EXTERNAL REVIEW COMMISSIONED BY TRENT

STRATEGIC HEALTH AUTHORITY

RELATING TO DECEASED PARTIES:

MJ AND PS/J

CONTENTS

1. INTRODUCTION

1.1 This report has been commissioned by Trent Strategic Health Authority (TSHA) and consequently is the property of TSHA. The mental health services Trust was asked to establish an external review in order to examine the quality and scope of all health services having contact with MJ and to consider the process of PS/J's (6 years of age) referral to child and adolescent mental health services (CAMHS), prior to being found hanging in the cellar of the family home in the early hours of the 8th July 2003. Her step-father MJ was found hanging later that day (8th July 2003).

1.2 The professionals appointed to undertake this task operate outside the area where services are provided and progressed within clear terms of reference. Details of the terms of reference and panel membership are attached at Appendix 1. A key to the acronyms utilised within the report can be found on page 34.

1.3 The report is written with the benefit of much hindsight, after reviewing files, interviewing staff and interviewing MJ's widow, also mother of the deceased child. It is important to highlight that despite concerted efforts, certain pieces of information were unavailable to panel members in relation to determining the identity of a private counsellor who was visited by MJ and gaining access to his army records with historical details on his discharge. This information may not have affected the outcome of this investigation but is important to note if safeguarding children is 'everyone's business'.

1.4 This report highlights a number of concerns with regard to safeguarding children and the need to develop more robust systems in general practice (primary care) when making referrals to secondary care services. This is particularly with a view to ensuring that all services are fully informed about family history in order to guarantee 'joined up' partnership working with other local agencies.

2. METHODOLOGY

2.1 The National Patient Safety Agency (NPSA) provided the panel with an overview of the Root Cause Analysis (RCA) approach to incident investigation and assisted the panel with utilising some of the RCA tools and techniques to investigate and analyse this incident. This report therefore broadly follows the RCA methodology provided by the NPSA. The NPSA did not provide any opinion or views in the analysis of this incident.

2.2 A crucial element of any patient safety incident is the ability to learn from the event and enhance the ability to deliver a safe and effective service to patients. RCA is a retrospective systematic process of the analysis of a patient safety incident. Its purpose is to identify what, how and why a particular event occurred. The output from such an analysis is then used to identify those areas that require change and provide for recommendations and sustainable solutions; in order to minimise the chance of recurrence of a similar incident.

2.3 A large and varied data set was mapped and gathered for the panel in order to identify and analyse problems, agree the root causes and contributory factors. This information consisted of patient records, including risk assessments, correspondence and multidisciplinary notes. The panel considered child protection issues and examined tabular timelines, policies and procedures, GP records, training records, reports and transcripts provided by external agencies, and a written submission by AJ (wife and mother of the deceased parties).

2.4 As part of the process, interviews were also conducted with the appropriate professionals to assist the panel with its deliberations.

2.5 The Chair and Panel Co-ordinator met with AJ in the presence of her victim support worker. This was in order to gain AJ's perspective on the care and treatment of her deceased husband, and to identify any particular areas of concern that she wished the panel to take into consideration.

2.6 AJ gave a detailed verbal and written chronology of MJ's psychological difficulties leading up to the death of her youngest daughter, the subsequent suicide of her husband and events following these tragic outcomes.

2.7 The panel acknowledges AJ's experiences have been harrowing and it is commendable that she was able to give such a detailed account of them, and with hindsight, share her insights into the possible escalation of her husband's behaviour and moods prior to the incidents of the 8th July 2003.

2.8 In addition to concerns about the healthcare of her late husband, AJ raised a number of issues relating to the police investigation of the murder of her daughter, her perceived lack of support for her eldest daughter and perceived failure of social services to act on the recommendations of the ACPC report. However valid these concerns may be, these matters lie outside the terms of reference for this investigation.

2.9 In the main this review focuses on the quality and scope of health services afforded to MJ prior to the incidents on the 8th July 2003, and therefore AJ's perspective on MJ's care and treatment is critical to this review. In this respect AJ raised two concerns which are taken directly from her written account:

"Although, to me, it seems I was always at the doctor's begging for help, I need to know how many times my visits and MJ's visits were recorded in our records, and should the medical profession have been more alert to a possible child protection issue?"

"My letters of complaint which I wrote after MJ came out of hospital on the 27th December were never acknowledged or acted upon. Why?"

2.10 The review also examines the detail of PS/J's referral to CAMHS but with more brevity, given the lack of engagement by the family.

3. CHRONOLOGY OF EARLY BACKGROUND – JUNE 1994 TO EARLY AUGUST 2002

3.1 **June 1994**. MJ was discharged from the army. It is reported that he received a sentence of 52 days in army prison for possession of amphetamines. It is noted that MJ had previously experienced suicidal thoughts when in the army. However the panel was unable to gain access to MJ's army records.

3.2 **21st November 1994**. MJ failed to attend his appointment at a drug addiction clinic in Kent. This followed his GP(1) appointment on the 7th November 1994 when he presented with mood swings, aggression and drug abuse.

3.3 **May 1999.** MJ integrated with the household. AJ had met MJ whilst working at a local newsagents. After a short time in their relationship, AJ, LJ and PS/J moved in with MJ.

3.4 **25th August 1999.** Noted that LJ was mute and subsequently had urinary problems and abdominal pain.

3.5 **10th October 1999**. From the health visitor's records, it appears that there was a pre-arranged visit to PS/J but access was not gained. Routine surveillance was not pursued although there was no evidence from records of any health concerns.

3.6 **24th January 2000**. PS/J attended GP(2) surgery with a one week history of diarrhoea. The family had registered with a new GP in Kent and apparently moved there to avoid problems with PS/J's father LS.

3.7 **26th January 2000**. PS/J was taken to GP(2) in Kent for the second time, suffering with diarrhoea, reassured.

3.8 **10th June 2000**. MJ and AJ get married.

3.9 **By 2001**. The family moved to live near Sheffield (unclear whether this was everyone).

3.10 **26th May 2001**. PS/J was registered with GP(3) practice in Nottinghamshire.

3.11 **29th May 2001**. Family received a standard letter from the health visitor (HV), for PS/J to attend routine growth and development review. There is no evidence of any response from parents and no apparent follow-up.

3.12 **21st June 2001**. MJ attended GP(3) complaining of pain in joints. GP(3) diagnosed repetitive strain injury.

3.13 **17th August 2001**. PS/J attended GP(3) surgery twice on this date. She had been seen earlier that day with a 2 day history of temperature, but had been well hydrated and had no evidence of meningism. She attended later on because she was feeling worse; fever had increased, not drinking. Child admitted to hospital.

3.14 **31st August 2001**. Hospital letter to GP following PS/J's admission for viral infection. This had settled quickly and weight on discharge was noted to be16.3kg.

3.15 **27th September 2001**. PS/J had pre-school booster.

3.16 **6th December 2001**. PS/J attended GP(3) surgery and seen by practice nurse for second MMR vaccinations.

3.17 **23 January 2002**. MJ attended GP(3) surgery for treatment of wart on right index finger.

3.18 **15th May 2002**. PS/J's mother (AJ) returned school health questionnaire. No concerns were identified.

3.19 **22nd May 2002**. PS/J had a school entrant health review. Hearing test normal.

4. EMERGING FAMILY PROBLEMS – JULY 2002 TO JULY 2003

4.1 In August 2002, MJ drove to his 'Nan's' house in Kent but could not remember driving away from home with this intention, just arriving there. He was absent without leave from work and had been under pressure. There were also problems with his step-children and their relevant fathers. In addition, during this period, MJ and AJ were suffering severe financial pressures.

4.2 MJ was prescribed anti-depressants by his GP(3) in September 2002. AJ reports that he took these haphazardly and continued to exhibit mood swings.

4.3 On 19th November 2002, GP(3) referred PS/J to CAMHS with behavioural problems.

4.4 MJ was explosive about the children having contact with their real fathers. A lengthy argument developed on the 26th December 2002 resulting in MJ taking an overdose, consuming alcohol and being admitted to hospital. This was an impulsive act and he did not intend to die.

4.5 MJ refused to engage with specialist mental health services following referral by the GP on the 6th June 2003. The level of arguments at home continued to increase over the months to come but AJ reported that there were fewer mood swings by the end of June 2003.

5. ESCALATION OF FAMILY VISITS TO GP SURGERY BETWEEN 20TH AUGUST 2002 AND 6TH JUNE 2003

5.1 MJ and AJ were relatively frequent visitors to their GP(3) surgery, attending on 20 occasions during the period of 20th August 2002, when MJ first reported psychological and emotional difficulties and the 6th June 2003, when he was referred to specialist mental health services.

5.2 There are a number of recorded entries in the notes of AJ and MJ detailing AJ's concerns for her husband's mental well being. The first entry demonstrating AJ's concern for her husband was on the 9th September 2002. During a routine consultation for a physical complaint, AJ reported that her husband was having a 'breakdown' and it is documented that GP(3) had a long discussion with AJ about her concerns.

5.3 MJ had been referred to primary care mental health services to see a NPMH, some 5 days earlier and was continuing to see GP(3) at regular intervals. He was not showing signs of a serious mental illness and therefore no further action was taken. He attended the surgery on a further 5 occasions prior to taking an overdose of his prescribed antidepressant medication on the 26th December 2002. MJ presented a mixed picture, at times reporting some improvement but on other occasions stating that he was experiencing stress and describing symptoms of reactive depression.

5.4 PS/J had two appointments with GP(3) during this period. On the 8th November 2002, the GP records note she was not eating and complaining of a 2 week history of stomach pain The result of a urine test was normal.

5.5 PS/J attended the surgery again on the 18th November 2002 regarding stomach pain. She was referred to CAMHS on the 19th November 2002.

5.6 On the 8th January 2003, MJ and AJ attended a GP(3) appointment together, concerned about 'paranoid behaviour'. MJ was reported to be checking telephone calls and expressing feelings of being unworthy. Concern was also expressed that MJ had become obsessive about the 'Soham Murders' in Cambridgeshire which had occurred the previous summer. The following week MJ saw GP(3) and indicated that he was feeling much better and that his situation had improved.

5.7 On the 5th March 2003, AJ attended the surgery, reporting to GP(3) that MJ was receiving private counselling and making a good improvement.

5.8 On the 31st March 2003, AJ reported to GP(3) that her husband's well-being was declining and that he had ceased to attend counselling. She was tearful, over-eating but did not have any suicidal thoughts. AJ was advised to try RELATE and was prescribed a small dose of an anti-depressant to be seen again in a week but the patient did not attend, (records lack clarity as to whether this refers to AJ or MJ).

5.9 On the 15th April 2003, MJ reported to GP(3) that he was again having problems at work but felt he had resolved his family issues. MJ did not attend the surgery again.

5.10 AJ attended MJ's appointment at the GP(3) surgery on 5th June 2003, reporting that MJ was becoming much worse. On this basis GP(3) promptly referred him to specialist mental health services on 6th June 2003.

6. PS/J'S REFERRAL TO CAMHS

6.1 PS/J was 6 years of age when GP(3) made a referral to the child and adolescent mental health service (CAMHS) on the 19th November 2002. She was referred with disturbed sleep, lack of appetite and abdominal pain. A history of family stresses was noted as step-father suffering from a crisis of confidence related to step-children and their biological fathers. It was also noted in the referral letter that it was apparent that the two parents were handling the situation differently and that GP(3) had encouraged consistency.

6.2 On the 4th December 2002 a CAMHS appointment letter was issued addressed to AJ, inviting both parents to attend with PS/J. The date of the appointment was the 17th December 2002. The family failed to attend.

6.3 On the 23rd December 2002 the CAMHS psychiatric social worker (PSW) wrote to AJ inviting further contact following the failed appointment on the 17th December 2002.

6.4 On the 28th February 2003 the PSW, CAMHS issued a letter to GP(3) stating that the family had failed to attend on the 17th December 2002 and also failed to respond to the follow-up letter asking if they required a further appointment. The case was closed.

7. LETTERS OF COMPLAINT FROM AJ

7.1 AJ recalls sending two letters of complaint to services about her husband's care and treatment following his overdose on the 26th December 2002. One letter was sent to the GP surgery, addressed to the NPMH. Unfortunately this letter was not dated, nor was it date stamped on receipt by the service. Neither is it clear how this letter was initially received in primary care and transferred to the NPMH. The second letter was sent to the hospital that dealt with MJ's medical admission.

7.2 Due to the NPMH's sickness absence, it had been necessary to cancel MJ's next appointment originally scheduled for early February 2003. The NPMH telephoned MJ on the 14th February 2003 to arrange an alternative appointment and left a message on the answer-phone. In consideration of the letter from AJ expressing her concerns and previous discussions with MJ and AJ, the NPMH telephoned again on the 17th February 2003. During this telephone conversation the NPMH discussed the letter of complaint directly with AJ, speaking to both Mr and Mrs J. However MJ maintained that he did not want another appointment, despite the concerns articulated by AJ during this communication.

7.3 The NPMH discussed the difficulty she was having engaging with MJ with his GP and it was agreed that the case would be kept open for three months in case MJ decided he wanted to renew contact but he chose not to do so.

8. OVERVIEW REGARDING MJ'S CARE AND TREATMENT FROM AUGUST 2002 – FEBRUARY 2003

8.1 MJ's first report of psychological symptoms was to GP(3)on the 20th August 2002. He presented with emotional problems due to work stresses and his feeling about his step-children's fathers. He was advised not to work and asked to return the following week when a sick note was issued for a further sick period of one week. On his third visit, on 3rd September 2002, MJ was given a further sick note and the following day referred by letter to the NPMH who operated out of the GP(3) surgery.

8.2 The NPMH service is primary care based and offers short term interventions to patients who have mild to moderate psychological and emotional difficulties. The responsibility for the medical care and treatment is retained by the GP. Referrals are screened and if the patient is deemed to be suffering from a serious mental health problem or is assessed as presenting a risk to themselves or others, the service can refer on to the appropriate specialist mental health service who would risk assess the client and provide a level of service based on the assessed level of need and risk.

8.3 Given the nature of the primary care-based service which operates on an opt-in basis, if clients fail to attend they are offered alternative appointments. However the service does not provide assertive follow-up for clients who persistently fail to engage.

8.4 MJ was seen for assessment by the NPMH on the 13th December 2002. During the intervening period from referral to assessment MJ continued to see his GP and was prescribed anti-depressants. Anti-depressant medication appeared to have little effect and in her account, AJ recalls that her husband would not take the

medication prescribed consistently. At assessment MJ presented with reactive depression caused by work related stresses and his home life. He was not considered to be suffering from a serious mental illness or personality disorder and there was no indication that he was a risk to himself or others. He was amenable to therapy at this juncture and presented as caring and concerned for his family. A care plan was formulated for MJ to continue his anti-depressant medication and receive one-to-one support from the NPMH for 'anger management'.

8.5 On the 26th December 2002 whilst under the influence of alcohol, MJ took an overdose of anti-depressants. He was admitted as an emergency medical admission to hospital and was seen and assessed by the Department of Psychological Medicine (DPM) the following day. The DPM assessment concluded that MJ had taken an overdose impulsively whilst intoxicated, against a background of an argument with his wife (AJ). There was no planning or concealment of the overdose and at assessment there did not appear to be any real suicidal intent. MJ expressed that he neither wanted nor expected to die. He had a low mood but was not considered clinically depressed and there was no indication of severe mental illness. MJ was discharged back to GP(3) with continuing follow-up from the NPMH.

8.6 The next scheduled appointment with the NPMH in the first week of February 2003, was cancelled due to the practitioner's absence from work. MJ was contacted on the 14th February 2003 to arrange an alternative appointment and a message was left on the answer-phone. He was contacted again on the 17th February 2003 when the NPMH spoke to both MJ and his wife. MJ declined further contact.

8.7 Given the difficulty the NPMH was having engaging with MJ, it was agreed with his GP on 7th March 2003 that the case would be kept open for three months, in view of the fact that MJ may decide he wished to renew contact. However, should he fail to do so the case would be closed. MJ did not engage further.

9. MJ's REFERRAL TO SPECIALIST MENTAL HEALTH SERVICES

9.1 AJ kept her husband's appointment with GP(3) on the 5th June 2003, stating that MJ was unable to attend because he felt let down by the NHS. AJ described him as getting worse and ranting at his 11 year old step-daughter (LJ) the preceding day. His mood was variable and he showed poor insight into his behaviour.

9.2 On the 6th June 2003 GP(3) made a prompt referral to a consultant psychiatrist in a community mental health team (CMHT), stating that MJ had depressive symptoms, paranoia and aggression. He commented that MJ had originally presented in August 2002 with stress-like symptoms precipitated by difficulties with his step-daughters' natural fathers. A change of anti-depressants was documented following the overdose on the 26th December 2002. GP(3) also annotated that MJ had developed paranoia and obsessive thoughts about the two murdered children in Cambridgeshire.

9.3. The CMHT issued an appointment within two weeks and wrote to MJ on the 12th June 2003 offering an appointment with the consultant's specialist registrar. This was scheduled for 23rd June 2003. MJ failed to attend. GP(3) was informed on the 3rd July 2003. Also on this date, a follow up letter was sent to MJ inviting further contact and stating that if he did not respond by the 14th July 2003, he would be discharged back to his GP.

10. FINAL EVENTS

10.1 On 7th July 2003 AJ went to bed at 1830hrs because she was feeling unwell. MJ seemed fine and AJ's daughters were still playing outside in the garden. AJ woke briefly at 2100hrs but went back to sleep.

10.2 In the early hours of the 8th July 2003, AJ was attacked by her husband who was trying to strangle her and also stabbed her in the arm. Due to her screams AJ's eldest daughter entered the bedroom, switched on the lights and assisted in pulling MJ off her mother. MJ told AJ that he had raped and killed PS/J. He then took the car keys and left the house immediately after the attack.

10.3 Shortly after this, LJ found her younger sister hanging by a belt in the cellar. AJ reports that MJ had watched the 'Blair Witch Project' film many times and had apparently done so the previous evening. AJ was of the view that there were similarities between PS/J's death and the final scenes in this film.

10.4 An ambulance was called and on arrival at Accident and Emergency resuscitation was initiated at 0330hrs. A paediatric arrest call was put out before the arrival of the child and history taken from the paramedics. The ambulance crew identified no CPR in progress on arrival.

10.5 At 0350hrs PS/J was certified dead. After three cycles the decision was made to stop resuscitation. This decision was agreed by the paediatric consultant who was contacted for this purpose.

10.6 Later that morning (8th July 2003), at approximately 1125hrs, MJ was found hanging near the entrance to a park.

11. ANALYSIS AND FINDINGS REGARDING MJ'S CARE AND TREATMENT & PS/J's REFERRAL (CAMHS)

11.1 Areas of Good Practice

The panel identified some areas of good practice as follows:

- GP(3) strived to help members of the family by making appropriate referrals.
- Prompt referral letter from GP(3) to NPMH on 4th September 2002.
- The referral letter from GP(3) to specialist mental health services, contained some information over the last year and made the referral based on details given by MJ's wife (AJ).
- Appointment with specialist mental health services (CMHT) was issued within two weeks of receiving GP(3)'s referral letter.
- Prompt response by CAMHS and in relation to follow up letter.

11.2 AJ's concerns regarding MJ's welfare

11.2.1 The panel finds that the level of support offered to MJ was appropriate given his presentation. Throughout his contact with GP(3) he had no signs or symptoms of suffering from a serious mental illness or a personality disorder, exhibiting symptoms of low mood due to his personal circumstances. He was prescribed anti-depressant medication and referred to the primary care mental health service for counselling.

11.2.2 MJ's attempted overdose in December 2002 was not a serious attempt to take his own life. It was an impulsive act combined with alcohol and he was not considered to be clinically depressed.

11.2.3 In June 2003, following increasing concerns on the part of his wife, MJ was referred to specialist mental health services. He received a timely appointment from the CMHT to see a consultant psychiatrist's specialist registrar which he failed to attend. In accordance with the mental health Trust's agreed Policy on Action To Be Taken Following a Patient's Failure to Attend, MJ was offered a follow-up appointment and subsequently discharged back to his GP following his lack of engagement.

11.2.4 MJ did not engage with the services offered to him, and his wife (AJ) previously reported to the GP(3) that he felt let down by health services.

11.2.5 The panel is of the view that access to the primary care NPMH service could have been more expedient. However, it is difficult to draw any conclusion that speedier access or additional offers of intervention would have benefited the client, given MJ's reluctance to engage.

11.2.6 There was no indication that MJ presented as a serious risk to his family. In her account of MJ's demeanour prior to the 8th July 2003, AJ, with the benefit of hindsight, has been able to identify some behaviours that she now finds concerning. However, there is no evidence that the events of the 8th July 2003 are related to MJ's mental health state or that the events could have been prevented by improved access to either primary care-based services or specialist mental health services.

11.3 AJ's letters of complaint

11.3.1 Whilst there is evidence that the contents of AJ's letter to the NPMH were considered and acted upon, it is clear that the organisational complaints procedure was not adhered to in relation to the processing of a patient-related complaint. Nonetheless the NPMH did respond to AJ's letter of complaint by telephone.

11.3.2 AJ recalls that she sent a second letter of complaint. This was following her husband's overdose and was sent to the hospital dealing with MJ's medical admission. It was not addressed to a named practitioner or a department, and despite an extensive search, it has not been possible to trace it.

11.4 Safeguarding Children

11.4.1 Safeguarding children and young people is a complex and multi-faceted process. It is rarely clear-cut or obvious to most professionals and relies on them having a sound knowledge from academic and clinical literature, together with clinical expertise.

11.4.2 The possible risk factors identified via this review had presented over a period of time. For example, children's behavioural problems without medical cause, including muteness, disturbed sleep, lack of appetite, urinary problems and abdominal pain. These possible indicators of risk in an environment of family conflict, where employment and financial issues, step-parenting and adult mental health issues also presented, are more difficult for workers to identify.

11.4.3 Parents and carers of children are ultimately responsible for safeguarding children's welfare. Professionals can only act on information provided to them in order to form a basis for assessing and analysing risk, and providing intervention. This also includes the client and family members sharing information with key professionals – for example, where there are any concerns regarding attitudes or behaviour towards children. Therefore working together is crucial in safeguarding children.

11.5 Contributory Factors relating to Care/Service Delivery Issues

11.5.1 Referrals to specialist mental health services were made in isolation resulting in a lack of a systematic approach in primary care.

11.5.2 The letter of complaint to NPMH was not responded to via an official organisational process.

11.5.3 Limited assessment in primary care of the risk to children within the household of an adult with mental health difficulties (albeit these were deemed to be low risk).

11.5.4 Primary care services do not generally have systems in place to follow up persistent DNAs (this is reasonable where there is low risk).

11.6 Patient Factors

11.6.1 MJ exhibited seemingly low level mental health difficulties and was assessed as low risk **(Root Cause)**.

11.6.2 There is no evidence that children were spoken to by general practitioners.

11.6.3 Family moved GP practices several times; therefore, limited continuity of care.

11.6.4 MJ felt that the NHS had failed him and this may have contributed to his lack of engagement.

11.7 Individual Factors

11.7.1 Limited up-to-date child protection (CP) and risk assessment (RA) knowledge.

11.7.2 The NPMH seemed unfamiliar with organisational complaints procedure.

11.7.3 All practitioners have a responsibility to safeguard children but have limited resources to pursue this routinely in primary care.

11.7.4 AJ's concerns lacked detailed recording in GP notes.

11.8 Task Factors

11.8.1 No formal risk assessment tool appeared to be available to GP regarding children in the household of adults with mental health issues

11.8.2 Risk assessment guidance is not yet in widespread use across disciplines in primary care as per 11.8.1.

11.8.3 Poor processing of AJ's complaint in primary care. Filed in records and answered by telephone.

11.8.4 Child protection and risk assessment forms have a tick-box option with no justification of the decision **(Root Cause)**.

11.9 Communication Factors

11.9.1 Referrals to specialist mental health services did not mention that another family member had been referred **(Root Cause)**.

11.9.2 GP records have a limited capability to track key patient issues either for a single child or to cross reference information between children and other family members **(Root Cause)**.

11.9.3 Little evidence of clear links between key members of the primary care team in circumstances where children form part of the household where an adult with mental health issues is living.

11.10 Team and Social Factors

11.10.1 Primary care mental health services were not fully integrated within primary care, causing barriers to effective joint-working.

11.10.2 There was a poor team reaction to the handling of AJ's complaint in primary care and no documentary evidence to support whether or not discussions took place, which would have been good practice.

11.11 Education and Training Factors

11.11.1 GP(3) did not appear to have received updated risk assessment (child) or child protection training. It was unclear whether the NPMH's training was current.

11.11.2 Complaints procedure induction and training not made available to all staff, including contracted staff.

11.11.3 Poor follow-up of non-attenders on child protection training. There is a lack of availability and awareness of what child protection training different staff require.

11.11.4 Lack of child-focused supervision for staff.

11.11.5 Unclear whether any general practitioner training for child protection included the relationship between unexplained physical symptoms and potential abuse.

11.12 Working Condition Factors

11.12.1 Limited time with patients at each consultation in primary care, to make a full assessment of patient problems and needs.

11.12.2 Limited leadership for complaints handling within primary care.

11.13 Organisational and Strategic Factors

11.13.1 Whole systems functioning not a priority within primary care working practices **(Root Cause)**.

11.13.2 Safety Culture: Ineffective integration of all staff irrespective of contract or services results in isolated working practices **(Root Cause)**.

11.13.3 Lack of ability to respond organisationally to non-engagement with services **(Root Cause)**.

11.13.4 If there had been an integrated history from all members of the family, then maybe the child protection issues could have been assessed more appropriately **(Root Cause)**.

12. RECOMMENDATIONS ARISING FROM AN EXTERNAL REVIEW OF A SERIOUS INCIDENT INVOLVING AN ADULT(MJ) AND A CHILD (PS/J)

Recommendation 1	Standardised referral letters (in part) should give an assessment of risk for child(ren) more explicitly and provide key issues/risks to a secondary provider. They should also give enough information to identify where other family members have issues pertinent to child safety.
Recommendation 2	There needs to be clarity on what training staff should attend irrespective of discipline or geographical boundaries. Safeguarding children training needs to be formalised and structured across the organisation(s).
Recommendation 3	The Framework for the Assessment of Children in Need [DH 2000] is a key tool for use by all professionals attempting to safeguard children's welfare. This or any subsequent common assessment tool should be utilised by everyone working with children and their families.
Recommendation 4	A risk assessment should review both parents' or carers' backgrounds so that any pertinent information is included.
Recommendation 5	It is important that children's views and feelings should form part of any risk assessment.
Recommendation 6	Assessing risk to safeguard children's welfare should be standard and training provided for all practitioners who come into contact with families where there are children in the household.
Recommendation 7	IT systems should alert primary care practitioners when a child is within the household of an adult with mental health issues and should highlight key patient issues.
Recommendation 8	Letters received by primary care should be date-stamped on the day of arrival.
Recommendation 9	There should be induction for all staff on organisational (NHS) Complaints Procedure.
Recommendation 10	Staff working with families where safeguarding children may be an issue need time to undertake qualitative assessments, appropriate child-centred training and child-focused supervision.
Recommendation 11	Risk assessments concerning child protection issues must be detailed and fully recorded in patient records, in addition to any pro-forma that is completed.
Recommendation 12	Professionals working with families with children in primary care mental health services, should access GP records prior to the commencement of work with the client/family, so that as much information as possible is known to a practitioner from the outset.

13. CONCLUSION

13.1 The panel is of the opinion that primary care would benefit from a more robust and systematic approach to its IT systems and standards of record keeping. This investigation revealed an absence of a consistent exchange of relevant and detailed information. Improvements would facilitate effective partnership working with local agencies and a 'joined up' approach within primary care per se. If the family's integrated medical history had been available, it is possible the child protection issues could have been assessed more appropriately.

13.2 The key question which the panel has asked throughout the course of this review is whether or not the actions or omissions of any professional involved in this case had a direct bearing on the tragic outcome. The panel could not find any such explanation in the devastating sequence of events leading up to the death of either PS/J or her step-father.

EXECUTIVE SUMMARY

Introduction

MJ was a 28 year old man who had been in brief contact with primary care mental health services in December 2002 and had declined further contact. He was last seen by his GP on the 15th April 2003. He was subsequently referred to specialist mental health services on the 6th June 2003 based on concerns raised by his wife about his deteriorating behaviour. However MJ did not engage.

In the early hours of the morning (8th July 2003) AJ was attacked by her husband whilst she was asleep. She was assisted by her eldest daughter and MJ then left the house immediately after the attack. Shortly afterwards the youngest child, PS/J was found hanging in the cellar. She was taken by ambulance to the accident and emergency department, where resuscitation was initiated. Sadly the child was certified dead at 0350 hours and later that morning, MJ was found hanging at the entrance to a park.

Prior to these incidents occurring, MJ and AJ had visited their general practitioner (GP) on 20 occasions in the period 20th August 2002, when MJ first reported psychological and emotional difficulties, to 6th June 2003, when he was referred to specialist mental health services.

Nature of the Investigation

The main focus of this investigation was to review the quality and scope of all health services provided to MJ prior to the incident. The panel also scrutinised the detail of PS/J's referral to the child and adolescent mental health service (CAMHS) but noted that the family did not respond to the appointment and follow up correspondence, resulting in PS/J not being seen by this service.

A root cause analysis approach (RCA) was adopted in undertaking the investigation. The review panel was provided with an overview of the method by the National Patient Safety Agency (NPSA) and was therefore able to utilise some of the RCA tools and techniques, for which thanks are extended.

The panel considered a large and varied amount of information in order to analyse the issues concerned. Interviews were also conducted with relevant professionals and with AJ (wife and mother of the deceased parties) in the presence of her victim support worker. In addition the review panel considered a written submission from AJ in order to understand particular areas of concern and is grateful for her input to the process.

Provision of Services

MJ's psychological problems were initially managed in primary care. His general practitioner referred him to the primary care mental health service and a full assessment was undertaken but MJ declined further contact. He was subsequently referred to adult mental health services and received a timely appointment but chose not to attend.

PS/J had previously been referred to the child and adolescent mental health service but the family did not engage.

Findings and Recommendations

After considerable deliberation, the review panel finds that the level of support offered to MJ was appropriate given his presentation.

The possible risk factors identified via this review in relation to safeguarding children had presented over a period of time. For example, children's behavioural problems without medical cause, including muteness, disturbed sleep, lack of appetite, urinary problems and abdominal pain. These possible indicators of risk in an environment of family conflict, where employment and financial issues, step-parenting and adult mental health issues also presented, are more difficult for workers to identify.

Parents and carers of children are ultimately responsible for safeguarding children's welfare and professionals can only act on the information provided to them in order to form a basis for assessing and analysing risk, and providing intervention. This also includes the client and family members sharing information with key professionals where there are any concerns regarding attitudes or behaviour towards children.

The panel finds that the GP strived to help members of the family and made appropriate referrals to specialist mental health services. However these referrals were made in isolation and therefore the adult mental health service was unaware that a child of the family had previously been referred. Although this would not have affected the outcome of either referral as there was no engagement with services, it does emphasise the importance of effective communication and integrated working practices.

Therefore whilst the panel has identified some examples of good practice, we are of the opinion that there are specific areas for improvement and a number of concerns regarding the need to develop more robust systems in primary care.

The recommendations of the panel are:

1. Standardised referral letters (in part) should give an assessment of risk for child(ren) more explicitly and provide key issues/ risks to a secondary provider. They should also give enough information to identify where other family members have issues pertinent to child safety.
2. There needs to be clarity on what training staff should attend, irrespective of discipline or geographical boundaries. Safeguarding children training needs to be formalised and structured across the organisation(s).
3. The Framework for the Assessment of Children in Need [DH 2000] is a key tool for use by all professionals attempting to safeguard children's welfare. This or any subsequent common assessment tool should be utilised by everyone working with children and their families.
4. A risk assessment should review both parents' or carers' backgrounds so that any pertinent information is included.
5. It is important that children's views and feelings should be listened to as part of any risk assessment.
6. Assessing risk to safeguard children's welfare should be standard and training provided for all practitioners who come into contact with families where there are children in the household.
7. IT systems should alert primary care practitioners when a child is within the household of an adult with mental health issues and should highlight key patient issues.
8. Letters received by primary care should be date-stamped on the day of arrival.
9. There should be induction for all staff on organisational (NHS) complaints procedure.
10. Staff working with families where safeguarding children may be an issue need time to undertake qualitative assessments, appropriate child-centred training and child-focused supervision.
11. Risk assessments concerning child protection issues must be detailed and fully recorded in patient records, in addition to any pro-forma that is completed.
12. Professionals working with families with children in primary care mental health services, should access GP records prior to the commencement of work with the client/family, so that as much information as possible is known to the practitioner from the outset.

Conclusion

Throughout his contact with the GP, MJ had no signs or symptoms of serious mental illness or personality disorder but was exhibiting symptoms of low mood.

Whilst the review panel concludes that there were no actions that might have been taken by health professionals, that could have changed the course of these tragic events, and that the risk of harm to others was unpredictable, there are distinct areas that should be improved upon, as outlined in the recommendations of this report.

APPENDIX 1

1. TERMS OF REFERENCE FOR EXTERNAL REVIEW:

PS/J's referral to Child & Adolescent Mental Health Services, prior to being found dead in suspicious circumstances on the 8th July 2003.

MJ's referral and contact with Adult Mental Health Services, prior to his suicide on the 8th July 2003.

1.1 The details of GP referrals to Adult Mental Health Services and Child and Adolescent Mental Health Services.

1.2 The quality and scope of all health services' contact with MJ prior to the incidents on the 8th July 2003, including consideration of family history and any psychiatric history.

1.3 The availability of local and specialist services to meet both individuals' assessed heath and social care needs.

1.4 The extent to which care and support corresponded with statutory obligations, relevant Department of Health guidance and operational policies and procedures. This should include a review of the professional judgements made and what indicators were used to assess risk, what protocols were in place for risk assessment and how they were used and documented.

1.5 To examine the adequacy of the collaboration and communication between the professional groups involved.

1.6 To review the availability of child protection training for staff working in a healthcare setting.

1.7 To adopt an analytical approach to the external review and make recommendations where appropriate to Trent Strategic Health Authority.

1.8 To ensure the report is made available to the Chief Executive of the mental health services Trust concerned.

1.9 To ensure the report is made available to the Chief Executive of the relevant Primary Care Trust (PCT) responsible for the primary care service providing care and the Chief Executive of the lead commissioning PCT.

1.10 To ensure that any lessons learnt from the report are shared with other mental health trusts and primary care trusts, that any implications of the report are considered within a fixed time-frame and that the Strategic Health Authority (Trent) is asked to review progress against any action planning deemed to be appropriate.

2. MEMBERSHIP OF THE PANEL:

2.1 The review Panel consisted of the following individuals:

Kay Darby (Chair)	Associate Director, Specialist Mental Health Services, Leicester, now Director of Nursing and Service Design, Lincolnshire Partnership Trust
Dr Andy Clayton	Medical Director, Derbyshire Mental Health Services
Christine Durance	Independent Nurse Consultant (special interest in Vulnerable Children & Child Protection Issues)
Tim Watts	Assistant Director, Social Services, Leicestershire
Elaine Read	Panel Co-ordinator & Project Manager
Pauline Mace & Ian Pegg	Panel Administrators

APPENDIX 2

KEY SOURCES ACCESSED BY THE PANEL:

This section of the report describes the background documentation reviewed, interviews conducted and relevant literature studied within the context of the clinical care delivered:

1. Mental Health Services Trust Policies & Procedures:
   - Policy & Procedure for Do Not Attends (DNAs)/Cancellations
   - Policy for the Management of Patients who fail to engage with Services
   - Policy for Safeguarding Children

2. The following information was provided to the Panel with permission of H.M. Coroner's Office:
   - Transcripts of Coroner's Inquests
   - Statements/reports provided to the Coroner
   - Post-mortem reports

3. Area Child Protection Committee letter to Mental Health Services Trust – notification of serious case review December 2003.

4. Executive Summary of ACPC Overview Report concerning the Death of a Child – March 2004

5. Health Internal Review Conducted by Named Doctor Child Protection and Named Nurse Child Protection, Primary Care Trust – 2003

6. Child Protection Training Records – Mental Health Services Trust

7. Mental Health Services Trust Records relating to MJ including:
   - Risk Assessments
   - Correspondence
   - NPMH Records

8. Mental Health Services Trust Records consisting of correspondence relating to PS/J (19th November 2002 to 28th February 2003) – family did not engage.

9. MJ and PS/J's GP records

10. Written submission - AJ's Story

11. Tabular Timeline from November 1994 to July 2003

12. The Panel conducted interviews on the 4th May 2005 and the 28th June 2005 with the following staff:
    - PSW CAMHS, Psychiatric Social Worker
    - NPMH Primary Care, Nurse Practitioner Mental Health
    - TL, DPM, ex-Team Leader, Department Of Psychological Medicine, Mental Health Services Trust
    - GP(3), General Practitioner for family
    - SCPLN, Senior Child Protection Lead Nurse, Mental Health Services Trust

TABULAR TIMELINE OF EVENTS - CHRONOLOGY

Date & Time	07/11/94
Name of Subject	MJ
Event	Attends GP(1) appointment
Supplementary Information	Mood swings, aggression and drug abuse. Army discharged MJ in June.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	21/11/94
Name of Subject	MJ
Event	Failure to attend drug addiction clinic in Kent
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	May 1999
Name of Subject	MJ
Event	MJ joins the household
Supplementary Information	AJ met MJ whilst working at a local newsagents. After a short time in their relationship, AJ, PS/J and sibling (L) moved in with MJ.
Source of Information	ACPC
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	25/8/99
Name of Subject	LJ
Event	LJ mute
Supplementary Information	LJ thereafter has urine problems, abdominal pain
Source of Information	ACPC report
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	10/10/99
Name of Subject	PS/J
Event	Pre-arranged visit – no access
Supplementary Information	No evidence from records of any health concerns
Source of Information	HV Records
C/SDP (Issue)	Routine surveillance was not pursued
Contributory Factors	
Notable Practice	

January 2000 MJ, AJ, LJ and PS/J move to Kent to avoid problems with PS/J's father LS.

Date & Time	24/01/00
Name of Subject	PS/J
Event	Attended GP(2) surgery with a one week history of diarrhoea
Supplementary Information	Child fit and well. Registered with new GP(2) Canterbury, Kent. AJ, MJ, LJ & PS moved to Hailsham, Kent to avoid all the problems with LS (PS/J's father).
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	26/01/00
Name of Subject	PS/J
Event	Further attendance re: diarrhoea. GP(2)
Supplementary Information	Reassured
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

The family moved near Sheffield in 2001. (Not clear whether this was everyone). By May 2001 PS/J was registered with GP in Nottinghamshire.

Date & Time	26/05/01
Name of Subject	PS/J
Event	Registered with GP(3) practice in Notts
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	29/05/01
Name of Subject	PS/J
Event	Standard letter sent for PS/J to attend routine growth and development review
Supplementary Information	No evidence of any response from parents. These records do not show any indication that PS/J has moved out of Nottingham previously.
Source of Information	HV Records
C/SDP (Issue)	No follow-up of routine growth and development review
Contributory Factors	
Notable Practice	

Date & Time	21/06/01
Name of Subject	MJ
Event	Attended GP(3) surgery complaining of pain in joints. GP(3) diagnosed repetitive strain injury.
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	15/08/01
Name of Subject	PS/J
Event	Correspondence to AJ arranging an appointment for PS/J to be seen by CAMHS in December 2002.
Supplementary Information	Source of appointment request unclear and year inconsistent.
Source of Information	ACPC Report
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	17/08/01
Name of Subject	PS/J
Event	Attended GP(3) surgery with history of temperature x 2 days.
Supplementary Information	Reassured, as well hydrated and no evidence of meningism.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	17/08/01
Name of Subject	PS/J
Event	Re-attended GP(3)surgery - worse
Supplementary Information	Fever increased, not drinking. Child admitted to hospital. Presumably attended later in the day as no time noted in the records.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	31/08/01
Name of Subject	PS/J
Event	Correspondence from hospital in Nottingham following admission for viral infection.
Supplementary Information	Settled quickly, weight on discharge noted as 16.3kg.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	27/09/01
Name of Subject	PS/J
Event	Pre-school booster
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	06/12/01
Name of Subject	PS/J
Event	Attended GP(3) surgery, seen by practice nurse for second MMR vaccinations
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	23/01/02
Name of Subject	MJ
Event	Attended GP(3) surgery for treatment of wart on right index finger
Supplementary Information	
Source of Information	GP Records, ACPC Report/Chronology
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	26/02/02
Name of Subject	PS/J
Event	DNA entrant health review
Supplementary Information	
Source of Information	School health
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	15/05/02
Name of Subject	PS/J
Event	Health questionnaire returned by mother (AJ)
Supplementary Information	No concerns identified
Source of Information	School health
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	22/05/02
Name of Subject	PS/J
Event	Entrant health review
Supplementary Information	Hearing test normal
Source of Information	School health
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/08/02
Name of Subject	MJ
Event	Discharge letter from A & E following injury to index finger
Supplementary Information	Referral to GP(3) quite limited. Criteria limited
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	20/08/02
Name of Subject	MJ
Event	Attended GP(3) surgery after failing to turn up at work
Supplementary Information	Absent without leave from work. MJ drove to Kent to his "Nan's" due to the pressure at work. Emotional problems with work and step-children, and their relevant fathers. could not remember driving away from home with this intention, just arriving there. Said to be finding work difficult – driving to where he was brought up. GP records state clearly that MJ should not be at work, plan to be seen next week
Source of Information	GP Records and AJ's Story Document
C/SDP (Issue)	Inadequate assessment of risk to children in household when an adult presents with mental health issues
Contributory Factors	See 'fishbone' diagram
Notable Practice	

MJ and AJ experiencing severe financial pressures, MJ was also having difficulties at work. AJ reported to GP(3) that he was obsessed about the 'Soham Murders' whereby two children had been abducted and murdered in July 2002; in particular his step-daughters' safety.

Date & Time	27/08/02
Name of Subject	MJ
Event	Attended GP(3) Surgery.
Supplementary Information	Much the same, diagnosed with stress. Certificate for one week.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	03/09/02
Name of Subject	MJ
Event	Attended GP(3) Surgery.
Supplementary Information	No change, now looking for alternative work. Decision to refer to NPMH and provide further sick note. Letter to NPMH briefly outlines the problem, including MJ's difficulty in dealing with step-children's fathers and controlling his anger in these situations.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	04/09/02
Name of Subject	MJ
Event	Referral letter from GP(3) to NPMH for stress management. Further sick note provided to MJ.
Supplementary Information	Issues around anger management. No risk assessment of this in relation to children in the household. In referral letter but not in GP records, therefore poor record keeping.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	04/09/02
Name of Subject	MJ
Event	Referral letter to NPMH from GP(3)
Supplementary Information	Problems at home and work. Also with the fathers of his step-children, resulting in difficulty controlling his anger. Handwritten note on referral "review 19/02/02" – letter sent 30/09/02. No evidence of any questions asked regarding impact of MJ's anger on the children in the household.
Source of Information	NPMH Records – Mental Health Services Trust
C/SDP (Issue)	See 'fishbone' diagram
Contributory Factors	
Notable Practice	Prompt referral

Date & Time	09/09/02
Name of Subject	AJ
Event	Informs GP(3) that MJ is having a "breakdown".
Supplementary Information	
Source of Information	ACPC Report/Chronology
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	17/09/02
Name of Subject	MJ
Event	Attended GP(3) surgery
Supplementary Information	Complaining of stress, a further sick note issued
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	24/09/02
Name of Subject	MJ
Event	Attended GP(3) surgery
Supplementary Information	Now back at work and has sorted out problems there but needs to deal with sleep problems. Further discussion but no comment made as to the content of this conversation. Had approximately 5 weeks off work
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	05/11/02
Name of Subject	MJ
Event	Attended GP(3) surgery complaining of bouts of depression and mood swings.
Supplementary Information	Described work as "ok" but home being the problem. Has an appointment with NPMH in December but feels unable to be cheered up. Mostly feels depressed, sleep poor, appetite and libido was noted to be down. GP(3) prescribed anti-depressant.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	05/11/02
Name of Subject	MJ
Event	Attended GP(3) surgery, seen by the practice nurse having cut his left hand on metal at work.
Supplementary Information	Tetanus status was checked and found to be up to date
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/11/02
Name of Subject	PS/J
Event	Attended GP(3) surgery. PS/J was not eating and complaining of pain in her stomach x 2 weeks.
Supplementary Information	Further note stating PS/J's sleep was disturbed, home was very stressful. Step-father was on anti-depressants. PS/J weighed 18kg. Abdomen was soft on examination. Prescribed Ranitidine
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	12/11/02
Name of Subject	PS/J
Event	Normal urine test
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	18/11/02
Name of Subject	MJ
Event	Attended GP(3) surgery, seen by practice nurse and wound re-dressed
Supplementary Information	No sign of infection
Source of Information	GP notes record 18/11/02 as above. ACPC report inconsistent (8/11/02).
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	18/11/02
Name of Subject	PS/J
Event	Further attendance at GP(3) surgery regarding stomach pain. Referred to CAMHS
Supplementary Information	
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	19/11/02
Name of Subject	PS/J
Event	Referral letter from GP(3) to CAMHS
Supplementary Information	PS/J has behavioural problems – disturbed sleep, lack of appetite and abdominal pain. History of family stresses noted. Step-father suffering from a crisis of confidence related to step-children and their biological fathers. Also noted in the GP(3)'s referral letter that it was apparent that the two parents were handling the situation differently and GP(3) encouraged consistency. 10 weeks afterwards, GP(3) referred step-father (MJ) to NPMH for anger management.
Source of Information	GP Records (referral letter), HV Records, Mental Health Services -Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	22/11/02
Name of Subject	MJ
Event	Attended GP(3) Surgery
Supplementary Information	Noted to have no side effect from fluoxetine but also no improvement in mood, although sleep was noted to be slightly better. MJ suspended from work.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

MJ had attended the GP surgery on 9 occasions since 20th August 2002.

Date & Time	04/12/02
Name of Subject	PS/J
Event	CAMHS appointment letter addressed to AJ inviting both parents to attend with PS/J. Date of appointment was for 17.12.02 with CAMHS Psychiatric Social Worker.
Supplementary Information	
Source of Information	Mental Health Services -Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	Between 13/12/02 and 14/02/03 – cannot confirm date
Name of Subject	AJ
Event	Letter of complaint
Supplementary Information	Letter addressed to NPMH. Some confusion regarding how this was received in primary care and how letter was transferred to practitioner. It appears that the NPMH telephoned AJ to discuss contents directly (one message left and then conversation with Mr & Mrs J).
Source of Information	HV Records (hospital letter)
C/SDP (Issue)	Letter not processed under NHS Complaints Procedure.
Contributory Factors	See 'fishbone' diagram
Notable Practice	NPMH did respond to letter of complaint by telephone

Date & Time	13/12/02
Name of Subject	MJ
Event	NPMH assessment
Supplementary Information	Good history taken. Impression of reactive depression caused by work problems and home life. Noted MJ is on Prozac (fluoxetine) 20mg. Plan to continue Prozac, anger management 'one to one' and write to GP(3). Assessment made of risks to children, no risks identified. Genogram included in the records. Previous suicidal thoughts noted when in the army and when off work. No suicidal intent of plans at assessment. This is the only face to face contact with MJ.
Source of Information	NPMH Records - Mental Health Services Trust
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	17/12/02
Name of Subject	PS/J
Event	Family DNA CAMHS appointment
Supplementary Information	
Source of Information	HV Records (hospital letter)
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	20/12/02
Name of Subject	MJ
Event	Attended GP(3) Surgery
Supplementary Information	Noted that work problems were now completely resolved. Sleep remained a major problem. GP(3) changed anti-depressant medication
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	23/12/02
Name of Subject	PS/J
Event	Letter to AJ from CAMHS Psychiatric Social Worker inviting contact following DNA appointment
Supplementary Information	Letter states referral will be closed if no contact after a month
Source of Information	Mental Health Services -Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	26/12/02
Name of Subject	MJ
Event	Overdose of anti-depressants. Medical admission to hospital in Nottingham
Supplementary Information	Also consumed alcohol
Source of Information	GP Records (hospital letter)
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	31/12/02
Name of Subject	MJ
Event	Letter from DPM to NPMH and GP(3), advising of MJ's admission (26/12/02) to hospital following overdose of 26 Amitriptyline and 12 Prozac tablets.
Supplementary Information	Impression was of an impulsive overdose fuelled by alcohol, following argument with AJ. No planning or concealment – "neither wanted or expected to die". However this contradicts information provided by AJ. MJ found to be psychologically fit for discharge (low risk) and as he was already seeing NPMH, no follow-up.
Source of Information	Mental Health Services -Trust Records. ACPC report
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	06/01/03
Name of Subject	MJ
Event	Attended GP(3) – advised further time off work
Supplementary Information	.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/01/03
Name of Subject	MJ
Event	MJ attended GP(3) surgery with AJ
Supplementary Information	Described getting paranoid ideas, checking telephone calls etc. When he is bad he feels that people don't think he's worth treating. Also noted that LJ's father was violent to her mother (AJ) and on one occasion allegedly raped her. AJ left him. AJ stated MJ had 53 days in army prison for possession of amphetamines and felt LJ's father (DM) got away with what he did. GP(3) also notes that MJ had become obsessive about the two children that were murdered in Cambridgeshire the preceding summer i.e. July 2002
Source of Information	GP Records and AJ's Story document
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	13/01/03
Name of Subject	MJ
Event	Attended GP(3) Surgery
Supplementary Information	Generally much better, talking to wife more (AJ). Work "okay", seeing somebody, not clear who.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	13/01/03
Name of Subject	MJ
Event	Letter to GP(3) from NPMH summarising assessment of MJ on 13.12.02
Supplementary Information	Good history taken. Impression of reactive depression caused by work problems and home life. Noted MJ is on Prozac (fluoxetine) 20mgs. Plan to continue Prozac, anger management 'one to one' and write to GP. Assessment made of risks to children, no risks identified. Genogram included in the records
Source of Information	NPMH Records – Mental Health Services Trust
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	20/01/03
Name of Subject	MJ
Event	Attended GP(3)
Supplementary Information	Described as being less positive at the moment, to be seen in one week
Source of Information	GP Records
C/SDP (Issue)	No follow up of MJ by GP(3), next seen in April 2003
Contributory Factors	
Notable Practice	

Date & Time	14/02/03
Name of Subject	MJ
Event	Telephone call to MJ from NPMH
Supplementary Information	Message left on answer-phone inviting contact for an appointment as the last one was cancelled due to the practitioner's sickness. Offer of another appointment appears to be in response to discussions between MJ, AJ and NPMH. Record in 'plan' section of notes – "following discussions with MJ and AJ, offered joint appointment. Speak to GP".
Source of Information	NPMH Records - Mental Health Services Trust
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	17/02/03
Name of Subject	MJ
Event	Record of telephone call to MJ and AJ from NPMH
Supplementary Information	AJ expresses concern for her husband but he declines further contact. MJ angry that 'anger management' therapy needed. GP informed
Source of Information	NPMH Records - Mental Health Services Trust
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	28/02/03
Name of Subject	PS/J
Event	Letter from CAMHS stating the family failed to attend on the 17/12/02 and also failed to respond to follow up letter asking if they required a further appointment.
Supplementary Information	Case was closed
Source of Information	GP Records Mental Health Services -Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	05/03/03
Name of Subject	AJ
Event	Attended GP(3) Surgery
Supplementary Information	Husband (MJ) now accessing private counselling and improving well. AJ feels she would like to go ahead with sterilisation reversal and referral made**.**
Source of Information	ACPC Report.
C/SDP (Issue)	No record in MJ's GP notes
Contributory Factors	
Notable Practice	

Date & Time	07/03/03
Name of Subject	MJ
Event	Record of no further contact (NPMH)
Supplementary Information	Therefore discharged back to GP(3) in three months time if no contact from MJ
Source of Information	NPMH Records - Mental Health Services Trust
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	31/03/03
Name of Subject	AJ
Event	Attended GP(3) to discuss MJ's health
Supplementary Information	Husband described as going 'down hill a bit' and ceased attending counselling. Described patient as also struggling, becoming tearful with poor sleep. In addition comfort eating but no suicidal thoughts. Advised to try RELATE and prescribed a small dose of Amitryptyline 75mg and to be seen following week.
Source of Information	ACPC Report/Chronology
C/SDP (Issue)	No record of this in MJ's GP notes. MJ's DNA did not get GP(3) follow-up.
Contributory Factors	
Notable Practice	

Date & Time	15/04/03
Name of Subject	MJ
Event	Attended GP(3) Surgery
Supplementary Information	More problems at work. Had not been at work for the preceding week but had resolved family problems. Further sick note given. Seemed to have insight into own illness.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	05/06/03
Name of Subject	MJ
Event	AJ attends GP(3) appointment on MJ's behalf
Supplementary Information	MJ unable to attend because he felt let down by NHS. Wife (AJ) described him as getting worse, ranting at the 11 year old step-daughter the preceding day (04/06/03); variable mood but GP(3) notes he appears to have poor insight into his behaviour.
Source of Information	GP Records and AJ's Story document
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	06/06/03
Name of Subject	MJ
Event	GP(3) referral letter to Consultant Psychiatrist
Supplementary Information	GP(3) states MJ has depressive symptoms, paranoia and aggression. Comments he originally presented in August 2002 with stress-like symptoms precipitated by difficulties with his step-daughters' natural fathers. GP(3) documents changes of anti-depressants following overdose on 26/12/02. Development of paranoia and obsessive thoughts about the two murdered children in Cambridgeshire. GP(3) states MJ had been reluctant to attend GP surgery because he felt let down by NHS.
Source of Information	GP Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	Referral letter from GP(3) contained information over last year and makes referral based on information given by wife (AJ).

Date & Time	12/06/03
Name of Subject	MJ
Event	CMHT offers appointment with psychiatrist for 23/06/03
Supplementary Information	
Source of Information	Mental Health Services –Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	Appointment issued within 2 weeks

Date & Time	23/06/03
Name of Subject	MJ
Event	MJ fails to attend psychiatric appointment
Supplementary Information	
Source of Information	Mental Health Services -Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	03/07/03
Name of Subject	MJ
Event	GP(3) informed that MJ failed to attend psychiatric appointment
Supplementary Information	
Source of Information	Mental Health Services-Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	03/07/03
Name of Subject	MJ
Event	Letter to MJ from psychiatrist offering further contact following a DNA appointment
Supplementary Information	Invitation for MJ to contact psychiatric service to make a further appointment, stating that if did not respond by 14/07/03, he would be discharged back to GP(3)
Source of Information	GP Records Mental Health Services Trust Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	Appointment with psychiatrist issued within two weeks of referral

Date & Time	08/07/03 – early hours of the morning
Name of Subject	MJ
Event	Attacks AJ in the bedroom by attempting to strangle her, stabbing her in the arm.
Supplementary Information	LJ entered the bedroom where the attack was occurring, switched on the lights and assisted in pulling MJ off her mother; therefore stopping the attack. MJ told AJ that he had raped and killed PS/J. He took the car keys and left the house immediately after the attack on AJ.
Source of Information	AJ's Story document
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/07/03
Name of Subject	PS/J
Event	Older sister (LJ) found PS/J hanging by belt in cellar
Supplementary Information	Assumption that MJ had murdered PS/J. MJ was obsessed by the 'Blair Witch Project film (similarities between PS/J's death and the final scenes in this film).
Source of Information	Accident & Emergency Records AJ's Story document
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/07/03. 0330hrs
Name of Subject	PS/J
Event	On arrival in A & E, resuscitation initiated.
Supplementary Information	Cardio-respiratory arrest called through 'red phone'. Paediatric arrest call put out before arrival of child. History taken from paramedic crew. Ambulance crew identified no CPR in progress on arrival.
Source of Information	Accident & Emergency Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/07/03. 0350hrs
Name of Subject	PS/J
Event	Certified dead
Supplementary Information	After 3 cycles, decision made to stop resuscitation. Paediatric Consultant contacted – agreed with above decision.
Source of Information	Accident & Emergency Records
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

Date & Time	08/07/03.
Name of Subject	MJ
Event	Found hanging at the entrance to a park at approximately 1125hrs
Supplementary Information	Coroner's Verdict – 'suicide'
Source of Information	Coroner's Office. AJ's Story Document
C/SDP (Issue)	
Contributory Factors	
Notable Practice	

ANONYMISATION KEYS:

This section of the report defines the individuals and organisations involved:

Key	Designation	Department or Affiliation
MJ	Index Patient/Husband/Step-father (deceased)	Index Family
AJ	Wife and Mother of deceased parties	Index Family
LJ	AJ and DM's daughter	Index Family
PS/J	AJ and LS's daughter (child deceased)	Index Family
GP(1)	MJ's General Practitioner prior to meeting AJ	General Practice, primary care
GP(2)	General Practitioner when family moved to Kent	General Practice, primary care
GP(3)	General Practitioner for family on moving back to Nottinghamshire and at the time of the incidents	General Practice, primary care
NPMH	Nurse Practitioner Mental Health	Primary Care Mental Health Services
DPM	Team Leader DPM - undertook assessment of MJ	Department of Psychological Medicine
PSW	Psychiatric Social Worker	Child & Adolescent Mental Health Services (CAMHS)
CMHT	Consultant Psychiatrist	Community Mental Health Team, Adult Mental Health Services
HV	Health Visitor	Primary Care
SCPLN	Mental Health Services Trust	Senior Child Protection Lead Nurse

The National Patient Safety Agency root cause analysis (RCA) Contributory factor classification framework

Individual Factors

Individual Factors	Components
Physical issues	❑ General Health (e.g. nutrition, diet, exercise, fitness) ❑ Physical disability (e.g. eyesight problems, dyslexia) ❑ Fatigue
Psychological Issues	❑ Stress (e.g. distraction / preoccupation) ❑ Specific mental health illness (e.g. Depression) ❑ Mental impairment (e.g. illness, drugs, alcohol, pain) ❑ Motivation (e.g. boredom, complacency, low job satisfaction) ❑ Cognitive factors (e.g. attention deficit, distraction, preoccupation, overload and boredom)
Social Domestic	❑ Domestic / lifestyle problems
Personality Issues	❑ Low self confidence / over confidence ❑ Gregarious / interactive, reclusive ❑ Risk averse / risk taker

Team and Social Factors

Team Factors	Components
Role Congruence	❑ Is there parity of understanding ❑ Are role definitions correctly understood ❑ Are roles clearly defined
Leadership	❑ Is there effective leadership – clinically ❑ Is there effective leadership – managerially ❑ Can the leader lead ❑ Are leadership responsibilities clear and understood ❑ Is the leader respected
Support and cultural factors	❑ Are there support networks for staff ❑ Team reaction to adverse events ❑ Team reaction to conflict ❑ Team reaction to newcomers ❑ Team openness

Communication Factors

Communication Factors	Components
Verbal communication	❑ Verbal commands / directions unambiguous ❑ Tone of voice and style of delivery appropriate to situation ❑ Correct use of language ❑ Made to appropriate person(s) ❑ Recognised communication channels used (e.g. head of service)
Written communication	❑ Are records easy to read ❑ Are all relevant records stored together and accessible when required ❑ Are the records complete and contemporaneous (e.g. availability of patient management plans, patient risk assessments, etc) ❑ Are memo's circulated to all members of team ❑ Are communications directed to the right people
Non verbal communication	❑ Body Language issues (closed, open, aggressive, relaxed, stern faced)

Task Factors

Task Factors	Components
Guidelines Procedures and Policies	❑ Up-to-date ❑ Available at appropriate location (e.g. accessible when needed) ❑ Understandable / useable ❑ Relevant; Clear; Unambiguous; Correct Content; Simple ❑ Outdated; Unavailable/missing; Unrealistic ❑ Adhered to / followed ❑ Appropriately targeted (e.g. aimed at right audience)
Decision making aids	❑ Availability of such aids e.g. CTG machine, risk assessment tool, fax machine to enable remote assessment of results ❑ Access to senior / specialist advice ❑ Easy access flow charts and diagrams ❑ Complete information - test results, informant history
Procedural or Task Design	❑ Do the guidelines enable one to carry out the task in a timely manner ❑ Do staff agree with the 'task/procedure design' ❑ Are the stages of the task such that each step can realistically be carried out

Education and Training Factors

Education and Training	Components
Competence	❑ Adequacy of knowledge ❑ Adequacy of skills ❑ Length of experience ❑ Quality of experience ❑ Task familiarity ❑ Testing and Assessment
Supervision	❑ Adequacy of supervision ❑ Availability of mentorship ❑ Adequacy of mentorship
Availability / accessibility	❑ On the job training ❑ Emergency Training ❑ Team training ❑ Core skills Training ❑ Refresher courses
Appropriateness	❑ Content ❑ Target audience ❑ Style of delivery ❑ Time of day provided

Equipment and Resources Factors

Equipment	Components
Displays	❑ Correct information ❑ Consistent and clear information ❑ Legible information ❑ Appropriate feedback ❑ No interference
Integrity	❑ Good working order ❑ Appropriate size ❑ Trustworthy ❑ Effective safety features ❑ Good maintenance programme
Positioning	❑ Correctly placed for use ❑ Correctly stored
Usability	❑ Clear controls ❑ User manual ❑ Familiar equipment ❑ New equipment ❑ Standardisation

Working Conditions

Work Environment Factor	Component
Administrative factors	❑ The general efficiency of administrative systems e.g. reliability ❑ Systems for requesting medical records ❑ Systems for ordering drugs ❑ Reliability of administrative support
Design of physical environment	❑ Office design: computer chairs, height of tables, anti-glare screens, security screens, panic buttons, placing of filing cabinets, storage facilities, etc. ❑ Area design: length, shape, visibility, cramped, spacious
Environment	❑ Housekeeping issues – cleanliness ❑ Temperature ❑ Lighting ❑ Noise levels
Staffing	❑ Skill mix ❑ Staff to patient ratio ❑ Workload / dependency assessment ❑ Leadership ❑ Use Temporary staff ❑ Retention of staff / staff turnover
Work load and hours of work	❑ Shift related fatigue ❑ Breaks during work hours ❑ Staff to patient ratio ❑ Extraneous tasks ❑ Social relaxation, rest and recuperation
Time	❑ Delays caused by system failure or design ❑ Time pressure

Organisational and Strategic Factors

Organisational Factor	Components
Organisational structure	❑ Hierarchical structure, not conducive to discussion, problem sharing, etc. ❑ Tight boundaries for accountability and responsibility ❑ Clinical versus the managerial model
Priorities	❑ Safety driven ❑ External assessment driven e.g. Star Ratings ❑ Financial balance focused
Externally imported risks	❑ Locum / Agency policy and usage ❑ Contractors ❑ Equipment loan ❑ PFI
Safety culture	❑ Safety / efficiency balance ❑ Rule compliance ❑ Terms and Conditions of Contracts ❑ Leadership example (e.g. visible evidence of commitment to safety) ❑ Open culture

Patient Factors

Patient Factors	Components
Clinical condition	❑ Pre-existing co-morbidity ❑ Complexity of condition ❑ Seriousness of condition ❑ Treatability
Social factors	❑ Culture / religious beliefs ❑ Life style (smoking/ drinking/ drugs/diet) ❑ Language ❑ Living accommodation (e.g. dilapidated) ❑ Support networks
Physical factors	❑ Physical state – malnourished, poor sleep pattern, etc.
Mental/ psychological factors	❑ Motivation (agenda, incentive) ❑ Stress (family pressures, financial pressures) ❑ Existing mental health disorder ❑ Trauma
Interpersonal relationships	❑ Staff to patient and patient to staff ❑ Patient to patient ❑ Inter family – siblings, parents, children

Glossary of Terms

Care Delivery Problem (CDP)

These are problems relates to direct provision of care. They arise in the process of care, usually actions or omissions by members of staff. They have two essential features a) care deviated beyond safe limits of practice b) the deviation had at least a potential direct or indirect effect on the eventual adverse outcome for the patient, member of staff or "general public" Vincent et al (1999)

Contributory Factor

Contributory Factors are those factors which affect the performance of individuals whose actions may have an effect on the delivery of safe and effective care to patients and hence the likelihood of CDPs or SDPs occurring.

Improvement Strategy

An improvement strategy is an agreed plan of action targeted at improving the health, safety and well being of the affected patient(s), the staff and the organisation with the express aim of reducing the risk of such circumstances coming together to cause harm in the future.

Recommendation

A course of action that is recommended to address the problems identified and analysed during the incident investigation.

Root Cause (RC)

The root, or fundamental issue, is the earliest point at which action could have been taken that would have stopped the incident happening. NPSA NRLS.

Root Cause Analysis (RCA)

A structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it. *Anderson B, Fagerhaug T (2000).*

Service Delivery Problem (SDP)

These are failures identified during the analysis of the incident, which are associated with the way a service is delivered and the decisions, procedures and systems that are part of the whole process of service delivery.

In addition to the above, this key identifies other abbreviations utilised within the report and in the representation of root cause analysis:

CP	Child Protection
CPA	Care Programme Approach
RA	Risk Assessment(s)
DNA	Did Not Attend
SLA	Service Level Agreement(s)
MH	Mental Health