, Community Psychiatric Nurse, was appointed to take over the care of Adrian Jones.

4.39 No social worker as such was involved in Adrian Jones' care at this transfer.

4.40 The Phoenix Centre, based in Newton Aycliffe, consisted of a Team Leader, who was a Nurse, five CPNs and one Support Nurse, two Social Workers who were based there, linked to the team, and one OT. Psychology and Physiotherapy sessions were available in the Centre, and the geographical patch covered was Shildon, Newton Aycliffe and surrounding areas. Five GP practices related to the Phoenix Centre at that time, and Dr Bray, Consultant Psychiatrist, did sessions at the Phoenix Centre.

4.41 It would seem that he was passed on to Russell Wyatt's care because he, like Alan

Coyle, had known Adrian Jones for quite some considerable time, having nursed him in an acute ward within Winterton in the past. Alan Coyle had sent a letter to Adrian Jones' GP confirming that Russell Wyatt had taken over as key worker, and informed him of the contact arrangements with the Phoenix Centre.

4.42 The case was handed over to the CPN Russell Wyatt on the 20 April 1995, and the patient was only seen on one occasion on that day for 15 minutes. A further home visit on the 4 May 1995 was ineffective, as Adrian Jones was not at home, and this was followed up by a letter sent to him the next day.

4.43 An outpatient appointment with Dr Bray in May 1995, equally failed, and this was followed up by a letter sent to Adrian Jones on the 26 May requesting that he contact Russell Wyatt, CPN, regarding an appointment.

Richard Marshall's assessment was sent to Dr Cantlay on 18 April. This information does not appear to have reached Russell Wyatt, although the referral from Alan Coyle to Russell Wyatt suggests that Adrian Jones should have a male worker. Russell Wyatt did not see the need to pass this information on to the GP and Adrian Jones was seen twice during this period by a female GP who did not have access to his records.

4.44 His last admission to hospital was on 10 June 1995, which was at the request of the Police Surgeon, Dr Alcock. This episode is described in more detail in paragraph 6.14 of this report.

4.45 Following Adrian Jones's discharge on the 12 June he had no further contact with the service.

4.46 Russell Wyatt, CPN, then states that on the 12 June he received a message from Richard Lamb, Social Worker, stating that Adrian Jones had been in trouble with the police over the weekend, had been admitted to Ward 38 at Winterton Hospital, under the care of Dr Bray, but had been discharged on 12 June. Richard Lamb had obtained this information from nursing colleagues, but, despite being on the hospital premises, he was neither officially informed of the events of the weekend, nor was he invited to the discharge meeting.

4.47 Adrian Jones had been given an appointment to see Dr Bray on the 15 June 1995 at the Phoenix Centre. However, he did not attend for that appointment.

4.48 Following this period of time in hospital a Section 117 review date was set for the 26 June 1995 and was confirmed by letter of the 13 June 1995.

4.49 Given Adrian Jones' long history and acquaintance with the service, and given the type of handover that Alan Coyle, CPN, gave, and as Adrian Jones was lacking compliance around medication at this time it would seem yet again that the care of Adrian Jones was seen to be more aimed towards maintenance rather than assertive, or aggressive, follow up. Again the referral to the Phoenix Centre, which has a multi-professional team available to it, only seemed to trigger the link between a CPN and Adrian Jones. Throughout Adrian Jones' care between 1985

and the incident, his care had been dealt with by a Nurse and Consultant, with one or two referrals to Psychologists. No-one else really, and certainly no other professional group, had been involved.

4.50 The admission between 10 and 12 June to Winterton Hospital culminated in some level of risk assessment by staff in the ward. But the nature of the discharge process did not lead to any of that being communicated to the Phoenix Centre and the Team. Obviously Dr Bray was due to reassess Adrian Jones some three days later on 15 June, and given his previous non compliant behaviour and what appears to be a lack of ability to engage him, this might well have been seen as reasonable. However, the reason he was admitted on 10 June for two days was based around a very serious assault on a Police Officer, resulting in actual bodily harm. Even though his behaviour in hospital during that time (two days) was exemplary, risks still existed because of his previous behaviour. None of these immediate risks were passed through to the Phoenix Centre and to those who would be looking after him subsequently. Dr Bray, however, was aware of that history to some extent, and was due to see him on 15 June at the Phoenix Centre and therefore could have briefed the team.

4.51 On 19 June the incident occurred in which Douglas Heathwaite was killed.

SECTION 5

THE CARE OF DOUGLAS HEATHWAITE

5.1 Douglas Heathwaite was born in Spennymoor in 1948. He had a very bad childhood, with excessive behavioural problems at home, resulting in him being sent to an approved school at the age of 11 years. He first married at the age of 24 years. His marriage lasted approximately 13 years, before his wife left him because of his alcohol problems. At the time of the offence he had been living with a girl friend for some two and a half years. His early years show that he had problems related to drink and was unable to restrain himself. His criminal record included burglary, motoring offences, assaulting a policeman, drunk and disorderly.

5.2 Douglas Heathwaite first came to the attention of Durham Psychiatric Services in 1976, then aged 27 years, when he was first seen in the outpatients clinic by Dr Josephine Rutter. He was referred because of a long standing mild obsessional behavioural disorder, but gave a history of poor schooling, truanting and problems with the Police, resulting in him being sent to a special residential school in Torquay from 11 to 15 years. He also presented with a history of heavy alcohol abuse, although he was not reported to be drinking heavily at that time.

5.3 Douglas Heathwaite remained in contact with Dr Rutter until 1980, when he continued to be drinking heavily, but appears to be have been lost to any psychiatric follow up from then on.

5.4 In 1986 he was first admitted to Winterton Hospital with a history of alcohol problems lasting some 13 years, under the care of Dr Bray. After a spell of inpatient detoxification he was discharged on 17 March 1986. His compliance was very poor, with non attendance on three outpatient follow up appointments, and he was lost to any follow up at that time.

5.5 This pattern continued through to 1992, culminating in his admission to Winterton Hospital in June 1992, under the care of Dr Bray. He was seen by Dr Rajah, who was then working as an associate specialist with Dr Bray. He received elective detoxification with Chlordiazepoxide[1]. He had a forensic history at this time regarding thefts and fighting, but had agreed on discharge to take Disulfiram[2]. Dr Rajah continued at intervals to oversee Douglas Heathwaite's care at this time and until his death in 1995. During this period he was referred to Social Services but the record of the referral and its subsequent outcome cannot be traced.

5.6 Between July 1992 and December 1992 Douglas Heathwaite presented a chaotic lifestyle, was involved with the Police because of problems with neighbours and showed an increase in the amount of aggression towards his girlfriend.

5.7 In April 1993 the Community Addictions Service based at Newton Aycliffe had become involved with Douglas Heathwaite who was allocated an addictions

[1] A Benzodiazepine commonly known as Librium and used for alcohol withdrawal
[2] Antabuse, a drug used to treat alcohol dependence

therapist. Douglas Heathwaite attended fourteen sessions with the nurse therapist at this time, while at the same time becoming a client of Julie Daneshyar, Social Worker. At this time joint working was commenced between Douglas Heathwaite, his girlfriend Barbara, and the team at the addictions service. A Comprehensive Needs Assessment was completed by Julie Daneshyar and Douglas Heathwaite was admitted to "Braeside" residential centre on 7 April. There is evidence of close working between the Nurse Therapist and Care Manager all through this and subsequent months.

5.8 Douglas Heathwaite discharged himself from Braeside in June 1993 and overdosed. Following a suggestion from him that he might lose control and kill his partner he was re-admitted to Braeside on 22 June 1993.

5.9 In July 1993 Douglas Heathwaite, Julie Daneshyar, and staff at Braeside signed a working agreement to cover his period of residence and this included a temporary cessation of contact with his partner, no drink or drugs, addictions counselling, and a commitment to actively seek alternative accommodation and day-time occupation.

5.10 Out of 50 planned attendances to meet with the nurse therapist in the alcohol counselling service, Douglas Heathwaite attended all but five. His last attendance at this service was on 4 April 1995, some two months prior to his death.

5.11 During 1993 and 1994 several admissions occurred to hospital, based on a mixture of poor mood, some overdoses and alcohol misuse. There was evidence of Care Programme Approach reviews held on Douglas Heathwaite in November 1993, which included his General Practitioner, and further review meetings were identified for both December 1993 and May 1994.

5.12 In November 1993 Douglas Heathwaite requested another Doctor to look after his care, other than Dr Bray, so his GP at the time referred him to Dr Rajah. Dr Rajah took over his case in January 1994 as RMO and continued with the CPA care plans as indicated.

5.13 During this period alternative housing was actively being sought in conjunction with Social Services.

5.14 At this time attempts were being made to offer detoxification in the community, using Chlordiazepoxide.

5.15 Treatment was also being attempted with Antabuse, although Douglas Heathwaite was poorly compliant, and continued to drink while taking it, so it was stopped in March 1994.

5.16 Further attempts to treat him with Antabuse continued through 1994.

5.17 During 1994 Julie Daneshyar did hand over the case to Margaret Gregory, Social Worker, while she was away on maternity leave. The involvement of Margaret Gregory focused around the giving of assistance with finance and accommodation issues, which were pertinent to Douglas Heathwaite's care. Keith Kay, the Nurse

Therapist, was indeed still seeing Douglas Heathwaite on a weekly or fortnightly basis.

5.18 During 1994 there appears to be increased evidence of violence of some kind involving Douglas Heathwaite and his girlfriend. He at this time was increasing his drink and use of Antabuse, and left Braeside Hostel in June to live with his brother but still regularly visited his partner. There were a number of incidents of self-harm and of violence toward his partner over the next few weeks. There was also a charge of breaking and entering and he was to appear in Court on 11 August 1994.

5.19 Julie Daneshyar was on maternity leave from July 1994 and her successor, Margaret Gregory, worked hard but without success, until she too went on maternity leave at the end of December 1994, to help Douglas Heathwaite to obtain suitable permanent accommodation. For a variety of reasons she was unsuccessful. No local Housing Association or Local Housing Authority would consider Douglas Heathwaite for a tenancy.

5.20 At this point in time his compliance on medication, namely Antabuse, Chlordiazepoxide and Fluvoxamine[3] was poor, with a discontinuation of Antabuse in September of 1994. The CPA meeting on 27 September 1994 acknowledges these difficulties and offers some planning towards the future.

5.21 The rapid response home nursing service was involved in Douglas Heathwaite's care during October 1994, following referral by the Nurse Therapist from the Community Addictions Service. At this time he expressed ideas of worthlessness making vague suicidal threats, and this was basically a response to a crisis at home. A second visit was arranged, but as Douglas Heathwaite was not present and there were concerns about his safety the team waited and when Douglas Heathwaite returned to the house he was admitted to Ward 38 at Winterton Hospital at 8.00 pm to relieve both the crisis situation in the home, as well as deal with his intoxicated state. At this time a personality disorder was diagnosed along with drug and alcohol misuse. He was subsequently discharged on 19 October, with a management plan relating to both medication, which was Fluvoxamine 50 mg at night, and Naproxen[4] 250 mg at night, and an outpatient follow up at the Lady Eden Day Unit and continued work by Margaret Gregory, Social Worker, and referral back to Keith Kay, Community Addictions Service.

5.22 The opinion at this time was that Douglas Heathwaite was capable of looking after himself, stable and well at the time of discharge from hospital. There was some concern about his placement in the community, which had been confirmed by the Social Worker, but he was not sure where he wanted to go on discharge. He certainly lacked motivation, was not depressed as such, but had no structured life within the community, and really no plans for his future.

[3] An antidepressant of the SSRI type, commonly known as Faverin.
[4] An anti inflammatory drug.

5.23 During 1994 when the number of violent incidents increased and his chaotic behaviour was more evident, there appears to be no re-assessment under the Community Care Act or any attempt to convene a meeting to review these incidents.

5.24 Following a stay at Winterton Hospital in January 1995, Dr Rajah discharged Douglas Heathwaite from hospital. He was then discharged into bed sit accommodation, with a question over whether this was the appropriate place for him to be discharged to, and whether therefore discharge totally was appropriate. In fact within weeks he returned to drinking ten pints a day as a regular feature, and admitted to being on the drink all the time.

5.25 Julie Daneshyar returned in January 1995 and helped Douglas Heathwaite to find a shorthold furnished tenancy in Bishop Auckland. She further offered assistance with outstanding fines and arrears, as well as a bond in the form of a promissory note for the landlady. Support work from Carers UK was also arranged. This arrangement obtained until March when Douglas Heathwaite was re-admitted to hospital for detoxification and exploration of other health matters.

5.26 Another admission in 1995 led to Douglas Heathwaite being treated yet again with Antabuse; however, he continued to drink while on the ward. He did remain in hospital while planned accommodation was being found, but finally went on leave on 5 April, failing to return. Social Services notes give a rather different impression in that they clearly identify a breakdown in multi-disciplinary working at this point, but these events are not corroborated by any other notes. What is clear, however, is that extensive enquiries were made by Julie Daneshyar regarding accommodation. She was again unsuccessful. His bed was kept open until he returned. He visited the ward the following day, on 6 April, saying he wished to be discharged, which occurred. An outpatient appointment was made for him for 25 May 1995. We can find no trace of a discharge care/treatment plan other than the outpatient appointment.

5.27 CPA reviews and meetings continued right up to and including the 4 April 1995. Here a Care Programme Approach meeting was held as he was fit for discharge following an admission on 1 March 1995. At this point in time the objectives set out with his care plan included:

Assisting with budgeting, shopping and other domestic matters
Offering support for accessing services
Monitoring relationship skills and offering advice and support
Monitoring of alcohol use and mental health generally
A regular liaison with Julie Daneshyar, or Keith Kay, both working within the Community Addictions Service.

There were additional objectives set at that point in time, which included:

To broaden experience of work situations
To offer a work experience in a caring, supportive atmosphere
To improve self confidence and skill levels.
To reduce social isolation.
To increase constructive activities.

Ongoing activity to support Douglas Heathwaite in maintaining his present gardening job.

5.28 At this meeting in April 1995 additional advice and referral was being sought from the Psychology Department for either direct client input or advice to existing workers. There was a clear identification of three key people in Douglas Heathwaite's care at this time, namely Julie Daneshyar, Care Manager/Social Worker, Keith Kay, Addictions Counsellor, and Dr Rajah, Consultant Psychiatrist.

5.29 At this time the Community Addictions Service made themselves available as and when appropriate for Douglas Heathwaite to access, while Dr Rajah was continuing to monitor his mental health state through outpatient appointment attendance.

5.30 On 20 April Douglas Heathwaite appeared to be living in an unsuitable bedsit, supported by his new partner. An appointment was arranged for him with the Disablement Employment Agency for 4 May and Julie Daneshyar attended that appointment with Douglas Heathwaite.

5.31 On 25 May 1995 he was seen in outpatients, where chronic alcohol abuse, plus an inadequate personality were described. It was noted at that time that except for intermittent abuse of alcohol he had no further symptoms of a withdrawal state, and any mood swings were not intermittent and non-intrusive, with no evidence of any suicidal intent. He was described at this time as coherent, rational and rather cheerful. There were plans for him to be seen at future sessions.

5.32 In May his accommodation improved slightly and Douglas Heathwaite received counselling support from Julie Daneshyar. However, at the end of the month he became homeless again and within the next few days Julie Daneshyar helped him find an alternative flat, guaranteeing a £200 bond to the Landlord and providing some crockery. He was later given a grant of £30 to help him "settle into his new accommodation".

5.33 Julie Daneshyar had arranged to see Douglas Heathwaite on 16 June but because of an emergency was unable to keep that appointment. She did not see him again.

5.34 In the period from April 1995, following a discharge from hospital, and the incident in June 1995, while at the time still drinking, Douglas Heathwaite did show signs of stability. The conversation with Community Addictions Service on 13 April 1995 identifies him ending the conversation reasonably happy after discussing how he felt. This was the last contact that the Community Addictions Service had with him.

SECTION 6

ISSUES AND CONCLUSIONS

ADRIAN JONES

6.1 Adrian Jones was a difficult patient with a long history of mental illness going back to 1984. During that time he was looked after by at least seven consultants and he changed his place of residence frequently. Consequently he was on the list of various GPs in different districts and attended three different hospitals. This involved changes in the Social Workers and other agencies responsible for his care. Inevitably this gave rise to difficulties in continuity of treatment, availability of records, policies of care and management and substantial gaps and shortfalls in appropriateness of attitudes, assessment, co-working and management.

6.2 Nevertheless in our view there was a fundamental shortfall in assessment related to his basic schizophrenic condition with psychotic episodes on the one hand and his continuing drug and alcohol abuse on the other hand (dual diagnosis). It is not clear to us that there was at any stage pro-active approach for handling these problems either by health professionals or social services. There was no evidence that we found of pro-active strategic approach actively pursued for dealing with his problems and we noted that the handling of his case was described as re-active by several witnesses. We did not find any evidence of firm medical leadership based on a strategic approach, holding on to the diagnosis and driving it down the organisation in such a way as would embed it in the multi-disciplinary care plan for the patient.

6.3 If there had been such a strategic approach appropriately recorded in a care plan in the records of the patient, that could have been the basic tool to be used on a regular and continuing basis for re-assessment, available to the professional carers even if there were inevitable changes in the location of the patient. We saw no evidence of such an approach being accessible or available to people taking over responsibility for Adrian Jones. Thus when there was a change of RMO there was no visible evidence of a re-assessment. Similarly in April 1995 when Russell Wyatt took over as the responsible CPN there was no evidence of re-assessment of Adrian Jones at that stage or indeed of meaningful contact of more than 15 minutes in a period of two months leading up to the index offence.

6.4 There was clearly a problem in engaging Adrian Jones and achieving compliance in relation to medication and alcohol abuse. He had a number of stays in hospital under Sections 3, 5 and 37 of the Mental Health Act and on many occasions he was granted leave on condition that he took his medication and did not abuse alcohol. The hospital records show that on many occasions there was non-compliance by Adrian Jones with both those conditions. There would seem to have been virtually no possibility of such compliance. One of the expert witnesses whom we heard described that as negligent complacency on the part of the RMO.

It did seem to us that appropriate management where an order under a Section existed and more frequent use of the Mental Health Act would have achieved greater progress in managing the problems of Adrian Jones. It should have been incorporated in a strategic policy as we have mentioned above.

6.5 Our findings in relation to consultant leadership were not confined to the issue of dual diagnosis. They went further than that and extended to issues of management, of training and continuing education, of relationships and of complacency. There was no evidence that the consultants were appropriately managed by the Medical Director. There was no regular organised training or professional development undertaken either by the consultants or for non consultant non training grade medical staff. There was no evidence of any consistent organised training in the Care Programme Approach policy within the hospital for any of the medical staff. All that took place was on site and in the presence of patients. The Clinical Officer involved, Dr Satyadeva, had no study leave either in this post or in his previous locum posts. The Royal College of Psychiatrists on a visit to Winterton Hospital in June 1995 found that three posts for Junior Doctors at Winterton were either unsuitable or unacceptable because of lack of adequate supervision. There was clearly a problem about the adequacy of junior medical staff which was drawn to the attention of the Medical Director in May/June 1995 by the Divisional Manager of Acute Services. The response was to suggest that there should be a reduction in admissions. It was not the task of the Inquiry to investigate the proposed retraction of services at Winterton Hospital but it was manifest that that process was having an impact on the wards at the Hospital in terms of morale, staffing, management and patient satisfaction. The relationships between consultants and towards patients evidenced by correspondence and records which we read was unsatisfactory and bordered on the unprofessional.

6.6 In relation to care in the community for Adrian Jones, we found no evidence of a comprehensive assessment or re-assessment of his needs. In all the records we inspected we found no evidence of appropriate care planning. We are aware that he was a difficult and probably unco-operative patient but that is not an adequate explanation. On 25 January 1994 a CPA meeting was held at which it was decided to hand over responsibility for Adrian Jones' support from Social Services to the Customer Services Team based at that time at Winterton Hospital. This Team was staffed partly by qualified Social Workers who had no direct responsibility for Adrian Jones or knowledge of the details of his condition and problems. They did not have instant access to his records or his care plan or any risk assessment. Effectively they could do no more than point him towards the appropriate person, agency or source of care provision. This was in stark contrast to what we found to be the case in relation to Douglas Heathwaite and yet both patients were the responsibility in part at least of Durham County Council.

6.7 As we have mentioned above there were frequent changes of the professional carers for Adrian Jones largely but not wholly because of his change of address. This clearly had an impact on the treatment which he received. The lack of a strategic plan and comprehensive care plan made it virtually impossible to maintain any continuity in his treatment. One of the major barriers to achieving continuity was the delay in the transfer of records from GP to GP which at the

relevant time could take anything up to five months. Messages were not passed on even if they had serious implications such as the question of Adrian Jones being a danger to women on their own. Clearly the question of appropriate medication was a problem for the incoming GP without access to previous records. It was further exacerbated by lack of connection between the wards and the GP and the patient's own opinion of what medication was appropriate added to the problem. There was clearly a lack of long term planning in his care towards integration in the community. In addition there was a lack of co-operation between the hospital and the GP in relation to CPA or Section 117 meetings. We found no evidence of attendance by a GP responsible for Adrian Jones at any such meeting in spite of the existence of policies and advice which recommends it. We were made aware of the administrative difficulties as well as the financial aspects of the problem but nevertheless the outcome was quite contrary to proper practice.

6.8 As we have mentioned above we found serious problems about record-keeping, exchange of information and sharing of knowledge about Adrian Jones. Non-attendance of GPs at CPA and Section 117 meetings deprived them of first hand knowledge of what was happening at ward level. There were other examples of failure to communicate important information to GPs. When there was a change of GP the passing of records from GP to GP took far too long and prejudiced adequate care for the patient. There was similar lack of exchange of important information in an appropriate way between other services such as Social Services, CPNs and housing agencies. Perhaps the most significant delay occurred in April 1995. Adrian Jones had been seen by the Clinical Psychologist Richard Marshall who produced a report dated 18 April 1995. The report clearly indicated that Adrian Jones was a damaged individual who sought excitement in a way that was harmful to himself and could put others at risk of being harmed by him. There is no evidence that any notice was taken of that report either by the consultant to whom it was addressed or by others. It is not clear that it reached for example the key worker responsible for Adrian Jones in the Community and yet the report was in the records of Dr Cantlay the RMO and copies had been sent by Richard Marshall to Adrian Jones' GP and to Alan Coyle, the then CPN.

Finally in relation to records and notes we were very concerned about the adequacy and availability of records at Winterton Hospital. In very many places they were totally illegible, frequently disordered, initialled rather than signed, and misfiled so that adjacent pages could be not just weeks or months apart but years apart. We find it difficult to believe that in the light of modern technology it should be impossible to produce some order into this chaos. Even if action is confined to following the wisdom of the NHS Training document "Just for the Record", some improvement would be achieved.

It is clear to us that on the issues of records, notes and information exchange, standards need to be set and protocols should be established in the interests of patients and the wider community and indeed of those who have to work in the various services.

6.9 It became clear to us that there was a substantial shortfall of co-operation between the various agencies involved or which should have been involved in the care of Adrian Jones. In order to achieve what has now become known as assertive outreach there has to be full exchange of information and structured co-

operation between agencies. In the case of a patient such as Adrian Jones there has to be fully co-ordinated co-working between the NHS, Social Services, and Housing authorities as well as the Police and Probation to say nothing of the voluntary agencies if it is going to be possible to manage the policy of care in the community. There is nothing new in this proposition but unless it is implemented then there will be more such cases as this one. There is evidence of good practice in the recent publication "Pulling Together" published by the Sainsbury Centre for Mental Health; it should be taken on board.

6.10 One of the aspects which is most important in the care of patients such as Adrian Jones is that of Clinical Risk Management. Exhaustive search of all the relevant records revealed virtually no evidence of risk assessment having taken place in spite of all the publications and guidance which recommend it. This includes the fact that when the Supervision Register came into being it was decided that Adrian Jones was categorised as not suitable to be entered on it. As late as 12 June 1995 - one week before the index offence - in the CPA meeting in Winterton Hospital it was decided that it was not appropriate that he should be entered on it. That was 48 hours after his violent assault on a Police Officer and one week before the fatal attack on Douglas Heathwaite. There must be realistic assessment of risk in relation to patients such as Adrian Jones if there is to be appropriate Clinical Risk Management. Without it patients and others will be at risk.

6.11 If care in the community is to be improved it is essential that the co-operation of the families of patients is secured wherever possible. So far as we could ascertain very little constructive work was done with the family of Adrian Jones. No contact was made at any time with his sister and only limited contact with his parents. The handover by Social Services to the Customer Services Team could only have reduced any contact even more. If Adrian Jones had been supported by the Addictions Unit one would have expected more contact with and support for the family. That did not happen and there was no evidence of any follow up with the family on occasions when Adrian Jones was discharged from hospital.

6.12 On the evidence before us there did not appear to be adequate co-operation between Winterton Hospital and the CMHT based at the Phoenix Centre. There was some barrier because of sectorisation within County Durham so that although there were resources at the Phoenix Centre, Adrian Jones did not benefit from them. A policy of assertive outreach was not pursued and DNA, certainly if it occurred, usually put an end to any pursuit of a care plan. There needs to be closer co-working between wards and the CMHT. For example, there should be CMHT presence at a CPA or Section 117 meeting on discharge of the patient from hospital.

6.13 One of the major problems of managing the care of Adrian Jones in the community was the question of housing accommodation. This involved availability, retention of tenancy when found and the actual process of finding accommodation. This was an area in which there appeared to be very little support given by Social Services. This was in complete contrast with what was done for Douglas Heathwaite as we indicate later in this report. Again the

handing over of responsibility for Adrian Jones to the Customer Services Team only served to aggravate this problem. Another problem is the shortage of appropriate accommodation, or support in finding it which is offered by agencies whether statutory or voluntary in County Durham. There appeared to be only one dry house and one wet house in the whole County. There did not appear to be any method of prioritising accommodation for seriously mentally ill patients. But the provision of such accommodation is an essential part of the totality of the care plan and this problem needs to be addressed. It is not sufficient to delegate it to the patient himself with the limited support of the Customer Services Team.

6.14 On Saturday 10 June Adrian Jones was arrested for drink driving, and in the process of this arrest he attacked the Police Officer, viciously dragging him by his hair across the seat of his car and out of the car and then banging his head against the car. He was taken to the police station and was seen there by Dr Alcock the Police Surgeon. Later in the day Dr Alcock saw him again and referred him to Winterton Hospital - it would seem essentially for detoxification. Adrian Jones was given police bail to enable this to happen. Adrian Jones was kept in Winterton until Monday 12 June. On admission he was seen by the Clinical Officer, Dr Satyadeva, who checked with the Duty Consultant Dr Cantlay before admitting him. On Monday 12 June Adrian Jones was seen by Dr Bray who had just become his RMO at the request of Adrian Jones and his GP. On the Monday morning Dr Bray was minded to keep Adrian Jones in the Hospital and this was agreed by Adrian Jones. However a few hours later, about lunchtime, Adrian Jones decided he wanted to be discharged. According to the evidence before us neither Dr Satyadeva nor Dr Bray had had access to Adrian Jones' notes even though he had been in the Hospital for over 40 hours. The decision to discharge him was reached without reference to the notes, or knowledge of the report of Richard Marshall. At the insistence of the named nurse, Beverley Langley, Dr Bray held what was called a CPA meeting at which only Adrian Jones, Beverley Langley and Dr Bray himself were present. It has been described as a minimal meeting. It lasted ten minutes. Boxes were ticked and words ringed. The effect was that Dr Bray was discharging Adrian Jones indicating amongst other things that there was no significant risk of serious violence to others and that he should not be entered on the Supervision Register. It noted that an outpatient appointment was to be made with Dr Bray within four weeks. The discharge was made by Dr Bray without him being aware apparently that Adrian Jones was subject to Section 117 of the Mental Health Act. As it happened Richard Lamb from Social Services was on the premises but was not invited to attend the CPA meeting as would have been in accordance with good practice. From his knowledge of Adrian Jones he was aware of the Section 117 situation. An outpatient appointment was sent out to Adrian Jones for 15 June, which he did not attend. We noted that although the discharge was described as a CPA meeting there was no presence of GP, Social Worker, CPN or family member. It was indeed minimal. All this was in spite of the fact that the relevant admission to Winterton Hospital 48 hours earlier arose from a serious assault on a Police Officer.

DOUGLAS HEATHWAITE

6.15 In general terms many of the issues raised and conclusions reached in relation to Adrian Jones are also relevant to the care and treatment of Douglas Heathwaite as well. This applies in particular to the problems of training of staff, the retraction of Winterton Hospital and some of the housing difficulties.

6.16 His situation was much better than that of Adrian Jones largely due to the quality of the care provided by his key worker Julie Daneshyar, the Care Manager employed by the Social Services Department of Durham County Council. There was universal praise for her work from all those who worked with her as well as from the professional expert witnesses whom we heard. In particular the quality of her notes and the preparation work for the various CPA meetings as well as the time spent in supporting Douglas Heathwaite were exceptional. In addition she worked particularly well with Keith Kay, the Addiction Counsellor and Nurse Therapist. It may have been significant that they worked out of the same office. There was never any question of Douglas Heathwaite being referred to the Customer Services Team.

6.17 Julie Daneshyar spent an enormous amount of time identifying appropriate housing for Douglas Heathwaite. Mostly she was successful but her efforts were also frustrated by the shortage of suitable or appropriate agencies to provide for the needs of this group of patients.

6.18 A particular shortfall in the case of Douglas Heathwaite was the lack of suitable treatment or training for anger management which was his special problem.

6.19 Even in Douglas Heathwaite's case there was evidence of complacency at top level i.e. at consultant level in the management of his care. Again the care was seen to be re-active rather than pro-active.

ADDITIONAL CONCLUSIONS

6.20 In addition to the issues and conclusions outlined above there were two matters which we noted, which applied to the care and treatment of both men and which are overarching in our consideration of the whole of our remit.

6.21 In the course of the Inquiry we read many documents and publications relating to the problems highlighted in our report. The documents and publications in question included both national and local items. There are many documents which contain policies and procedures dealing with the problems of patients with similar problems to both these men. Particular examples at national level are HSG(94)5 dealing with the introduction of Supervision Registers for mentally ill people and HSG(94)27 giving guidance on the discharge of mentally disordered people. In the case of both these documents we found substantial shortfall of performance by

the services involved. As we have already indicated it appeared to us that failure to include Adrian Jones on the Supervision Register when it was introduced and certainly in June 1995 was inappropriate. Similarly the Guidance on Discharge seemed to us to be more honoured in the breach than in the observance in relation in particular to CPA meetings. They were rarely fully attended, almost never by GPs and were frequently labelled as minimal, a word which we found to be totally inappropriate for such matters. The performance by the various professionals in relation to the two men varied enormously. In the case of Douglas Heathwaite, Julie Daneshyar would prepare an agenda for all participants several days before. In the case of Adrian Jones no such agenda was seen by us and there were only brief notes of what had happened at the meeting.

6.22 At local level there was submitted to us a paper written by Alan Davies for South West Durham Mental Health Trust dated January 1995 entitled "Section 117 Care Programme Approach and Care Management in Joint Care Planning". This was praised by all the witnesses we heard, including the expert witnesses, and by ourselves. However, even a policy of such quality is of little value unless it is properly used as a management tool and implemented by all the relevant disciplines.

6.23 It was clear to us, both from the outcomes which occurred, and from the evidence which we heard that there was insufficient training directed at the implementation of this particular policy. Clearly a policy which involves joint care requires training on a basis which enables all disciplines involved to understand its meaning and how it is to be implemented. Such training needs to be mandatory for all professions concerned and we saw no evidence that this was the case. There is a clear need for this to be addressed in the areas where these events took place.

6.24 On the subject of training and continuing education and development there is a clear need for this to be addressed in a number of areas of work. We have in mind particularly the field of medical care. It is no longer acceptable in any speciality of the medical profession to allow doctors to continue practising without renewing their skills and bringing themselves up-to-date with all the developments and best practice relating to their speciality. The evidence we saw and heard indicated that that was not happening on the particular ward in Winterton Hospital which we were considering. That has to be the responsibility of the Medical Director.

6.25 Training in engaging with and motivating patients with drug and alcohol problems must not be confined to community addiction teams. In the light of the increasing numbers of patients with dual diagnosis, this training must be available to all staff.

6.26 When a significant amount of risk is identified following a full risk assessment, a more assertive use of the Mental Health Act 1983 should be considered for those patients who fail to comply with medication or with other forms of treatment.

SECTION 7

RECOMMENDATIONS

Although we have identified a number of matters in relation to the care and treatment of these two men which were the subject of criticism and which led us to offer suggestions for future management of similar problems there were a few points which we felt were crucial both in relation to these two men and to the future care of patients with similar problems. These are as follows:-

7.1 Dual Diagnosis

We were not able to find the words dual diagnosis anywhere in all the records, notes and reports relating to these two men and particularly in relation to Adrian Jones. Yet in relation to him the expert evidence which we heard was clear that his condition was one which should have been so identified and which should have triggered off an approach appropriate to that diagnosis. Accordingly by modern standards such conditions do need to be looked at on the basis of dual diagnosis with the consequences which that would have for the appropriate handling of his care and treatment.

7.2 Assertive Outreach

A further implication of that diagnosis is to plan and implement assertive case management. It is necessary to adopt a strategic long-term policy, to monitor the progress of such policy, to re-assess the care plan on a continuing basis and to ensure that the care plan is implemented by all the services involved. Consideration should be given in appropriate cases to involving other agencies such as the Police and Probation Service. This would include assertive outreach action rather than just offering re-active response.

7.3 Records

In order to implement appropriate care-planning for such long term policy it is clearly essential that proper records should be kept and that exchange of all necessary records and information should take place. There may be arguments about confidentiality but the interests of the patient can only be best served by such free exchange.

7.4 Training and Development

The very nature of the conditions which affected these two men demanded appropriate contributions to their care plans from various services. The appropriate delivery of the necessary care and treatment can only be achieved if there have been the necessary arrangements and delivery of education, training and development on a shared basis for all those people working in the relevant services. Without such education, training and development the care plan will fail and the patients and those with whom they are in contact will suffer.

APPENDIX I

REMIT FOR INQUIRY

1 To examine all the circumstances surrounding the treatment and care of Mr Jones and Mr Heathwaite by the mental health services, in particular:

(i) the quality and scope of their health, social care and risk assessments;

(ii) the appropriateness of their treatment, care and supervision in respect of:

(a) their assessed health and social care needs;
(b) their assessed risk of potential harm to themselves or others;
(c) their psychiatric history, including any history of drug or alcohol abuse;
(d) the number and nature of any previous court convictions.

(iii) the professional and in-service training of those involved in the care of Mr Jones and Mr Heathwaite, or in the provision of services to them;

(iv) the extent to which Mr Jones' and Mr Heathwaite's care corresponded to statutory obligations; relevant guidance from the Department of Health including the Care Programme Approach HC(90)23/LASSL(90)11 and discharge guidance HSG(94)27 and local operational policies;

(v) the extent to which their prescribed care plans were:

(a) effectively delivered, and
(b) complied with by Mr Jones and Mr Heathwaite;

(vi) the history of Mr Jones' and Mr Heathwaite's medication and compliance with their regimes.

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

(i) the agencies (South West Durham Mental Health NHS Trust and Durham County Council Social Services) involved in the care of Mr Jones and Mr Heathwaite or in the provision of services to them, and

(ii) the statutory agencies and Mr Jones' and Mr Heathwaite's families.

3 To prepare a report and make recommendations to County Durham Health Authority.

APPENDIX II

PROCEDURE ADOPTED BY THE INQUIRY

We substantially adopted the procedure used in the Christopher Clunis Inquiry, as suggested to us by the Management Team of County Durham Health Authority. The detail is as follows:

1 Every witness of fact will receive a letter in advance of their coming to give evidence informing them:

(a) of the areas and matters of concern which we wish to cover with them; and

(b) that they may bring with them a friend, relative, member of a trade union, solicitor, or anyone else they wish to accompany them; and

(c) that it is the witness who will be asked questions and who will be expected to answer; and

(d) that when they come to give oral evidence to us they may raise any matter which they wish to, and which they feel might be relevant to our Inquiry; and

(e) that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2 We shall ask each witness of fact to affirm that his/her evidence is true.

3 Any points of potential criticism will be put to a witness of fact (either when they first give evidence or, more probably, at a later time) and they will be given a full opportunity to respond.

4 We may ask professional bodies or expert witnesses to give oral evidence to us about their views and recommendations.

5 We will invite anyone else who feels they may have something useful to contribute to our Inquiry to make written submissions to us for our consideration.

6 All our sittings will be held in private.

7 The findings of the Inquiry and its recommendations will be made public but we will not make public any of the evidence that has been submitted to us except as disclosed within the body of our Report.

APPENDIX III

LETTER TO WITNESSES

[date]

[address]

Dear [name]

Independent Inquiry into the Death of Mr Douglas Heathwaite

As you are aware from previous correspondence, the Authority has set up an Independent Inquiry to consider the circumstances leading to the death of Douglas Heathwaite on 19 June 1995. I have been appointed as manager to the Inquiry. The Chairman and members of the panel are grateful to you for the information you have already supplied.

A further copy of the remit of the Inquiry is attached.

The Inquiry Panel will be glad of the opportunity of meeting you and discussing further with you the issues which you have covered or will be covering in your written statement.

The Inquiry is to be held between Tuesday 27 January and Wednesday 4 February 1998 and I am now scheduling the attendance of those whom the panel wishes to meet.

I am hoping that it will be possible for you to attend the meeting of the panel, here at Appleton House, on [day, date]. I have scheduled this for [time] for approximately 45 minutes. You will appreciate that the panel will need to spend longer with some witnesses than with others and I would therefore be glad if you could please arrive at Appleton House some 15 minutes earlier than the scheduled time and be prepared to stay a little beyond the end of the scheduled time if necessary. I hope that these arrangements are convenient.

I attach a plan showing the location of Appleton House. On arrival at Appleton House please make yourself known to the receptionist who will be expecting you.

(cont'd...)

I would be grateful if you would please note the following points:

- The members of the Inquiry Panel will be:

Mr Arthur Taylor	-	Solicitor (Chairman of Panel)
Dr Simon Baugh	-	Director of Mental Health and Medical Director Bradford Community Health NHS Trust
Mr Peter McGinnis	-	Director of Nursing and Quality Leeds Community and Mental Health Services Teaching NHS Trust
Mr Martyn Tuckwell	-	Assistant Manager Mental Health Newcastle upon Tyne City Council

- The Inquiry will be held in one of the Committee Rooms in Appleton House.
- You may bring with you a friend, relative, member of a trade union, solicitor or anyone else whom you wish.
- It is to you that the members of the Inquiry Panel will address questions and invite an answer; the person accompanying you will not be able to address the Inquiry Panel.
- When you give oral evidence you may raise any matter which you wish and which you feel might be relevant to the Inquiry.
- You will be asked to affirm that your statements are true.
- If any member of the Inquiry Panel wishes to express any concern to you then you will be given a full opportunity to respond.
- The proceedings of the Inquiry will be recorded on tape; the tape will be transcribed as soon as possible after the discussion concerned and you will be provided with a copy of the transcript of the discussion in which you were involved; you will be invited to indicate any concerns which you may have with the transcript within seven days.
- The Inquiry Panel has invited written representations from various interested parties to advise on arrangements for persons in similar circumstances to Mr Jones and Mr Heathwaite and to make any recommendations they may have for the future.
- All sittings of the Inquiry will be held in private.
- The findings of the Inquiry and its recommendations will be made public.
- The Inquiry Panel will not make public any of the evidence submitted either orally or in writing, save as is necessary in the body of the Panel's report.
- The Inquiry Panel will make its findings on the basis of the evidence which it receives.

(cont'd...)

I would be grateful if you would please confirm at your earliest convenience that you will be able to attend at Appleton House to meet the Inquiry Panel as indicated above. I enclose a pre-addressed envelope for your response.

Please telephone me on 0191 333 3350 (my direct line) if you have any doubt or query arising from this letter.

Thank you for your assistance.

Yours sincerely

David Baggott
Authority Secretary

Enc

APPENDIX IV

LIST OF WITNESSES/INTERVIEWEES

NAME	STATUS - IN JUNE 1995 (Unless Otherwise Stated)
Dr David Alcock	Police Surgeon
Jean Bell	Staff Nurse, Winterton Hospital
Dr Paul Bowden	Expert Witness - Forensic Psychiatry
Dr George Bray	Consultant Psychiatrist, Winterton Hospital
Dr Ian Bremner	General Practitioner
Valerie Bryden	Chief Officer, South Durham and Weardale Community Health Council
Wayne Cairns	Divisional Manager, Acute Psychiatric Services
Dr Les Cantlay	Consultant Psychiatrist, Winterton Hospital
Alan Coyle	Community Psychiatric Nurse
Julie Daneshyar	Care Manager, Social Services Department, Durham County Council
Alan Davies	CPA Manager, Winterton Hospital
George Dickinson	Bus Driver
Christopher Dunn	Customer Services and Finance Manager, Social Services Department, Durham County Council
Jim Easton	Director of Commissioning, County Durham Health Authority (current position)
Judith Endean	Team Manager for South West Durham Mental Health Team, Durham County Council (retired)
John Fitzgerald	Taxi Driver

NAME	STATUS - IN JUNE 1995 (Unless Otherwise Stated)
Professor Kevin Gournay	Expert Witness - Nursing
Dr Christopher Green	Consultant Forensic Psychiatrist, Hutton Centre
Norman Heathwaite	Brother of Douglas Heathwaite
Robert Heathwaite	Father of Douglas Heathwaite (could not attend)
Russell Heathwaite	Brother of Douglas Heathwaite
Ernest Jones) Margaret Jones) Gwyneth Birch)	Parents and sister of Adrian Jones
Keith Kay	Addiction Counsellor and Nurse Therapist, Winterton Hospital
Peter Kemp	Director of Social Services, Durham County Council
Dr John Kent	Consultant Forensic Psychiatrist, Wakefield: author of expert report for Crown Court. (could not attend)
Richard Lamb	Care Manager and Approved Social Worker, Social Services Department, Durham County Council (could not attend)
Beverley Langley	Staff Nurse, Winterton Hospital
Dr Alan Lewis	General Practitioner
Richard Marshall	Clinical Psychologist
Dr Howard Martin	General Practitioner
Dr Stephen Martin	Consultant Psychiatrist, County Hospital, Durham (for the late Dr Anthony White)
Judith Morton	DART (Durham Accommodation Resource Team)

NAME	STATUS - IN JUNE 1995 (Unless Otherwise Stated)
Dr Selva Rajah	Locum Consultant Psychiatrist, Winterton Hospital
Gillian Rochford	Standards Development Officer, Social Services Department
Dr Dinah Roy	General Practitioner
Dr Jayathevar Satyadeva	Clinical Officer, Psychiatry, Winterton Hospital
Dennis Scarr	Borough Housing Policy Officer, Sedgefield Borough Council (current position)
Paul Shield	Manager, Braeside Residential Home (could not attend).
Yvonne Slater	Friend of Douglas Heathwaite
John Stamp	Senior Staff Nurse, Home Nursing Rapid Response Team, Winterton Hospital
Charles Waddicor	Expert Witness - Social Services
Margaret Whellans	Operations Manager, Social Services Department, Durham County Council (current position)
Len Wilson	Chief Executive of South West Durham Mental Health NHS Trust (Chief Executive of South Durham NHS Trust in June 1995)
Dr John Woodhouse	Director of Public Health, County Durham Health Authority (current position)
Russell Wyatt	Community Psychiatric Nurse

APPENDIX V

BACKGROUND HISTORY AND RELEVANT CHRONOLOGY

1 DOUGLAS HEATHWAITE

Douglas Heathwaite (usually referred to as Doug in casenotes) was born on 11 November 1959. He was the second of ten children, having six brothers and three sisters. At the time of his presentation to mental health services in 1976, his father was unemployed at the age of 52 and his mother was 50 years old. His mother died in 1993. It was recorded that one brother "likes a drink", but little other mention is made of his large family being in contact with mental health services. There is an entry of May 1993 that states "his large family of brothers and sisters all reject him because of his violence and drunken behaviour".

Mr Heathwaite reported his childhood as having been "very bad" and he was in trouble with the Police from the age of 7 or 8 years. This resulted in him being sent to a special school in Torquay and when he left education he said that he was able to read and write, but little else according to notes. He gave his age when leaving education at various times as being 15, 16 or 18½.

His first employment was as a miner, which he had to give up after four months because of his health. He had been diagnosed as suffering from asthma since childhood and was thus thought to be unsuitable for mining. Between the ages of 18 and 24 years he worked in a factory. There was subsequent reference to factory work, but during much of the time that he was in contact with mental health services he was unemployed or engaged in gardening projects.

He married at the age of 25, but this relationship broke up in 1985 and they subsequently divorced. The woman he married already had two sons and they had one son together. Subsequent to the break up of his marriage, Mr Heathwaite had a number of girlfriends, some of whom became well known to the therapists working with Mr Heathwaite, as joint sessions were undertaken because both had problems of various sorts including substance misuse.

His past medical history of asthma has already been noted and once he was apparently prescribed steroids and he allegedly reacted to these by "going up the wall". He had an episode of sexually transmitted disease around 1976 which was apparently fully treated. He was diagnosed as having arthritis of his knee in 1992 and was prescribed appropriate non-steroid anti-inflammatory drugs.

It is recorded that he began drinking alcohol at the age of 16. His use of alcohol first led him into trouble at the age of 18 when he was convicted of drinking and driving. It will be seen from the following summary of his contact with mental health services that abuse of illicit drugs was occasionally an issue.

RELEVANT CHRONOLOGY

26.07.76	Outpatient assessment. Complains of obsessional urge to pull stockings to pieces. When his wife objects he becomes very annoyed. Increasing irritability. Used to be a heavy drinker, now occasional only. Six months ago arrested for being drunk and disorderly. Diagnosis tension, behaviour and neurotic problems. His aims are to have a house with a garden rather than a flat and to have a job.
20.10.80	Wife seeking legal separation unless he seeks help and improves. Unemployed fourteen months, main problem drink. Court appearances for burglary, motor offences, drunk and disorderly, assaulting a policeman. TCI (to come into) Ward 15 (no evidence that admission did occur).
08.03.86	Admitted to Winterton Hospital. History given of alcohol problems over 13 years and increasing problem over the previous six months. Wife left him, he is verbally abusive. Works in factory, twelve hour shifts (three years). Drinks twenty pints per day. Diagnosis at various times during the admission as alcoholism or problem drinking plus reactive depression. Treatment Heminevrin. Wants to drink in moderation. After discharge (17.03.86) did not attend follow-up appointments on three occasions.
20.01.92	GP referral. Due to his behaviour difficulties. Depression and aggression. Recently attacked girlfriend in presence of Community Psychiatric Nurse.
03.03.92	Re-referral. Letter, notes stress in relationship with girlfriend. Had been taking six to seven pints of beer per drinking session for at least a week. Fluoxetine was prescribed.
24.03.92	More relaxed, able to decrease alcohol intake. Continue Fluoxetine.
21.04.92	Recent alcohol abuse and had assaulted girlfriend. Police involved led to remand. Girlfriend withdrew complaint.
02.06.92	Six to eight weeks daily drinking 11.00 am to 10.00 pm. Intoxicated with blackouts and suicidal ideation, therefore admit.
09.06.92	Admitted. Noted that he was drinking lager from 11.00 am to 11.00 pm and hits girlfriend when drunk. The admission was for elective detoxification with Chlordiazepoxide. A forensic history of remand several times because of thefts and fighting was noted. He agreed to take Disulfiram and his girlfriend was to supervise.
22.06.92	Discharged.
09.07.92	Taken to Braeside Hostel.

12.08.92	Problems with neighbours, two incidents involving Police.
24.08.92	Start anger management work.
08.09.92	Alcohol again, query on Disulfiram, attends alcohol counselling.
23.09.92	Joint work with Mr Heathwaite and girlfriend.
29.10.92	Physically aggressive to girlfriend leading to superficial injuries.
11.11.92	Drinking again.
17.11.92	Depressed. Mother has terminal cancer.
23.11.92	Reported to have taken LSD.
25.11.92	OD (overdose) Paroxetine after drinking bout.
27.11.92	Requires inpatient detoxification. Not suicidal.
01.12.92	Admitted. Situational depression and alcohol related problems. Coping difficulties. For one month drinking 32 units per day. Mother ill. Treatment Chlordiazepoxide.
10.12.92	Went away from hospital. Hit man in community who he believed had recently hit his girlfriend.
11.12.92	Discharged.
05.01.93	Has left Barbara (girlfriend).
07.04.93	Four weeks heavy drinking with £100.00 plus for a week. Mother died eight weeks ago. Described "compulsions" to hit girlfriend.
18.05.93	Suicidal. Heavy alcohol use and a number of other substances including alcohol, cannabis, diazepam, pain killers, anything available. Homeless. Worries that he would hurt someone around him as he is being extremely violent to one or two females he had recently been associated with. Alcohol, eighteen pints.
13.07.93	Continues to drink but reduced intake.
27.07.93	Feels less in control of temper. Verbal not physical aggression.
26.11.93	No illicit drug use. Dramatic decrease in alcohol.
15.12.93	Thioridazine effective in taking edge off temper.

17.01.94	Change of Consultant from Dr Bray to Dr Rajah at the request of GP. Confusion in correspondence about one "note" about "conditions for changing consultant".
08.02.94	Re-referral with mood swings. Temper control difficulties. Resident at Braeside for seven months. No contact with girlfriend for last week or so. Alcohol intermittent plus withdrawal symptoms for community detox.
17.02.94	Admission to hospital, Antabuse prescribed.
18.02.94	Drank alcohol as "experiment".
01.03.94	Discontinue Antabuse. Librium 10mg tds add Fluvoxamine 50mg.
15.03.94	Discharged.
18.03.94	Medical admission, two overdoses and unresolved alcoholism.
12.04.94	Overdose reactive to girlfriend's demands. Treatment Antabuse, decrease Librium, increase Fluvoxamine 100mg.
01.05.94	No recent alcohol. Variable mood swings.
11.05.94	Increase drink on Antabuse, little motivation to work on this. No illicit drugs.
21.06.94	Had holiday in Greece. Recently Antabuse Chlordiazepoxide, Fluvoxamine. Query still drinking on Antabuse.
15.07.94	Recommence alcohol and drug use. Assaulted girlfriend regularly.
02.08.94	Left Braeside. Living with brother, on Antabuse, Librium, Fluvoxamine.
13.09.94	Had discontinued Antabuse two weeks ago. Commitment is in doubt.
27.09.94	Care Programme Approach meeting noted alcohol plus illicit drugs.
07.10.94	Recent increase in violence to girlfriend. Progressed to drinking spirits.
11.10.94	Admitted emergency admission via crisis intervention service. Reported that when intoxicated he said that he had planned to kill his girlfriend and/or himself. Noted he had been drinking heavily previous two days, plus using LSD and cannabis. Diagnosis personality disorder plus drug and alcohol abuse (episodic).
19.10.94	Discharged.
01.11.94	Fluvoxamine and Librium. Still abusing alcohol.

03.01.95	Feels life is futile. Deteriorating mental state.
09.02.95	In bedsit accommodation. Fluvoxamine and Librium. Alcohol intermittent abuse. Typically 10 pints each of two days. Two weeks ago admitted with overdose of Librium. Suicidal ideation.
01.03.95	Admitted "on the drink all the time" last week overdose.
06.03.95	Out tonight and drunk two bottles Newcastle Brown Ale after hearing worrying news.
13.03.95	Reactive depression with alcohol abuse and social problems.
20.03.95	Prepared to be on Antabuse. Librium.
21.03.95	Had two pints despite being on Antabuse. Accident report: Mr Heathwaite stated he was followed to the bus stop and that a man attempted to hit him. Douglas retaliated and hit back leading to swelling and bruising of his right hand.
22.03.95	Stopped Antabuse.
24.03.95	In consultation with the staff described as being "obnoxious" and raising his voice.
04.04.95	Care Programme Approach meeting, fit for discharge but no placement found by social worker. Missing in the evening.
05.04.95	Discharged as he had been absent without leave previous day. Diagnosed as chronic alcohol abuse inadequate personality.
13.04.95	Seen in the community very drunk, suicidal, minor overdose.
25.05.95	Outpatient appointment. Diagnosis chronic alcohol abuse plus inadequate personality to continue Fluvoxamine. Noted "except for intermittent abuse of alcohol he has no further symptoms of withdrawal state. The mood swings are intermittent and non-intrusive with no evidence of suicidal intent. He is coherent, rational and rather cheerful".

Further reviews were planned.

2 **ADRIAN JONES**

Mr Jones was born in Spennymoor on 30 June 1964. He is the youngest of three children, having two elder sisters.

It is believed that he began to show behavioural problems from the age of seven years and he was seen at that stage by a child psychologist. His parents withdrew him from follow-up when they could see no apparent improvement.

At the age of fourteen years he was withdrawn from mainstream education at Spennymoor Secondary School because of disruptive behaviour and truancy. He assisted in his father's antique business until he was eligible for employment on a youth training scheme. He has held only a few jobs, typically being dismissed after a few weeks because of persistent absenteeism.

He left home at the age of seventeen years. Apparently his parents were unable to cope with his behaviour. At this stage he was drinking to excess and demanding food and money. He found various types of accommodation such as a rented caravan and hostels. At one stage his parents moved into a caravan in order that Mr Jones could not locate them, allegedly due to his father's fear of him.

There is no evidence of him establishing any long term relationships, nor has he sustained any hobbies or activities. His time in the community appears to have centred around the abuse of alcohol and, at times, illicit drugs.

RELEVANT CHRONOLOGY

January 1984	Referred by GP to John Lyons, Psychologist.
22.02.85	Domiciliary visit by Consultant Dr Rutter.
28.02.85	Admitted informally to Winterton Hospital.
05.08.85	Discharge from Winterton.
09.09.85	CPN follow up/day unit attendance since 12.08.85. Day Unit attendance ceased due to threats of violence made to staff in the unit.
13.09.85	Requesting admission. Refused by consultant due to non compliance.
16.09.85	Information from CPN that Adrian had moved to Darlington.
March 1986	Fined for offences of drunk and disorderly and Assault Occasioning Actual Bodily Harm.
20.03.86	Spennymoor CPN services receive re-referral from GP.

03.04.86 Visited by CPN. Abusive and hostile in manner.

16.04.86 Admission to Winterton Hospital. Quote from GP referral letter:

"He pursued his father with a knife and his father, whilst escaping, fell through a plate glass window. He also has his whole family in a constant state of anxiety and indeed terror, wondering what will happen next".

12.05.86 Discharge from Winterton (after failure to return from leave).

10.10.86 Admitted to Winterton informally. Entry of 21.10.86.

"Note history of trouble with law - shoplifting, actual bodily harm, drunk and disorderly etc."

(24.10.86) Attempting to obtain money from patients to purchase cannabis.
(27.10.86) Referral to social services for accommodation.
(31.10.86) Intoxicated, showing signs of aggression towards the staff. Transferred to Duggan Keen Unit on Section 5(2) Mental Health Act 1983).

03.11.86 Discharged against medical advice following lapse of legal detention.

17.11.86 Admitted informally to Winterton Hospital. Numerous episodes of drinking alcohol during this admission.

05.01.87 Discharged against advice.

October 1987 Convictions for committing a nuisance and breach of the peace.

04.11.87 Re-referral to CPN services by GP.

05.11.87 Admission to Winterton Hospital under Section 3 Mental Health Act 1983 into Duggan Keen Unit. Behaviour aggressive and unpredictable, paranoid ideation. Conclusion of Consultant assessment was:

"he was not fit to leave due to his paranoid ideas this afternoon and his underlying aggression. It was noted that he had been recently knocked out when he boxed at Spennymoor Recreation Centre". Medical recommendation for Section 3 "he is a known schizophrenic who has recently refused treatment. He is becoming increasingly deluded and aggressive".

14.11.87 Transferred to Ward 15.

06.01.88 Transferred to Duggan Keen Unit following incident (throwing plates).

10.01.88	Transferred to Ward 15.
15.01.88	Unpredictable and aggressive behaviour.
16.02.88	Absent without leave (AWOL).
25.02.88	Expressing suicidal ideation. Received six sessions of electro convulsive therapy (ECT). Change of consultant to Dr Cooper.
11.03.88	Overdose of leave medication. Admitted to Bishop Auckland General Hospital.
07.04.88	Further overdose whilst on leave. Admitted to Bishop Auckland General Hospital.
05.05.88	Detention renewal.
13.06.88	Hospital Manager's meeting. Remained detained.
23.06.88	Placed in Duggan Keen Unit following aggressive behaviour on Rehabilitation Ward during assessment period.
24.06.88	Change of consultant to Dr Bray.
07.07.88	Aggressive towards father whilst on leave. Returned to hospital by Police.
12.07.88	Admitted to Bishop Auckland General Hospital following overdose of Aspirin.
04.08.88	Reclassified to informal status.
16.09.88	Discharged. Treatment on discharge - Haldol Deconate.
04.10.88	From the CPN notes "he does admit to being paranoid at times and only last evening had been fighting due to his provocative behaviour in a public house in Spennymoor. He admits freely to constantly getting into fights in drink and it appears that he takes this as part of a night out drinking". He says he is not paranoid at the moment but sometimes people do talk about him, and this provokes a violent response.
14.10.88 - 11.01.89	Outpatient follow up.
11.01.89	Moved to Darlington.
20.07.89	Living in Durham area. GP referral to psychiatric services. Failed to attend appointment with Dr Walsh, Consultant at County Hospital.

14.02.90	Re-referral to Durham Psychiatric Services. Consultant, Dr White, Day Unit/Outpatient. Outpatient follow up over succeeding months. Noted no specific anxiety symptoms. His motivation to attend a day centre varied. It was noted that he was drinking to excess.
15.01.91	Letter from Adrian requesting change of consultant to Dr Martin.
08.02.91	GP referral to Dr Fisher.
03.07.91	Dr Fisher responds that he attended for his appointment on the wrong day and was abusive to medical records staff. "During the past few weeks Mr Jones had taken to presenting to the duty doctor at the County Hospital at weekends. He claims that he is in desperate need of medication, in particular tranquillisers, and he has various excuses why he can't obtain these from yourselves. I discussed the case with my colleague, Dr White, and I feel that Mr Jones is too chaotic for us to deal with in our alcohol and drug team and I would perhaps suggest that he be re-referred back to Dr White's team, although I doubt whether anyone is in a position to help him at the moment, given his rather chaotic attitude to treatment".
03.08.91	Informal admission to Winterton Hospital via Police Surgeon. In a manic state. Consultant Dr Bray.
06.8.91	Discharged against medical advice.
06.08.91	Informal admission to County Hospital following self presentation. Consultant Dr White.
07.08.91	Discharged.
09.08.91	Informal admission to Winterton.
10.08.91	Discharged against medical advice.
19.08.91	Taken into Police custody. Drunk and disorderly behaviour, violence, suspicion of burglary and criminal damage. Assessed by Dr Rajah.
20.08.91	Sedgefield Magistrates Court - Possessing an offensive weapon. Adjourned. Remanded in custody to HM Prison, Durham.
30.08.91	Examined by Dr Martin in prison.

19.09.91 Admitted to Winterton Hospital from HM Prison, Durham, under Section 3, Mental Health Act 1983, into the Duggan Keen Unit. Consultant Dr White. The report of the approved social worker making the application for Section 3 notes that he had been "very erratic in his behaviour, and aggressive and abusive in his language. He lived 'rough' for a brief period before breaking into his parents' home. Because of his aggressive behaviour, his parents contacted the Police and he was remanded in custody for possession of an offensive weapon. He expressed both grandiose and delusional ideas and was clearly in an agitated state. He also expressed considerable hostility towards a former girlfriend".

(26.09.91) Suggested depot treatment "became very angry and threatening".
(30.09.91) Transferred to Ward 13.
(04.10.91) AWOL procedure implemented. Returned to Ward same day.
(09.10.91 Threatening towards Dr White and nursing staff. Transferred to Duggan Keen Unit.
(10.10.91) Violent incident towards Dr Martin. In this incident he physically halted Dr Martin's progress. Physical restraint was applied to minimise injury to RMO.
(13.10.91) Violent incident towards a fellow patient. In this incident he kicked patient AH and punched his right eye.
(05.11.91) Transferred to Ward 13. In the nursing notes is the comment that "Adrian told staff he's always found aggression his best weapon of interaction".

13.11.91 Discharged by nearest relative (father) from hospital.

02.12.91 Self presentation to County Hospital. "His complaint was that he was shaking and he had various disturbing thoughts about people who have hurt him." "His mood was depressed and he told me that life was not worth living". The belief was that Mr Jones caused many of the symptoms by his own behaviour, possibly abusing alcohol or illicit drugs and demanding sudden changes in his medication which bring about extra-pyramidal side-effects.

12.12.91 Attended Dr White's outpatient clinic.

16.01.92 Informal admission to Winterton Hospital. Consultant Dr White. (24.03.92) Requests change of consultant.

08.04.92 Discharged against medical advice. Diagnosis Schizo Affective Disorder in an individual with a sociopathic personality disorder.

27.04.92 Informal admission to Winterton Hospital. Consultant Dr Bray.

18.05.92	Discharged. Diagnosis - Personality problem currently anxious with some depressive features.
19.05.92 - 01.07.92	Attendance at Winterton Day Unit. Requested own discharge from day unit.
July 1992 - July 1993	Attendance at Dr White's outpatient clinic.
08.07.93	Informal admission to Winterton Hospital. Consultant Dr Bray.
12.07.93	Discharged to Plawsworth Centre for the homeless. No follow up.
16.08.93	Admitted from Holme House Prison under Section 48 of Mental Health Act 1983 charged with theft (not paying a taxi fare). Consultant, Dr Cantlay. Verbally abusive to staff.
25.08.93	Physically aggressive towards fellow patient and staff. Violent incident report completed. Made a threatening and abusive telephone call to a landlady of a Spennymoor pub.
28.08.93	Attempted to kick and bite staff. Violent incident report completed.
01.09.93	Sexually suggestive and aggressive towards female staff member.
06.09.93	Claims to have raped a woman with another male patient. Also stated he had a homosexual relationship for five years.
10.09.93	Court reported from Dr Cantlay recommending Section 37 Mental Health Act 1983.
08.10.93	Report from Dr Martin recommending Section 37 Mental Health Act 1983.
11.10.93	Placed on Section 37 Mental Health Act 1983.
02.11.93	Attempted to assault another patient. Sustained fracture to hand.
25.01.94	Section 117 meeting held.
08.02.94	Granted 28 days leave.
08.03.94	Discharged.
08.03.94 - 12.04.95	Community Psychiatric Nurse visits.

27.05.94	Letter from Dr Cantlay notes "his long history of bipolar affective illness and a behaviour which is worsened by a tendency to abuse alcohol". He suggested a prescription of Propanol to assist in the side-effects from anti psychotic medication.
14.10.94	Section 117 Review Meeting.
12.04.95	Moved to Newton Aycliffe.
18.04.95	Response by Psychologist, Richard Marshall, to Dr Cantlay's referral includes the following "one of the best periods in his life was when he was involved in a notorious gang of youths in Spennymoor... found violence to be exciting "...Sexually he has found that he needs to employ aggressive fantasies in order to achieve any sexual pleasure and is quite impotent without this. "...Seeks excitement in a way which is harmful to himself and can put others at risk of being harmed by him".
10.06.95	Admitted to Winterton Hospital following drink driving offence and assaulting a Police Officer. Police surgeon referral.
12.06.95	Discharged.

APPENDIX VI

BIBLIOGRAPHY

1 DOCUMENTS SUPPLIED TO THE PANEL

Medical Notes relating to Adrian Jones Volumes 1 to 3.

Notes from County Hospital, Durham City, relating to Adrian Jones.

Medical Notes relating to Douglas Heathwaite. Addictions Notes relating to Douglas Heathwaite.

Medical Notes relating to Adrian Jones received from Hutton Centre, St Luke's Hospital, Middlesbrough.

File of Dr Cantlay, Consultant Psychiatrist, relating to Adrian Jones.

Psychology Notes relating to Adrian Jones.

Documents provided by Durham County Council Social Services Department.

File of County Durham Probation Services on Adrian Jones.

Report of Durham Constabulary.

Witness Statements provided by County Durham Probation Service.

Leave of Absence Forms and Associated Documentation for Adrian Jones.

Nursing Standards in use on Ward 38, Winterton Hospital.

Policies used by Junior Doctors on Ward 38, Winterton Hospital.

Complete list of Policies in use on Ward 38, Winterton Hospital.

January 1995	Policies Numbers 31, 37, 38, 45 and 58 of South West Durham Mental Health NHS Trust.
1993/94 to 1995/96	Copies of Service Agreements between various General Practices and South West Durham Mental Health NHS Trust and South Durham Health Care NHS Trust relating to Adult Mental Health Services.
1993 to 1997	Copies of Contract details between County Durham Health Authority and South West Durham Mental Health NHS Trust including Service Specification of Adult Mental Health Services. Statistical information on expenditure from 1990/91 to 1995/96 and on Service Priorities from Durham County Council Social Services Department.

1996	Annual Report of the Director of Public Health for County Durham.
1997	County Durham Health Authority Public Health Statistics.
February 1991	Report of NHS HAS and DHSS Inspectorate joint visit to services for mentally ill people and for elderly people in the Darlington Health District.
May 1991	NHS HAS and DHSS Inspectorate joint visit to services for mentally ill people and elderly people in the North Tees Health District.
April 1994	Mental Health Act Commission visit to South West Durham Mental Health.
January 1995	Social Services Inspectorate visit to County Durham to inspect home support services.
January 1995	Joint Care Planning Policy document of South West Durham Mental Health NHS Trust and South West Durham Social Services Mental Health.
April 1995	Mental Health Act Commission Visit to Durham Social Services Department.
November 1995	Independent Inquiry by South West Durham Mental Health NHS Trust relating to Douglas Heathwaite.
November 1995	Independent Inquiry by South West Durham Mental Health NHS Trust relating to Adrian Jones.
December 1995	Royal College of Psychiatrists' review of Training in Psychiatry at hospitals in Durham County.
December 1995	Report of NHS Executive Northern Yorkshire to County Durham Health Commission in relation to Mental Health Assessment and Care Programme Approach.
July 1997	Transcript of Proceedings at Crown Court, Teesside re Adrian Stephen Jones.

2 DOCUMENTS AND PUBLICATIONS CONSIDERED BY THE PANEL

1983	Mental Health Act 1983 HMSO.
1990	Department of Health HC(90)23/LASSL(90)11 Caring for People.
August 1993	Department of Health, Welsh Office. "Code of Practice" Mental Health Act 1983 pursuant to Section 118 of the Act.
July 1993	Transcript of Crampton and others v Secretary of State for Health (The Beverly Allitt Case).
February 1994	Department of Health HSG(94)5. Introduction of Supervision Registers for mentally ill people from 1 April 1994.
May 1994	Department of Health HSG(94)27. Guidance on the discharge of mentally disordered people and their continuing care in the community.
1994	NHS Training Directorate "Just for the Record".
February 1994	Ritchie J, Dick D, Lingham R. Report of the Inquiry into the Care and Treatment of Christopher Clunis HMSO 1994.
January 1995	Sheppard D (Ed), Learning the Lessons. Summary of events leading to Mental Health Inquiry Reports between 1985 and 1994 and their terms of reference. Zito Trust 1995 and
July 1996	Learning the Lessons: 2nd Edition.
July 1995	Davies N, Lingham R, Prior C and Sims A. Report of the Inquiry into the circumstances leading to the death of Jonathan Newby.
October 1995	Department of Health. Building Bridges. A guide to arrangements for inter agency working for the care and protection of severely mentally ill people.
November 1995	Mishcon J, Dick D, Welch N, Sheehan A, Mackay J. The Grey Report.
1996	Blom-Cooper L, Grounds A, Guinan P, Parker A, Taylor M. The Case of Jason Mitchell.
April 1996	Royal College of Psychiatrists: Assessment and Clinical Management of Risk of Harm to other People.

1996	NAHAT. Duties of Managers for the review of detention under the provision of the Mental Health Act.
December 1996	Brown A G, Harrop F M, Cronin H J, Harman J C. Report to Northumberland Health Authority into the Care and Treatment of Richard Stoker.
April 1997	Richardson G, Chiswick D, Nutting I. Report into the Treatment and Care of Darren Carr.
November 1997	Adams J, Douglas P, McIntegart J, Mitchell S. Report into the Treatment and Care of James Ross Stamp.
1997	Journal of Psychiatry. John Reed: Risk Assessment and Clinical Risk Management.
1997	The Sainsbury Centre for Mental Health. Pulling Together. The Future Roles and Training of Mental Health Staff.
1998	Medication, Non-Compliance and Mentally Disordered Offenders. A Study of Independent Inquiry Reports. The Zito Trust.

APPENDIX VII

GLOSSARY OF TERMS

AWOL	Absent without leave
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DART	Darlington Accommodation Resource Team
DNA	Did not attend
DRO	Disablement Resettlement Officer
DV	Domiciliary Visit
FME	Forensic Medical Examiner
GP	General Practitioner
MHA	Mental Health Act
MHRC	Mental Health Resource Centre
OT	Occupational Therapist
RMN	Registered Mental Nurse
RMO	Responsible Medical Officer
SR	Supervision Register