REPORT OF THE INDEPENDENT INQUIRY PURSUANT TO HEALTH SERVICE GUIDELINE (94) 27 INTO THE CARE AND TREATMENT AFFORDED TO DALE PICK

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Report of the Independent Inquiry into the Care and Treatment of Dale Pick

An inquiry was established under Health Service Guidance (94)27 into the care and treatment of Dale Pick. Dale Pick was involved in an incident in Leicester that led to the death of Michael Doherty by stabbing. Subsequently, Dale Pick was found guilty of manslaughter by diminished responsibility on plea. He was sentenced to a hospital order with restrictions under Sections 37 and 41 of the Mental Health Act 1983. The homicide occurred on 25 September 2002. Dale Pick had been discharged from Beaumont Ward on the Bradgate Unit, Leicestershire Partnership NHS Trust, on 17 September 2002 where he had been an informal patient.

The independent inquiry was set up by the Leicestershire, Northamptonshire and Rutland Strategic Health Authority with the full co-operation of the Leicestershire Partnership NHS Trust. The members of the appointed panel were:

Professor Michael Gunn, Associate Dean of Nottingham Law School, Nottingham Trent University, Chair of the Panel

Dr. Elizabeth Gethins, Consultant Forensic and General Adult Psychiatrist, Department of Community Mental Health, RAF Cranwell, Medical Specialist to the Panel

Ms Sue Haynes, Associate Director Forensic and Older Person Services and Criminal Justice Services, Northamptonshire Healthcare NHS Trust and Nurse Specialist to the Panel.

The Panel commenced its work with a scoping meeting on 11 December 2003 and completed its work with the submission of its report to the Authority in October 2004.

History

1. At the time of the homicide, Dale Pick was a 35 year old man. He lived with his mother. There is some evidence that other people in his family had mental health problems. As a child Dale Pick was treated for epilepsy. He appears to have had a poor school attendance and achievement record and left school without any qualifications. It appears that he was disruptive at school. After leaving school, Dale worked for a period as a labourer but had had no recent employment. Dale Pick had been married in his early 20s for two years.

2. Dale Pick has a history of alcohol and substance abuse. He commenced drinking in his early teens and appears to have become dependent upon alcohol. Whilst his intake reduced when married, it rose on its breakdown. He subsequently attempted to reduce his reliance upon alcohol, receiving help from his mother who controlled his finances. However, this did not always work since there were occasions when he would commit acquisitive offences in order to raise money for both alcohol and drugs. Dale Pick also has a history of drug abuse. These drugs have included cannabis, LSD, amphetamines, heroin and cocaine. He has received treatment for heroin

addiction. There was evidence of use of amphetamines at the time of the homicide. Whilst he had a long history of drug misuse, there is evidence that latterly his drug use was an effort to self-medicate to control his psychotic symptoms.

Offending history

3. Dale Pick's offending history is of acquisitive offences to fund his drug and alcohol use. There are no convictions for offences of violence. In 1986 he was convicted of criminal damage and of failing to surrender to bail. In 1996 he was convicted of burglary and theft, of theft from a motor vehicle and of burglary and theft (which led to his first prison sentence of 12 months). In 1998, he was convicted of burglary and theft (for which he was sentenced to prison for 30 months) and of burglary and theft (for which he was sentenced to prison for 18 months). Finally, in 2001 he was convicted of burglary and theft and sentenced to prison for six months.

History of violence

4. It is important to recall that Dale Pick has not been convicted of any offences of violence. However, there is a documented history of violence in his mental health records. There is some evidence that he was involved in fights when in prison. In a forensic nursing screening assessment from August 2002, it is stated that Dale Pick had a reputation for violence. It is also documented in his mental health records that: Dale Pick was known to carry a knife with him in the community; in 2001 he had made threats to kill his girlfriend; in November 2001 he went into his mother's bedroom when she and her partner were asleep with a large knife; in May 2002 he went to a drug dealer's home after voices told him to harm the dealer although he did not do so; in May 2002 he was hearing voices telling him to harm people, and it is also recorded that he reported to staff that he had punched a woman. There are multiple records of threatening and abusive behaviour towards staff. Indeed during his final admission to hospital, he was involved in an incident whereby he threatened a male nurse with a broken cup. This incident was of sufficient concern as to lead to Dale being secluded and it triggered an uncompleted Section 3 assessment.

Psychiatric history

5. The records indicate that Dale Pick's first contact with mental health services was in 1994 when he was in contact with a community drug treatment team. He was first thought to be suffering from psychotic symptoms during the course of one of his prison sentences in 1997. He received treatment in the form of anti-psychotic medication. There was also consideration that he might have a borderline personality disorder. During a subsequent prison sentence, he was thought to be suffering from psychotic symptoms and, in 2000, was referred to the general psychiatric services. In July of that year, he was admitted to hospital after an increase in his psychotic symptoms. The diagnosis was of a personality disorder and a drug-induced psychosis. He was discharged on anti-psychotic medication.

6. Dale Pick was admitted to the Bradgate Unit, Glenfield Hospital, as an informal patient on 2 November 2001. This period of admission lasted until 4 December 2001. During this period, there was clear evidence of a range of matters that are centrally important to this Inquiry. There was evidence that:

- he had "thoughts and voices telling him to stab his mother's partner";
- he had entered his mother's bedroom with a knife on four occasions when her partner was there and they were sleeping;
- he was carrying a knife outside the house, because he felt unsafe and thought he might be attacked;
- he was experiencing command auditory hallucinations that were telling him to kill his 'stepfather';
- he had derogatory auditory hallucinations in relation to his girlfriend that told him to harm her;
- his alcohol intake had increased, this appears to have been an attempt at self-medication as he said he took it "to silence the voices"
- there was concern about the risk he presented to himself;
- his depot medication was ineffective after the first week.

7. Dale Pick was discharged on 4 December 2001 on oral anti-psychotic medication. At this stage, it was thought that he had a primary diagnosis of a psychotic illness rather than a drug induced psychosis or personality disorder.

8. Dale Pick was next admitted to hospital on 19 March 2002 after suffering some seizures. His admission was very brief, lasting about a day, and was focussed on reviewing the medication for the seizures.

9. In the community, his care was reviewed at regular intervals. In June 2002, it is recorded that he had heard a voice telling him to do bad things and to hit a woman. The "real" Dale Pick then apologised to her. It was also recorded that he was carrying a knife. On 3 July, he was recorded as being aggressive when the community psychiatric nurse (CPN) tried to accompany him to a forensic assessment appointment. Looking back, there are clear records of Dale Pick struggling to control his anger, hearing voices telling him to cut people up (January 2002) and to harm and mutilate people. He had also acted on those hallucinations in that he visited the home of a drug dealer intending to harm him in response to auditory hallucinations (May 2002).

The last hospital admission

10. Dale Pick's last admission to hospital commenced on 10 July 2002. As with the previous admissions, this was an informal admission to Beaumont Ward at the Bradgate Mental Health Unit. It followed recorded concerns in the community about the voices that he was hearing telling him to hurt others, and concerns about his knife carrying. Immediately prior to his admission, there were concerns in the community with regard to a possible relapse and the community team's inability to stabilise his mental health.

11. The initial medical assessments indicate that the information with regard to his mother's partner was understood and that his drug taking was understood. During this admission, he was noted to be paranoid on a number of

occasions as recorded in both the nursing and medical notes. Indeed, the nursing notes in July and August record his fluctuating mental state with reference to his agitation, paranoia, pressure of speech, flight of ideas and his incoherence at times. Work was being undertaken by the then staff grade psychiatrist to endeavour to try to clarify his diagnosis and develop a treatment plan. On 1 August 2002, it was recognised that, whilst Dale Pick might have a personality disorder, he might also have a psychotic disorder that was drug exacerbated rather than drug-induced. The doctor recorded auditory hallucinations of a command nature and was of the view that Dale Pick appeared to be a risk to others.

12. On 8 August 2002, a different doctor took the view that Dale Pick was "a bit paranoid, and anxious and unwell and labile in mood." Dale Pick was advised to stay in hospital and take his medication, but that "if he threatens to take his discharge may be assessed again with a view to put him on Section 5(2)." On 13 August, the staff grade psychiatrist, formed the opinion that it was possible that the primary diagnosis was of a psychotic illness, and she recorded her opinion that, taking into account his apparent treatment resistance to other medications (notably olanzapine and chlorpromazine), a trial of clozapine should be considered. It would appear that, with the departure of this doctor, this investigation and line of thinking was not pursued further over the course of the next month, despite there having been no change in consultant.

13. There was further documented evidence of auditory hallucinations of a command nature indicating increased risk. The most serious incident occurred on the night of the 15/16 August 2002. Dale Pick became increasingly paranoid and very angry. After some verbal interaction, Dale Pick went near the nurses' office on the ward "with a broken cup in his hand and threatening to slash [a staff nurse's] throat." A response team was called and Dale Pick was secluded. This occurred very early in the morning of Friday, 16 August, and the seclusion was ended approximately two hours later. This matter was considered at the ward round on 16 August and the consultant in charge of Dale Pick's care, Dr Beharry, took the view that Dale Pick should be referred to the intensive care ward. Dr Beharry completed one of the two medical recommendations necessary for application of Section 3 of the Mental Health Act 1983 (compulsory admission for treatment). Dr Beharry gave his opinion that the section was needed because Dale Pick was "Threatening staff. Paranoid ideas about staff and patients. Threatened to kill a member of staff and another patient. Unpredictable behaviour. Needs to be treated in a secure environment." When the other doctor and the approved social worker (ASW) arrived on the ward at 13.00, to consider making the second medical recommendation and the application for the Section 3 respectively, Dale Pick absconded.

14. Dale Pick was eventually returned to the ward early in the morning of 17 August. Despite the approved social worker ringing to check what was happening on Monday 19 August, no further action was taken regarding the Mental Health Act assessment. The ASW's report of his involvement was written some time after the event, but this makes it clear that there was a strong case for a Section 3 and it is clear that the ASW would have

completed an application. Other than the telephone call on the Monday morning, the ASW did not follow up on the Section 3. Since Dale Pick had returned to the ward and the care of the in-patient team, it is inappropriate to be critical of the ASW, who was not a member of the regular care team for Dale Pick, although it might have been better practice to have followed up his case over the next few days to have as clear a picture as possible as to why the section was not pursued and, in particular, to have a clear record of the basis for the decision at the ward round not to pursue the section.

15. It would appear that Dale Pick had settled on the ward and was making it clear that he did not wish to be sectioned, did not wish to go to the intensive care ward and did not wish to receive depot medication. Reliance appears to have been placed upon his apparently improved behaviour and his assertions as above. Of concern is the fact that there is no clear record made of why the Section 3 was not pursued, especially in light of the seriousness of the reasons given for considering the section in the first place. There is no entry in the medical records between 16 August, when Dr Beharry recorded his decision to provide the Section 3 medical recommendation, and 6 September when a record was made of the consultant forensic psychiatrist endeavouring, unsuccessfully, to meet Dale Pick.

16. Over the subsequent month, Dale Pick presented no further problems on the ward. Indeed the staff appear to have been sufficiently satisfied by his behaviour that, by the middle of September, they were allowing him to remain at home on leave from the ward.

17. A ward round was held on 10 September 2002. It was not established as a pre-discharge meeting and does not appear to have involved a discussion about planning discharge for Dale Pick in the near future. The locum consultant psychiatrist cannot now recall the ward round meeting, but presumes that he was convinced by Dale Pick's stabilisation that a Section 3 was no longer necessary. It would appear that the staff took the view that, because he settled so quickly, the incident was behavioural, i.e. personality driven and not psychosis driven. However, it could have been both and this possibility does not appear to have been considered. Dale Pick was not available for the ward round. Indeed, he had not been on the ward much in the preceding two or three weeks which limited ward staff's capacity adequately to assess him. The CPN expressed concerns about him and the overall efficacy of the admission. The CPN had not been informed about the incident that led to Dale Pick's seclusion.

18. Dale Pick was discharged after a Care Programme Approach meeting held on 17 September 2002. The records of the meeting do not reveal fully the basis upon which the decision to discharge was made. At that meeting, it appears that the community workers retained concerns about Dale Pick in the community. They felt admission had achieved nothing, that Dale Pick remained a risk and that there was nothing more they could do in the community. The response to these concerns was that Dale Pick should not be visited by a community worker on their own, but in pairs for health and safety reasons.

19. The contributing factors to the decision to discharge Dale Pick appear to have been (1) his improved behaviour on the ward subsequent to the incident leading to seclusion on 16 August; (2) his apparent preparedness to comply with treatment (though there was a recorded long history of non-compliance); and (3) the forensic psychiatry assessment that was completed on the morning of the CPA meeting on 17 September. The acting consultant forensic psychiatrist confirmed orally that the forensic service did not have anything to offer to Dale Pick (see paras. 48-52, below).

20. The decision to discharge Dale Pick was taken despite the community psychiatric nurse, who was Dale Pick's primary worker in the community, stating that "there appeared to be little change in Dale's mental state from previous meetings and there was still some concern that Dale was taking illegal drugs." She made it clear that Dale Pick was insisting on discharge and insisting on accepting only oral medication and not depot medication. It is clear that this worker had deep concerns about Dale Pick and the risks that he presented. At the same meeting, it is recorded that Dr Beharry, the consultant psychiatrist in charge of Dale Pick's care and treatment, "and most of the multi-disciplinary team present agreed that Dale needs to be 'followed up' in the community." We were not able to get to the bottom of what may have been a disagreement, but we believe that it is possible that it was not about the propriety of community follow up, but was about a concern as to whether Dale Pick should be discharged at all, and so a concern as to whether community follow up would be appropriate.

21. The team leader, Dr Beharry, although apparently in favour of discharge, stated that Dale Pick was "'extremely unpredictable' and was 'quite dangerous' particularly with regards to previous threats with a weapon." Those at risk of harm were perceived to be those close to him in relationship terms e.g. mother and community workers, rather than those proximate to him. At the meeting, the ward nurse representing the key nurses (none of whom were present, though their presence is good practice at a discharge meeting) "agreed that Dale presented as extremely unpredictable and uncontrollable when he has taken illegal drugs."

22. By 17 September 2002 it would appear, from all the evidence that the Panel received, that there was a range of factors which were available for consideration at a discharge meeting, but which do not appear to have been fully considered:

1. The possibility that Dale Pick had a primary diagnosis of a psychotic illness rather than a drug induced psychosis. Should this have been explored further and given greater credence?
2. Given this, should clozapine have been considered, particularly when it was already known that olanzapine did not treat his symptoms effectively?
3. The incident leading to his seclusion was not known to any member of the community team, who were already very concerned about the risks that he presented, which is why the discharge meeting decided that no community member should visit Dale Pick on their own.

4. As none of the ward key nurses were present and the junior doctor was new and does not appear to have fully read the notes, the probability is that the only person who had knowledge of the seclusion incident was Dr Beharry. Despite his initial concerns as reflected on 16 August by his desire to get Dale Pick into the intensive care ward on a Section 3, they appeared largely to have been removed by 20 August when he did a ward round. Dale Pick had become compliant in what appears, to the Panel, to have been a limited sense (that is in order to achieve certain ends, which were that he did not want to be on a section, he did not want to be transferred to the intensive care ward and he did not want to be on depot medication). Dr Beharry remained convinced of the traditional diagnosis. Dale Pick's apparent manageability in the community was later confirmed by the report of the acting consultant forensic psychiatrist.

23. The CPN last saw Dale Pick on 24 September, which is the day before the incident occurred. There was nothing at that stage in his behaviour which suggested he was in need of immediate admission to hospital.

24. In the light of the history of this admission and what was known of Dale Pick, one question for the Inquiry is the propriety of the decision to discharge Dale Pick on 17 September. Other important questions that arise are whether those at risk were properly identified, since the risks appear to have been presumed to be to those close to Dale Pick (i.e. family and community workers) rather than anyone proximate or in his vicinity. Further, there is the question of whether a firm diagnosis was achieved as, at the time of discharge, it was clear that it was considered that he had a personality disorder and drug-induced psychosis, despite a potential opinion (that has turned out to be the correct view) that he had a psychotic illness that needed treatment.

25. Whilst these questions raise serious issues, it is important to recall that there has been no trial of the facts in relation to the actual incident on the 25 September 2002. This means that it is not known whether this was an incident in which Dale Pick was the lead actor whose actions were a product of his mental disorder, or whether he was provoked to defend himself, pre-emptively, by the actions of the other parties to the incident. This will mean that, even if the Inquiry concludes that errors were made in the decision to discharge Dale Pick, the issue of any causal link between that decision to discharge and the homicide is not one that the Inquiry will be able to reach.

Issues arising

26. From the above a series of issues arise that need to be considered.

Care in the Community

27. The community workers engaged well with Dale Pick. They were able to assess the risks when they had the relevant information. Indeed, their awareness of risk precipitated two of Dale Pick's admissions to hospital. The CPN sought support in relation to her work with Dale Pick particularly

regarding the risks he presented. Dale Pick formed good relationships with his CPNs, but he found change difficult to handle. In the space of two years, he had four CPNs. This was well handled by the CPNs themselves, but it added to the difficulties of engaging Dale Pick well with the psychiatry service as a whole. The team endeavoured to engage Dale Pick's mother, but clearly the perception of his problems and his needs were not the same for her and the team. In addition to supportive CPNs, Dale Pick and his family also had good social work input.

28. It quickly became obvious to the Panel that one particular difficulty facing the CPNs was the size of their caseload, which was high and above recommended numbers. They managed to see patients when it was needed, but having to prioritise meant that the care of other patients suffered and that engagement was frequently in response to a crisis rather than a continuous therapeutic programme. The Panel is aware that this problem has been recognized by management as part of the wider problem of under resourcing within the Trust. However, **we recommend that the Trust specifically review CPN caseloads, workload and staffing levels.**

Ward Environment

29. The evidence before the Panel suggests that Beaumont Ward was working under considerable clinical pressure, high bed occupancy levels, overcrowding on the wards, the challenge of dealing with high levels of violence and aggression and managing serious untoward incidents as well as maintaining an experienced clinical workforce. This has led to a sense of frustration and pessimism amongst staff who felt trapped, having to react to seemingly unrelenting demands which create constant crises. One witness described it as being "like Beirut" referring to the level of violence and aggression, the lack of control and the unsafe nature of the ward. Such conditions did not allow the fundamental change necessary to develop the ward.

30. The ward was under enormous clinical pressure. Bed occupancy levels were very high, one witness suggested that, on occasions, it reached 150%, although subsequent information indicates that this was not factually correct. The turnover rate was also very high.

31. The ward was very busy in terms of activity. Many witnesses talked about the number of visitors to the ward e.g., ex-patients visiting existing patients - sometimes taking them off the ward, ex-patients visiting the wards for cups of tea and a chat, and other people wandering in and out of the ward with no obvious patient or treatment related purpose. There was real concern about how "open" the ward was and how easy it was to access. This posed many difficulties for staff and patients in terms of health and safety, but also in relation to the protection of patients' privacy and dignity. The problem was compounded by a physical environment that did not allow for safe and effective control of access and observation of patients. The Panel has been informed that work has more recently taken place to begin to remedy this situation.

32. The ward served an inner city area where the mental health morbidity is fairly high for standard reasons: high unemployment rates; significant drug problems; high crime rate; poor environment. It was acknowledged that this sector required input from two consultant psychiatrists but only one consultant covered the sector for the majority of the time at the time of the incident.

33. The Panel is also of the impression that very little therapeutic work was being done on Beaumont Ward with the in-patients. For the reasons stated above, the ward environment was not conducive to positive therapeutic interactions. Whilst there were undoubtedly serious workload pressures, we believe that action could and should have been taken. Amongst other things the ward should have had even greater professional support. Whilst the Panel acknowledges that some support was available from management and professional leaders, the Panel believes that it needed to be better focussed.

34. There were a number of issues which exacerbated the ward difficulties. One was staff recruitment and retention. The ward had had no permanent consultant psychiatrist for some five years. It was also difficult to recruit non-consultant doctors because of the known usage of locum consultants. Even doctors trained locally were not keen to take up permanent positions. There was extensive usage of bank and agency nurses. At times, the Panel was told, there would only be one qualified nurse on duty. The Panel was also told that often there would be one or two bank or agency nurses on a shift of three or four nurses. The impact of this was significant. It limited the core team's ability to carry out therapeutic work within the ward as they were busy co-ordinating and inducting new staff, trouble-shooting and had, of course, to make time for their own supervision and professional development. The Panel was also told that bank and agency staff sometimes came to the ward with the attitude that they were there to make up numbers rather than become actively involved in patient care. The Panel was informed that there were constant vacancies for core ward staff. In consequence, while core team members were obviously close and supportive of each other, the overall staff morale was low.

35. The evidence to the Panel indicates that the Trust had some concerns also about the management of the ward which, it believed, fed into the tension already existent. This is not a matter on which the Panel is in a position to draw a conclusion but it is noted as an issue which did not help the situation on Beaumont Ward. The Panel also notes that the Trust decided to institute a review of the ward, which has subsequently, the Panel understands, been completed.

36. The Panel was informed that staff were frustrated that nothing seemed to be changing with regard to the clientele on the ward, bed occupancy or incidents. Indeed, the witnesses and evidence gave the Panel the impression that there was a sense of a "bunker" mentality amongst ward staff and a feeling that there was no effective interest from the management structure, a comment that was not directed at the ward manager, but at management at more senior levels within the Trust. The ward team seemed to be of the view that they could never say no to new admissions on the basis of the safety of the ward. Ordinarily, the Panel would expect that the ward

management team would have the power to refuse to take new admissions where safety was understood to be at issue. There appears to have been a lack of clarity amongst staff regarding their available discretionary powers in this regard. Further, the staff did not feel empowered to deal effectively with the inappropriate behaviour of some patients (and visitors) in terms of numbers and Trust support. Admission to hospital should require of the patients certain standards of behaviour and compliance with appropriate hospital and ward rules. Staff must feel confident they will be supported in enforcing them.

37. In the Panel's opinion the ward staff need to have and to understand that they have a greater say in the day to day running of the ward, they need to be more involved and to understand that greater involvement is desired, particularly in decision making. From this will flow the ability better to manage and control their environment. **We recommend that the Trust give consideration to how it can more effectively empower staff. We recommend that consideration be given to the circumstances in which ward doors can be shut to safeguard patients, but without thereby creating locked wards.**

38. Further evidence that compounds the staff view that senior management did not recognise their needs is that, despite saying that they recognised how stretched the ward was, the Panel understands that they removed the forensic beds from the ward and later placed assertive outreach beds on the ward. The Panel feels that this either displays little understanding of the difficulties facing Beaumont Ward or displays insufficient understanding of staff perceptions. It is fully acknowledged that adult in-patient wards are becoming more challenging environments because they essentially admit patients that cannot be managed in the community by the new services. Assertive outreach patients are probably the most difficult of these. The changing patient profile and inherent increase in difficulty in managing them on any ward does not appear to have been recognised by the Trust.

39. The Panel has a concern about the general ability of staff and Trusts to focus on and support general adult psychiatry. We are aware of the pressure to develop a myriad of new services which bring with them new money. We would remind staff, however, that general adult psychiatry is still the core business even with the creation and development of new specialities. **We recommend the Trust reflect on the ward related difficulties highlighted in this report. The Trust may benefit from undertaking an audit of the work that General Adult psychiatry wards are expected to undertake against their capacity, to ensure a safe, supportive and therapeutic environment for patients.**

Medical Staffing and Leadership

40. As previously stated, Beaumont Ward had had no permanent consultant psychiatrist for some five years. There had been a series of locum consultant psychiatrists, with some staying for very brief periods. Dr Beharry, the locum consultant psychiatrist at the time of Dale Pick's discharge in September 2002, had worked on Beaumont Ward since 7 December 2001. His contract was terminated on 23 September 2002. He worked on a monthly contract, with

one week's notice for termination. Most of the time the locum consultant psychiatrist covered the sector alone. This sector is acknowledged as needing input from two consultants. The extensive number of locum consultant psychiatrists on Beaumont ward appears to have had a detrimental effect on ward morale, on continuity of care and on team working. While this may have been less of an issue at the time of Dale Pick's discharge given the period for which Dr Beharry had been working with the team, there is a sense that the team did not feel they could contribute meaningfully to therapeutic and security decisions.

41. The Panel has noted the Trust's recent strategy to recruit a number of consultants. It does appear that the Trust is now proving to be successful in addressing the significant problems of medical recruitment. For this, it is to be commended. We are hopeful that, provided they have the necessary experience, personal qualities and support, their presence will have a positive and stabilising effect. **We recommend that the Trust continue to keep the medical staffing issue under review.**

Team-working and Communication

42. As detailed above there were significant factors militating against effective team working on Beaumont Ward. Effective team working relies upon confidence and trust amongst and between team members. When colleagues knew one another, there appears to have been good team working. Effective team working also relies upon effective communication. Patients like Dale Pick are often moving between hospital and the community and so each team needs to be very well aware of all relevant information. Whilst lines of communication appeared to be open in this case, it did not mean that all appropriate pieces of information were passed on, and this appears to be true of the seclusion incident as indicated above.

43. Dale Pick was secluded on 16 August, but very few people, other than those directly involved, were aware of it. In particular, it appears that members of the community team were unaware of the incident. Whilst there was agreement to his discharge, there is some indication that this was reluctant agreement on the part of the community team and it seems likely that, had this incident been more clearly identified and discussed, such reluctance might have hardened to objection to discharge, though we cannot be sure that this would have been the case.

Record Keeping

44. Good record keeping is vital primarily because it is the only means whereby a patient's care can be tracked by those providing it. It should inform all members of the team, especially where that membership varies. It should provide a forum that can assess traits, behaviours and risks carefully. In this case, there are some instances of poor record-keeping. This is most noticeable in the medical notes where there are no entries between 16 August, when there was a decision to implement the procedure for the use of Section 3 of the Mental Health Act 1983 and a subsequent transfer to the secure ward, and 6 September, when the process leading to discharge

commenced. What is not apparent, therefore, is the developing consideration of Dale Pick's case leading to a decision that, despite his seclusion for a violent incident one month earlier, it was right and proper to discharge him in September.

45. The nursing notes of the ward rounds do not indicate any reflection back upon the incident (though the notes of nursing activity shortly after the incident appear to indicate that staff were aware of the need to keep a clear eye on Dale Pick's behaviour). The nursing notes are a record of events rather than having any reflective or analytical content.

46. **We recommend that concerted action be taken to improve the quality of record keeping by means of review of all policies and procedures and staff training and audit of activity. We recommend that, in taking steps to improve record-keeping, the Trust also endeavours to secure improvements in communication and team-working and, in particular in the sharing of necessary information between hospital-based and community-based workers.**

47. Good record keeping is also essential for a post-incident review. There should always be a desire to learn from incidents. This can only be achieved when the sequence of events can be examined clearly and carefully. The longer after the incident the review occurs, the more difficult it is to have an effective review without clear and detailed record keeping. The Panel was faced with incomplete records in some important respects and many people, understandably, did not have full recall of what occurred or what was said at the time. The most important review is one that occurs as speedily after the event as is consistent with objectivity and impartiality so that lessons can be learned and action implemented as swiftly as possible. Thus, **we recommend that the Trust, with the Strategic Health Authority, continue to implement and improve internal reviews based on sound investigative and issue-interpretation procedures, notably root cause analysis and other tools and approaches as recommended by the National Patient Safety Agency of the NHS.**

Forensic psychiatry referral

48. The team was sufficiently concerned about the risk Dale Pick posed that they referred him to the forensic psychiatry team for an opinion. This referral was made on 12 February 2002. Because there were difficulties in getting Dale Pick to attend numerous arranged appointments, the staff grade forensic psychiatrist and the forensic psychiatric nurse did not see Dale Pick until 18 July 2002, and the acting consultant forensic psychiatrist did not see Dale Pick until 17 September 2002. The nursing screening assessment, from the appointment on 18 July, recognises that Dale Pick's case is a complex one with mental health diagnostic difficulties complicated by drug misuse. The conclusion was that the offences Dale Pick had committed put him below the threshold for transfer to the forensic services; it was noted that he had no fascination with, or predictors for, violence that would alternatively suggest the forensic services should offer something. It was also noted that "close relationships good, relationship with community team good, risk indicators

noted and joint visiting. Acknowledged that there may be a risk of assault with weapon up to an attempt to kill when seriously deteriorated. There are no current active threats." It was concluded that it was difficult to see how the forensic service might be able to help, although discussion and assistance with care planning at a nursing level was recognised as something that could be offered. Because of the diagnostic difficulties, the forensic nurse did, however, refer Dale Pick to the acting consultant forensic psychiatrist for further assessment.

49. A similar picture emerges from the report from the acting consultant forensic psychiatrist. He interviewed Dale Pick on 17 September 2002 and later provided an oral report to the CPA meeting - this was the day on which Dale Pick was discharged. The written report was submitted within a reasonable time thereafter. One issue to note is that the psychiatrist in question was a consultant in rehabilitation psychiatry with very limited forensic experience and no forensic psychiatry supervision (though access to the East Midlands Centre for Forensic Mental Health was possible). This was not unusual at the time as such psychiatrists were providing cover altruistically, though being paid for it, in order to provide a district forensic service in the absence of a consultant forensic psychiatrist. The service would otherwise not have been available. They were, therefore, put in a position of extreme difficulty by the inability of the Trust to attract appropriately qualified forensic psychiatrists to do this difficult and necessary work.

50. The conclusion reached by the consultant, was that the forensic service was not appropriate for Dale Pick's needs and that the "Community Services would be happy to liaise with the CMHT on issues of concern." This assumes that the only options were either forensic psychiatry or general adult psychiatry provision but both would involve care in the community. In the Panel's opinion, this misses the point that on-going informal admission or compulsory admission might have been appropriate. These options are not recorded as having been considered.

51. It would appear that the seclusion incident of 16 August was lost from discussion. This critically different piece of information between the time of the nursing assessment and that of the psychiatrist was not considered by the forensic psychiatrist. It is not referred to in his report. However, the information was available in the nursing record. The organisational inability to provide appropriately qualified psychiatrists meant that the opinion formed by the acting forensic psychiatrist, who was undertaking two roles at the same time, did not fully comply with what might otherwise have been expected by way of a full assessment. That assessment should have drawn on a review of his complete history and all recorded information available. The assessment should also have given full consideration of the range of options available to the general adult psychiatry service as an alternative to access to the forensic service and community care provision. In the circumstances, we are not critical of this matter not being explicitly raised. **However, we recommend that those consultants who lead clinical services are appropriately qualified i.e. forensic psychiatry is a specialty which should be led by a forensic psychiatrist. We recommend that the Trust not allow consultants to cross cover beyond the remit of their specialty.**

52. The forensic service reports supported the view that care in the community was appropriate for Dale Pick. Even though there was further information available that could have been considered more fully, the same conclusion might have been reached.

Risk assessment

53. There was a risk assessment in relation to Dale Pick. We would venture to suggest that, with the benefit of hindsight, it is possible to draw attention to some weaknesses in relation to it that will repay all staff in the Trust learning from this incident. There was an assessment that those most at risk were those closest to Dale Pick in relationship terms. Thus, the community team, after his last discharge, would only visit him in teams of two for sensible health and safety reasons, and attention was paid to the safety of his family and friends. However, anyone coming into contact with Dale Pick could be regarded as being at risk. It is important to recall that Dale Pick was regularly understood to have in his possession a knife, it appears for defensive purposes. If an incident occurs, it is not possible to use a knife unless one is ready to hand, thus, the fact that he was known to carry a knife was a critical element of any risk assessment. Dale Pick was a known drug user. He was regarded as having a personality disorder and a drug induced psychosis. Whilst it is now clear that he has a psychotic illness, this diagnostic possibility needed to be very clearly factored into the risk assessment. The greater the availability of drugs, the more likely he would take them. Those on drugs are more likely to use violence than those not on drugs. Finally, Dale Pick's behaviour is to be taken into account. Whilst he did not attack his mother's partner, he did enter the bedroom and wield the knife over him, he also threatened a nurse with a broken cup one month before he was discharged.

54. None of this says that he should not have been discharged in September 2002, but there should have been a very clear statement of the risks that he was believed to present which took into account all the relevant factual information available to the team. The actual recording of the decision to discharge is very brief, and may well be an incomplete record of the discussion, but it does seem to the Panel that not all the relevant factors were fully taken into consideration. We emphasise that we are not confident that a different decision would have been reached had such information been fully discussed.

55. With regard to the risk assessment in relation to Dale Pick, the record indicates that some key indicators were recorded. Some useful information had been collated by the community team at about the time that Dale Pick was admitted to hospital. However, there are some difficulties in any such procedure. First, there is the potential for focussing only on health and safety issues. Certainly, the health and safety of the community staff played a part in deciding to ensure that they were only to visit in pairs after his last discharge. But the community workers were not the only people potentially at risk. Secondly, there is the classic difficulty in becoming risk complacent. In some cases it is easy for staff to accept risk as part of the job without sufficiently independent and objective reviewing of the nature of those risks, and

whether a better or different response might be required. As a document intended to achieve a clear purpose, i.e. the safety of the patient and the public, it is a document which must be regarded as dynamic and must be kept up-to-date and objectively re-assessed periodically. Further it must be easy of access so that it is to the forefront of the minds of those staff working with the patient. Such documentation was not readily identifiable in the information before the Panel.

56. In conclusion, the Panel **recommends that some further work on improving risk assessment procedures should be undertaken. The Panel recommends that the Trust monitor and review the efficacy of its current risk management strategy.**

Use of the Mental Health Act

57. The Panel was not able to determine why the possibility of detaining Dale Pick under Section 3 was not pursued after it had been commenced on August 16 but not completed because Dale Pick absconded. It had been proposed as a response to him being secluded after a violent incident that caused his locum consultant psychiatrist to describe him as 'dangerous.' It seems most likely, though there is an element of speculation on the part of the Panel, that the Mental Health Act assessment was not pursued because Dale Pick settled on the ward. It would seem that he settled because he did not want to be sectioned, he did not want to have the drug treatment proposed and he did not want to be transferred to the intensive care ward. Indeed, he became so compliant that regular and lengthy leave was granted leading to his discharge just one month after the seclusion incident.

58. The internal inquiry report raises a concern that use of the Mental Health Act might have adversely affected engagement with Dale Pick. The Panel accepts that this is always a risk with the use of the compulsory powers available under the Act. However, whilst there was engagement, it was not as effective as the community team would have liked and was very much on Dale Pick's terms. In any case, the factors militating in favour of the Act in August were sufficient to justify compulsory detention, as was initiated by Dr Beharry. It is not clear why this was not followed through. In the Panel's opinion, being concerned about the patient's response must not be determinative of whether or not to use the Act. Further, the use of the Act should not be used as a threat to achieve an outcome. **We recommend that induction and up-date training on the use of the Mental Health Act, particularly with regard to policy on when and how it should be used, be reviewed.**

Diagnostic Issues

59. It is clear that the doctors had some difficulty reaching clarity regarding Dale Pick's diagnosis. The continuing view appears to have been that he had a personality disorder and a drug-induced psychosis. A lot of attention, e.g., in the report of the internal inquiry, was placed on the dual diagnosis issue. However, on review of the records there is considerable evidence that Dale Pick had a psychotic illness that warranted further investigation and

treatment. This was recognised by the staff grade psychiatrist in early August. Her examination reveals a range of symptoms consistent with a diagnosis of schizophrenia and her proposal for a trial of clozapine was consistent with a viable view of Dale Pick i.e. that he had a treatment resistant psychosis. There is no evidence that this suggestion was followed through. Dr Beharry was of the view that there was no evidence of a functional psychotic illness and has consistently held to the diagnosis of personality disorder and drug-induced psychosis.

60. It is now established that Dale Pick has a primary diagnosis of a psychotic illness. It is clear that the staff grade psychiatrist was moving towards this diagnosis in early August, but this was not followed through when she left. Had it been followed through, the treating team might have felt that there was something positive that they could do for Dale in terms of treatment.

The Decision to Discharge

61. A decision to discharge Dale Pick was made on 17 September. Normally, one multi-disciplinary meeting is held at which it is indicated that discharge will be considered at a subsequent meeting. It does not appear that this formality was followed. However, it seems likely that the attendees at the ward round were aware that discharge would be considered. At this stage of his informal admission to hospital, Dale Pick was rarely on the ward. He was being granted leave home regularly. We have already traversed the information deficit at the time of this meeting, but tempered that with the information from the acting forensic psychiatrist. Our major concern is that the recording of this meeting is so thin that it is impossible for anyone involved in Dale Pick's care, never mind those considering whether a proper decision was made, to understand the basis for the decision to discharge and what was to be the subsequent treatment plan (other than that the community team follow up in teams of two and medication for Dale Pick). It appears that he remained on the fast track for admission which was a means whereby known patients could get back into hospital quickly.

Management

62. There is a number of issues that the Panel wishes to highlight in terms of the Trust senior management. In the recent past, the Trust has operated in a climate of significant service change, significant levels of external inquiries and changes in chief executive and senior management structures and membership. For the Panel, this was highlighted by the frequency with which we met the responses "I wasn't around at the time;" "I don't know, that pre dated me;" "it's not my responsibility" when addressing questions to management staff.

63. We recognise the challenges and demands of running complex mental health services. However, management and staff have to be given an appropriate level of support to address the challenges. In order to bring about system wide change the management structure must have the confidence and the trust of the workforce. There should be involvement of all staff and patients in the development of the Trust with a strong emphasis on

creating a learning growing culture. Developing effective communication channels and effective relationships between all professional groups should be a goal of the service.

64. **We recommend the Trust ensure that their strategic intentions are communicated to, understood by, and owned by, all staff groups.**

Learning from inquiries and incidents

65. Learning from inquiries and incidents is very important. **We recommend that the Trust continue its efforts to improve organisational memory.** The essential element of this that we identify is the need to ensure that key lessons are learned and continue to be implemented. Clearly, the recommendations from some inquiries, etc become dated as they are context, time or resource specific. But some recommendations have a longevity that is not so specific and, for example, we would recommend that this Report be read with a view to identifying those messages that need constantly to be learned and reinforced, e.g., the importance of record keeping, high quality risk assessment, etc.

The internal inquiry report

66. The Panel has taken the view that the recommendations from the internal inquiry report were of some value, but that there is room for some improvement. In the Panel's opinion, the internal inquiry was not sufficiently comprehensive. It did not get to grips with some of the ward and community issues. This is hardly surprising, since the internal inquiry did not meet with all ward and community staff, that is the primary care givers who had direct knowledge of events. It is possible that this could reflect a barrier between staff and senior management.

67. A review immediately after an event is of vital importance. It is the time when information and recall is most clear. It is also a time when a Trust needs to display a level of understanding of how serious incidents impact upon its staff.

68. The Panel has some comments to make upon the recommendations made by the Internal Inquiry as follows.

The role of in-patient care

i. Given the challenges of engaging and working with people with dual diagnosis further consideration needs to be given to the role of in-patient care as part of the whole system and how this role can be effectively fulfilled.

ii. Jointly agreed protocols for admission and support for people with a dual diagnosis should be available to all staff, in particular those working in primary, secondary and tertiary care. The Trust should give consideration to specific fast track admission arrangements for people with a dual diagnosis and the development of associated specialist nursing skills on all adult in-patient wards. This training and expertise will also need to be incorporated in the establishment of the crisis resolution team(s).

i. & ii. The Panel believes these do not reflect the real issues in this particular case, because the Panel does not take the view that dual diagnosis is the real issue here. As indicated above, the Panel takes the view that the more likely understanding of DP is that he has a psychotic illness that could have been more effectively treated with medication.

Consultant recruitment and retention

iii. Consultant recruitment and retention should continue to be afforded priority. Peer support for locums and clinical leadership to support permanent consultants requires consideration; this should take account of the specific difficulties in the care and treatment of people with co-morbidity.

iii. It is accepted that the Trust is doing what it can to improve the recruitment of consultants and to retain them, and that this appears to be successful. The Trust management is to be commended for this as it has proved that the problem is not insoluble.

Care pathways and care co-ordination

iv. The process of referral and assessment to the Forensic Service, Assertive Outreach Team(s) and Drug and Alcohol Service should be reviewed. A more integrated process of developing an appropriate level of specialist skills into Adult Mental Health as well as reciprocal support between teams should also be encouraged. Referral, assessment

iv. In so far as it goes this recommendation about the process of referral and assessment to the Forensic Service, etc, is fine, but the issues are not just about the need to develop appropriate protocols since it is the need to take the appropriate action that is necessary. Having said that, the Panel takes the view that the Internal Inquiry is right in wanting to get down the time taken

and treatment protocols should include clear response times for referral, assessment and joint working. The protocols need to specifically address the appropriate response for assessment prompted by homicidal ideation and challenging behaviour.

between referral and assessment.

v. The key worker/care co-ordinator should follow up referrals made by the team to other specialist teams – this might include assertive outreach, drug and/or alcohol teams, forensic services, personality disorder services and psychotherapies. This will be both prior to and following discharge. The Team Manager should monitor this as part of supervision and team meetings.

v. The recommendation for follow up seems to be acceptable, but it is not clear who is to undertake this function. It might be a recommendation aimed at the patient's key worker when an in-patient or the CPA care co-ordinator. The risk with this recommendation is that each will think the other one is doing. The Panel would recommend that it be the role of the CPA care co-ordinator. The Panel would recommend that the Trust consider giving guidance on how the CPA co-ordinator is to chase up a referral and to whom s/he goes if initial chasing up does not produce results.

vi. The care and treatment of people with a dual diagnosis is now the subject of national guidance (Policy Implementation Guide Dual Diagnosis Good Practice Guide, NIMHE/Department of Health, 2002). This reflects the complexity and challenges in this area of work. The implementation of this guidance in the Trust will be considering the development of a Trust-wide strategy with a managed clinical network across teams, clearly agreed care pathways and treatment protocols.

vi. The Panel has no comment upon this recommendation.

The Care Programme Approach and risk assessment

vii. The Strategy for dual diagnosis needs to link CPA policy explicitly with the implementation of Drug Testing and Treatment Orders including an agreed trigger a full multi-agency approach to assessment of clients with a dual diagnosis. This should include a clear compliance contract with the service user. The CPA policy in screening and applying CPA levels needs to include more specific guidance in relation to the needs of people with a dual diagnosis.

vii. The Panel does not understand this recommendation as drug testing and treatment orders are sentences imposed upon criminal conviction. Therefore, issue in relation to these orders, which are not directly related to DP's case must be kept separate from CPA procedures and risk assessment. Further, the Panel would not limit the focus to that on dual diagnosis for the reasons given above. In any case, the Panel would take the view that the CPA does not need to focus on any particular diagnosis as it is a procedure or framework to apply to all people with mental health problems.

viii. The Trust needs to consolidate expertise; training and clinical guidance to support staff working with the clinical challenges presented by multiple diagnosis and associated processes for risk assessment. The Trust should with partners therefore review the application of drug treatment and testing orders for people with a dual diagnosis of substance misuse and mental illness.

viii. The Panel full endorses the recommendation that training is important in relation to risk assessment. But the recommendation should not be regarded as being limited to issues arising from dual diagnosis. Further, the Panel would wish to ensure that the training and guidance seeks to secure an understanding of risk assessment as dynamic and not static. Again, the Panel does not understand the reference to drug treatment and testing orders.

ix. The recommendations in a report to the Trust Senior Management Team on working with people with a personality disorder are currently being progressed in the context of the NIHME national guidance. The action plan for DP should demonstrate a clear link with this work.

ix. The Panel agrees that it is right to implement the relevant national guidance on personality disorder, but in so far as it relates to DP the Panel takes the view that the importance of this diagnosis in relation to this case is not clear. Since he might have personality difficulties, and that is really important, it is appropriate for psychiatrists to have access to personality disorder service workers from whom to seek advice and help.

Record Keeping

x. The Trust has a duty to ensure that clinical records are accessible and readily evidence key clinical information. This includes both computer and paper-based records.

x. The Panel agrees with this recommendation on the need to keep clinical records accessible and that they readily evidence key clinical information, but the Panel would emphasise more the need for the records to contain all necessary and relevant information. That information needs to be recorded legibly and it is important to be able to identify easily the person creating the information. Finally, it is important to have a single set of clinical records, which is a requirement for CNST level 2.

xi. Clinical records should always record outcomes particularly in the case of the application of the Mental Health Act, CPA and discussions about referrals to other services. Leave arrangements whilst still an inpatient, or failure to return from leave, should be properly recorded and acted upon within clinical records.

xi. The Panel agrees with the recommendation that clinical records should always record outcomes, particularly in the case of the application of the Mental Health Act, CPA and discussions about referrals to other services.

xii. The Trust policy for record keeping needs to include a requirement for a clear diagnosis in case notes (or specific reasons where diagnosis is difficult or unclear).

xii. The Panel agrees with the recommendation that the Trust policy for record keeping needs to include a requirement for a clear diagnosis to be recorded in the cases notes, but the Panel reiterates the point that it does not take the view that the diagnosis of a drug-induced psychosis and personality disorder would have been accurate in this case, and recalls the work undertaken in early August 2002 to review the diagnosis.

xiii. A case summary of previous service contact should include:

- Family involvement
- Risk factors, including paranoia, and self harm
- Symptoms
- Types of hallucinations and response

xiii. The Panel agrees that it is good practice to ensure that there is a case summary maintained including the matters in the Internal Inquiry report and that on future contact, therefore, it is easily reviewed. The Panel would raise concerns, however, as to how this

• Compliance and engagement • Forensic history including violence and/or threats • Medication issues • Complex needs This needs to be followed up on summary sheets so that on future contact, key points can be easily reviewed.	recommendation is to be implemented.
xiv. The Trust should consider introducing standards for the recording of risk elements related to convictions.	xiv. The Panel agrees that risk assessments should accurately record the convictions of individuals. However, this should be regarded as one part of the need to improve the undertaking of and recording of proper risk assessments.
xv. A development programme should be undertaken to encourage and reiterate to nursing staff the importance of analytical mental health assessment rather than circumstantial comments within clinical records. This would lead to nurses feeling empowered to formulate professional clinical opinions on patient care which are properly documented and expressed in multi-disciplinary team reviews. Similar consideration should be given to the standards for medical records expected of locum consultants and doctors in training. Conclusions should always remain explicit in both nursing and medical notes.	xv. The Panel agrees with the recommendation that there should be a development programme undertaken to encourage and reiterate to nursing staff the importance of analytical mental health assessment. This is a demanding recommendation for the Trust to meet in terms of the time it will take and the training that will be required. The Panel also agrees with the recommendation that similar consideration should be given to the standards for medical records expected of locums and doctors in training.

Conclusion

69. It is clear that the staff that the Panel met have been deeply troubled by the death of Michael Doherty and the consequences for Dale Pick. They are clearly working in a manner in which they hope to make improvements in their own practice, as well as hoping that this happens for the Trust and its management.

70. The Panel hopes that it has made a positive and constructive contribution to the learning from this tragic incident. The Panel is mindful that not all questions related to the homicide can be answered by this Report. We are also aware that the same themes as in other Reports are apparent, that is the need to learn lessons with regard to risk assessment, improving communications, addressing issues around the working environment that staff encounter on a daily basis, the lack of a safe and therapeutic environment for patients, and the need to include staff in decision-making processes.

71. In summary, in this Report, the Panel makes the following recommendations:

- We recommend that the Trust specifically review CPN caseloads, workload and staffing levels (para. 28)
- We recommend that the Trust give consideration to how it can more effectively empower staff (para. 37).
- We recommend that consideration be given to the circumstances in which ward doors can be shut to safeguard patients, but without thereby creating locked wards (para. 37).
- We recommend the Trust reflect on the ward related difficulties highlighted in this report. The Trust may benefit from undertaking an audit of the work that General Adult psychiatry wards are expected to undertake against their capacity, to ensure a safe supportive and therapeutic environment for patients (para. 39).
- We recommend that the Trust continue to keep the medical staffing issue under review (para. 41).
- We recommend that concerted action be taken to improve the quality of record keeping by means of review of all policies and procedures and staff training and audit of activity (para. 46).
- We recommend that, in taking steps to improve record-keeping, the Trust also endeavours to secure improvements in communication and team-working and, in particular in the sharing of necessary information between hospital-based and community-based workers (para. 46).
- We recommend that the Trust, with the Strategic Health Authority, continue to implement and improve internal reviews based on sound investigative and issue-interpretation procedures, notably root cause analysis and other tools and approaches as recommended by the National Patient Safety Agency of the NHS (para. 47).
- We recommend that those consultants who lead clinical services are appropriately qualified i.e. forensic psychiatry is a specialty which should be led by a forensic psychiatrist. We recommend that the Trust not allow consultants to cross cover beyond the remit of their specialty (para. 51).
- We recommend that some further work on improving risk assessment procedures should be undertaken. The Panel recommends that the Trust monitor and review the efficacy of its current risk management strategy (para. 56).

- We recommend that induction and up-date training on the use of the Mental Health Act, particularly with regard to policy on when and how it should be used, be reviewed (para. 58).
- We recommend the Trust ensure that their strategic intentions are communicated to, understood by, and owned by all staff groups (para. 64).
- We recommend that the Trust continue its efforts to improve organisational memory (para. 65).

72. The Panel wishes to thank all those who gave evidence to the Panel for doing so in a full and frank manner. Clearly, the time lag between the incident and this Inquiry was long and so not all the Panel's questions could be answered.

73. The Panel wishes to thank Melanie Sursham for the excellent administrative support that she provided.

74. Finally, the Panel wishes to record its condolences to the family and friends of Michael Doherty.

APPENDIX A

LEICESTERSHIRE, NORTHAMPTONSHIRE AND RUTLAND STRATEGIC HEALTH AUTHORITY

The Independent Inquiry pursuant to HSG (94) 27 into the Care and Treatment of Dale Pick

Remit for Inquiry

1. To examine all the circumstances surrounding the care and treatment of Dale Pick by the mental health services, including primary care, up until the murder of Mr Michael Doherty on 25 September 2002. In particular:

   a. the quality and scope of his health, social care and risk assessments,

   b. the appropriateness of his treatment, care and supervision in respect of:

      i. his assessed health and social care needs and
      ii. his assessed risk of potential harm to himself and others
      iii. the role of informal carers and in particular Mr Pick's mother

      Taking account of any previous psychiatric history, including drug and alcohol abuse and the number and nature of any previous court convictions,

   c. the extent to which Mr Pick's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, and Discharge Guidance HSG(94)27 and local operational policies,

   d. the extent to which his prescribed care plans were:

      i. effectively drawn up

      ii. delivered and

      iii. complied with by Mr Pick

2. To consider the appropriateness of the professional and in-service training of those involved in the care of Mr Pick, or in the provision of services to him.

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

a. the agencies involved in the care of Mr Pick or in the provision of services to him and

b. the statutory agencies and Mr Pick's family, taking particular cognisance of the need for sensitivity in regard to any dealings with his family and/or the victim Mr M Doherty and his family.

4. If matters are identified during the inquiry related to agencies other than health and social services, they are to be regarded as outside the scope of this inquiry, and referred to the Director of Finance & Corporate Services (DFCS).

5. To refer all matters related to children at risk, suspected or established child abuse, or child protection, regarded as outside the scope of this inquiry, to the chairman of the appropriate Area Child Protection Committee (ACPC)

6. To consider practice in regard to available evidence and current expectations, and identify sources of support and/or evidence of good practice which will assist service and/or professional development.

7. To prepare a report with recommendations to Leicestershire, Northamptonshire and Rutland Strategic Health Authority by June 2004. If during the course of the inquiry it becomes clear that this timescale cannot be met that the Panel Chairman informs the Director of Finance and Corporate Services.

8. To provide a report on progress within 4 months of the establishment of the Inquiry.

9. To consider such other matters as the public interest may require.

APPENDIX B

DOCUMENTS REVIEWED BY THE PANEL:

Records relating to DALE PICK:
Hospital records 1994 - 2002
General Practitioner records 1967 to 2002
Leicester Social Services records 1996 - 2002

Previous Leicestershire Homicide Inquiry Reports:
Kevin Hewitt – July 2001
Investigation into the Care and Treatment of DP – April 2003 – Leicestershire Partnership NHS Trust
Trust Interim Report - DP
Significant Adverse Event Investigation into the Care and Treatment of DP – November 2003 – Leicestershire Partnership NHS Trust (LPT)

Miscellaneous:
Mental Health Act Commission Reports from 2000 onwards
Mental Health Act Commission – Discussion Paper – The Threshold for Admission and the Relapsing Patient

Leicestershire Partnership NHS Trust – Annual Report 2002-2003
Mental Health Act training – Leicestershire Partnership NHS Trust (LPT)
LPT - Care Programme Approach Policies – April 2001, September 2002, August 2003
Risk Assessment Training Policies and Procedures 2003 - LPT
LPT - Use of Beds Policy
LPT – Root cause analysis in significant adverse events/serious untoward incidents
LPT – Audit of significant adverse events/serious untoward incidents from January 2002 onwards
LPT – Service Improvement for Dual Diagnosis – Report by L Dugmore, Nurse Consultant, February 2004
Trust Procedure for the appointment and employment of Locum Doctors
LPT Minutes of Recruitment and Retention Steering Group
Leicester City Adult Mental Health Service Business Plan December 2003
LPT Acute Mental Health Inpatient Reprovision Project – Future Bed Requirements Report – The Sainsbury Centre for Mental Health – March 2003

A brief audit of the Leicestershire & Rutland General Psychiatrists' concerns, and aspirations for the future of the local services - Northern Centre for Mental Health – 2001
Psychosis: Do they know it's drug-induced? Phil Cooper. Community Psychiatric Nurses Association March 2003.
Diagnosis and Management of Substance Use Disorders among Inpatients with Schizophrenia – Kirchner JAE, Owen RR, Nordquist C, Fischer EP. 1998 American Psychiatric Association.
Substance misuse, offending and mental illness: a review – Phillips P. 2000 Journal of Psychiatric and Mental Health Nursing.

APPENDIX C

WITNESSES AND INTERESTED PARTIES

Witness/Party*	Relevant position+
Amanda Allen	Michael Doherty's niece
Dr Noble Beharry	Locum Consultant Psychiatrist+
Jane Capes	Nurse on Beaumont Ward
Dr Margaret Cork	Chief Executive, Leicestershire Partnership NHS Trust
Dr Meriel Cullen	Staff Grade Psychiatrist+
Wendy Culleton	Community Psychiatric Nurse
Bee Clempson	Community Psychiatric Nurse+
Lander Christine Cooper	Social Worker
Paul Dempsey	Professional Nurse Advisor to Adult Mental Health+
Mr and Mrs Robert Durning	Mrs Hamell's daughter and husband
Roland Elsdon	CPN (Forensic Services)
Dr Stephen Fallow	Consultant Psychiatrist
Gill Ferguson	General Manager, City Adult Mental Health Services
Teija Flannigan	Nurse on Beaumont Ward
Dr S D Geelan	Consultant Psychiatrist
Mena Hamill	Michael Doherty's sister
Anna Hamill	Michael Doherty's niece
Zoe Hill	Nurse of Beaumont Ward
Wal Holynski	Joint Commissioning Manager – Mental Health, Melton Rutland and Harborough Primary Care Trust
Dr Jane Hoskyns	Medical Director, Leicestershire Partnership NHS Trust
Dr M Hunter*	General Medical Practitioner
Rose Johnson	Community Psychiatric Nurse
Mike Kambasha	Nurse on Beaumont Ward
Chris Keran	Community Psychiatric Nurse
Bridget Kramer	Community Psychiatric Nurse
Sue Mason	Ward Manager+
Rob Mayer*	Staff Nurse, Beaumont Ward
Linda MacFarlane	Dale Pick's Community Psychiatric Nurse
Dr Shona McIlrae	Locum Staff Grade Psychiatrist+
Dr C Meakin	Consultant Psychiatrist
Detective Superintendent Martin Morrissey	Senior Investigating Officer, Leicestershire Constabulary
Dr S Navalkissor	Staff Grade Psychiatrist+
Robert J Nisbet	Service Manager – Forensic and Counties Treatment and Recovery Services
Dr Alun Wyn Parry*	Locum Staff Grade Psychiatrist+
Jatin Pattni	Psychology Trainee+

Dale Pick	
Mrs S O Pick	Dale Pick's mother
Kate Phipps	Director of Adult Mental Health Services, City+
Dr M S Reddy	Locum Consultant Psychiatrist+
Ian Reed	Deputy Ward Manager
Dr K Shenoy	Locum Consultant Psychiatrist+
Dr H P Singh	Locum Consultant Psychiatrist+
Andrew Stanley	Service Manager, Adult Mental Health, Leicester City Council+
Stephanie Stoney	Michael Doherty's partner
Mandy Towers	Nurse on Beaumont Ward
Rob Whitaker	Nurse on Beaumont Ward
Mia Wincott	Healthcare Support Worker on Beaumont Ward
Pete Wright	ASW

***Indicates witnesses who gave written evidence only.**
+Indicates position held at the time of involvement in the matters under inquiry.

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