The Report of the Inquiry into the Care and Treatment of Joe Janes

Commissioned by: East Kent Health Authority

Panel: Kris Gledhill, Barrister; Dr Michael Farrell, Consultant Psychiatrist; Anne Gay, Senior Social Work Manager; Chris Hughes, Nurse Manager

Inquiry Manager: Lynda Winchcombe

Sections:

1. **Introduction**

1. We were asked to conduct two inquiries, one relating to Joe Janes and one relating to Joseph Day. The two men are inextricably linked because the former killed the latter on 15 July 2001 at Willow Lodge, a supported housing facility operated by Rethink (then the National Schizophrenia Fellowship). Joe Janes later admitted manslaughter on the grounds of diminished responsibility (based on his schizophrenia) and was admitted to a medium secure hospital unit under sections 37 and 41 of the Mental Health Act 1983. As there was a lot of overlap in terms of witnesses, we heard evidence as part of one process.

2. The central issue raised under our terms of reference was whether Joe Janes should have been placed at Willow Lodge, into which he moved on 12 July 2001[1]. A subsidiary issue was whether, in light of his condition, Joseph Day should still have been a resident at Willow Lodge at that time[2]. We have produced two separate reports in order to allow separate consideration of the publication of each report; we have recommended to the Health Authority that the one relating to Mr Janes be made public but that the one relating to Mr Day be kept confidential to the Authority, the relevant statutory authorities involved (Trust and County Council), and Rethink; naturally, it should be shared with Mr Day's family[3]. Our reports were presented to the Authority without any anonymity granted to any of the witnesses who gave evidence to us or who appear in the narrative (save in a few instances)[4].

3. Before commencing with the chronology of the facts and our analysis, we should note that we sought to involve the families of Mr Day and Mr Janes in our process: to this end, we secured limited funds from the Health Authority to allow them to be legally represented, invited them to make individual submissions at the outset of our evidential hearings as to their concerns on the basis of what they understood at that stage, endeavoured to keep them informed as to the progress of the inquiry, and invited them to make representations on what was a close to final draft of our report[5]. We have set out in more detail as part of the chronology the facts the circumstances of the setting up of the inquiry[6] because this is relevant to the recommendations we make. In addition, we have set out in an Appendix the reasons why we adopted this procedure in case this is of interest to other panels conducting similar inquiries[7].

---

[1] The text of our terms of reference in relation to Mr Janes is set out at Appendix 1

[2] The text of our terms of reference in relation to Mr Day are not reproduced in this report.

[3] Our reasons for this recommendation are set out in Appendix 2; Mr Day's mother was able to see and comment on a late draft of our report relating to her son.

[4] Our reasons for this are also in Appendix 2; in fact, we only received one request for anonymity.

[5] Mrs Day saw both reports relating to her son and Mr Janes; Mr Janes' mother only saw the one relating to her son.

[6] See below at pages 63-64

[7] See Appendix 3.

4. A summary of our conclusions is that we found a number of failures on the part of the statutory authorities and of Rethink in that procedures were not in place or were not sufficiently robust; in this context, we also feel that a number of individual professionals made errors, though we should emphasise that procedures or protocols should exist to cover for individual errors. The net effect of this was that the decision-making process which lead to Mr Janes being placed at Willow Lodge was imperfect in that it was not fully-informed; however, we have to emphasise that the final step in this process was at the end of a series of decisions which, certainly when taken collectively, involved underplaying the needs of and risk posed by Mr Janes. Whilst we note that it is possible that Mr Janes would still have been placed at Willow Lodge if these defects had not existed (in part because of a lack of alternatives in terms of placements in the community), it is also a realistic possibility that different steps would have been taken (including, perhaps, detention in hospital). However, we urge people not to read this summary alone but to follow the chronology and the process of our reasoning.

5. We have split our report into 2 main sections: one is a chronology of the events and the second is an analysis of some of the more important issues and themes which are repeated in the chronology. However, we make comments on an ongoing basis in our chronology, which is consequently one which contains a significant amount of analysis as well: it is not simply a recitation of facts.

2. Chronology

1. The chronology has been compiled from a detailed review of the documents with which we were provided, supplemented by statements and oral evidence from witnesses. We should record that we had cooperation from all relevant witnesses with only one exception. We should like to thank those who provided statements, and particularly thank those who attended to give oral evidence to us and who replied to detailed potential criticisms we put to them: despite the relative informality of an inquiry compared, for example, to a court-room, we appreciate that it can still be a disturbing experience to have an inquiry conduct an investigation, and we should record that all witnesses behaved professionally towards us.

2. In order to understand the chronology, it is useful to identify at the outset some of the main locations and persons involved. The following are the main locations which appear in the narrative:
    - Shepway Mental Health Service/Radnor Park Day Service – Folkstone: attended by Mr Janes
    - Arundel Unit, Ashford Hospital: the in-patient facility which Mr Janes attended on occasions as a voluntary patient, going to Scarborough Ward and Edgehill Ward
    - Willow Lodge: NSF/Rethink supported accommodation in Folkstone, where Mr Day was a resident and into which Mr Janes had just moved at the time of the homicide
    - Carr-Gomm – Dolphin Lodge: supported accommodation which rejected Mr Janes' application shortly before he applied to Willow Lodge
    - Trevor Gibbens Unit: Medium Secure Unit in Maidstone where Mr Janes is currently detained and to which he was referred for a forensic assessment several months before the homicide

3. As to the main relevant persons, these can be split into three categories. First, those involved in the homicide and family members:
    - Joseph Day: the victim; a resident at Willow Lodge
    - Joe Janes – the assailant; a recently-arrived resident at Willow Lodge
    - Mrs Penny Day – mother of Joseph Day
    - Mrs Lesley Doyle – mother of Joseph Janes

4. Secondly, the doctors and other professionals:
    - Dr Peter Byrne: RMO to Joseph Day and Joe Janes until May 2001 (when Dr Kooij took the role)
    - Dr CE Catto: Joe Janes' GP.
    - Dr Clare Dunkley: Forensic psychiatrist at the Trevor Gibbens Unit, who provided a forensic assessment on Mr Janes in March 2001
    - Dr Kooij: locum consultant for Mr Day and Mr Janes from mid-May 2001 (taking over from Dr Byrne).

- Dr Bastiaan Veugelers: SHO to Dr Byrne in 2001.
- Dr Karen White: consultant psychiatrist and colleague to Dr Byrne, who provided consultant cover when Dr Byrne was on vacation, including when Dr Dunkley's forensic report was received.

- Marilyn Brennan: Coordinator of care offered to Joe Janes, and a member of the admissions panel at Willow Lodge.
- Caroline Gale: Student Social Worker working with Mr Janes.
- Sue Guy: Senior social work; supervisor of Caroline Gale; member of the Admissions Panel at Willow Lodge.
- Brett Luckhurst: Keyworker for Mr Janes at the Radnor Park Day Service until he left the service.

5. Finally, there are the Willow Lodge/Rethink (NSF) Staff and those involved in the Rethink decision-making process which offered a place to Mr Janes:
    - Raphael Fox – Manager
    - Edward Greenwood – Operations Director, who conducted the internal report into the homicide
    - Jacky Hammond – area manager; involved in the aftermath of the incident.
    - David James – Community Mental Health Worker, who was the link person between Willow Lodge and Joe Janes.
    - Marilyn Brennan (see above), Sue Guy (see above), Celia Robinson (Southern Housing Group – the "landlords" at Willow Lodge), Heather Murray (one of Rethink's important and experienced volunteers), and Raphael Fox (see above) – the Panel who considered Mr Janes' application for admission to Willow Lodge.

6. Also relevant to understanding our chronology is the fact that we were able to have an illuminating session on the question of the statistics and other evidence available relating to the issue of mental illness and risks posed to others[8]. The relevance of this is that whilst Mr Janes clearly did pose a risk in fact (as the homicide indicates), the main question for us was whether in the chronology there were instances when it was possible to say that this risk was understated or missed. However, this has to be put in context by noting that there are only a small number of people suffering from schizophrenia (which was the established diagnosis of Mr Janes) are involved in homicides[9], that this represents about 1 in 3000 patients admitted to hospital in a year on account of schizophrenia, and that whilst the risks may be increased if the patient abuses alcohol or illicit drugs, it remains a very rare occurrence. The other feature to note is that predicting and assessing risk with any degree of objectivity is difficult.

7. The following are the main features in the chronology and an indications of the concerns which we have:

[8] This is summarised in full in Appendix 4.
[9] The statistic we were told was about 12 per year.

1) Mr Janes' first contact with social services was in February 1999, when his mother called for assistance because of her son's volatile behaviour: although this is very much in the background, we are concerned that the response of social services was to suggest that Mr Janes, then aged 16, be placed in bed-sit accommodation.

2) The first referral to a psychiatrist came in March 2000. Initial action was perfectly proper and a provisional diagnosis was reached and treatment commenced; a long history of drug abuse was noted. Mrs Doyle was involved and asked to provide information, which was found to be of assistance to the psychiatrist involved, Dr Byrne. We do have some concerns, however, as to the recording of information and a view expressed that Mr Janes was likely to be drug-free in the future.

3) Mr Janes was briefly the responsibility of the Ashford Mental Health Team in September/October 2000 because he moved.

4) In November 2000, Mr Janes attacked a friend with an axe, an incident which could easily have been fatal: although there was no police involvement, the incident came to the attention of Dr Byrne. Mr Janes was not admitted to hospital: this is a matter we have some concerns about, though we note that a treatment plan was put into effect, involving day hospital services.

5) At the end of January 2001, Dr Byrne referred Mr Janes to the Trevor Gibbens Unit in Maidstone for a forensic assessment.

6) In February 2001, Mr Janes was admitted to the Arundel Unit at Ashford Hospital, following aggressive behaviour towards his family; this was just before a pre-arranged CPA meeting. We are concerned of the lack of an indication that this hospital admission changed the care plan applicable to Mr Janes; and we are also concerned of the lack of an indication in the records we have seen that it was recognised that, as Mr Janes was living at home with younger sisters, there was child protection issue should he return to his home address.

7) He was released from hospital in March 2001, apparently going to bed and breakfast accommodation: we have concerns both as to the fact that he was released in the circumstances and the place to which he was released.

8) In fact, Mr Janes returned to his mother's house. Shortly thereafter, an application was made to Carr Gomm for supported accommodation; this was arranged by social services.

9) On 12 March 2001, the forensic assessment requested by Dr Byrne in January was completed by Dr Dunkley at the Trevor Gibbens Unit: she assessed him as needing hospital admission to bring his paranoid symptoms under control and allow a proper community care package to be put into place. She was sufficiently concerned about the risks posed by Mr Janes that she faxed her report and telephoned through to express her concerns.

10) The immediate response to this assessment was complicated by the fact that Dr Byrne was on leave and his cases were being covered by his colleague, Dr White. She did not arrange to see Mr Janes: we feel that this was a case which did require an immediate assessment from a consultant, though we accept that Dr White was merely providing cover for a patient who had been allowed to leave hospital recently by a consultant colleague and it might have been difficult for her to take a different approach.

11) In fact, Mr Janes was reviewed on 16 March 2001 by a junior doctor: it appears that he did not have the forensic report available, which is a matter of great concern. There was a further review on 23 March, and it was decided not to admit him to hospital formally.

12) The application to Carr Gomm was taken further, with further information provided; an application was also made to Willow Lodge.

13) At this time, it is apparent that the view of social services is that their role was to secure accommodation because that is the role that had been assigned to them under the CPA process: we feel that this is an erroneous approach because social workers have a specific duty under the Mental Health Act to raise the issue of placing people under the compulsory provisions of the Act. We do accept that the lack of action by others involved in the CPA process is equally problematic.

14) When Dr Byrne returned from leave, he arranged for Mr Janes to be admitted to hospital urgently. This was the appropriate action to take, but we do have concerns about the management plan and in particular the lack of involvement from the drug and alcohol team (which seems not to have been fully integrated into mental health services at the time) and the lack of a comprehensive risk assessment; a management plan was worked out by Dr Byrne but we have concerns as to the recording of this plan.

15) Mr Janes remained in hospital until the middle of May 2001: but he was difficult to engage in treatment other than accepting depot medication, and he continued to use drugs and alcohol; and there was pressure by members of his care team to have him discharged. There are a number of features of the events during this time that cause us concern:

    (i) his application to Carr Gomm was rejected, essentially on risk grounds, and so the application to Willow Lodge was the one to be pressed forward: there does not appear to have been any reconsideration of whether the plan to place Mr Janes in supported accommodation was the appropriate action; indeed, there does not appear to have been any reconsideration in light of other important developments, namely the forensic assessment and the admission to hospital;

    (ii) there were efforts to have Mr Janes discharged on the basis that he was causing problems on the ward by bringing drugs on; he signed to a contract which indicated that he would be discharged if he broke ward rules as to drugs or alcohol, although it was in fact the view of Dr Byrne that he should be made a compulsory patient if he sought his discharge: there were mixed messages and there was no clear record that the view of the consultant in charge was that Mr Janes should be kept in hospital despite the contract;

    (iii) another important development was that Dr Byrne left his post and Dr Kooij took over as a locum consultant: there was no proper hand-over documentation as to risk and the management plan.

16) Mr Janes was allowed to leave hospital on 14 May 2001 and also withdrew his application to Willow Lodge. He was allowed to leave to live with a friend, though he soon returned to his mother's house and revived his application to Willow Lodge.

17) There was a CPA meeting on 29 May 2001: we are concerned that at this meeting there was incomplete information available (for example, in-patient notes were not available to Dr Kooij), and there appears to have been a conclusion that Mr Janes was drug free (which he was not).

18) On 22 June 2001, the admissions panel at Willow Lodge (which included members of social services and the day care mental

health team) accepted Mr Janes' application: there is a significant dispute as to what information was made available to the panel, and whether there were reassurances provided that he was not misusing drugs at the time. We are concerned that the panel did not ensure that they had enough information to allow a final decision, and also that the composition of the panel undermined its independence.

19) Before Mr Janes moved to Willow Lodge, which took place on 12 July 2001, there were a number of instances where fresh information relevant to the decision to place him there came to light (or could have with some basic investigation) – including his behaviour at home, and possibly information as to his recent behaviour in hospital - but the chance to reassess whether his placement was proper was not taken.

20) The homicide occurred very shortly after Mr Janes arrived at Willow Lodge, on 15 July 2001.

21) We deal also with the dealings between Mrs Day and both the statutory authorities and Rethink, and the circumstances in which our inquiry came to be appointed. A number of matters of concern arise.

8. A detailed account of this brief chronology now follows.

1. First Contact with the Statutory Authorities

9. On 28 February 1999, Mrs Doyle contacted social services at Shepway about getting her son, who was then aged 16, to leave home because he was volatile, his conduct including the throwing of glass objects. There was a meeting on 1 March 1999. According to social service records and a statement provided to us by the Team Leader of the Shepway Children and Families Duty and Assessment Team, advice was given as to how to make arrangements for Mr Janes to have his own housing and how he could apply for benefits. The final entry on the records is a telephone call on 2 March 1999, which records that contact is being made by Joe Janes with Shepway District Council Housing.

10. We were told by Mrs Doyle that her action in contacting social services was prompted by her realisation that she needed help in coping with her son. She noted that Joe's father had died in August 1997, and his behaviour had become problematic for the family to deal with. As for the suggestion made by social services following their meeting, she records her view that it was not viable for Joe to live independently in a bed-sit, as he would not be able to cope.

11. Although this is very much in the background narrative, and so not central to our inquiry, we have to express concern that the advice given was that a 16 year-old (still a child) who was engaging in challenging behaviour should be placed in bed-sit accommodation on his own. Social services were aware that there were 2 other children (then aged 13 and 8) and that Joe was volatile.

12. It has to be said that from the point of view of members of the public who, like Mrs Doyle, seek help, "social services" may be seen as one entity, and so a contact with one department which proves to be fruitless (in the sense of not leading to a satisfactory solution) leaves an impression that contact with other departments will be equally unproductive and so not worth contacting or confiding in. Of course, "social services" should function seamlessly, so that a referral to one team leads on to contact with the appropriate team; and the response should be appropriate.

13. In due course, Mr Janes did move out from his mother's house and began living in a flat above a take-away shop; he obtained work as a wood-cutter. He had ongoing problems with drinking alcohol to excess and drug abuse, and his mother arranged an appointment with the Kent Addiction Centre in Folkstone.

2. First Referral to Psychiatric Services and Initial Action

March/April 2000 – GP appointments

14. On 28 March 2000, Mr Janes presented to his GP with anxiety and depression, possibly due to alcohol use or withdrawal. Dr Catto, a partner in the practice with which Mr Janes and Mrs Doyle were registered, provided us with a statement and was interviewed by us. We also had copies of Mr Janes' GP records. On this visit, Dr Catto prescribed Dothiepin. This was stopped when Mr Janes returned on 11 April, indicating hallucinations, possibly as a reaction to the drug or possibly as a flash-back to previous drug abuse.

5 June 2000 – GP Appointment – Referral to Psychiatric Services

15. He presented again on 5 June 2000 complaining of hallucinations, both auditory and visual, possibly caused by drug abuse. He indicated that he had used magic mushrooms in the past, and recently Ecstacy and Ketamine. A referral was made to Dr Byrne at the Shepway Mental Health Centre, Radnor Park Avenue. On 28 June, he was offered an appointment on 4 August, which he missed; however, he was seen on 10 August 2000.

10 August 2000 – Psychiatric Assessment – Dr Byrne

16. The assessment carried out on 10 August 2000 was by Dr Byrne. In his letter of 14 August to Dr Catto, Dr Byrne made a provisional diagnosis of schizophrenia and Risperidone was prescribed. He noted "eighteen months of significant psychotic symptoms" which had commenced in the context of poly-drug abuse (which had been ongoing for 3 years) but had worsened despite a reduction in drug use. The specific problems were paranoid delusions of people speaking about him and laughing at him. Dr Byrne indicated that he had asked the CPN team to become involved, and had also asked Mr Janes to return with his mother in a month so that he could obtain a collaborative account of the symptoms and also explain to the family the seriousness of the illness.

17. Clearly, at this stage, the medical agencies – GP and the appropriate area consultant psychiatrist – acted with expedition appropriate to the situation. We also note that Dr Byrne had noted the importance of obtaining an account from Mr Janes' family.

18. Dr Byrne provided us with a detailed statement and appeared at a meeting of the Panel in London (where he now works) to give evidence to us. He indicated that this initial assessment was viewed by him to be an urgent one. He also commented that there was a long history of binge drinking; in terms of drug abuse, his assessment was that Mr Janes was a young man who would take anything.

7 September 2000 – Further Assessment – Dr Byrne

19. On 7 September 2000, Dr Byrne carried out a further assessment. This was with Mrs Doyle in attendance. In a letter of 14 September 2000 to the Ashford Mental Health Centre – the case being referred there because Mr Janes had moved – Dr Byrne described the attendance of Mrs Doyle as "most helpful". Dr Byrne was able to obtain from Mrs Doyle an account of her son's aggressive and threatening behaviour. He told us that this was important because whilst Mr Janes' account and presentation gave an impression that he was a charming young man who was concerned about his illness, the account given by Mrs Doyle was entirely contrary.

20. This is, we feel, a highly important point which needed to be kept at the forefront – namely the impression given by Mr Janes alone does not provide the full picture and therefore gives a false impression. Dr Byrne noted to us that Mr Janes was willing to provide a significant amount of information as to his drug use: but he also felt that Mr Janes minimised the extent of his substance abuse and, more importantly, his threatening behaviour. Mrs Doyle's information was therefore central to an understanding of the nature of Mr Janes' illness and the risks posed and therefore to the approach to be taken to his management.

> See further our analysis in Part 3: although it is clear that Dr Byrne obtained adequate information from Mrs Doyle on this occasion, it was a regular feature of dealings involving Mr Janes that there was no system to ensure that proper information from third parties such as his mother.

21. Our concern, however, is that we cannot find that this entirely valid conclusion by Dr Byrne is properly highlighted in the documentation available to others, and this is a failure: the letter of 14 September 2000 to the Ashford Team does indicate that the information from Mrs Doyle was important, but not the extent that it gave a wholly different picture. Dr Byrne informed us that his aim in this letter, written to a colleague, was to ensure that Mr Janes was able to engage with services; and that he did not wish to present Mr Janes as a "hopeless case" or to present the receiving psychiatrist with an excessive amount of information. (Dr Byrne noted that his hand-written notes and other material would be available to the Ashford Team.)

22. We have no doubt that the Ashford Team could (and should) review all relevant material: but it is important that documents which can properly be expected to contain an accurate summary of the main points – including a letter to transfer a case from one consultant to another – do contain in summary form the relevant features. The reason why this is important is that people with mental health problems are often seen by many different professionals and in many different settings, and a professional reviewing a file will look to documents which can be expected

to set out a summary of important features. If information about a patient's behaviour is provided by a reliable informant and supports a conclusion that the patient's account is not accurate (especially if that account is credible), this is information which should be recorded prominently so that it can be taken into account by other professionals.

> See further our analysis in Part 3: there were many instances when it is apparent that the recording of information, risk assessments or management plans was inadequate.

23. The conclusion of Dr Byrne following this meeting, as recorded in his letter to the Ashford team, was that Mr Janes was likely to remain free of illicit drugs. This is perhaps surprising because he was a young man with a significant history of drug abuse, described by Dr Byrne to us as someone who would try anything: we feel it was wishful thinking to indicate that Mr Janes was likely to remain substantially drug-free, and that planning for his treatment should have rested on a contrary view. This is not to say that there were no hopeful features in Mr Janes' case: he had referred himself for treatment and seemed to be able to make a link between his symptoms and his substance misuse. However, these positive features did not allow a statement of opinion that he was likely to remain substantially drug-free: this was premature. In the context of the history of drug-misuse, the correct approach was to assume a continuation of that behaviour (even if not at the same level) until there was proper evidence of a lack of such behaviour. We note that Dr Byrne had requested CPN involvement, which should have provided an ongoing review of Mr Janes' use of drugs.

24. We are not suggesting that Dr Byrne underplayed in his diagnosis of Mr Janes that drugs and alcohol played an important role. Our concern is the lack of any treatment programme which dealt with drugs and alcohol problems. We note, for example, the lack of involvement by the drugs and alcohol specialist service.

25. Again, this is an important comment because the issue of drug use is an important feature in the narrative (including in relation to his acceptance at Willow Lodge, where the homicide occurred) and the risk assessments carried out: views formed that Mr Janes was not a regular user of illicit drugs (or that his use was occasional) would no doubt be supported by reviewing material from a consultant psychiatrist such as Dr Byrne giving his opinion as to this at an early stage in the psychiatric intervention in Mr Janes' case that he was likely to remain free of illicit drugs.

> See further our analysis in Part 3: it is important to involve drugs and alcohol services within mainstream mental health services.

26. Mrs Doyle in her statement to us indicated that it was apparent to her that

her son was using excessive amounts of drugs and expressing severely paranoid ideas during this period, when he was living in short-term accommodation. She records that he was seen by CPNs during this period, but nothing was picked up in relation to drug abuse.

27. As mentioned above, the referral to the CPN team was initiated by Dr Byrne. We were able to speak to Jon Thomas, who was assigned: however, he told us that he only saw Mr Janes a few times, and that he ceased to be involved because he (ie Mr Thomas) moved. It does not appear that there was a specific CPN assigned in place of Mr Thomas.

3. Ashford Mental Health Team

28. As noted above, Mr Janes moved: he went to Wye and so was referred on to the Ashford Mental Health Team. Dr Vogel, the relevant consultant, asked her SHO, Dr Anjorin, to assess him, which was done on 27 September 2000. The outcome of this was recorded in a letter of 10 October 2000 from Dr Anjorin to Dr Catto. This set out the history given by Mr Janes (which was similar to that given to Dr Byrne); in terms of drug use, Mr Janes reported still using cannabis regularly, occasionally amphetamine, but also binge drinking; paranoid thoughts were still expressed, though he did not report any hallucinations. It was reported that Dr Anjorin discussed the case with Dr Vogel, who also saw Mr Janes. Their conclusion as expressed to Dr Catto was that the probable diagnosis was schizophrenia with a differential diagnosis of a drug-abuse induced mental and behavioural disorder. The plan was to continue the use of Risperidone and advise abstention from drug use, including giving Mr Janes the contact number for the drug and alcohol team at the Mount Zeehan team in Canterbury.

29. Dr Vogel provided a statement to us and confirmed that her practice was for her SHO to assess new patients and then present the case to her with a care plan for the patient. She indicated that on reviewing the notes, she has noticed a potential discrepancy in relation to the record in the letter to Dr Catto as to Mr Janes' use of amphetamine, which she feels may have understated what they were told as to the then-current use of amphetamine by Mr Janes. She feels on a review of the notes that Mr Janes may have reported that he was using a gramme of amphetamine a week, which would explain their advice that he make contact with the Drug and Alcohol Team. It is also to be noted that Mr Janes reported that he felt worse after using amphetamine.

30. Mr Janes was offered further out-patient appointments in October and November, but did not attend: the out-patient notes indicate that Mrs Doyle called to say that he would not attend the November appointment and that Mr Janes would not telephone to indicate why he was not attending. The Ashford Team discharged him from their service in early

December, by which time they thought he had returned to the Folkstone area. By this time, events had in fact moved on, with a significant incident.

4. The "Axe Incident"

31. The significant incident was that on 25 November 2000 Mr Janes attacked a friend with an axe. We have not had Mr Janes' account of this incident: although he agreed to meet the Inquiry Panel[10], he was not able to give us any evidence in any detail (nor did we expect this of him). However, we have had various descriptions of what Mr Janes said had happened, and we also had the statements given to the police about the incident (which were not obtained until after the homicide). Dealing first with the latter:

> DJEM explained that he had got to know Mr Janes quite well over a period of 2½ years; that he had changed over that period, becoming less outgoing and depressed; he was a heavy drinker and drug-abuser, though he was thought to be okay when not drinking or taking drugs. He indicated that he, Mr Janes and 2 others had been drinking, Mr Janes quite heavily; that Mr Janes had left the room, but returned after a few minutes and swung an axe at the victim twice, before the latter was able to escape; Mr Janes dropped the axe when asked to do so and then left. DJEM described Mr Janes as being "expressionless" and showing no remorse. LAN gave a similar account of the incident.
>
> ADW, the victim of the attack, explained that he had known Mr Janes for 4-5 years, that he seemed okay if he was not drinking or taking drugs but that he became "strange" if he was drinking or taking drugs, and that he would take a variety of drugs except heroin. He gives a similar account of the attack, and also that Mr Janes' expression "was as if nothing was wrong" and that there was no sign of remorse. ADW went to the hospital and reports that there was severe bruising to his arm and broken fingers; he did not report the matter to the police.
>
> In addition, and not connected with the axe incident, DMS gave a statement to the police in which he explained that he had known Mr Janes for 5 years, and that he had changed following the death of his father; he was not present at the axe incident, but recalled an incident a couple of months previously when Mr Janes had made threats against AW during the evening and, as he was leaving, revealed that he had taken one of DMS's mother's kitchen knives, which he handed over on request.

[10] The circumstances of this meeting were that we visited the Trevor Gibbens Unit in Maidstone to discuss Mr Janes' case with his then-current care team; this was with Mr Janes' consent. There had previously been discussion of whether we should meet Mr Janes as a panel or whether one of our number, most likely our medical member, Dr Farrell, should see him alone. The options were discussed with his care team, who in turn discussed it with Mr Janes before it was decided by them that he should meet us the entire panel.

32. Dr Byrne records that when he saw Mr Janes on 29 November 2000, he was given an account that he had been very drunk, became paranoid and attacked his friend with an axe without any warning.

33. We note, of course, that the accounts of those present at the axe attack have not been cross-examined: but we also note that they are not inconsistent with the account given by Mr Janes. However, even if the incident is highly exaggerated in these accounts, it is one of the utmost seriousness. It involves reacting to the symptoms of illness, even if in combination with alcohol and drug misuse, by an attack which had the obvious potential to be fatal, namely an axe being swung by a tree cutter at the head of the victim.

34. This attack did not lead to criminal proceedings: these may well have resulted in some form of compulsory treatment under a hospital order. However, it should be noted that the civil provisions of the Mental Health Act 1983 are designed both to assist those who are ill, but also to protect the public from the small minority of those with mental health problems who pose a risk to the public; whether people engage with psychiatric services via the criminal justice system or the civil system should not matter. The criminal system can be viewed as a method by which the facts of criminal conduct are more conclusively established. The test for detention is essentially the same, namely whether there is a mental disorder of a nature or degree to warrant detention.

35. What is plain is that the mental health professionals had a full account of this incident and the question is to be raised as to what was the response to that and whether it was appropriate. This has to be assessed both as an immediate response and the impact that the response had in the longer-term.

36. The incident with the axe came to light contemporaneously. On 27 November 2000, Mrs Doyle was told about the incident by the mother of victim. She then took steps to involve Dr Catto. Her account is that she specifically requested that her son be sectioned – ie placed in hospital under psychiatric care. She says that this was refused: it appears that it was. In documents from the social services file apparently prepared for or arising from a CPA review in February 2001, it is recorded that "Following the axe attack, Joe asked to be "sectioned" but was told that it was something he had to deal with."

37. Dr Catto's statement indicates that on hearing about the incident he made immediate telephone contact with Dr Byrne and an appointment was made for him to review Mr Janes on 29 November 2000. Dr Catto told us that if he comes into contact with someone who may need to be sectioned under the Mental Health Act 1983, he is able to phone up the relevant consultant and arrangements will then be made by the psychiatric services

to attend with an approved social worker. When he reflected on his evidence to us, Dr Catto's best recollection was that Mrs Doyle did raise the issue of her son being sectioned, but that he had no information that Mr Janes' behaviour at the time of this appointment was such that he could not be sectioned. Dr Catto, of course, is a GP and cannot be expected to take a lead role in decisions as to placing someone under section: he did take the necessary step of involving the psychiatric team, though we do not support his view that someone who has recently been involved in a serious assault but who seems calm a few days later is beyond the scope of the Mental Health Act. Although it does not follow from involvement in a violent incident that detention under the Mental Health Act is necessary, that is a feature in support of the use of compulsory powers.

38. Dr Byrne also records that when he saw Mr Janes on 29 November 2000, he asked to be admitted to hospital. Dr Byrne did not accede to this request as he felt that the reasons put forward by Mr Janes – who stated that he needed to be away from alcohol – were not adequate to justify a hospital place. He assessed the motivation to give up alcohol as poor, and in any event alcohol might be available in the hospital. An additional feature put forward by Dr Byrne was that the lack of structure in Mr Janes' life was unlikely to improve as a result of him being admitted to hospital and that it might become harder for him to achieve independent living.

39. We are concerned as to this response: there had been an attack which could easily have been fatal and which was apparently linked to Mr Janes' illness as it occurred after he had become paranoid; even if the incident only occurred because of a combination of mental illness and excessive use of alcohol, this was something which might recur, and was more likely to recur outside hospital. At the very least, there was a need to assess Mr Janes more carefully, which required a period as an in-patient; or an immediate referral to a forensic service. Had Mr Janes been charged with an offence, it is likely that this is what would have happened: as we have indicated above, the outcome in terms of the reaction of the agencies to a dangerous incident should not depend on whether the criminal justice system has become involved.

40. Having said that, we do note that Dr Byrne made reference to the attack in letters written about the case (and he informs us that he conveyed the information to relevant staff orally) and put an alternative plan into action: he continued Mr Janes' medication and referred him to the Radnor Park Day Hospital, requested CPN support and informed the Mental Illness Support Team of the case. Addiction counselling was offered to Mr Janes, but he declined it. These, of course, are useful steps to take: the problem is that they create an impression that the incident with the axe was not to be viewed with the utmost seriousness. Dr Byrne's account to us was that he did not feel that he would have received any support to have placed Mr Janes on section at this time: this is, necessarily, a point which cannot be

answered definitively, so all we can do is express our surprise that this was the state of affairs.

41. We note that, as set out above, there were some positive reasons not to make use of compulsory powers: but in the context of what had occurred, the balance was in favour of admission to hospital for assessment in light of the seriousness of the incident. This would also have served the purpose for the longer-term of marking out that the axe incident was one which was clearly serious in the assessment of Mr Janes' illness because it lead to an admission to hospital: as it did not, the corollary was a risk that the incident might be viewed as related more to an excess of drink and alcohol rather than mental illness. Of course, the context is that it is apparent that the mixture of mental health problems and drug and alcohol problems is the latter tend to make the former worse.

> See further our analysis in Part 3: although we can accept that it was a judgment call as to whether or not to use compulsory powers, and that Dr Byrne would be dependent on others to put the necessary arrangements in place, there are instances in the chronology where the non-use of compulsory powers – including on this occasion – may well have contributed to the underplaying of the risks posed by Mr Janes.

42. Jon Thomas, who had been the CPN assigned following the first assessment by Dr Byrne, told us that he heard about the axe incident and was able to put this together with his memory of how Mr Janes presented – in particular with his view that he was living in a computer game – and this caused him to become concerned about the risk presented: he records that he passed on his concerns to Marilyn Brennan, his supervisor, and also spoke to Sue Guy in social services.

5. The Lead Up to the Forensic Referral

Assessment of 21 December 2000

43. The referral made to the Radnor Park Day Service by Dr Byrne lead to an assessment carried out on 21 December 2000 by Brett Luckhurst, a staff nurse with the service who was assigned as Mr Janes' keyworker. The information obtained was that Mr Janes was using cannabis, was not taking his Risperidone, was paranoid and got angry easily. He was referred to various groups at the Service, was to have further sessions with Mr Luckhurst, and an appointment was made for him to see Dr Byrne at the end of January 2001.

44. In an initial assessment carried out by Mr Luckhurst, under the heading "Risk factors identified" it is noted "ABH on a friend whilst Joe was intoxicated with alcohol and drugs and became paranoid". Mr Luckhurst,

who gave evidence to us, explained to us that he did not have the details of this incident, which was the axe incident described above, until it came out in a subsequent session with Mr Janes: in particular, he was not aware that a weapon had been used. His account was that after he found out about the truth of the axe incident, he voiced his concerns and asked that a forensic assessment be done, which Dr Byrne declined to do: there is no written record of this request and it is not necessary for us to resolve whether a request was made and/or rejected at this time as a forensic assessment was soon requested. What we do need to comment on, of course, is that a system needs to be in place to ensure that the keyworker in a day service to whom a patient is referred knows the details of significant incidents which impact upon risk: this is both to allow the appropriate package of treatment to be designed, but also to ensure that issues of risk to staff are considered. (We have no way of knowing why Mr Luckhurst did not know the details of the axe incident when he first met with Mr Janes, and so we cannot say if a particular individual was at fault: what has to be ensured is that a robust system is in place to ensure that information which is central to an assessment of the risk posed by a patient is made known to those working with the patient.)

> See further our analysis in Part 3: this is an example of a recurrent theme, namely that important information was not passed-on. It emphasises a weakness we have noted, namely that there was no adequate system for ensuring that the various members of the care team, who were on different sites, were aware of important information.

Review of 29 January 2001 and Request for Forensic Assessment

45. On 29 January 2001, there was a review by Dr Byrne. He told us that before this review, there had been discussions with the team at the day hospital and it was agreed that the situation with Mr Janes was a serious one because of the combination of features, namely schizophrenia with a conscious decision not to take the prescribed medication, continuing drug abuse and alcohol misuse, and a low threshold to aggression.

46. At the review on 29 January, Dr Byrne obtained the consent of Mr Janes to be assessed by the forensic unit at the Trevor Gibbens Unit in Maidstone. In a letter to Dr Catto of 31 January, Dr Byrne states that Mr Janes appeared to be as well as he had seen him, but that there were recent aggressive incidents with his family which were not associated with alcohol.

47. The letter of referral to the forensic team sets out the axe incident as the index offence leading to the involvement of forensic services, but also notes aggressive incidents with his family; and gives a summary of findings from his involvement with the psychiatric services thus far. We should comment that the referral to the forensic team was a proper step

to take to mark out the level of concern about Mr Janes and to seek assistance from those with additional expertise in dealing with the small proportion of those with a mental illness who may also pose a risk to others. Dr Byrne told us that referrals to the Trevor Gibbens Unit, which was part of another Trust, were unusual: the team are to be commended for noting that Mr Janes required this unusual approach to be taken.

48. There was also a preliminary risk assessment completed by Brett Luckhurst and Marilyn Brennan, his Team Leader. This was done on 5 February 2001 on a form which records that it is a joint East Kent Community Trust/Kent County Council document, and a copy was sent to Caroline Gale, who was the social worker assigned. She was a student social worker, albeit one who came to the task with a significant amount of experience in social care. The document records that there is a risk of harm to others and that a full risk assessment is to be carried out.

6. Admission to Hospital – February 2001

49. Before the forensic assessment had been carried out, Mr Janes was admitted to hospital. This was on 25 February 2001. Mrs Doyle indicated to us that her son had kicked a chair at her and appeared to be unwell: she reports that she called both the police and social services, but neither seemed interested, and so she left her house, returning later that day with a relative. At that stage, a doctor was called and Mr Janes was then admitted to Scarborough Ward at the Arundel Unit in Ashford.

50. As an immediate background to this, we note from social services files that Mr Janes had been assessed as requiring enhanced CPA and a social worker was to be assigned (Caroline Gale). This reflects, quite properly, the acceptance that his case was towards the higher end of the scale of those who come to the attention of services on account of mental health problems.

51. Social services were aware that part of their role was assistance in securing alternative accommodation for Mr Janes. On 19 February 2001, Mrs Doyle called to ask that there be speedier action in relation to housing than the time-scale she had been given because the situation at home was becoming more volatile, with verbal aggression and manhandling of her by her son, and her daughters were reported to be upset by the situation. As a result of this, Caroline Gale saw Mr Janes on 20 February and housing forms were completed. We commend this flexibility in bringing forward the visit.

52. The referral note leading to the admission is from Dr Klim, written on the notepaper of South East Kent and East Sussex Doctors on Call Limited, and records that Mr Janes had stopped taking his Risperidone a few days previously, was agitated in the morning, spitting at his mother and

threatening to take a hammer to her head, and felt he might become agitated again that evening. He was admitted at 10pm as an informal patient, and the preliminary assessment points to a risk of self-harm and of harm to others, the former arising from his feelings of depression and guilt. He was assessed as aggressive and unpredictable, the cause possibly being a deterioration in his mental state, though he was calm on his admission.

53. Dr Byrne indicates that admission to Scarborough Ward rather than Edgehill Ward means that the latter must not have had any spare beds. He was able to see Mr Janes the next day at a pre-arranged CPA meeting, which was attended by various people, including Mrs Doyle, Brett Luckhurst and Caroline Gale. Dr Byrne indicated that the assault on his mother was not something rooted in any paranoid ideation and that the admission to hospital was "to protect his family from his violence".

54. A care plan was drafted as a result of this CPA meeting on 26 February 2001. It is headed "enhanced level" and sets out as its aims quarterly reviews of Mr Janes' mental health by Dr Byrne and fortnightly meetings with Brett Luckhurst, plus referrals to other services including occupational therapy and art therapy; the involvement of social services was to pursue options for Mr Janes to live independently. The keyworker assigned under the CPA process was Marilyn Brennan, the supervisor of Brett Luckhurst at Radnor Park (though Ms Brennan is not recorded as having been at the CPA meeting).

55. There is no indication on the face of the care plan that any suggestion was raised that his recent admission to hospital affected the care plan to be put in place. It does record that there had been a change in medication, to Olanzapine. However, there is no indication that other action was to be taken with any real urgency. We feel that this does not sit well with what we were told by Dr Byrne that this admission to hospital was to protect his family from violence which was not rooted in paranoid ideation: this is something which suggests the need for specific investigation and action, which should be included in the CPA process.

56. It was also noted on the care plan that Mr Janes was to be referred for a forensic assessment, but again there was no indication that any steps would be taken to review the care plan on receipt of the forensic assessment: the next date for a CPA review was set as 11 June 2001. Nor does it appear that there was to be contact with the forensic service to speed up their assessment of Mr Janes in light of this recent development.

> See further our analysis in Part 3: this is an example of management of the case where it seems that there was no modification of what was in place despite the fact that there were significant developments occurring or likely to occur in the near future.

57. The records of social services do not seem to have a full copy of the CPA documentation. There is a "summary of his assessed needs" dated 5 March 2001, which arose from the CPA meeting, and other documents which appear to be linked with the CPA process. A document in these files record that Caroline Gale was given the Case Management role. Other records from social services' file indicate that Caroline Gale recorded a full account of recent developments at the CPA meeting: her note refers to the attack on Mrs Doyle being a matter of "sheer temper", and that she had to consider her safety and that of her younger daughters. This should, of course, have made it plain to social services that child protection was a real issue: we see no signs of that being recorded contemporaneously or on a review of the files. When this is added to the earlier contact from Mrs Doyle on 19 February 2001 to social services as to early steps being required to locate accommodation for Mr Janes because of the upset caused to his sisters by his behaviour towards his mother, we would have expected an indication that there should be a proper assessment of whether child protection measures should be investigated should Mr Janes leave hospital and return to his mother's home.

> See further our analysis in Part 3: one of the concerns we have is the lack of any indication in the records of social services that child protection issues were ever considered.

58. According to Caroline Gale's note, at the time of the CPA meeting, Mr Janes was recorded as having agreed to stay in hospital for up to 2 weeks, and that his housing needs would become more urgent after that time: he was willing to be placed in supported housing (if eligible) whilst local authority housing was obtained.

59. However, 2 days later, Ms Gale visited Mr Janes again and recorded that he wished to leave hospital (and had been informed by staff that there was no reason for him to remain in hospital), and so steps had to be taken in relation to accommodation. There is a record of a telephone discussion on 2 March between Mrs Doyle and Katie Smith, a social worker who was covering for Caroline Gale, in which matters of accommodation options were raised: it is quite apparent from this discussion that Mrs Doyle was concerned about her son and his ability to cope for himself, and was unable in that circumstance to refuse permission for him to return home, as the other option was that he be placed in unsuitable temporary accommodation. This, of course, is the understandable reaction of a mother: but the purpose of the statutory services is to ensure that families who cannot cope with violence – particularly when there are child protection issues raised because of the presence of children in the home – should not have to face the dilemma which confronted Mrs Doyle. Ms Smith records that she suggested that Mrs Doyle "may have to be strong at some point and say no".

60. The indication on the records of social services is that their concern was locating accommodation. Child protection issues are nowhere recorded.

> See further in the Chronology and our analysis in Part 3: we have concerns that social services believed that their function was in essence limited to the provision of accommodation, apparently because the CPA process was in place and this is what was assigned to them. We feel that this was an error of approach.

7. Release from Hospital

61. In a letter of 2 March 2001 to Dr Catto, Dr Byrne states that the admission had been an emergency; that Mr Janes' medication had been changed, and that emergency accommodation was being sought as his mother was, understandably, not accepting him back at her home. Mr Janes was apparently keen to leave hospital and Dr Byrne records that he found no evidence of paranoid ideation or psychotic features and so there was no reason to detain him.

62. In his evidence to us, Dr Byrne was of the view that Mr Janes was discharged to bed and breakfast accommodation; in fact, he returned to his mother, though there may have been a plan that she would have him overnight and then present him to the local authority housing department as homeless. We would point out that bed and breakfast accommodation for a vulnerable young man such as Mr Janes would be far from ideal.

63. We are concerned about this sequence of events in light of the information then available. Dr Byrne explained to us that it was unusual for him to seek a forensic opinion; this emphasised that a view was being formed that Mr Janes might well be an unusual case. The context of this request was that Dr Byrne was fully aware of the incident involving the axe and of the instances of aggression by Mr Janes against his mother. After the forensic request had been requested but before it had been obtained, there was an incident of aggression requiring a hospital admission to protect his family. Dr Byrne noted to us that this admission occurred when Mr Janes was not intoxicated, had picked a row and became physically aggressive to such an extent that his mother had to call for help: but only days later, there was no reason to detain.

64. This admission to hospital was a proper response to the situation: but the admission was of a short duration, and brought to an end when it was believed that Mr Janes was heading towards bed and breakfast accommodation. We feel that the fact that this incident of aggression merely resulted in a short-term admission to hospital creates the impression that the hospital admission was more a response to housing

difficulties than as a step which was needed to assess fully the extent of Mr Janes' illness and the risks he might pose to others (which could not be done in the course of such a short admission, and which was a matter being assessed at the time via the forensic referral).

> See further other parts of the Chronology and our analysis in Part 3: this is an example of the management of the case which may have helped to undermine the risks which were evidenced by the actions of Mr Janes.

65. Dr Byrne explained to us that he felt that there were difficulties in arranging to have people hospitalised: we do not have the information available to assess that as far as that area of East Kent is concerned, but we have to say that Dr Byrne's contemporaneous letters, such as that to Dr Catto on 2 March 2001, and the failure to make use of compulsory powers (if persuasion to remain as a voluntary patient failed) to allow a forensic assessment to be completed before consideration was given to Mr Janes being released, do not support a view that he wished to have Mr Janes in hospital for any longer period than he was in hospital on that occasion.

66. We note that it is apparent that there were difficulties in assigning a CPN to Mr Janes.

8. Application for Accommodation

67. Following his release from hospital, Mr Janes missed an appointment with Dr Byrne on 5 March 2001. However, on 6 March, he attended social services to see Caroline Gale in order to complete a form for Carr Gomm, a supported housing service. Ms Gale's notes indicate that Mr Janes smelled of alcohol, but she allowed the meeting to proceed because he was not threatening. In the course of the meeting, Mr Janes explained to Ms Gale that he was still using cannabis and a small amount of alcohol, and had not been taking his Olanzapine as he had thrown his tablets away by accident.

68. We have seen the application form for Carr Gomm; there are a number of matters which merit comment. In the first place, whilst it is recorded that Mr Janes' need for accommodation was because his mother had asked him to leave home, there is no information given as to why this was so; further, there is no obvious place to refer on the form to incidences of violence unless they have lead to a conviction. (There is a part of the form for "additional information", but it is unrealistic to expect that the applicant will give in this section full details of information which is unlikely to be of assistance.)

69. Further, in relation to drugs, although it is recorded that Mr Janes' current

situation is that he has a problem with drugs, on the part of the form relating to more information, it is recorded that he has overcome the problem he had with illegal drugs. There is some inconsistency here.

70. We note at this stage that there are 2 elements of this which may be thought to give rise to obvious concerns. The first is that the dealings with Mr Janes were by Ms Gale, a student social worker, albeit one with a background in social care. The assignment of a student is despite the fact that Mr Janes had an obviously complex history in terms of his drug abuse and had been referred for a forensic assessment (which was clearly a somewhat unusual situation). We should make plain that we do not feel that there is anything necessarily wrong with a student social worker being involved in difficult case as part of a learning experience: however, this is predicated on adequate supervision from a social worker of experience suitable for the nature of the case, and it is the latter who should be the assigned social worker. We have been assured by Kent Social Services that it is invariably the case that the social work supervisor is the allocated worker: this is clearly how it should be, as a student cannot properly assume responsibility for a case. However, we have to point out that the records do not show much direct involvement in the case from the student supervisor, who had limited meetings with Mr Janes; further, as noted above in relation to the first CPA meeting, the Case Management role appears to have been assigned to Caroline Gale.

> See further our analysis in Part 3: we have concerns as to a number of instances where staff of a junior level were carrying out assessments, albeit with supervision, despite the complexity of the case, which suggested that senior staff should have taken a more direct role in the assessments.

71. The second issue which arises is that the role being taken by social services was the location of what was felt to be suitable accommodation for Mr Janes. Although this was part of a CPA process, our concern is that by limiting their actions and discussions to the implementation of the CPA plan for Mr Janes to be found accommodation, social services failed adequately to consider what Mr Janes' wider needs were (which, as part of the multi-disciplinary team, they would have fed into the CPA process).

> See further in the Chronology and our analysis in Part 3: we have concerns that social services believed that their function was in essence limited to the provision of accommodation, apparently because the CPA process was in place and this is what was assigned to them. We feel that this was an error of approach.

9. The Forensic Assessment

72. On 12 March 2001, the forensic assessment requested by Dr Byrne was carried out by Dr Dunkley at the Trevor Gibbens Unit. We have seen the report prepared from this assessment. We note that the process followed by Dr Dunkley involved a lengthy discussion with Mrs Doyle as well as with Mr Janes.

73. The report supported the view that Mr Janes was most likely suffering from schizophrenia which might have been prompted by drug misuse, rather than suffering from a drug-induced psychosis. She noted that the risk of violence did not necessarily arise from misuse of drugs, though that exacerbated problems. (We note as an aside that none of this would count as news to the team already responsible for Mr Janes.)

74. Dr Dunkley expressed particular concern that Mr Janes had moved back into the family home, and that the risk at home was multiplied by the fact that he was not using his prescribed medication and was continuing to use alcohol and illicit substances. *We share these concerns and make the point that the fact that they were expressed contemporaneously by Dr Dunkley makes it plain that these are not concerns which arise only with the benefit of hindsight.*

75. The report concluded with recommendations as to the steps to take. Dr Dunkley noted that Mr Janes, who presented as a "relaxed and willing informant", required urgent assessment for readmission to hospital to stabilise his condition as he was continuing to experience symptoms of paranoia, was unable to take his medication, and was abusing alcohol. She suggested that depot medication be tried, as he was unlikely to be able to comply with oral medication. She noted that he needed counselling to ensure that he abstained from misuse of alcohol or drugs, and habilitation to acquire domestic skills to be able to live in the community. Release was envisaged by Dr Dunkley when his symptoms were adequately controlled by medication and the above steps were taken; and this would require a full package of CPA care at the enhanced level with an assertive outreach team involved. We note, of course, that those responsible for the care of Mr Janes had already already reached the conclusion that enhanced CPA was necessary.

76. Dr Dunkley suggested that Mr Janes might benefit from cognitive therapy. She noted that if he was not receiving regular medication and was abusing alcohol and drugs "there is a strong risk of harm to self and others" and he would clearly be detainable under the Mental Health Act.

77. We feel that this report expresses a fairly clear view that Mr Janes posed risks and needed to be in hospital so that his paranoid symptoms could be brought under control by medication and a proper community support package put in place before he could be released from hospital.

78. It is important to note the sequence of events following the interview with Dr Dunkley, which was on the morning of 12 March; her report was typed that day. In her evidence to us, Dr Dunkley explained that she had asked her secretary to drop her other work and prepare the report. She also explained that, for the first time in her practice, she had made immediate telephone contact with the referring team to express her concerns and ensure that the report could be faxed across. This indicated the extent of her concern about Mr Janes and the need to establish a regime to control his illness.

79. In the context that only a small proportion of those with mental illness present a danger to the public, the report of Dr Dunkley – which after all was requested in order to provide an assessment of the level of risk presented by Mr Janes - provided a clear indication that there were good grounds to believe that he might be one of that small group of patients. And that he should be managed accordingly: given that there was good evidence that he had committed a serious offence – namely the incident with the axe, albeit that he had not been prosecuted for it – this was not a case of a medical opinion based on speculation as to the potential for harm.

80. Dr Dunkley told us that she was surprised by the sequence of events which followed her assessment and the communication of it to the treating team, which we move onto next.

10. The Immediate Response to the Forensic Assessment

81. Dr Dunkley said that she was left with the impression that Mr Janes would be assessed by his team that evening or the next morning. Dr Byrne was away from his post on leave at the time, and so Dr Dunkley had spoken to Dr White, the other consultant for the Shepway area, who was providing cover for Dr Byrne in his absence. Dr White provided us with a statement and gave evidence to us.

82. Dr White, an experienced consultant, had no previous knowledge of Mr Janes (save for occasions when his name had been mentioned in team meetings which she attended). There was no formal handover of the case to her, and she has told us that she was given no indication that a forensic report was expected during the period when she was providing cover. She recalls that Dr Dunkley expressed her concerns about Mr Janes and outlined the conclusions that would be in her report, suggesting the need for a reassessment of him and a need for a change in medication. In her statement to the Inquiry, Dr White could not recall whether there had been discussion of whether Mr Janes met the criteria for compulsory admission to hospital; in her evidence to us, she recalled that the concerns expressed by Dr Dunkley included that Mr Janes was not in hospital and,

as he was on oral medication, was not complying with his medication regime. It is likely from this context that, whilst Dr Dunkley would not tell a fellow consultant that a patient should be sectioned, she would have expressed her view that he was sectionable and so could properly be managed under compulsory powers. That view is certainly contained in her report. (At the very least, the language used would have conveyed to another psychiatrist the view that Mr Janes was a patient who needed to be in hospital.)

83. As someone who was merely offering consultant cover for a colleague's caseload, Dr White would not be expected to know what arrangements were already in place for follow-up with Mr Janes, who had very recently been allowed to take his discharge from hospital. She would also have her own caseload to deal with, but she indicated that the call from Dr Dunkley was the first one she had received from her about a forensic assessment, which would make it plain that this was an unusual situation and, we feel, should have marked this case out as an unusual one which might well have required a level of attention which was equally out of the ordinary, even in relation to a patient who was on the books of another consultant for whom cover was being offered. Dr White explained that when she read the report from Dr Dunkley, which she thinks would have been in the following 24 hours, she was alerted to the fact that there was a situation developing which was of concern. She then took steps to discover what follow-up was being offered in light of Mr Janes' recent discharge and the need to take further steps following the receipt of the forensic assessment.

84. The forensic report was made available to others involved in the care of Mr Janes. There is an entry in the records of the Radnor Park Day Service dated 12 March 2001 by Brett Luckhurst which conveys that Dr Dunkley had expressed that she was very concerned; he arranged to see Mr Janes the next day, and made an appointment for him to see Dr Veuglers, the SHO to Dr Byrne on 16 March 2001. On 13 March 2001, Mr Luckhurst did see Mr Janes, and was informed that he did not wish to continue with group work; a risk assessment was completed by Mr Luckhurst and Marilyn Brennan, which noted that there was a risk of serious harm to others, that it was likely to occur, that the axe incident could have been fatal, and that the danger existed even without intoxication. It was also noted that Mr Janes still used cannabis and drank to excess regularly.

85. We have noted above that there was nothing in the records of the CPA meeting on 26 February 2001 to indicate that there was a plan to reconsider the situation on the receipt of the forensic report, which at that time had been requested, and should be considered as something likely to inform the CPA process. It seems that there was nothing done by those involved in the CPA process who had access to the forensic risk assessment to suggest that there was a need to call an additional meeting within the CPA process to ensure that the information and opinion

contained within the forensic report was taken into account within that process, which is central to the management of a patient[11].

86. It is probable that those from the health side of the care team would take their lead from the psychiatrists. This emphasises the importance of their reaction. In that context, we are concerned that Dr White did not take steps to see Mr Janes herself, despite the content of the forensic report and the circumstances in which it was received. We make the point above that Dr White did consider the forensic report and ensured that arrangements were in place for a further review of Mr Janes in light of the seriousness of situation: this was an entirely proper response to the receipt of the forensic report. However, we do feel that the situation was one which called for the direct involvement of a consultant psychiatrist, given its unusual and complex nature. The failure to do this may have undermined the impression which should have been conveyed to others that the case of Mr Janes was an unusual one.

87. However, we should add that we feel that Dr White was confronted with a difficult situation in relation to a patient who was not on her list and who had not been handed over formally to her: she was merely providing cover for a patient on another consultant's list. The forensic report did not produce any new information, but gave an assessment of what the situation demanded; but the context was that Mr Janes had been allowed by her consultant colleague, Dr Byrne, to take his discharge only days earlier, and the follow-up following discharge seems to have been handed to a junior doctor in Dr Byrne's team. Clearly, as Dr White was able to explain to us in her evidence, there was a change of tack suggested in the forensic report which would come as something of a surprise to Mr Janes. But if the previous approach has not been appropriate, a change in tack may be required. So, despite it being a difficult situation, we feel that Dr White should have taken more proactive action to ensure that she was involved in taking a decision herself after assessing Mr Janes in person: it may well have been that she would have decided that it was not necessary at that time to take any further action, and that the current management plan was correct, but the unusual features of the case were such that it required involvement from a consultant level psychiatrist.

See further other parts of the Chronology and our analysis in Part 3: we are concerned that decisions taken in the course of the management of Mr Janes on a number of occasions may have lead to the undermining of the level of risk he was felt to pose.

88. The matter of the review of Mr Janes by a psychiatrist involved in providing care to him was left to a junior doctor, albeit one who Dr White

[11] It seems that the CPA meeting date was set for 11 June 2001 at the meeting at the end of February; in fact it was held on 29 May 2001, and so was hardly brought forward despite the forensic report and, as is described below, a further admission to hospital.

thought had better knowledge of Mr Janes (though this, in fact, was questionable as he – Dr Veugelers - had only seen him during his recent admission).

89. It is also clear that the forensic report was seen by social services as the social work supervision notes refer to the forensic assessment and concern expressed. However, we note that what is missing from the notes in the social services file is any indication that anything different needed to be done in light of the conclusions from the forensic assessment. We would have expected that a social services team which was in the process of making arrangements for Mr Janes to move into supported accommodation would have recognised that the receipt of the forensic report was a matter of some significance which merited at the very least a review, by senior members of the team, of whether there was a need to alter the care plan or approach being taken with regard to a client. This was particularly so in light of the contents of the forensic report.

> See further in the Chronology and our analysis in Part 3: one of the issues which came to the fore during our investigation was whether social services had to carry out functions as part of the CPA team or had independent duties. Our view is that the latter is the case and that the actions or omissions of social services have to be assessed in light of this.

11. The Next Reviews of Mr Janes – 16/23 March 2001

90. On 16 March 2001, Mr Janes was reviewed by Dr Veugelers, the Senior House Officer in Dr Byrne's team. As we have said, in relation to a case which involved difficult problems, where advice had been received from a forensic consultant that a reassessment was required with a view to detention, leaving this assessment to a junior doctor could only contribute to the appearance that Mr Janes was not viewed as a difficult case (ie one which required direct assessment by a consultant) but rather as a more run of the mill case (and as such suitable for review by a junior doctor).

91. Dr Veugelers gave evidence to us. He explained that he had first met Mr Janes during his admission at the end of February 2001, and so was aware of the main issues in his case. When he saw Mr Janes on 16 March 2001, he was told that compliance with medication was not complete (put at around 50%) and that he was still using cannabis and alcohol, and living at home. In his statement to us, Dr Veugelers indicated that he was awaiting the outcome of the forensic assessment and the application for supported housing at the time of this review. This suggests that Dr Veugelers, despite being the doctor who was conducting the actual examination after the forensic report, had not seen the forensic report. If this is so, clearly there had been a serious failure of communication: the

forensic report from Dr Dunkley had not been supplied to the doctor who carried out the review of the patient. It is essential that procedures be in place to ensure that, when an important review is carried out following an event such as a forensic assessment, all relevant information is available to those making the assessment.

> See further other parts of the Chronology and our analysis in Part 3: there are a number of instances where there appear to have been failures to ensure that all members of the treating team had available all the relevant information.

92. Dr Veugelers made a further appointment for Mr Janes to return to the out-patients' clinic on 23 March. Dr White explained that she discussed the situation with Dr Veugelers on 20 March in light of the forensic assessment and the further review, and was informed that the results of the assessment carried out on 16 March was that there was no change in Mr Janes' mental state as compared with the situation applicable when he was allowed to leave the hospital on 2 March. It was apparently agreed that the report from Dr Dunkley would be discussed with Mr Janes on 23 March and that he would be offered the opportunity of coming into hospital so that his medication could be changed to the suggested depot medication. However, by this time, as there had already been the assessment by Dr Veugelers on 16 March, the impetus from the forensic assessment had been lost.

93. Dr White was candid in her view about whether Mr Janes could be placed under compulsory detention if he was not agreeable to the offer to be admitted to hospital: it was unlikely that he was detainable unless by 23 March he had deteriorated and he was not taking the prescribed medication, in which case the matter would await the return of Dr Byrne.

94. We put to Dr White the obvious question of how this approach could be squared with the views of Dr Dunkley as explained in the forensic assessment. She explained that if Mr Janes was willing to take medication in the community and was not exhibiting signs and symptoms of a nature and degree that would warrant detention, it was difficult to complete a medical recommendation for admission. We gave Dr White the chance to review the material relating to the axe incident: she explained to us that the details of the incident were not fully known to her at the time of her involvement in March 2001, but that, although her first reaction was that it might have changed her management plan, on further thought it would not have changed things because it was an incident from several months previously.

95. As we have said above, we do appreciate that there was a dilemma here in that there was an obvious contrast between what had occurred at the start of the month, when the consultant in charge had allowed Mr Janes to

leave hospital prior to the receipt of the forensic report, and the situation as seen by the forensic psychiatrist. However, the fact remains that the primary material made it plain that Mr Janes had been involved in a potentially fatal attack, was seen as posing a risk of violence to others, was not stable on medication, was still abusing drugs and alcohol (which increased the risks he posed), and was living at home (where there was a recognised risk of violence). These are all factors which indicate that the criteria for detention for assessment under s2 of the Mental Health Act 1983 were made out. The Act allows detention if the nature or the degree of the illness warrants: this is a disjunctive test, and so irrespective of the current severity of the symptoms (which goes to the question of the degree of the illness), if its nature is such as to justify action being taken, that is open to the mental health professionals involved.

96. At the review on 23 March 2001, Dr Veugelers found that there had been no change in Mr Janes' mental state; however, he had used alcohol and cannabis, though he said that he had taken his medication. There was a discussion of the treatment options suggested by Dr Dunkley, but Dr Veugelers reports that Mr Janes declined to participate: however, he agreed to be seen again by Dr Byrne on the latter's return from leave.

97. In his evidence to us, Dr Veugelers explained that there was a difficult balancing act to carry out, between bringing him into hospital "and maybe reducing the risk to others" and alienating him from mental health services. He wrote a letter dated 23 March 2001 to Dr Catto, in which he summarised Dr Dunkley's views, the conclusions of his own mental state assessment, and that discussion between himself, Dr White and Brett Luckhurst produced the conclusion that Mr Janes was not detainable.

> See further other parts of the Chronology and our analysis in Part 3: we are concerned that decisions taken in the course of the management of Mr Janes on a number of occasions may have lead to the undermining of the level of risk he was felt to pose.

98. We note that there is a record in the notes of the Radnor Park Day Service that on 19 March 2001 Caroline Gale reported that she had taken a call from Mrs Doyle in which it was said that anger was expressed at the diagnosis in Dr Dunkley's assessment and a second opinion was requested. Mrs Doyle was apparently advised to call Dr Byrne's secretary to make an appointment to discuss the matter with him. Mrs Doyle told us that she was not angry, but was taken aback by the severity of the diagnosis of Dr Dunkley and the fact that she had been warned that incidents like that with the axe could be repeated in the absence of treatment. This, of course, is an understandable reaction of a mother in the circumstances.

99. We note that Dr Dunkley's report had concluded with a suggestion that Mr

Janes' family should receive a package of "illness education": this was clearly needed, and we note with concern that there is little in the records to suggest that anything was done in this regard beyond suggestions that the matter be discussed. Dr Byrne pointed out to us that, when he returned from leave and reviewed Dr Dunkley's report, he had sought to emphasise this recommendation (and some other parts of the report) by underlining this part of Dr Dunkley's report before he faxed it to other professionals: however, as he also noted, there were no specialist nurses available in East Kent to allow him to carry out this recommendation in full. This would, of course, make it important that the professionals to whom the report had been supplied made alternative arrangements to ensure that the package of education was put into place.

12. Further on the Accommodation Application – Carr Gomm

100. On 20 March 2001, Carr-Gomm asked for more information from Brett Luckhurst to assist with the application. Mr Luckhurst replied on 28 March, setting out references to Mr Janes' aggression to his mother and the axe incident, noting that he was inconsistent with his medication, that he was reported still to binge drink but that, despite a history of poly-drug abuse, he now just used cannabis, and that he had anger management problems.

101. In addition, Carr Gomm's own assessment form was sent back to them, stating that it was filled in by Caroline Gale and Joe Janes. This refers to the incidents of violence (the axe incident and kicking the chair at Mrs Doyle), but states that the axe incident was attributed to excessive alcohol and drug consumption; it also states that tensions at home were due to arguments with his mother, hence the need for alternative accommodation. In terms of his alcohol use, it is stated that Mr Janes no longer drinks except for a weekly consumption of 2 glasses of alcohol. It is also said that he was cooperative in addressing his risks.

102. We wish to comment that the information passed on to Carr Gomm. It was adequate (and ultimately lead to a decision that they could not safely offer a place for Mr Janes). However, there is a contrast between the information provided by Mr Luckhurst and that part of the information which was provided by Caroline Gale, which we feel underplayed the risks identified by others in relation to Mr Janes. We are not suggesting that there was a deliberate underplaying of the risks posed: but the account given – which would clearly provide reassurance to the home, being from someone who could expected to be in possession of accurate multi-disciplinary information about Mr Janes – did not mesh with the objective information and relied heavily on self-report from Mr Janes. In relation to this self-report, there is no record that any checks were carried out, for example with Mrs Doyle. (We note, for example, that in the social work records of 3 April 2001, Caroline Gale records that she did not believe the

self-report of Mr Janes, having contrary information from Mrs Doyle: this makes the point that the reliability of important self-reported information has to be assessed before it is passed on to an organisation which might rely upon it.)

> See elsewhere in the Chronolgy and our analysis in Part 3: there are instances where information which was relevant to their decision-making could have been volunteered to non-statutory agencies involved in service provision. We are not suggesting that information was withheld: but some clearly relevant information had to be sought which perhaps should have been supplied in the first place.

103. Whilst Carr-Gomm had been considering the application, contact was made on 22 March 2001 with the National Schizophrenia Fellowship, who ran Willow Lodge, a supported accommodation project in Folkstone.

13. The Lead Up to a Further Admission to Hospital

104. On 28 March 2001, Mr Janes was seen by Brett Luckhurst. He reported good compliance with his medication and low use of alcohol, but expressed concern about how long his sessions would be continuing as he felt he was getting nothing out of them. Mr Luckhurst spoke to Dr Byrne after the session, setting out the main points of the forensic report, which Dr Byrne had not yet seen (it presumably being his first day back from leave). Dr Byrne indicated that he would investigate the possibility of admission to hospital.

105. On 2 April 2001, Mr Luckhurst again saw Mr Janes, this time with Marilyn Brennan. The notes of the meeting record real antipathy for Mrs Doyle. Mrs Doyle told us that Mr Janes was drinking heavily and abusing drugs at the time, continued to be aggressive (kicking off the glove panel of her car in temper, for example) and would simply take money if she declined to give it to him. This emphasises the importance of obtaining collaborative information from those who have a lot of contact with a patient such as Mr Janes, since that information might demonstrate a different picture, as it had on the facts when Dr Byrne first assessed Mr Janes[12].

> See further other parts of the Chronology and our analysis in Part 3: we are concerned that there are a number of occasions when obtaining important information from Mrs Doyle was not done, with a result that important information was missed.

106. Mr Luckhurst records that as his meeting with Mr Janes was ending,

[12] August/September 2000: see above in the Chronology. In addition, it was apparent that Dr Dunkley's forensic assessment had found input from Mrs Doyle very useful.

he asked him what he had in a case he was carrying, and discovered that it was an air gun he was trying to sell. It was decided that issues of risk relating to Mr Janes needed to be discussed amongst staff at the day service.

107. On 3 April 2001, Mr Janes met with Caroline Gale to discuss his needs assessment. This was a meeting which was observed by Sue Guy, Caroline Gale's Practice Teacher. There had been reports from Mrs Doyle of verbal aggression following a drinking binge; it is recorded that the home situation was deteriorating, and that Mr Janes had stated that he did not like his mother, which increased the risk to his family. The outcome of the meeting was that there would be a further meeting with Mr Janes the next week.

108. Sue Guy provided a statement to us and was interviewed by us. She was the Senior Practitioner in the Shepway Mental Health Team, and explained to us that the team was unstable and frequently suffered from staff shortages which required that cases be managed within the duty system rather than being allocated or allocated to an already pressured and often inexperienced team. (Leroy Lewis, the Team Manager, agreed in his evidence to us that his team was not fully staffed and that having extra social workers available would have assisted issues of allocation and so on.)

109. Ms Guy described this meeting with Joe Janes, her first, as one in which her focus was on how Ms Gale acted. She also told us that the role of social services at the time was to find accommodation for Mr Janes, and that it was not the practice of her team to put together a formal assessment of needs under the National Health Service and Community Care Act 1990. She clarified that her view was that when there was an individual to whom the CPA process applied, the obligations of social services were those identified in the CPA review and assigned to social services. In short, she told us "the CPA process supercedes the Community Care Act 1990 as it incorporates all that was enshrined in the Community Care Act within the process of CPA". We do not think this is right.

See further in the Chronology and our analysis in Part 3: one of the issues which came to the fore during our investigation was whether social services had to carry out functions as part of the CPA team or had independent duties. Our view is that the latter is the case and that the actions or omissions of social services have to be assessed in light of this.

110. Our view is that Sue Guy, in early April 2001, was faced with a situation which required proactive action in which she, as a senior social worker, should have taken a lead role in response to the information

presented to her. The CPA process may well have been the method by which the necessary action was planned and coordinated: but the lack of action taken within that process, which should be initiated by the CPA coordinator, does not absolve others involved in the process.

111. Mr Janes clearly presented complex problems, and had been involved in serious violence in the recent past; there was the unusual situation of a forensic report having been obtained, which had clear recommendations for action to be taken on account of the risk posed, including hospitalisation; however, Mr Janes remained out of hospital in accommodation with his mother, where reports made to social services indicated that he was aggressive and binge-drinking; and the family situation was one which involved 2 other children and so raised family protection issues. In addition, as both s13 of the Mental Health Act 1983 and the Code of Practice issued under s118 of Act make plain, the Approved Social Worker (and Sue Guy had this qualification) is responsible for coordinating assessments as to whether a patient should be admitted to hospital, taking into account risks to the patient and risks to others: this cannot be avoided because there is a CPA process in place.

112. Instead, the supervision records show only Ms Guy discussing barriers to communication between Mr Janes and Caroline Gale because of the age gap between them, and ways of encouraging Mr Janes to take responsibility for himself. Whilst this is information which may have to be recorded as part of the teaching process for Ms Gale, as being relevant to the areas of competence she had to demonstrate in her training, our concern is that it is the only record of any decision-making or analysis of the situation applicable to Mr Janes and whether further action was required by social services.

113. This is something of importance because it reinforced the lack of action taken by others, creating the impression that Mr Janes was not a case of any particular complexity, which could be allowed to drift along – thereby undermining the forensic assessment. We wish to make it plain that Ms Guy's approach, which we criticise on the basis that it reinforced the inaction of others and hence the impression created that Mr Janes was not an unusual case, was no doubt caused in large part by the inaction of others. This is certainly not a case where there was a misjudgement by one senior professional only: rather, there was a general lack of response to the situation of Mr Janes.

114. In the context of the relatively low-key reaction to the axe incident, the subsequent permission to Mr Janes to leave hospital despite his admission in February 2001, and the low-key reaction to the forensic assessment, it is easy to understand why the clarity of the approach suggested by Dr Dunkley was lost.

This is reflected in other parts of the Chronology and our analysis in Part 3: there were failings within both health and social services which had the effect that the risks identified in relation to Mr Janes, as properly collated by the forensic assessment, were undermined.

14. Admission to Hospital – 10 April 2001

115. Social services records indicate that on 4 April 2001, Caroline Gale was informed about the incident with Mr Janes bringing in an air pistol to the day unit, and indicated that she would advise Dr Byrne of recent developments. On 5 April, there were discussions with Marilyn Brennan: it was reported that Dr Byrne had still not seen the forensic assessment, and there was discussion about having Mr Janes placed at The Birches (which we understand is an NHS facility) to provide some respite for his mother if he was not admitted to hospital.

116. On 9 April 2001, Dr Byrne saw Mr Janes. He told us that he had reviewed Dr Dunkley's report and was impressed with its conclusions. On 6 April 2001, he had made arrangements for a bed to be available for Mr Janes at the Arundel Unit at the William Harvey Hospital in Ashford, and had formed the view that he would place Mr Janes under section if he did not agree to attend as a voluntary patient. At the meeting with Mr Janes, Dr Byrne explained that he impressed upon him the need for admission, to change to medication by injection and to locate somewhere suitable for him to live on discharge.

117. As a result, on 10 April 2001, Mr Janes was admitted as an informal patient to Edgehill Ward, where he remained until 14 May 2001. This was hospital admission which preceded the homicide: for that reason, it merits close review. In addition, there were a number of events which merit comment. For these reasons, there is a much fuller account of the following events, together with analysis, in Part 3 of the Report. In short, we commend the decision by Dr Byrne to admit Mr Janes to hospital in response to the forensic assessment despite the fact that this amounted to a change in tack: this allowed the chance to regain the momentum which should have been built from the receipt of the forensic report towards providing a proper management plan for Mr Janes. We do have some concerns about the fact that it was a voluntary rather than a compulsory admission because the use of compulsory powers may send out a different message: we do accept, however, that there were proper reasons to make use of voluntary admission as long as it was accompanied by a clear message that compulsory powers would be used if necessary.

118. The treatment plan did not involve any input from a specialist drugs and alcohol team: this is something of a concern to us as there is clear guidance that this should be a part of mainstream mental health services

because of the potential for drug and alcohol abuse to impact adversely upon mental health. However, what was done was the introduction of depot medication, with which Mr Janes was compliant. This was clearly a positive development, though it has to be tempered by the lack of a plan to ensure that it was working in the sense of dealing with Mr Janes' underlying psychosis. The context of this is that there were concerns about the reliability of Mr Janes' self-report and the extent to which he voluntarily provided information. In addition, and with the benefit of hindsight, it is clear from the acceptance by the prosecution that the homicide of July 2001 occurred when Mr Janes' responsibility was diminished by psychotic symptoms that the medication was not working. Further, his treatment team at the Trevor Gibbons Unit (the medium secure unit where Mr Janes has been treated since August 2001) indicate that there has been a long-term continuation of the negative symptoms of schizophrenia, suggesting that the illness is acute.

119. Although our views are clearly illuminated by this hindsight information, the contemporary context was Mr Janes' presentation as an unusual and complex case and his identification as a patient having the potential for significant violence[13]. When this is added to the concern as to the reliability of Mr Janes' self-report, we would have expected an approach being put in place which involved a careful analysis of the effectiveness of the medication being used. It is clear that Dr Byrne had been monitoring the medication he prescribed – this is made plain by the fact that the anti-psychotic medication had been changed. But we feel that more was needed to assess whether there was not only full cooperation in accepting medication but also whether the treatment plan was successfully dealing with the underlying illness.

120. This leads on to another area of concern. One of the aims of the admission was the need to develop a management plan for Mr Janes. This is something which has to be predicated on the completion of a detailed risk assessment leading on to a management plan. Of course, we acknowledge that the CPA process was in place: but this is aimed at ensuring after-care. In Mr Janes' case, given the identification of the unusual features of it, what was needed was a plan which ensured that appropriate steps were taken before issues of release and the community-based management plan were put into action.

121. What is contained in the records is a number of short-form risk assessments, which are no substitute for what was required. We note that these short-form assessments include one done on his admission, which noted that there was a risk of harm to others, and set out the incidents of concern; this was accompanied by a preliminary care plan suggesting that his illness was a drug-induced psychosis, or possibly paranoid

[13] As was made plain by the axe incident and the previous admission to hospital in February 2001 to protect his family; all this was reinforced by the forensic assessment provided by Dr Dunkley.

schizophrenia.

122. Dr Byrne informed us that he was not given any training by the Trust on risk assessment. Although we would expect there to be proper training offered on risk assessment techniques, we also feel that it is perhaps a self-evident aspect of dealing with a general adult psychiatric population, most of whom will pose a risk to their own health or welfare, a small number of whom will pose a risk to others: in the absence of these features, they would probably not come to the attention of psychiatric services. It should be at the forefront of good practice to ensure that there is a risk assessment completed as part of the management plan. This may be easier in some cases, depending on the nature of the illness and the characteristics of the patient: indeed, in some cases, the risk assessment may be almost obvious.

123. We are not suggesting that Dr Byrne had not turned his mind to risk assessment and Mr Janes: that is far from the truth, because he was clearly alert to the issues (and that was the real reason why Mr Janes had been persuaded to come into hospital, because of the forensic risk assessment carried out by Dr Dunkley). We also have no reason to disbelieve Dr Byrne's account that he had in mind a management plan to deal with Mr Janes.

124. The problem is the written recording of this management plan. The treatment plan for Mr Janes involved a somewhat fractured provision of services on different sites and by different services, each of whom would have separate files which would not duplicate important information. This made it more important that there be a document available in which the consultant at the apex of the treatment team set out the essential aim for the admission to hospital and the steps which needed to be taken before the admission could be said to have achieved its aim. This need not have been anything detailed, and could have been in the form of a short memorandum which referred back to Dr Dunkley's forensic assessment and summarised the important parts of the care plan suggested there. Anything less than having such a document available leaves a substantial risk that the proper management plan will not be put into effect, which might well breach the duty of care to the patient.

> See further our analysis in Part 3: there are a number of issues raised here which are of great significance in understanding whether anything went wrong in this case.

125. We should note also that the records of social services indicate that Mrs Doyle phoned on 10 April 2001 and expressed her surprise that Mr Janes had been admitted to hospital. This reiterates what we have said above, namely that there was a need for a proper package of education for Mrs Doyle to ensure that she was able to understand her son's illness.

15. The Course of The Admission

126. The discharge summary sent to Dr Catto sets out a record of failure with the exception that Mr Janes was successfully commenced on depot medication. It states "Difficult to engage in treatment. Continues to use cannabis and alcohol on the ward." It recorded that he was discharged to an address with a friend, which could hardly be counted as a suitable address. The records of the multi-disciplinary meetings chart the lack of progress, as do other documents we have seen. We will describe the various relevant events during the admission in chronological order. Again, as with the immediately preceding part of the Chronology, there is a much fuller account of the following events, together with analysis, in Part 3 of the Report.

Social Work Supervision Meeting on 10 April 2001

127. On 10 April 2001, there was a meeting between Sue Guy and Caroline Gale as part of the supervision of the latter's training. This refers to the concerns about the risks from Mr Janes and the difficulties about communication with Mrs Doyle because of her ambivalence to her son being in hospital[14]. But the advice given and action taken seems to have been discussions about determining whether Mr Janes was happy for issues to be discussed with his mother and concerns about issues of confidentiality arising.

128. We do not wish to undermine the importance of teaching social workers about important issues such as confidentiality when it comes to discussing the affairs of adult patients with their parents, but what concerns us about this supervision is what is missing from it, including any assessment of whether there was to be a change in approach to the task in hand. Naturally, we accept that notes of a supervision session might concentrate more on the element of teaching which has gone into the session: but we cannot find elsewhere in social services files any review of whether the current work being undertaken, which concentrated on the finding of supported accommodation, was appropriate in light of the developments. The forensic report, on the basis of which Mr Janes was admitted to hospital set out a need to stabilise and offer treatment before Mr Janes could be found accommodation: this reasoning might affect the location and type of accommodation which was appropriate within the care package being developed.

129. We do not underestimate the difficulties of resources, which seems to have been a problem in the Shepway area in the sense that there was limited choice of supported accommodation: but the principle must be that

[14] This comes from the notes of the meeting: we are not endorsing any conclusion that there were in fact difficulties in communicating with Mrs Doyle; it is apparent that there were a number of instances of Mrs Doyle calling social services.

a patient's needs have to be assessed first, and then a decision taken as to the resources to be assigned. The assessment of needs requires taking into account all relevant information, and modifying it over time as there are important developments.

> See further in the Chronology and our analysis in Part 3: this is a situation which raises the issue of the duties of social services within the CPA process and whether there were independent duties. Our view is that the latter is the case and that the actions or omissions of social services have to be assessed in light of this.

First Multi-disciplinary meeting

130. On 17 April 2001, it was reported that Mr Janes was spending a lot of time in bed; although he was pleasant and polite with staff, and Dr Veugelers reported to us that there had been no problems on the ward, he also told us that alcohol was detected in Mr Janes' breath that day, and a drug-screen showed the presence of cannabis.

Refusal by Carr-Gomm

131. On 18 April 2001, the application made to Carr-Gomm was refused. This was based on the lack of available staff to guarantee that there would be no instances of drug/alcohol misuse.

132. We asked Carr-Gomm to provide some information as to the process they follow in determining an application. We were told that they had changed their referral procedure in the late 1990s so as to ensure that they have information covering the potential client's needs and the risks posed. The involvement of health and social services is achieved through the process of referral and contact such as interviews and any visits to the home.

133. The decision from Carr-Gomm is again is a development which could have caused a pause for thought: the fact that Mr Janes was rejected on the basis of a risk assessment might well have triggered a review of the suitability of the placement of Mr Janes in residential accommodation. However, the evidence suggests that Carr-Gomm was viewed as a resource offering lesser levels of supervision. This in turn raises the question of why it was the first place to which application was made in light of the level of risk he was felt to pose. This supports the impression that, despite the unusual features of his case, including the apparently recognised risk to others, Mr Janes was not treated as being out of the ordinary.

Art Therapy

134. On 20 April 2001, Mr Janes started art therapy. This, of course, is a positive feature. Marilyn Brennan was clear in her evidence that this was part of a plan to address Mr Janes' need to deal with the death of his father. We note that there was a risk assessment relating to this: the art therapist, in a statement to the police after the homicide, indicated that she had to inform staff when Mr Janes was present, to ensure that there was someone in the next office, wear a personal alarm and was to refuse to see him if he had been using drugs or alcohol. This is also something which makes a comment appropriate: namely, the contrast between the warning given to staff which is recorded here and what we have been lead to believe applied to other staff. In particular, we note that social services staff – in particular the student social worker, Caroline Gale – did not have such instructions provided. However, we should make it plain that there are no reports from any professionals who indicate that Mr Janes at any time appeared threatening to them.

Application to Willow Lodge

135. Following the refusal of Carr Gomm to offer accommodation, the application to the NSF/Rethink's Willow Lodge facility was pressed forward. The sequence of events seems to be that on 18 April 2001, there was a ward round. By that time, Mr Janes had been transferred to depot medication and the team was informed that Carr Gomm had refused him. Caroline Gale records in the social work notes that Dr Byrne had suggested that Willow Lodge might be appropriate. Dr Byrne was clear in his evidence to us that it was not a matter of choice in the sense that Willow Lodge was the place where he felt that Mr Janes' needs would be met, but rather that this was the only available placement for someone in his position. He explained to us that spaces within hospital-based rehabilitation services were very limited (he had only had one patient admitted to such services during his 18 months in post in East Kent).

> See further our analysis in Part 3: lack of resources to allow a patient to be placed in a location suited for his needs is clearly a matter for concern.

136. At that stage, it was expected that Mr Janes was to be on the ward in the Edgehill Unit for up to 6 weeks; this period of time could well have allowed a proper assessment of how he was responding to medication and how the other necessary elements of his treatment plan were being put into practice. As will be discussed below, this is not what happened.

137. On 20 April 2001, Caroline Gale met with Mr Janes to complete the form for admission to Willow Lodge. We had a statement from Ms Gale and she attended to give evidence to us. She felt that her remit was to

assist Mr Janes to locate accommodation. As to whether Willow Lodge was an appropriate location, she said that it was in her view a good location as Mr Janes could not stay with his mother and was telling the professionals that he was abstaining from drug use and had reduced his alcohol intake (though she also told us that she did not believe his account as to his drug and alcohol use).

138. The application form referred to the Carr Gomm refusal, and indicated that he could not live at home because of aggression (usually verbal). At the outset, we understand, there was no reference to the axe incident, although there is clearly a place on the form for indications to be given of incidents of violence (and drug/alcohol misuse). As with the application to Carr Gomm, it is a matter of concern that incomplete information was passed on at the outset. This defect was remedied (though not, apparently, until much later in the process) and the completed version refers to the axe incident and states that Mr Janes continues to use cannabis and amphetamine on an occasional basis.

> See elsewhere in the Chronology and our analysis in Part 3: non-statutory agencies play an important part in service provision and are entitled to have all relevant information passed to them.

Further multidisciplinary meeting on 23 April 2001 – Willow Lodge involvement

139. The next multidisciplinary meeting was on 23 April 2001. The notes record that there were no positive or negative symptoms of Mr Janes' schizophrenia (and Dr Byrne confirmed this to us). Dr Byrne told us that he had impressed on Mr Janes the importance of avoiding alcohol and illicit drugs. The notes record that Mr Janes was still drinking and indicated that he was depressed on the ward.

140. Willow Lodge had been invited to send someone along to the ward round and Sai Lee attended. He was clear in his account to us that he was informed that the axe incident was linked to drug use but that Mr Janes was currently clear of drugs, which is contrary to what we were told by Dr Veugelers in relation to a recent failed cannabis screen. Willow Lodge had a policy that people with an active drugs or alcohol problem would not be accepted. There is an apparent factual conflict here: we should make plain that we do not feel that we are in a position as an inquiry panel (and accordingly without either the power to place people under oath or to have evidence received with the benefits of cross-examination and submissions made by legal representatives) to reach a conclusion as to whether information was consciously withheld from Willow Lodge.

141. This dispute relates to an important issue in the case, namely the information passed on to Willow Lodge for its own assessment of whether

Mr Janes was suitable for them. We have had access to the internal inquiry undertaken by Rethink after the homicide. The conclusions of this review were several, including for example that the arrangements for admission needed to be amended to ensure that the admission panel was fully independent but also that misleading information was passed on to Rethink.

142. In their evidence to us, Rethink staff were consistent in supporting this conclusion, namely that not all relevant information had been passed on to it. Of course, Rethink were entitled to hold their own inquiry, and were perhaps bound to do so in light of the facts that the homicide had a particular impact on Willow Lodge and that they needed to review policies and procedures speedily in order to allow Willow Lodge to return to being an operational facility as soon as practicable, and also to ensure that they were following best practice there. However, it was difficult to disentangle the extent to which Willow Lodge staff giving evidence to us were stating what had become accepted to be factual by virtue of the conclusions of their internal inquiry. In making this comment, we should make it plain that there is no suggestion that Rethink staff had been coached in any sense: it is simply a fact that once there is a collective account available, particularly if it is in any sort of authoritative form, that passes into people's memories.

143. We also note[15] that the completed application form to Willow Lodge did refer to the axe incident and current drug use by Mr Janes. So there was the basis upon which further action/investigation could have been carried out. Further, members of staff at Willow Lodge were aware of hospital procedures to check for drug and alcohol use.

Review at the End of April

144. There was a multi-disciplinary meeting on 29 (or 30) April 2001 in which it is recorded that Mr Janes indicated that he had recently taken amphetamine and had been drinking with old friends, was isolative when on the ward and spending a lot of time off the ward. Dr Byrne gave us an account that he had reviewed Mr Janes, who had originally said that he had not been using alcohol but then said that he had 6 pints of beer at the weekend, and had also used amphetamines on a visit to Lyminge. The reaction of Dr Byrne was to amend the management plan by increasing the dosage of Mr Janes' depot medication, suspending Mr Janes' trips to the day hospital in Folkstone and requesting regular drugs screens. In addition, as is recorded in the notes, Dr Byrne's indication was that Mr Janes' should be detained under s5(2) of the Mental Health Act 1983 if he sought to discharge himself from hospital, so that he could be assessed for further detention under the Act if necessary. Dr Byrne explained to us

[15] This is developed below in a separate section dealing with the circumstances of Mr Janes' ultimate acceptance by Willow Lodge.

that he had informed Mr Janes that he had to take his course of treatment seriously, since otherwise the risk was that he would have a "psychiatric career" (his exact words) of regular contacts with the police and multiple admissions to hospital, including under section.

145. We note, of course, that binge drinking and use of drugs had been involved in the axe incident and would no doubt be a cause for particular concern.

Multidisciplinary meeting on 8 May 2001

146. A significant sequence of events was about to occur. On 7 May 2001, a risk assessment was completed by Staff Nurse Crowther: this was a short-form assessment, and it refers to there being a risk of harm to others, both family and strangers; that the risk was of serious injury and it was very likely. The overall risk posed by Mr Janes was given as high. The narrative referred to recent dreams reported by Mr Janes of him dissecting bodies.

147. As we have mentioned, there were a number of risk assessments: this is the only one which placed Mr Janes in the high risk category (though we note that this was more a matter of him being scored slightly more highly than on earlier assessments – out of a score of 25 – and consequently moving from the high end of medium risk to the lower end of high risk). These are fairly crude instruments, but the question posed is the action taken on the basis of the assessments made.

148. The next day, 8 May 2001, there was a multidisciplinary meeting, and things had clearly taken a turn for the worse in terms of the view taken of Mr Janes. His urine tests had revealed cannabis and amphetamine use, he had returned to the ward intoxicated, was spending a lot of time in bed and became angry when efforts were made to discuss drug and alcohol use.

149. The primary nurse went so far as to recommend his discharge on the basis that he was supplying drugs on the ward and putting other patients at risk; it is apparent that Dr Byrne was able to counter this request. The notes of the multi-disciplinary meeting indicate that it was thought that Willow Lodge would offer a place in a short time. The main step taken as a result of the meeting was to require Mr Janes to sign a contract in relation to drug and alcohol use. This is recorded in the medical notes, and is signed by Mr Janes with Dr Byrne as a witness, and stated that Mr Janes would be discharged if he broke one of 4 rules, including being positive for cannabis or amphetamines, having greater than 50mg of alcohol per 100ml of breath, or refusing a drug screen.

150. There is clearly a tension here, which is analysed further in Part 3 of our Report, between the indication given at the previous multi-disciplinary

meeting that Mr Janes was to be placed under compulsion by use of s5(2) of the Act if necessary and the written contract signed on this occasion that he had one last chance before being discharged.

151. In his evidence to us, Dr Byrne explained that what was his last meeting with Mr Janes was not an easy one. He explained to us that it was still his view that Mr Janes should be placed under s5(2) if he sought to leave the ward. He told us that he had arranged to write out the contract on a fresh page of the medical notes so that Mr Janes would not be aware of the instructions as to s5 being used. However, it is apparent from other sources that Mr Janes was aware of this: on 3 May 2001, Mrs Doyle telephoned Caroline Gale and expressed her anger that Dr Byrne had told Mr Janes that he would be placed on s5 if he sought to leave the ward.

152. More importantly, it is not clear from a reading of the written documentation surrounding Mr Janes' admission that the management plan remained that Mr Janes was to be detained if he sought to leave. We should mention that the only witness we wished to see who we were not able to see was the Ward Manager at the hospital: he was not able to speak to us because he was on sick-leave, and a set of questions we asked for written answers to were not answered. However, we had access to the notes made and we assume that, as contemporaneous records, these are accurate. Nevertheless, it would have been useful to have an account given of the problems on the ward at the time and the impression the staff had as to what was the plan for Mr Janes.

> See further our analysis in Part 3: the importance of recording and transmitting information as to management plans for a patient is made plain by this situation.

Dr Byrne Leaving the Hospital – Hand-Over to Dr Kooij

153. Dr Byrne left the service on 11 May 2001. He informed us that his resignation had been accepted in February. It is, of course, unfortunate that there is a change of treating psychiatrist in the middle of a course of treatment, but that is not an unusual occurrence and a proper system should be in place to allow a treatment plan to continue in such circumstances. Dr Byrne describes having what he termed "an informal meeting" with his replacement, Dr Kooij: we also understand that Dr Byrne was not aware until the very end of his employment that Dr Kooij, whom he knew as Dr White's Specialist Registrar, was to be his replacement.

154. This meeting was at Radnor Park in Folkstone, not at the hospital in Ashford where Mr Janes was at the time an in-patient. Dr Byrne recalls that there were only a few in-patients at the time, but that there had not been time to prepare a signed list of patients: consequently, he thinks that

he may have handed over a hand-written list of patients. It is also Dr Byrne's view that he impressed the need of Mr Janes continuing with his admission and having a proper package around discharge.

155. There is no documentary evidence in relation to this. We feel that part of the responsibility of a psychiatrist who is moving and passing on cases is to ensure that there is readily-accessible documentation as to the risks in a patient's case, whether as to self-harm or harm to others. One of our recommendations is that there ought to be a formalised hand-over procedure at which the out-going consultant can alert the incoming consultant to the major factors in a particular patient's case: an informal meeting with a hand-written list of patients and a few words of warning in the case of a patient such as Mr Janes is not adequate. Of course, a new consultant should review all the relevant papers and formulate his or her own plan: but the circumstances of the hand-over compounded the lack of a clear written treatment plan for Mr Janes (or even a clear written endorsement that the suggestions of Dr Dunkley were being adopted).

> See our analysis in Part 3: the nature of service provision in this area involved split sites and so different sets of notes, which made it particularly important that there be proper recording of management plans, at least in summary form, which could be readily available to the relevant professionals, whichever site they were working at.

Mr Janes' Visit to Willow Lodge; Discharge from Hospital

156. May 2001, Mr Janes was taken by Caroline Gale to Willow Lodge. Things appeared to go well, though we understand from those who are currently caring for Mr Janes that it is a feature of his presentation that he will often say what he thinks people wish him to say. But after the visit, he informed Caroline Gale that he did not wish to go there; indeed, later that day, he withdrew his application. He also discharged himself from the Arundel Unit. He had been reviewed by Dr Veugelers before he went to Willow Lodge; he recorded that there had been no problems over the week-end. When he decided to discharge himself, the SHO who examined him found no reason to detain him: the medical records include a note that the situation had been discussed with nursing staff, who felt there was no reason to detain him. (Caroline Gale is recorded as informing her supervisor that hospital staff viewed the situation as Mr Janes using the hospital as a "doss house", and so it is not surprising that they were happy for him to leave.) Mr Janes indicated that he was going to stay with a friend.

157. Clearly, whatever view Dr Byrne had as to his plan for Mr Janes to be detained if he sought to leave, ward staff and junior members of the medical team were either not aware of it or disagreed with it. The former is perhaps more likely since it is unlikely that Mr Janes' discharge would

have been allowed without a review from the replacement consultant. We note in this regard that Dr Kooij was due to start his post the next day, 15 May.

16. Events Following Discharge

158. Mrs Doyle has told us that she was mystified when her son was discharged to live with a friend. The notes in social work files record that on 14 May 2001, before Mr Janes had decided to discharge himself, Mrs Doyle expressed anger about the fact that there was no quick decision as to the placement at Willow Lodge: her concern was that he would return home and cause trouble. The social worker records that she had discussed options for Mr Janes, though maintaining confidentiality by not passing on information he had not wished his mother to know, namely his continued use of illegal substances.

159. There is a record in the files of the Radnor Park Day Service that an offer of family therapy was made to Mrs Doyle on 15 May 2001. (Marilyn Brennan has indicated her view that family therapy was important as Mr Janes' use of drugs and alcohol and poor relationship with his mother were part of his unresolved grief at the death of his father and the burden of taking on an extra role in the house as the main male figure.) This was rejected by Mrs Doyle on the basis that she felt that the need was for practical support to her son and talking to someone would not assist: we have to say that, whilst family therapy may have a longer-term role in a case such as this, we sympathise with Mrs Doyle's view that the priority had to be to given to putting some practical arrangements in place.

160. Brett Luckhurst, having been informed that Mr Janes had been allowed to leave the hospital, records that he spoke to Dr Kooij, whose first day in post was 15 May 2001, and was advised not to administer any depot medication as the issue of the treatment plan would be discussed at a CPA meeting which was set for 29 May 2001.

161. Mr Janes soon returned home, as - perhaps not surprisingly - things did not work with his friend. On 22 May 2001, Brett Luckhurst records that Mr Janes was living in the back garden of his mother's house in a tent. This is, of course, an obviously unsatisfactory position, both from the point of view of the care and treatment of Mr Janes, a young man with complex needs, and from the point of view of Mrs Doyle and her daughters, who were in a position which they should not have had to face.

162. It seems that the application for a place at Willow Lodge was revived; Raphael Fox, the Manager, gives the date as 17 May 2001. On 23 May, Mr Janes and Mrs Doyle visited, together with Caroline Gale: they met with Mr Fox and David James, a Community Mental Health Worker at the facility. It was apparently at this meeting that it was made clear that

information missing from the application form (as to history of violence and drug/alcohol problems) had to be completed.

17. CPA Meeting on 29 May 2001

163. This was Dr Kooij's first opportunity to see Mr Janes. Dr Kooij gave us a statement and attended to give evidence. He was a locum consultant, but was still in the final stages of training, and was under the supervision of Dr White in that respect. At the time of the consultation, he had available only the outpatient notes: he did not have the notes from Mr Janes' recent in-patient admission in Ashford, nor did he have access to the files from the nursing and other notes compiled at the Radnor Park Day Hospital.

> See further in our Chronology and in our analysis in Part 3: the need to have a reliable summary of the most important information available before decisions are taken is apparent from a situation such as that here, where Dr Kooij was interviewing and assessing a patient with complex mental health needs but with very limited records.

164. The CPA meeting was attended by Brett Luckhurst: unfortunately, from the point of view of the consistency of the care team involved with Mr Janes, he was also leaving his position. Also in attendance were Caroline Gale and David James from Willow Lodge. Mrs Doyle had been invited but Mr Janes withdrew his consent for this. The outcome of the meeting was that treatment by depot injection was continued (and Mr Janes was said to raise no problems in this regard). Brett Luckhurst in his notes records that consideration should be given to discharging Mr Janes from the Day Service because he was not willing to participate in either group work or 1:1 work (explaining that he did not want to keep talking things over), and did not think he wanted to continue to art therapy, and so there was little prospect of the Day Service offering any real input.

165. Following the meeting, Dr Kooij wrote to Dr Catto (letter of 1 June 2001) summarising the position and stating that Mr Janes had reported being free of illicit drugs and alcohol since his discharge from hospital; however, it was also noted that he reported being anxious, particularly when others were around.

166. We have some concerns about this meeting. In the first place, the fact that it is recorded in the letter to Dr Catto that Mr Janes was reportedly free of drugs suggests that those who knew or thought to the contrary did not speak up about this.

167. In the second place, it is apparent that the meeting did not focus on a full review of what had been a significant few months, which, if the

starting-point is the previous November, had commenced with a very serious incident of violence, had seen aggression towards his family, two admissions to hospital, the compilation of a forensic report, ongoing use of illicit drugs to the extent that he was asked to leave hospital because he was said to be supplying others, and an indication that he had little interest in continuing to engage with the services other than by way of taking his depot medication. In the context of the personnel involved – ie a new consultant taking over, a keyworker about to leave – we feel that it was necessary to engage in a full review to make use of the fact that someone who had known the patient well for some time was about to leave and there had been a significant number of events. Dr Kooij has pointed out that the meeting lasted 20-30 minutes and covered a number of areas, including medication, Mr Janes' attendance at the day hospital, his drug and alcohol misuse, his accommodation; there was also some comment on his ability to deal with violence in that he reported having walked away from a potential fight recently.

168. Having said that, it seems likely that the sequence of events described above, including such matters as the failure to act on the forensic report immediately, the decision not to use compulsory powers in April, the mixed messages in Dr Byrne's indication that s5 was to be used but that Mr Janes was to sign a contract in which he would be asked to leave if he breached rules – all of these matters combined to down-play the importance of treating Mr Janes in the way suggested by Dr Dunkley. It would be difficult to expect that a new locum consultant coming into post would suggest a significant change from the apparently limited implementation thus far of the management plan implicit in Dr Dunkley's forensic report.

169. In the third place, despite the fact that Mr Janes was again living with his mother, albeit sleeping in a tent in the garden, there is no indication that a proper attempt was made to ask her to provide information which might have informed the view taken by the professionals as to what was required as a management plan at that time. However, we do note that there was an ongoing process of assessment for Mr Janes at Willow Lodge, which would have resolved the accommodation problem if he was accepted and a space was immediately available (and so his sleeping arrangements were seen as temporary), and there was due to be a further CPA meeting at the end of June.

See further our analysis in Part 3 of the Report: there are number of issues arising at this meeting which reflect other themes running through the Chronology.

18. The Admission to Willow Lodge

170. Following the CPA meeting, the next few weeks involved the assessment of whether Mr Janes should be offered a place at Willow Lodge. He visited again on 30 May 2001 and in subsequent weeks. We understand that David James was the main point of contact, and he provided an assessment of Mr Janes. David James, who provided us with a statement and gave evidence to us, describes it as carrying out a risk assessment. He indicated to us that he was reassured by Mr Janes that he was not using illicit drugs.

171. Mrs Doyle is clear in her recollection that Mr Janes called the Arundel Unit (on 5 or 6 June) indicating that he was unwell and wished to be readmitted to hospital. When we spoke briefly to Mr Janes, this was one of the things he told us. Mrs Doyle records that her son was told that he would not be readmitted[16].

172. On 14 June 2001, Mr Janes saw Marilyn Brennan, who had taken over from Brett Luckhurst as his point of contact at Day Services. However, the notes record, Mr Janes indicated that he wanted no further contact with Day Services, and in effect would limit his involvement to attending for his depot injection. It is, of course, a positive matter that Mr Janes was established on and was compliant with his medication regime. This must be tempered by the fact that there was no proper assessment as to whether it was being effective in controlling Mr Janes' symptoms: whilst we accept that there is no evidence of him reporting psychotic symptoms, the fact is that it was apparent that he was not an individual whose self-reporting was to be considered wholly reliable.

173. The decision making panel at Willow Lodge met on 22 June 2001. In advance of the meeting, there had been a discussion between Caroline Gale and Marilyn Brennan as to sharing risk assessment information with the Panel: it was agreed that this should be done as it would inform the Panel. In fact, one of the factual disputes in the narrative is just what information was shared with the Panel.

174. Those in attendance were Raphael Fox (NSF/Rethink), Sue Guy (Social Services), Marilyn Brennan (Health), Celia Robinson (from the Southern Housing Group, the "landlords" at Willow Lodge) and Heather Murray (Group chair). David James was present as the worker who had assessed Mr Janes. We understand that the involvement of Marilyn Brennan and Sue Guy as members of the decision-making panel was a requirement of the commissioning arrangements whereby places at Willow Lodge were funded.

175. We heard a significant amount of evidence about the meeting of the

[16] We made efforts to identify who Mr Janes spoke to, but it was not possible to work out who this was.

Panel; we were able to hear from all the participants. There are no proper minutes of the panel, which is unfortunate (and we note that Rethink now insist that there are full minutes kept). There are some differences of recollection as to some important issues relating to risk assessment information. In particular, there is a difference of view as to whether the forensic assessment prepared by Dr Dunkley was made available to the Panel. We can summarise the difference of view in the following terms:

Marilyn Brennan, who told us that she was in charge of coordinating the care package offered to Joe Janes, was of the view that the Panel had been sent Dr Dunkley's report and so the members were fully informed about the forensic risks, and had been sent the discharge summary prepared when Mr Janes left hospital; she was clear that the Panel was fully aware that Mr Janes had been asked to leave hospital because of drugs problems, and that he was using drugs and alcohol at the time, though at a reduced rate from his past. She emphasised the relevant staff at Willow Lodge, in particular David James, had formulated their own risk assessment, which they were competent to do, though she accepted that they would rely heavily on information provided by health and social services.

David James was clear in his evidence that the Panel was given reassurances by Marilyn Brennan and Sue Guy that there was no risk or minimal risk. He also indicated that reassurance was given that the risky behaviour presented in the past had been in relation to drug use.

Heather Murray was clear that the Panel was reasssured by Marilyn Brennan and Sue Guy that Mr Janes was no longer using illegal drugs and willing to remain abstinent, was stable on his anti-psychotic medication and willing to continue taking it.

Celia Robinson identified the CPN on the Panel (which would be Marilyn Brennan) as providing an assurance that Mr Janes was no longer using illicit drugs (which had been identified as the cause of the axe incident); she also recalled that David James indicated his view that Mr Janes was not currently abusing drugs.

Raph Fox indicated that as information relating to risk assessments was recent, specific assurances were sought from the professional members of the panel as to risk issues, and the reassurances were given that there were no current drug use issues and that the risks posed by Mr Janes did not prevent his admission.

Sue Guy's evidence to us was that she was still assessing in her own mind what was the risk situation (which itself is something of a matter of concern as she was supervising a student social worker in relation to the case), but felt that there was information available to the Panel from various sources, including the assessments of David James, which

allowed a decision to be reached.

176. As we have indicated previously in relation to matters where there are factual disputes, we do not feel that the Panel process allows us to reach definitive conclusions as to who is right as we do not receive evidence on oath and there is no adversarial procedure. We do note that a few days after the Panel Meeting, on 28 June 2001, there was a further of the short-form risk assessment forms completed by Marilyn Brennan which indicated that Mr Janes did not pose a risk to others, though he had in the past – in other words, that the relevant risk factors were in abeyance. It is possible that this document sets out a conclusion which was informed by the conclusion of the Panel: but it is consistent with the suggestions made other witnesses that reassurance was given to the Panel that the risk posed by Mr Janes was low. Ms Brennan explained to us that the reason for this assessment was that, on the day it was done, Mr Janes did not appear to have been using drugs, was compliant with medication and not exhibiting risky behaviour, and so on that day was given a low risk assessment.

177. In relation to drug use, Ms Brennan noted that Mr Janes had been assuring her that he was not misusing alcohol or abusing drugs: we do think that this is something which merits a comment. Mr Janes had a long history of drug use; he had been using drugs and alcohol during a recent admission to hospital (to such an extent that staff including his key nurse wished him to be excluded from the hospital on account of involvement with drugs). It was not proper to accept an indication from him that he was not using drugs and alcohol, or that this was a risk factor in abeyance, in the absence of proper verification: having said that, we note that the CPA meeting of 29 May 2001 had also lead to a report to Mr Janes GP to the effect that he was reportedly free of drugs.

178. Equally, we note that in relation to Ms Brennan's account that Mr Janes was complying with other elements of his care package, the report from the CPA meeting of 29 May 2001 was that consideration should be given to discharging Mr Janes from the day care centre because of his limited cooperation with the elements of the package which were offered there (save for his acceptance of depot medication).

179. Irrespective of the truth as to whether the Panel was given assurances as to risk from the professionals on the panel, and in particular Ms Brennan, it is clear that the Panel had available to them information as to the main issues involved in the decision in hand, namely whether to offer a place to Mr Janes. They were informed that there had been a serious incident involving an axe and that there had been problems with abuse of illicit drugs. Their decision had to take into account the needs of Mr Janes but also the obligations of the organisation to the other residents at their facility and the staff there.

180. We note that that the decision-making Panel included representatives from social services and health, which we understand was a requirement imposed by the commissioning authorities. We also note that this is a matter which has now been dealt with in discussions between Rethink and the local commissioning authorities so that the make-up of the Panel determining whether to accept applications for places at Willow Lodge is now one which ensures that it is independent of the placing authorities. This is proper, given the responsibility of the panel and the need for independence from those presenting a case to it.

> See further our analysis in Part 3 of our Report: the decision-making process at Willow Lodge, and the make-up of the Panel, including representatives from health and social services, are matters of concern.

19. Events Leading to Mr Janes Moving to Willow Lodge

Fresh Information to Social Services

181. Following the decision to offer Mr Janes a place, it is reported that he presented as looking forward to the move. He visited to do things such as decorating the room allocated to him. Caroline Gale's placement came to an end and Mr Janes was allocated to Andrew Longley: however, we note that Mr Longley was on a 6-month locum contract and may not have been the best person to pick up a complex case. In any event, he never met Mr Janes.

182. There is a record in the social work files that on 27 June 2001, when Mrs Doyle called to ask when her son would be moving into Willow Lodge, she did explain that there had been some recent "scary moments", which she would not discuss further, and that she was planning to move away and not let him know. There may be something of a factual dispute as to what was said by Mrs Doyle, in that she denies that there were ever occasions when she refused to discuss things. She points out that she wished to have her son placed away from home as soon as possible and so would have no incentive not to pass on information which made plain that it was inappropriate for him to be living with her.

183. It is not necessary for us to resolve any factual dispute in this regard, even if we were equipped to do so. The simple fact is that Mrs Doyle expressed that there were problems and that she was sufficiently worried that she wished to move away to a location which was secret from her son. Mrs Doyle had borne the brunt of the challenging behaviour of her son; she had younger children to care for, and was entitled to expect that assistance be given by the authorities to deal with the situation, irrespective of the details.

184. The fact that she wished to move to a place where her son could not find her is something which should have rung alarm bells as to whether what was happening – ie placing him in a home with other vulnerable individuals – was appropriate for his needs and for the protection of others. In particular, as part of the supervisor's review of the social services file, Sue Guy should have been able to review the entry and raise the issue of whether the risk information presented to the Willow Lodge Panel had been accurate; further, this is information which should have caused Marilyn Brennan at the review on 28 June 2001 to reconsider her assessment (which on that date noted that Mr Janes did not pose a present risk to others), and to engage in consideration as the CPA coordinator as to whether the ongoing plan was proper.

185. Of course, there was something of a quandary for those involved in the care of Mr Janes: the fact that there were problems with the environment at home and that, as the forensic report had indicated, there were concerns as to the risk posed by Mr Janes to his family meant that it was necessary to find him accommodation away from home. But the information they had relating to Mr Janes had to be taken into account in determining what that accommodation should be: after all, aggression towards his family had been a reason for him being admitted to hospital only a few months previously. It was not only concerns about Mr Janes' best interests which had to be taken into account, but also the interests of others.

186. We asked Ms Brennan if she was aware of the information passed to the social workers as to there being "scary moments" and she indicated that she was aware that things were not good at home and Mrs Doyle was looking forward to him leaving. (She also notes that she was told subsequently by Mrs Doyle that things were okay at home: however, this was in the context that she had not built any relationship with Mrs Doyle to the extent that the latter would confide in her.)

187. So both health authority staff and social work staff were aware that the sort of behaviour by Mr Janes which had caused problems before and lead to admissions to hospital was being repeated. However, there is no indication that any thought was given to whether or not he should be readmitted to hospital in light of this evidence of further aggressive behaviour rather than placed in a location such as Willow Lodge.

> See further our analysis in Part 3: this raises both issues of the extent to which information from Mrs Doyle was incorporated into assessments of risk, and the extent to which fresh information was taken into account in determining whether management plans should be amended.

Fresh Information to Willow Lodge

188. There was also an instance of Mrs Doyle reporting to staff at Willow Lodge that there had been recent events which meant that she wished her son to move into Willow Lodge and so away from her. We think this occurred in a brief conversation between Mrs Doyle and Stephen Gibbons, a Community Mental Health Worker at Willow Lodge. He records that he met Mrs Doyle when Joe was showing her his room: his view was that she looked at the end of her tether and expressed her concern that he move as soon as possible, but that she would not give details as to why this was her concern as it would prejudice the placement. Mr Gibbons indicates that he immediately raised this with other members of staff as a matter they should be concerned about. Mrs Doyle's account is that she was keen to discuss matters as she was about to hand over the care of her seriously ill son to the staff at Willow Lodge, but she indicates that she had a vague and lethargic response and the matter was not taken any further.

189. This is not a dispute we have to resolve: whichever account is accurate, there was information relevant to the issue of Mr Janes' placement which was not investigated further by the decision-makers at Willow Lodge. We note that Rethink have now amended their procedures to improve communication with the families of proposed residents and to ensure that they can have input into the process where appropriate.

> See further our analysis in Part 3: some of the concerns we have as to occasional failures by the statutory authorities to take account of important information from third parties such as Mrs Doyle who are likely to have relevant information are replicated in this approach by Willow Lodge staff.

190. Another matter of factual dispute arose in the course of the Inquiry, which related to a staff meeting at Willow Lodge immediately before Mr Janes moved in. This revolves around the issue of whether or not specific concerns were raised about Mr Janes, the risk of violence from him and recent evidence of use of drugs. We have differing accounts given of what happened in the staff meeting and whether or not the minutes of the staff meeting are an accurate record of what was discussed (not, we should add, in the sense that they are in any way doctored, but arising from the fact that the minute-taker was unable because of absence to complete the minutes and the partial hand-written notes were used by someone else to complete what was in fact an inadequate account of the meeting because the hand-written notes were not sufficiently comprehensive).

191. We do not think it necessary to resolve this factual dispute (and we do not think it helpful to record the differing accounts we have or to identify who they come from). Again, whatever the truth of the matter, it is important to note that there were issues raised which could have lead

those in a managerial role to reassess the decision to admit Mr Janes – either in reliance on information provided as to his drug use (if that is what was passed on) or by investigating further the situation relating to the risk of violence posed by Mr Janes based on his past, given that the issue had been raised as to whether Willow Lodge was a suitable place for someone who had used violence and it was known that Mr Janes was in this category.

192. Mr Janes moved to Willow Lodge on 12 July 2001. He had a depot injection that day. He had raised concerns about side-effects, and it is recorded in the Day Service notes that his dose was to be reduced on 26 July.

20. The Homicide and Subsequent Events

193. The homicide occurred on 15 July 2001. We have been shown the witness statements prepared for the trial, plus the unused material made available to the defence. There was an argument in the residents' lounge between Mr Janes and Joseph Day, who was thought by some witnesses to have been uncharacteristically angry. This was at around 8.30pm. Mr Janes left the room, returned with a knife and stabbed Mr Day. The wound was fatal. Mr Janes told various people that he had reacted because he did not like being called names, but had not wished to kill Mr Day (and had therefore aimed low). He made full admissions to the police, explaining that he had been responding to voices.

194. After his arrest and interview, Mr Janes was charged with murder and held in custody to appear at Dover Magistrates Court. On 17 July 2001, he was remanded into custody and the case was transferred to Maidstone Crown Court. Concerns were raised as to Mr Janes' mental state and the ability of the prison to deal with him. As a result, a psychiatric assessment was carried out by Dr Dunkley. This lead to him being transferred to the Trevor Gibbens Unit under s48 of the Mental Health Act. The warrant of transfer was issued on 6 August 2001 and he moved on 8 August.

195. On 6 August 2001, Mrs Day made an official complaint to the Trust. An internal review was set up, but we were told that there was confusing advice from the Department of Health as to what such an internal review should do and how it should operate. This lead to what has been called the "Scoping Report" prepared by Dr White and John Hughes, which was provided on 7 September 2001 and listed various areas of concern (without providing any answers, that being left to others, including this Inquiry). We have been assured by the Health Authority that it is their understanding that homicides which occur in situations such as this one should lead to the use of an independent investigation: this does not emerge as being the understanding of the relevant parties in the

immediate aftermath of the homicide.

196. The NSF (which became Rethink) also decided to carry out its own investigation. As we have noted above[17], they had good reasons to conduct their own review. This was carried out by Edward Greenwood, based on enquiries between 20/7 and 17/10 (including a review of various records and interviews of NSF/Rethink staff). A draft report was circulated to health and social services staff, who made comments before a final version was produced; it is fair to say that the statutory agencies did not share the same view as Rethink as to the conclusions in the report. We were able to see the draft and final reports and interviewed Mr Greenwood. As this NSF/Rethink report remains an internal report, it is not appropriate to discuss its contents more than is necessary, save to say that it does emphasise issues around lack of information passed on to the Panel which accepted Mr Janes to Willow Lodge in relation to which we have made comments above which do not absolve NSF/Rethink.

197. On 25 October 2001, Mr Janes was started on Clozapine, which is often used for treatment-resistant schizophrenia, though we understand that it may in any event be a preferred drug at the Trevor Gibbens Unit.

198. The criminal proceedings continued. On 29 January 2002, Dr Majid supplied a report to the criminal defence team (which was passed to the prosecution and, we understand, to Mrs Day and so has been circulated to some extent). The conclusion was that Mr Janes suffered from treatment resistant schizophrenia, exacerbated by drug and alcohol misuse, and was so suffering at time of the offence, and so his responsibility was diminished so as to reduce the crime to manslaughter. On 1 March 2002, Dr Joseph presented his report to the Crown Prosecution Service: in essence, he agreed with Dr Majid, including the important conclusion that Mr Janes suffered from schizophrenia triggered or exacerbated by drug use, and his responsibility was diminished.

199. On 8 March 2002, at the Crown Court, the prosecution accepted a plea of Not Guilty to Murder but Guilty of Manslaughter on the Ground of Diminished Responsibility. The judge made a hospital order under s37 of the Mental Health Act 1983 with a Restriction Order without limit of time under s41. Mr Janes was placed back at the Trevor Gibbens Unit.

200. We were able to speak to the team which has treated Mr Janes since his admission from prison to the mental health system at the Trevor Gibbens Unit. The information we note in particular is that:

- he is viewed as a non-aggressive, passive individual;

[17] In relation to the provision of information to staff at Willow Lodge: see the account of the multidisciplinary meeting on 23 April 2001 at the Arundel Unit, to which Sai Lee from Willow Lodge was invited.

- he is being treated with Clozapine, in part because other drugs had not worked;
- from the time of his admission, he was observed to be exhibiting the positive symptoms of schizophrenia for several months; but he did not report the symptoms, and would mask them (not necessarily deliberately) – in short, his nature was such that he would simply answer yes to everything or move away so as to avoid answering questions; his primary nurse told us that he could not allude to his positive symptoms because he truly believed that the positive symptoms of his illness were reality – in other words it took him a long time to realise that they were symptoms of an illness rather than reality.
- the negative symptoms of schizophrenia persist;
- he is felt to have significant anger-management problems, which he recognises, though he is not aggressive unless pushed to a point where he snaps

21. Dealings with Mrs Day After the Homicide; Setting up our Inquiry

201. Mrs Day recalls being visited by the police and by those who had been involved in the care of her son; she particularly remembers Andrew Mulgrew, Mr Day's CPN, being supportive (and we are aware that Mr Mulgrew's important role was noted by others). However, in her evidence to us, she indicated that she felt that her efforts in the months following to make sense of what had happened to cause this tragedy were less than satisfactory because of what she perceived as obfuscation and maladministration. In particular, she was concerned about the delay in setting up this Inquiry, and the frustrating process of having to chase numerous agencies as there was an apparent lack of adequate inter-agency cooperation. We have set out in the early part of our report the chronology of the establishment of this Inquiry and the fact that there was some confusion as to what was required. In the end, the Health Authority announced the establishment of the Inquiry to the press before informing Mrs Day, despite the fact that she had been in regular correspondence requesting information.

202. Mrs Day asked us to consider making recommendations as to a more humane and stream-lined approach to the management of processes such as our Inquiry.

Initial Contact from the Trust

203. At the end of July 2001, the East Kent Community NHS Trust wrote to Mrs Day offering their sympathies. By then, she had had the unfortunate experience of having had to identify her son's body as part of the legal process, and had done so in the context of his body not having been prepared at all. She was also informed in early August by the Hospital

Manager at the William Harvey Hospital as to mortuary policies when there is a death into which there are police inquiries: however, it does not appear that she was particularly well prepared for this by the officers present.

Complaint from Mrs Day and Initial Responses

204. At an early stage, in August 2001, Mrs Day wrote to the Trust, Kent County Council Social Services and to the National Schizophrenia Fellowship to make plain that she wanted a number of questions answered. (We note that amongst the points raised was that she wished to have assurances that she would be involved in any investigations or inquiries set up as a result of the homicide.)

205. The initial replies to Mrs Day were speedy and appropriate: the Trust wrote on 9 August 2001 that it was collating information and would reply, and Kent County Council sent a similar holding reply on 10 August 2001. The NSF/Rethink Deputy Chief Executive, Liz Felton, telephoned and then wrote to Mrs Day setting out a course of action, including arranging a meeting with Mrs Day as part of their investigation into the incident. It is clear that there is a contrast between the responses from the statutory authorities and that from the NSF/Rethink. The latter had a clear plan in place and was able to give Mrs Day a name and a time-scale for when she would meet the individual charged with the investigation. In contrast, the letters from the statutory authorities read as holding letters, which is what they were, although both of their letters give contact details with individuals involved in the administration of their complaints processes.

206. We have seen the internal notes produced within the statutory authorities prior to their initial replies. We were struck by a number of features. First, that steps seem to have been triggered by the receipt of the complaint from Mrs Day: this was three weeks after the homicide which, by virtue of the involvement of a patient recently discharged from hospital and placed in supported accommodation in a process involving social services' input, was one which obviously was going to call for some form of investigation by both health and social services. In short, steps should already have been taken by the Trust and the County Council by the time the complaint came in (and irrespective of whether there was a complaint).

207. The second feature apparent from the notes – which was compounded by evidence we heard – was that the Trust and Social Services did not know what each others' procedures were in relation to complaints; and the Trust in particular seemed unclear as to what process should be set going (in accordance with NHS guidance)[18]. Again, this is something of a

[18] We have been assured by the Kent and Medway Strategic Health Authority that they are clear as to the need to set up an Inquiry (in accordance with Health Service Guidance (94) 27) whenever there is a homicide by a patient in the care of mental health services.

surprise, though it is apparent that there may well have been a distinct lack of guidance from the Department of Health in this regard, as the file note relating to communication with the Department indicates a lack of clarity in their advice as to what should be happening in the situation.

208. The third feature is that it is apparent before the letters were sent out by the Trust and the Council to Mrs Day, there was already a date set for an initial review to be carried out by Dr White (the acting Medical Director of the Trust) and John Hughes (Mental Health Services Manager within the Council). We see no reason why this information could not have been provided to Mrs Day.

Further Events

209. On 13 August 2001, Lori Eden, the Patient Liaison Manager for the Trust (and Mrs Day's point of contact) wrote to Dr White to ask for a draft response to Mrs Day's complaint by 30 August 2001; she drew attention to Mrs Day's request to be involved in the process.

210. On 21 August 2001, Dr White and Mr Hughes met to discuss their task, which had become a scoping exercise: we have not been able to trace how it was decided that this was the line to take, but the evidence we heard orally suggested that this was based on advice from the Department of Health as to the appropriate course to follow. On 23 August 2001, Dr White indicated to Lori Eden that the scoping exercise would be finished on 7 September 2001. There is no indication in the documents that there was any plan to involve Mrs Day at this stage.

211. In this context, it is hardly surprising that on 13 September 2001, Mrs Day wrote to the East Kent NHS Trust asking for the timescale for inquiries and an indication of whether the Trust or Social Services were taking the lead role. Having apparently not had a reply, she wrote to Kent County Council on 25 September 2001 asking similar questions.

212. On 5 October 2001, the Trust and Council sent a joint letter to Mrs Day. This set out that there was an urgent scoping review being carried out: in fact, this scoping review had been completed. The letter then indicated that the East Kent Health Authority and the County Council would then decide whether to convene an independent inquiry, and an outline was given of the procedures of such an inquiry. We do not see why this information could not have been provided to Mrs Day right from the outset.

213. There was then a further letter of 25 October 2001, which confirmed that the East Kent Health Authority was to take the lead role in establishing the Inquiry.

214. Again, a contrast can be drawn between this position adopted by the statutory authorities and the response of the NSF/Rethink. On 9 October 2001, Edward Greenwood wrote to Mrs Day as a follow up to a meeting with her; it is clear that he had been able to provide her with some information as to how investigations were to be conducted by the statutory authorities and also how he would proceed with his own internal inquiry. We are not in any sense suggesting that the NSF/Rethink inquiry was better than that carried out by the joint Trust/County Council scoping report team, and we note that Rethink's contacts involved some unfortunate careless mistakes, but there was the valuable additional element of a relatively speedy meeting between Mrs Day and the NSF/Rethink official who was in charge of taking their inquiry further: Trusts, Health Authorities and Councils should seek to adopt this approach wherever possible.

The Setting Up of the Inquiry

215. On 7 November 2001, the Inquiry Manager was appointed to manage the inquiry and find a panel.

216. On 26 November 2001, Mrs Day was prompted to write to the East Kent Community NHS Trust to point out that she had had no contact since the letter of 25 October 2001, and so was simply unaware as to whether there had been any progress, leaving her with the impression that she was being excluded from the Inquiry process and forcing her to question the ability of the Trust to communicate with her. On 28 November 2001, the South East Kent Community Health Council reinforced in a letter to the Trust the need for better communication. On 29 November 2001, the Trust set out further details about the progress on the setting up of the Inquiry: we feel that had this level of explanation been offered at a much earlier stage, Mrs Day's frustrations at the process would have been lessened.

217. On 5 December 2001, a Panel of three was proposed (lawyer, psychiatrist, social worker) by the Inquiry Manager.

218. The Trust were in a position to explain to Mrs Day by a letter of 31 January 2002 that an Inquiry Panel had been established. This, however, was a false start. On 6 February 2002, following (i) a request that the panel include a nurse manager and (ii) the withdrawal of the social work member of the proposed panel, a revised Panel of four was proposed. But there was then a process of having the Panel approved.

219. On 8 March 2002, the criminal proceedings were completed. By late March 2002, Mrs Day was again in a position where she felt compelled to write about the delays and the lack of communication (letter of 24 March 2002). On 26 March 2002, Mrs Day was informed that the panel membership had not been approved by the Regional Office of the NHS. It

has to be said that the clear impression that a lot of the significant communications with Mrs Day were in response to her requests for information in situations where the Trust management should have ensured that the relevant material was passed on to her.

220. This frustration felt by Mrs Day was compounded by the fact that she received information that the Trust and County Council had objected to her seeing the draft of the report prepared by the NSF/Rethink. In fact, there was what might be called a healthy discussion between the NSF/Rethink on the one hand and the Trust and County Council on the other as to whether the NSF/Rethink report should be released at all, given objections which the latter two organisations had about the report. We see no reason why this could not have been explained to Mrs Day in broad terms, so that at least she could have an understanding of what was occurring, which would have prevented her concluding (as she expressed in her letter of 24 March 2002) that she was being viewed as not a suitable person to read the NSF/Rethink report.

221. On 28 March 2002, the NSF/Rethink wrote to Mrs Day to say that the internal report was being provided on a confidential basis; she was also asked to bear in mind that the report was based on the limited information available and was not an independent review. This was later supplied and Mrs Day was able to pass on her comments as to its conclusions (which she did in a letter of 9 May 2002, which allowed the NSF/Rethink to reply with further comments on the points she raised in a detailed letter of 25 May 2002).

222. On 30 April 2002, the Kent and Medway Health Authority (into which the East Kent Health Authority was merged) issued a press statement about the delays in setting up the Inquiry. (We have seen some correspondence suggesting that there was a telephone conversation with a local newspaper rather than a press statement: however, we have seen a written document which appears to be a press statement and has a fax header dated 30 April.) It explained that the two main reasons were the need to find a replacement panel member for one who had to stand down and the need to extend the terms of reference of the panel.

223. Of these two features, the former did not in our view have any impact on the delay in our setting to work (because the Panel would not have been able to commence any substantive work until after the criminal proceedings had finished, which had not occurred when one of the originally-proposed panel members decided that he could not sit); neither did the latter feature, because it is possible to establish an Inquiry and amend its terms of reference. In fact, the revised panel was identified before the criminal proceedings had been completed.

224. On 3 May 2002: the revised Panel of four was appointed.

The Work of the Inquiry

225. To complete the Chronology, we should set out the time-table of the Inquiry. The first meeting was on 27 May 2002, at which we discussed procedures in outline. On 12 June 2002, the Inquiry Manager met separately with Mrs Day and Mrs Doyle to discuss the inquiry process.

226. Thereafter, the Inquiry Manager set about compiling the initial written materials for the Panel. On 22 July 2002, we met, after the initial compilation of written materials, to discuss the need to follow procedures to involve the family of Mr Day and the family of Mrs Janes as far as possible[19]; and to identify likely witnesses.

227. Thereafter, on the basis of the written materials supplied, initial chronologies of relevant events were prepared. On 17 and 18 September 2002, we visited Willow Lodge, held meetings with Mrs Day and Mrs Doyle in Canterbury, had presentations from health and social services and Rethink as to the structure of services in the area. We also had informal meetings with staff members likely to be called as witnesses to explain the inquiry process and the procedures we would adopt. We made further decisions as to witnesses to be called: by this time, the Panel had been supplied with several lever arch files of documents from the Trust, social services, the police/CPS and various other sources (and many additional documents were produced during the inquiry process.)

228. Witnesses were sent written material as to the Inquiry's terms of reference and procedures, and given the chance to provide a written statement. Several dates were set aside for witnesses: we heard evidence in Canterbury on 29 and 30 October 2002, 4 and 5 November 2002, and 12 and 13 November 2002. We decided at the end of this process that it would be necessary to ask some witnesses further questions, and there were still some witnesses from whom we had not heard. So, on 7 January 2003, in London, we heard evidence from further witnesses; and on 10 January 2003 we returned to Canterbury to hear from witnesses called back to give further evidence. Some others were asked additional questions in writing.

229. On 12 February 2003, the Panel met to discuss tentative conclusions on the basis of evidence to date. On 25 February 2003, we met with Joe Janes (though he felt able to speak to us only briefly) and his current care staff. At the end of this evidential process, there was one witness who had not been able to attend any hearings (being on sick leave during the relevant period): we decided to ask a series of written questions of that witness, though we did not receive a reply. We also sought permission to release the evidence of one witness to the families of Mr Day and Mr Janes for their comments, but we did not receive permission for this.

[19] See Appendix 3.

230. A preliminary draft of the report was then prepared by the Panel Chair on the basis of the discussions to date, which was submitted for comment by the other Panel members at the end of April. On the basis of the written comments of the Panel members, and following a detailed review of the written materials supplied and the transcripts of the evidential hearings, the second draft of the report was completed over the summer of 2003 (and at the same time, the separate report into the care and treatment of Mr Day was written). Care was taken because of the number of comments we had which were critical or could be construed as being critical of individuals or organisations.

231. Time was given for the other Panel members to comment on these drafts. Then, in October 2003, detailed letters were sent to several individuals and organisations setting out (with detailed reasons given) criticisms which were open to the Panel. This was in accordance with the procedural rule that "any points of potential criticism" be put to witnesses, who have to be given "a full opportunity to respond". Those involved were given a chance to respond in writing (by 1 December 2003) and also given the opportunity to seek to meet the Panel to offer further oral evidence. The Panel convened on 20 November 2003 to discuss responses by then received to the letters with potential criticism and to discuss further the draft report collectively rather than by the circulation of written comments.

232. On 1 December 2003, two members of the Panel met with two officers of Rethink to discuss further their comments on the parts of the draft report they had seen. Most people to whom letters had been sent were able to respond by the deadline of 1 December.

233. A further draft report was then completed and sent to Panel members at the end of December, which took into account all the relevant new material, including the replies to the letters of potential criticism. We had in the run-up to the end of 2003 been discussing how to ensure that the procedure of drafting the final report was as fair as possible to all concerned. Our view was that (i) the detailed letters of potential criticism, with a chance to reply and the chance to have an oral hearing with members of the Panel, meant that there was fairness towards those individuals and organisations who were at risk of being criticised by the Panel; but (ii) it would not be fair to Mrs Day or to Mrs Doyle not to invite them to see our supposedly final draft and comment upon it before it was actually completed. (We understood that it had not been unusual for the families of those involved in similar inquiries in the past to be given the report only shortly before its publication, thereby limiting or excluding their ability to comment on the conclusions before they were completed.)

234. In light of this latter conclusion, a flexible interpretation was followed of our rules of procedure. These allow, at the discretion of the Inquiry Chair, oral evidence to be given by "anyone else who feels they

may have something useful to contribute to the inquiry". This was felt to be wide enough to allow this additional step, namely that supposedly final draft was released to Mrs Day and Mrs Doyle for comments. However, in order to preserve the confidentiality of the reports, we invited Mrs Day and Mrs Doyle to give undertakings that the content of the reports would not be revealed by them.

235. This had been due to occur in January 2004. However, at the request of the Health Authority, we were asked to discuss the then-available draft of the report with them before we met Mrs Day and Mrs Doyle. We agreed to this: the report is one which is commissioned by the Health Authority and is provided to them, and they have the final decision as to matters such as publication; in terms of our procedural rules, there is a provision that the draft report may be made available to the Health Authority (and social services and the relevant NHS Trust) to allow them to make comments on points of fact.

236. This discussion in fact involved a large number of representatives of health and social services and it was not possible for them to meet until 12 February 2004. This was attended by the Panel Chair and the Inquiry Manager. There was an oral discussion relating to the structure of the reports and, in relation to criticisms of Kent County Council social services, of the substance of these criticisms. It was agreed that these various matters would be put in writing.

237. This meeting was in fact very helpful. Although the Panel were already alert to the fact that the style of the report would have to be amended to ensure its clarity, the comments passed at the meeting of 12 February and the subsequent correspondence assisted in this; further, the substantive comments of the County Council in particular (in relation to criticisms made of social services) made plain that it was necessary to ensure that the basis of our complaints was explained with greater clarity.

238. Following this, a further revision of the report was completed by 8 March 2004 and shared with the Panel. This was then supplied to Mrs Day and Mrs Doyle (on a confidential basis) for their comments at meetings held on 15 March 2004. Mrs Doyle indicated that she might wish to make some additional comments in writing. Mrs Day also supplied some written comments, mainly about the inquiry process.

239. The final version of the report was then drafted and provided to the Health Authority on 22 April 2004.

3. Analysis of the Main Areas of Concern

1. In the preceding section, we have made plain that the chronology reveals a significant number of areas of concern as to the care and treatment of Mr Janes. There are a number of themes which we will try to draw together in this section.

2. The context of our comments on the issues which arise is that a homicide occurred in which one vulnerable man was killed by another whose actions were at least partly caused by a mental illness which was not adequately controlled: that is the corollary of the findings within the criminal process whereby the prosecution and defence expert evidence was agreed that Mr Janes was not guilty of murder but was instead guilty of manslaughter on the grounds of diminished responsibility and was then detained under the Mental Health Act 1983 on account of his mental illness.

3. The second element of the context is the difficulty of predicting dangerous behaviour (as we have set out in summary above[20]). It is both an inexact science, and it also involves trying to identify that someone belongs to a statistically small group.

4. A third, and obvious, element of the context is that we are looking at events with the benefit of hindsight, which allows anyone to say that Mr Janes should not have been placed at Willow Lodge at the time. However, we are conscious that we have to assess what happened on the basis of what was known at the time. We are also conscious that the making of a professional judgement is rarely a precise matter: there will often be room for a difference of view, and it is always possible that events will not turn out as predicted. We have taken this into account in the views we have reached, particularly where we have formed a view which is critical of either an individual or an organisation.

5. We should add that, in her initial representations to us, Mrs Day raised as particular concerns the decision-making in relation to the discharge of Mr Janes from the Arundel Unit in May 2001 with a view to his move into the environment of Willow Lodge and the recording of information relevant to the decision-making and the risk assessments involved in the process. She also noted her concerns as to whether resource constraints resulted in Mr Janes being placed in an environment which was unsuitable for him. For reasons which have been trailed in our assessment of the important facts in the chronology, and which we now set out in more detail, we feel that Mrs Day's concerns are well-founded.

[20] See in more detail Appendix 4

1. Obtaining and Recording Adequate Information

6. A central concern of professionals involved in the mental health system must be to obtain sufficient information about a patient and to assess its reliability, and carry out further assessments, so that properly informed judgments can be made. This is particularly so where the individual concerned poses a risk to his or her own safety or the safety of others. We have reached the clear conclusion that there were several obvious failures to make fully-informed judgments on the risk posed by Mr Janes.

7. It does not follow from this that we believe that the homicide would not have happened if all relevant information had been obtained: it may be that fully-informed decisions would have reached the same conclusions as the less fully-informed decisions which were in fact made, and that Mr Janes would still have been placed at Willow Lodge in the same circumstances. The most we can say is that there is a realistic possibility that different steps would have been taken if the information which was available or easily obtainable had been acted upon appropriately.

8. This area of concern can be broken down into various sub-headings:

(i) The Importance of Information from Mrs Doyle

9. The forensic report from Dr Dunkley is one which makes it plain that a psychiatrist has sat down and explored with Mrs Doyle in a systematic fashion the behavioural problems that were indicative of the potential risk posed by Mr Janes. However, it cannot be said that she discovered new information: Dr Byrne made plain to us that he was aware of the extent and quality of the behaviour by Mr Janes at home, and he was able to gain significant knowledge when he interviewed Mrs Doyle. Whilst Dr Byrne's knowledge is apparent in various locations in the papers we have seen (including in letters written to other people), and summaries of the risks posed by Mr Janes point to violence at home, there was nothing recorded which makes it plain that this feature had to be central to the assessment of Mr Janes and the management plan for him.

10. The importance of this is that it appears that Mr Janes was invariably apparently compliant in his dealings with professionals: consequently, they could form an impression of him which was inconsistent with how he could be in other settings. In other words, based on his presentation when dealing with professionals, he was not seen as someone who could be very aroused and confrontational because this was not how he appeared to them except on a few occasions. In general, he appeared to be a "quiet, pleasant young man", to use a description given of him to us by Sue Guy.

11. We were told by some witnesses that the statutory agencies gave the impression that they viewed Mrs Doyle as more a cause of problems than

a source of relevant information. No-one within the statutory agencies agreed that this was their view, and we were not in a position to make any findings in that regard. However, it is apparent that there was no concerted effort to obtain a full picture from her and to ensure that the up-to-date analysis of Mr Janes' condition was informed by input from her. Had it been emphasised that Mrs Doyle had important information to convey which affected the true assessment of Mr Janes' illness and the risks he posed, it may be that steps would have been taken to ensure that relevant information was obtained from her on a regular and systematic basis. It is true that there are a number of occasions when files record that information has been provided from Mrs Doyle and shared amongst the professionals: but this appears to have been a result of haphazard contacts rather than a concerted effort to obtain a full picture.

12. This was a failing which was continued by Rethink: there is no indication that they took the opportunity to obtain full information from Mrs Doyle; and there was the specific instance after Mr Janes had been accepted when Mrs Doyle made comments which were not investigated further[21].

> We recommend that the Trust and Social Services, and also Rethink, review their arrangements and protocols to ensure that when they are compiling risk assessments, they have arrangements in place to ensure that information is obtained from those with whom clients reside.

<u>(ii) The Trust – Need to Have a Recorded Management Plan Which Could be Shared</u>

13. What is perhaps the most important failing within the Trust was the failure to have an easily accessible and sufficiently comprehensive account of information which pointed to the potential for dangerous behaviour. Such material is necessary so as to properly inform decisions. This applies not only to reliable information from family members but also other information judged to be important.

14. It must be remembered that the treatment programme for Mr Janes involved different sites and different people, and consequently different sets of notes: this creates difficulties in ensuring that relevant information is passed between the different teams to inform their decisions. Particularly when there is such a fragmented arrangement, it is important that there is a system to ensure that there is a sufficiently robust method by which all significant information is collated and shared.

15. An obvious way to do this is to have a comprehensive risk assessment and treatment plan which is prepared by or under the direction of the RMO, reviewed and revised when necessary, and shared amongst all relevant staff involved in the treatment programme for a patient. Given that there

[21] See part 19 of the Chronology and further below.

are already programmes in place for planning and reviewing patients – the CPA process, ward rounds – this is not a burdensome requirement. We would not envisage that this be a particularly detailed document, but something on which can be recorded events and features of a patient's presentation which are felt to be particularly significant and should always be borne in mind in decision-making and which sets out the current treatment plans and significant issues such as when a patient should be considered for admission to hospital under compulsion. Such a document, if properly revised, would provide a suitable safeguard. It is normal practice when a patient moves from one hospital to another, or when he is discharged from in-patient facilities to an out-patient team, to have a discharge summary: our suggestion is little more than having a similar document in the course of treatment.

16. The benefit is that it would help to avoid the situation which occurred here. As was noted in the course of the chronology, Dr Byrne indicated to us that he accepted the forensic report of Dr Dunkley as to the basis for the treatment plan. But this was not recorded adequately: so the view which Dr Byrne endorsed that it was necessary to maintain Mr Janes in hospital following his admission in April 2001 until a proper package of care was put in place – which was reflected in, for example, the indication in the case notes that the use of s5(2) Mental Health Act 1983 should be considered if Mr Janes sought to leave[22] – was not clearly understood by others. Hence, within a week or so of this indication that compulsory powers should be contemplated if necessary, others were suggesting that Mr Janes be required to leave the hospital because of his ongoing use of drugs[23], which could only be suggested by a responsible professional if they did not understand that the reason why Mr Janes was in hospital was because he posed a risk to others and had to be stabilised and a suitable aftercare package had to be put in place before he could be released.

17. Another example of the benefit of a proper management plan would be that it would focus minds on important issues such as whether a patient should be placed under section. Dr Byrne explained to us why it was his judgment that informal admission was proper[24]: he also noted that the failure of Mr Janes to abide by ward policies on drink and drugs would have supported compulsion. Consequently, the ongoing failure of Mr Janes to abide by ward rules was a factor in favour of compulsion (so that his leave could be placed under control) rather than a factor in favour of his discharge.

18. Equally, the existence of a summary risk assessment and management plan would have ensured that the hand-over from Dr Byrne to Dr Kooij

[22] See part 15 of the Chronology, and the reference to the multidisciplinary meeting at the end of April 2001.
[23] See part 15 of the Chronology, and the reference to the next multidisciplinary meeting on 8 May 2001.
[24] See part 14 of the Chronology, and further discussion in this Part.

was more satisfactory. As we have noted, there was an informal meeting[25] with a hand-written list of patients and a recollection by Dr Byrne that he pointed out that Mr Janes was a patient who required special care. The basis of any such view would have been easily communicated if there had been a such a document.

19. The informal nature of the handover was a particular problem because Dr Byrne had placed into the medical notes on 8 May 2001 an indication that Mr Janes was to be discharged if he breached his contract as to abiding by the rules about drugs and alcohol; there was no record that we have seen that indicated to anyone picking up the case that this in fact was not intended, and that it was designed to in effect frighten Mr Janes into participating with the part of his treatment package which involved abstinence from alcohol and illicit drugs[26]. Of course, we accept that on 30 April 2001, Dr Byrne had indicated that any effort by Mr Janes to end his informal admission should lead to the use of s5 of the 1983 Act: but the contract of 8 May 2001 indicating that he should be discharged if he abused drugs or alcohol is subsequent to this and, in the absence of an indication that this contract did not mean what is said, a natural meaning of the file would be that the consultant in charge had changed his view as to the steps to be taken.

20. This does not mean that a new consultant should not review all the papers – including the forensic assessment and the full notes of the admission – before reaching a decision as to the appropriate way to deal with a patient. However, the circumstances of the hand-over compounded the lack of a clear written treatment plan for Mr Janes (or even a clear written endorsement that the suggestions of Dr Dunkley were being adopted).

21. As a final example, the CPA meeting of 29 May 2001, which we have expressed various concerns about[27], could well have been more appropriate. We have noted that Dr Kooij, the new RMO, had available only the outpatient notes: if these had included a copy of the risk assessment/management plan, then the decision-making process at this meeting would have been more suitable. It may be that the same decision would have been taken at the end of the process, but there is the possibility that it would have been realised that the release of Mr Janes at that time was not appropriate as the necessary elements of a treatment plan had not yet been put into place.

[25] See part 15 of the Chronology, and the reference to the hand-over to Dr Kooij.
[26] See our comments below in relation to the management of the case.
[27] See part 17 of the Chronology; see also below in this section.

We recommend that the Trust review its processes and ensure that there is a suitable method available of recording an adequate risk assessment and management plan for patients, particularly those who are identified as posing a risk of self-harm to themselves or to others, which can be placed on the various different records kept by the different elements of the care team.

We also recommend that the Trust ensure that there is a formalised hand-over procedure at which the out-going consultant can alert the incoming consultant to the major factors in a particular patient's case. It is simply not good enough to have an informal meeting with a hand-written list of patients and a few words of warning in the case of a patient such as Mr Janes.

(iii) Dr Byrne

22. Having made the point that there was a defect in the system in place, we have to make the point that this does not wholly excuse the professionals involved. Although there were different teams in the day-hospital and the in-patient facility, the lead psychiatrist was involved at both hospital locations. Dr Byrne was the Responsible Medical Officer during most of the relevant time and had all the relevant information available. We feel that he could have provided his own analysis of the risks posed by Mr Janes (including the importance of obtaining information from Mrs Doyle to provide factual material on which to base the assessment of risk, which he told us he felt was important) and the management strategy to be employed.

23. Even though the Trust did not have a set form for this (and the short-form risk assessment we have seen is no substitute for what is required), and he had not had any specific training in matters of risk assessment, we feel that a consultant psychiatrist should have a system for ensuring that those involved in the care of a particular patient (and, where the patient is one who presents risks to others, safeguarding those to whom the risk is directed) are aware of the essential elements of what is required in a particular case. Even if this is only done in those cases which are out of the ordinary, it should have been done in Mr Janes' case because there were features which marked him out from an early stage as being an unusual case, including the axe attack on his friend in November 2000 and the fact that he had been sent for a forensic assessment.

24. This would not have required anything involving any great detail. Dr Byrne gave evidence that he recognised that Mr Janes was a risky individual: he endorsed the views of Dr Dunkley. Indeed, he had taken steps such as interviewing Mrs Doyle which allowed him to reach similar conclusions. He took the sensible step of having Mr Janes admitted to hospital in April 2001 as soon as he came back from leave and had read the forensic

report. A clear, written endorsement that the plan outlined in the forensic report was to be the basis of the admission would have helped to ensure that all staff viewed and managed Mr Janes as one of the small minority of those suffering from schizophrenia who pose a risk to others. The absence of such a document created the risk that the forensic report was undermined in the sense that it became a report in the file rather than something which was central to what was needed as a plan of management for Mr Janes.

(iv) Social Services

25. There was also a clear failing to obtain information and investigate further on the part of social services. The fact that Mr Janes was known to be volatile at home, where his mother lives with his younger sisters, made it plain that there were child protection issues. However, no formal family assessment was undertaken; nor was there any apparent exploration of the risks posed to the children. All that seems to have been offered was some form of family therapy, which Mrs Doyle understandably rejected as not something which could help with the problems she faced: this in any event seems to have come via health as a method of dealing with Mr Janes' unresolved grief relating to the comparatively recent death of his father[28].

26. This represents a failure by social services to carry out their responsibilities under the Children Act 1989. There is guidance on the need to undertake a comprehensive assessment, which is now contained in the Framework for the Assessment of Children in Need and their Families[29], implemented from 1 April 2001. This takes into account the duty of Social Services (together with other local authority departments and health authorities) to both safeguard and promote the welfare of vulnerable children.

27. At the time of our first real concern about the absence of child protection issues (in February/March 2001 – at around the time of the first admission to hospital, which was prompted by the need to offer some protection to Mr Janes' family), this framework was not implemented: but social services would have been aware of it and should have been making plans to implement it at the time. At the very least, this new guidance should have acted as an alert to trigger the identification of Mr Janes' sisters as potential children in need, such that there was a need for liaision with the Children and Families Team.

28. It is our impression that Social Service continued to see their involvement as solely to find alternative accommodation for Mr Janes (which was their

[28] This may have been one of the features in the development of Mr Janes' mental health problems: we have not commented on this because it is not our function to deal with an analysis of the cause of these problems.

[29] Issued jointly by the Department of Health, Department of Education and Employment and the Home Office 2000, and known as the Assessment Framework

task because services such as Carr Gomm or at Willow Lodge are usually accessed via social services). This limitation meant that they failed to full fill their responsibilities to carry out a full assessment in relation to child protection matters.

29. This comment applies equally to the lack of such an assessment when there were further developments in the chronology which pointed to the need for action in part because of concerns about the effect of Mr Janes' behaviour on others.

See also below in relation to the role of Social Services in relation to mental health matters.

(v) Willow Lodge

30. This failure to obtain information continued within Willow Lodge. Although there was information available that there had been problematic behaviour at home, there is nothing which demonstrates that the staff at Willow Lodge made efforts to obtain a first-hand account of the problems. Instead, there was reliance on views from professionals within the health and social services, which views were inadequately informed. We accept that it is appropriate for an organisation like Rethink to place reliance on other agencies to provide assessments: but it cannot delegate its decision-making because it has the responsibility to the other residents at places like Willow Lodge, and so this permissible reliance must be nothing more than an element in the decision-making process.

31. There were clearly opportunities for the staff at Willow Lodge to sit down with Mrs Doyle and seek information from her which could then have informed their decision-making process (or triggered them to ask additional questions of the health and social services professionals). This was, we feel, a failure by the organisation as a whole to ensure that there were proper protocols in place and by the managerial staff to ensure that adequate information was sought in relation to the application by Mr Janes.

32. We are aware that Rethink have changed their policies as a result of their internal review following this tragic homicide: we understand that there is now in place a much more robust method of ensuring that relevant sources of information are interviewed, including family members with whom a client interacts.

(vi) Information About the Axe Incident

33. This merits specific comment. It does not require hindsight to be clear that the incident in which Mr Janes attacked a friend with an axe reveals his potential risk: it could have been fatal in its own right. Even without the

benefit of the accounts of the victim and other witnesses, or a criminal prosecution, enough was known about the incident to make it plain that it was serious.

34. Even so, the importance of an incident in terms of the role it plays in the development of a management plan depends on a full understanding of the circumstances. For example, a wholly unprovoked attack by an individual without any signs of mental illness might cause more concern than an attack by an individual who was at the time suffering from what was a then-untreated mental illness but who had now been stabilised on a medication regime with which he was compliant. Equally, an attack carried out in an unusual set of circumstances, such as a lengthy binge of drinking and taking drugs, might cause less concern if an individual moves into an environment where that set of circumstances can be prevented.

35. However, to make the assessment of the importance of a particular serious incident in relation to a particular individual, there has to be a proper investigation of the circumstances of the event, and a proportionate response to it. That is what is missing here. We feel that there was a low-key approach to something which had to be viewed with the utmost seriousness. An account was obtained of what had happened, but nothing which was comprehensive or which involved seeking accounts from third-parties. We accept that psychiatrists are not detectives: but an attack with an axe is an unusual event which requires a thorough investigation. This is not satisfied by making a referral, some time after the event, to a forensic psychiatrist for an assessment.

36. The result of the failure to provide a sufficiently comprehensive assessment of the axe incident was that there were apparently different views about it, including an impression that it was prompted by an unusual session of binge drinking and combinations of drugs – and so an incident which caused less concern so long as Mr Janes was in a supervised setting and reduced his drug use.

37. The effect of this failure to respond appropriately, and to ensure that the seriousness of this incident as an indicator of risk was borne in mind, was that the assessment by Dr Dunkley, which pointed to the importance of this incident in assessing the risk potentially posed by Mr Janes (which it is important to note was done before the homicide and so cannot be said to have been coloured by hindsight) may well have been downplayed.

We recommend that the Trust and Social Services ensure that they have arrangements in place so that in the small number of instances where a client is involved in a serious forensic incident which does not lead to the police becoming involved, they are able to investigate that incident properly to ensure that their management plans are fully informed.

(vii) Information About Behaviour During the April/May 2001 Hospital Admission

38. The particular concern here is that there was no proper analysis carried out as to the impact of Mr Janes' behaviour during the admission to hospital in April and May 2001: he was admitted pursuant to an unusual set of circumstances, namely the compilation of a forensic report which pointed to risks posed; whilst the risk was not dependent on drug and alcohol abuse, these were felt to raise the risk posed. It was clear that the behaviour of Mr Janes in the course of this admission to hospital indicated that, despite clearly-phrased advice to him, he continued to abuse drugs and use alcohol.

39. We do not see that this continuation of his behaviour was analysed and taken into account in any comprehensive fashion. It is true that there were steps taken in response to specific incidents (eg suspending visits to the day hospital because of alcohol and drug use): but there was no documented effort to analyse how this sort of behaviour affected the approach which had to be adopted to deal with Mr Janes. This is not to say that it was missed by the treating team: for example, Dr Byrne told us, when discussion whether this admission to hospital should have been under compulsion or as an informal patient, that a failure by Mr Janes to abide by the ward's requirements as to the use of drugs and alcohol was a feature in support of the use of compulsory powers. But this does not appear to have been revisited: there is no recorded assessment of whether, in light of Mr Janes' behaviour, he should be placed under section as a method of seeking to compel compliance with this aspect of the treatment plan.

40. This is perhaps a reflection of our main concern as to this period, namely the management of the case, which is developed in the next section.

(viii) Dr Kooij

41. We do also have a comment about Dr Kooij. The CPA meeting of 29 May 2001 was, in effect, his first time to consider the case of a patient who had recently been admitted to hospital in response to a forensic report and who had been allowed to leave hospital in circumstances when he was abusing alcohol and had failed drugs screens, which were thought to increase the risk he posed. We were reminded by Dr Kooij that he did not have access to all the case notes at the time, and had only the out-patient notes from Radnor Park. The concern we have is that he was involved in decision-making without having all the relevant information. The lack of access to all the notes was a result of the fragmented arrangements in the area: although this emphasises the need to have a proper system whereby a concise management plan, with information on risks, can be placed on all relevant files, we do make the point that a consultant coming fresh into post should also make sure that he or she has available and has consulted

all the relevant records before reaching any conclusions on a particular case. In short, as far as is reasonably practicable, he or she should have and review all relevant records before making any substantive decision in the course of the management of a case. We do accept on the facts that, as Mr Janes had been an informal patient and had been allowed to leave hospital, this would undermine any sense that it was urgent to review whether he needed to be returned to hospital.

(ix) Passing-on Information

42. One final matter of comment in relation to the recording of relevant information is the fact that it has to be shared appropriately as well. In addition to the point discussed above about having a comprehensive risk assessment and management plan which can be shared within the care team, we noted in the chronology that there were concerns as to the information supplied to Carr Gomm and Willow Lodge at the outset: although any gaps in information were remedied in the course of the process, there is a basic concern that there was not full disclosure at the outset.

2. The Management of the Case

This also involves concerns relating to various different issues, some of which are interrelated.

(i) Staff of the Appropriate Level

43. There can be little doubt that the case was not an easy one. The features which make this obvious include: the history of alcohol abuse and poly-drug use, enduring behavioural problems in the home environment, the actual use of unanticipated but extreme violence and the threats made to Mrs Doyle of extreme violence. In this context, the presentation of Mr Janes to professionals as apparently compliant whilst at the same time continuing to use drugs despite advice to the contrary meant that the management of the case was one which called for experience.

44. One of the functions of those in managerial positions must be to ensure that the cases are dealt with by staff of appropriate seniority. In a complex case, whilst delegation of specific tasks may be possible and junior staff may be involved as a learning experience, decision-making should be carried out by appropriately senior staff in order to ensure that appropriate experience is brought to bear, but also so that the message is conveyed to others involved that the case is one which is complex.

45. However, particularly within social services, there was limited direct involvement from senior staff: this was caused, it seems, by a view that the CPA process ensured that the case was appropriately supervised (on which see below). There were also specific examples within psychiatric services of less experienced staff than we would have expected being involved in important instances: for example, the assessment of Mr Janes following receipt of the forensic assessment of Dr Dunkley left to a junior doctor rather than the consultant providing cover for the case; and when Mr Janes decided to leave hospital in mid-May 2001, he was reviewed only by a junior doctor (though we accept that this occurred during the few days between one consultant leaving and another coming into post).

46. We feel that the central roles played by junior and inexperienced staff was inconsistent with the complexity of the case, which was apparent at an early stage. Again, without denying the importance of junior members of staff being involved in difficult cases, there are instances where a case is such that more senior professionals need to be involved to a greater extent in a primary assessing role (rather than a reviewing role) to ensure that (i) the difficulty of the case is marked out and (ii) decisions are made which have the benefit of their experience.

We recommend that the Trust and Social Services review their procedures to ensure that the small number of cases which involve complexities such as Mr Janes involve adequate primary rather than reviewing input by more senior personnel.

(ii) Responsibilities Outside the CPA Process; Failings of the CPA Process

47. An issue which was raised by senior social workers (particularly Ms Guy) and social work management who saw the outline of our comments, was that our criticisms of social work decision-making and the approach adopted (namely of limiting their role in essence to the securing of supported accommodation because that was the task assigned under the CPA process) was misplaced precisely because the CPA process was in place and any failures were of the operation of the CPA process rather than of social services.

48. We do not agree that this is the correct approach: our view is that it remains the obligation of the relevant social worker (or supervisor if a student is involved) to ensure that there is a sufficiently robust and comprehensive process of ensuring that social service obligations are met. This may be something that can be discussed and formulated within the CPA process, and it may be that the CPA process could ensure that the assessed needs were met: but that will not necessarily be the case and so it cannot be assumed that the application of the CPA process to a client means that social service obligations are merely those given to social services in the course of that process. Even if on the particular facts of the case all assessed needs can be met under the CPA process, there is a duty to ensure that the CPA process is properly used. So, if events occur which should change the decisions which are currently delineated by the CPA process, and the CPA coordinator does not call forward the next CPA review to assess this, then the various professionals involved in the CPA process should accept their responsibility to ensure that there is a further CPA meeting.

49. Social services have a distinct statutory duty under community care legislation to assess needs for community care services: this duty is wider than that applicable under the CPA process (even though the latter has been widened in scope recently). The CPA process is designed to ensure that people with mental illness do not lose contact with services and to provide a systematically assessed and coordinated package of care for their mental disorder (with regular reviews). But community care obligations may cover, for example, difficulties other than those relating to a mental disorder for which treatment is being given, and there may be other duties to those affected by the particular individual, such as duties to children living in the same household in relation to whom there are child protection issues. Whilst the CPA process may allow consideration of

some of these issues, including risk to others, its focus is on the provision of services to the individual with mental health difficulties.

50. We accept that recent Department of Health guidance[30] emphasises the importance of having a single care planning process involving health and social services, and has also made it plain that the CPA process should apply not just to in-patients about to be discharged from hospital (its original coverage) but also all those with mental health problems whatever their setting. However, this sensible policy approach cannot avoid duties imposed by community care legislation on social services. The legislation remains in existence.

51. If the view was formed by those working within social services that when a CPA process was in place, the limit of their duties was to do what was assigned to them as actions required under the CPA, there was a risk that action appropriate to the case would not be planned and taken. However, we do not wish to overstate this point of law because in practice the precise legal analysis should not matter. This is because, as noted above, the limit of the obligation of social services within the CPA process is not just to implement what has been assigned to them: they have obligations to ensure that the CPA process is fully informed and takes into account developments (as part of the review process which is part of the CPA approach).

52. So, plans formulated and actions taken by social services under their wider community care responsibilities would have to be fed into the CPA process (and there might be situations where the results of following the requirements of the CPA process also met any obligations which might arise under community care legislation).

53. The care and treatment of those who are mentally unwell is a multi-disciplinary process for good reason, as it allows the experience of various professionals to be involved in the process of determining what should be done, for the best interests of the patient and, in those rare cases where there is a risk to others, for the protection of the public. This is because different professionals will bring a different approach to a problem – on the basis of their own training and experience - which should ensure that the decision-making process is more fully informed. This requires that social service professionals do not restrict themselves to merely being a conduit to locating accommodation: it requires them to form a view of what is needed and to then ensure that the relevant agencies do what is required. Obviously, if all the other agencies are doing their own job responsibly, it is not difficult to ensure that all the relevant steps are taken: however, when this is not happening, professional responsibility requires that efforts be made to spur other agencies into action.

[30] See the November 1999 Department of Health publication "Effective Care Coordination in Mental Health Services"

54. We have commented within the Chronology that the action of the CPA process on the facts of this case was problematic: for example, the February 2001 meeting did not appear to have written into it the need for a review as and when the expected forensic report was available (which had been sought shortly before this meeting); and there was no CPA meeting called to discuss the action to be taken on receipt of the forensic report. This is clearly a cause for concern, and was not assisted by the lack of immediate action taken by the psychiatrists who headed the health part of the CPA team. The CPA process was not operated in the appropriate manner.

55. But that cannot be an adequate explanation or excuse for social services not taking action. We feel that the relevant practitioner, Sue Guy, in early April 2001, was faced with a situation which required proactive action in which she, as a senior social worker, should have taken a lead role in response to the information presented to her. Mr Janes clearly presented complex problems, and had been involved in serious violence in the recent past; there was the unusual situation of a forensic report having been obtained, which had clear recommendations for action to be taken on account of the risk posed, including hospitalisation. However, Mr Janes remained out of hospital in accommodation with his mother, where reports made to social services indicated that he was aggressive and binge-drinking; and the family situation was one which involved 2 other children and so raised family protection issues. In addition, as both s13 of the Mental Health Act 1983 and the Code of Practice issued under s118 of Act make plain, the Approved Social Worker (and Sue Guy had this qualification) is responsible for coordinating assessments as to whether a patient should be admitted to hospital, taking into account risks to the patient and risks to others: this cannot be avoided because there is a CPA process in place which has not produced an appropriate response when confronted with the same information.

56. So, in addition to ensuring that their own input to the CPA process was adequately informed, social services had to make their own decisions on such important matters as whether Mr Janes should be assessed for the use of compulsory powers under the Mental Health Act 1983 in light of the nature of his illness and the risks posed.

57. It is with this background and in this context that we are critical of the omissions of social services during Mr Janes' admission to hospital in April 2001. For example, the supervision session of 10 April 2001[31] seems to have dealt with issues of communication difficulties and confidentiality: important as this is, and accepting that notes of a supervision session might concentrate more on the element of teaching, our concern is that we cannot find elsewhere in social services files that the expected review

[31] See Chronology part 15.

of whether the current approach being taken towards Mr Janes was appropriate in light of the developments, including his admission to hospital in response to the forensic report. The rationale for his being admitted to hospital was (or should have been) known to the social work team to be the plan of action set out in Dr Dunkley's forensic report, which was copied to social services and available on their file. This set out a need to stabilise and offer treatment before Mr Janes could be found accommodation: equally, the reasoning behind this admission might require a careful choice as to the location and type of accommodation which was offered after the treatment package had been put in place.

58. We do not underestimate the difficulties of resources, which seems to have been acute in the Shepway area: but the principle must be that a patient's needs have to be assessed first, and then a decision taken as to the resources to be assigned. And the assessment of needs requires taking into account all relevant information, and modifying it over time as there are important developments. His case could not be approached on the basis that the CPA task they had been assigned was still the only action to take: even if all dealings with Mr Janes were to be within the CPA process, it would be important for the social work team to address their minds to whether they should raise at the next CPA meeting the suitability of what was at the time being proposed in light of developments such as an admission to hospital because of a forensic report which highlighted the potential risks of a particular individual.

> We recommend that the Trust and Social Services review their training and their operative procedures to ensure that the CPA process is viewed as a method of planning and delivering service provision, but does not absolve the various professionals involved from meeting responsibilities placed on them by other sources, including community care legislation and the Mental Health Act 1983, which set out statutory duties which cannot be set aside by policy guidance.

(iii) Clarity of Planning

59. One of the key requirements of the delivery of a decent service for vulnerable individuals such as Mr Janes is proper planning of what is required to meet his needs. The requirements of community care law and the CPA process are based upon this premise: there should be a systematic assessment of need and a plan then put into place as to how to meet the needs, with a review process to ensure that changes are made when necessary. This applies not just to the provision of after-care (to which the CPA process is particularly assigned), but also in the making of decisions as to whether or not a particular individual requires admission to hospital. There are limited beds available within psychiatric in-patient services, and it is easier to ensure admission when a patient's disorder is of a particular degree. But the Mental Health Act expressly refers to

admission on the basis of nature or degree: this disjunctive formulation conveys the fact that there are some patients who may require admission on the basis of features other than a particular crisis in their presentation.

60. Clarity of planning is particularly important in a complex case. Although Dr Byrne indicated in his evidence to us that he had recognised the complexity of Mr Janes' case from the outset of his involvement, and that the report and plan of action set out in the forensic assessment from Dr Dunkley provided a basis for the management of the case, we have concerns as to the clarity of the planning put in place – or, at the very least, the recording of the plans.

61. There are a number of instances of this. Although Mr Janes was assigned to the enhanced level of the CPA process at an early stage and was referred for a forensic assessment, there was no planning to ensure that the CPA process was informed by the receipt of the forensic report. Another example from around the same time is that the admission to hospital in February 2001, which arose out of a need to offer protection to Mr Janes' family, was also something which should have caused consideration of whether it was necessary to amend the management plan. The failure to do this, particularly when added to the fact that Mr Janes was allowed to leave hospital in early March although the forensic report remained outstanding, contributed to problems. As Dr White noted in her evidence to us, there was a difficulty in responding to the forensic report by immediately arranging for Mr Janes to be admitted to hospital: namely, this was a complete change of tack, given that he had recently – ie days earlier - been allowed to take his discharge[32].

62. The admission to hospital in April/May 2001 was the occasion when there was the most need for a proper written management plan because (i) it followed the receipt of the forensic assessment, which made plain the need for a strategy to be put into place, (ii) the living situation for Mr Janes was wholly unsatisfactory and the relationship with his mother had been put under repeated strain such that plans had to be made on the basis that she would not be able to offer accommodation for the future, and (iii) there was about to be a change of RMO due to the end of Dr Byrne's tenure (and other staff who had had significant contact with him had also moved on or were about to move on, namely his keyworker and social worker).

63. As we have noted above, it was for Dr Byrne to ensure that this management plan was put into place and recorded adequately so that others could follow it (though it is also a matter for the Trust to ensure that such management plans are part of the working process adopted within the Trust). Whilst we have no reason to doubt what Dr Byrne told

[32] In this context, as we have noted in the Chronology, Dr Byrne is to be applauded for changing tack when he returned from leave and read the forensic report: see further below in the analysis.

us, namely that he had a strategy in his mind, it is difficult to find a proper record of it which was made available to all those involved in the treatment of Mr Janes, who were on different sites. Particularly as Dr Byrne was about to leave, this recording and communication of the management strategy was crucial.

64. The confusion from the lack of a clear management plan was perhaps most apparent at the multidisciplinary meetings on the Arundel Unit at the end of April 2001 and early May 2001[33]. At the former, Dr Byrne had recorded that powers under s5(2) of the Mental Health Act 1983 should be used if Mr Janes sought to leave. However, by the next meeting, staff were calling for Mr Janes to be removed from the ward. The context is supposed to have been that Mr Janes was in hospital pursuant to the plan of assessment and management set out in Dr Dunkley's forensic report, as approved and implemented by Dr Byrne; whilst he had been admitted as a voluntary patient, this was because he was willing to agree to the treatment plan and, as Dr Byrne told us, failure to abide by ward rules in relation to drugs and alcohol was a basis for the use of compulsory powers, not for removing him from hospital. We have commented that the suggestion from nursing staff was a reflection of a lack of clear understanding of the treatment plan. Dr Byrne was able to counter this (as long as he was in post, which was only to continue for a few days after the meeting on May 2001). But we have concerns about the management plan used, namely the contract signed that Mr Janes would be removed from the ward (the context being that he had no supported accommodation yet arranged and there were doubts as to whether his mother was able to offer him a place).

65. We can, of course, understand that there are difficulties in a general psychiatric ward with drug abuse, and patients who appear to be the cause of problems are unlikely to be popular with the staff who have to deal with the day-to-day issues that arise. We fully accept that it is difficult on a general psychiatric ward to have a patient who is offering limited cooperation with his treatment plan, becomes angry when efforts are made to discuss his drug and alcohol use, and causes particular management problems on the ward by bringing drugs onto the ward. This understandable approach from the nursing staff towards Mr Janes may have been influenced by the fact that he was a voluntary patient who would be able to come and go as he pleased. One of the effects of being a voluntary patient is that he would not be regarded as someone for whom there was a priority that he remain on the ward. In the absence of him being placed on section, with his leave from the ward being regulated by s17 of the Act, the nursing staff have very limited powers.

[33] See Chronology part 15; see also the discussion above in relation to the lack of a management plan, which is equally applicable here.

66. We can accept that something such as the contract, with a threat of discharge for breach of its terms, was a way of trying to make the point to Mr Janes that it was particularly important for him to abide by the rules of the ward, as a method of trying to increase his motivation to abstain from drugs and alcohol. However, given the message conveyed by the terms of the contract, it was necessary to have properly recorded, so that all professional staff were aware, that the view of the consultant in charge was that breach of the contract was in fact not a basis for discharging Mr Janes from hospital but a basis for detaining him. At best, those present in the ward meeting on 8 May – nursing staff, Dr Byrne and his SHO – would be aware of this view: but anyone reading the notes would not.

67. We feel that these events suggest that, despite matters such as the short-form risk assessment of Mr Janes as a "high risk", the general view of him cannot have been that he was a significant forensic risk, despite the fact that the reason for his presence in hospital at that time was the forensic assessment of him by Dr Dunkley as a risky individual. The responsibility lay ultimately with the Responsible Medical Officer to ensure that the message was understood that Mr Janes was a patient whose presence in hospital was essential until the plan of action set for him in consultation with the forensic assessment had been put in place successfully. This is where matters such as a comprehensive assessment done by or under the direction of the lead psychiatrist, setting out a management plan from the outset of the admission, would have assisted.

68. Instead, in terms of material written into the medical notes, there was an apparent change from previous instructions that Mr Janes should be considered for compulsion if he sought to discharge himself to an indication that he should be required to leave the ward if he carried on with behaviour which, on any realistic assumption, was likely, given his long-standing history of drug abuse and alcohol misuse.

69. In his evidence to us, Dr Byrne explained that what was his last meeting with Mr Janes was not an easy one. He explained to us that it was still his view that Mr Janes should be placed under s5(2) if he sought to leave the ward. He told us that he had arranged to write out the contract on a fresh page of the medical notes so that Mr Janes would not be aware of the instructions as to s5 being used: in his statement to us, he indicated that Mr Janes did not know about this. However, it is apparent from other sources that Mr Janes was aware of this: on 3 May 2001, Mrs Doyle telephoned Caroline Gale and expressed her anger that Dr Byrne had told Mr Janes that he would be placed on s5 if he sought to leave the ward.

70. Aside from this, there is a question about the propriety of keeping away from Mr Janes the fact that compulsion would be used. Dr Byrne explained to us that he felt that Mr Janes had an incentive to remain on the ward, as he would otherwise be homeless, which he believed was a matter which was important to Mr Janes; and an incentive to comply with the contract

as it was the way of ensuring that he was placed at Willow Lodge. However, he did not wish Mr Janes to be aware of the planned use of s5(2) because he wished to give Mr Janes as much incentive as possible to change his behaviour. There is nothing wrong with seeking to point out to a patient such as Mr Janes the potential adverse consequences of their failure to change their behaviour and to provide an incentive to change. But it seems to rely on an assumption that a young man with a long-standing problem of drug abuse and a diagnosis of schizophrenia would be able to make a rational choice in this regard. There is no suggestion that Mr Janes lacked capacity to make decisions: but capacity is not central to the use of detention.

71. We feel it would have been better to be up-front with Mr Janes as to the need for him to comply with all aspects of his treatment plan, not just the acceptance of medication, and to use the powers of compulsion under s3 of the Act in the absence of compliance: this would also have avoided the confusion left in the medical notes as to what was the actual plan. Dr Byrne emphasised to us that his plan was then set out at the end of April: but the contract in the notes in early May would be understood to modify this in the absence of a written indication to the contrary.

72. We note, in this context, that Mr Janes was discharged days after Dr Byrne left his post. This suggests that whatever view Dr Byrne had as to his plan for Mr Janes to be detained if he sought to leave, ward staff and junior members of the medical team were either not aware of it or disagreed with it. The former is perhaps more likely since it is unlikely that Mr Janes' discharge would have been allowed without a review from the replacement consultant. We note in this regard that Dr Kooij was due to start his post the next day after Mr Janes left, 15 May. In short, the continuing goals of the admission were not clear, which we feel must have contributed to the sequence of events leading to Mr Janes' discharge.

73. We should mention that the only witness we wished to see who we were not able to see was the Ward Manager at the hospital: he was not able to speak to us because he was on sick-leave, and a set of questions we asked for written answers to were not answered. However, we had access to the notes made and we assume that, as contemporaneous records, these are accurate. Nevertheless, it would have been useful to have an account given of the problems on the ward at the time and the impression the staff had as to what was the plan for Mr Janes.

(iv) Informal admission in April 2001

74. The fact that Mr Janes was not placed under compulsion in May 2001 when his misuse of drugs and alcohol continued raises also the issue of whether the admission in April 2001 should have been informal in the first place. As we have noted, admission was arranged by Dr Byrne immediately after he read the forensic report. Further, it is plain that there

is much to be said for the principle that engagement with psychiatric services should be voluntary; there is a stigma in relation to being "sectioned" (though, certainly in terms of family response, it is often possible to overcome much of the problem by a proper explanation). In addition, as Dr Byrne noted, Mr Janes agreed to admission and to the use of depot medication as part of that plan. His view was that this level of agreement meant that the criteria for detention were not met, though they would have been if he had indicated that he was not willing to stay or had refused to accept the depot medication; he also indicated that a refusal by Mr Janes to abide by the ward policy on drink and drugs would also have supported detention.

75. There are, however, factors which point the other way and support the use of compulsory powers. The concern felt as a result of Mr Janes' potential for violence had to be made plain. The impression we had is that Mr Janes was not a particularly aggressive or angry patient (though he had a different reaction to his family), and this might lead staff dealing with him to form the impression that the forensic report was either wrong or that the incidents of violence linked with Mr Janes were the result of an unusual set of circumstances and so out of character. In short, placing Mr Janes' under section would have prevented the danger of professionals dealing with him being lulled into downplaying his potential. Of course, it may be that an approved social worker would not at that time have agreed to apply to place Mr Janes under compulsory powers for either assessment or treatment: that is speculation, though the view of Dr Byrne was that he would not have been able to persuade either a second doctor to complete a medical recommendation or a social worker to make an application.

76. In the context of the fact that Dr Byrne was about to leave the service, the use of compulsory powers by the psychiatrist in charge of the case, who had been involved with Mr Janes since he first came to the attention of the psychiatric services, would have carried an important message to those taking over the care of Mr Janes. Anyone conducting a psychiatric assessment of Mr Janes knowing that he had been placed under compulsory powers would have had their attention drawn to the question of what had changed since he had been placed under section in response to the forensic assessment which highlighted the risks posed by Mr Janes. This by itself gives a good indication as to the view formed by the psychiatrist who knew him well of the nature of his illness, namely that it was one which involved risks to others.

77. This is something which might well have altered the approach taken to the management regime applied to him. For example, whilst it might not have prevented his abuse of illegal drugs whilst in hospital – which we are aware is often a significant problem – it would have ensured that different factors were weighed in the balance when decisions were being taken about how to deal with this. In the case of a voluntary patient, the fact

that he is causing management problems by abusing drugs makes it more tempting to seek to have him removed from the ward: if he is a compulsory patient, this is not an option and other management techniques have to be used.

78. The Code of Practice issued under s118 of the Mental Health Act 1983 provides guidance that a patient who is willing to be admitted informally should be placed under compulsion as a matter of last resort. But the Code of Practice goes on to state that informal admission is not appropriate "if detention is necessary because of the danger the patient presents to himself and others". The situation relating to Mr Janes was that he was admitted to hospital on the strength of the forensic assessment precisely because it was felt that detention was necessary because of the risk he posed to others. At the very least, this had to be assessed further and a treatment plan put in place to deal with it.

79. Having said all this in support of the use of a compulsory admission in April 2001, we do note that at the time when Mr Janes came into hospital, he was willing to stay voluntarily and to accept depot medication, which are powerful features against the use of compulsory powers. As long as the message was made clear to all those involved that Mr Janes needed to be in hospital, with compulsory powers used if he was not willing to remain and participate fully in his treatment plan, we cannot say that it was wrong not to use compulsory powers at the outset of the admission in April 2001. As we have made plain in the previous section, it is the lack of clarity in this message which is the main concern.

(v) The involvement of the drugs and alcohol team

80. What is more of a concern is the treatment plan provided for Mr Janes when he was admitted. He was a man with a history of poly-drug abuse on the top of an unpredictable capacity for violence, which could be extreme. There was a clear need for intervention by the drugs and alcohol team, but there is no indication that they were involved. Indeed, although we have no definitive evidence on this (and so our comments are necessarily tentative), we are concerned as to whether there was a proper working relationship between the drugs and alcohol service and the general psychiatric services. Dr Byrne has indicated to us that in his 17 months in East Kent, he never met a member of the drugs and alcohol service or had any communication from them, and had any attempts at referral by him refused on the basis that the clients were "psychiatric".

81. It is noticeable that, whilst on various occasions in the chronology there are references to Mr Janes needing assistance from the drugs and alcohol team, nothing was done to put this into practice. This points to a lack of integration in that the staff who recognised that there was an issue which needed input were unable to call on that input. The Department of Health have recently produced a Mental Health Policy Implementation Guide –

Dual Diagnosis Good Practice Guide: this notes that "Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. *This should be delivered within mental health services.* This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively." (The emphasis is in the original.) The guide then explains what is required in order to ensure that mainstreaming works in practice.

82. Whilst it was clearly accepted and recognised that drug and alcohol abuse were part of the problem (and made Mr Janes' potential for unpredictable violence worse), we are very concerned that there was no formal assessment of the level of the drug and alcohol problems and no clear approach to alcohol and drug problems as part of the overall management plan. Put shortly, there was encouragement given to Mr Janes to give up on his use of drugs and to be moderate in his use of alcohol. But he was a young man with a history of poly-drug abuse, and it may have been that it was drug abuse that somehow triggered his illness: this is the sort of situation which called for input from a specialist drugs and alcohol team as part of the management strategy for him. All we find is that there are various suggestions that Mr Janes accept input from the drug and alcohol team, which he declined.

83. When this is added to the pressure from ward staff to remove Mr Janes from the ward because his use of drugs and alcohol posed a management problem, the impression given is two-fold. First, that ward staff did not have training on or access to sufficient specialist staff for dealing with dual-diagnosis patients, ie those with substance misuse problems as well as mental health problems. Secondly, that the risk posed by Mr Janes was underestimated. This supports a view that the forensic assessment was side-lined and the axe incident was either largely forgotten or an assessment was made that it was caused by an unusually extreme binge session of drugs and alcohol which was not going to be repeated and so no much of a reason for concern.

84. What should have been apparent from the history of Mr Janes as it was known at the time of his admission to hospital in April/May 2001 is that the primary goals should have been to stabilise him on medication and secure his abstinence from drug and alcohol abuse. The failure to involve the drugs and alcohol team, or to put in place any strategy other than threatening him with removal from the hospital if he did not comply with

the advice given that he abstain, suggests either that securing this abstinence was not recognised as a primary goal or that no adequate strategy was formulated (or a combination of both).

85. Furthermore, when Mr Janes was allowed to leave hospital, there is no indication that there was any plan in place to ensure that substance misuse did not become a problem. This is a clear misjudgment. The axe incident was an indicator of Mr Janes' potential for harm to others, and the witnesses we heard seem to have had two views of that: one view – as expressed particularly by Dr Dunkley – was that it was an instance which demonstrated the potential for violence by Mr Janes and should not be seen as being caused by a drug/alcohol binge; but that drug/alcohol misuse increased (though did not cause) the risk posed by Mr Janes. The other view was that the axe incident was caused by an unusual drug/alcohol binge and so was a risk if there was a further such unusual combination.

86. The first view appears to have been correct when viewed with the benefit of hindsight: as such, it required a strategy to deal with drugs and alcohol. However, even if the second view was correct, a strategy to deal with drugs and alcohol was essential because it would be necessary to avoid a recurrence of that situation. Given that, during this admission to hospital, Mr Janes was clearly involved with drugs and alcohol, the absence of a strategy to deal with that issue after his discharge was a serious failure on the part of the care team. Given that a fresh consultant had taken over, the other members of the care team – and in particular the coordinator of community provision, Marilyn Brennan – had a responsibility to ensure that this issue was addressed.

87. We accept, however, that making this provision was not as easy as it should have been in the East Kent area because of the apparent lack of integration of the Drugs and Alcohol Team within mainstream mental health services. We did not hear evidence on this specific issue: however, we understand that at the relevant time, the drug service was run independently of the Trust structure by the Kent Council on Addiction, with a separate alcohol service run by the Trust – with both services working in isolation.

88. We accept that it is often difficult to get individuals to engage with separate teams. This emphasises the need to have service provision integrated, and the need to have treatment for drug/alcohol matters included as part of the care plan applicable to the client.

89. We understand that there has been a recognition of the need for partnership working in this regard, and that there is now an Alcohol Consultant who is working with the Drug Service to bring the teams together. We simply state a reminder of the Department of Health guidance on the importance of ensuring that drug and alcohol services are

within the mainstream of mental health provision.

> We recommend that, if it has not already happened, there be a review of cases where mental health problems are compounded by drug and alcohol misuse to ensure that properly integrated service provision is offered to clients who present with a dual diagnosis, and that this is properly reflected in the core care plan applicable.

(vi) Ensuring that medication was working

90. Returning to the facts of Mr Janes' treatment plan in April 2001, one element which was put into effect was the introduction of depot medication, and it is apparent that Mr Janes was cooperating with this. But the question has to be asked as to whether it was working in the sense that it was dealing with his underlying psychosis. There is an issue here of what management plan was in place to discover reliable information as to whether or not Mr Janes was still suffering with psychotic symptoms: this is something which might have been difficult because of concerns about the reliability of Mr Janes' self-report. This concern makes the point that it was necessary to have a source of reliable information in this regard.

91. Two obvious points can be made with the benefit of hindsight: (i) the course of treatment in Trevor Gibbons Unit (the medium secure unit where Mr Janes has been treated since August 2001) involved an incident when, after taking illicitly obtained amphetamine, he was clearly unwell and reported psychotic symptoms; and there has been a long-term continuation of the negative symptoms of schizophrenia, suggesting that the illness is acute.

92. (ii) The account of the index offence makes it plain that Mr Janes was responding to psychotic symptoms. We have to accept this as accurate: it was raised by the defence expert at the trial and supported by the prosecution expert who formed an opinion as part of the trial process. From this account, it was clear that the depot medication was not dealing with the underlying illness.

93. Although these comments have the benefit of hindsight, the context is that Mr Janes presented as an unusual case who had demonstrated the potential for significant violence. Consequently, particularly in light of the concern as to the reliability of Mr Janes' self-report, we would have expected an approach being put in place which involved a careful analysis of the effectiveness of the medication being used. It is clear that Dr Byrne had been monitoring the medication he prescribed – this is made plain by the fact that the anti-psychotic medication had been changed. However, more was needed. It must be remembered that although only a very small number of those suffering from an illness such as schizophrenia pose a significant risk to other members of society, by the time of this admission

to hospital, Mr Janes had marked himself out as someone who might well be a member of this group by virtue of the axe incident and his aggressive behaviour at home. As such, there was a greater need for care to be exercised in relation to the important question of whether there was not only full cooperation by him in relation to the treatment plan put in place (in the sense that he accepted medication) but also whether the treatment plan was successfully dealing with the underlying illness.

(vii) The absence of a comprehensive risk assessment

94. An issue linked to the above is the documentation relating to risk assessments, and the failure of the lead professionals to formulate a comprehensive risk assessment so as to provide a management plan for Mr Janes. The purpose of the admission on 10 April 2001 was, in response to the forensic assessment and Dr Dunkley's suggested course of action, to provide a full assessment of Mr Janes and work on making him suitable for release by virtue of a range of treatment options. The starting point of this must be a comprehensive risk assessment and risk management plan.

95. Mr Janes ought to have been seen as a special case in light of the unusual factors relevant to him, in particular the serious example of violence in the axe incident and the aggression towards his mother, the unsuitability of his home as a place for him to live, his drug and alcohol history, and the concern expressed in the forensic assessment. In those circumstances, we would have expected a detailed risk assessment leading on to a management plan. This should have been coordinated by the lead psychiatrist, failing which the other professionals involved, particularly those at a senior level, should have ensured that this was done. Of course, we acknowledge that the CPA process was in place: but this is aimed at ensuring after-care, whereas what was needed for Mr Janes was a proper analysis and management plan which ensured that appropriate steps were taken before issues of release and the community-based management plan were put into action.

96. Instead, there are a number of short-form risk assessments in the files, which set out very brief summaries of the information and the risks posed. These are no substitute for what was required. We note that these short-form assessments include one done on his admission, which noted that there was a risk of harm to others, and set out the incidents of concern; this was accompanied by a preliminary care plan suggesting that his illness was a drug-induced psychosis, or possibly paranoid schizophrenia.

97. Dr Byrne has noted in the material he supplied to us that he was not given any training by the Trust on risk assessment. Although we would expect there to be proper training offered on risk assessment techniques, we also feel that it is perhaps a self-evident aspect of dealing with a general adult psychiatric population, most of whom will pose a risk to their own health or welfare, a small number of whom will pose a risk to others: in the

absence of these features, they would probably not come to the attention of psychiatric services. It should be at the forefront of good practice to ensure that there is a risk assessment completed as part of the management plan. This may be easier in some cases, depending on the nature of the illness and the characteristics of the patient: indeed, in some cases, the risk assessment may be almost obvious.

98. We are not suggesting that Dr Byrne had not turned his mind to risk assessment and Mr Janes: that is far from the truth, because he was clearly alert to the issues (and that was the real reason why Mr Janes had been persuaded to come into hospital, because of the forensic risk assessment carried out by Dr Dunkley). We also have no reason to disbelieve Dr Byrne's account that he had in mind a management plan to deal with Mr Janes.

99. The problem is the written recording of this management plan. The treatment plan for Mr Janes involved a somewhat fractured provision of services on different sites and by different services, each of whom would have separate files which would not duplicate important information. This made it more important that there be a document available in which the consultant at the apex of the treatment team set out the essential aim for the admission to hospital and the steps which needed to be taken before the admission could be said to have achieved its aim. This need not have been anything detailed, and could have been in the form of a short memorandum which referred back to Dr Dunkley's forensic assessment and summarised the important parts of the care plan suggested there. Anything less than having such a document available leaves a substantial risk that the proper management plan will not be put into effect, which might well breach the duty of care to the patient.

(viii) Resources

100. We should also make some brief comments on the impact of the lack of resources. We were informed that the social work team was often stretched. It is probably a truism that if there had been a greater flexibility available from having more social workers, then a more experienced social worker would have been making (rather than reviewing) decisions.

101. Another example is CPN cover. We record in the chronology that Mr Janes appears to have been left without a CPN when Jon Thomas moved on. We should add that Dr Byrne indicated in his evidence to us that he had concerns about the levels of CPN cover. We also had evidence given to us that there were reports of bullying and poor staff morale within the CPN service: this is not something on which we had comprehensive evidence, and so we mention it in passing only, with the obvious comment that an effective CPN service is often a key feature of a multidisciplinary team and that, whilst it will be seen that there were other people involved in the ongoing dealings with Mr Janes, there was no-one providing the

input to be expected from a CPN: in particular, the involvement between Mr Janes and the relevant services seems to have been from him attending the services rather than the services going out to reach him. In the case of young man whose compliance with the treatment programme was variable, outreach was an important element and a CPN would be a key part of this.

102. The final point about resources is the use of Willow Lodge. Following the refusal of Carr Gomm to offer accommodation, the application to the NSF/RETHINK's Willow Lodge facility was pressed forward. The sequence of events seems to be that on 18 April 2001, there was a ward round. By that time, Mr Janes had been transferred to depot medication and the team was informed that Carr Gomm had refused him. Caroline Gale records in the social work notes that Dr Byrne had suggested that Willow Lodge might be appropriate.

103. At that stage, it is recorded that it was expected that Mr Janes was to be on the ward for up to 6 weeks; this period of time could well have allowed a proper assessment of how he was responding to medication and how the other necessary elements of his treatment plan were being put into practice. Although that is not what happened, nevertheless, it is apparent that there was in place at that time a realistic time-scale for necessary steps to be taken.

104. However, Dr Byrne was clear in his evidence to us that it was not a matter of choice in the sense that Willow Lodge was the place where he felt that Mr Janes' needs would be met, but rather that this was the only available placement for someone in his position. This, of course, is far from ideal. Dr Byrne explained to us that spaces within hospital-based rehabilitation services were very limited (he had only had one patient admitted to such services during his 18 months in post in East Kent). It is clearly a matter of concern if an entire area is without an adequate number of beds for those who have complex mental health needs and potentially pose a risk to others, which leaves a consultant psychiatrist and the other members of the multi-disciplinary team are left with little option but to attempt to put a patient into a resource with may not be suitable for his or her needs.

105. We accept that pressure on beds in a general psychiatric ward may mean that retaining a patient there for a longer-term treatment plan may not be feasible – and such a ward may not be suitable from the point of view of the patient in any event.

3. Risk Assessments: Compilation and Use

(i) The Statutory Authorities

106. We have made various comments about management plans which have to be based on proper risk assessments being compiled first. This is particularly important, and so merits separate comment.

107. A patient who has demonstrated an ability to use significant violence, such as Mr Janes had used in the axe incident, must be the subject of a proper risk assessment, to be compiled and then used as part of the management plan. This involves proper recording of information in a format which is available to all relevant staff. This is developed above.

108. What we find on a review of the material in this case is the use of various short-form risk assessments, which may have a use but cannot be a substitute for the thorough assessment which was required. As an example of the limited value of these short-form assessments, we should note the assessment compiled by Marilyn Brennan shortly after Mr Janes had been accepted by the panel at Willow Lodge, which put him as a low risk: at first sight, this assessment is out of kilter with other assessments, and is not credible in light of the recent behaviour of Mr Janes and lack of clarity that his condition was stable.

109. Ms Brennan, however, was able to explain how she reached the conclusion: in short, on the day she completed that assessment, there were no real concerns about Mr Janes and so his risk was assessed as low; she also points out that she had spoken to Mrs Doyle and had not been alerted to any problems in Mr Janes' behaviour at home (though this may well reflect the part that no relationship had built up between Ms Brennan and Mrs Doyle such that the latter would confide in the former, as there was material from other sources which made it plain that there were problems). However, this method of compilation almost makes the point itself: a risk assessment which is based on a snap-shot view of a patient is of no value, but has the danger of providing a reassurance which is ill-founded. If this remains the approach adopted in East Kent as to the short-form risk assessments, it should be modified.

110. We feel that it is highly likely that the absence of a detailed risk assessment played a part in the approach adopted by the ward staff during the admission in April/May 2001 that Mr Janes be asked to leave because he was presenting a management problem. The limited value of the short-form risk assessments in made plain in this regard: at the time that pressure was being applied to have Mr Janes removed from the ward, a short-form assessment was compiled that he was high risk – the two do not fit together.

111. If there was a risk assessment document which drew on available information (much of which had been collated in the forensic assessment) and updated that information according to behaviour during the admission, it is possible that a different view would have been taken as to whether Mr Janes was detainable at the time he wished to leave hospital in mid-May 2001. Dr Byrne told us that he wished Mr Janes to remain in hospital, hence his instruction that s5 should be used if he left: but he had recently left the service, and the absence of a comprehensive risk assessment failed to provide the necessary counter in the decision-making process to the management problems posed by Mr Janes and the apparent lack of psychotic symptoms.

112. A properly structured risk assessment might well have provided a basis for the conclusion that the nature of Mr Janes' illness (as opposed to its degree) was such that he met the criteria for detention at least until there was a proper package of after-care in place and a proper assurance had been provided that the newly-established medication regime was working.

> We recommend that the Trust and Social Services ensure that the procedures they have in place in relation to the compilation of risk assessments for patients who pose a risk to themselves or others and the training of staff in risk assessments are sufficiently robust.

(ii) Willow Lodge

113. This failure of the multidisciplinary team to provide a proper risk assessment was reflected in the failure of the Willow Lodge management to ensure that their decision-making process was adequately informed by a risk assessment document. Although we accept that a voluntary sector body has to rely on assessments from other sources in its decision-making process, it does not delegate its decision-making: rather it uses the information from other sources as part of its process, but must ensure that it has adequate information and that its process is sufficiently robust.

114. What is clear is that the Panel were informed that there had been a serious incident involving an axe and that there had been problems with abuse of illicit drugs. Whilst it is understandable that there should be weight given to the views of those who appeared to know Mr Janes better, the members of the Panel had to reach their own conclusions and, in order to do that, had to ensure that they had available the relevant material. To give an obvious example: Raph Fox told us that whilst he was aware that there had been an incident with an axe in which a friend had been attacked, he was not aware that this was something which occurred in a group setting when Mr Janes had apparently reacted to things being said about him. This suggests that the Panel did not ask all the right questions.

115. We accept that there is pressure on panels to make decisions on the basis of information which is available. But it must always be borne in mind that responsible decision-making involves having all relevant information. We should make it plain that it does not follow from this comment that we feel that Mr Janes would not have been offered a place at Willow Lodge had further steps been taken to investigate the information provided and obtain further relevant material: but a reliable process should ask for relevant information to ensure that a fully informed decision can be made. This is not only an obligation to be placed on a receiving facility such as Willow Lodge: it is equally true that the statutory agencies have an obligation to ensure that all relevant information is made available. It may also be the case that the statutory agencies, as the ones with the information, have a particular obligation to make voluntary disclosure of relevant information: it may be difficult for an organisation such as Rethink to ask for appropriate material in the absence of knowledge of what material there is. The latter difficulty makes it important for a voluntary sector provider to develop a procedure of asking for information and then analysing what is provided and asking for additional material.

116. One thing which is worth noting is that the decision-making Panel included representatives from social services and health who were not independent in the sense that they had an incentive to place Mr Janes as a way of meeting needs he had been assessed as having and which it was their role to meet – which might undermine, even if only indirectly and almost sub-consciously, the other element of the equation in the decision to be made by the panel, namely the interests of the other residents and whether Mr Janes was a good fit for the group home. The members of the Panel clearly had obligations to all the residents to the home. We should make it plain that we are not suggesting that Ms Brennan or Ms Guy pressed for Mr Janes to be admitted to Willow Lodge even though they felt that it was an unsuitable placement (and one which would allow them to record as part of the CPA process that assessed needs had been met). We are simply making the point that from a structural point of view it is wrong to have a decision-making body which involves people who may have sub-conscious incentives in favour of a particular decision: their input should be in providing information and making representations to the decision-making panel rather than in reaching a decision.

117. We understand that the make-up of the Panel was in fact a requirement imposed by the commissioning authorities. We also note that this is a matter which has now been dealt with in discussions between Rethink and the local commissioning authorities so that the make-up of the Panel determining whether to accept applications for places at Willow Lodge is now one which ensures that it is independent of the placing authorities. This is proper, given the responsibility of the panel.

(iii) Contingency Planning – Willow Lodge

118. Another part of the failure at Willow Lodge is that there does not appear to have been any proper discussion or planning in relation to contingency planning for the management of Mr Janes if he returned to drinking to excess or abuse of drugs. He was a young man with a significant history of drug use: even if Willow Lodge was given an account that there was no current problem with drug abuse (on which, as we have noted, there is a dispute) common sense would indicate that it was a problem which might recur and for which there was a need for a contingency plan as part of a risk assessment applicable to Mr Janes.

119. We note in this regard that there is a factual dispute as to what the admission panel at Willow Lodge was told about Mr Janes' then-current drug use. Marilyn Brennan believed that the Panel knew that there was a problem, albeit that it was at a reduced level, whereas some other witnesses feel that there was a reassurance that there was no current problem. As we have explained, we are not equipped to resolve this dispute.

120. However, irrespective of what is the truth here, we should note that Ms Brennan was at the relevant time responsible for coordinating the care package to be offered to Mr Janes: she was a CPN (and no CPN had been specifically assigned) and had supervised Mr Janes' previous keyworker (who had not been replaced when he left the employment of the service). She was also a member of the admissions panel at Willow Lodge and so had a responsibility towards the other residents there to ensure that Mr Janes was appropriately placed in their midst. In light of her role, we feel she was the professional who was most clearly charged with the responsibility of ensuring that a proper regime was in place to monitor Mr Janes' use of drugs and alcohol and to prepare a strategy to deal with that: it was not exclusively a matter for her, but she was the person who had to ensure that it was in place as part of her role as the key worker and care coordinator for Mr Janes.

4. Conclusions and Recommendations

1. Our Terms of Reference are set out in an Appendix. We were asked that we examine whether the treatment, care and supervision of Joe Janes was appropriate in light of various factors:
   (i) his actual and assessed health and social and support needs;
   (ii) his actual and assessed risk of potential harm to himself and others;
   (iii) his previous psychiatric history and treatment including drug and alcohol misuse;
   (iv) the effect that substance misuse had on his mental state;
   (v) the documentation recorded relating to the above features.

2. Our conclusions, which are set out more fully in our chronology and our analysis, must first be put in the context set by the evidence we had on risk and mental illness, particularly schizophrenia: namely, only a small proportion of those with schizophrenia pose any risk to others, and the successful identification of those who pose that risk is a difficult task because of the small number involved. At the same time, and before the homicide, Mr Janes had been identified as someone who might well have been in this group by virtue of a serious assault (that with the axe), the severity of his threats to his mother and the instances of aggression towards her, and his abuse of drugs and alcohol. The forensic assessment which had been obtained, and the steps taken by the forensic psychiatrist to make sure that her report was understood, made all this plain in advance of the homicide.

3. The consultant psychiatrist in charge of Mr Janes' treatment until mid-May 2001 gave evidence that he accepted that Mr Janes was a risky individual and he made plans accordingly; a full CPA planning programme was put into effect and elements of the multi-disciplinary team were put in place. The concerns we have are, in essence, three-fold. First, that not all relevant elements of a multi-disciplinary team were engaged – most notably drugs and alcohol services; the main reason for this seems to have systemic, namely the lack of adequate integration between drugs and alcohol services and adult mental health services.

4. Secondly, there was an inadequate analysis of the risks posed by Mr Janes and an inadequately clear management plan put in place – or at the very least there was a lack of a clear record of this, such that information on risks and what the management plan was to deal with them were not sufficiently well-known to all staff dealing with Mr Janes (who were on different sites) and not sufficiently communicated to new staff becoming involved in his case (and it is to be noted that this was a case where there was, unfortunately, a significant turn-over of important personnel). Making sure that there is an adequate risk analysis and sufficiently robust management plan was the responsibility of the organisations involved in

the multi-disciplinary team (ie the Trust and the Council's social services department): in light of the need to make use of resources which were on different sites and in the absence of any single set of notes relevant to the case of Mr Janes, the organisations must make sure that there are protocols in place and documentation which ensures that there is a sufficiently clear risk assessment and management plan prepared in relation to patients and updated regularly so that there is no room for confusion as to what should be happening. In addition to this corporate responsibility, we feel that there were failings by individuals at senior and supervisory levels: these are set out in detail in the chronology and include failings to make plans sufficiently clear and failings to revise plans in response to important developments.

5. Thirdly, in relation to the placement at Willow Lodge, there was an inadequate investigation of relevant information at the time that Mr Janes was accepted and there was a failure to respond to new information.

6. As a result of these matters, there was an inadequate analysis of what Mr Janes' illness required in relation to care and treatment: as a result, there was a significant risk that the assessment of him as a potentially dangerous individual, as made plain by the forensic risk assessment, was underplayed in the treatment he was offered. It may be that, had there been a proper approach, little different would have been done and he would have been placed at Willow Lodge in the same circumstances, but we feel it likely that different steps would have been taken.

7. The other elements of our Terms of Reference included a request to comment on the extent to which there was compliance with the statutory obligations, particularly the Mental Health Act 1983 and relevant guidance (particularly the CPA and Supervision Registers). The CPA process was put into operation and Mr Janes was allocated to the Enhanced Level, which his needs clearly required. (The Supervision Register guidance does not appear to have been used in the region: but the revised CPA guidance stood in place of this.) However, our concern is that the CPA process was not used properly because it was seen as a replacement for all other responsibilities, particularly by social services; further, it was not operated with the necessary flexibility in that significant events did not lead to a review of whether the care plan in place was appropriate.

8. We were also asked to comment on
   - The drafting and delivery of care plans: there was a CPA care plan, which was delivered. However, as set out above, our concerns are whether there should have been a different care and management plan; and we have concerns about the lack of steps taken to update the CPA care plan in response to important developments.
   - Joint working: there was a flow of information between health and social services, and specific tasks were allocated to different agencies under the CPA process. However, there was a failure to involve

specialist drugs and alcohol services; there appears to have been limited CPN involvement; and there was inadequate clarity in the management plan which, because of the involvement of services on different sites, was particularly important.

- Risk management: the short-form risk assessment forms used within the services are inadequate as the only risk assessment forms; further, there was some indication that some staff were of the view that the form should reflect the position as it appeared on the day the short-form risk assessment was carried out – this is wholly unreliable because there are longer-term features which have to be reflected.

Recommendations

9. We have set out various recommendations in our analysis above. These are:
   - The Trust and Social Services ensure that the procedures they have in place in relation to the compilation of risk assessments for patients who pose a risk to themselves or others and the training of staff in risk assessments are sufficiently robust.

   - The Trust and Social Services, and also Rethink, should review their arrangements and protocols to ensure that when they are compiling risk assessments, they have arrangements in place to ensure that information is obtained from those with whom clients reside.

   - The Trust should review its processes and ensure that there is a suitable method available of recording an adequate risk assessment and management plan for patients, particularly those who are identified as posing a risk of self-harm to themselves or to others, which can be placed on the various different records kept by the different elements of the care team.

   - The Trust and Social Services should ensure that they have arrangements in place so that in the small number of instances where a client is involved in a serious forensic incident which does not lead to the police becoming involved, they are able to investigate that incident properly to ensure that their management plans are fully informed.

   - The Trust and Social Services should review their procedures to ensure that the small number of cases which involve complexities such as Mr Janes involve adequate primary rather than reviewing input by more senior personnel.

   - We also recommend that the Trust ensure that there is a formalised hand-over procedure at which the out-going consultant can alert the incoming consultant to the major factors in a particular patient's case. It is simply not good enough to have an informal meeting with a hand-

written list of patients and a few words of warning in the case of a patient such as Mr Janes.

- We recommend that, if it has not already happened, there be a review of cases where mental health problems are compounded by drug and alcohol misuse to ensure that there is proper integration between mental health and drug and alcohol services to ensure proper service provision to clients who present with a dual diagnosis.

10. We note that the service structure in place at the time of the homicide has now changed completely, and so we have not considered issues relating to the structure of services. The East Kent Community NHS Trust was reconfigured between April and July 2002 and an integrated mental health and social care trust was put in place, with social services staff seconded from Kent County Council: the Commission for Health Improvement provided a moderately encouraging report in January 2003. We have also been told that there have been steps taken to ensure that drug and alcohol services are integrated within mental health services, as the Department of Health recommends, and as the facts of this case demonstrate is sensible.

11. We also note that there were concerns as to the level of staffing within social services, and with the availability of suitable facilities for patients such as Mr Janes, who had not suitable accommodation to meet their needs within the family setting: as such, locations such as Willow Lodge were seen as all that was available. These are problems of resources: those in government responsible for resource allocation should take note that inadequate provision within mental health services may have significant effects because of the potential for the patient population to cause harm to themselves and, in a very small number of instances, to others. It is entirely possible that more resources allocated would have allowed the professionals involved to take additional time and create a better risk assessment and management plan in relation to Mr Janes.

12. It is this aspect of the case which requires particular attention. The formulation of a management plan for Mr Janes required a comprehensive risk assessment by his treating team which was robust and documented so that all those who had dealings with him were informed by it; and the management plan required proper documentation for similar reasons. The mental health trust should, if it has not already done so, implement a scheme whereby there is a properly documented risk assessment and management plan for all patients, together with protocols for review and updating. As we have made plain in our comments during the chronology, this should not need to be a particularly complex document, nor should it take much time to compile in the vast majority of cases. The risks and management plan for many patients will almost be self-evident (in which case brief documentation will suffice and reviews will be short): but the need to carry out the analysis of risks and form the management plan in

such a way as it can easily be communicated to all those involved in implementation will ensure that there is the necessary reflection in all cases, including responses to factual developments, and the necessary communication with sufficient clarity of the plan. This is nothing novel: it involves taking the approach of the CPA in relation to after-care and ensuring that similar good practice is applicable at all stages in dealing with a case. (Naturally, it should be linked in with the CPA process in relation to those to whom the CPA applies.)

13. There are two other recommendations we make in relation to social services. We have been concerned about the lack of child protection assessments done despite the information coming forward to the mental health team that there was a situation in which the protection of children was relevant. We recommend that there be an analysis of whether there is a need for a protocol to ensure close liaison between the children and families and the mental health teams when information comes to light which indicates that both elements of social services should be involved.

14. Further, we would invite social services to clarify the roles and responsibilities of mental health teams: we have been struck by views as to the CPA being a replacement for the often more general duties which arise under community care legislation and in relation to the duties of social workers to coordinate the assessment of whether in-patient mental health services are required – though we assume that the latter part of this will have been put into practice now that there is an integrated mental health and social care trust.

Recommendations as to Inquiries

15. We were asked specifically by Mrs Day to make some recommendations as to Inquiries. The first point we make is a practical one: we have found it very helpful to have had some correspondence from Mrs Day via her solicitor, who was able to assist her in providing statements to us and in making representations. The Health Authority acceded to our request that legal representation be allowed (and paid for as part of the Inquiry costs). A similar service was offered to and used at times by Mrs Doyle. We recommend that authorities which set up future Inquiries should consider offering to fund legal representation for at least the family of the victim to allow them (i) to make submissions at the outset as to the matters which are of concern to them and (ii) to participate in the ongoing inquiry process to the extent that it is appropriate on the facts of the particular case. These are matters in relation to which sensitive legal representative can provide considerable assistance.

16. The second point is also a practical one. We note above that there was a contrast between the response of the NSF/Rethink, which was quickly able

to give Mrs Day an idea of the structure of how they would investigate the matter, and the statutory authorities, who sent out holding letters which gave contact details of the coordinators of their complaints processes rather than of an individual charged with leading an investigation. We feel that part of the response to a homicide (or other Serious Untoward Incidents, to use current terminology) should be to provide family members with a contact name of a senior official who will be in charge of pressing forward any necessary investigation, and to give an idea of the time-scale set for any investigation being carried out.

17. The third point is also a practical one and is linked to the second point. The better level of communication from the NSF/Rethink to Mrs Day continued. We note that, as is apparent from the correspondence between Mrs Day and the NSF/Rethink about the contents of their internal review, this level of communication does not mean that a family will be more happy with the substantive outcome of the review, but it does mean that the family does not have the additional aggravation which Mrs Day clearly did have of feeling that communication with her was a problem for the authorities. Much of the communication from the Trust to Mrs Day was apparently in response to her requests for information, which left her with the reasonable view that low priority was given to communicating with her. In the context of having the personal tragedy of a death to cope with, it is intolerable that families then have to cope with the frustration of inadequate communication from the relevant authorities.

18. There is also the question of the time taken to appoint the Inquiry and for it to finish its work. We have made plain our concern as to the lack of speediness with which we were asked to commence our task. In the context of a process which will take some time to complete, we feel that steps should have been taken much more quickly. It was patent from the outset that this was a situation which was going to require an inquiry of some form. Our understanding is that there are a small number of organisations which manage Inquiries: if one had been called in right from the outset by the Trust and Council, it might have been possible for the whole process to have been commenced earlier. Whilst there is a legitimate concern that other legal proceedings have to be completed first – particularly criminal proceedings and any action taken by the coroner – the work of an Inquiry will invariably go wider. There is nothing to prevent the preliminary work of an inquiry being completed (at least the compilation of documents and the identifying of potential witnesses): it is only the taking of steps which might cause concern in the other legal proceedings (eg, interviewing witnesses) which in all probability have to await the completion of these proceedings.

19. In this regard, we note that it may not be necessary for the entire Inquiry Panel to be appointed for these initial steps to be commenced. A panel chair may well be able to do much of the preliminary work before other members, often appointed for the particular specialism, are in place. On

the facts here, an Inquiry Manager was appointed speedily in November 2001: but nothing substantive in terms of preparations for the actual Inquiry was able to happen for 6 months because of delays in appointing the Panel, which could not commence its work for some time until documents had been compiled and obtained. A more flexible approach which allowed initial steps to be taken in the immediate aftermath of the completion of the criminal proceedings would have been preferable. It would have allowed us to see people earlier: witness memories would have been fresher. Further, documents which had been filed away by the time we began our process in earnest would have been more readily available, and so on. The simple fact is that once a trail has gone cold, it becomes much more difficult and time-consuming to reconstruct it.

20. We have set out above the chronology involved in the setting up of our Inquiry. It is clear that there were a number of delays in the process, some of which may have been outside the control of the statutory authorities, but some of which must have involved a lack of decisiveness on their part. Of course, the NSF/Rethink's ability to conduct a purely internal inquiry and the fact that this was much more limited in its scope than that to be established by the Trust and Council allowed it to proceed more quickly[34].

21. The real delay caused by not allowing the Panel to commence work was that the necessary preparatory work could have been commenced at a much earlier stage – for example, the initial compilation of material to allow the drafting of detailed chronology on the basis of which a Tribunal can ask questions of witnesses, and make decisions as to witnesses to be called, and then be in a position to start the evidential hearings shortly after the criminal process had concluded rather than several months later. We are conscious that an Inquiry Panel, which involves members who have full-time posts elsewhere, will have time-tabling difficulties because diaries will have to be coordinated. In light of that, it is important that the process gets off to an expeditious start. As it happened, the impression was perhaps created that the Inquiry Panel would immediately commence work, whereas in fact it was necessary for the Panel Manager to set about getting material together before the Panel could do anything of a substantive nature.

22. It is right to record that Mrs Day has apparently found difficult the time it has taken for us to provide our reports. We have outlined the chronology of the Inquiry's hearings and the drafting of our reports, leading to this finished product. If it is the case that we could as a Panel have acted more quickly – perhaps by adopting stricter time-scales for material to be supplied to us by witnesses and by undertaking our individual responsibilities for drafting and commenting on the drafts of our report –

[34] Our main concern here is that there was a contrast between the level of communication, in relation to which the NSF/Rethink performed significantly better.

we are sorry that we have not done so and have added to Mrs Day's concerns as to the time taken. We can only ask her to accept that we have sought to be thorough and, given that we have made a number of criticisms of individuals and systems, that it was necessary for us to take time to make sure that our views were founded on a solid base and that those individuals and organisations criticised had the chance to respond to all potential criticisms. The Panel Chair wishes to accept, however, that he should have adopted a stricter timetable with an aim of producing the final report more speedily.

23. To assist this, we suggest that the lead agency which commissions an Inquiry sets out right from the outset a proposed time-table for completion of various stages of the work and for communicating with families directly involved, and then sticks to that time-table, assigning it proper priority.

24. As long as there is a role for having independent people to conduct an ad hoc review of the circumstances in which a homicide has occurred – which is something currently being debated - the context of this has to be appreciated. The independent people called in will inevitably be full-time professionals or managerial level staff in other organisations. Whilst some professionals – lawyers being the obvious example – may have the flexibility in arranging their diaries so as to be available, an inquiry panel will usually involve medical, social work and nursing professionals who may not have this flexibility because they will have full-time commitments. When one adds to that the need to take into account the need to obtain relevant documents, then to determine which witnesses to call and their availability, it is obvious that Inquiries will take some time to complete[35]. There is therefore lots of scope for time-tables to slip: this emphasises the need for these time-tables, so that the members of the panel can ensure that they have the appropriate time to complete their roles with expedition.

25. We will not involve ourselves in the question of whether there should be this independent review in the form of an Inquiry (the alternative being some form of governmental body charged with investigating incidents of this nature): as long as there are Inquiries, steps should be taken to do more than was done here to ensure that they commence quickly and that the families of victims are kept informed and involved from the outset.

[35] As we found, even without any suggestion that documents were being kept from us, it took a long time to have everything located and copied (and witness statements then prompted more documents being sought); the documents prompt the identification of further witnesses, and the process becomes one which almost lengthens itself.

Appendix 1 – Terms of Reference

General remit

- To examine the relevant circumstances surrounding the treatment and care of Mr Joe Janes by the mental health and social care services.
- To consider other matters as the public interest may require, which might arise during the course of the inquiry

Treatment and care

The appropriateness of his treatment, care and supervision in respect of:

- his actual and assessed health and social and support needs;
- his actual and assessed risk of potential harm to himself and others;
- his previous psychiatric history and treatment including drug and alcohol misuse.
- the effect that substance misuse had on his mental state
- the documentation recorded relating to the above.

Compliance

The extent to which Mr Janes' care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Home Office and Department of Health (Care Programme Approach (HC(90)23/LASSL(90)11) Supervision Registers (HSG (94)5); Discharge Guidance (HSG (94) 27; and local operational policies.

Care plans

The extent to which care plans were effectively drawn up with Mr Janes, and how these plans were delivered and complied with.

Joint working

To examine the process and style of the collaboration within and between all of the agencies, involved in the care of Mr Janes and the provision of services to him and his family.

Risk Management

To examine any issues of in-service training that arise in relation to those caring or providing services to Mr Janes and to consider the adequacy of the risk management and training of all staff involved in Mr Janes' care and supervision.

Report

To prepare a report and to make recommendations to the East Kent Health Authority and other relevant agencies.

Appendix 2 – Reasons for Recommendations as to Publication; Anonymity of Witnesses and Persons Involved in the Narrative.

As noted in our introduction, we were asked to conduct two inquiries, one relating to Joe Janes and one relating to Joseph Day. The two men are inextricably linked, the central question in our terms of reference relating to both inquiries was whether it was right that each man should have been at Willow Lodge on 15 July 2001, and there was a substantial overlap in witnesses. We therefore conducted our investigations into both terms of reference together.

However, we have produced two reports, and we recommend that there be a different approach to publication. Both inquiries focussed on the mental health of individuals: however, questions as to the mental health of Joseph Day attracted different considerations as to confidentiality. Our recommendations to the Authority are that the report relating to Joe Janes should be made public but the report relating to Joseph Day should remain private to the statutory authorities, Mr Day's family and Rethink. The reasons for suggesting the non-publication of the report dealing specifically with the propriety of the placement at Willow Lodge are:

(i) Joseph Day was the victim of a crime and did nothing to put his life into the public domain;

(ii) The report relating to whether he was appropriately placed at Willow Lodge necessarily deals with the essentially private details of Mr Day's psychiatric state at the time he was killed;

(iii) We can see no compelling reason to reveal these details.

In contrast, Mr Janes is in a very different position, it being a matter of public record that he committed an offence and that his mental illness was involved in this offending (as he pleaded guilty to manslaughter on the basis of diminished responsibility, which involves raising psychiatric evidence in the essentially open justice of the Crown Court). Further, there is a strong public interest in knowing if there were failings in the system which is designed both to offer support to those like Mr Janes who suffer from mental illness but also to offer protection to the public from that very small number of those who suffer from mental illness who pose a risk to the public.

We have also considered the issue of the naming of various professionals in the report relating to Mr Janes. This is, of course, a matter which has to be considered, particularly if there is criticism made. All those who appeared in front of us were made aware that the decision as to publication of the report would be a matter for the Health Authority, but we indicated that the tendency is towards publication unless there is a good reason not to publish. In this context, we only received one request from a professional witness for anonymity.

We note that it will probably be possible for anyone investigating the situation

to identify most of the professionals in any event, particularly those who play a prominent role in the narrative; certainly, the families of Mr Day and Mr Janes have been provided with a significant amount of material from other sources[36] from which they will be able to identify most of those involved (even if they do not immediately know them. So there are practical reasons which militate against anonymity. There is also a more important principled reason: professionals should be subject to scrutiny when it is necessary to investigate whether something has gone wrong which could have been avoided. This is not part of a "blame culture": it is part of an approach that professionals should be accountable and take responsibility if they have failed in the particular circumstances. We have endeavoured to be fair in the process we have followed: that is the main reasons our process has been elongated. Further, we have not purported to resolve factual differences which might have depended on issues of credibility and the like, and which we felt were more suitable for determination by a court-like process which we were unable to replicate. So for practical and principled reasons, we have not anonymised anyone in our report.

As to the one specific request from a professional witness to the Inquiry that they should be anonymised in the report, we have not acceded to this request for the reasons that support our general approach. In addition, on the particular facts, the matters which would have caused this particular witness, who was a junior part of the team involved, to seek anonymity are features we are aware of in making our assessment: in short, where the failures were of supervision/management, we have said so.

[36] For example, we are aware that Mrs Day was provided with a copy of the internal report from Rethink which was produced following the incident which identifies most of the main participants.

Appendix 3 : The Procedure We Adopted and the Reasons For It – Including a Discussion of Relevant Legal Principles

We are including this Appendix because we want to explain the procedure we followed and because we took the time to consider relevant case law, particularly in light of the European Convention on Human Rights: the latter means that our views may be of assistance to other inquiry panels.

The terms under which we agreed to carry out our work involved the following procedural rules:

1. Every witness of fact will receive a letter before appearing before the panel. This letter will ask them to provide a statement as the basis of their evidence to the inquiry and inform them:
    i. of the terms of reference and the procedure adopted by the inquiry;
    ii. of the areas and matters to be covered with them;
    iii. that when they give oral evidence they may raise any matter they wish which they feel may be relevant to the inquiry;
    iv. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness;
    v. that it is the witness who will be asked questions and who will be expected to answer;
    vi. that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact will be asked either to affirm or confirm that their evidence is true.
3. Any points of potential criticism will be put to witnesses of fact, either verbally when they first give evidence, or in writing later, and they will be given a full opportunity to respond.
4. Written representations may be invited from professional bodies and other interested parties regarding best practice for persons in similar circumstances to this case and as to any recommendations they may have for the future.
5. Those professional bodies or interested parties may be asked to give oral evidence about their views and recommendations.
6. Anyone else who fells they may have something useful to contribute to the inquiry may make written submissions for the inquiry's consideration and, at the chairperson of the panel's discretion, be called to give oral evidence.
7. All sittings of the inquiry will be held in private.
8. The draft report may be made available to the Health Authority, Social Services and the relevant NHS Trust for any comments as to points of fact.
9. The findings of the inquiry and any recommendations may be made

public.

These are rules which have been developed over time by our inquiry manager.

We also considered the extent to which our procedures should be influenced by the requirements of the Human Rights Act 1998 in case it should be decided that we were a body carrying out a public function and so were bound by the requirements of the Act[37]. We took the following cases to be a summary of the law relating to the process which should be pursued by an inquiry to comply with the procedural requirements of the European Convention, in particular Article 2 and Article 13.

In Edwards v UK, Appn 46477/99, 14 March 2002, reported in [2002] Prison Law Reports 161, the European Court of Human Rights considered whether Arts 2 and 13 European Convention were breached in the context of the killing of a prisoner by another, who was mentally ill. The context of this was that there had been an Inquiry into the killing.

The applicants' son, CE, was killed in Chelmsford Prison on 29 November 1994. He had shown signs of developing a serious mental illness. On 27 November 1994, he was arrested after approaching young women in the street and making inappropriate suggestions. The police suspected he was mentally ill, but an assessment by a mental health social worker concluded that he did not need urgent treatment. The next day, he was remanded in custody by the Magistrates' Court; action available to secure his transfer to hospital was not taken. At the prison he was screened by a member of the prison health care staff and placed in a normal cell on his own: although significant concerns had been expressed by various people as to his mental health, this information was not passed to the official carrying out the assessment.

RL, the killer of CE, had been arrested on 26 November 1994 for assault. At the police station, a police surgeon certified that he was not fit to be detained as he was mentally ill; however, a psychiatrist decided that he did not need to be admitted to hospital and that he was fit to be detained: his bizarre conduct before and after arrest was attributed to the effects of alcohol abuse, amphetamine withdrawal and a deliberate attempt to manipulate the criminal justice system. The psychiatrist had previously treated him and knew that he had been diagnosed at various times as suffering from schizophrenia or as having a personality disorder, but also as someone who became ill when abusing alcohol and drugs; the psychiatrist did not have access to his medical notes which showed that at the time consideration was being given to having him detained under the Mental Health Act 1983.

[37] See s6 of the Human Rights Act 1998, which prohibits a public body from breaching Convention rights unless required to do so by a statute.

Over the weekend, RL showed further bizarre behaviour and was violent to police officers, but was not re-assessed by a doctor. He was remanded in custody by the Magistrates' Court on 28 November 1994 and placed at Chelmsford Prison. He was screened by the same member of the prison health care service who had seen CE and admitted to the main prison; no information was passed on that he had previously been admitted to hospital.

RL was then moved into a cell with CE because of shortage of space. Shortly before 1am on 29 November 1994, RL attacked CE in the cell and stamped and kicked him to death. The emergency buzzer was activated from inside the cell but was inoperative as it had been interfered with. The prison officer on duty the evening before was aware that the buzzer was inoperative.

RL was found to be acutely mentally ill and was transferred later on 29 November 1994 to Rampton Special Hospital. On 21 April 1995, he admitted the manslaughter of CE by reason of diminished responsibility; the judge imposed a hospital order under s37 of the Mental Health Act 1983, together with a restriction order under s41. He was admitted to a high secure hospital, diagnosed as suffering from paranoid schizophrenia.

A Coroner's Inquest had been opened but adjourned pending the criminal proceedings against RL. After RL's conviction, the Coroner closed the Inquest, as there was no obligation to continue in those circumstances. A private, non-statutory inquiry was commissioned by 3 State agencies with statutory responsibilities towards CE – the Prison Service, Essex County Council and North Essex Health Authority. It opened in May 1996, but had no compulsory powers over documents or witnesses; 2 prison officers refused to give evidence, including one who had passed by the cell shortly before the attack. Its final report, of June 1998, found "a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner". It identified a series of shortcomings, including poor record-keeping, inadequate communication and limited inter-agency co-operation, and a number of missed opportunities to prevent the death of CE. There were specific failings identified on the part of the police, the prosecution, the magistrates court and the prison.

In February 1996, the applicants had been advised by their solicitors that they had a claim for funeral costs and a potential claim for compensation and any pain and suffering between CE's injury and death, but that taking into account legal costs it would not be economic to bring such a claim. In April 1996, the Criminal Injuries Compensation Board awarded the applicants £4,550 for funeral expenses but decided that there should be no dependency or bereavement award. In November 1997, the applicants issued a summons in the County Court for negligence against the Chief Constable of Essex and Essex County Council. They did not however serve it due to legal advice from their solicitors. After the Inquiry reported, they were advised that it was still inadvisable to serve the proceedings because the Inquiry had made no relevant findings in relation to whether any time elapsed between their son

being injured and his death, which would have determined whether they had any action in respect of pain and suffering experienced by their son before he died.

By letter of 25 November 1998, the Crown Prosecution Service decided that there was insufficient evidence to proceed with criminal charges for gross negligence manslaughter against anyone involved in the case. In December 2000, the Police Complaints Authority provided the applicants with a report into their complaints about police conduct in dealing with CE and in the subsequent investigation into the death, which upheld 10 of the complaints and made a number of recommendations to Essex Police in relation to practice and procedure.

The applicants complained to the European Court that there were breaches of

(i) Art 2 (right to life) from the authorities' failure to take appropriate steps to protect life and failure to provide an effective procedure for establishing the facts surrounding the death of a person in their care, through some form of public and independent official investigation to which the applicants had full access;

(ii) Art 6 (fair trial), as they had no effective access to court to bring civil proceedings in connection with the deprivation of their son's life (though this was not argued at the final stages);

(iii) Art 8 (right to respect for family life) from the lack of an independent investigative mechanism and access to court as the parents of a deceased son (though this was not argued at the final stages); and

(iv) Art 13 (right to an effective remedy).

The Government argued that the information available to the prison authorities in the period leading up to the attack, when viewed objectively and without the benefit of hindsight, showed that there was no real or immediate risk about which the prison authorities knew or ought to have known, as both prisoners had been assessed by professionals and there was no suspicion that RL would act violently towards his cell mate. The Government further argued that the Inquiry and range of court procedures available amounted to an effective procedure for determining the facts. (The government had also raised a preliminary objection as to the timing of the application, which was dismissed: see the note at the end of the report.)

It can be seen from the facts that there are a number of analogies to the situation in which we found ourselves, being a non-statutory inquiry sitting in private. There are, of course, clear differences on the facts of the Edwards case and the current situation: they are clearly not on all fours, but the decision in the Edwards case provides a benchmark from which it is possible to gather some principles which can then be applied to the current situation.

The European Court first considered Article 2 of the Convention. It is worth mentioning this in some detail, as it sets the background to the duties which can fairly be said to arise in the current context.

(i) The Duty on the State to Protect

Article 2 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. This involves a primary duty on the State to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. It also extends in appropriate circumstances to a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual.

The difficulties of policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources mean that the scope of the positive obligation must be interpreted so as not to impose a disproportionate burden on the authorities. The positive obligation will only be breached if it is established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

Those in custody are in a vulnerable position and the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody, particularly where that individual dies. Domestic law recognises this in the need for an inquest and the imposition of a tortious duty of care.

On the facts, RL was known to be mentally ill by his doctors and had a history of violence; at the relevant time, consideration was being given to have him detained under the Mental Health Act 1983, a fact not brought to the attention of the psychiatrist who examined him in the police station; the prison health worker who assessed him was not told of his previous record or committal to hospital or given details of his recent conduct. Information was available to show that he posed a real and serious risk to others. As the Inquiry found, there were serious short-comings in the system: the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass on information about RL to the prison authorities and the inadequate nature of the screening process on RL's arrival in prison disclose a breach of the State's obligation to protect the life of CE, who should never have been placed in a cell with RL. As a result, Art 2 was breached.

From this, we took it that it was necessary to examine whether there had been serious short-comings in the system which should have been in place to offer protection, including failures to pass on information, failures to screen and make risk assessments and so on. We should make it plain, however, that we do not take it to be the case that bona fide exercises of professional judgment which turn out to be wrong amount to a breach of Art 2.

(ii) The Procedural Obligations When There has been a Death in Certain Circumstances

It must be remembered that the European Convention is given a broad meaning and there are frequently additional rights implied into a substantive obligation designed to give effect to the primary obligation. These implied rights are often procedural in nature.

So, in Edwards, the second part of the decision of the European Court was that the obligation to protect the right to life under Art 2 of the Convention, read in conjunction with the State's general duty under Art 1 of the Convention to "secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention", also requires an effective official investigation when individuals have been killed as a result of the use of force, to secure the effective implementation of the domestic laws which protect the right to life. Naturally, this is met by the criminal prosecution of those responsible for a homicide.

However, it goes further than that. If the case involves State agents or bodies, to ensure their accountability for deaths occurring under their responsibility, there must be an investigation of that. This is not limited to situations where State agents have killed: it covers also situations where the default of State agents has lead to a death caused by a third party.

The form of investigation may vary in different circumstances: however, it must always involve the authorities acting of their own motion once the matter has come to their attention and so cannot rely on the next of kin lodging a formal complaint etc.

An effective investigation requires: (i) the investigators to be independent from those implicated in the events, both from a lack of hierarchical or institutional connection but also in practice; (ii) an ability to determine whether any force used was justified (if relevant on the facts, which will usually involve a case of killing by a state agent) and to identity and punish those responsible; (iii) reasonable steps to secure the relevant evidence (including eye witness testimony and forensic evidence); (iv) promptness and reasonable expedition, so as to maintain public confidence in the adherence to the rule of law and prevent any appearance of collusion in or tolerance of unlawful acts; (v) a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory, which will

vary from case to case, but must always involve the next of kin to the extent necessary to safeguard his or her legitimate interests.

On the facts of the Edwards case, CE was a prisoner under the care and responsibility of the authorities when he died from acts of violence of another prisoner. In this situation it is irrelevant whether state agents were involved by acts or omissions in the events leading to his death: the State was under an obligation to initiate and carry out an effective investigation. Civil proceedings at the initiative of the victim's relatives would not satisfy the State's obligation in this regard.

No inquest was held; the criminal proceedings did not involve a trial. As to whether the Inquiry complied with Art 2: (i) it was detailed and made finding adverse to the authorities, (ii) despite some shortcomings in the investigation, it was able to establish the principal facts; (iii) it was independent, despite being appointed by the authorities being investigated; (iv) the decision to hold an inquiry was taken 8 months after the death and the proceedings opened after 18 months, heard evidence over a 10 month period, and finally reported some 3½ years after the death; the complexity of the case was such that the Inquiry was commenced sufficiently promptly and proceeded with reasonable expedition.

However, (v) the lack of power to compel witnesses with material evidence (as happened) diminished its effectiveness as an investigative mechanism; (vi) despite the publication of the report, the death of a vulnerable individual due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare was such as to require the widest exposure possible, and no good reason had been established for holding the Inquiry in private; (vii) the next of kin were only able to attend the Inquiry when they gave evidence, and were not able to put questions to other witnesses, and had to await the publication of the Inquiry Report to discover the substance of the evidence; given their close and personal concern with the subject-matter of the Inquiry, they had not been involved in the procedure to the extent necessary to safeguard their interests. The lack of power to compel witnesses and the private character of the proceedings from which the applicants were excluded save when they were giving evidence failed to comply with the requirements of Art 2 of the Convention to hold an effective investigation, and so violated Art 2.

The analogies between this holding of the Court and our situation are self-evident.

(iii) Article 13 – Effective Remedy

The European Court then went on to consider Article 13 (which, we note, is not part of the Human Rights Act 1998, though the reason for that was stated by Ministers to be because the Act itself amounted to compliance with Art 13 and so it did not need to be a scheduled right). This requires a domestic

remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief; it must be effective in practice and law, and must not be unjustifiably hindered by the acts or omissions of the authorities. Where the case turns on an alleged failure by the authorities to protect persons from the acts of others, Art 13 may not always require that the authorities undertake the responsibility for investigating the allegations: a mechanism available to the victim or the victim's family will suffice. In the case of a breach of Arts 2 and 3 of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available.

On the facts of Edwards, a civil action in negligence might have furnished a fact-finding forum with the power to attribute responsibility for CE's death, but this was not pursued: however, it was not apparent and the Government had not argued that non-pecuniary damages (for the suffering and injuries of CE before his death or the distress and anguish of the applicants at his death) would have been recoverable or that legal aid would have been available to pursue them. Consequently, this avenue of redress was not of practical use. Further, no action was available under the Human Rights Act 1998 in relation to damages for the death of CE which occurred before the entry into force of the Act: the only potential claim would relate to the continuing breach of the procedural obligation. As to the Inquiry, it did not comply with the procedural requirements of Art 2, and did not provide any possibility of damages.

Consequently, the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the authorities failed to protect their son's right to life and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby, which is an essential element of a remedy under Art 13 for a bereaved parent. Accordingly, there has been a breach of Art 13.

Of course, applying this part of the Edwards decision by analogy to the current situation is not really for us: although we know about the current status of the Inquest (see the text of our report) and we know that there was a limited criminal process (owing to the acceptance of a plea to manslaughter), we cannot know whether other court action may be in contemplation (and did not ask whether that was so, since it was not really relevant to our terms of reference and might well be legally privileged information).

Having considered Edwards, we also considered guidance from the domestic courts in the case of (1) R (Middleton) v HM Coroner for West Somersetshire and (2) R (Amin) v Secretary of State for the Home Department and HM Coroner for West London decided on 27 March 2002 by the Court of Appeal, the Lord Chief Justice presiding: neutral citation [2002] EWCA Civ 390,

reported in [2002] Prison Law Reports 100. This concerned 2 deaths in custody, one a killing and the other a suicide.

ZM, a young Asian man, was held at Feltham Young Offenders Institution; he was killed by his cell-mate, a known-racist with a severe personality disorder, who was subsequently convicted of his murder. On behalf of his family, A, ZM's uncle, sought a public inquiry into the killing; the Secretary of State refused to hold such an inquiry. There was a detailed prison service investigation, which found various shortcomings and made recommendations; the Director General of the Prison Service had invited the family to participate in that. In addition, the Commission for Racial Equality was carrying out an investigation into racism within the prison service and had been asked to investigate the circumstances of ZM's death. The judge ([2002] Prison Law Reports 74) ruled in favour of A's challenge to the failure to hold a public inquiry, finding that a public inquiry with legal representation for ZM's family was necessary to comply with Art 2 European Convention, the right to life, which has been interpreted to include procedural obligations as to investigations into deaths whilst in state custody. The Secretary of State appealed with the permission of the judge to the Court of Appeal.

In the second case, M, the mother of a young man who had committed suicide whilst being held at HMP Bristol, challenged the adequacy for the purposes of Art 2 of an inquest. M's son had not been on suicide watch in the prison, despite having expressed suicidal tendencies. The Coroner directed the inquest jury that they were not able to find 'neglect' as part of their verdict; however, he did accept a note from them in which they raised concern as to the standard of care applied to M's son. Although he did not reveal the jury note, the Coroner took their comments into account in a letter written to the Chief Inspector of Prisons. The judge ([2002] Prison Law Reports 87) declared that the inquest was inadequate to meet the procedural obligations required under Art 2. The Coroner appealed.

The Court of Appeal noted that the right to life under Art 2 includes a duty placed upon the state to protect life in cases where its servants are or ought reasonably to be aware that a particular individual who is in the state's care, such as a prisoner, is at immediate risk of death or serious injury. Part of the obligation under Art 2 is to ensure an effective investigation to determine whether Art 2 is breached by deaths such as those in the instant cases.

The procedural obligation promotes the aims of minimising the risk of similar deaths in the future, giving the beginnings of justice to the bereaved and assuaging the anxieties of the public. What is required will vary with the circumstances, and a flexible approach is to be adopted. Whilst a credible accusation of murder or manslaughter by state agents will call for an independent and public investigation of the utmost rigour, an allegation of negligence leading to a death in custody does not require the same response.

In A, the Director General of the Prison Service had accepted that the prison service was at fault, an internal investigation had been carried out which made various recommendations (and in which the family's participation had been invited), and an investigation had been carried out by the Commission for Racial Equality. On the facts, these were appropriate to fulfil the state's Art 2 obligations to investigate and so a public inquiry was not required: hence the appeal was allowed.

In M, the coroner had limited the verdicts available to the jury because of his interpretation of the Coroners' Rules as preventing a verdict of neglect unless some specific individual was identified. However, the coroner, as a public authority, was obliged by s6 Human Rights Act 1998 to interpret those rules so as to comply with Art 2. Consequently, whilst it is generally correct to say that a verdict of systematic neglect as opposed to individual fault is not permitted, when it is necessary so as to vindicate Art 2 to give in effect a verdict of neglect, it is permissible to do so. This will arise where the coroner decides that a finding of neglect could serve to reduce the risk of repetition of the circumstances giving rise to the death being inquired into at the inquest. The publication of the notes of the jury identifying their concerns, which had now occurred, was sufficient on the facts. Hence, the appeal was allowed in part.

After we had heard witnesses, but before our report had been completed, the House of Lords overturned the decision of the Court of Appeal in the case of Amin. The ruling of the House of Lords ([2004] Prison Law Reports 140) was to the effect that the High Court judge had been correct and the Court of Appeal had diluted the requirements of the European Convention. In particular, the House of Lords emphasised that where there is a death in custody there must be an investigation into elements of fault by state agents which involves a sufficient element of public hearings and participation by the deceased's family. That had not been achieved in the range of investigations which had followed the death of ZM. The House also stressed the importance of the coroner in achieving compliance with Article 2. We understand that the case of Middleton is also to be considered by the House of Lords in 2004, together with other litigation as to the conduct of Inquests.

We were unable to comply with the requirement as to publicity because our rules of procedure specifically prohibited this. We took the view that we were a group of individuals commissioned to provide a report to the Health Authority and that our essential status was as a group of consultants, and that there was nothing which gave us a separate constitution as a body which could be considered to be a public body within the Human Rights Act. Although our report was commissioned by a public body, namely the Health Authority, that could not make us a public body and so require us to set aside such requirements as sitting in private which might arguably raise concerns as to whether we were complying with the procedural requirements of Article 2.

However, we did aim to involve the family of Mr Day (and the family of Mr Janes) as much as possible so as to be consistent with the aims of the Convention and to assist the Health Authority as a public body to meet its obligations.

Mrs Doyle, the mother of Mr Janes, was a witness in our inquiry; Mrs Day was not. Both were seen by the Panel at an early stage and asked to indicate what were the concerns they had in light of the information they had as to the chronology of events; in addition, we passed on updates as to the progress of the inquiry and there were several telephone calls and letters about specific issues. We persuaded the Health Authority to allow funding for legal representation for Mrs Day and Mrs Doyle to assist them in communicating with the inquiry. Finally, we took the step of discussing the report with Mrs Day and, separately, with Mrs Doyle in advance of handing it over as a final document to the Health Authority: we did this pursuant to our procedural rule allowing us to receive oral evidence from "anyone else who feels they may have something useful to contribute to the inquiry".

So, the process adopted was that we heard all the evidence; various drafts of the report were prepared until the Panel was satisfied of the conclusions expressed on the basis of the documentation we had received and the oral evidence. We then sent extracts of this version to individuals and organisations which were expressly or implicitly criticised. Once replies were received to these letters, the Panel considered whether the report had to be modified. The version prepared after this process was discussed first with representatives of the Authority at their request[38] and the resulting draft was the one discussed with Mrs Day and Mrs Doyle with the aim of seeking their views on the facts found and conclusions reached.

We also wrote to the Coroner, Ms Redman. The Inquest had been opened (for the purposes of hearing evidence on the cause of death and identification) and adjourned pending the outcome of the criminal trial. Ms Redman explained in her letter indicated that she exercised her discretion not to reopen the Inquest "as there had been a substantive hearing about the death in the Crown Court, leading to a conviction by way of a guilty plea". She added that she was mindful that the findings of the Inquest must not be inconsistent with the outcome of the criminal proceedings.

It is not our function to question the discretion of the Coroner, but we do note that there is encouragement in case law (see appendix) for Coroners to consider whether they need to seek a determination on issues of systematic neglect or fault. We will send a copy of our report to the Coroner so that she can determine whether there are any features of our findings which may make it appropriate for her to decide to reopen the Inquest.

[38] This is discussed in more detail in the Chronology.

Appendix 4. General Approach to Risk and Mental Illness

We were able to have an illuminating session with Dr Andrew Johns of the Institute of Psychiatry, based at the Maudsley Hospital. He was asked to assist on the question of the general statistics and other evidence available in relation to the question of mental illness and risks posed of danger to others. We set this out at this early stage because it is necessary to put into context the chronology, which involved us looking for instances where the risk in fact posed by Mr Janes (as made plain by the homicide) was understated or missed. This requires an understanding of what the risk is and so what the services should have been looking for in their dealings with Mr Janes.

A summary of Dr John's evidence on these general matters is as follows:

A: Statistics as to Risk

(i) Until quite recently, any psychiatrist reviewing the academic literature would have the view that the risk of dangerous behaviour from those with a mental illness is much increased, and that people with schizophrenia are dangerous people. A substantial body of work shows that in schizophrenia the risk of severe violence to others is increased by a factor of 3 to 6.

(ii) In the UK, the homicide rate tends to run at 5-600 per annum: it has crept up since 1950, though not dramatically. The proportion of homicides committed by mentally disordered defendants has gone down. About 40 perpetrators a year will have had contact with psychiatric services in the year before the homicide: of those, 12 will have schizophrenia, 4 will have affective disorder and the rest will have a mixture of substance misuse and personality disorder. On the basis of the admission rates for psychiatric services, the 12 homicide perpetrators with schizophrenia represent 1 in 4000 admissions over the same period of a year or so.

(iii) These figures are for men and women. As women are a lesser risk, the real figure for women is something like 1 in 33,000 women with schizophrenia every year are at risk of committing a homicide. For men, it falls to 1 in 3000. This figure of 1 in 3000 underlines the difficulty services face in identifying the small number who are actually at risk of committing a homicide.

(iv) Most community psychiatrists are not looking after 3000 people, but hundreds, and so their difficulties in spotting the 1 offender is increased to that extent. This puts risk in perspective.

(v) Drugs or alcohol abuse increase risk: there is good evidence that substance abuse increases the risk by a factor of perhaps 10 to 15, or even more. However, given the low baseline, it still only gets down to probably around 1 in 400 or 500. So it remains a rare event that a patient suffering from schizophrenia who abuses drugs or alcohol commits a serious offence, and predicting rare events is difficult.

B. Assessing Risk

(i) Until recently, psychiatry has been occupied by the task of clinical assessments, namely talking to the patients in enough detail, talking to informants, taking family histories and so on, so as to be able to understand the patient and their illness, and the risk they pose.

(ii) However, this is unsystematic, as clinicians behave in different ways. And it seems to have a low hit-rate. The Americans developed an actuarial approach based on validated instruments. The concept is that there is something about people with schizophrenia that can be measured that will predict risk. There has developed a risk assessment industry, with many instruments – such as the Hare Psychopathy Checklist (PCL-R) or the Historical and Clinical Risk Factor 20 (HCR20). These are not much-used in the UK. However, even with the best and most rigorous instruments, the chance of spotting the 1 in 3000 does not go up very much: so even in the best hands, the task is difficult.

(iii) Consequently, psychiatry is not about who will go bad or cause harm, as that is an almost impossible task. It is about the thorough assessment of the risk in that person, based on all of the research evidence. This will allow an assessment of what are the important factors for the individual (such as substance misuse, family relationships, impulsivity): for some of these risk factors psychiatry has some reasonable levers, and so this assessment leads to a practical response in reducing risk.

C. Response to Risk Assessment

(i) The more sensitive a risk assessment instrument is, the more false positives it throws up. This will produce a view that a fair number of patients with schizophrenia will be dangerous over the coming year. However, it is not possible in most services to provide all with a very high level of care. Resources have to be targeted to the most needy.

(ii) The Care Programme Approach came about in the wake of a number of high profile homicides. It is about a structured, simple format for gathering information that has some elements of risk in it. However, the CPA heading for "risk" can be left blank, and so a detailed risk assessment has to be added.

(iii) Who should be targetted? Those who are recently discharged (who must have been very unwell so as to get into an overstretched psychiatric service) are at high risk and should have more resources in the year from discharge. Substance misuse also increases risk, as it destabilises, makes symptoms worse, reduces compliance with medication and lowers the threshold for

violence. So those who suffer from schizophrenia and are recently discharged and misuse substances should be targeted.

D. Service Structure

(i) There is limited national or government guidance on how psychiatric services should be structured.
(ii) There are 2 models for the structure of general and forensic psychiatry.
(iii) In the parallel model, the forensic service looks after the major offenders in the community.
(iv) In the integrated model, there are within a Community Mental Health Team people with forensic expertise or training, and a forensic consultant may have input.
(v) Both models have tensions: in a parallel model, the general psychiatrists and the forensic psychiatrists take different approaches to risk; in an integrated model, the forensic workers are in danger of having their specialism overwhelmed by the demand for adult general services.