Blackburn with Darwen NHS
Primary Care Trust

THE REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MARK HARRINGTON

Commissioned by
Blackburn with Darwen Primary Care Trust

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EXECUTIVE SUMMARY

In the autumn of 2002, Mark Harrington pleaded guilty to the manslaughter of Anthony Rigby on 7th January 2002. He was sentenced to be detained under s.37 and s.41 of the Mental Health Act 1983 because the Court found him to be suffering from a serious mental illness.

As Mark Harrington had been receiving specialist mental health care, Blackburn with Darwen Primary Care Trust commissioned an Independent Inquiry into the care and treatment which he had been receiving up to and at the time of the incident.

Before this Independent Inquiry was set up, in accordance with normal procedure following a serious untoward incident, an Internal Inquiry had been held. We have read a copy of that report (dated 5th August 2002) and note that its recommendations have been formed into an action plan. We also note that responsibility for the implementation of these recommendations has been allocated, and timescales are being set.

It has become clear to us that Mark's illness first became evident during late summer 1999 ie when he was coming up to his 17th birthday, and then became progressively worse until he was detained under the Mental Health Act about 21 months later. During that time he had so threatened his parents and sister that on a number of occasions they barricaded themselves in their rooms. He had been excluded from his sixth form college for bizarre behaviour and intimidating other students: he was wearing a suit of armour made of car mats; padding his baseball cap; washing his food before cooking it himself in his bedroom, and developing a fascination for guns, knives, and swords.

Whilst he was detained in hospital he hit a male staff nurse with a heavy plastic ball in a sock in a bid to escape from the ward; he abused the leave he was granted from the ward by using illicit drugs, and there is evidence that he did not take the medication that had been prescribed for him.

When he was discharged from hospital he stopped taking his medication altogether; he failed to keep his outpatient appointments, he displayed further violence towards his mother, and he began to live for long periods in his car. All this time he was threatening his friends and they became increasingly afraid of him.

During the 11 week interval between his discharge from Queens Park Hospital, and his killing of Anthony Rigby, Mark's care was limited to four contacts with the service. Three of them were with his care co-ordinator Mr Ellis-Dears who: saw him at home on 31st October; wrote to him on 28th November, and spoke to him on the telephone on 21st December. Mark's fourth contact with the service was on 1st November when consultant psychiatrist Dr Chattree met Mark, by chance, in the hospital car park.

In examining the care Mark Harrington received from the NHS and other agencies, we conclude that:

- the patience, consideration and strength of character displayed by Mr Finlay, the Principal of St Mary's Sixth Form College, and his staff, when dealing with Mark, was praiseworthy;

- the care provided by the GP practice was appropriate and responsive;

- the care provided by consultant psychiatrist Dr Latif and his staff in the psychiatric intensive care unit was commendable;

- the analysis and assessment consultant forensic psychiatrist Dr Plunkett carried out was commendable, but his leisurely response to the second referral was unhelpful;

- consultant psychiatrist Dr Chattree failed to appreciate the severity of Mark's mental illness and consequently did not take into account all the circumstances when considering Mark's discharge arrangements from Darwen ward, and his subsequent care in the community. Paragraphs 231 to 241 sets out the particulars of these misjudgements, oversights, and shortcomings;

- both the community mental health staff and the police service worked entirely separately from each other even though the police knew Mark had a mental illness, although they did not know how serious it was, and the CMHT knew that a) Mark had regularly assaulted his mother, b) he was believed to have a firearm and c) they had been advised to inform the police if *'there was any raised perception of increased risk to others';*

- we strongly criticise the failure of care coordinator Mr Ellis-Dears to provide a service to Mark, and the irresponsibility of community mental health team manager Lindsay Griffiths in her team management.

We make 29 recommendations for improvement – many of which we understand are already *en route* to implementation.

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BACKGROUND

1. Following the conviction of Mark Harrington for the manslaughter of Anthony Rigby, Blackburn with Darwen Primary Care NHS Trust, in accordance with HSG (94) 27[1] commissioned an Independent Inquiry to consider the care and treatment that Mark Harrington had received from the statutory agencies in accordance with the following Terms of Reference:

    - Examine and comment upon the health and social care that Mark Harrington was receiving at the time of the incident.
    - Examine and review the suitability of that care in view of Mark Harrington's history and assessed health and social care needs.
    - Determine the extent to which that health and social care corresponded with statutory obligations, relevant guidance from the Department of Health and the local operational policies of the health and social care agencies involved.
    - Consider the adequacy of the health and social care treatment plans, their implementation, monitoring and review within the context of standard four of the National Service Framework for Mental Health.
    - Consider the exercise of professional health and social care judgement by those involved in Mark Harrington's care.
    - Consider the adequacy of liaison and communication between health, social and other relevant professionals in Mark Harrington's care.
    - Make recommendations about any actions that the panel believe should be carried out by the PCT and service providers because of their findings.

2. Report by mid October 2003.

3. On 11th November 2002, Mrs Carole Rigby, (the mother of Mark Harrington's victim, Anthony Rigby), met Mr Phil Hesketh, the mental health services manager of Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust, to seek answers to a number of questions raised by the death of her son. As Mr Hesketh was not able to answer all her questions at that time, the Inquiry Panel was asked to consider the questions Mr Hesketh had been unable to answer. The questions and our answers appear as appendix A.

[1] Guidance on the discharge of mentally disordered people and their continuing care in the community.

INTRODUCTION AND SCHOOLING

4. Mark Harrington was born on 9th September 1982, the younger of two children. His sister is just over a year older. Both Mark's parents have been diagnosed as having mental health problems

5. During his childhood Mark had the normal childhood illnesses, and between October 1995 and April 1998 he had no attendances at his GP practice. However, he did fail to attend an appointment he had made on 26th April 1996 - which is about the time, we understand, he experienced his first attack of paranoia. He had been smoking cannabis with friends and noticed a pain in his nose. He wondered if he had been punched on the nose and knocked out. Subsequently he suffered from head pains which he attributed to being knocked out and having had his drinks spiked. However, he told nobody about these sensations for two years. Consequently, it was not until the summer of 1999 - when Mark was approaching his 17th birthday, that his mother first noticed a change in her son's behaviour. Various witness statements made for his trial support this timing.

SCHOOLING

6. Mark transferred from Our Lady of St John High School to St Mary's Sixth Form College in September 1999 after gaining 5B's and 5C's at GCSE. We were told this would give him a GCSE profile score of 5.5, which is regarded as very reasonable.

7. When he transferred to St Mary's Sixth Form College there was no indication from Our Lady of St John High School that his behaviour was anything other than normal. At enrolment, he was regarded as a pleasant student who seemed capable of achieving the required results.

8. However, things did not go well during his first term:

   - *in medieval history he attended on only 63 out of a possible 78 occasions - ie a rate of 81%;*
   - *in physical education he achieved an attendance rate of 74%;*
   - *in media studies he achieved a rate of 72%, and*
   - *his attendance rate for general studies was a mere 25%*

   giving an overall weighted attendance rate of 73%. The acceptable level is 95%.

9. At the end of Mark's first term at the college, Mark's tutor wrote:

   - *'I am extremely concerned about Mark's attendance, attitude and commitment towards the subject. He joined late and has failed to catch up on the work missed.*

- *'I know that Mark has had personal difficulties this year. He has got to put more effort and energy into his work if he is not to waste his time. He is an able student with little commitment and no apparent motivation. If he fails to keep his promise to put in the necessary attendance and effort next term, I will put him on report so his progress can be monitored more closely. To be successful, the change needs to come from within him.'*

10. Between Christmas 1999 and June 2000 Mark caused *'extreme concern'* to the school.[2]

11. Early in June 2000, a media studies trip to London had been arranged and Mark was expected to go on it. However, he told Mr Finlay, the Principal, that he could not go because his father had not given him any money. Mr Finlay telephoned Mrs Harrington for clarification and told us that although it was plain Mrs Harrington and Mark were arguing whilst he was on the phone, she announced that Mark would be attending after all. The Principal explained that it was too late as the coach had departed, to which she replied that Mark would make his own way there. Mr Finlay tried to discourage this as it would not be in accordance with established practices, but Mark went anyway. This caused some concern amongst the students as there was anxiety about sharing a room with him.[3]

12. On 14th June the Principal summoned Mark to discuss his attitude and general behaviour in class, but Mark upstaged that intention and announced, in a dominant and non-stop fashion, that he wanted to drop physical education and take design technology. It was explained to him that was not possible because not only had he not done any preparatory work, but also the following year's timetable could not accommodate it. Mark insisted that he was capable and pointed out how good he was at design technology because of the work he had done at his previous school.[4]

13. Two weeks later another meeting was held by the Principal to discuss Mark's attitude and general behaviour in class. This time his mother accompanied Mark. However, this meeting was inconclusive so they met again on Friday 7th July. The Principal told them that both staff and students were concerned about his intimidating behaviour, unco-operative attitude, punctuality, attendance, and work rate. It was emphasised that he had broken his learning agreements and the situation could not

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[2] From Dr Butterworth's notes of his telephone conversation with the school principal.

[3] Mark told us that it was on this occasion that he first thought he had to kill somebody. He did not go on the media trip, he said, because he had crashed his car and his father refused to allow him to go. So after his father went to work his mother gave him the train fare. When he joined his class group '*they went to watch a show called My Family and for some reason* (when) *everybody walked in, one of the stewards said." where's Mark Harrington?" I said, "that's me" and they sat me separate from everybody else. I didn't know why. About half way through the film, a guy said, "Where's Mark Harrington?" and then said, "Do you want to work for the BBC?" Just out of the blue. I said, "doing what?" and he just shrugged his shoulders. I thought it was a bit strange and I said, "I have got my A levels to think about". I was asking the teachers on the way back, but they were more bothered about getting the right train on the tube, and every time I spoke about it afterwards, nobody seemed to know about it. . . . I thought something was going on, a conspiracy. I think I heard someone say kill someone but I was just shrugging it off'*.

[4] He claimed he had been awarded an A at GCSE, but in fact he got a B.

be allowed to continue. Mark would not discuss these issues. He was insistent that his application to study design technology must be re-considered and when his mother spoke, he first interrupted her, then shouted at her and finally argued with her. As his behaviour was uncharacteristic, the Principal asked him whether he was taking any illegal substances. He denied that he was at the time but admitted that he had taken them in the past. The meeting ended with an agreement that Mark could return to college provided he attended all classes, went to all his tutor sessions, his behaviour was appropriate, he stopped intimidating behaviour, and he saw the Principal or his Deputy every day.

14. No sooner had the autumn 2000 term started than more problems emerged. Mark had not done any of the work that had been set for him in June and July. During the first two weeks, he attended just one of seven media studies classes, two of seven medieval history classes, three of seven PE sessions and one of seven tutorials, giving an overall attendance rate of only 25%. In a history points test he got just three out of 20. Moreover, his *'intimidating'* behaviour had re-appeared.[5]

15. Over the next few days it is recorded that Mark:

    - made sinister remarks to his history teacher;
    - was disruptive in media studies, and refused to leave class when asked;
    - was found sitting in the centre of the assembly hall when it was empty;
    - was found standing in the darkened sports hall in his socks whilst his shoes were on top of the ladder of a climbing wall. When asked by the teacher what he was doing and why his shoes were there, he said that it was so that no one would steal them. Then, when told by his tutor and PE teacher to go to class, he ran off.

16. These occurrences led to another meeting between the Principal and Mrs Harrington, which was held on the morning of Saturday 9th September.[6] Mrs Harrington announced she was trying to obtain medical support for Mark as she recalled that Mr Finlay had said in the summer that he would not allow Mark back to college until he had some kind of medical help, but although Mark was reluctant to see a doctor Mrs Harrington insisted on it. She mentioned his previous use of cannabis and that she had been told this could lead to paranoia. She added that Mark would probably not attend on the following Monday, to which Mr Finlay replied that he did not want him in college at all as he thought he could be a danger to himself and others. Mrs Harrington agreed and said she would keep him away and keep the college informed of any developments in his medical treatment.

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5 Mr Finlay described the intimidating behaviour as '*staring at people. Not responding when asked by the teacher and at times making gestures to other students which they felt were intimidating*'.

6 Mark's 18th birthday.

17. The week commencing Monday 11th September 2000 was hectic for the college, with somebody from the Harrington family turning up and demanding an interview on four of the five weekdays.

18. On the Monday Mark and Mrs Harrington arrived at the college requesting an interview. Mr Finlay explained once again about Mark's unacceptable behaviour and absence from class and advised that he should seek medical help as agreed with his mother. Mark then spoke non-stop for a number of minutes, thus disrupting Mr Finlay's briefing commitment, and he produced a recording device which he refused to turn off. Mr Finlay concluded the meeting at 8.48 by escorting Mark off the premises. However, he learned later that morning that Mark had returned. The Deputy Principal found him talking to some students and recorded in his notes that he had *'spoken to Mark who at one point became excited and shouted at me. I explained that he was not going about things in the proper manner and asked him to go home. I also told him a letter would be sent to him, and Mr Finlay would agree to work being sent to his house. Eventually he calmed down and agreed to go home'*.

19. On the Wednesday, Mark and both his parents demanded to see the Principal. We were told the meeting started at 4.15pm with the news that Mark had been cut with a glass in a brawl outside a pub the previous evening, and that the alleged perpetrator was a member of the college. Mark acknowledged he had been fighting with a boy who he subsequently kicked whilst he was on the ground. Two minutes later Mark began talking and spoke non-stop despite frequent attempts by his mother and father to intervene. He discoursed at length about his poor attendance, his lack of achievement and his disruptive behaviour. He gave countless excuses, denied intimidation but then became domineering and intimidating to his parents. On several occasions Mark was shouted at by his parents, especially his mother, but he refused to listen to any comments from them or to allow them to enter the discussion. His mother became very exasperated and started shouting and several times stood up to leave the room but returned. Father was more restrained and sat there listening. It was clear that Mark's paranoia was becoming stronger as he referred to people following him down corridors, how he always had to be on the alert to avoid being attacked, and his belief that he had had special training to deal with this sort of incident. He spoke of an occasion when he was lying on his bed, face down, when he felt pressure on his back and thought that someone had poured liquid into his ear. His mother told him he was dreaming but he insisted it had taken place, and his mother was involved, even though the window and door were locked.

20. He was also concerned about the conspiracies involving him, the department of education, the police and his mother. This was when the Principal first learned that Mark padlocked his room at home to keep out intruders.

21. After 45 minutes, Mr Finlay interjected and asked Mr Harrington the purpose of the visit[7] Mr Harrington had just begun his reply when Mark interrupted and continued talking for a further 35 minutes. Mr Finlay concluded the meeting at 5.40pm and asked Mr Harrington to remain behind and Mrs Harrington to take Mark home.

22. Mark and Mrs Harrington left the room but could be heard talking in the corridor. Mr Harrington agreed with the Principal that Mark should have medical help, that he would not attend college, and he and his wife would try to support him in whatever way they could. His father said he was very concerned about his apparent paranoid behaviour. He reiterated what Mark had said: that he felt threatened in any situation and explained that Mark used to walk along the corridors and look in the windows of the doors to see the reflection of people walking behind him in case they attacked him. Mr Harrington left at 6pm. The meeting had lasted an hour and three quarters.

23. At 8.45am on Thursday Mark appeared at the college and demanded a letter explaining why he was not allowed to attend college because he was now 18 years old and not therefore dependent upon his parents. Mr Finlay agreed to give him a letter if he returned at 5.30pm. He returned at 5pm to pick it up. The letter said that he should not attend college in future and he would be given support at home in two subjects: media studies and medieval history.

24. On Friday the head of leisure, tourism and PE found Mark in the sports hall reception area. He was asked to leave the premises but he said that he had been given permission to collect notes for PE, which was untrue. At 8.45am the Deputy Principal found him in reception and took him in to see Mr Finlay. Mark was again informed that he had broken the agreement, but nevertheless the notes would be sent home to him. He then left the college.

25. On Monday 18th September Mrs Harrington requested a meeting with the Principal to query a low media studies mark. She also asked for current notes for medieval history and for the PE notes, in the hope that Mark could take the examination as an external candidate. Mr Finlay explained that would not be possible as there were several pieces of practical work that he had not completed.

26. The support that was provided for Mark involved the Deputy Principal going to Mark's house every Friday to deliver: marked work (in media studies and medieval history) from two weeks previously; set work for the following week, and to pick up the previous week's work. This arrangement provided constant support and weekly contact. However, the work had not always been done, and Mark was sometimes not at home when the Deputy Principal called. This arrangement continued for

7 Throughout this report, the subject is referred to as Mark Harrington, his sister as Linda Harrington, and his parents as Mr and Mrs Harrington.

some time, but it soon became apparent that Mark would need additional tuition, so it was proposed that he came into college after the normal working day. However, the two teachers involved were most unhappy about this arrangement until the Principal agreed to sit in the lessons with them.

27. Mark's attendance at these sessions was also intermittent, but notwithstanding this, he was allowed to take the examinations. In spite of this concession, he was absent for the general studies papers on 23rd and 24th May 2001, but he sat the medieval history papers on 7th and 11th June (for which he was awarded an unclassified result), and the media studies papers on 25th and 27th June (for which he was awarded an E grade pass).

THE CARE AND TREATMENT PROVIDED BY THE NHS

28. The borough of Blackburn with Darwen had a population of 137,470 at the 2001 census.

29. The Blackburn general medical practice with which the Harrington family was registered comprised five general practitioners (four whole time equivalent) with whom about 8,000 people were registered.

30. During his childhood Mark Harrington had no unusual illnesses, and between October 1995 and April 1998 he had no attendances at the GP practice (although he did have an appointment for 26th April 1996 that he did not attend - referred to in paragraph 5).

A&E ATTENDANCES

31 Mark attended the A&E department 13 times between June 1992 and September 2000. Three of the injuries resulted from playing football, two were lacerations, two were from falls, one was from a splinter and one was a sprain.[8]

32 In the summer of 1998 the nature of the injuries changed. It appeared that Mark was becoming involved in assaults. In July 1998 he attended A&E with a parent at 10.45pm with an injury to the index finger of his right hand. Just over a year later he was brought in *'by others'* in mid afternoon with an injury to his left arm and the right side of his face. Seven months later he attended following an alleged assault to the left side of his face. He re-attended six days later complaining of a slight decrease of vision on his left side. He was booked for review three days later but in fact arrived three days after that - on 12th June - complaining that his cheekbone felt pushed in and there was a lump below it. When reassured by the specialist registrar that there was nothing to be concerned about, Mark became quite agitated as he felt that there was a fracture and that he had been disfigured by it. He would not accept the doctor's explanation that it was probably a periosteal[9] reaction.

33. His last attendance was the most serious: he arrived in an ambulance at 11.30pm on Tuesday 12th September 2000 with lacerations to his face from an alleged assault, and was admitted. The discharge

[8] Further details are provided at appendix B.

[9] A dense layer of vascular connective tissue enveloping the bones except at the surfaces of the joints.

letter described him as having a deep laceration that was clean and more like an incision caused by a sharp object. It was closed under local anaesthesia.[10]

GP INVOLVEMENT

34. Two weeks before this incident, on Wednesday 30th August 2000, GP Dr Yates saw Mr Harrington, Mark's father, who told her of his concerns about Mark because not only had Mark tried to buy an air gun which resulted in him (Mr Harrington) receiving a telephone call from the shop owner asking whether he agreed with this purchase,[11] but Mark was also:

   - becoming aggressive and paranoid;
   - cleaning and washing bacon from sealed packs before he cooked it;
   - padlocking the door to his bedroom, and
   - smoking *'lots of cannabis'* in his room.

35. He requested an urgent appointment for Mark to be seen at home on Friday 1st September if he could not get him to attend surgery before then.

36. On 1st September 2000, Dr Yates telephoned Mr Harrington to arrange the appointment to see Mark for assessment. '*We sent for the doctor because of his bizarre behaviour,'* Mrs Harrington told us. *'One of the things he had said was that . . . he had been raped. He had been smoking pot,* (and he was) *obsessed with his food. Dr Yates didn't come; we put her off a bit. She wanted to come straight away (but) we thought he might get carted off immediately. I just didn't want a whole life in hospital for Mark. I was scared. I know in the back of my mind that there are pre-dispositions to things and they can start when you are 18 and I knew he was approaching 18. I was seeing this behaviour and hoping to settle him down.'*

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10 Mark told a consultant psychiatrist (who interviewed him 21 months later), that he was drinking with friends at the Dog Inn. A man (who he knew from his sixth form college) came to him and said he had been threatening his mate. Mark denied the accusation but the man repeated it and added that he believed Mark had also threatened to slit his friend's throat. Mark suggested they went outside to talk about it. They did this and he again reiterated that he had not threatened his friend but the man got him in a headlock. After Mark managed to free himself the man tried to punch Mark but Mark retaliated and his assailant fell to the ground. As he was getting up, Mark felt something hit him on the neck. It then became apparent that he had been 'glassed'. The attacker was subsequently imprisoned.

11 He replied that he was not at all happy with the idea, but see paragraph 48.

37. On Saturday 2nd September Mr Harrington telephoned Dr Yates and said he was fairly happy to leave things as they were at present, as Mark seemed better now that he was back at college. It was agreed that the family would contact the practice if they had any further concerns.

38. It was early in September 2000 that Mark began to wear 'body armour' under his clothes. At first, it was made of cardboard tied together with string and then he used old car mats. At one time he was wearing a (construction-site type) hard hat disguised by a large cotton hat and by turning up his collar, but later changed to using folded paper under his baseball cap. He also acquired a 10-inch serrated-edge hunting knife.

MARK IS ATTACKED

39. On Friday 15th September 2000 Mr Harrington spoke to GP Dr Ashe to tell him that Mark had been involved in a fight three days earlier and he had been 'glassed' in the face (it was in fact in the neck). The police had been involved – it was they who recorded *'he wears a car foot mat which he has shaped like a body armour and that he is one to look out for'*. Dr Ashe indicated that he was willing to see Mark but as Mark did not want to leave home for fear of another attack, a home visit was arranged for Monday 18th September. However, on Saturday 16th September, one of Mark's parents telephoned the surgery to express his/her concern about Mark's behaviour. He/she explained to Dr Rosbottom that Mark had been excluded from college because of his '*intimidating'* manner.[12] He had said that he had few friends and he felt that was because people were jealous of him and they wanted him dead. As a result of this conversation, Dr Rosbottom visited Mark at home on the Saturday morning and interviewed him. It was her impression that there was no evidence of psychosis at that time, but advised that the family should remain watchful.

40. On 21st September 2000 the sutures that had been inserted on account of his injury nine days earlier were removed by GP Dr Buckley. He noted that Mark seemed to be *'mentally okay'*.

41. Mr Harrington described to us 'the pressures of living with Mark' during the autumn of 2000, and admitted he was afraid of him at that time. During this period, Mark had started writing 'stories of things that had happened' and drawing pictures on his bedroom wall. Then he painted some words, in quite large red letters, on the wall underneath his bedroom window, which faced the main road. Nobody seems to be able to remember exactly what he painted but it could have been: *i. sly injected with heroin; ii. heroin, sly but evil; iii. sly but fatal heroin, or iv. sly but fatal.*

12 Paragraphs 13 and 98 refer.

42. Mark told us that he was feeling that people were getting at him all the time, trying to knock him out so this was a warning to them '*which meant keep off, leave me alone or it will be fatal for you*'.

43. His mother had the front of the house re-painted two or three days after the words appeared.

44. As CPN Heather Crook was due to see Mark's mother, Mrs Harrington, on Monday 9th October, on 4th October GP Dr Yates telephoned her to ask her to discuss Mark with Mrs Harrington, but there is no further reference to this suggestion in Mrs Harrington's medical notes. CPN Crook told us she could not recall the conversation.

45. On Friday 6th October 2000, GP Dr Buckley saw Mark in surgery. He recognised that Mark had paranoid ideas about college and there were pressures within the family, so he referred him to consultant psychiatrist Dr Chattree by telephone, explaining that although a domiciliary visit was not necessary, he would like the case to be regarded as urgent.

SPECIALIST MENTAL HEALTH CARE

46. Dr Nangia, senior house officer (SHO) to consultant psychiatrist Dr Chattree, reviewed Mark in the outpatient clinic on 26th October 2000 under the direct supervision of Dr Chattree. In her letter to the GP, Dr Nangia noted that both Mr and Mrs Harrington were known to the service. In the light of this, she felt that even though Mark had no overt psychotic symptoms or mood changes, it would be worthwhile involving the community mental health team (CMHT).

47. The referral to the CMHT resulted in approved social worker (ASW) Shirley Foster seeing Mark on 15th November. She noted that his paranoia was evident, and that he had been asked to leave college for intimidating fellow students. She wrote to this effect to SHO Dr Nangia and referred Mark to trust grade psychiatrist Dr Butterworth to be seen on 22nd November. However, Mark did not attend that appointment or the one that was made for 4th January 2001, although he did see Shirley Foster again on 20th December.

48. During November 2000, Mr Harrington bought Mark, quite legally, a 17mm air rifle, which some time later Mark, without his parents' knowledge, exchanged for a 17 mm air pistol.

49. Dr Butterworth first saw Mark on 17th January 2001 and his second meeting took place on 26th January. This time Mark's mother was present, so Dr Butterworth was able to talk to her as well. These two meetings enabled a very comprehensive assessment of Mark to be carried out, the findings of which were set out in a four page letter to Mark's GP. Dr Butterworth later summarised his

assessment in his report to the Internal Review Panel: Mark had a clear psychotic illness which required treatment. He noted that in view of Mark's difficulties it was not surprising that he found the idea of illness difficult to accept, and it was understandable that he was wary of Dr Butterworth's suggestion of medication. He also noted that Mrs Harrington was keen to play down Mark's difficulties - in fact he told us that Mrs Harrington did not accept that Mark had any kind of mental health problem - and she firmly denied that Mark had either threatened or offered any violence towards herself or her husband. There is clearly a disparity between this assertion and her husband's statement to the family GP two weeks earlier. (Paragraph 34 refers).

50. On 9th February 2001, Dr Butterworth saw Mark in clinic, but nothing seems to have emerged from that consultation. He told us that Mark used the session primarily to explore the possibility of medication and appeared to be trying to establish that Dr Butterworth was genuine and not somebody who was trying to poison him. Mark missed the next two appointments, so Dr Butterworth wrote to Mark's GP on 9th April to ask for his help in trying to engage Mark in his treatment. Dr Butterworth told us that he also kept Dr Chattree informed.

51. Between the end of April 2001 and the beginning of June 2001, Mrs Harrington called the GP out of hours service three times. The first occasion was on 28th April 2001 - the day after Mark failed for the third time to attend his appointment with Dr Butterworth. She told the duty doctor that she was very worried as Mark had been threatening her. This led to Mark being invited to attend the out of hours premises where he denied that he had any psychiatric illness and explained that he had had an argument with his parents. He was noted to be well-dressed, articulate and fully orientated. He did not express any delusional ideas and refused medication.

52. Following another telephone call, just before 2pm on 29th April 2001, the out of hours duty doctor requested a police escort to the Harrington household to assess Mark because he had threatened/assaulted Mrs Harrington that morning.[13] However, as Mrs Harrington had deferred making the call until Mark had left the premises, and because neither she nor her husband wished to pursue any formal complaint against Mark, no action was taken. After discussion with the police, Mr and Mrs Harrington were advised to contact the service if there were any further problems.

53. Dr Butterworth did not know of these developments, as he had not seen Mark since 9th February. In order to encourage Mark to return for treatment, he wrote to him on 14th May asking him to telephone so that he could obtain his permission to write to the college about his availability to do his A level examinations.

13 The out of hours service recorded she had been threatened, but the police records indicate she had been assaulted.

MARK'S FIRST ASSAULT ON HIS MOTHER

54. On 2nd June Mrs Harrington once again called the GP out of hours service. She asked for a home visit as she had been assaulted by her son. The notes of that meeting record that Mrs Harrington had a bruise on her arm where Mark had hit her, claiming after he had woken that morning, that she had hit him over the head and demanded her money. Mrs Harrington had also contacted the police. She told them '*Mark is threatening the family with violence – he's been acting strangely for a while now. He seems very paranoid. He's pushing Mr Harrington around tonight*'. However, as an appointment to see Dr Butterworth at Clarence House on 20th June for medical assessment had been arranged, the police did not visit the house.

MARK'S SECOND ASSAULT ON HIS MOTHER

55. On Tuesday 5th June 2001 Mrs Harrington contacted GP Dr Pollock after an incident whilst she and Mark were out in the family car. Dr Pollock called at the house at 4.30pm to be told by Mrs Harrington that Mark had tried to strangle her with his hands and had threatened that if she knocked him out again he would kill her. He also held her seatbelt so that she could not get out of the car, and put his hand over her mouth when she screamed. Eventually he dropped her off at home and drove off. Mrs Harrington mentioned to Dr Pollock that the court case involving Mark's attacker was coming up soon; that Mark had recently been arrested for an alleged burglary three days before, and that for the last six months Mark had been locking his bedroom door and window and cooking his own food on a camping stove in his room because he thought his father spat on it.[14]

56. Dr Pollock rang the crisis response team and asked them to visit the Harrington household after 6pm as Mark had said he wanted to go to B&Q to get a part for his car radio.[15] The team - mental health workers Ann Chapman and Paul Leach - arrived at about 6.30pm to find him repairing his car radio on the driveway.

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14 Mr Harrington had reported this to GP Dr Yates 10 months earlier. Mrs Harrington also told Dr Butterworth two weeks later, that whilst they were in the car, Mark claimed that she was doing something to him whilst he was driving. This led to him slapping her across the face. She told Dr Butterworth her purpose in telling him was so that *'we could take appropriate action when the time was right'*, ie not before the end of his exams on 27th June. Dr Butterworth discussed this incident with Dr Chattree and they decided that if she was still of the same mind, then use of the Mental Health Act did not seem appropriate at that stage. Dr Butterworth spoke to Mrs Harrington again, stressing that they were concerned about her safety and asked her to contact him again if there were any further incidents. She did so on 29th June and this was the catalyst that led to Mark's detention under s.2 of the Mental Health Act the next day.

15 The crisis response team is a jointly managed project between Blackburn, Hyndburn and Ribble Valley Health Care NHS Trust and Blackburn with Darwen Social Services. There are two teams of two people. Each of the teams has a member with a nursing background and a member who is an approved social worker. Their normal tour of duty is evenings during the week, and days at the weekend and bank holidays. They told us their role was to provide a quick assessment at a time of crisis by providing a service that is responsive to people who are experiencing mental health crises and to their carers.

57. He invited them into the house and they met both parents. He was calm and polite but nevertheless they expressed their concern following the incident that morning when he had threatened his mother in the car. He admitted he was aggressive towards his mother. He openly discussed his fear that people were going to knock him out and perhaps inject him with drugs and tamper with his food and drink, and that he would not be able to do anything about it. He thought that a friend had injected him with heroin on one occasion because he had a red spot which kept appearing on the back of his hand over a vein. He also referred to an incident in which people climbed in through his bedroom window whilst he was asleep and pinned him to the bed so that he could not move. He told them that while he was driving he asked passengers to put their hands on their knees so that he could see them. He always made certain that he could see people around him to ensure that they were not going to knock him out. He acknowledged that he had a camping stove in his bedroom and cooked all his own food, and that he had been doing this for six months.

58. The team spoke to his parents. Mark's father thought that he was posing a physical threat to the family and that he should be taken to Queens Park Hospital or arrested. His mother seemed to feel that Mark had suffered many stressful events and he should be encouraged to complete his education. The team were told that Mark had an appointment with Dr Butterworth on 20th June and it was agreed that Mark would keep this appointment.

59. In accordance with their normal practice, the team wrote a long report on the incident that night and faxed it immediately to GP Dr Pollock with copies to Dr Butterworth and CPN Heather Crook.

60. On 20th June 2001 Dr Butterworth saw Mark in clinic for the fourth and last time. He recorded that Mark was suffering from a major psychotic mental illness of gradual onset over the previous two years, and that his symptoms were gradually becoming more prominent. He told us that he had been told that Mark had slapped his mother's face, but not about his attempts at strangling her or his threats to kill her. Dr Butterworth's notes of the meeting record that Mrs Harrington had expressed fear of Mark but that she wanted nothing done until he had finished his examinations on 27th June. At interview, Mrs Harrington confirmed this. Dr Butterworth offered Mark medication but he refused it. They agreed his next outpatient appointment would be on 2nd July.

61. A police report the next day noted that at 3.11am Linda Harrington contacted them stating that her mother, father and brother were *'having a big fight – they are all screaming and shouting'*. The operator noted that the caller sounded distressed and stated that her mother had a mental illness. An officer attended and classed the incident as a non-violent domestic. Mr Harrington left the premises and a request was made (it does not say by whom) to treat all calls from that address as urgent.

MARK'S THIRD ASSAULT ON HIS MOTHER

62. On Wednesday 27th June 2001 (the day Mark took his last A level paper) he again assaulted his mother whilst in the car. He believed that she was tickling his face so he hit her, causing bruising to her lip. He later said '*she has been bugging me for ages*.' Mrs Harrington did not tell Dr Butterworth about it until two days later - the morning of Friday 29th June. However, she did notify the police about it: at 8pm on Wednesday 27th June, she reported she had been assaulted by Mark. She said the attack was unprovoked and that Mark had psychiatric problems. She phoned again an hour later to tell the attending officers that she would wait for them on the driveway as Mark was in the house and she was afraid of him. The police attended but no arrests were made.

63. When Dr Butterworth learned of the incident, he arranged for GP Dr Yates and ASW Shirley Foster to meet him at the Harrington home to assess Mark for s.2 detention.[16] ASW Foster also requested police assistance and waited with Mrs Harrington outside the house for the police to come. According to the police records, Mark absconded before the police arrived. However, we were told at interview that during the assessment process Mark went upstairs on a pretext of getting some clothes, and absconded through a window. When Dr Butterworth checked Mark's bedroom he found knives and a hammer.

64. At 3.39 the next morning, Saturday 30th June 2001, Mrs Harrington telephoned the police to report that Mark had returned home and stolen her car, but she declined to make a complaint. Five hours later she telephoned again to report that Mark had returned home. However, he had left before the officers arrived to arrest him. At 11 o'clock, Mr Harrington telephoned to say Mark had re-appeared and driven off again. Finally, at 3.45pm, Mr Harrington telephoned again to report that Mark had returned home.

65. Mark had returned with the intention of stealing some of his parents' money, (so he later told a consultant forensic psychiatrist), but he ate some food and fell asleep. He awoke to the police (in full riot gear) knocking on his barricaded door. He offered no resistance when he saw the police support unit, even though, as the police later told the nurses, he had been holding knives and a hammer when he opened the door. He was handcuffed and escorted to Queens Park Hospital. It was recorded that he had a fascination with all types of knives and that he had a hunting knife and a samurai sword – presumably this information also came from the police.

[16] Section 2 of the Mental Health Act enables a patient to be detained for up to 28 days for assessment.

INPATIENT CARE

66. On Saturday 30th June 2001, Mark was admitted under s.2 of the Mental Health Act, to F4 ward at Queens Park Hospital under the care of consultant psychiatrist Dr Chattree.[17] Because of the circumstances of his detention, it was immediately decided that Mark should be assessed by staff from the psychiatric intensive care unit (PICU). This was carried out by staff nurse Iain Fletcher who recommended that as there was a risk of Mark becoming violent towards others and absconding, it would not be safe to treat him on an open ward. However, as there were no beds vacant at the time, a temporary exchange was arranged and Mark was immediately transferred to the PICU under the care of consultant psychiatrist Dr Latif. Mark declined oral medication and asked for an injection instead. He was prescribed lorazepam and haloperidol as required, and placed on 1:1 observations.

67 As a consequence of the pressure Mark's admission placed on the PICU beds, a PICU bed in a different hospital was immediately sought. Consequently, two nurses from Cheadle Royal PICU arrived at 2pm the next day – 1st July 2001 – to determine Mark's suitability for transfer. It is recorded that '*during the interview he denied totally any problems. Slightly guarded. No thought disorder evident. Spoke clearly enough but was obviously sedated'*. On 3rd July a staff nurse telephoned Cheadle Royal PICU to establish whether a decision to transfer had been made, but was told that the consultant was not available and they would call back. It is not recorded whether this occurred.

68 At about 8.30pm on Wednesday 4th July Mark *'approached the* (ward nursing) *office in a relaxed, pleasant, calm and rational manner'* (he) *spoke pleasantly and suddenly, without warning, he took a sock which contained a weighted ball*[18] *from his jacket, and struck staff nurse Jason Connolly on the head with it'*. He required restraining as he continually fought with the staff. He was taken to the destimulation room and given 4mg lorazepam. His plan, he explained a few days later, was to *'take out the big guy, get the keys and escape'*. It is recorded that he showed no emotion or contrition when the plan went wrong and the seriousness of his action became apparent, although he did write an apology four days later.[19]

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17 Both wards F4 (also known as Ambleside ward) and F6 were old-style wards that were due for closure during Mark's inpatient stay. This meant that during his stay in the PICU, Mark was moved to the new PICU, known as Calder ward, and subsequently from there to the open ward known as Darwen ward.

18 The ball was made of liquid-filled plastic, about the size of a tennis ball, rather like a boule we were told, and intended to be used in a child's skittles game.

19 We understand that although staff nurse Connolly had a headache after the attack, he remained at work and at no time took any sickness absence connected with the attack. We did not meet staff nurse Connolly as we were told he had gone to work in the south of England. We were also told that staff nurse Connolly was well over 6' tall and weighed about 18 stone.

69 Later that evening he was found to be in possession of a small wooden skewer. When asked to hand it over he attempted to stab a male nurse with it. He was disarmed and refused oral medication. During restraint, he referred back to the attack with the ball and sock, and *'stated that he had planned the events and was first of all going to strangle her (*nursing auxiliary Hudson*) but decided to take out the big guy in order to get hold of the keys and let himself out of the building. He showed no remorse'*.

70. The police were informed about the incident the following morning, but concluded that as the offender was mentally ill and he would not be prosecuted, and as staff nurse Connolly did not intend to make a complaint, they would not take any action.

71. Four days after the attack on staff nurse Connolly and the discovery of a small wooden skewer on his person, Mark was found with a metal clamp from the table tennis table secreted down the side of his bed. He passed it to the staff nurse. Two days later, during the evening of 10th July, an item described as either a kebab skewer or a wooden cocktail stick was found concealed in the foam of one of Mark's slippers. He justified having these three separate weapons because *'he did not feel safe'*.

72. The day after the attack with the ball and sock, Thursday 5th July 2001, Dr Latif referred Mark to consultant forensic psychiatrist Dr Plunkett.[20] Dr Latif wrote that Mark had been presenting with persistent paranoid delusions for the past couple of years but did not attend outpatient appointments for assessment. He described him as '*emotionless, cold callous and without remorse'*. He also mentioned the pre-meditated attack on staff nurse Connolly and concluded that Mark was '*uncontainable'* in the PICU and needed to be removed to a secure environment. Dr Latif, presumably from prior knowledge of the shortage of beds at Guild Lodge,[21] offered '*to accept back a former patient in exchange in order to facilitate a quick transfer'*.[22] The letter was faxed the following day and although Dr Plunkett's office sent out a standard request letter for an assessment form to be completed and returned, Dr Plunkett did in fact see Mark and the nursing staff for 90 minutes during the afternoon of Monday 9th July 2001.

73. The nursing notes of the meeting record that:

- Mark said, when speaking about the attack on staff nurse Connolly '*that his regret was that "it didn't work," '*

20 At interview the clinical nurse manager told us that when this incident occurred *'they realised that they were dealing with somebody they hadn't really come across before. His whole demeanour, his coldness and his calculatedness was something we had not come across previously and very much smacked of a hardened forensic case, which he wasn't as he was only 19 . . .* (but) *he made everyone feel uneasy.'*

21 The local medium secure psychiatric unit.

22 We comment on this at footnote 62.

- Dr Plunkett felt that Mark should go to Guild Lodge.[23] No bed was available then but one would be found. He recommended that his medication should be changed to 2.5mg haloperidol six times per day and his lorazepam should be reduced.

74. Dr Plunkett's reply to Dr Latif's referral was dated 11th July, but as its receipt was not date-stamped we cannot be certain when it arrived other than to note it is marked to *'file in F6 notes 23/7/01'*.

75. The letter recounted a brief history of Mark's condition and noted Dr Plunkett's view that he found Mark to be '*excessively sedated*' and rather detached from the interview process. He found Mark's lack of remorse for his actions *'striking'* and noted the absence of seclusion facilities on the unit. He urged Dr Latif to bring this to the attention of the management. He asked that the lorazepam be stopped and he requested *'an extensive background and family history'*. He speculated that Mark might respond to the neuroleptic treatment[24] he was undergoing and if he did, then he would not require treatment in a more secure setting. Finally, he explained that if Mark was to be admitted it could not be as part of a *'swap or exchange'*.

76. On 15th July Mark was prescribed risperidone, and at the ward round the following day he was described as warmer, more approachable and showing partial insight. His observation levels were reduced from 3:1 to 1:1 when in his room and the ward, and 2:1 when in the bathroom and toilet. It was decided to alter his medication by gradually phasing out haloperidol, starting risperidone 6mg and reducing his lorazepam to 3mg twice daily.

77. At lunchtime on Wednesday 18th July - a week later than expected - two nurses from Guild Lodge visited Mark to assess him. It is recorded that Mark answered all their questions appropriately and he appeared relaxed in mood. Their report - when it was signed and dispatched more than four weeks later[25] - found him to be appropriately placed and recommended that he continued to be assessed within the PICU.

78. The next day the Mental Health Review Tribunal which had been arranged to hear Mark's appeal against his s.2 detention ruled that he should not be discharged because it had no doubt that if the section was lifted, he would leave the hospital, not comply with his medication or other services, and thereby put others at risk by his unpredictable and violent behaviour. On the same day his haloperidol was stopped.

23 And he - or somebody just like him, told Mark much the same thing, Mark told us.

24 Anti-psychotic drugs.

25 To be strictly accurate, we presume it was dispatched. The copy we saw was from Mark's Guild Lodge notes. We could not find a copy of it in the Queens Park Hospital notes.

79. Mark's behaviour improved quite rapidly from then on. On 21st July he *'apologised to staff nurse Connolly for what he had done to him stating that he was sorry and he was not well at that time. He had meaning in his voice and showed concern'*. Three days later he verbally apologised again. After a further three days observations were reduced to 1:1.

80. On 25th July the s.2 order was converted to a s.3 order, thus allowing Mark's detention to continue for up to a further six months for treatment.

81. He transferred to the new PICU (Calder ward) on Saturday 28th July, and at the ward round two days later, it was decided to reduce his observations levels to every five minutes. His lorazepam dosage was reduced from twice per day to night time only, and the planning of his transfer to Darwen ward over the next two weeks commenced.

82. On 31st July Mark experienced an acute dystonic reaction[26] following the administration of 6mg of risperidone. There was some concern about him hyperventilating (breathing unnecessarily rapidly), so he was treated with benzhexol 5mg.

83. On 2nd August Mark was described as '*continuing to do well'* and was granted his first period of half an hour's escorted leave around the ward garden. Four days later he was described as calmer and more relaxed, with no psychotic symptoms. It was agreed to stop his regular lorazepam and replace it with 'as required' medication, with effect from the next day.

84. At the ward round on Thursday 9th August Dr Latif decided that Mark's escorted leave could be increased to an hour per nursing shift, and he should go to Darwen ward, unescorted, for a half hour each day to familiarise himself with the ward. Accordingly, Mark visited Darwen ward that morning and continued to visit the ward each day until he transferred there during the evening of 13th August.

85. Consultant psychiatrist Dr Latif's last entry, on Monday 13th August stated '*Mark is improved remarkably. Developed good insight. Not aggressive. No concern re self harm or harm to others. No self-neglect. Mark was explained in detail re medication and its compliance. He is willing to take medication and comply. Plan continue on risperidone and move to Darwen ward when bed is available. 15 minutes observations'*.

26 A state of abnormal muscle tone resulting in muscular spasm and abnormal posture, likely to be a side effect of the drug therapy.

DARWEN WARD

86. The transfer of Mark to Darwen ward on Monday 13th August - and to the care of consultant psychiatrist Dr Chattree, marked the end of a forty-four day stay in the PICU. We were told that the average length of stay on the PICU was 18 days but that a number of people had been detained there – and indeed been returned there after transfer – for longer than six weeks. Mark told us that one man had been a patient there for six months.

87. The Darwen ward nursing notes record that Mark settled in well and that he was relaxed and pleasant in mood and speech content, that his behaviour was fully appropriate that first day, and indeed each day until 22nd August when he was unaccountably sick. He told the nurse that he had vomited undigested food, which he thought might have been something he had eaten whilst away from the ward the day before - when he had his first session of home leave.[27]

88. The next day - Thursday 23rd August, 10 days after his transfer to the Darwen ward - it was noted that he had been indulging in childish behaviour: he had used a wet-floor sign as a megaphone to ask for methadone (which is a heroin substitute usually prescribed for heroin addicts). Later that day he was playing with a small ball and throwing it at people, and asking fellow patients to bring his clothes.

89. In response to his changeable behaviour, a urine specimen was collected to determine whether he was using illicit drugs. Five days later the ward was notified that opiates had been found in his urine, suggesting he had been taking heroin or a similar drug.

90. The following day, Friday 24th August, one of the nurses challenged him about taking illicit substances on the ward and the notable change in his behaviour. Mark admitted that he was a little 'giddy,' and that he had laughed at other patients but denied having smoked cannabis or used heroin. He suggested that he might have been giddy because he had drunk some vodka earlier that day whilst on leave. He added '*that he'd smoked cannabis on only two previous occasions when he had been an inpatient and that was when he'd run off'*.[28] He also stated that on Wednesday he had found a joint by the front entrance and had smoked that. He was advised against taking illicit substances, particularly whilst he was on medication. It was also recorded that later that evening one of the staff nurses became aware that certain patients on the ward had been in possession of heroin and cannabis the previous evening, and that Mark had accepted some.

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27 Under s.17 of the Mental Health Act, the responsible medical officer may allow a detained patient to leave the ward for a specified duration and purpose subject to such conditions as he considers appropriate.

28 Which was clearly untrue. He had never run off whilst he was an inpatient.

91. On Saturday 25th August it was noted that he was walking bizarrely and still targeting vulnerable patients. This behaviour continued for another two days, and the nurse noted that he associated with two patients who were believed to be taking drugs. On Monday 27th August he returned from leave with a video called 'Hannibal Lector' that he had already been refused permission to play, and tried to put it on. A nurse switched it off and again told him he could not play it. That evening he was caught with another patient in his room, and was believed to be smoking cannabis. He continued with his immature and disruptive behaviour and is reported to have been seen lighting a cigarette in the garden at about 7pm when the patient with whom he was standing, punched him in the face for no obvious reason. He was examined by the duty SHO, Dr Nangia, but there was no apparent swelling or bruising.

92. During the evening of Tuesday 28th August, Mark asked staff nurse Wilson whether *'anyone had ever left here and gone and murdered someone?'* That same day the drug screen sent to the lab the previous Thursday was reported as positive for opiates and negative for cannabis, confirming that he had taken heroin but not cannabis. The staff nurse re-acted by confining Mark to the ward environs by re-programming his pass card. That evening, when Mark had returned from his afternoon leave, he queried why his pass had been cancelled and following a conversation with the ward manager and the staff nurse who had carried out the cancellation, in recognition of Mark's explanation that it was a *'one-off,'* and his undertaking to improve his attitude, external access was reinstated the next day. However, that evening he continued to intimidate other patients, asked again whether anyone had left the ward and murdered anyone, and described one of the nursing assistants as a murderer. He also asked whether any staff had been assaulted on this ward.

93. On the same day he was seen by Dr Dziobon, SHO to Dr Chattree. He recorded that Mark *'remains settled. Behaviour is normal and modulated. Denies delusion however his overvalued ideas/ obsession regarding violent attacks on himself, rape etc. Considers this normal behaviour in the context of this institution (a place he has not been before) has no insight. He worryingly describes hitting his mum with the idea of knocking her out. He says he did not lose his temper! At the moment his behaviour and mood normal. He is obviously intellectually gifted has denied drug use however search was +ve* [positive for] *opiate. He is requesting leave.'*

94. At the ward round on Wednesday 29th August Dr Chattree decided to write to Dr Plunkett to invite his views about the risk of discharging Mark at this stage. This led to Dr Dziobon writing to Dr Plunkett two days later. The letter recounted Mark's involvement with the service and declared that recently Mark's behaviour had remained settled and well modulated. There is no doubt, the letter continued, that at the moment Mark was settled and much better than when he first arrived on the unit - he does not wear a head guard any more. However, he does seem preoccupied and amused by other patients' suffering and he has a fascination with guns, knives, rifles and weaponry.

95. Dr Dziobon concluded the comprehensive description of Mark's condition by asking for an assessment of Mark's risk to himself and others and for a view as to whether it was appropriate and safe to discharge him, and for guidance in observing, monitoring, and managing him within the community so as to minimise the danger to others.

96. Mark's behaviour deteriorated during the first week of September: on the first the nursing notes record that he always seemed to be at the centre of any management problems on the ward. For instance that day he had asked his mother to bring him in a video entitled 'The Joy of Killing'. The next day he was noted to be still acting immaturely - he was seeking out vulnerable patients, teasing them and still betraying signs of paranoia.

97. These characteristics led one of the nurses on duty to speak to Mrs Harrington and enquire exactly what he did whilst he was on leave. When Mrs Harrington revealed that she had dropped Mark off at the park for a *'kick around'* for three quarters of an hour, she was reminded that it was a condition of Mark's leave that he was in her company at all times.

98. Mark continued to be giggly, immature and deliberately irritating to other patients. Perhaps that was why, on 4th September, he was once again punched in the face by a fellow patient. Two days later he was described as being unhappy because he was not allowed unescorted leave in the grounds. It was explained to him that this was due to his drug taking. He stated that he had found a joint in the grounds.[29] He was noted to be staring at other patients in an intimidating manner.

99. At the ward round on Friday 7th September, which Mr Ellis-Dears attended, it was recorded that senior practitioner Mr Ellis-Dears had been appointed as care coordinator; that Mark should have three hours leave daily and overnight leave the following week, and Mr Ellis-Dears should liaise with Mrs Harrington regarding Mark's behaviour whilst he was on leave.

100. These decisions seem to have had a dramatic effect on Mark because his behaviour improved quite noticeably for a week or so: subsequent entries in his nursing notes repeatedly mention his relaxed, pleasant and settled behaviour with no problems except for two lapses: he continued to find other patients' inappropriate behaviour amusing, and he *'accidentally'* set off the fire alarms, which he also found amusing.

101. By the 17th September, because of his continuing good behaviour, Mark's s.17 leave was increased to overnight leave.

102. A drug screen urine sample was taken from Mark on 18th September. It tested negative for all drugs.

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29 The same as he had said on 24th August.

103. Two days later Mr Ellis-Dears attended an s.117 meeting on the ward.[30] Mark was due to go on home leave but as he indicated that he would not take risperidone when he was discharged (although he said he was happy to take it whilst in hospital) his leave was cancelled.

104. The nursing entry for Saturday 22nd September records that Mark spent the morning wandering around the ward exhibiting child-like behaviour. SHO Dziobon, who saw him that day, noted that he continued to antagonise other patients and he was verbally abusive to an auxiliary nurse. When he was asked to discuss this he became obstructive, saying he was going for a walk in the garden and would be back later. Dr Dziobon also noted that Mark's condition was deteriorating, and rescinded his leave for that day.

105. The next day Mark was smoking in the quiet room (a non-smoking area) but despite the obvious tobacco smell, he denied it. He continued to view the inappropriate behaviour of others as a source of amusement; he showed off in front of other patients and he insisted on having a shower at 1am.

106. At about lunchtime on Monday 24th September Mark's leave was restored. When he returned from his three hours leave towards the end of the afternoon, he again displayed *'deeply immature and inconsiderate behaviour and he appears to delight in 'winding up' other patients and mocking them'*. There are similar entries in the nursing notes for the following two days.

107. At the ward round on Friday 28th September 2001, Dr Chattree wrote that although there was no return of symptoms, there was some indication of insight declining and he appeared to be taking delight in other patients' distress and *'allegedly'* taunting/teasing some of them. However, there were no threats of aggression or hostile acts and no adverse reports from his home leave. The home leave under the care of Mrs Harrington should continue, and his risperidone should be increased from 6mg to 8mg a day. Dr Chattree noted that he was still awaiting the forensic opinion from Dr Plunkett (that he had requested on 31st August).

108. On Saturday 29th September, Mark went on leave for three hours in the company of his mother, and returned two hours late. This was the first recorded late return-from-leave. On the ward it was noted that he *'continued to sneakily target patients in a discreet manner'*. The next day he *'continued in a child-like manner to intimidate patients all evening',* and the day after it was noted that he has *occasionally been goading other patients attempting to wind them up and his behaviour has verged on being childish throughout the afternoon'*. Again, the day after he was seen to be pulling faces behind patients' backs. This behaviour continued on and off until he next went on overnight leave on Wednesday 3rd October.

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30 Section 117 of the Mental Health Act refers to the duty to provide aftercare for people who have been detained under a specific section of the Act, including Mark's s.3.

109. Unaccountably, the Friday 5th October ward round recorded Mark as pleasant and appropriate but getting bored on the ward. He was therefore made a key card holder so that he could go off the ward at any time provided he did not leave the hospital. Again, it was noted they were still awaiting the forensic opinion but as Mark appeared to be settling, it was decided the discharge process should continue. To that end, the following week's ward round would be a discharge meeting to which Mark's parents and his care coordinator should be invited. In the meantime his home leave could be increased to four hours a day, with two overnight stays between Saturday and Thursday.

110. For the rest of that day and the next, Mark was described as pleasant, appropriate and settled. However, when he returned from leave at 7pm on Sunday 7th October, he appeared giddy; very animated; mildly elated; with child-like behaviour and dilated pupils. When questioned he denied having taken any illicit substances; volunteered to give a urine sample and suggested that his inability to get to sleep the night before had affected him.

111. When he returned from leave on 10th October, although he smelt of alcohol, he denied having drunk any. However, he was now relating and interacting well with other patients.

112. The pre-discharge meeting was held on Friday 12th October 2001.[31] It was led by Mark's responsible medical officer (RMO) consultant psychiatrist Dr Chattree and attended by his care co-ordinator Mr Ellis-Dears and the SHO. The meeting decided that the s.3 order would be discharged and one week's discharge leave allowed to Mark before returning for the ward round, with his mother, on 19th October. However he returned to the ward during the afternoon of Sunday 14th October and spent much of the time in the company of other patients. The following day he returned to the ward for an appointment with Dr Plunkett. He was described as *'settled in mood and interacting with fellow patients'* and he *'was advised to discard his samurai sword'*.

113. Dr Plunkett's report of this interview is dated Wednesday 17th October, nearly seven weeks after Mark had been referred to him, but as no date of its receipt is recorded,[32] we can say with certainty only that it had been received by Thursday 1st November because it was discussed at the multi disciplinary team meeting (MDT) that day.

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31 Mr Ellis-Dears was particularly critical of this meeting. He said there was no consultation. Dr Chattree did not ask his opinion about discharge. *'I believe the risk factors were not made transparent. I believe there was never an opportunity to say let's just work together and go in the right direction. I believe there was a momentum to discharge this person and what I find interesting is that now the incident has happened, I have nursing staff approaching me saying we always knew this was going to happen and actually highlighted that to me. I think that is the same with the nursing staff. There is a culture where we just sit there and put up with it. At the time, I had actually approached the nursing staff as I would usually do in the past and I checked out with them, how did they feel about this person coming off the section? What are the intentions? I believe that is a good way of working with the team and they were in total agreement with what I was saying. Having approached Dr Chattree, I came away frustrated and disappointed and I notified my manager of this'.*

32 Although, in his 10th April 2002 report to Mark's solicitors, Dr Chattree wrote that *'prior to* [Mark's] *discharge, a further opinion of the forensic psychiatrist was obtained to allow appropriate planning for risk management in the community'*.

114. We asked Dr Plunkett why it had taken so long to respond to Dr Chattree's referral. He explained that he wanted to speak to Dr Chattree about the basis of it because he had spoken to Dr Latif about Mark at one of the secure liaison meetings (held at Guild Lodge every quarter), and he understood that Mark was doing very well and there were no concerns.[33] He had therefore asked his secretary to arrange for Dr Chattree and himself to discuss the referral, but even though she telephoned on a number of occasions, no call was returned.[34] In addition, four months after we interviewed him, Dr Plunkett wrote to tell us that he had had two weeks leave that month.

115. Dr Chattree had underlined the following sentences in Dr Plunkett's letter, which we have italicised:

- *I did however gain a significant feeling that he was guarded and there was a likelihood that residual paranoid symptoms still exist.*
- (He is) *unlikely to comply long-term, and as such relapse in his mental state is likely in the future.*
- (Mark could not see the connection between use of weapons such as coshes and other weapons such as knives and I found his explanation less than reassuring). *I advised* [Mark] *that this would be an issue, which needs to be explored further by those visiting him.*
- *I feel that the police will have to be informed if there is any raised perception of risk to others. It sounds as though they may need a considerable degree of support, and consideration must be given to their vulnerability.*
- *The presence of such weapons in his house must of course be a concern to the CMHT and to his mother.*
- *I feel that in view of the evidence of residual symptoms, consideration must be given to the use of other atypicals were he to relapse. My prime concern would be that he does not have prolonged periods of untreated illness and as such, he should have a low threshold for change in his medication if he continues to generate doubts in relation to his illness.*

116. On 19th October 2001 Mr Ellis-Dears sent Dr Chattree a completed care plan and safety profile and attended the meeting at which Mark was discharged. His medication was unchanged.

117. There seemed to have been some confusion about the appointment of the care coordinator. On 7th August staff nurse Platt asked somebody in the community mental health team who was to be the care coordinator, and was told it was to be Dr Butterworth, but as he was on leave she was unable to speak to him. On Tuesday 28th August the nursing notes record that Dr Butterworth was informed

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33 However, Dr Latif told us that he '*made a general remark that Mark was well managed by Dr Chattree's team*'.

34 Dr Chattree told us that he had no knowledge of these attempts, and his several references in Mark's notes at the time that he was still awaiting forensic opinion would tend to support this.

of Mark's leave arrangements and was invited to see Dr Chattree at the Friday 31st August ward round to discuss s.17 leave. The following day, Wednesday 29th August, the nursing notes record that Dr Butterworth had again been told of Mark's leave arrangements and he undertook to speak to community health team manager Lindsay Griffiths about the decision to appoint a social worker or a CPN as the care coordinator. At the ward round on 7th September, attended by Mr Ellis-Dears, it was announced that Mr Ellis-Dears had been appointed as care coordinator and on 13th September - six days later - he met Mark and his mother, for the first time, at the family home whilst Mark was on leave. Six days later - on 19th September - Mr Ellis-Dears spoke to Mrs Harrington on the telephone. However, when Dr Plunkett assessed Mark on 15th October nursing staff told him that Dr Butterworth was to be the care coordinator and he referred to this appointment in his 17th October letter. When he received the letter, Dr Chattree naturally copied it to Mr Ellis-Dears because he was Mark's care coordinator and to Dr Butterworth as he was part of the contingency arrangements for Mark's care. When he received the copy, Dr Butterworth telephoned Dr Chattree to query his position and was told his original understanding was correct. Dr Chattree told us that he had decided that Dr Butterworth was not to be involved, except if Mr Ellis-Dears consulted him in an emergency, as his time would be better spent seeing new patients.

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EXAMINATION AND COMMENT UPON THE HEALTH AND SOCIAL CARE THAT MARK HARRINGTON WAS RECEIVING AT THE TIME OF THE INCIDENT

118. Mark had been a patient in Queens Park Hospital between Saturday 30th June 2001 and Friday 19th October 2001 – a stay of nearly 16 weeks. However he had been receiving attention from the mental health professionals for eight months before that.

119. On Wednesday 31st October 2001, twelve days after Mark's discharge, care coordinator Mr Ellis-Dears called at Mark's family home and spoke to both Mark and his mother.[35] The discussion seems to have been limited to progress with income support, the lack of response from the occupational therapy referral, and concerns about medication and tiredness.

120. The next day the Integrated Care System review was carried out in the outpatients department. Mark did not attend, but his mother and Mr Ellis–Dears were present. Mr Ellis-Dears' notes of the meeting record his surprise at the contents of a letter from Dr Plunkett that he had been given by Dr Chattree that had passages underlined as detailed in paragraph 115.[36]

121. The letter referred to the likelihood that both Dr Butterworth and Mr Ellis-Dears would provide follow-up to Mark following his discharge. As this was different from his understanding of the arrangements, Mr Ellis-Dears noted that he would discuss the matter with Dr Butterworth. Paragraph 117 refers. Another outpatient appointment was arranged for 29th November.

122. After clinic, Dr Chattree met Mark by chance in the hospital car park. Mark apologised for not attending clinic and explained he had problems with his car. That was the last time Dr Chattree saw Mark Harrington. Just over a month after Mark's discharge, Dr Dziobon wrote a discharge letter to Mark's GP and copied it to Mr Ellis-Dears. The GP practice stamped the letter as being received on

35 The Darwen ward manager told us that if somebody was on three or four days leave, she would expect the care co-ordinator to follow them up, and the policy – which she was quite sure was in place at that time – is that all patients who are discharged from acute services should be visited within seven days of discharge. She also told us that she would interpret Dr Plunkett's opinion that Mark '*will clearly need a high level of community support'* as meaning that his care coordinator would see him at least once a week at first and he might consider requiring him to attend the day hospital. In her experience, missing attendance at a day hospital was one of the first indications that a patient was becoming non-compliant.

36 Although Dr Chattree told us he had forwarded the letter to both Dr Butterworth and Mr Ellis-Dears (who have offices in the same building) and Dr Butterworth certainly received his because he queried the reference in the letter to himself.

5th December – more than six weeks after the discharge. Dr Dziobon noted that Mark had been discharged on 19th October and that an outpatient appointment had been made for 1st November. The letter pointed out that Mr Ellis-Dears had been assigned as care coordinator as he "*was keen to work with Mark and offer support and guidance and is well in tune to pick up relapses*". The SHO felt that diagnosis was difficult to define accurately but there was no doubt that Mark had had a period of psychosis and with a heavily weighted family history it would seem appropriate to give the diagnosis of schizophrenia. He also felt that Mark had at least an element of anti-social personality disorder. Dr Chattree approved this letter.

123. Mark told a consultant forensic psychiatrist (while on remand before his trial) that when he came out of hospital he bought a car and as he had decided to put in a claim for Criminal Injuries compensation,[37] he drove to the compensation claims offices in Glasgow. He had stolen his mother's credit card. He slept overnight in the car before delivering the claim form in the morning. Whilst sleeping, he told us, he had a dream that two witches stood at his window and he could not move. He believed the witches were trying to cast a spell over him.

124. We asked Mark whether, after he was discharged from Queens Park Hospital, he continued to prepare his own food or eat with his family. He told us that he was happy enough to eat with his family but his lifestyle and theirs were so different that in fact they never seemed to want to eat at the same time.

125. 'He was now on benefits,' his mother told us, *'so most of the time he would buy his own stuff and cook it in the family kitchen. At weekends, he seemed to keep different hours from the rest of the family so he did not eat with us then either, although he assured us he did not have any inhibitions anymore'*. In fact, he told us, he would sometimes eat with his mother when they went to McDonald's together, or with his friends on a Friday night at the chip shop. We were not able to establish how often he did eat with friends, but think it could not have been very frequently as a number of them, in their deposition police statements, described how frightened they were of him at this time. One of them revealed that he and Mark had been drinking together on 19th, 21st 22nd and 24th of December. It was at one of these sessions that Mark explained how people were always flicking cigarette ash on him but he had discovered that if he pushed his hands through his hair every 3? minutes it got rid of the ash. And this is what he was observed to do.

126. Mark also believed that there was a conspiracy to get everyone addicted to heroin. He would buy only a particular brand of sealed cigarettes, and even then he would examine them carefully, because he believed people were lacing them with drugs. He also believed that he was being drugged and he accused one of his friends of doing it and resetting the clock so that he would not know. He also

37 For the injuries he received during the 'glassing' incident are described in paragraph 33 and footnote 10.

accused people of spitting on him when his back was turned and of burning the back of his hair. Another of his friends reckoned that he heard him say about 20 times over a two year period that he *'was gonna get them one by one - you watch me blow them away'*. One of Mark's female friends made a witness statement to the police that Mark was worse after he came out of hospital than when he went in, and that he had asked her boyfriend if he could get him a gun. On another occasion he went amongst a large group of Asian teenagers and asked them whether any of them could get him a gun.

127. Sometimes he carried his hunting knife in his car and one night when he was with Anthony Rigby and another young man, after they had been sniffing lighter fluid, he held the knife to Anthony Rigby's throat, nicked it slightly, then cut the skin between Anthony's thumb and forefinger as he pulled it away. Mark also told his friends that he had been in a hospital in the Lake District – presumably because of being detained in Ambleside ward.

128. He told us that it was about this time that he felt he had been picked out by *'Intelligence'* and that when he did carry out his killing – which he saw as an induction test – he would be helicoptered away for special services training.

129. On 19th November Mark attended the GP practice to obtain a four-week sick note. He mentioned that he was thinking of starting a university course in January. Two days later he called again to get a sick note to cover the period from 27th October to 19th November. Dr Pollock noted at the time that his medication chart on the computer looked as if his usage was low, although in his experience, he told us, very few people call in monthly for their medication if they are not taking it.

130. Mrs Harrington told us that when she '*visited him on the ward, the medication must have been good because he quite liked it there and (he was) more able to laugh. Mark is a very jokey person and light hearted and he is very funny, he can make you laugh. That side of him seemed to come back.*

131. 'I was told they were going to discharge him but still have some sort of community section around his neck whereby if he didn't take his medication, they could whip him back in. What I do recall very strongly because I was very grateful for it, was this idea if he didn't take his tablets, they could whip him back in, but this didn't appear. It was Mark Ellis-Dears who was telling me. Then they decided that was a bit much, after one admission, and they would have to complete the section and they explained a few ins and outs of the legalities.

132. 'They didn't do this and I thought okay. I thought they would put him on injections and he would have to have the medication, but they didn't do that either. Then I went to see Dr Chattree along with Mark Ellis-Dears and I think they said something about injections or tablets and I was thinking about injections and I was sort of asked but it wasn't my decision, and they said something like with young people tablets are better.

133. *'I thought if he doesn't take his tablets, we will get him back in but it happened so quickly. I didn't know he wasn't taking them. We found,* [after his arrest], *a packet of risperidone tablets in his room, the last date of which was November 28th. I think that was the date they were dispensed. Those tablets would be to take for the whole of December. I don't think he had taken more than one. I remember him saying they blocked his nose.'*

134. Mark corroborated this. He told us that he did once take a dose of tablets when *'he wasn't feeling so hot . . .* [and then] *went downstairs to get something to eat and . . . collapsed and dropped the food and went to bed'*. He was on short-term leave from Darwen ward at the time.

135. Linda Harrington, Mark's sister, told Mr Hesketh, the Mental Health Service Director, in a meeting they had on 26th March 2002, that Mark had made progress in hospital and that he was okay for a few weeks after discharge, although she felt he should not have been discharged home. She also thought Mr Ellis-Dears should have visited more often. When she spoke to Mr Ellis-Dears in November and explained about Mark's problems, he appeared not to understand and asked Linda if she thought family therapy might be of help. Linda replied that her mother might not be up to it.

136. Mr Ellis-Dears does not seem to have consulted Mrs Harrington's CPN about this idea – indeed, Linda Harrington told Mr Hesketh, at the meeting referred to above, that just before Christmas 2001 she several times telephoned Heather Crook but did not get much help.[38] She found her defensive and felt as if she was being *'fobbed off'*.

137. On 28th November 2001, Mr Ellis-Dears wrote to Mark to ask him to get in touch to arrange an appointment, but there is no record of a reply. Mark did not attend for review at Dr Chattree's out-patient clinic the next day.

138. On 6th December GP Dr Buckley saw Mark. He had been attacked that morning and sustained a blow on the left side of his mouth. He recorded that he had a small cut on the angle of his lips and some bruising but no specific treatment was needed.

139. On 19th December 2001 Mr Ellis-Dears made another attempt to speak to Mark by telephoning him. Instead he spoke to Mark's sister, Linda. She told him that Mark had been stealing from his mother's bank accounts, and their father was considering moving out and had suggested that she did the same.

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[38] CPN Crook told us that when she met Mrs Harrington on 26th November 2001, they agreed the date of their next meeting was to be 17th December. However, as Mrs Harrington failed to keep that appointment, CPN Crook left a card with an appointment for 23rd December. Mrs Harrington again failed to keep the appointment so CPN Crook left a note asking her to make contact so that they could arrange to meet. She also made a mental note to follow that up after Christmas, as Mrs Harrington was unlikely to be at work during the school holidays.

Mr Ellis-Dears suggested holding a family conference to get everyone in the family together, including Mark. But nothing came of it, Mrs Harrington told us, and Christmas and New Year came and went. Then it was too late, she added. She felt let down by Mr Ellis-Dears in many ways.

140. According to the internal review report, at 5.15 pm the next day, Linda called the crisis response team to ask for someone to visit her mother who was becoming unwell. The visit took place at 7pm and although a voluntary assessment was carried out, nothing further came from it.

141. On Friday 21st December 2001 Mr Ellis-Dears spoke to Mark on the telephone for the first time since his discharge from hospital. He undertook to write to him with an appointment, but there is no copy of this letter in the file. That same day Mark promised one of his teenage friends - according to a witness statement - for the third time that he would get all five people on his list one by one.

142. Sometime later, two witnesses described in their police statements, how Mark drank a lot of alcohol, smoked a lot of cannabis and displayed serious paranoid behaviour that weekend. Coincidentally, both Mr and Mrs Harrington also realised that Mark was showing signs of his illness again, and they agreed he should be re-admitted to hospital. However, as Mr Ellis-Dears was not in touch with them, their assessment was not conveyed to him.

MARK'S FOURTH ASSAULT ON HIS MOTHER

143. Boxing Day was on a Wednesday in 2001 and it was on that day, Mrs Harrington told us, she came to the conclusion that Mark *'was nutty'*. They had set out that evening in her car to go to a house near Chorley[39] to see a man about a car for Mark. When they arrived, Mark left his mother in the car whilst he went inside the house. He returned about 15 minutes later and suggested that they went to see their relatives in Birmingham. It soon became apparent however, that they were in fact going to London, but ended up in Bournemouth where Mark's maternal grandmother lived. Mrs Harrington told us that although she did not want to go, as Mark was driving, she felt that she could not stop him. [40]

39 Although Mark told a consultant forensic psychiatrist the destination was Bury and he told us it was Manchester.

40 Mrs Harrington and Mark's recollections of these events are understandably hazy and in some cases incompatible and at a variance with what Mrs Harrington told the West Midlands and Lancashire police forces. We have therefore tried to set out what we think is the most likely sequence of events, identifying, when possible, the most significant variations.

144. They stayed overnight at a service station in the south of England. On the return journey, Mark told a consultant forensic psychiatrist, that whilst he was driving through London his mother started shouting at him and behaving very strangely. Mark accused her of pimping him, of knocking him unconscious, and of flicking cigarette ash into his hair whilst he was driving. They were then on the motorway between London and Birmingham. Without warning, Mark punched his mother in the eye and caused bruising. He then said that he would murder her if she did not give him the details of how she had abused him. Mrs Harrington started waving her hands and screaming out of the window in an attempt to attract the attention of other drivers, but Mark, seemingly unperturbed, announced that when the low fuel light came on, he was either going to shoot her or, if she preferred, he would knock her unconscious with a spanner.

145. The alarm this threat brought about caused Mrs Harrington to wave her arms and struggle even more vigorously, she told us, but Mark managed to stop her from doing that (whilst still driving) and re-iterated his promise that when the fuel light came on he was going to shoot her in the head. Mrs Harrington re-started waving her arms in an effort to distract his attention and hopefully, cause him to miss when he attempted to shoot her. Soon afterwards, the fuel light came on and, she told the police, he produced a pistol from the front of his trousers. She described the weapon as having a beige-coloured wooden handle with a four to five inch muzzle. He then pointed the pistol at Mrs Harrington's temple and pulled the trigger. Mrs Harrington told the police that she heard a bang but did not feel any pain. Her opinion was that he had *'shot past her'*. Mrs Harrington quickly realised that she had not suffered any injury and looked to her left. She had not seen any damage to the inside of the car, even though both the windows and the doors were closed.

146. However Mrs Harrington told us that the bullet hit the grab handle and smashed it following which Mark said, '*I can't believe I missed, and I've got no more bullets*.' Later, he told her his life was so bad that he '*near enough had to kill someone to get into prison*'. Mrs Harrington told him that if things were that bad he should go to the police and tell them.

147. Mark told us: '*I assaulted my mum on the motorway. I had lost the bullet at the petrol station – it had dropped off somewhere. I found a fitting for an electric screwdriver so I just pushed that in the end. When I pulled the trigger, my mum pushed my arm up and the bullet went over her head, because it wasn't a perfect circle, it was hexagon I think. It shot upwards at an angle. It shattered the* [grab] *handle. I don't know what happened to it then: it must have bounced somewhere in the car, but there were no broken windows. After I shot her, she was shocked and so was I. I had some blood on my sleeve.*'

148. After the incident, they went to a petrol station to fill up. Mark told his mother to '*get me a full tank of petrol, 20 cigarettes, £10 top up card and £10 cash*'. She did this and they went to a McDonald's in Birmingham and had something to eat. Mrs Harrington then gave Mark her bank card so he would

have somewhere to sleep and some money, thinking that the authorities would be able to monitor his whereabouts whenever he used the card and find him by knowing the car's licence number.

149. We were told it was nearly midnight on Thursday 27th December when they found a bank in Birmingham with a cash withdrawal machine from which Mark obtained £200. When he returned to the car, he found that his mother had run off. He looked around briefly but could not find her and after establishing that there were no police about, he set off for Leeds. Mrs Harrington told the Lancashire police that she took the opportunity to leave the car so that she could attract the attention of a person who could then alert the local police. But she told us that as soon as she escaped, she went straight to Smethwick police station and gave them a full and comprehensive statement, including the details of her car and bank card, and asked them to get her a coach home. In fact, it seems she did both as the police records show she was in the police station for about four hours. She arrived home early in the morning of Friday 28th December, slept for a couple of hours and then telephoned Blackburn police at about noon. Soon afterwards, a police officer called at her house and she told him about the events of the day before, including references to the firearm and the abduction.

150. Contact between the two police forces was immediately established and it became clear that Mrs Harrington had not told the West Midlands police about any firearm in the car and neither had a formal complaint of assault or abduction been made. Mrs Harrington was believed to have made her own way home by train after leaving her son and car in the area.

151. It seems as if Mark had driven directly from Smethwick to Leeds because a couple of hours later, just after 2 o'clock on the morning of Friday 28th December 2001, Mark was stopped in his mother's car on Tunstall Road, Holbrook, Leeds by a police officer. He was body checked and cleared. The Lancashire records do not record the reason for stopping Mark or whether the car was searched.

152. Seven hours later, a car was seen parked and obstructing the pavement on Burnley Road, Colne outside the post office. The informant spoke to the man in the car and described him as a young white male aged between 17-19 years. He was wearing a white jacket and looked quite scruffy. This description was similar to that given about Mark to officers by Mrs Harrington. The informant had challenged the occupant of the car and told him to stop blocking the path, as people could not pass. She then stood in the bus stop across the road and when the car drove off the driver gestured towards her. No speech took place, but the witness described him as pointing his finger at her in a '*threatening manner*'. No mention of a firearm was made, but the informant stated that she had contacted the police because she thought he might have been planning to rob the post office.

153. Mark told us he then drove back to London. On the way, the car stopped working but he was able to get it going again and continue. A few miles later, it broke down again, so he pulled on to the hard shoulder to carry out further work on it. This attracted the attention of two police officers (the police

log records this as taking place at 7.30pm) who told him he was parked in a dangerous place and he must put on his hazard lights and pointed him in the direction of the nearest garage. Mark said the police gave him a lift to a phone box where he learned it would cost about £700 to repair the car, so he abandoned it and returned to the north by train. He thought he was on the M3 when this occurred.[41,42]

154. That same evening – Friday 28th December – about eight hours after Mrs Harrington had reported the shooting in the car, a police officer was asked to arrange for the family to be re-housed. He was also told that if they were not amenable to this suggestion, they should be provided with a means of emergency communication with the police. However, it is recorded that within 15 minutes of making the offer, the family told the police they were not making any formal complaint and they thought the police were *'over-reacting'*.

155. There was also a note in the file that the attending officer formed the opinion that Mrs Harrington's mental state was questionable. Although *'she was clear to a certain degree about the events stated',* he had written, Mrs Harrington would, '*on numerous occasions talk about unrelated matters in a confused manner. This obviously raised questions,'* in the attending officer's mind, *'about the validity and quality of the information supplied'*.

156. Just after 11pm on (Monday) New Year's Eve 2001, Mark was stopped whilst driving his car on Knott Lane, Colne. Mrs Harrington understood that he had gone there to see a man about repairing his car. Mark gave his home address to the police and his car, a red Renault, was found to be free from firearms or other similar looking articles. It appeared to officers that he had been sleeping in the car. Mrs Harrington was very disappointed to learn the police had not taken him to Queens Park Hospital - he had duped them again, she thought.

157. Two days later, on Wednesday 2nd January 2002, Mrs Harrington's CPN Heather Crook told Dr Butterworth that she had received a telephone call from Linda Harrington about the Boxing Day incident. At that time, they believed, Mark was being sought by the police. Dr Butterworth passed this information on to Mr Ellis-Dears and Dr Chattree immediately, but none of this is recorded in Mark's notes.

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41 In fact, he was on the M40.

42 This car was thoroughly searched on 29th December 2001 and no evidence of any firearm being discharged in it was found. On 10th January 2002, Mrs Harrington retrieved her car from Slough. She told us she had been told it had been examined by police forensic staff but they could find no evidence that a gun had been fired in it. This same finding was relayed to the Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust mental health services manager by a Blackburn police officer. On 18th January 2002, two Lancashire police officers examined the car in which Mrs Harrington stated that a firearm had been discharged in December 2001, but they too, could find no visible evidence that a firearm had been discharged in the car, nor was there a record of the car ever being subjected to forensic examination.

158. At 12.20pm on Thursday 3rd January 2002, Mark was stopped in a white BMW on the A59 at Clayton-le-Dale. He claimed he had owned the car for about a week. The officers noted he was wearing dark clothing and a dark baseball cap, and he had knitted gloves on the front seat beside him.

159. At about the same time, Mrs Harrington arrived at the CMHT offices in response, she believed, to Mr Ellis-Dears' telephoned invitation to see her because he was concerned about her condition. At the time of her arrival, Mr Ellis-Dears was not present, but he arrived shortly afterwards. He was understandably puzzled at her presence, as he had not, he assured her, invited her to Clarence House. In fact, it now seems Mark had impersonated Mr Ellis-Dears to get his mother out of the house so that he could go home for a shower.

160. As they were together, Mr Ellis-Dears noticed Mrs Harrington's black eye and she was able to tell him about her Boxing Day car journey. The conversation ended with Mr Ellis-Dears advising Mrs Harrington to ring the police and seek a place of safety if Mark should turn up over the weekend.[43] Although we could find no record of Mr Ellis-Dears' recommendation in any of the notes, we were able to corroborate his advice because Mrs Harrington told us she telephoned the police – and the police records confirm that she did. She did so, she told us, because soon after she arrived home, Mark entered the house to take a shower. Both Mrs Harrington and her daughter Linda went to their bedrooms where they remained until Mark looked into Linda's room and '*scared* (her) *to death*'.

161. The call for help was made just after 5pm, and an officer rang her back about an hour later and spoke to her at some length. Mrs Harrington had by then decided she did not require a place of safety, but asked for help to secure her home. A police officer was deputed to attend and assist her to obtain and fit a security device. He also asked whether there was anything she wanted removing from the house so she gave him the household meat cleaver. Later that evening he took Mrs Harrington to B&Q to purchase a bolt for the back door which he fitted for her the next day. However, we were told it was not very secure: when he returned home that evening, Mr Harrington just kicked the door in and removed the bolt.

162. The next day, Friday 4th January 2002, Mark was stopped by the police in his white BMW in suspicious circumstances outside British Home Stores in Blackburn. No offences were noted, but the officer recorded that *'this lad is mentally unstable and is not to be underestimated'*.

[43] Notwithstanding Dr Plunkett's admonition that '*the police would have to be informed if there is any raised perception of risk to others*'. Paragraph 115 refers.

163. Mark told a consultant forensic psychiatrist that he drove around in Preston for most of Sunday 6th January. One of Mark's friends, in a statement to the police, said that whilst he and Anthony Rigby were asleep that morning, Anthony's mobile rang. It was Mark asking if he could call round for a bath. Anthony told him he could not as he had company. Anthony apparently did not think the request odd as *'it was run of the mill to Rigby who received calls from Mark Harrington at all times of the day with odd requests. For example Mark had asked Rigby for a tow to Burnley to scrap one of his cars earlier in the week'.*

164. In the early hours of Monday morning 7th January, Mark was back in Blackburn. He told a consultant forensic psychiatrist that he drove into the town centre then parked at Tesco's. Whilst he was parked a policeman stopped to ask him what he was doing. At the time the policeman was talking to him, he had the gun and cartridges in his pocket but before getting out of the car, he placed the gun in the car door pocket. The policeman ordered him out of the car, handcuffed him and took him to Blackburn police station where he was detained for a time then released. He returned to his car and drove home. The gun was still there. This was the gun he used to shoot Anthony Rigby a few hours later. However, there is no evidence in the Lancashire police files to support this and it is difficult to believe this took place.

165. Mrs Harrington told us that Mark arrived home at about 9.45am on Monday 7th January, ostensibly for a shower, and mentioned that he had been talking to the police and they had released him at about six o'clock that morning. Mrs Harrington told him that some letters had come for him about going to Preston University, which he said he would deal with, but he was a bit worried that it might be too late for the course.

166. It seems Mark went out shortly afterwards because Mrs Harrington recalls having the television on and wondering whether he had said he was going to Anthony's, she told us. She wandered round the house trying to remember, and then went into the front room and heard the weather man say something like *'shoot like a camera'*. Then she recalled that Mark had said something about the weather man saying shoot. Still confused, she went upstairs, then, becoming anxious, she decided she had to do something about it so returned downstairs and telephoned the police to tell them that she thought that Mark had gone to Anthony's and asked them to pick him up there. We asked her what made her think that he had gone to Anthony's and she replied that she thought he would have gone to the post office to cash his benefit cheque and then go to Anthony's before going to Preston. There is however, no mention of this telephone call in the records of the Lancashire police.

167. Mrs Harrington remained in the house and at 4pm CPN Crook arrived for her appointment. She told us that she noticed that Mark had been allowed back into the home. Mrs Harrington told us that she told CPN Heather Crook all about it. *'Surely,'* she said, *'we must be a family case. Three of us mentally ill. She said it is not like that in clinical psychology - you just have one patient. Heather Crook kept saying, 'you are my patient. I am worried about you'. To me my response I wanted to*

make which I didn't, was that if you are concerned, you will make sure my son is not a murderer and you will get him in hospital and that would be for my health.'

168. Linda Harrington told us that '*Mark never properly came home between what happened to Anthony and what happened with my mum. We were so scared of him*'.

169. Mark was arrested about 48 hours after the incident and charged with the attempted murder of Anthony Rigby. Mr Ellis-Dears was invited to act as appropriate adult at the police station. Three days later, two days before his 19th birthday, Anthony Rigby died and the charge was raised to murder.

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EXAMINE AND REVIEW THE SUITABILITY OF THAT CARE IN VIEW OF MARK HARRINGTON'S HISTORY AND ASSESSED HEALTH AND SOCIAL CARE NEEDS

PRE-ADMISSION

170. Mark's mental health problems first became apparent to Mark himself about the spring of 1997 ie when he was coming up to 15 years old; to his mother during the summer of 1999 and to others outside the family a year or so later.

HOSPITAL STAY

171. Mark was detained in Queens Park Hospital for nearly 16 weeks. The first six weeks were spent in the psychiatric intensive care unit, where he was well-managed and cared for, even though the aftermath of his assault on staff nurse Connolly was not well-handled from a managerial point of view.

172. The care and treatment provided in acute in-patient units remains the key element of current mental health practice for individuals with acute psychotic symptoms. At the point of Mark's admission, he was in a severe state of crisis, with symptoms of acute psychosis and disturbed, violent behaviour. The decision to transfer him immediately to the PICU was fully justified. He responded well to the controlled and intensive medical and nursing regime - once the violent incident involving staff nurse Connolly had been dealt with - and his compliance with medication, due to close nursing supervision, was an essential factor in his recovery and enabled his transfer to Darwen ward to take place.

173. However, the subsequent reduction in supervision and structured therapeutic activity had such an adverse effect on his remaining stay in hospital and his discharge home, that his stay on Darwen ward undid most of the progress achieved while he was on Calder ward. The reasons for this are considered below.

MEDICATION

174. There is evidence of Mark's reluctance to take medication from both his GP and Dr Butterworth. Mark also commented on his non-compliant attitude during his stay in the PICU, although the closely supervised regime there made non-compliance very much more difficult. When he transferred to Darwen ward, his developing pattern of non-compliance does not seem to have been

noticed by staff. Given his age, his behavioural presentation and his use of illegal substances, this was a serious oversight.

RECOMMENDATION

- The use of rating scales to assess psychotic symptoms would improve the assessment of mental state and assist in decisions about compliance.

SUBSTANCE MISUSE

175. Before admission, Mark was known to use cannabis and solvents. During his stay on Darwen ward he continued to use illegal substances obtained on the ward from fellow patients and whilst on leave. This again does not feature as a major item of concern in his care plans - the issue affected his leave only once and does not appear to have affected his case management at all. Given Mark's psychiatric presentation and tendency to episodes of violent behaviour, there does not appear to have been any active plan to reduce or manage his deviant behaviour effectively.

176. We consider that the care team on the ward did not deal with drugs issues at all well. They knew drugs were present on the ward ten days after his admission and ordered a drugs test which was found to be positive for opiates. When Mark displayed these same characteristics subsequently, they only once requested another test. Although we have not looked at the notes of the other patients on the ward at the time, we have the impression that there was an attitude of resigned tolerance to drugs on the ward – sadly a widespread attitude in far too many mental health wards.

RECOMMENDATIONS

- The trust should support the care team in dealing with inpatient substance misuse by producing a robust policy to deal with the issue. The policy should recognise that:
  - i. previous substance misuse or excessive alcohol consumption, should always act as an indicator of a potential for disturbed behaviour and be identified on care plans;
  - ii. continued substance misuse should trigger a case review by the care team and appropriate action should be taken to both reduce it and modify future care plans;
  - iii. all patients suspected, or with a history, of misusing substances should be subjected to automatic drug testing on return from leave however short.
- The trust should, in partnership with the police, consider the use of acute wards as training areas for police sniffer dogs, to reduce the supply of illicit substances.
- The police should be requested to consider formal warnings to patients found to be in possession of illicit substances.

THERAPEUTIC ACTIVITY

177. Considerable emphasis is placed on the role of multi-professional teams in today's acute hospitals. Research in the United States has shown that multi-disciplinary treatment with clear aims, well defined roles for staff, and discharge plans, leads to more effective care of mental health patients on acute wards,[44] and the most effective acute wards provide high levels of staff and patient interaction.[45]

178. Although there is evidence of contact between Mark and the nursing staff during his time in hospital, due to staffing constraints and the lack of planned therapeutic activities, these contacts seem to have been a matter of simple observation rather than actively and purposefully engaging with him, thus making it difficult to assess Mark's mental state accurately.

179. Darwen ward had no occupational therapists or psychologists, thus reducing the diversity of activity for patients and the opportunities for, and probably accuracy of, a more comprehensive assessment.

RECOMMENDATIONS

- The staffing levels on Darwen ward should be examined to reflect the need for planned therapeutic activity.
- The range of therapeutic activities available for younger adults in the wards should be broadened by the involvement of a planned programme of weekly activities, coordinated by occupational and psychological therapies.

ACCESS TO LEAVE

180. Although the use of leave periods before discharge is accepted practice, there does not appear to have been any real assessment of the success of the leave, other than relying on feedback from Mark's mother. Considering that before his admission, Mrs Harrington had difficulty in accepting that Mark was suffering from a mental illness and worked hard to protect him from psychiatric involvement, the reliability and impartiality of her reports should have been questioned. Indeed, paragraphs 89-92 and 96-98 show that the nurses both knew and were concerned about Mark's use

44 *Hargreaves et al, 1990*

45 *Ellsworth et al,1979; Collins et al, 1985* ; **Acute problems - a survey of the quality of care in acute psychiatric wards** - The Sainsbury Centre for Mental Health 1998.

of illicit drugs, but this was not taken into account when deciding upon his leave. In reality, Mark's leave appears to have been used merely as preparation for re-settlement in the community. Other methods, such as care coordinator visits, discussion with other family members and structured interviews with Mark, should have been employed to assess the success of his leave.

WARD ROUNDS

181. Although Darwen ward rounds were believed to have been multi-disciplinary, the notes suggest that sometimes they took place without key nursing staff being present. It is also clear that future action points were not always recorded accurately in the multi-disciplinary records by the medical staff. Nurses told us that their views on patients' progress seemed to have little influence on medical decisions about discharge. This clearly negates the multi-disciplinary approach to care and treatment, and is against the Nursing and Midwifery Professional Code of Conduct in relation to protecting patients and ensuring their needs are met.

RECOMMENDATIONS

- Home leave should be part of a planned programme of care that is monitored through home visits by a named care coordinator together with feedback from a number of different sources.
- Nursing staff should assess the value of leave taken by patients on their return before further leave is planned, with a positive leave assessment acting as the main consideration for further leave.
- A policy for multi-disciplinary teams should be developed and all staff should comply with it. The policy should require that, amongst other things:

  i. the roles of the multi-disciplinary team members are defined;

  iI. records of attendance at ward rounds and discharge planning meetings are kept;

  iii. key discussion points and any disagreements about care and treatment decisions are accurately recorded.

CARE PLANNING

182. The care planning process on the PICU is based around the completion of a care process form. On Darwen ward, the process seemed to be informed by the observation and daily record/continuation

sheet, and the completion of safety profiles, most of which were a retrospective assessment of Mark's behaviour.[46]

183. There was reference to Mark's presentation before admission but this was not followed up, and seems to have had little influence on his further care planning.

184. The policy for ICS Case File construction does not appear to have been adhered to and the care plans were not individually based: they did not have planned constructed interventions, nor were they outcome focussed, and there was little evaluation or re-assessment of need. Nursing staff simply recorded their observations and did very little about them.

RECOMMENDATIONS

- The in-patient care planning process should be reviewed to enable easier transfer of care between community care and hospital episodes.
- Pre-admission information should be an integral part of hospital care planning. It should therefore be checked and explored as the opportunity arises with carers and others who were involved with the patient before his/her admission.

POST DISCHARGE

185. During the 80 days between Mark's discharge from Queens Park Hospital on Friday 19th October 2001 and Anthony Rigby's murder on Monday 7th January 2002, Mark's care was limited to being:

- seen at home once by Mr Ellis-Dears (on 31st October);
- seen by chance in the hospital car park by consultant psychiatrist Dr Chattree, on 1st November.
- written to by Mr Ellis-Dears (on 28th November);
- spoken to on the telephone by Mr Ellis-Dears (on 21st December),

186. This level of contact is clinically inadequate, professionally deficient, managerially irresponsible and quite unjustifiable.

46 We asked about safety profiles after having noticed that during Mark's nearly 10 week stay on Darwen ward, only six forms were completed: the day of his transfer to the ward: 13th August, 19th August, 29th August, 2nd September, 22nd September and 24th September. We were told that although the forms were completed, in those days, they would seldom be read. Nor were they used to inform any risk assessments that were developed – perhaps because there was no formal system of bringing them into the formulation of the care plan. When we put this to the ward manager she told us she would expect a risk profile to '*be done prior to every period of leave, every change in mental state and one on discharge,*' and she certainly *'wouldn't expect a fortnight to go by without one being done'*.

DETERMINE THE EXTENT TO WHICH THAT HEALTH AND SOCIAL CARE CORRESPONDED WITH STATUTORY OBLIGATIONS, RELEVANT GUIDANCE FROM THE DEPARTMENT OF HEALTH, AND THE LOCAL OPERATIONAL POLICIES OF THE HEALTH AND SOCIAL CARE AGENCIES INVOLVED

187. The Integrated Care System used at the time of the incident was a local version of the Care Programme Approach (CPA) system that was introduced in 1991 with the aim of ensuring the delivery of coordinated services. The CPA has four key features which services must deliver:

i. systematic assessment of need;

ii. consideration of a personalised care plan with key contacts;

iii. coordination of care by a named person - the care coordinator;

iv. regular reviews and revisions of the care plan.

In 2000, further guidance was issued by the Department of Health to enable the CPA to harmonise with other reforming initiatives. The changes included the integration of CPA with Care Management, the introduction of two levels of CPA: standard and enhanced, and a requirement that all health and social service mental health providers must jointly identify a lead officer to work across agencies to deliver an integrated approach.

188. The Blackburn Integrated Care System, whilst superficially attractive and comprehensive, had a serious shortcoming: it did not clearly identify the roles and responsibilities of the consultant/RMO[47] or the multi-disciplinary team. This deficiency may have contributed to the later decision to revert to the conventional CPA system.

189. Since 1997, the Department of Health has published a number of policy documents which, taken together, have significantly influenced the development, delivery, and quality of mental health services. Key government policy documents include:

[47] All patients who are detained under the Mental Health Act must have a named consultant psychiatrist responsible for their care and treatment, known as their RMO – responsible medical officer.

Modernising Mental Health Services, Safe, Sound and Supportive (1998)

190. This document sets out the service template that users, carers and the general public should expect from a modern mental health service, which is focussed on the individual, and is evidence-based and outcome-driven.

A First Class Service (1998)

191. This aims to raise the quality of services, through a process of clinical governance, life-long learning and rigorous professional self-regulation, which outlined a system of standard setting across the NHS (eg National Institute for Clinical Excellence and National Service Frameworks, Commission for Health Improvement).

The National Service Framework for Mental Health (1999)

192. A 10-year programme focussed on adults with mental health problems aged between 16 and 65 years. The NSF contains seven standards that address different aspects of care, with performance milestones and indicators relating to individual practice, service organisation and care delivery. Recognition is given to the needs of carers who should, when appropriate, have a written care plan which is implemented in discussion with them. The NSF reinforces the duty on local authorities under the Carers (Recognition and Services) Act 1995 to assess the ability of the carer to provide and continue to provide care to a person with mental health problems.

The NHS Plan (2000)

193. A framework that outlines a range of changes, over a 10-year period, in service delivery, workforce and priorities including:

- early intervention teams to provide treatment and support to young people with psychosis;
- crisis resolution services for service users in crisis;
- assertive outreach teams to reach out to and involve and engage service users;
- additional community mental health team workers.

The Mental Health Policy Implementation Guide (2001)

194. This provides service commissioners and providers with detailed descriptions of service models for the key elements of the mental health service outlined in the NHS Plan and the NSF. The guide encourages both a whole system approach and local creativity to enable services to respond to local needs.

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195. The extent to which the mental health services in Blackburn complied with the policy guidance is considered below:

PRE-ADMISSION

196. Mark's first formal contact with the specialist mental health services was with SHO Dr Nangia, who reviewed him in the outpatients department on 26th October 2000. Given Mark's family history, and his age and presentation, Dr Nangia appropriately involved ASW Shirley Foster of the CMHT. Between October 2000 and his admission on 30th June 2001, Mark had contact with Dr Butterworth, who became his care coordinator, and with the crisis response team. He started to show strange or unco-operative behaviour: paranoia at home; writing 'happenings' on his bedroom wall and warnings on the outside of the house; a pattern of non-compliance with outpatient appointments; reluctance to accept medication, and aggressive behaviour towards fellow students, his family and particularly his mother.

197. This was the first presentation of a young man with a possible psychosis, who from a policy perspective was not engaged assertively through early intervention processes. The pattern of visiting Mark at home, contact in the outpatient department and with the crisis response team seemed to be uncoordinated and not in keeping with effective care planning processes. We discussed this issue with Dr Butterworth. He referred to the tension between the rights and liberty of the individual and those of society in an era of increasing awareness of 'human rights'. Notwithstanding this, we believe that although the appropriate policies were in place, the service did not promote the safety of Mark, his carers or the public of Blackburn, and questions remain over the application of Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust policies by the mental health care team.

HOSPITAL STAY

198. The main area of concern about the application of policy during Mark's hospital stay is the assault on staff nurse Jason Connolly on Wednesday 4th July 2001. From a care perspective, this should have greatly influenced the subsequent care and treatment of Mark when he was discharged from hospital, even without the subsequent report from the consultant forensic psychiatrist. Although the medical and nursing records adequately described the incident at the time - and the incident was well discussed within the mental health nursing community - subsequent records and risk assessments seem to underrate the importance of it. In retrospect, it could have been considered as attempted murder – Mark repeatedly said that his action was to *'take out the big guy'* to obtain keys and escape from the PICU. It was indeed fortunate that death or serious brain damage did not ensue. From a clinical governance perspective, the procedures to support the serious and untoward incident

reporting were poorly applied and managed,[48] with little apparently learned from the incident; poor de-briefing processes, and little impact on the subsequent care and treatment Mark received following his transfer to Darwen ward. At the very least it should have influenced the date of his discharge and have prompted active pursuit of Dr Plunkett's report.

199. Concerns have also been expressed regarding Mark's compliance with medication whilst on Darwen ward. Given his known reluctance to accept medication in the community, there was no record of it in his care plan. If there had been, and the notes had been read, it should have influenced his discharge care plan.

200. The discharge planning process was supposed to be multi-disciplinary. However, the records of the discharge planning do not reflect any concern for Mark's previous aggressive behaviour, his non-compliance with medication, or any of the risk factors outlined in the risk profiles. In addition, we were told by a number of nursing staff that the concerns they raised about Mark's clinical presentation were not reflected in the medically-led pre-discharge process. Indeed, there was no record of any nurse being present at any of the MDT meetings held for Mark on Darwen ward[49] even though we were assured by the clinical nurse manager that MDT meetings were never held without a nursing presence.

POST DISCHARGE

201. The NHS Plan indicates that following discharge, patients with identified risk factors should be visited at home within seven days of discharge.

202. Similarly, the Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust Integrated Care Policy System states that, '*within care plans, particular attention should be made to non-compliance, dual diagnosis, problems with substance misuse and people leaving hospital, to be followed up with a face to face contact within seven days of leaving hospital'*.[50] This did not happen.

203. Mark's care plan was not prepared as a multi-disciplinary document. Nor did it take into account

[48] It is clear to us that the premeditated, unprovoked, serious assault of an unprotected nurse with a ball in a sock is covered by the trust's policy of the handling of serious untoward incidents, and that this deed would certainly classify as a category C, if not a category B incident.

[49] Except that at the s.117 meeting held on 14th September 2001, but he/she did not sign his/her name as required by the policy. We have also referred to these practices in paragraph 181.

[50] The community risk management section: page 18.

the history of Mark's previous involvement with the service, risk assessments, non-compliance, known substance abuse or carers' needs.

204. Mark's mother was known to the CMHT: she had her own care coordinator, yet her needs were not considered in the care planning process, and there was no coordination between the respective care coordinators. The family was proposed in the flawed care plan as the main source of monitoring of Mark's progress after discharge. This is in conflict with both national and local stated good practice.

RECOMMENDATIONS

- There should be a single record of service contact that covers both community and hospital care.
- Previous non-compliance with medication should be identified in care plans and risk assessments to encourage medication usage checks to be carried out.
- Risk profiles should be completed sequentially and regularly, wherever possible, by the same staff to encourage comparison, consistency, and to highlight change.
- The community services should focus on patients with severe and enduring mental illness, with the development of early intervention and assertive outreach services.
- Discharge care plans should be prepared by the multi-disciplinary care team, and should take into account all care history and contact with the service.

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CONSIDER THE ADEQUACY OF THE HEALTH AND SOCIAL CARE TREATMENT PLANS, THEIR IMPLEMENTATION, MONITORING, AND REVIEW, WITHIN THE CONTEXT OF STANDARD FOUR OF THE NATIONAL SERVICE FRAMEWORK FOR MENTAL HEALTH

205. Standard four of the National Service Framework states that all service users on CPA should:

- Receive care, which optimises engagement, anticipates or prevents a crisis, and reduces risk;
- Have a copy of a written care plan which:
  - i. includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator;
  - ii. advises their GP how they should respond if the service user needs additional help, and
  - iii. is regularly reviewed by their care coordinator;
- Be able to access services at any time of the day or night.

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206. What is revealed by consideration of the care plans completed by staff at each stage of Mark's contact with services, when measured against these standards?

PRE-ADMISSION

207. Although Dr Butterworth was inappropriately, in our view, initially appointed as Mark's care co-ordinator, it has to be recognised that he did not carry out the duties of the post, and it is difficult to see how he could have done so, given his position and workload in the care team.[51] This reflected

[51] The task of a care coordinator is to bring together all the services required by a patient to deliver the care plan. Only mental health workers in the medical, nursing, psychology, social services, or therapy professions, working in the mental health field can be appointed to this role.

in the construction of his care records, which, although they were thorough and insightful, did not reflect the principles of the care programme approach. Similarly, both his assessment and treatment plan were commendable, particularly in relation to his attempts to support Mark through his A levels, even though they were based on poorly researched evidence of Mark's educational status and potential.

208. Although there were no community staff responsible for the coordination of Mark's care before his admission to hospital, the involvement of CPN Crook as Mrs Harrington's care coordinator is important. In the period leading up to Mark's admission, and in particular following Mark's reported assaults on his mother on 5th and 27th June 2001, there is no evidence in Mrs Harrington's community records that any advice or action was taken by CPN Crook about what Mrs Harrington should do if a further family crisis occurred. Nor is there evidence of contact with and advice to her GP. There is no record in the daily record/continuation sheets of the GP out of hours service visits to the home on 29th April and 2nd June, nor of the crisis response team's involvement on 5th June 2001. It is not until Mark is admitted to hospital, recorded in her notes on 20th July 2001, that CPN Crook mentions the strain Mrs Harrington was under. These instances emphasise the lack of co-ordination of the crisis response service with known clients on the care programme, and between carers and care coordinators.

209. Although Mrs Harrington's care planning was poorly structured with ill-defined outcomes, we are pleased to record that it has improved markedly since the incident, suggesting an organisation that has learned lessons.

RECOMMENDATIONS

- Those who are appointed as care coordinators should receive training in the role and function of the post.
- When more than one member of a family is involved with services, the role of the care co-ordinators should be clarified and agreed.
- The role of the trust grade psychiatrist in the care team should be defined.[52]
- The crisis response team should be re-focussed to give emphasis to those known to the service and subject to the care programme approach, so as to ensure appropriate crisis response as outlined in standard four of the NSF.

52 We do not intend this to be construed as a criticism of Dr Butterworth. We found he was widely respected for being approachable, helpful and close to MDT members.

POST DISCHARGE

210. The care plan completed by Mr Ellis-Dears did not reflect the individual needs of Mark, his previous contact with services, or adequately reflect the context of standard four of the NSF.[53] There was no coordination of service provision, no planned contact time, and no planned reviews even after receipt of the forensic report. In summary, the care plan was inappropriate and ineffective, offering no support to Mark, his carers or other members of the care team.

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[53] We believe this is because, as set out in paragraph 250, Mr Ellis-Dears did not read Mark's notes before his first meeting with him, nor did he read them before writing the care plan.

CONSIDER THE EXERCISE OF PROFESSIONAL HEALTH AND SOCIAL CARE JUDGEMENT BY THOSE INVOLVED IN MARK HARRINGTON'S CARE

GP PRACTICE

211. We considered whether Mark should have been referred to the psychiatric service earlier than 6th October 2000 given that, five weeks earlier, on 30th August 2000, GP Dr Yates saw Mr Harrington who told her that Mark:

- was becoming aggressive and paranoid;
- was cleaning and washing bacon before he cooked it;
- padlocked the door to his bedroom;
- had been smoking lots of cannabis in his room, and
- had tried to buy an air gun.

212. Dr Yates was understandably concerned at this information and agreed with Mr Harrington's suggestion to see Mark within 48 hours and if Mr Harrington could not get Mark to attend surgery, then she would make a home visit. However, when Dr Yates followed up Mark's non-attendance at surgery she allowed herself to be dissuaded from a home visit by Mark's mother, because she was concerned that as Dr Yates *'wanted to come straight away,* (Mark) *might get carted off immediately'*. At this stage, there was no evidence available to Dr Yates that Mark was a danger to others, so her decision not to proceed with the visit was probably correct. This was confirmed when a week later Mr Harrington telephoned Dr Yates to tell her that he was fairly happy to leave things as they were, because Mark seemed better now that he was back at college, and he undertook to contact the practice if they had any further concerns.

213. A week later - on Friday 15th September 2000 - GP Dr Ashe was told that Mark had been involved in a fight which resulted in him being 'glassed,' and that as he was afraid to visit the surgery for fear of another attack, he asked for a home visit. This was arranged for Monday 18th September. However, the following day, one of Mark's parents telephoned to express his/her concern about Mark's behaviour. He/she explained to Dr Rosbottom that Mark had not only been excluded from college because of his '*intimidating*' manner, but he had also said that he had few friends, which he felt was because people were jealous of him and they wanted him dead. As a result of this conversation, Dr Rosbottom visited Mark at home later that day. It was her impression that there was no evidence of psychosis at that time, but that the family should remain watchful. This conclusion, in the light of Mark's history, is more questionable, in our view. However, it has to be recognised that

a week later, when the ‘glassing’ incident sutures were removed by GP Dr Buckley, he noted that Mark seemed to be ‘*mentally okay*’.

214. It is clear that Dr Yates continued to be concerned about Mark because as she knew CPN Heather Crook was due to see Mark’s mother on Monday 9th October, on 4th October she asked her to check how Mark was with Mrs Harrington.

214. Two days later, ie a fortnight after he had last seen him, GP Dr Buckley saw Mark in surgery. He recognised Mark’s paranoid ideas were causing pressures within the family, so he referred him to consultant psychiatrist Dr Chattree as an urgent case.

216. Following that referral, as more than eight months passed before Mark was detained under the Mental Health Act, it would seem that even if the GP practice had referred Mark earlier, it would not have made any difference. Accordingly, we make no criticism of the general practice’s handling of Mark Harrington’s illness.

DR DAVID BUTTERWORTH

217. Dr Butterworth saw Mark in clinic four times during 2001: 17th January; 26th January; 9th February and 20th June. At the time Mark was over 18 years old. Following the first two interviews (the second of which Mrs Harrington attended) Dr Butterworth wrote an excellent assessment of Mark’s condition and invited Mark to return to clinic two weeks later. That meeting was largely unproductive, and he failed to attend the following three appointments.

218. The last time Dr Butterworth saw Mark in clinic was when he attended on 20th June 2001 with his mother. At that meeting Dr Butterworth could reasonably have concluded that Mark was a danger to other people and should therefore be detained for assessment under the Mental Health Act. Instead, after consultation with Dr Chattree (footnote 14 refers), he offered him medication, which he refused, and set his next outpatient appointment for 2nd July.

219. In considering whether this was the correct action we are mindful that Dr Butterworth knew the family – he had met Mark three times and Mrs Harrington once before; he had diagnosed Mark as suffering from a major psychotic mental illness; he knew that Mark had assaulted his mother twice in three days, and that she was afraid of him;[54] he had the crisis response team’s report; and he had judged that Mark’s symptoms were gradually becoming more prominent.

54 On 2nd and 5th June - paragraphs 54 and 55 refer.

220. However, he told us he did not know of Mark's attempts to strangle his mother, or of his threats to kill her. In addition Mrs Harrington was quite clear in her request that Mark be allowed to finish his A level examinations the following week.

221. We find the decision whether to detain Mark to be delicately balanced. On the one hand, we recognise the tensions described by Dr Butterworth in paragraph 197, and having met Mark ourselves we can attest to his plausibility and the variability of his presentation.

222. On the other hand, we believe that Mark was clearly a danger to others and that Dr Butterworth probably gave more weight to Mrs Harrington's request than he should have done – certainly this is the view of Mr Harrington.

223. So we asked ourselves whether, if Mark had been detained on 5th or 20th June, instead of on 29th June, it would have made any difference. We take the view that the very earliest Mark could have been detained would have been 5th June. If that had taken place, then clearly Mrs Harrington would not have had to endure the third assault,[55] and an earlier start on Mark's treatment might have been beneficial. However, we do not believe that the three week delay made any appreciable difference to Mark's illness. And presumably Mrs Harrington felt the delay was justified because she had not only pressed for a delay, but she did not call for help from the medical profession until two days after the third assault. She did however, report it to the police, but as the police attended her house and did not make an arrest, she had presumably again declined to make an official complaint. We are also mindful that Dr Butterworth saw Mark at the time and we did not. He also knew Mrs Harrington. Accordingly, we conclude that it would be wrong to second guess him when the judgement is so finely balanced. Therefore, we support and approve of Dr Butterworth's decision to arrange another clinic appointment for Mark, even though we are aware of Mark's poor record of attendance at clinic appointments.

224. We believe Dr Butterworth was practising psychiatry at a high standard and his contribution to the service was widely respected by other community staff, even though we believe the supervisory system that was in place for Dr Butterworth at that time to be deficient. He was formally seen by the clinical director once a month, although he was always able to contact any of the consultants whose patients he was treating. We note that the current system is that Dr Butterworth has a weekly formal supervisory session, conducted in turn by each of the consultants whose patients he treats. This change pre-dated this Inquiry.

55 Paragraph 62 refers.

DR SHASHANK CHATTREE

225. Dr Chattree impressed us at first as a careful and caring psychiatrist who supervised his junior doctors thoroughly. When Mark first attended as an outpatient, Dr Nangia, his SHO, saw him, then presented the case to Dr Chattree who then interviewed Mark himself, and finally checked the letter Dr Nangia wrote to the referring GP.

226. Unfortunately despite this careful approach, the tragedy of Anthony Rigby's death ensued. We asked ourselves why?

227. It is understandable that Dr Chattree's initial judgement was to treat Mark as an *'ordinary'* patient: a young man with a first episode of schizophrenia. He would not have known that long before Mark was seen by Dr Nangia, a host of people believed Mark had serious mental health problems. These included many of the staff of his sixth form college; his teenage friends and contemporaries, and his father and sister – but not his mother who repeatedly denied that Mark had any serious psychiatric illness.

228. There was an interval of 10 months between the first time Dr Chattree saw Mark in clinic on 26th October 2000, and when he saw him on Darwen ward on 29th August 2001. During that time, he would have known, because Dr Butterworth told us he kept him informed, that:

    - he (Dr Butterworth) had written that he felt that Mark had a clear psychotic illness which required treatment, and that Mrs Harrington was keen to play down Mark's difficulties;
    - GP Dr Pollock had called out the mental health crisis response team to Mark and they had reported he had *'some very paranoid ideation'* and *'that his behaviour was threatening';*
    - Mark threatened to strangle his mother and physically restrained her in the car and on other occasions;
    - Mark had slapped his mother's face in the car.

229. He also knew that Mark seemed *'preoccupied and amused by other patients' suffering and he had a fascination with guns, knives, rifles and weaponry,'* because that is what his SHO wrote in the referral letter two days later to Dr Plunkett.

230. However, he not only seems to have forgotten these facts, but he also seemed to be unaware:

    - that Mark's father had been an inpatient of his during the autumn of 2000, and on a ward round had expressed his grave concerns about Mark;
    - of the potentially lethal assault Mark had made on staff nurse Connolly while under Dr Latif's care;

- of the evidence that Mark was continuing to abuse drugs;
- of his bullying behaviour towards other patients on the ward.

231. And he seems to have presumed that Mark was responding well to treatment and cooperating, and so could be processed routinely through the inpatient ward, back into the community. In fact, Mark was neither cooperating nor responding well.

232. He did not know that Mark probably stopped his medication almost as soon as he arrived on Darwen ward,[56] and discovered that he could get away with it there, unlike on Calder ward, where supervision was too close at medication times to be able to *'palm'* the tablets.[57]

233. Dr Chattree interviewed Mark on 2nd September 2001 to obtain his agreement, as the Mental Health Act code of practice requires, to treatment with medication continuing beyond three months. Mark said that he would take medication on the ward (though we believe he had already in fact stopped taking it), but made it plain that he would not take it in the community.

234. This should have rung alarm bells and led to a review at the next weekly case conference about Mark's compliance, ways to check on it, and the likely necessity of switching his medication from tablets (which are easily avoided) to a long-acting injection given by a nurse.

235. However, on 28th September, Dr Chattree recorded that there was *'some evidence of insight declining,'* and decided to increase Mark's medication from 6mg of risperidone daily to a total of 8mg daily,[58] but to continue allowing Mark to go home on leave, and to await the results of the forensic assessment which he had requested from Dr Plunkett. We find the increase of dosage at this time to be contrary to what we would have expected if Mark had really been making such good progress.

236. The forensic assessment was long delayed, but Dr Chattree seems to have been working on the basis that Mark was heading steadily and inevitably towards discharge and ignored what was going on - perhaps because he was misinformed. There were also fewer reports of Mark causing disturbances on the ward, probably because he was using his home leave and was off the ward much of the time.

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56 Dr Chattree was on annual leave when Mark transferred from Calder ward to Darwen ward, and he did not return to duty until 24th August. He saw Mark for the first time at a ward round on 29th August, so he would not have been familiar with his mental state and behaviour when well controlled by regular medication, and free from the influence of illicit drugs.

57 Mark's steady deterioration, following his rapid improvement when his medication was closely supervised on the PICU, supports his repeated accounts to both us and the two consultant forensic psychiatrists by whom he was assessed for pre-trial reports, of stopping his medication soon after he arrived on Darwen ward.

58 But this may have been futile, as Mark probably took little, if any, of it.

237. We believe it was a serious misjudgement to discharge the s.3 order on 4th October, when it still had more than three months to run. This prevented Mark being discharged home on trial leave and liable to rapid recall to hospital, and precluded the use of s.25, which would have offered some increased controls and enhanced care in the community. Consequently, Mark was discharged home to live with his mother, his most likely future victim, whom he had already attacked three times. Predictably therefore, just over two months later, Mark could have killed his mother on the motorway when he is alleged to have shot at her in the car when the red fuel warning light came on.

238. We also believe that if he had been properly assessed, he should have been discharged on extended leave, still under s.3, not to home, but to a well-supervised hostel from where objective reports could have been received about his behaviour. Alternatively, he could have received intensive CPN and social worker supervision at home, while being given long-acting injectable medication, and still be liable to recall to hospital under his continuing s.3, as Mrs Harrington believed was going to happen. Paragraphs 131 and 132 refer.

239. When Mark was discharged on 19th October, Dr Chattree still had another chance of retrieving the situation. He had wisely sought the opinion of consultant forensic psychiatrist Dr Plunkett about the risks of discharging Mark and how to manage him safely in the community. The long delay before Dr Plunkett's report arrived did not make things easier for Dr Chattree but even so, when he did receive it at the end of October, we know that he studied it carefully because he underlined many passages and distributed copies (with his underlining) to colleagues including Mr Ellis-Dears.[59] However, apart from passing a copy, apparently without comment, to Mr Ellis-Dears at their review meeting on 1st November 2001, there does not seem to have been any discussion of its content, even when Mark failed to keep his appointment with them that day. Dr Chattree appears to have been re-assured by a brief chance encounter afterwards with Mark in the hospital car park, where Mark apologised for missing his appointment on the grounds of problems with his car. So, yet another opportunity was lost to modify Mark's care by introducing much tighter monitoring and controls on his behaviour - limited though these would have been in comparison with the situation had Mark's s.3 not already been discharged.

240. Dr Chattree then seems to have assumed that Mr Ellis-Dears was monitoring Mark thoroughly and would inform him if anything was amiss. There does not seem to have been a close, well-established, working relationship between them, and Mr Ellis-Dears commented to us unfavourably about this.[60] Despite this, we strongly believe that Dr Chattree, having read Dr Plunkett's letter and taken it so seriously that he underlined portions of it, should have taken more interest in this case.

59 Paragraph 113 refers.

60 Footnote 30 refers.

So that when the final opportunity for Dr Chattree arose to treat Mark, on 29th November, ie when Mark failed to keep his second outpatient appointment, Dr Chattree responded by writing to Mr Ellis Dears asking him to *'investigate'*. It was reasonable for Dr Chattree to expect Mr Ellis-Dears to take some action in response to this request, but when he heard nothing in reply from Mr Ellis-Dears, in a case like this, he should have had a mechanism for reviewing the situation himself after a short period.

241. We believe, that had Dr Chattree seen Mark in outpatients, or visited him at home in December, it is likely that however much Mark attempted to conceal his paranoid ideas and experiences, the deterioration by then would have been plain to an experienced clinician who already knew him, and that would have led to Mark's urgent re-admission to hospital. However, because of Mr Ellis-Dears' gross neglect, Dr Chattree did not see him.

242. Nor did Dr Chattree take any action when he was told on Wednesday 2nd January by Dr Butterworth about the Boxing Day incident[61] - presumably in the belief, alas, that as Mr Ellis-Dears had also been told, and the police were looking for Mark, there was little more he could do.

DR MOHAMMED LATIF

243. We were impressed with the service provided by Dr Latif, and we think his suggestion of a 'swop' of patients between Guild Lodge and Calder ward so as to facilitate Mark's admission there, was sensible and enterprising – he clearly recognised there was pressure on Dr Plunkett's beds. We can understand Dr Plunkett's concern that this was not the 'correct' way of doing things, and acknowledge that to be so. However, we believe there is a case for some flexibility of attitude in a case like this so that 'the best does not become the enemy of the good'.

244. We note that Dr Latif was liked and respected by both Mark and the nurses on Calder ward.

DR SIMON PLUNKETT

245. Dr Plunkett was then a well-trained but relatively inexperienced consultant forensic psychiatrist, a specialist in the assessment and management of aggressive and violent offender patients at Guild Lodge, the medium secure psychiatric unit near Preston. His help was requested by Dr Latif in the crisis shortly after Mark was admitted to the psychiatric intensive care unit (Calder ward) at Queens Park Hospital. He responded on 9th July 2000 - the day he received the request - alone, on his way

61 Paragraphs 143 to 149 refer.

home at the end of a working day. He found it difficult to assess Mark because he was heavily sedated by the large doses of medication he had been receiving. (This was probably the only way Dr Latif and his team could manage Mark's behaviour, because their locked ward lacked the physical security of somewhere like Guild Lodge, and Mark had already demonstrated that he could mount near lethal attacks on even formidably large members of staff).

246. Dr Plunkett indicated verbally to the PICU nurses, and to Mark himself, that he considered that Mark should be transferred to Guild Lodge. However, when his assessment letter, dated 11th July, arrived it was critical of Mark's over-sedation and resulting difficulties in assessment; requested more information; was evasive about transfer to Guild Lodge; and rejected Dr Latif's offer to take back, in exchange for Mark's admission, a difficult patient from Dr Latif's team who had had a contentiously long stay at Guild Lodge.[62] Clearly the urgency had evaporated: Dr Plunkett's nurses did not turn up to see Mark until 18th July, and their report was dated 14th August. Notwithstanding this, we conclude that Dr Plunkett's initial view – that Mark was dangerous and required transfer – was the correct one, and that he erred in allowing his initial, appropriate clinical impression – for whatever reason – to be overruled by the Guild Lodge admissions panel.

247. Had Mark been admitted to Guild Lodge in early July 2001, it is our view that his management would have been greatly improved, and his follow-up better organised. Whilst there was concern over stigmatising Mark as a *'forensic patient'*, in this serious case it would have served as a clear warning that here was a very dangerous young man whose management required special care.

248. Dr Plunkett's second contact with Mark was on 15th October, as a result of Dr Chattree's request of 29th August. Such a delay seems sadly accepted as normal for the forensic service for a non-urgent request (in contrast to the urgent request of 5th July), but it seriously affected Mark's management. We were impressed by Dr Plunkett's clear and thorough assessment report of 15th October, and the warnings it gave, particularly that Mark was still paranoid and unlikely to comply with medication. But by then it was too late to stop him being discharged home, and Dr Plunkett's sensible suggestions do not appear to have modified Dr Chattree's management, despite Dr Chattree's underlining passages in the report. Nor did it inspire Mr Ellis-Dears to give Mark the intensive follow up his case demanded.

249. So in this second assessment, Dr Plunkett's professional judgement was not at fault: the problem was the lack of expeditiousness of his response.

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62 In his response to our request that he check the factual accuracy of the statements in this report that refer to him, Dr Plunkett wrote to explain that he had agreed that the patient concerned was transferred to Guild Lodge for a period of three weeks, as soon as possible, during a telephone conversation with Dr Latif on 6th June 2001. However, he continued, Dr Latif failed to adhere to this agreement, consequently the patient did not return to Dr Latif's care for about three months. This incident seems to have influenced Dr Plunkett's response to Dr Latif's subsequent request for help.

MR MARK ELLIS-DEARS

250. Mr Ellis-Dears told us that he did not read Mark's notes before his first meeting with him, nor did he read them before writing the care plan.

251. When he did meet Mark and the family, he did not consider the risk factors within the family – nor did he even after he had been given a copy of Dr Plunkett's letter.

252. He acknowledged that Mark was on enhanced Integrated Care System (ICS) and that required him to be seen within seven days of discharge. (Indeed, Dr Chattree told us that he would have expected Mark to have been seen twice a week for the first few weeks after discharge, and several of the other people who we interviewed thought he should have been seen every four or five days).

253. To his credit, Mr Ellis-Dears admitted that he did not discharge his responsibility as Mark Harrington's care coordinator. He offered a number of explanations for this. He described Dr Chattree as autocratic, because he did not:

- consult or involve Mr Ellis-Dears in any decisions concerning Mark;
- lead the multi-disciplinary team as Mr Ellis-Dears thought he should have done;
- seem to think that care decisions should be a team responsibility.

In addition, Mr Ellis-Dears also had some additional responsibilities, in his role as an ASW, with a demanding case at Calderstones NHS trust.

254. He told us that he brought these matters to the attention of his manager, Lindsay Griffiths, at the monthly supervisory meeting held on 21st November - the last one before the incident - and showed her Dr Plunkett's letter. Mrs Griffiths recalled the meeting, acknowledged that Mr Ellis-Dears had shown her Dr Plunkett's letter, and admitted she did not read it.

255. It is clear to us that the attention which Mark received following his discharge from hospital, from the community mental health services of Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust in general, and Mr Ellis-Dears in particular, was seriously deficient.

MRS LINDSAY GRIFFITHS

256. Mrs Griffiths was the manager of the community mental health team which included both senior practitioner Mr Ellis-Dears and CPN Heather Crook.

257. It is clear from the notes and our interviews that neither Mr Ellis-Dears nor CPN Crook ever consulted with each other about the Harrington family, and Mrs Griffiths did nothing to see that they did. Within the mental health team, supervision was carried out by monthly meetings. At the meeting held on 21st November, Mr Ellis-Dears showed Mrs Griffiths the letter Dr Plunkett had sent about Mark, but Mrs Griffiths did not read it. Consequently, the advice and admonitions in the letter were ignored.

258. We conclude that Mrs Griffiths did not discharge her responsibilities for the management of Mark Ellis-Dears and Heather Crook adequately, nor did she ensure the ICS process was carried out effectively.

SENIOR MANAGERS

259. It became apparent whilst interviewing the senior managers of the service, that at the time of the incident there was not only poor management supervision and direction, but there was also a general acceptance of the differing cultures of the service and little drive to harmonise them. We believe this was not helped by the service having a joint management structure and health and social care managers sharing management responsibilities without clear lines of management accountability. Notwithstanding this, we were impressed with the determination of both Steve Hamer and Diane Wainwright to provide services which focussed on those with the greatest need.

MRS HEATHER CROOK

260. Although strictly outside the remit of this Inquiry, Mrs Crook's role in the affair cannot be ignored. If she had consulted with Mr Ellis-Dears about the effect Mark was having on her patient – Mark's mother – or if she had carried out her responsibilities more conscientiously, Mark's deterioration might have been brought to the attention of the medical staff and Dr Plunkett's advice about informing the police been taken, despite Mr Ellis-Dears' almost non-existent care for Mark.

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CONSIDER THE ADEQUACY OF LIAISON AND COMMUNICATION BETWEEN HEALTH, SOCIAL AND OTHER RELEVANTPROFESSIONALS IN MARK HARRINGTON'S CARE

THE NURSING STAFF

261. It is interesting to compare the notes of the multi-disciplinary team meetings (MDTs) of the PICU with those of Darwen ward. The most striking feature is the lack of a record of a nurse presence in Darwen ward – although we were assured by the clinical nurse manager that no MDT occurs without the presence of a nurse. That being the case, it seems that the nurses were not at that time, at least, making much of an impression at MDT meetings.

262. However, they were fairly comprehensive in recording observations, and from the records of contact between the community services - particularly insofar as the appointment of the care coordinator was concerned - it seems clear that relationships were professional and satisfactory.

263. We were assured, and we have no reason to doubt, that care coordinators have unrestricted access to patients' notes and they regularly engage in appropriate conversation about patients who are to be discharged under their responsibility.

THE COMMUNITY MENTAL HEALTH WORKERS

264. We were unimpressed with the communication and liaison between the community mental health workers – with the exception of the crisis response team who we feel provide an excellent out of hours service to both GPs and the community, with almost instant feedback via a report faxed to all concerned by following morning.

265. CPN Heather Crook's alleged explanation to Mrs Harrington, when asked why she did not involve herself with the whole family as three of them had mental health problems, '*that in clinical psychology you just have one patient*'[63] so dismayed us that we asked for a copy of Mrs Harrington's community notes. From these we learned that although CPN Crook wrote copiously and conscientiously about her visits to Mrs Harrington over the years, Mark - who if he was not the entire cause of Mrs Harrington's condition, certainly aggravated it - did not get a mention in Mrs Harrington's notes until 25th June 2001, and then only to the effect that there had been an argument between Mark and his father.

[63] We have referred to this conversation in paragraph 167, and surmised that CPN Crook actually said '*clinical psychiatry*' and Mrs Harrington misheard.

266. At interview we asked CPN Crook why, when she shared the same offices as Mark's care co-ordinator and Dr Butterworth, she did not initiate a family conference but we did not get a satisfactory answer.[64] Clearly she knew what was happening with Mark, although she could not recall GP Dr Yates requesting her to ask Mrs Harrington about Mark on 4th October 2000, but she did receive a copy of the crisis response team's report of their visit to the Harrington home on 5th June 2001. On both of her next monthly visits, Mark was mentioned and during December 2001, he was mentioned many times. It would seem that by then she was at last appreciating the effect Mark was having on his mother, but even then she did not organise a family conference.

267. We believe that CPN Crook provided mainly a 'contact' service to Mrs Harrington, that was delivered in an essentially 'blinkered' fashion.

268. Thankfully, we have been told that practice has changed now and with the re-structuring of the community mental health service and a number of new appointments, the 'blinkered' approach to families with mental illness is an attitude of the past.

THE POLICE SERVICE

269. We learned from the police that the officer who was often present in the hospital around this time - referred to by the nurses as their police liaison officer, and who they found to be helpful generally and particularly useful in accessing police services when they were needed - was PC Michael Winward, who worked with Bob Stafford, the clinical manager for the Pendleview psychiatric unit. His role was to reduce the number of absconders and patients missing from the ward.[65] This post has now been transferred elsewhere, but following our discussion with the Divisional Commander he has undertaken to examine the possibility that following the present re-structuring of community policing methods, a stronger link with the hospital can be re-instated.

270. We were also supplied with a comprehensive report of Mark's involvement with the police since his first contact with them a week after his 17th birthday. The report also sets out all the contacts the Harrington family have had with the police since then. Consequently, it has been very useful in enhancing the accuracy of our report.[66]

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64 Later she wrote to us and explained that she was not involved with the whole family because of confidentiality issues and she is not a trained or accredited family therapist.

65 This was not a permanent post, merely a temporary re-allocation of duties.

66 A summary of all the contacts between the Harrington family and the police between June 2000 and 7th January 2002, together with some details of Mrs Harrington's car inspections after that, are shown as appendix C.

271. The report makes it clear [67] that as Mark did not have a police record for anything ‘serious’ he would not normally come to their attention unless other agencies requested it. We can understand that the police did not take Mrs Harrington’s complaints *very* seriously: we have read the transcripts of her telephone conversations: but we would have hoped that somebody might have wondered whether there was a pattern developing in the Harrington family.

272. The police began to search for Mark after his mother reported the Boxing Day incident at about noon on 28th December. Mark was first apprehended just after 11pm on New Year’s Eve – 2? days later. Both he and his car were found to be *‘offence-free’*. At that time there were two warning signals: Mental and Ailment on his file. This had been created on 27th December 2001 in response to the report made by Mrs Harrington. Presumably, the police officers, even if they had seen the markers, did not feel they had sufficient grounds to detain him. There had it seems, been some discussion about this amongst the officers who were looking for Mark because it is recorded that the Burnley patrol asked whether they had any powers to detain him. Section 136 of the Mental Health Act was mentioned, as was searching for firearms and any large quantities of money, but nothing came of it because his presentation at that time, the police told us, did not meet the s.136 criteria and he had not committed an offence.

273. Mark was stopped again at about noon on 3rd January 2002. It was noted he was wearing dark clothing, but he did not seem to have been committing an offence.

274. In between those two stop checks, a police officer who visited Mrs Harrington at her home, during the evening of 28th December 2001, noted that *‘Mrs Harrington’s mental state is questionable. Although she is clear to a certain degree about the events stated, Mrs Harrington would on numerous occasions talk about unrelated matters in a confused manner. This obviously raised questions, about the validity and quality of the information supplied’*.

275. On 4th January 2002, Mark was stopped in suspicious circumstances outside British Home Stores in Blackburn. The officer noted that *‘this lad is mentally unstable and is not to be underestimated’*.[68]

276. We cannot therefore resist the conclusion, that this was an opportunity missed. The officer had obviously seen something about Mark that pointed to him having a mental health problem, but even though he was not wanted for a crime, given that there was a marker on his file, we would have hoped that he might have been removed under s.136 of the Mental Health Act to a place of safety for assessment of his mental state.

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67 For the relevant extract, see appendix D.

68 This was reminiscent of the police officer who recorded after the glassing incident on 12th September 2000, that Mark *‘wears a car foot mat which he has shaped like body armour and he is one to look out for’*.

277. In summary, the police had contact with Mark five times in the week between Friday 28th December 2001 and Friday 4th January 2002: once in Leeds; once on the M40; once in Colne; once at Clayton-le-Dale and once outside British Home Stores in Blackburn. But, the police told us, as his presentation did not meet the criteria for arrest, he was allowed to continue on his way.

278. However, they also told us that if a senior NHS person, such as Mark's care coordinator or his consultant psychiatrist, had informed them that they believed Mark had become a danger and should be detained for assessment and treatment, he would have been detained.

279. It is absolutely plain from this tragic episode that both the mental health community services of Queens Park Hospital and the Eastern Division of the Lancashire Constabulary worked within their own boundaries and did not liaise. It is also clear that if they had liaised, although the police could not reasonably have been expected to have initiated this, a very distressing incident might have been avoided.

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MAKE RECOMMENDATIONS ABOUT ANY ACTIONS THAT THE PANEL BELIEVE SHOULD BE CARRIED OUT BY THE PCT AND SERVICE PROVIDERS BECAUSE OF THEIR FINDINGS

PATIENT RECORDS

1. Pre-admission information should be an integral part of hospital care planning. It should therefore be checked and explored as the opportunity arises with carers and others who were involved with the patient before his/her admission.

MEDICATION

2. Previous non-compliance with medication should be identified in care plans and risk assessments to encourage medication usage checks to be carried out.

3. The use of rating scales to assess psychotic symptoms would improve the assessment of mental state and assist in decisions about compliance.

NURSING RECORDS

4. Nursing care plans and records should be a key reference document for the team.

5. Risk profiles should be completed sequentially and regularly, wherever possible, by the same staff to encourage comparison, consistency, and to highlight change.

WARD STAFFING

6. The staffing levels on Darwen ward should be reviewed to reflect the need for planned therapeutic activity.

7. The range of therapeutic activities available for younger adults in the wards should be broadened by the involvement of a planned programme of weekly activities, coordinated by occupational therapists and psychologists.

SUBSTANCE MISUSE

8 The trust should support the care team in dealing with inpatient substance misuse by producing a robust policy to deal with the issue. The policy should recognise that:

   i. previous substance misuse or excessive alcohol consumption, should always act as an indicator of a potential for disturbed behaviour and be identified on care plans;

   ii. continued substance misuse should trigger a case review by the care team and appropriate action should be taken to both reduce it and modify future care plans;

   iii. all patients suspected, or with a history of, misusing substances should be subjected to automatic drug testing on return from leave however short.

9. The trust should, in partnership with the police, consider the use of acute wards as training areas for police sniffer dogs, to reduce the supply of illicit substances.

10. The police should be requested to consider formal warnings to patients found to be in possession of illicit substances.

HOME LEAVE

11. Nursing staff should assess the value of leave taken by patients on their return before further leave is planned, with a positive leave assessment acting as the main consideration for further leave.

12. Home leave should be part of a planned programme of care that is monitored through home visits by a named care coordinator together with feedback from a number of different sources.

DISCHARGES

13. The frequency of follow up appointments for recently discharged patients should be prescribed.

14. Discharge care plans should be prepared by the multi-disciplinary care team, and should take into account all care history and contact with the service.

15. More frequent use should be made of s.25 when high risk patients who have enduring mental illness are discharged.

MULTI DISCIPLINARY WORKING

16. A policy for multi-disciplinary working should be developed and all staff should comply with it. The policy should require that, amongst other things:

    i. the roles of the multi-disciplinary team members are defined.

    ii. records of attendance at ward rounds and discharge planning meetings are kept;

    iii. key discussion points and any disagreements about care and treatment decisions are accurately recorded.

COMMUNITY MENTAL HEALTH TEAMS

17. The community services should focus on those with severe and enduring mental illness, with the development of early intervention and assertive outreach services.

18. The in-patient care planning process should be reviewed to enable easier transfer of care between community care and hospital episodes.

19. There should be a single record of service contact that covers both community and hospital care.

20. The supervision of community mental health workers should be strengthened by carrying out independent external audit checks of their practice.

21. Those who are appointed as care coordinators should receive training in the role and function of the post.

22. When more than one member of a family is involved with services, the role of the care coordinators should be clarified and agreed.

23. The role of the trust grade psychiatrist in the care team should be defined.

24. The crisis response team should be re-focussed to give emphasis to those known to the service and subject to the care programme approach, so as to ensure appropriate crisis response as outlined in standard four of the NSF.

POLICE[69]

25. Training should be offered to police officers to:

    i. improve their recognition of mental health conditions;

    ii. enhance their familiarity with the appropriate sections of the Mental Health Act to improve their confidence in its usage;

    iii. provide them with knowledge of the most suitable contact points with the service.

SERVICE MANAGEMENT

26. The trust and the local authority should agree a single line management structure that reflects the needs of the care groups for whom they are responsible, and provides clear lines of managerial responsibility and accountability.

27. Closer links should be developed between the forensic and general adult services to strengthen relationships, foster good practice and improve the use of the trust's resources.

28. The trust should consider supporting the families of victims whenever serious untoward incidents occur.

29. Disciplinary action should be considered in appropriate cases.

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69 Recommendations 9 and 10 also apply to the police.

APPENDIX A

MRS RIGBY'S QUESTIONS

1. What investigations have been carried out to prepare the internal report and will I be able to see this report? I know I am entitled to see the external report, but this will be months away and I cannot wait that long.

   Whilst the internal report does not mention how many times the team met, it does indicate that the panel of four people took statements from 10 people and interviewed 11. They produced a 30 page report that provided a useful foundation for our Independent Inquiry. The distribution of the report is a matter for the hospital that commissioned it. We suggest you contact the chief executive of Lancashire Care NHS Trust.

2. Whose care was Harrington under and why was he not chased up and further action taken when he failed to attend his appointments? You say he had been diagnosed schizophrenic – surely he needed to be seen regularly to ensure he was taking his medication – which it has now been established he wasn't.

   During his $3^1/_2$ month inpatient stay, Mark Harrington was under the care of consultant psychiatrist Dr Latif for the first six weeks and consultant psychiatrist Dr Chattree for the remaining 10 weeks. At discharge, his care became the responsibility of community mental health worker Mr Ellis-Dears and Dr Chattree. In fact, it could be argued that Mark missed only one appointment: an out patient appointment arranged for 30th November. Although he did not attend his first out patient appointment on 1st November, he did meet Dr Chattree in the car park and, apparently plausibly, apologised and explained the reason for his lateness. However, it is true that his care in the community was very disappointing and unprofessional. The details of this, and our comments appear in the report.

3. What tests were carried out on Harrington to say he was not a risk to the public and could be treated as an outpatient? I have been told a risk assessment was carried out on him and yet you failed to pick up on his obsession with weapons and firearms. Surely an obsession like this, of a schizophrenic, should be spotted during any risk assessment?

   There is no doubt in our minds that when Mark was transferred from the psychiatric intensive care unit to Darwen ward, his condition had not only stabilised, but he had responded positively to treatment. Clearly this was due to the care and treatment he had received on Calder ward. It is also apparent to us that soon after his transfer to Darwen ward, he not only reduced or stopped taking his medication, but he started using illegal substances again. Taken together, these responses to his freedom exacerbated Mark's paranoia and led to the crescendo of aggression during December 2001 that peaked in January 2002.

It was known to Dr Chattree that Mark had a fascination with guns, knives, rifles and weaponry. Indeed his letter to Dr Plunkett referred to it.

4. What factors are taken into consideration in a risk assessment? Are they to be changed or altered in this way as they obviously are not detailed enough and have some sort of flaw.

   The risk assessment of psychiatric patients is not an exact science. People change their attitudes and behaviour in response to influences such as alcohol, narcotics, depression, anger or provocation. It is also true that the best indicator of future behaviour is past behaviour. When Mark was discharged it was known that he had a history of violence towards others – particularly his mother – although it was not appreciated at that time just how afraid both his family and many of his friends were of him. However, the letter sent by consultant forensic psychiatrist Dr Plunkett set out the very real dangers that Mark might present to the community, but his warning went unheeded.

5. What made you think he was sane enough to be let into the community on his own with no constant supervision?

   Mark Harrington's return to the community was not a sudden event. Shortly after he was transferred from the psychiatric intensive care unit to the care of consultant psychiatrist Dr Chattree in Darwen ward, preparations for his discharge began – as indeed they do for nearly all patients. Essentially these preparations were changes to his medication, unescorted leave on the hospital premises, three hours home leave in the care of his mother at a time initially, gradually increasing through overnight leave, weekend leave to a full week's leave (with two returns to the ward during the week). His mother indicated that his leave was going well, and the care coordinator supported the arrangements. There never was, nor could there be, ***constant*** *supervision. Constant supervision is available only in locked wards or secure units.*

6. How long was he in hospital for and what treatment did he receive while he was there? This treatment obviously didn't work. During the Court hearing, they said he missed four appointments and failed to take his medication. What action was taken to try and locate Harrington and ensure he took his medication? Were you aware he had not been taking his medication? If not do you not need some sort of check to make sure he takes his medication? To me and my family it just feels as though you have washed your hands of him and could not be bothered chasing around after him – is this the case?

   Mark Harrington was admitted to hospital on 30th June 2001 and discharged on 17th October 2001 – a period of nearly 16 weeks. Whilst he was there, he received the usual range of treatment for a patient with his condition. The details of his treatment, including his medication, are detailed in the report. The four appointments that he is said to have missed were between November 2000 and May 2001 (ie before his admission to hospital). The failure to take his medication began during his stay in Darwen ward and continued after his discharge. Tragically, very little effort was made by the care coordinator to see Mark during the 11 weeks between his

discharge from hospital and the murder of your son. Consequently Mr Ellis-Dears had no knowledge that Mark was failing to take his medication.

7. I have been told about incidents that have happened in your mental care unit involving Harrington being extremely violent. One of those incidents includes him hitting a nurse about the head with pool balls placed in a sock by him. That in itself could have killed somebody and yet months later he was allowed to be roaming the streets with no care whatsoever. Surely your 'risk assessment' should have picked up that somebody who could hit a nurse, of all people, with pool balls is a risk to the public? Yet he has not had the care and attention he obviously needed. If he had had that care and attention he would not have been able to murder my son – for this I do and always will blame Queens Park Hospital unless I received satisfactory answers to the contrary.

   The details of the attack on the staff nurse in the psychiatric intensive care unit are set out in paragraph 68 of our report. Fortunately, the nurse was not seriously injured - he did not take any time off work as a result of the attack – but certainly the staff on duty thereafter took the incident very seriously and for several weeks – until the medication started working fully – Mark Harrington was accompanied day and night by at least one nurse and sometimes by two or even three nurses.

8. The two doctors who examined Harrington said that his condition was rapidly deteriorating. Were your doctors also of this opinion? If they did not get a chance to see Harrington before he murdered my son, surely this shows you that there is some flaw in your systems in that you can allow somebody to make the decision not to take medication and attend appointments which could help them and stop them doing things like this.

   The two doctors who saw Mark did so a long time afterwards and they knew he had killed somebody. Queens Park Hospital doctors did not have anything to do with Mark once he had been discharged. In fact, as the report states (paragraph 122) the last time Dr Chattree saw Mark Harrington was in the car park of Queens Park Hospital on 1st November 2001, when Mark apologised for being late for his first outpatient appointment. The Mental Health Act allows patients to be discharged under certain conditions that would enable more intensive supervision, as if on licence (s.25) but this was not used in Mark's case. Mrs Harrington told us she understood that this sort of arrangement was to be used (see paragraphs 131 and 132). Our views on this decision are set out in paragraph 238.

9. Do you think you need to make any changes here at Queens Park? I know there is an external investigation taking place but that is by an outside authority. Do you think you have contributed to this tragedy in some way by allowing Harrington to miss his appointments and not take his medication? I know you can say that it was his choice but if he is mentally ill he should not be allowed that choice, as he is not capable of choosing the right option.

   The internal review report set out a number of recommendations for changes which the panel felt

would improve the care of mental health patients and reduce the possibility of these events happening again. This report sets out a further 29 more.

10. Why weren't my family and myself told about this investigation? It took me to write to you to find out anything. Can you imagine how it feels having to read about things in the paper that involve my family? Myself, my family and Anthony deserve more than this and you have caused so much stress and worry by us not knowing what is happening. We wanted answers and to know what had happened. Instead we were ignored and it felt as if you were brushing the whole thing under the carpet because we had no idea what was happening. It has been 10 months since this started. Ten months of absolute hell and you could have made it just that little bit easier by writing a few lines just to let us know that you doing something. Is that really so much to ask?

    Clearly the procedure for the handling of what is known in the NHS as a serious untoward incident, should have been explained to you. Briefly, incidents are graded by their severity, and an incident of this seriousness will not only attract an internal review, but an independent external inquiry also. As the name implies, none of the panel are connected in any way to the hospital/unit involved and the panel members are usually experienced in this sort of work.

    We hope that you find this report will explain all the circumstances that led up to Anthony's death, and that you find it to be accurate, fair and comprehensive. We also hope that you recognise the merit of the recommendations and believe that the implementation of them will significantly reduce the likelihood of the same sort of thing happening again.

11. Finally, why have two doctors who have only examined him a few times, been able to say he is danger to the public and should be sectioned, yet your department has let him go home and be able to murder my son. This will haunt me and my family for the rest of our lives – we too are serving a life sentence and you could have stopped this happening.

    Mark Harrington was clearly a danger to the public when he was sectioned on 29th June 2001. There can be absolutely no doubt about that. The staff of Darwen ward believed, when Mark was discharged on 17th October 2001, that Mark would no longer be a danger to the public if he continued to take his medication and his care in the community was supervised by the care co-ordinator who had been appointed to carry out this work. The fact that Mark did not take his medication, that he re-started substance abuse, and that his care coordinator did not know of these highly significant behaviour aberrations led to the horrendous events of 7th January 2002. As a panel, we have been very concerned by all we have learned, and, like everyone else involved in this matter, we wish it could have been otherwise. If the clock could be turned back, it would be done. However, that is impossible and all the NHS and social services staff who have been affected by this tragedy, extend their condolences to you.

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APPENDIX B

A&E ATTENDANCES

1. On 23rd June 1992 with trauma to Mark's nose. Mrs Harrington was not happy with shape of Mark's nose so were invited to return to clinic on 22nd June to say whether she wanted manipulation of the fractured nose. They did not attend.

2. On 10th March 1995, Mark was brought in by parent at 10.30am with an injury to his left index and middle fingers from football the previous evening. The injuries were X-rayed and diagnosed as left finger/phalanges sprained/strained.

3. On 21st August 1995 self-referral with injury to back. Treated with (NSAID) non-steroidal anti-inflammatory drug, and discharged to GP for further management

4. On 16th January 1996 by ambulance at 10.45pm with laceration to his right leg caused by a Stanley knife. The wound was dressed and he was referred to his GP for further treatment.

5. On 26th April 1996 at 11am brought in by a parent with a metal splinter in his left index finger. The wound was dressed and he was discharged.

6. On 19th January 1997 Mark was brought in by a parent at 8.30pm with an injury to his left ankle from football that day. Normal treatment provided and not admitted.

7. On 29th January 1998 brought in by a parent with injuries to his right arm from a fall two days previously. He was diagnosed as having sprained his right wrist and was invited to be seen again if necessary.

8. On 28th November 1997 brought in by a parent with an injury to his right knee from playing football at school the previous day.

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9. On 18th May 1998 self-referral with a laceration to his right index finger. Wound dressed and discharged to his GP.

10. On 6th July 1998 Mark was brought in by a parent at 10.45 pm with an injury to the index finger of his right hand. His hand was X-rayed and the wound was dressed.

11. On Tuesday 10th August 1999 Mark was brought in by others at 3.30pm with an injury to his left arm

and the right side of his face. His injuries were X-rayed and diagnosed as left wrist contusion/bruising.

12. On Tuesday 30th May 2000 assaulted on his face. He re-attended on 5th June complaining of slight decrease of vision on his left side. Booked for review on 9th June but arrived on 12th June.

13. At 11.30pm on Tuesday 12th September 2000, Mark arrived in an ambulance with lacerations to his face from an alleged assault. Admitted to ward.

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APPENDIX C

SUMMARY OF THE CONTACTS BETWEEN THE HARRINGTON FAMILY AND THE POLICE BETWEEN JUNE 2000 and JANUARY 2003.

21st June 2000	A police report noted that at 3.11am Linda Harrington contacted the police stating that her mother, father and brother were having a '*big fight – they are all screaming and shouting*'. The operator noted that the caller sounded distressed and stated that her mother had a mental illness. An officer attended and classed the incident as a non-violent domestic. Mr Harrington left the premises and a request was made (it does not say who by) to treat all calls from that address as urgent.
29th April 2001	Mark's GP requested a police escort to make a home call at the Harrington household to assess Mark because he had assaulted his mother. The visit did not take place because Mark was not at home at that time, and Mr and Mrs Harrington decided not to make a complaint.
2nd June 2001	Mrs Harrington contacted the police and told them '*Mark is threatening the family with violence – he's been acting strangely for a while now. He seems very paranoid. He's pushing Mr Harrington around tonight*.' However, as Mark's parents declined to make a formal complaint and an appointment for Mark to see a psychiatrist was less than three weeks away, no house call was made.
27th June 2001	Mrs Harrington reported she had been the victim of an unprovoked assault by her son Mark who had psychiatric problems. She met the officers on the driveway of her house as she was afraid of him but no arrests were made.
29th June 2001	Police called to be present for a mental health assessment. Mark absconded so it did not take place.
30th June 2001	Between 3.39am and 3.45pm, Mrs Harrington telephoned the police four times to tell them of Mark's arrivals and departures. Finally, he remained in the house long enough for the police to arrive and escort him to Queens Park Hospital for detention and assessment.
5th July 2001	The police were informed of Mark's assault on staff nurse Connolly on the ward but as the staff nurse did not wish to make a complaint, and as they knew Mark would not be prosecuted, they took no action.

28th December 2001	Mrs Harrington reported to the Smethwick police the details of the abduction and threats to kill, which Mark had carried out the previous day. However, the Lancashire police records show that the West Midlands police were not told of a firearm being used in the car nor had a formal complaint been made. At 2 o'clock that morning, Mark was stopped in Leeds by the police, for an unknown reason. He was body checked and cleared. At 9am Mark, still in his mother's car, was believed to have caused an obstruction on the pavement outside the post office on Burnley Road, Colne. The police were informed but he had departed before they arrived after gesturing and pointing his finger in a threatening manner at the informant. At 7.30pm Mrs Harrington's car broke down on the M40 and after being visited, at the roadside, by two police officers from the Thames Valley force, Mark abandoned it and returned to the north west. At about the same time the police offered to re-house the Harringtons, but they declined, saying they were not making any formal complaint and accused the police of 'over-reacting'. The attending officer formed the opinion that '*Mrs Harrington's mental state was questionable*. *'Although it is clear to a certain degree about the events stated'*, he had written, *'Mrs Harrington would on numerous occasions talk about unrelated matters in a confused manner. This obviously raised questions'*, in the attending officer's mind, *about the validity and quality of the information supplied'*.
29th December 2001	Mrs Harrington's car was thoroughly searched and no evidence of a firearm being discharged in it was found.
31st December 2001	Just after 11pm, Mark was stopped whilst driving his car in Colne. His car was found to be free from firearms or other similar looking articles. It appeared to the officers that he had been sleeping in his car. There is also a reference in the file that about twenty minutes later, Blackburn police received a call from the Pennine communications centre stating that a patrol in Burnley asked whether they had any powers to detain him. It seems a conversation took place and s.136 was mentioned. As was searching for firearms and any large quantities of money but nothing seems to have come of it.
3rd January 2002	Mark was stopped just after 12 noon on the A59 near Clayton-le-Dale. He was reported to be wearing dark clothing and a dark baseball cap. No offences were discovered.

	Just after 5pm Mrs Harrington, following Mr Ellis-Dears' advice, telephoned the police and asked for a *'place of safety'*. An hour later she changed her mind, and asked that her home be made more secure.
4th January 2002	A police officer fitted a door bolt to Mrs Harrington's back door that he and Mrs Harrington had bought at B&Q the evening before. Mark was stopped in suspicious circumstances outside British Home Stores in Blackburn. No offences were noted, but the officer recorded that *'this lad is mentally unstable and is not to be underestimated'*.
7th January 2002	Mark told his mother and a consultant forensic psychiatrist that early that morning, a police officer came across Mark who was parked at Tesco's in Blackburn town centre; asked him what he was doing and invited him to get out of the car. At the time Mark said, he had a gun and cartridges in his pocket but before getting out of the car, he placed the gun in the car door pocket. The policeman ordered him out of the car, handcuffed him and took him to Blackburn police station where he was detained for a time then released. He returned to his car and drove home. The gun was still there. However, there is no evidence in the Lancashire police files to support Mark's account. Mrs Harrington told us she telephoned the police to tell them that she thought that Mark had gone to Anthony's and asked them to pick him up there. There is however, no mention of this telephone call in the records of the Lancashire police.
10th January 2002	Mrs Harrington retrieved her car from Slough. She told us she had been informed it had been examined by police forensic staff but they could find no evidence that a gun had been fired in it. This same finding was relayed to the Blackburn, Hyndburn & Ribble Valley Healthcare NHS Trust mental health services manager by a Blackburn police officer.
18th January 2002	Two Lancashire police officers examined the car in which Mrs Harrington stated that a firearm had been discharged in December 2001, but they too could find no visible evidence that a firearm had been discharged in the car, nor was there a record of the car ever being subjected to forensic examination.

APPENDIX D

AN EXTRACT FROM THE REPORT COMPILED BY THE EASTERN DIVISION OF LANCASHIRE CONSTABULARY FOR THIS INQUIRY

Before the Crime and Disorder Act 1997 was implemented, it would be fair to say that the police and probation service were reluctant to share potentially vital information. However, the implementation of the Act has encouraged closer working practices between agencies. The police and the probation service have agreed a protocol which allows information sharing through the 'high risk strategy meeting' forum, although it must be noted that this only works in relation to convicted offenders who fall under the remit of the probation service as the legislation was mainly focussed on registered sex offenders, although other offenders of note would sometimes be included. Health authorities were not compelled to share information held, although they could access the meetings if requested.

In April 2001, a 'high risk offenders team' was established in the Eastern division of the Lancashire Constabulary. Its remit is to monitor and manage 'high risk offenders' resident in the division.

The high-risk offender team is reliant upon information from other agencies in order to conduct risk assessments and monitor potentially dangerous offenders within the division. In particular, professional and medical assessments are essential for those individuals who have few or no convictions and so would not usually come to police attention.

In response to this issue, this team has attempted to strengthen links with the local mental health authorities. Pete McFarlane of the community mental health team now works from the Blackburn custody office and will attend MAPPP's if requested (**M**ulti **A**gency **P**ublic **P**rotection **P**anel meetings) in order to share any medically confidential information.

No contact was made with any officer on this team before the murder of Anthony Rigby. Any information held about Mark Harrington was in the form of reports from his family, other agencies and through vehicle stop checks conducted by police officers.

The only working relationship the police had with staff at Queens Park Hospital was instigated by PC Michael Winward. He worked with Bob Stafford the clinical manager for Pendleview psychiatric unit at the hospital. This was a partnership aiming to reduce the number of absconders and missing patients from the ward.

Before January 2002, the only convictions Mark Harrington had were for driving offences although he had received a caution for a common assault. He had not been imprisoned or made subject of a hospital order

and there was no probation service intervention. Therefore, he would not be classified as a high risk 'violent offender' for police and probation purposes. The only ongoing contact Mark Harrington had with any authority would have been through the mental health services.

However, following his manslaughter conviction, Mark Harrington would now fit into the violent offender category and should he be released into the community, the police and probation service would have a statutory duty to monitor and manage any risk he may pose to the public. To be effective this could only be done in partnership with other agencies.

In conclusion, it is clear that Mark Harrington had a mental health illness, which resulted in the tragic death of Anthony Rigby. However, as the relationship between the police and the mental health authorities had not been sufficiently developed at that stage, it is unlikely that the police would have been able to foresee the potential risk that Mark Harrington posed to the public. There has been a noticeable improvement in the working relationships between agencies since this incident. This must be encouraged and developed in order to manage effectively the ever-increasing number of violent/sex offenders within the division.

THOSE WHOM WE INTERVIEWED

Ann Chapman	approved social worker, CMHT
Barry Wilson	charge nurse, Darwen ward
Christine Platt	staff nurse, Calder ward
David Butterworth	trust grade psychiatrist, CMHT
David Mallaby	divisional commander, eastern division, Lancashire Constabulary
Diane Wainwright	clinical nurse manager, Pendleview unit, QPH
Hayley Wallwork	staff nurse, Darwen ward
Heather Crook	care coordinator to Mrs Harrington, CMHT
Ian Fletcher	primary nurse to Mark whilst on Calder Ward
Janice Saddington	manager of Darwen Ward
Linda Harrington	sister of Mark Harrington
Lindsay Griffiths	manager of community mental health team
Mark Ellis-Dears	senior mental health practitioner, Blackburn with Darwen Borough Council
Mark Harrington	the subject of the inquiry
Michael Finlay	principal, St Mary's Sixth Form College, Blackburn
Mohammed Latif	consultant psychiatrist, Queens Park Hospital
Monica Nangia	SHO to Dr Chattree
Neil Smith	detective chief inspector, Lancashire Constabulary
Patricia Harrington	mother of Mark Harrington
Paul Leach	staff nurse, CMHT
Peter Cook	ward manager, Calder ward
Peter Harrington	father of Mark Harrington
Richard Pollock	general practitioner, St George's surgery
Shashank Chattree	consultant psychiatrist, Queens Park Hospital
Shirley Fletcher	approved social worker, CMHT
Simon Plunkett	consultant forensic psychiatrist, Guild Lodge
Steve Hamer	manager of community mental health services
Tim O'Shea	head of mental health, Blackburn with Darwen Borough Council
Zoe Davie	staff nurse, Darwen ward

ACKNOWLEDGEMENTS

We would like to thank in particular Gillian Collinge for arranging all our meetings with unfailing courtesy and promptness. In addition, the staff of the primary care centre at QPH who, over a period of nearly six months, cheerfully provided us with all the help and support that they could, even though we were disrupting their normal arrangements. In addition, we thank Chief Superintendent David Mallaby and Detective Chief Inspector Neil Smith for the thoroughness of the report they prepared for us – we believe it contributed significantly to the accuracy and the balance of our report, and Michael Finlay, the Principal of St Mary's Sixth Form College, for taking the time to see us and keeping such comprehensive records of Mark's period at his college.

APPENDIX G

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APPENDIX H

THE PANEL

Bill Greenwood *Chairman*	Solicitor (non practising) GHT, Burnley
Trish Anderson	Director of Mental Health Wigan Metropolitan Borough & Five Boroughs Partnership NHS Trust
Dr Angus Campbell	former Consultant Forensic Psychiatrist Mental Health Services of Salford NHS Trust
David Curtis	Director of Nursing and Corporate Development Pennine Care NHS Trust
Peter Tallentire	former Director of Personnel Royal Liverpool Children's NHS Trust, Liverpool

LANCASHIRE CARE TRUST, BLACKBURN WITH DARWEN UNITARY AUTHORITY AND BLACKBURN WITH DARWEN PRIMARY CARE TRUST

ACTION PLAN IN RESPONSE TO THE RECOMMENTATIONS PRODUCED BY THE EXTERNAL INQUIRY INTO THE SERIOUS UNTOWARD INCIDENT INVOLVING MARK HARRINGTON – FINAL VERSION 19.11.03

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
PATIENT RECORDS	**1. Pre-admission information should be an integral part of hospital care planning. It should therefore be checked and explored as the opportunity arises with carers and others who were involved with the patient before his/her admission.**	Lancashire Care Trust/Blackburn with Darwen Social Services	1.1 Review admission procedures including assessment & care planning systems/ arrangements within the in patient unit at Queens Park Hospital.	Dec 03	1.1.1 CPA Care management systems are in place which include systematic arrangements for assessing health & social care needs involving the service user, carer and relevant others .	
					1.1..2 Action Learning sets now in place facilitated by the Health advisory Service for staff working within CMHT and Inpatient services to strengthen the interface between community and inpatient services with regard to procedures, care coordination and leadership arrangements	
					1.1.3 Staff receive regular training in Risk	

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
PATIENT RECORDS					Management and Risk Assessment processes and records are kept on attendance at training programmes.	To be audited by the integrated teams
			1.2 Transitional protocols to be developed and implemented between Education Services and Child and Adolescent Mental Health Services (CAMHS) and CAMHS and Adult Mental Health services	Jan 04	Draft protocol for transition between CAMHS and Adult Services	Transition Protocols to be agreed by relevant agencies.
			1.3 Case notes to be audited for documentary evidence of Carer/Others involvement in care assessment & planning processes.	Quarterly		Audit of casenotes/ CPA documentation to be undertaken re involvement of family members/carers/ others in care assessment & planning in line with standard 6 of the National Service Framework.

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
MEDICATION	**2. Previous non-compliance with medication should be identified in care plans and risk assessments to encourage medication usage checks to be carried out.**	Lancashire Care Trust	2.1 Medication Compliance issues to be explicitly identified as part of risk assessment and audited.	Mar 04	Section 10 of the CPA policy now implemented and provides guidance for staff on risk and crisis management strategies.	Audit of care plans to be completed re medication compliance issues.
			2.2 Care Coordinator to be responsible for ensuring issue of compliance/non compliance is identified, recorded and actioned in Care Plan and that a safety profile has been completed and a crisis/contingency plan in place and agreed with the Service User.	Jan 04	2.2.1 Section 10.15 of the CPA policy implemented and states that risk assessment should guide the practitioner towards a conclusion of the safety issues. 2.2.2 All Care Coordinators now produce crisis contingency plans in consultation with the Service User in the event of crisis or non-compliance. All care plans are now performance managed by CMHT managers 2.2.3 New safety profile completed at each CPA review as standard. Facility in place to formulate risk within safety profile for inclusion in the care plan & agreed by all	

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
MEDICATION CONT..			2.3 Full medication history to be carried out as standard for all patients to assess efficacy.	Jan 04	2.3.1 Section 10.16 of the CPA policy implemented which states the importance of paying particular attention to non compliance issues within care plans.	Need to establish with Primary Care
			2.4 Identify relevant Pharmacy support to provide advice and support to clinicians.	Jan 04	2.4 Pharmacy Service delivered through a Service Level Agreement via East Lancashire Hospitals for supply of medicines only.	Explore development of existing SLA
			2.5 Pharmacist to lead on continual monitoring of each medication plan prescribed for individual service users	From Jan 04		

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
MEDICATION CONT..	**3. The use of rating scales to assess psychotic symptoms would improve the assessment of mental state and assist in decisions about compliance.**	Lancashire Care Trust	3.1 Programme the use of rating scales to assess psychotic symptoms as standard e.g. psychotic symptom index and to assess side effects e.g. LUNSA's	Jan 04	3.1.1 Risk assessment tool has been modified and a training programme is in place to support implementation. A record is kept of those who attend the training programme.	
			3.2 Review and amend operational policies to reflect the above standard.	Jan 04		
NURSING RECORDS	**4. Nursing care plans and records should be a key reference document for the team**.	Lancashire Care Trust	4.1 Nursing Care Records to be integrated into one multidisciplinary health record.	March 2004	4.1.1 Development of electronic CPA and electronic health record in progress. 4.1. 2 Lancashire Care Trust to become an 'early adopter' national Integrated Care Record System.	
			4.2 Audit programme in place for monitoring access, content and quality of health record	Jan 04	4.2.1 Audit completed: 64 CMHT case files audited and action plan developed in response to audit findings	Action plan of learning points to be fully implemented
			4.3 Standards for record keeping to be agreed and implemented by the multidisciplinary team.	Mar 04	4.3.1 Effective Care Co-ordination group have produced a benchmarking tool to be rolled out across the Trust as part of the process for auditing content and quality of health record.	Appointment of an Audit Assistant & Peer Audit by ECC group

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
NURSING RECORDS CONT..		Lancashire Care Trust	4.4 Review training needs of multidisciplinary team for record keeping and documentation and identify the level of administration and clerical support required to improve the support to the multidisciplinary team.	Feb 04		Appointment of clerical and administrative support.
			4.5 Implement programme of training to address learning requirements.	Feb 04	4.5.1 CPA Coordinators are able to provide basic training in risk assessment and risk management only within the current resources available.	
			4.6 Review of Interagency sharing of information agreement to include standards for record keeping, access and security.	Completed	4.6.1 Achieved as per CPA Policy	To be monitored and reviewed anually
	5. Risk profiles should be completed sequentially and regularly, wherever possible, by the same	Lancashire Care Trust/Blackburn with Darwen SSD	5.1 Standards jointly identified, agreed, and implemented which are applicable to all disciplines pertaining to	Achieved	5.1.1 Standards within CPA policy agreed by all agencies. New Safety Profile completed at each CPA review as standard.	

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
NURSING RECORDS CONT…	**staff to encourage comparison, consistency, and to highlight change.**		the completion of risk profiles/CPA documentation.			
			5.2 Audit of compliance against this standard to be undertaken.	Jan 04	5.2.1 Audit of 64 case files completed – action plan now being implemented.	
			5.3 Role of Named Nurse to be defined within inpatient area regarding risk assessment.	Completed	5.3.1 Achieved. Defined within the CPA policy	Further work to be undertaken within Acute Care Forum
			5.4 Role of Care Coordinator to be defined within CMHT regarding risk assessment.	Completed	5.4.1 Achieved. Section 3 of the CPA policy outlines clear role and responsibilities of the Care Coordinator.	
			5.5 Training programme in place to prepare staff to undertake the role and function of a Named Nurse/Care Coordinator	Feb 04		Programme to be developed by ECC group
			5.6 Role of Responsible Medical Officer should be defined and subsequently actioned	Jan 04		
			5.7 All incidents of patient violence are reported and influential to the patients care plan.	Jan o4		Policy audit Introduce training

			5.8 All staff to be trained in violence and aggression management	Mar 04		
			5.9 Levels of violence and aggression to be recorded and reported monthly as part of the Trust's reporting framework	Mar 04		

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
WARD STAFFING	**6. The staffing levels on Darwen ward should be reviewed to reflect the need for planned therapeutic activity.**	Lancashire Care Trust.	6.1 Clinical Governance Review of care systems on Darwen Ward to be conducted and to include: a. Communication b. Activities c. Therapeutic Intervention d. Staffing e. MDT working f. Bed Capacity & Management issues g. Record keeping & Documentation.	Dec 2003	6.1.1 A whole systems review of Clinical Quality is currently in progress	
	7. The range of therapeutic activities available for younger adults in the wards should be broadened by the involvement of a planned programme of weekly activities, coordinated by occupational therapists & psychologists	Lancashire Care Trust	7.1 Advice to be obtained from Child & Adolescent Mental Health Services with regard to meeting the needs of young people admitted to inpatient facilities at Queens Park Hospital.	Jan 04	7.1.1 Activities Coordinator recruited to Calder Ward outside of current available resources	

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
WARD STAFFING CONT..			7.2 Young Persons Coordinator to be identified with specific responsibility for of young people admitted to inpatient wards and for developing arrangements to address the interface between leisure and therapeutic activity.	Feb 04		
			7.3 Each ward to have access to Activities Coordinator.	Apr 04		
SUBSTANCE MISUSE	**8. The trust should support the care team in dealing with inpatient substance misuse by producing a robust policy to deal with the issue. The policy should recognise that:**	Lancashire Care Trust/Blackburn with Darwen SS/Lancashire Police Force	8.1 Review current Policy in line with national best practice e.g. “Models of Care” and arrangements in place for dealing with issues of substance misuse in inpatient areas focusing on: - Specialist support to inpatient areas - Presenting risks - Security - Health & Safety - Operational policies & procedures – Guidance for staff	Jan 04	8.1.1 ‘Zero Tolerance’ policy introduced into ward areas. 8.1. 2 Arrangements in place with local police for supporting staff to manage presence of illicit substances within inpatient areas. 8.1. 3 CPA Policy implemented and incorporates details of how case reviews should be conducted (Section 7)	Staff Training

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
SUBSTANCE MISUSE CONT..	**a. previous substance misuse or excessive alcohol consumption, should always act as an indicator of a potential for disturbed behaviour and be identified on care plans;** **b. continued substance misuse should trigger a case review by the care team and appropriate action should be taken to both reduce it and modify future care plans;** **c. all patients suspected, or with a history of, misusing substances should be subjected to automatic drug testing on return from leave however short.**		8.2 Care Coordinator to liaise with Pharmacist to address impact of co morbidity and compliance with medication.	Feb 04		
			8.3 Dual Diagnosis pathway to be rolled out across the organisation.	Apr 04	8.3.1 Work in progress to develop Dual Diagnosis pathway across Lancashire care Trust. 8.3.2 Interagency awareness training available for In patient staff.	
			8.4 Identify dedicated Dual Diagnosis practitioner to provide expertise within inpatient areas.	Apr 04		Identify Dual Diagnosis practitioner

THEME	RECOMMENDATION	AGENCIES RESPONSIBLE FOR RESPONDING	REQUIRED ACTIONS	TIMESCALE FOR COMPLETION	PROGRESS TO DATE	OUTSTANDING ISSUES
SUBSTANCE MISUSE CONT…			8.5 Risk factors associated with alcohol consumption/drug misuse to be identified as part of risk profile and improved working relationship's developed with Substance Misuse Network with regard to: - Screening - Surveillance - Treatment	Jan - Apr 04	Risk profiles modified to strengthen process of risk assessment	Programme of work to be agreed with Substance Misuse Network re appointment of Dual Diagnosis Practitioner
			8.6 Care Co-ordinator to liaise with inpatient staff and substance misuse network to plan and specifically report on effectiveness of care management arrangements in place to manage risks associated with substance misuse when client returns from leave.	Dec 03		CMHT managers to monitor performance and report to senior managers

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SUBSTANCE MISUSE CONT..	**9. The trust should, in partnership with the police, consider the use of acute wards as training areas for police sniffer dogs, to reduce the supply of illicit substances.**		9.1 This issue be part of a consultation exercise with user and carer groups	Mar 04		
		Lancashire Care Trust/Lancashire Constabulary	9.2 Protocol to be agreed with local constabulary regarding surveillance arrangements in inpatient units.	Feb 04	See Section 8 above	
	10. The police should be requested to consider formal warnings to patients found to be in possession of illicit substances.	Lancashire Care Trust/Lancashire Constabulary	10.1 Zero Tolerance approach adopted within in patient units and formalised into Trust policy	Completed	10.1.1 Achieved – Policy in place	
			10.2 Production of a patient information leaflet to be given to patients during admission.	Completed	10.2.1 Notices and leaflets displayed in in-patient areas and entrances to wards.	Focused piece of work involving Service Users to advise on amendment to

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SUBSTAMCE MISUSE CONT..						operational policy within inpatient unit.
			10.3 Trust Policy publicised on notice board within in patient units	Completed		
			10.4 Service User involvement to assist with development of initiatives to reduce availability of illicit substances on in patient areas.	Feb 04	10.4.1 Service User forum established. 'TalkBack' scheme which facilitates feedback on service quality from Service Users	
HOME LEAVE	**11. Nursing staff should assess the value of leave taken by patients on their return before further leave is planned, with a positive leave assessment acting as the main consideration for further leave.**	Lancashire Care Trust/Lancashire Constabulary/Black burn with Darwen SSD	11.1 Review and strengthen current leave policies in place.	July 04	11.1.1 Leave policies ratified by Board at Lancashire Care Trust in March 2003 and meets CNST requirements.	Effectiveness of new policy to be audited for effectiveness against recommendation.
			11.2 Joint protocol on management of home leave to be agreed by LCT and BWDSS and documentary evidence required	Jan 04		

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HOME LEAVE CONT..			to be submitted by Care Coordinator re effectiveness of leave arrangements as per CPA Policy			
	12. Home leave should be part of a planned programme of care that is monitored through home visits by a named care coordinator together with feedback from a number of different sources.	Blackburn with Darwen SSD & Lancashire Care Trust	12.1 Effective Care Coordination group to audit outcomes of leave via CPA and effectiveness of leave policy.	Quarterly	12.1.1 Audit programme in place to measure and monitor effectiveness of CPA implementation.	
			12.2 Blackburn With Darwen Social Services and Lancashire Care Trust to agree processes by which home leave will be supervised and monitored by the Care Coordinator	Jan 04	12.2.1Home leave arrangements are explicitly recorded in the CPA documentation 12.2.2 Arrangements in place for auditing Service User compliance with CPA 12.3.3 Mental Health Act Commission reports on compliance following visits to	Home Leave protocol to be included in operational policies

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HOME LEAVE CONT..					inpatient areas.	
					12.3.4 Leave arrangements audited as per CPA policy	
					12.3.5 Leave arrangements discussed at both MDT meetings and CPA meetings.	
DISCHARGES	**13. The frequency of follow up appointments for recently discharged patients should be prescribed.**	Blackburn with Darwen Social Services and Lancashire Care Trust	13.1 Job Descriptions of Care Coordinators to reflect their responsibility for ensuring 7 day follow up arrangements are in place in line with national guidance.	Completed.	13.1.1Duties of Care Coordinator are combined within CPA Policy and reference to care coordination duties are contained within job descriptions	
			13.2 Audit of 7-day follow up.	Completed	13.1.2.Achieved. 7 day follow up monitored monthly and standard set for 100% compliance	
			13.3 The frequency of appointments to		13.3.1 Care Coordinators record	

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DISCHARGE CONT..			be determined in advance of discharge and recorded on the care plan. System will be established to ensure responses to non compliance.		agreed times & location of their visits on CPA care plan. Care plan is signed by Service User. Documentation is audited for compliance.	
					13.3.2 Systems in place for monitoring above within supervision sessions by CMHT Manager.	Supervision arrangements to be strengthened by developing guidelines regarding the sharing of supervision records in integrated teams.
			13.4 Transition of Care arrangements within CPA policy to be reviewed and strengthened where required.	Apr 04		Transition protocol to be developed

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DISCHARGES CONT..	**14. Discharge care plans should be prepared by the multi-disciplinary care team, and should take into account all care history and contact with the service.**	Blackburn with Darwen Social Services and Lancashire Care Trust	14.1 Review of CPA discharge arrangements which should reflect risks relating to compliance and co morbid substance misuse.	Dec 03	14.1.1 Achieved. A rolling programme of audit is in place within the Effective Care Coordination Group to monitor the effectiveness of CPA arrangements	
			14.2 Discharge planning to be agreed by all partner agencies and to include documentary evidence that risks associated with discharge and compliance with medication have been identified and later audited.	Completed	14.2.1 Achieved. Crisis & contingency plan now forms part of CPA care plan which is formulated by Care Coordinator and Service User and CPA policy stipulates that discharge plans are prepared by Care Coordinator and Multidisciplinary Team 14.2.2 CPA database established and records when care plans are: a. signed by service user. b. signed but not agreed by service user. c. rejected by service user.	

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DISCHARGES CONT..					14.2.3 Recording and reporting of CPA compliance now included as part of the performance review of Associate Directors	
			14.3 Discharge Planning to be commenced on admission as standard and includes the allocation of the Care Coordinator within 48 hours of admission.	Completed		CPA Policy to be amended to reflect new standard for the identification of Care Coordinator
	15. More frequent use should be made of s.25 when high risk patients who have enduring mental illness are discharged.	Lancashire Care Trust/Blackburn with Darwen Social Service Department	15.1 Service Users of known high risk to be considered for section 25 leave as standard.	Achieved	15.1.1Use of section 25 is an integral part of the risk assessment/ risk management training programme in place.	
			15.2 Use of section 25 to be formally reported to Multi Agency Protection Panel (MAPP)	From Feb 04	15.2.1 Use of Section 25 is monitored by Mental Health Act Commission. 15.2.2 There is joint	Reporting arrangements to be clarified

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					agency representation on local MAPP.	
			15.3 Monitor use of Section 25 through Mental health Act sub group.	Nov 03	15.3.1 MHA sub group has been established	
MULTI DISCIPLINARY WORKING	**16. A policy for multi-disciplinary working should be developed and all staff should comply with it. The policy should require that, amongst other things:** **the roles of the multi-disciplinary team members are defined;** **records of attendance at ward rounds and discharge planning meetings are kept;** **key discussion points and any**	Lancashire Care Trust/Blackburn with Darwen SS Department	16.1 Review multidisciplinary team roles, responsibilities, function & effectiveness. Organisational standards to be developed relating to care meetings.	Completed	16.1.1 Inter-Agency CPA Policy in place agreement in place which underpins the following: - training requirements - supervision arrangements - minimum standards expected of a care coordinator	Clarify the role of the Multi Agency Protection Panel (MAPP)
			16.2 Establish appropriate administrative arrangements to record content of meetings.	Jan 04	16.2.1 CPA Review form is now completed at each CPA review. This constitutes a record of the discussions which take place between members of the MDT.	

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	disagreements about care and treatment decisions are accurately recorded.				16.2.2 Key issues identified and joint action plan developed between Blackburn with Darwen SS department and Lancashire Care Trust in Jan 03 as part of Internal Review into the serious incident involving MH with regard to the following: - Role of RMO - Risk assessment & safety profiling - Care Planning - MDT working - Role of the Care Coordinator - Post Discharge Follow up and care - Supervision	To raise awareness of the role of the Mentally Disordered Offender Worker within Mental Health Services.

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COMMUNITY MENTAL HEALTH TEAMS	**17. The community services should focus on those with severe and enduring mental illness, with the development of early intervention and assertive outreach services**.	Lancashire Care Trust and Blackburn with Darwen SSD	17.1 Develop 24 hour services for people who require Assertive Outreach	Dec 03 Dec 05 (Early Intervention NSF Target)	17.1.1 All CMHTs are focused on delivering care to those with severe mental illness	Development of Assertive Outreach Services on target to be fully operational by Dec 03.
			17.2 Implementation of Crisis Services and Early Intervention to support those presenting with Severe Mental Illness	Ongoing development. NSF Target Dec 04	17.2.1 Over 85% of CMHT caseloads reflect service users on Enhanced level of CPA.	Manageable workloads to be researched and the findings actioned for all Mental Health Teams
			17.3 Resource and capacity issues to be clearly defined and agreed between Commissioner and Provider agencies for CMHTs, AOT, Crisis and Early Intervention.	Jan 04		Development of Crisis Services to be planned.

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COMMUNITY MENTAL HEALTH TEAMS CONT…	**18. The in-patient care planning process should be reviewed to enable easier transfer of care between community care and hospital episodes.**	Lancashire Care Trust/Blackburn with Darwen SSD	18.1 Role, function and responsibilities of Care Coordinator in relation to transfer and named Nurse to be monitored.	Mar 04	18.1.1 See progress relating to recommendations 1,3, 5,12,13,14,15 & 17.	
			18.2 Review arrangements in place regarding the function of Multi Agency Protection Panels in support of raising awareness of and improving response to those who present with complex and significant risk factors.	Mar 04		Referral, care planning & reporting arrangements to be clarified
	19. There should be a single record of service contact that covers both community and hospital care.	Lancashire Care Trust/Blackburn with Darwen SSD	19.1 Introduction of an integrated service user record to be available electronically. See recommendation 4	Mar 04	19.1.1System currently being piloted and populated. 19.1.2 Full system available March 2004.	

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COMMUNITY MENTAL HEALTH TEAMS CONT…	**20. The supervision of community mental health workers should be strengthened by carrying out independent external audit checks of their practice.**	Blackburn with Darwen SSD and Lancashire Care Trust.	20.1 System of independent external audit of practice to be introduced e.g. NIMHE, Sainsbury, etc	Jul 04		To agree programme of work with NIMHE/Sainsbury

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	21. Those who are appointed as care coordinators should receive training in the role and function of the post	Lancashire Care Trust/Blackburn with Darwen SSD	21.1 Implement a rolling programme of training and update for Care Co-ordinators aimed at total role clarification	Jan 04		
	22. When more than one member of a family is involved with services, the role of the care coordinators should be clarified and agreed.	Lancashire Care Trust/Blackburn with Darwen SSD	22.1 Guidance to be produced for practitioners on how to deal with multiple and complex contact with services of whole family service users.	Feb 04		ECC group to advise on amendment to CPA where indicated.
	23. The role of the Trust grade psychiatrist in the care team should be defined.	Lancashire Care Trust	23.1 Job description and job Plan to clearly reflect role in context of care team approach	Feb 04		Job Plans to be revised

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COMMUNITY MENTAL HEALTH TEAMS CONT…	**24. The crisis response team should be re-focussed to give emphasis to those known to the service and subject to the care programme approach, so as to ensure appropriate crisis response as outlined in standard four of the National Service Framework.**	Lancashire Care Trust/Blackburn with Darwen SSD	24.1 Review, development and implementation of fully functioning Crisis Service to be fully operational and financially resourced.	Jan 04	24.1.1 Service Development need identified in Local Delivery Plan. (LDP) Work in progress to refocus Assessment and Brief Intervention Team. (ABIT)	
			24.2 Access to CPA to be available for Crisis Services.	Apr 04		
POLICE	**25. Training should be offered to police officers to:** **(i) Improve their recognition of mental health conditions;** **(ii) Enhance their familiarity with the appropriate sections of the Mental Health Act to improve their confidence in its usage;**	Lancashire Constabulary/Lancashire Care Trust/Blackburn with Darwen SSD.	25.1 All agencies to agree a multi-agency training programme and identify funding requirements.	May 2004		Training programme to be developed
			25.2 Review of arrangements in place around use of Section 136 of the Mental Health Act	Feb 04		
			25.3 Further development of Criminal Justice Liaison Service through discussion with Local	Jan 04		

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POLICE	**(iii) Provide them with knowledge of the most suitable contact points with the service.**		Constabulary and Multi Agency Protection Panels.			
SERVICE MANAGEMENT	**26. The Trust and the local authority should agree a single line management structure that reflects the needs of the care groups for whom they are responsible, and provides clear lines of managerial responsibility and accountability.**	Blackburn with Darwen SSD and Lancashire Care Trust	26.1 Line management arrangements in place for CMHT's. Lancashire Care Trust and Blackburn with Darwen Social services to review current arrangements for joint management.	Jun 04		
			26.2 Review existing Single Line Management arrangements and the partnership arrangements in place for the joint management of services.	Jul 04		

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SERVICE MANAGEMENT CONT..	**27. Closer links should be developed between the forensic and general adult services to strengthen relationships, foster good practice and improve the use of the trust's resources.**	Lancashire Care Trust/Blackburn with Darwen Primary care Trust/Secure Commissioning Team	27.1 Transition Protocol to be developed between local mental health services and Secure Services which specify process for referral, opinion and transfer.	Dec 03	27.1.1 Protocol currently being developed.	Protocol to be implemented.
			27.2 Review of Low/Medium secure needs in East Lancashire area in conjunction with the with Secure Commissioning Team	Mar 04		
			27.3 Review to be undertaken into the of the length of stay in the PICU	Dec 03	Clinical Governance review currently ongoing	
	28. The Trust should consider supporting the families of victims whenever serious untoward incidents occur.	Lancashire Care Trust/Blackburn with Darwen Social services	28.1 Review of current arrangements in place including the Serious and Untoward Incident Policy.	May 04	28.1.1.Serious Untoward Incident Policy reviewed and amended which shows how families are supported.	Policy to be reviewed again to ensure it reflects contribution from Social Care

			28.2 Develop Partnership arrangements with the Independent/ Voluntary sector	May 04		

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SERVICE MANAGEMENT CONT..			that can support families affected by a serious incident			

	29. Disciplinary action should be considered in appropriate cases.	Lancashire Care Trust/Blackburn with Darwen SSD.	29.1 Each agency to take appropriate action.	Jan 04		

ANY RESOURCE REQUIREMENTS ARISING AS A RESULT OF IMPLEMENTING THIS ACTION PLAN WILL BE NEGOTIATED AND AGREED WITH BLACKBURN WITH DARWEN PRIMARY CARE TRUST
DATE OF ACTION PLAN - NOVEMBER 2003