AUG 1995 ANTHONY SMITH DERBY

Names and some details have been changed. Where names have been changed the substitutions are consistent, where places have been changed this is not necessarily the case.

INTRODUCTION

On the 8th August 1995 xxx xxxx(1), [ANTHONY SMITH] in a deranged episode of violence at home, killed his mother, Mrs xxx [GWENDOLINE SMITH] and his young half-brother xxx [DAVID]. He later went to the surgery of his General Practitioner, Dr Yyyy, and asked that an ambulance be called and the police informed. He was subsequently arrested at the GP surgery, without further incident. He was detained and on the 6th March 1996 he appeared before the Crown Court in Nottingham and pleaded guilty to manslaughter. He was ordered to be detained, without limit of time, in Rampton Hospital.

In such circumstances, it is now current practice that the relevant Health Authority institutes an independent inquiry to review the events in detail and to make recommendations as appropriate.

We were appointed by the Southern Derbyshire Health Authority, the Derbyshire County Council and the Derbyshire Family Health Services Authority (2) at the end of January 1996, to undertake that task. An independent secretary was appointed to assist us. (3) We commenced work and held our preliminary meeting on 1st February 1996. (4)

We were given detailed Terms of Reference. (5) In addition we took into account that the judge who sentenced XX made it clear that he considered that there should be a full inquiry as to the circumstances that led to this tragedy. (6) We therefore determined to look as closely as possible at the background of XX's life and at all the detailed circumstances leading up to the terrible climax.

On appointment, we began a series of meetings of a general nature to familiarise ourselves with essential features of the background, being unable, until the trial of XX had been held, to speak to the crucial witnesses. Once XX had been dealt with by the Crown Court we were able to commence a series of meetings which took the form of consideration of the circumstances and implications of the relevant events in XX's life, his breakdown and particularly of the treatment he received after his illness led him to seek medical help. The meetings were held in private, in Derby. They were informal in nature, although a shorthand note was usually taken, and we sought to cover not only the facts surrounding the tragedy but also, more generally, the structure of care available and the way in which the various professional staff had identified and performed their roles. The names of witnesses, and the dates they were seen, are set out in Appendix IV.

At XX's father's request, we arranged the meeting at which he came to talk to us as late as possible in our inquiry. Understandably he wished for a period of grace before having to discuss, in some detail, the terrible tragedy that had occurred in his family. He asked that

Jayne Zito of the Zito Trust and a colleague of hers be allowed to accompany him and we were pleased to agree.

Nothing that we do can undo what has occurred. We would like, however, at the commencement of our Report to express our extreme sympathy to Mr Peter X; to thank him for his co-operation; and to hope that he and his daughter find some consolation in the expectation that our Report may, at least to some extent, achieve its principal objective - to avoid similar tragedies that might otherwise occur.

Our Report has been structured, as the Table of Contents indicates, into various parts. We have first identified three relatively distinct phases -

A the period prior to XX entering hospital,

B his stay in hospital,

C the weeks following discharge.

Each of these phases is dealt with similarly. The events of each period are first summarised, in narrative form, covering all the facts and significant features necessary to support the following sections. The next section selects and discusses particular incidents and topics where it was felt that consideration and comment are likely to be helpful. The third section, covering each period, involves the setting out, as recommendations, of all those changes of attitude, approach or practice which we feel should be given serious consideration. These will be seen to vary in scope very considerably, covering for example, attitudes, general aspects of practice and in many instances fairly minute detail. All these have been chosen because it was felt that a weakness had been disclosed and some thought and action was required to see if matters might be improved.

We have decided to underpin this approach, which is largely thematic, by a brief chronology to which reference can be made to check where any individual point fits into the timescale. That will be found in Appendix III.

At a somewhat different level we believe that we have identified six more general aspects that should be the subject of wider consideration and debate. An example of these is counselling, a newly growing profession, which has filled an obvious need. This and other matters of similarly general application are dealt with in the second chapter of our Report. They are counselling, admission to hospital, treatment in hospital, a social circumstances report prior to discharge, communications and the aftermath.

Footnotes

1) XXX XXX was referred to in our terms of reference as XX. Without any intention of disrespect, we decided that it would be appropriate to continue to refer to him in this way throughout our report.
2) subsequently the Southern Derbyshire Health Authority.
3) see Appendix I.
4) see Appendix IV.
5) see Appendix II.
6) see also Appendix II.

REPORT OF THE INQUIRY INTO THE CARE OF XXX XXX

SOUTHERN DERBYSHIRE HEALTH AUTHORITY & DERBYSHIRE COUNTY COUNCIL

August 1996

CHAPTER ONE

THE EVENTS

A. PRIOR TO ADMISSION TO HOSPITAL

1. Outline summary of events

(i) Early life at home

XX (formerly ZZ) was born in xxx and brought up in xxxx. His father had left his mother before he was born. When he was two, his mother remarried and XX was adopted and took the name of his stepfather - XX. A half-sister was born in 1976 and a half-brother in 1983. He was told of his adoption at about the age of 8 and this appears to have given rise to no change in the family relationships. His period of growing up appears to have been unremarkable and presented no difficulties or unusual signs until he was about 13 when he tended to withdraw from family activities. This was thought to be a relatively normal impact of adolescence. It was not until he was 20 that serious tensions appear, especially between Xx and his mother, and even then there was apparently no violence, although his father did think that he might be making threats to his mother.

His school record was not particularly good but he did gain some CSEs. He left school at 16 and secured a Youth Training Scheme placement in a warehouse. He did not complete the year, feeling that he had not the ability to become a van driver. There followed a series of short periods in labouring and factory jobs. With hindsight, it now appears that his mental illness was certainly showing some effects by the time he was 20. He appears to have had a number of friends, with whom he, for example, attended football matches. He was telling these friends of his own age of some of his problems, which included an indication that he was being troubled by voices. This information he did not disclose to his family. His friends have reported that he had an adverse attitude to his mother, including some aggressive feelings.

His period as a member of the T.A. appears to have been reasonably successful and did not give rise to adverse comments on his sociability. However he had a large number of short periods in employment and does not appear to have integrated closely in any of these. He increasingly appears to have spent considerable time in solitary pursuits - walking, running and cycling in the surrounding countryside. In 1994, on one of his excursions, he was violently set upon by a group of young males and this led to him taking a greater interest in collecting weapons 'of defence', and carrying one of them on his excursions 'for protection'.

The tendency towards isolation appears to have been reflected at home where he began to spend a large part of his time alone in his own room. The family appear to have felt, not unreasonably, that XX should be encouraged to set himself up in independent accommodation. However he appears to have lacked confidence and made no serious effort to do so. There must have been some tension as a result.

(ii) Medical History

XX was registered with a local practice based at XXX. It is a practice of four doctors (one part time) and although they do not have separate lists there tends to be an informal grouping of patients with particular doctors. Dr Yyyy appears in recent years to have worked with the X family and they would generally see her.

His early medical history has little of significance. He had some experience of cannabis and a single experiment with 'magic mushrooms'. It is obvious, in retrospect, that for four or five years he was developing a schizophrenic illness that was giving rise to difficult relationships at home and worsening an unstable relationship with his mother. He appears to have become very health conscious and keen to keep fit, but much of this may well have been an attempt by him to lessen the symptoms of his illness.

He appears to have had a good attitude to his doctors, consulting his G.P. from time to time, for relatively minor medical problems without his deeper problems becoming obvious. His current G.P., Dr Yyyy, first met him in May 1994. He complained of tachycardia and was referred to a cardiologist who identified no physical cause for his symptoms. It was assumed that the problem was psychosomatic. Dr. Yyyy herself had been able to see that he had some personal problems and decided to refer him for counselling. Her reference to counselling sums up the impression he was giving-

"... having a lot of problems, having arguments with his mum, not sleeping well, and having nightmares.."
He was allocated to Mr AAA, a qualified counsellor on professional placement, supervised by Mr BBB, one of the counsellors regularly used by the practice.

He was assiduous at attending counselling sessions, with Mr AAA, which XX appears to have valued. These continued up to, and briefly after, his admission to Derby City General Hospital. The sessions were treated as therapy and no reports were submitted by the counsellor to his G.P. - this was apparently the usual practice.

We have not been able to discover the extent to which he confided in his counsellor (but had there been clear signs of mental disturbance we would have expected this to have been reported to his GP) and prior to his admission to hospital it was only skilled questioning by his GP, Dr. Yyyy, which uncovered these hidden thoughts.

Dr Yyyy saw him again in October 1994, for a separate medical matter, and next saw him in May 1995. She appears to have had no occasion to examine XX again over those months and the question whether he was during that time showing overt symptoms of a mental illness to anyone with whom he came into contact cannot be known. He came next to the surgery on the 25th May 1995, on his own initiative, complaining of sleeplessness and nightmares. On skilled

and direct questioning, he disclosed auditory hallucinations and paranoid features. Dr Yyyy felt this needed specialist attention and so she decided to make arrangements for an assessment by a consultant psychiatrist. She made contact with Dr CCC, a consultant at Ward Q of the Psychiatric Department of the Derby City General Hospital, who was the Responsible Psychiatrist for Dr Yyyy's area, requesting an urgent appointment for XX. This was fixed for 14th June. The psychiatrists from the hospital routinely held clinics at the G.P.'s clinic. The patient was advised to bring with him a member of his family or a friend.

A letter of referral, setting out the outline facts and the G.P's impressions, which included the marking "urgent", was sent to Dr CCC and appeared to be received on 5th June 1995. On it is noted the arrangement of the subsequent appointment for 14th June 1995 at the outpatient Clinic. It clearly indicates Dr. Yyyy's preliminary opinion of developing schizophrenia.

XX duly presented himself alone, despite the advice to bring someone with him, at the Outpatient Clinic where he was examined by Dr CCC. He had apparently not told his family of the appointment. It was clear that he was suffering from paranoid schizophrenia. There were suspicions that he might be dangerous and he needed to be in hospital for a full diagnosis and treatment. He said he was happy to be admitted as an informal patient and promised to present himself the following day. Contact with his family was made by a G.P. at Dr Yyyy's practice who passed on Dr CCC's opinion that XX needed hospital treatment and would be admitted on the next day. She was clear that immediate treatment was necessary and that an Order for Assessment under S.2 of the Mental Health Act would be appropriate. But as XX was fully co-operative she did not think that at that stage an Order was required. She kept this possibility in the forefront of her considerations for some days but as there were no signs of XX being unwilling to co-operate, an Order was never felt to be necessary.

Dr CCC wrote to Dr Yyyy, Xx's GP, detailing her initial assessment prior to admission. It was a reasonably full report setting out her impressions, briefly summarising his personal history and background, medical history and detailing his mental state on examination. The conclusions indicate that he had "a severe mental illness". This required treatment in hospital, and the patient had agreed to come in informally. Should he change his mind his illness was such that he would be assessed for compulsory detention under the Mental Health Act.

2. Consideration of those events

(i) Role of the GP

It is clear that Dr Yyyy in May 1994 was able, without difficulty, to assess that XX had underlying personal problems that were affecting his general well-being. Her choice of counselling, at that stage, seems to be very appropriate, and within limits was very successful as it gave XX some much needed confidence and support. On his visit to the surgery a year later, Dr Yyyy was quick to identify first rank symptoms indicating schizophrenia and she acted quickly to ensure that he was fully assessed by a Consultant Psychiatrist.

(ii) The use of Counselling

There were good reasons for referring XX to counselling in 1994. It appears to have been appreciated by XX and given him some reassurance and support. His persistence with it, even after his breakdown and period in hospital, gives the clearest evidence of this.

However, it is difficult to be precise as to the exact objectives of the counselling. Our lack of formal access to the counsellor's notes of what transpired at XX's meetings with the counsellor make a full assessment of the purpose of the sessions and the benefits XX derived impossible to make. It is clear that, in spite of a year's counselling sessions, XX's psychotic symptoms were not detected.

It is also debatable whether the sessions were continued for too long a period without a review of progress, but since XX was keen to remain in contact with his counsellor, its not being terminated is understandable. Even though we have no indication of the impression XX was giving to the counsellor, the lack of communication with the GP does not appear to be wise. It is possible that the concept of confidentiality could inhibit a referral to appropriate specialist help. This is a most important matter for consideration that arises from our enquiries and we expand our views in a special section below, dealing there in particular with the more general questions as to the organisation of a counselling service and the appropriate integration of the work done by the counsellor into the general pattern of medical and social work help available to a patient.

B. PERIOD IN DERBY CITY GENERAL HOSPITAL - WARD Q

1. Outline summary of events

On the day after his out-patient appointment, on 15th June, as arranged, XX came to hospital, arriving by himself. Dr CCC had told Dr. DDD, her Senior House Officer, of his impending admission. Dr DDD received him and spent some forty-five minutes or so talking to XX and recording her impressions of his condition in the Medical File that had been opened for him. She had no doubt that he was showing clear symptoms of schizophrenia, but found him very forthcoming and interesting to talk to.

XX was admitted as an inpatient to allow consideration of his symptoms that were indicating schizophrenia and for any subsequent treatment thought to be necessary. It was his first admission to a psychiatric hospital. On the day of admission a care plan was formulated by the nursing staff - this requires the nomination within 72 hours of a "named nurse". This was not done at first, so there was no "named nurse" in existence whilst the orientation, planning, implementation and evaluation phases were being initially considered.

Admission information was routinely sent to the Community Mental Health Team who would have responsibility for XX on his discharge - in this case the xxxx Community Mental Health Team (yyyy). It seems likely that they were told informally.

On XX's admission Dr DDD, on Ward Q, spoke to Dr CCC and checked her opinion on appropriate medication. XX, who had indicated he was not keen on medication, was told of what was proposed and seemed to accept what had been decided.

The patient was further discussed at a Multi-disciplinary Meeting (MDM), comprising medical, nursing, and occupational therapy staff, which noted the appropriate medication, and decided that his mental state was to be initially assessed so that, should he unilaterally decide to leave, it would be clear whether he could be detained under the Mental Health Act, by use of S.5(2), followed by an Order under S.2. Dr CCC's initial impression was that this might well be required and was to be considered as a possibility.

Every day, at each change of shift, the staff would consider how each patient was and report overnight observations. Other than difficulty in sleeping, for which he was given Temazapam, XX presented no problems. He was described as a model patient.

On 21st June, Dr CCC decided that the progress made by XX was such as to allow a period of leave over the next weekend. This decision, which is the responsibility of the Consultant, was based on a discussion of all the information available. It appeared that XX had not reported hearing voices for several days, appeared settled and was prepared to continue with his medication. One of the principal sources of information for decisions was the multi-disciplinary meeting (MDM) which was held in Ward Q weekly, on Thursdays. No formal notes were taken of these meetings as such but references were made to matters of importance in a patient's notes, as appropriate. These meetings supplemented the Clinical Ward Rounds which also took place weekly, at which the patients were seen and reviewed by the Consultant. The "named nurse" did not attend as a matter of routine.

Xx indicated that his father would pick him up for the leave but, in fact, he went home by himself. Appropriate medication was prepared for him and he was to return on Sunday lunchtime. The weekly MDM decided to continue the care plan as envisaged.

It is appropriate to note at this stage that XX's father recalls visiting, with his wife, in the evenings, four times during XX's first week in hospital. On at least one occasion XX's brother David came too. Mr X is also aware that XX was visited by some friends of his own age on Saturday, 17th June. On each visit the family first reported to the nursing station on Ward Q and enquired for XX. XX would then be told they were in the waiting room and would arrive to see them. None of these visits are recorded and there was no contact at any time with professional staff.

On the 25th June XX, after his leave, returned to hospital. He had little to say at first about his period at home but he later indicated that he had not got on well with his mother. He also said that he wished to discuss this with Dr CCC.

It was reported to us that on 27th June, because of the progress XX was making, he was allowed out of the hospital 'for the afternoon'. We subsequently learnt from XX that he had been spending considerable time out of hospital without permission. On some occasions he says he went to town and on others home. His absence was not authorised nor recorded and the staff of Ward Q appear to have been unaware of them. It appears that a provisional decision had been made to discharge XX in a few days' time. Due to his reluctance to accept oral medication it was decided to medicate him by injection. A test dose of Depot medication was accordingly given on 28th June. This decision was recorded in the nursing notes of 28th June.

On the 28th June his father, who was expecting his son to be discharged, came to the hospital to take XX home. He had on this occasion sought an interview with Dr CCC at which he expressed considerable concern about Xx. Although it appeared that XX was back to his 'normal self,' Mr X pointed out that his son had weapons hidden away and in particular a steel baseball- like bat with a serrated edge had disappeared. He also reported that on XX's last leave he had found a small number of XX's tablets discarded in the bin. He reported that he was causing difficulties and said XX 'is splitting up the family'. The family had been concerned about his safety for two years and could not understand why the counsellor had not "picked something up". This information appears to have been noted but it was made clear that XX would be discharged in the next few days and the plans for his after-care were explained. The need for the family to keep in touch with the hospital and the G.P. was stressed. Dr CCC suggested XX rejoined her with Mr X. They discussed the tablets but, because Dr CCC sensed an increasing discomfort during the discussion, and so as not to heighten the tension still further, she did not proceed with the three-way discussions beyond that point. The question of weapons does not appear to have been raised.

However, the concern shown by Mr X in his interview with Dr CCC contributed to her decision to substitute a period of leave for the intended discharge, so that XX's behaviour could be monitored further before actual discharge. The intention was that XX would return on 6th July, have a further Depot injection, and if all had gone well, then be discharged. The "named nurse" does not appear to have been involved in these decisions.

The MDM on 29th June, after XX's departure, confirmed that he should have a week's leave and then be discharged, unless further problems had arisen.

Xx returned by himself at the end of the leave on the 6th July. He was seen by Dr DDD and not Dr CCC, who was available for consultation if necessary. He reported that there had been some difficulties during the period of leave - he had felt somewhat slowed down and had had an argument with his mother. More positively he indicated that he had been given his job back. He was given a further Depot injection and discharged.

On the 13th July, a discharge letter, written by Dr DDD, was sent to Dr Yyyy. It gave a résumé of the admission, family history, personal history, mental state on admission, examination and investigation and the treatment and progress in hospital. It gave a full account of relevant matters but it must be noted that there was no mention of the concern XX's father had reported over his collection of weapons, nor of the apparent tensions in the family, nor of non-compliance with oral medication. It is impossible to say when the letter arrived at the G.P.'s surgery but it was estimated that it should have come to the attention of Dr. Yyyy within a week after it was written, but it does not appear to have done so.

The indication of progress in hospital also included some information about his employment problems. Because of Xx's ambivalence on this it was necessarily rather uncertain.

The follow-up arrangements were set out - he would be seen by Dr CCC in the Long Eaton clinic. It was important that if he did not comply with treatment he should contact the hospital or his GP. Father was thought by Dr CCC to have agreed to "keep an eye on medication" but he has no recollection of undertaking that responsibility. The medication given on discharge

was recorded. It consisted of Depixol injections fortnightly, Sulpiride twice a day and Procyclidine as necessary.

2. Consideration of those events

(I) Nursing in Ward Q.

(i.) Description

Ward Q is a general psychiatric ward, in a relatively recently built unit, in the grounds of Derby City General Hospital, which is a large general hospital with extensive facilities. These include a range of psycho-therapeutic activities and recreational and social provision. The Ward serves a population of approximately 108,000, most of whom are from the nearby towns of xxxx and yyyy. There is accommodation for 25 patients. Although located on the Derby City General Hospital site, it is owned by and forms part of Southern Derbyshire Mental Health NHS Trust.

The ward operates a recognised nursing model based on Hillegard Peplaus. Patients are allocated a "named nurse". There is a strong emphasis upon the development of nursing skills and of team work. Appropriate courses for the upgrading of skills are held. The Ward is approved for both Project 2000 Mental Health Branch students and for Conversion of Enrolled Nurse Training.

The mental health resources linked to the ward are

1. Outpatient clinics at some G.P. surgeries and at xxxx Community Hospital,
2. Community Mental Health Teams,
3. Drop-in Day Centres,
4. Access to specialist services,
5. Psychotherapy, Behaviour therapy,
6. Specialised Social Workers

(ii.) Ward Programme Activities

XX has since indicated that he was very bored by his time in hospital. No doubt, to an extent this was due to his personality and illness. Although there is apparently a full programme of activities XX appears to have done little and he says that he frequently left the ward, and the hospital. He had been to town, and even been home, several times. Surprisingly, most of this absence appears to have been unauthorised and undetected. He had not wanted to take part in most activities. He had been told there were facilities in the hospital, such as a general workshop, which it was thought might interest him, but he showed no inclination to attend. However, he was keen to use the gymnasium but was told that there would not be an acceptable level of supervision.

(iii.) Nursing Policy

A system of "named nurses" is operated, each patient being allocated a specified nurse within 72 hours of admission. The patient's "named nurse" will attend the MDMs, according to availability, but not as a matter of routine. The Ward Rounds involve the Consultant, the

Junior Doctor and a nurse, usually the nurse in charge of the Ward. It so happened, because of leave - of both patient and nurse - that XX's "named nurse", EEE, did not attend any of the MDMs. There was, however, a 'green sheet' system of general communication, by which matters of importance could be reported in the notes and so would come to the attention of all review meetings. It is a matter of chance that during XX's stay, because both he and his "named nurse" had periods of leave, they were both in the hospital at the same time for, it would seem, merely five days. Although there is a system of "associate nurses" to ensure continuity of care, in this instance the practice did not comply with the policy.

(iv.) Care Programme Approach

Although the Ward operates the Care Programme Approach, the allocation of XX to Level 1, which is itself a surprising outcome of the assessment, meant that there was no special planning of care for XX subsequent to his discharge. Whilst he was in hospital, apart from the need for routine medication, involving injections given by the Community nurses, no other factors were identified as requiring continuing attention.

However, on 20th June, whilst in hospital, XX indicated that he had been sacked and that this was worrying him. A staff nurse (not the named nurse) undertook to contact his employer to explain the situation - and presumably try to keep the job open. There is some doubt as to how far this happened. He does appear perhaps to have regained his job but very shortly left, whether on his own or his employer's initiative is not clear but in practice he cannot be said to have 'gone back to his previous employment'.

It might be thought difficult, except with hindsight, to be critical of the allocation of XX to Level 1 of the Care Programme Approach but there does appear to have been information available that would have indicated that a higher level was prudent. Certainly events indicated that there was a real need for a higher level of supervision and support.

One of the underlying factors affecting the evaluation must be that XX, newly diagnosed as suffering from schizophrenia, had contact during his stay in hospital with the qualified medical staff, which was clearly inadequate to have a proper appreciation of his progress and the difficulties he was likely to encounter at home.

(II) Medical assessment

There is no doubt that the medical assessments made initially by Dr DDD and subsequently confirmed by Dr CCC, who had already examined the patient before admission, were completely correct. Similarly the choice and doses of medication whilst in hospital and on discharge are in conformity with good medical practice.

Markedly less attention, however, was given to the more general aspect of the patient's general needs and to his social background and difficulties. This has several elements;

1. Little was done to use the time XX spent in the Ward to assess his general capabilities and his social problems.
2. Little thought and certainly no clear directions were given as to how he could purposefully pass his time in hospital, whilst such assessment was being done. Medical

notes indicate a referral to the occupational therapy department, but nothing appears to have come of it, because of a lack of urgency. The way he spent his time underlines a failure to ensure that he was engaged in supervised and fruitful activity.

3. Warning signs of some non-compliance with medication during leave, and the underlying possibility of danger from an unhealthy fascination with weapons were not given enough weight.
4. On the question of dangerousness the evidence is difficult to interpret. Certainly after she had spoken to Mr X on 28th June Dr CCC was aware of the importance of weighing his opinion with the facts she had. She recorded her concerns and informed the staff. She clearly did not take the decision to release XX without considering this factor along with all the others.
5. The apparent advantages of early discharge - the availability of a job (which was doubtful and not investigated), meeting the patient's wishes to return home, and confidence that his illness could be well controlled by conventional drug therapy all led towards the decision not to unduly delay discharge.

More generally, the lack of communication with XX's family is unfortunate, if possibly explicable. XX appeared to be an adult and self-contained young man; his relatives had not apparently pressed on his admission for an early meeting with the doctors; his illness looked to be relatively easy to control and release from hospital might secure a return to his job. One of the factors that may well have influenced the approach was the current importance given to confidentiality, for it has to be acknowledged that as XX was an adult there may well have been hesitation in involving others without explicit permission.

Yet it is the failure to recognise fully the social aspects of XX's problems, rather than the medical treatment of his classical psychiatric illness, that proved to be one of the most important and unfortunate aspects of his care.

(III) Social Work Involvement

The reason for the lack of social work involvement whilst he was an in-patient is one of the most perplexing features. On admission, all the information available came either from the admission letter from his GP, who did not know the family especially well or from the facts volunteered by XX himself. Although the matter was no doubt given serious attention at the time the Care Plan was considered it is difficult to see that this could be fully effective without a wider range of information from XX's relatives, and perhaps his friends and employer, being available.

It is important to note that neither XX nor his family had had previous involvement with the Social Services. There had been no request for help with the problems that were arising.

No reason has been established, other than a concentration on medically treating XX's symptoms, to explain the absence of a referral to Social Services. Furthermore, no inhibitors to such a referral have been identified, such as impaired working relationships, resource problems, or lack of confidence in the ability of Social Services to respond.

At strategic level there exists a sound Joint Planning framework, and at local operational level there are agreed joint operational procedures, supported by joint training. Particularly relevant

are the processes to recruit, train and accredit Approved Social Workers, which have been undertaken on a joint basis with local health services, and which have resulted in adequate numbers of these specialists in Mental Health work being available in local Area Social Work teams, and in Community Mental Health teams.

Support for this work was also available from a range of services including occupational therapy, day care, either at home or in day centres, and more generally through links with other key departments such as housing and employment.

Social work support to Psychiatric Hospitals is provided from Area Social Work Teams and from Social Workers based in Community Mental Health Teams. As such the management of the service is not unified yet but moves towards this have begun.

RECOMMENDATIONS

1. It appears essential that a psychiatric patient with a severe psychiatric illness whose recent history is not known should be assessed by a social worker after admission to hospital and prior to the decision to discharge. Where there appear to be difficulties, an assessment of family or employment circumstances should be made.

Given the psycho-social nature of the impact of schizophrenia, and other severe psychiatric illnesses on the patient, relatives and carers, it is important to ensure that a multi-disciplinary and multi-agency approach is always adopted.

2. There should be adequate social work resources available to support the implementation of Recommendation 1.

3. That the role and responsibilities of the "named nurse" should be reviewed, including the extent of the responsibility to co-ordinate the services given to the patient.

4. That "associate nurses" be appointed for each patient so as to ensure continuity of care over the three shifts and during other absences of the "named nurse".

5. That the "named nurse", or an "associate nurse", should be present at all occasions when decisions are being taken as to the future of the patient. This is especially so with regard to the consideration of a patient at the weekly Multi-Disciplinary Meeting. Records of key decisions should be co-ordinated and kept available for consultation by the team of "named" and "associate nurses". Any plan of action should be communicated to those concerned. The responsibilities of the "named nurse", as set out in the Philosophy of Care for Ward Q, are excellent and should be adhered to.

6. The care plan should specify a programme of activities within the Ward Programme relevant to the patient's care and to assist rehabilitation.

7. That the "named nurse" should have a duty to make and maintain contact with the appropriate relatives, friends or carers of the patient so as to form a link with events and opinions of importance to the making of decisions involving the patient.

8. Following leave - weekend or long leave - a clear record of behaviour and incidents at home should be ascertained. Where appropriate, relatives, friends or carers should be interviewed.

9. The co-ordination of the various sources of social work assistance to patients and discharged patients requires careful consideration.

10. All staff should be made aware that crucial information, for example, the knowledge of some non-compliance with oral medication and of the interest in and possession of weapons, should be communicated to the multi-disciplinary team and to the clinical ward round and a system devised to ensure this takes place. An ongoing assessment of risk should be an integral part of the process.

11. Prior to discharge, a package of care should be arranged to meet the individual's health and social needs.

12. Discharge should include provision for feedback, properly documented to maintain accuracy of information.

13. Where an intended discharge is delayed for further consideration, a full review meeting should be held prior to discharge being granted.

C. DISCHARGE AND HANDING OVER TO COMMUNITY CARE

It is good practice that consideration of a patient's needs on discharge should start as soon as possible after admission. This procedure is enshrined in the relevant local policies but does not appear to have been adhered to. The failure to assess and pass on the difficulties that would face XX was detrimental to the determination of the level of care required from the community team. In particular, no mention was made of social and family difficulties. The same weakness can be detected in the timing and content of the Report sent to his G.P.

1. Outline Summary of Events

On 6th July XX was discharged and his supervision was handed over to the Community Mental Health Team in xxxxx. A team member from that area was usually in attendance at the Ward Q MDMs so might well have been aware of the plans for XX's discharge. Instructions on the treatment XX was to have were sent to the xxxxx Office.

On the 13th July, a discharge letter, written by Dr DDD was sent to Dr Yyyy. It gives a fairly full, accurate résumé of the admission, family history, personal history, mental state on admission, examination and investigation and the treatment and progress in hospital. There was no mention of resistance to medication, of any potential family difficulties, nor of the possession of weapons.

The indication of progress in hospital also included some information about his employment problems. Because of XX's ambivalence on this it was necessarily rather uncertain.

XX visited his G.P., on the 17th July to obtain certificates relating to his employment and again on 27th July. Dr Yyyy appears not, on these occasions, to have seen the discharge letter or summary. The letter would usually come by post, but in some instances the patient brings along a summary. There is no record of the date on which Dr DDD's report was received by the practice.

FFF, a Community Support Nurse (CSN) was allocated XX, who did not, from the information available, appear to present complex difficulties, although his hostile attitude to medication was known. The process of allocation appears not to take into account the features of each individual case. There is no practice of liaison with the G.P. The nurse first rang XX's home on 10th July. XX seemed happy at his getting into contact. Mr FFF found out that he would be able to visit XX at home but XX made it clear he was very reluctant to take an injection. XX also indicated that he was aware of the nature of the medication and its side effects, and did not wish to continue with the Depot medication, but he agreed that he would see Dr CCC.

On the 19th July, FFF visited XX, taking a Depot injection with him. He saw XX by himself. In the conversation they had, XX was relaxed and open, showing some insight but appearing overall very flat. He discussed hearing voices but said that they had lessened since he was taking the Sulpiride. He checked that XX had a supply of tablets which he said he would continue to take and offered the injection which was adamantly rejected. He indicated that his non-compliance, and his previous discarding of tablets was because they did not mix with alcohol. XX also reported that he had "left" his job. He indicated that the nature of the work had changed from that before his admission to hospital, so he had "left that day". He indicated a willingness to see the CSN to talk about his future and a visit in two weeks was arranged. There was an amount of social conversation, on football for instance. The CSN gave XX a telephone number to contact him if he wished to do so.

FFF informed Dr CCC's colleague, Dr ZZZ, in Dr CCC's absence, who advised him to leave a message with Dr CCC's secretary. Dr DDD in Ward Q was also informed of the appointment being requested.

On 20th July, the next day, FFF reported his visit in some detail in a letter to Dr CCC, with a copy to Dr Yyyy. The original letter bears a note by Dr CCC - apparently indicating concern, "make sure he's got an appointment to see me". XX's mother was very worried and on the same day she telephoned FFF saying that XX was sleeping better and was less irritable but expressing a worry that he had lost his job. He was remaining isolated in his room. She asked to see Dr CCC. She also attempted to get an appointment with Dr Yyyy, telephoning the surgery, but was told the earliest date available was 10th August. There was no indication that this was for an urgent matter, the surgery was very busy at the time and so the date fixed was not until after the tragedy occurred. Dr Yyyy indicated that if there had been any suggestion of urgency she would have been able to see Mrs X earlier, at the end of a normal surgery.

The family were worried about XX not settling at home. His father raised with him the possibility of finding independent accommodation, without any positive response from XX. A quarrel appears to have taken place on 6th August.

On 3rd August, some two weeks after his first visit FFF again called to see XX. He did so to attempt to administer the medication, to make a psychiatric assessment and to see if he could help generally. Again XX was very friendly. He explained that he had given up his job because it was not to his liking, but was confident he could get another. There was a discussion as to possible tensions within the family. XX's mother joined them and appeared to be somewhat flat in her responses, indicating that she felt that her son should start to get on with his own life. Her subsequent conversation indicated some real and long-standing tension in their relationship, so the nurse tactfully terminated the visit, having suggested that she and XX might care to discuss those problems with Dr CCC.

As a consequence of the worries caused by his visit the nurse phoned Dr CCC to tell her of the situation. At her suggestion he initiated with her secretary the possibility of an appointment for XX and his mother to see Dr CCC. It was fixed for 23rd August.

It was on the 8th August that Xx killed his mother and subsequently his half-brother. He left hand-written notes around the bodies indicating that he knew he was mentally very ill. He then went to the doctor's surgery and reported the killings; the police, who had been called, arrived and arrested him. His father was informed and left his work and returned home.

He has told us how difficult he found it. He was unable to get into the house, although he was provided with necessary clothes.

2. Consideration of those events

(i) Discharge from hospital

The procedures for discharge from Ward Q are apparently well established. XX was referred to the xxxxx Community Mental Health Team and a discharge report was prepared and sent to his G.P., Dr Yyyy which took some time to arrive at the surgery.

(ii) Community Psychiatric Nursing

Although the allocation of patients by the community team is informal - cases are discussed, some workers volunteer to take a particular case on to their caseload and others are allocated by their supervisor - it appears to combine professional judgement with some attention given to the personal suitability of the nurse. The seriousness or degree of difficulty determines the level of nurse allocated - Community Psychiatric Nurse (CPN) or Community Support Nurse (CSN). Mr FFF, an experienced nurse, indicated to his supervisor that he would be willing to take XX on to his caseload and as there appeared to be no particular difficulties or unusual circumstances this was felt to be appropriate. The discharge document had limited information on the medication he was on when he was discharged and indicated that he was non-compliant. His first task was to administer the next injection when it was due, and he arranged for a visit by telephone. Had there been fuller information available, allocation to a CPN might have been thought to be more appropriate.

The CSN appears to have done well in establishing a good and friendly relationship with XX. He also dealt with the refusal to take the injection in a professional manner, ensuring that Dr CCC was informed. His second visit to XX was to see if he would now accept an injection but

also to retain contact. He was well received by XX, although he refused the injection. They had a friendly conversation. However, on this visit he found himself involved in a difficult and emotional conversation with XX's mother which, very sensibly, he drew to a close as best he could. He immediately informed Dr DDD of the outcome of this visit. XX had indicated he would be prepared to see Dr CCC again. The outcome of the first visit had been reported by the CSN in a letter to Dr CCC and he made further contact following his second visit.

The general failure to identify the complexity of XX's problem and pass on information so that an appropriate level of experienced community nurse was assigned the task of visiting was unfortunate, but in the circumstances FFF appears to have coped very well with unexpected difficulties. It is especially noteworthy that he continued to visit when he indicated that established practice might well have led to support for XX being terminated on the grounds of non-co-operation.

(iii) Response to emerging difficulties

There was plainly enough going wrong to indicate the need for a thorough and speedy review of the discharge. It is at present difficult to envisage a clear chain of responsibility and there appear to be few rules or accepted practices as to what should be done. Clarification is of particular importance where, as here, a job sharing system is in place.

Although the Consultant had overall charge, and was easily contactable, there is an obvious difficulty in obtaining a speedy review when there is indication that serious problems are arising. Decisions such as whether to terminate the involvement of the Community Nurse, to seek medical opinion from the G.P. or the Consultant appear to be dealt with haphazardly. If a junior community nurse is reporting considerable difficulties and a tense social background there appears no machinery to give priority to a full review of the problems that are being reported. Merely to note circumstances and slot consideration into the normal cycle of after-care may not always be adequate and it must be extremely difficult for a junior professional to secure more immediate action to consider the deteriorating situation he has encountered.

RECOMMENDATIONS

14. Schizophrenia, defined as a 'severe mental illness' should fulfil the criteria for Level II/III of the Care Programme Approach and merit a co-ordinated care package. Within the 'level of need' (Appendix 1 CPA) it is recommended that criteria 3.4 should include consideration of risk assessment.

15. Nursing documentation should record the discharge process.

16. Action should be taken to ensure greater clarity of responsibility once an in-patient reverts to care in the community.

17. The front-line carer - CSN or CPN - should have, in addition to the normal process of reporting through his seniors, the power to initiate promptly a full review of circumstances which are causing serious concern.

18. The employee specification should set out the competencies required of the post holder and identify the appropriate grade.

19. The delegation of work should follow the appropriate competencies.

20. The quality of the discharge information passed to the community service should be reviewed to ensure that appropriate professional matters are routinely covered.

21. The Consultant should ensure that the patient's G.P. receives notice of the discharge as soon as possible and his medical and social details as necessary to ensure continuity of care.

22. A clinical supervision network should ensure that individual staff are fully supported.

23. The Trust should publish patient information leaflets on medication and ensure this information is promptly communicated to the patient and carers.

24. Patients in the community should not be removed from follow-up, on any grounds, without full consideration of the circumstances, involving all the professionals concerned.

25. It is important to strengthen the role of the Community Link Nurse with Ward Q so as to establish continuity of care compatible with the Care Programme Approach.

26. The practice of changing the Community Link Nurse every 3 months should be reconsidered.

CHAPTER TWO

GENERAL ASPECTS

A. INTRODUCTION

It has become apparent from events that we have studied in great detail that there are issues of general application that form a background to the specific treatment of XX. They arise from widely-accepted attitudes and practices which underlie many of the actions taken, and which shape quite fundamentally the individual decisions made. They therefore require careful analysis and consideration. They have each played a background role in contributing to the evolution of the events under review and in each case a modified approach, whilst not necessarily averting the tragedy, may well have contributed to maintaining XX in a state of health and at a level of control that would have lessened the danger. These matters are -

The concept of confidentiality as it applies to counselling.

The importance of such protection for the patient is very clear but a professional counsellor should always be prepared to identify situations where it is important that others should be made aware of facts or opinion, both for the protection of the client and of others who may be in danger.

The difficulty that arises where a patient, who could be sectioned has agreed to enter hospital voluntarily but on partial recovery decides to refuse treatment.

In view of the improvement, a Consultant may feel that the imposition of an Order is no longer possible, despite the belief that a further period of supervision in hospital is essential for the patient's recovery to a level at which release is safe.

The question of the balance in the treatment of the patient's mental illness itself and attention to personal and social factors that appear to have contributed to the onset of the illness and may tend to precipitate a relapse after discharge.

Rapid improvement is common after a relatively short period of administration of the appropriate medication. This should not divert attention from the need to identify and attempt to tackle the underlying personal or social problems, beginning if possible whilst the patient is still in hospital.

An important instance of commonly-encountered pressures - the social circumstances to which the patients will return on release from mental hospital, must as far as possible be thoroughly investigated and the level of support available should be an important factor in the decision to discharge.

Whilst detention in a psychiatric hospital, whether compulsorily or through persuasion, cannot be justified solely on social grounds, assessment of safety in the community inevitably involves consideration of these factors.

B. THE ISSUES

1. Counselling

There has, in recent years, been a rapid growth of the use of counselling. It both adds to the effectiveness of the work of General Practitioners and enables some intensive work to be done with individual patients for which the GP could not possibly find time. It will no doubt continue to grow.

In looking at XX's treatment we had no doubt that, once Dr Yyyy had detected that XX had worries which appeared to embrace both physical and emotional problems, it was entirely appropriate to refer him first to a cardiologist and subsequently to counselling. The G.P. practice, and Dr Yyyy in particular, had made the use of counselling a feature of their care of patients. XX was just the sort of young man, finding it difficult to cope and with obvious social problems, who was likely to benefit from such a referral.

We are equally clear that it is right to assume that the work done with the counsellor, Mr AAA - whose notes were not formally disclosed to us, was of real potential benefit to XX. He clearly valued the help he was being given in this way. The question is raised as to why nothing happened with regard to his psychotic symptoms during the year of counselling. This was because they were not detected by Mr AAA. This suggests that the training of counsellors does not provide the necessary skills to allow them to recognise serious psychotic illness in their clients.

We feel it is most important to draw attention to the confidentiality of the information passing from patient to counsellor. Dr Yyyy had no set policy on this. She did not ask for routine 'reporting back' but appeared to expect that matters of concern to a counsellor would be

referred back to her by the counsellors used in the practice. Mr AAA did not do this. However, he appears to have been of the opinion that his professional code prevented unilateral disclosure by him to anyone of anything but most serious matters. In general, it seems important that the guidance given to counsellors and, in particular, trainee counsellors should be reviewed to ensure that the position is clearly stated.

It is our impression, from what we have been able to discover in general enquiries and from documents kindly sent to us by the British Association for Counselling that the approach to problems that arise where mentally ill patients are being counselled are not yet fully developed. Their document on the Code of Ethics and Practice says -

B4.1 Confidentiality is a means of providing the client with safety and privacy. For that reason any limitation on the degree of confidentiality is likely to diminish the usefulness of counselling.

4.2 Counsellors treat with confidence personal information about clients, whether obtained directly or indirectly or by inference...

4.3 Counsellors should work within the current agreement with their client about confidentiality.

4.4 Exceptional circumstance may arise which give the counsellor good grounds for believing that the client will cause serious physical harm to others or to themselves, or have harm caused to him/her. In such circumstances the client's consent to a change in the agreement about confidentiality should be sought whenever possible unless there are good grounds for believing the client is no longer able to take responsibility for his/her own actions. Wherever possible, the decision to break confidentiality should be made only after consultation with a counselling supervisor or an experienced counsellor.

It is difficult to find fault with those guidelines except the guardedness of 4.4. Clarity is lacking as to the action to be taken where a counsellor encounters circumstances leading to a belief that the client may well be mentally ill and even possibly dangerous. It should be made clear, without any doubt, that where such circumstances are encountered, the counsellor has a duty to disclose to an appropriate professional, skilled in the identification and treatment of mental illness, the worries that have arisen. Where a group of counsellors form part of a team serving the practice patients it would be reasonable to make clear at the outset that the counsellor would, in circumstances where he felt it important for the well-being of the client, be entitled to pass to his colleagues such information or worries as he thought essential to protect the client's health.

Had the extent of professional powers and responsibilities been clearer to Mr AAA we have little doubt that he would have regarded it as within his professional duty to report any worries he may have had about XX's stability to Dr Yyyy, who had referred XX for counselling. Obviously the patient's agreement should be sought, but in the occasional case a decision could properly be taken to inform the G.P. We do not suggest that the counsellor's strict adherence to his concept of confidentiality is a matter for criticism - it is for that reason that we deal with the issue here as a matter for general clarification so that all counsellors are alerted to the importance of sharing such information - without necessarily having obtained

the client's permission - with appropriate colleagues. Indeed it is arguable that Dr Yyyy, being herself bound by professional rules of confidentiality still maintained the shield of protection with which the counsellor was rightly concerned.

It is our hope that the bodies who at present are seeking to structure counselling as an important profession make sure that the point we have made is clearly set out in their Codes of Conduct. The sensitive handling of confidential information cannot be governed solely by a strict rule of confidentiality nor by the 'contract' between client and counsellor. Professional responsibility adds the additional burden, on rare occasions, of protecting the client by breach of confidentiality, certainly where the information is passed to other professionals with their own regard for confidentiality.

The situation also raises the question of the supervision of a counsellor, in this case on professional placement. It is not clear whether there is an adequate system in place. The question is one which should be considered by all G.P.s as a group, and by all those concerned with Community Mental Health.

The intervention of counselling was plainly of some benefit to XX. It was indicated to us that the organisation of counselling services required to be improved and this seems appropriate.

The priority to provide counselling services requires review with the purchasers of this service. The balance of resources allocated to meet a range of needs, from emotional distress to the most severe mental health conditions, needs to be evaluated.

2. Informal admission or compulsory detention

The central feature of treatment in hospital is the accurate identification of the illness, the determination of the appropriate medication and assessment of its effectiveness. Once stability has been achieved, consideration has obviously to be given to return to the community. If, however, the patient does not give his co-operation, consideration has to be given to the availability of detention orders under the Mental Health Acts which enable those phases of diagnosis and treatment to be ensured for unwilling patients, in the interest of their own health and safety and the safety of others, by imposition initially of an Order under S.2 Mental Health Act 1983.

XX was regarded by Dr CCC, correctly we have no doubt, as liable to be placed under such an Order when she first examined him. He was plainly suffering from a serious illness - schizophrenia, which was affecting his behaviour and meant that he was at least a danger to himself unless treated.

XX appears to have been, his illness apart, a very pleasant young man and he agreed to enter hospital without the necessary imposition of an Order. He duly appeared as promised. His schizophrenia was easily recognisable and the standard medication in a normal dosage was administered. He made a rapid improvement and was soon returning to a state where he said that he was feeling much better and showing that he was keen to return home and restart work.

Dr CCC confirms his speedy improvement on medication. She did not indicate to us how long she would ideally have liked him to remain as an inpatient but in explaining why he was

discharged quite quickly, said that she did not regard him as any longer 'sectionable'. That is to say his mental state had improved to such an extent that although he was by no means fully recovered he was no longer so ill as to be liable to the imposition of an Order. So she did not feel she was in a position to have resisted a refusal to stay and felt, in view of the apparent improvement, on balance it was better that he return home and continue to receive his medication as an out-patient. This did not appear to her to present any danger.

It is our impression that Dr CCC was expressing a generally-held view that, once there is a certain degree of improvement, an informal patient having been assessed and treated in hospital cannot at that stage be restrained by an Order so that treatment can be continued with certainty.

Assessment of the state of a patient with mental illness in terms of liability to be 'sectioned' involves a difficult judgement, since liberty has not lightly to be taken away. It is, however, one that psychiatrists are familiar with and used to making. An apparently difficult question arises, however, where the patient who could have been put on a section, such as XX, agrees to enter hospital voluntarily and medication speedily reduces the symptoms of the illness to a level which may well be thought to fall below what would normally be regarded as the threshold for sectioning.

It is surely part of the structure of the Mental Health Act that a patient, sectionable upon entry to hospital, must reach a level of improvement and of adequate insight that would warrant the discharge of a sectioned patient before the right to section lapses. It would be contrary to the structure of the statute, and against the wider interests of the patient and the public, to believe that once improvement has started and the patient's condition improved, the safeguard of detention is thereby lost even though improvement has not reached the level where the patient could be safely discharged if an Order had been imposed.

It seems important to stress that the test to be applied to a patient, sectionable at the beginning of treatment but admitted informally, who seeks to leave hospital at a stage that is premature, is not that which is used on initial sectioning in the community. It is rather - 'would that patient, if an Order had been in place, have been discharged from it at the current stage of improvement'. If not, it is surely both reasonable and responsible to make an Order, no doubt explaining the reasons and indicating that if improvement continues it is likely to be removed before it has run its four weeks' course.

We would add here that it appears to have been reasonable to decide that XX had improved to such an extent that his wish to leave could be accepted. It was a matter for judgement by Dr CCC and she clearly took into account that he was going home where he would not be alone and that his job was available to him. It was her indication that she felt the alternative of the imposition of an order detaining XX, had she felt it necessary, was not available to her that has prompted these comments.

3. Treatment in Hospital

The short period that XX spent in hospital - XX slept there for 11 nights between his admission and discharge - and the way he appears to have occupied himself whilst in hospital raises the very wide question of the purpose of treatment in hospital.

Plainly the central purpose is to diagnose and to begin treatment of the psychiatric illness. It is clear in the circumstances being reviewed that neither of these tasks were particularly difficult since XX was plainly suffering from schizophrenia, as indicated by the GP on referral, and he responded quickly and well to the usual medication. Indeed, in one sense the problem had been rapidly identified and potentially solved, for had he continued with his medication we have little doubt that there would have been no relapse and the tragedy would have been avoided. It was other pressures which led to non-compliance with medication and XX's relapse.

We feel it necessary, however, to raise wider aspects of XX's period in hospital. He appears to have been offered attendance at a workshop in the hospital, but declined this and no particular persuasion was used. It is, moreover, difficult to discover accurately what he did whilst in the hospital. It was suggested to us by the staff that he took part in some ward activities, which we do not doubt, but he himself indicated that he quite often went home and to town, we must assume without this being noticed. We were unable to verify this but must comment that, no doubt because his illness presented no problems of diagnosis or control, there appears to have been a failure to observe him closely, assess him generally and to ensure he had something to occupy himself with.

There may have been special reasons for what happened, it is difficult for us to be certain. We did, however, gain the impression that the focus was on treating the illness rather than the patient in the round. This is not uncommon in psychiatric practice, in cases such as XX, where the effect of the drug treatment is good and there is apparently a reasonably stable background.

It should have been very clear that there were some serious social problems and that XX had never been able to develop his potential nor to find an appropriate job which interested him for long. It is unlikely that a return to such a lifestyle would itself have precipitated a return of his illness, but it would undoubtedly have increased the chances of a relapse. A routine investigation of the social background would have disclosed that he needed some urgent assistance and support with these aspects of his life.

4. A social circumstances report prior to discharge

It followed from the narrow medical and scientific approach that no social work assessment of XX's social background was sought and, therefore, the situation to which XX was discharged was not fully assessed. It is worthwhile noting that had he been under section, and he had made application to a Mental Health Review Tribunal, a full, specially-prepared, home and social circumstances report would have been available to the Tribunal. The preparation of the report would have entailed an interview with XX and with his family by a social worker assessing matters such as his home circumstances, job prospects and need for further training. The question of his setting up independently, which was a possibility mentioned for XX, would also have been considered. Such a report for XX would undoubtedly have shown that he was likely to meet a range of problems and that he might well find it exceptionally hard to cope.

One of the important conclusions that can be drawn, and it forms an important part of our recommendations, is that no patient with a major mental illness should be discharged from hospital without there being available for consideration a full, up-to-date social work report

covering matters such as the home circumstances and work prospects. We strongly recommend that such a report should be prepared in all such cases prior to discharge. For many patients the information will be well-known and readily available and merely need collecting together and perhaps up-dating. XX's discharge is an illustration where, despite indication of tensions, there was a lack of social investigation which can now be seen to be an important omission.

5. Communications

Where a patient has suffered a psychiatric illness and been admitted to hospital, there will almost certainly be very many carers involved; consultant, hospital psychiatric department, community nurse - the list is very long indeed. There is bound to be considerable difficulty in ensuring, at the various stages, adequate communication between those immediately involved.

Similarly a great deal of information about a patient, the illness and progress is recorded in many different places. For example, initially there are the notes of the G.P., detailed daily ward notes and any number of specialist assessments. It is, therefore, a problem to ensure that relevant information is always promptly passed to those who are taking over responsibility for the next phase of care. In practice, of course, much of the information is disseminated and generally known. Transmission takes the form of passing on significant information as new phases of care arise.

It is clear, however, from our investigation that further thought needs to be given to the timing and form of the information given. Two random, but important, examples concerning XX will serve to illustrate this.

It does not appear that all the information sent from the hospital to his G.P., when XX was discharged, came to her notice, as quickly as is desirable. The precise reason for this was difficult to determine. Similarly, it was also apparent that, once the patient was being cared for in the community, the accepted methods of communication were not as efficient as they should have been. The most notable instance related to procedure rather than what actually happened. It was indicated to us that had the CSN or CPN decided to terminate efforts to persuade XX to accept Depot medication, this decision may have been taken without prior discussion with his consultant psychiatrist and may not even have been speedily communicated.

We did look in great detail at these matters and saw clear indications that a review of the network and methods of communication would be of benefit. The existing system of communication of routine matters will probably merely require reconsideration and up-dating. Where there are major matters arising, discharge and refusal to take the prescribed Depot injection are the two clear examples here, there should be consideration of more immediate forms of communication - telephone, fax and E-mail for example.

There is no doubt that a multi-disciplinary, multi-agency review of communications would be beneficial. Admission, discharge and other transfers of information should be considered within this review by all those involved. These matters are now of particular importance and relevance prior to the disaggregation of services between Derbyshire County Council and the newly-created unitary authority for Derby City.

RECOMMENDATION

27. There should be one healthcare record for each patient through all contacts with the Trust.

6. The Aftermath

Although they may be thought strictly to fall outside our terms of reference, it is essential that mention be made briefly of a small number of issues that concern XX's father.

It should be noted that XX's father, who clearly had worries about his son's health and welfare, felt that he had been unable to ensure that his feelings were fully understood and taken into consideration whilst XX was in hospital. The impression he got was that, no doubt because XX was an adult, his views were not given great weight, whereas what XX said was more readily accepted.

He also felt that where there is a serious psychiatric illness, families should be involved as early as possible. Although the legal concept of 'adulthood' is of great importance, where a patient is suffering from a severe psychiatric illness, proper weight has to be given to the experience and views of those who have been close to him.

There needs to be information and advice on the nature of the illness and the effects of medication.

The description given by XX's father of his own experiences immediately following the tragedy also gave us considerable concern. He does not feel that he was treated with consideration.

On returning to his home, where the tragedy had occurred, he was, understandably, refused entry by the police. He was provided with necessary clothing and taken to a relative's home. Since then he has received continuous support from the "Family Officer" of the Derbyshire Constabulary.

For the reason indicated at the outset of this section, we did not look into the matter in detail but had noted the apparent lack of contact from the hospital and the primary health care team.

C. DETAILED RECOMMENDATIONS ON MORE GENERAL MATTERS

It appears to us sensible to set out these recommendations in groups, involving the various processes that XX encountered. We have been made aware that a considerable number of changes have already been initiated but for the sake of the completeness of our Report we set out all the matters which we have seen as deserving attention.

1. Counsellors

The increasing use of Counsellors is noted. The Southern Derbyshire Health Authority appears to encourage their use, but as yet there is no fully developed framework for their organisation.

The actual appointment of counsellors has been taken over from the Family Health Services Authority - involving a commitment that may be full-time, or for as little as six hours.

Their use depends upon the initiative of general practitioners and there is very wide variation.

RECOMMENDATIONS

28. The central organisation of all counselling services should be further strengthened so as to support effective use and to co-ordinate appointment and training.

29. The current training should be offered to all counsellors with the purpose of clarifying their role in the care of patients/clients and of ensuring their ability to recognise when there is the need for reference to other specialists. They need to have an understanding of the early symptoms of mental illness.

30. Bearing in mind the current variations of counselling practice that currently exist, guidance should be made available to G.P.s as to the most effective use of the differing forms of counselling.

31. Building on the varying rules and practice of the various professional bodies in counselling, clear rules should be promulgated by the Health Authority, setting out for counsellors the basic standards expected. Clarity of the rules as to the sharing of information is crucially important.

32. Standard requirements, also set out in the Job Specification, including the duty to attend training and discussion sessions, should also be included in contracts offered to Counsellors. The current support for counsellors should be extended to include trainees and qualified counsellors on professional placement.

33. More collaboration would be appropriate between mental health services and primary care counsellors. Counsellors should have a periodic opportunity to discuss their work generally with Psychiatrists, G.Ps., and social workers. This might be achieved by an annual study session.

34. Attendance at joint training sessions for general practitioners and practice staff on the use of counsellors should be encouraged.

35. The limits of confidentiality between the various professionals concerned with a patient's care should be carefully defined, indicating the circumstances in which others must be informed.

36. As comprehensive a register of counsellors as possible should be available, setting out the type of counselling they are prepared to offer.

2. Assessment and planning to meet social care needs

Detailed good practice guidance to inform and support co-ordination of multi-disciplinary and multi-agency working is set out in the Department of Health Circulars - HC(90)23 and

HSG(94)27. They deal with assessments and care planning, particularly in relation to discharge from hospital and with the care programme and the processes of care management. Also described are the arrangements to involve patients and relatives in discharge and care planning, subject to any constraints arising from lack of consent by the patient.

They have been adopted by the Southern Derbyshire Health Commission and the Southern Derbyshire Mental Health Trust and in documents drawn up jointly with Derbyshire County Council Social Services Department - evidenced by the publication 'People and the Care Programme Approach'. These publications were commended by John Bowis, Parliamentary Under-Secretary of State.

We have, however, identified several weaknesses in the application of the procedures.

RECOMMENDATIONS

37. The discussions of the patient's progress and problems in the hospital should be given more formality; the philosophy of care and nursing being operated should be clearly identified and the responsibility for dealing with problems made clear.

38. Steps should be taken to ensure that at appropriate times patients and their carers are included in discussions concerning discharge and after-care.

39. A discharge letter by, or on behalf of, the consultant should deal with social aspects in addition to the strictly medical. It should always be approved by the consultant.

3. The Care Programme Approach

The designation of 'Care Programme Approach' status is crucial to the level of after-care. Dr CCC decided, on 21st June, that XX should be on level 1 and that no social work referral was required.

RECOMMENDATIONS

40. Screening for the Care Programme Approach should be ongoing throughout the period as in-patient.

41. In the case of all patients, a social worker and wherever possible relatives should be involved in this screening.

42. Schizophrenia, a severe mental illness, should warrant level 2 or level 3 of the Care Programme Approach, thus receiving a multi-disciplinary review of need or a co-ordinated care package.

4. In Patient Care

The central role of the Consultant and her Senior House Officer is clear. This is supported by the input at Multi-Disciplinary Meetings (MDM's), held regularly. The role of the "named

nurse", in the case we examined, appears to have been underplayed. During the short stay of XX his "named nurse" was on leave for several days, but also, within the regular structure, the nurse was not expected to attend the Clinical Ward Round or the MDM when patients were being reviewed. The designation as "named nurse" did not take place within 72 hours as laid down and so XX's nurse was not involved in the initial planning of care.

The "named nurse's" absence from MDMs is most surprising and wrong. As is the failure to nominate a 'stand-in' to cover absences.

The initial phase of care was non-specific and lacked clear identification of individual need. Although some occupation was offered, it does not appear to have been regarded as part of the assessment and a refusal was quickly accepted.

The nursing documentation prior to week-end leave and thereafter was found to be inadequate. There was no identification of the goals set, nor assessment of the leave on return, as laid down in the model of nursing used on Ward 34.

In the absence of adequate notes of various discussions on the Ward, we have had to assume that communication to the community team was largely oral and most probably inadequate because it did not include concerns about the family background and the existence of weapons.

The only communication with the family, whilst XX was an in-patient, was initiated by Mr X, XX's father. It does not appear that the serious concerns he was expressing were given sufficient weight. In addition, Mr X was not made aware of the difficulties which were likely to arise following discharge, nor given information about the possible consequences of a schizophrenic illness.

RECOMMENDATIONS

43. Effective training of the named nurse and the delineation of the duties and responsibilities within the ward philosophy of care are essential.

44. The nursing handover should explicitly involve the passing on of relevant patient information, which should be documented.

45. There should be early identification of the particular needs of the patient as an individual, as well as in terms of his illness.

46. The information passed to those undertaking community care on discharge should be full, as set out in the development model of nursing used in Ward 34.

47. Firm efforts should be made to devise and supervise an inpatient programme to occupy and assist in the rehabilitation of a patient.

48. Ward staff should ensure that they are aware of a patient's location at all times during their inpatient stay.

49. Prior to discharge it is essential to have a co-ordination meeting to assess needs and nominate, as appropriate, a care co-ordinator.

50. The assessment of the home circumstances of patients, particularly those with behavioural problems such as with schizophrenia, should be regarded as essential.

5. Treatment and Care in the Community

It is important to put in place a clinical supervision network, so that individuals have appropriate support and are not left at risk. It was indicated to us that,` where Depot medication is refused, discharge from supervision may take place. The level of competence and experience of a CSN should be considered before a case is assigned, and discharge should be broadly assessed by the carers concerned.

The consideration of XX by the Community Mental Health Team failed to recognise any special difficulties. It appears to deal with a considerable number of cases in a relatively short time - 40 to 60 in about 2 hours - and cannot be sure to identify and deal adequately with cases of difficulty. Allocation of patients to individual nurses should not be purely administrative but should be based on the patient's needs and the experience and expertise of the nurse allocated.

RECOMMENDATIONS

51. A formal network of clinical supervision should be established and consideration should be given to the recommendations of the Butterworth Report on clinical supervision in nursing.

52. The Community Mental Health Service should receive full professional information from those with medical responsibility for the patient.

53. Allocation of individual patients should take full note of the difficulty of the case and the level of experience of the nurse.

54. Initial home assessment of those diagnosed as suffering from schizophrenia should be made by a Community Psychiatric Nurse.

55. A Community Nurse should be designated, for a period of a year or so, in each of the relevant areas, as a formal link with Ward 34.

56. After a year has elapsed from the implementation of these recommendations, a review should be undertaken to assess their impact and to give an opportunity to consider any necessary reinforcements of their objectives.

CHAPTER THREE

CONCLUDING REMARKS

The primary purpose of independent inquiries such as this is to determine if there are any lessons to be learned and to identify remedial actions that should be taken. Immediately after the tragedy we have examined, the relevant authorities, very properly, began to review what had occurred and to initiate a programme of changes, to remedy any perceived weaknesses. It was our task to look at the matter widely and to make independent suggestions for improvement where this appeared to be necessary.

It appears to us, after our enquiries, that there are three levels at which weaknesses in the detection and treatment of mental illness can occur. The first, and most important, of these concerns the organisation of the different levels of care and the instruction and training of the professionals concerned in its provision. The second and more difficult area concerns the relationships and responsibilities which are meant to ensure that the necessary care and attention is identified, and put in place. This involves the acceptance that certain responsibilities have to be accepted by the professionals concerned, the levels of care determined and above all the various individuals and agencies involved effectively co-ordinated. Finally, and more difficult to assess, in the light of many current attitudes and assumptions generally accepted in society, those having the task of looking after those with mental illness must be prepared to ensure that the correct level of control, advice and guidance are available to patients who are temporarily suffering from severe mental illness and consequently unable themselves to make decisions that ensure their own safety and well-being and the safety of others. Recent emphasis, both of political principle and legal regulation, has tended to stress the rights of the individual to an extent that might be thought to inhibit action which is restrictive but is proposed solely and responsibly with the protection of the patient in mind. It is the task of those reviewing situations, such as those that we have been concerned with, to emphasise that the duty of society to protect those with mental illness, both from harming themselves and doing harm to others, is paramount. Such action has to be taken within a clear code of conduct - which appears at the present time to be somewhat lacking - but those charged with care should not be unnecessarily inhibited from doing what their professional training, carefully applied, deems essential.

There is no doubt that the most difficult aspect of the problems posed is the reconciliation of fair and humane treatment of the patient and protection of those who may be harmed if the control is inadequate. Too restrictive an approach will undoubtedly curb unnecessarily the freedom of most patients, whilst ensuring greater security overall; too little may lead to an unacceptable number of 'incidents' which are likely to cause public outrage and a call for stricter controls. Inevitably the extent of controls deemed to be reasonable will depend initially on professional judgement. That judgement will be generally based on standards adopted by the professions concerned, which must inevitably involve some flexibility in the hands of individual practitioners. Additionally, the attitude of the public will have a powerful influence, but it will oscillate quite considerably. When an incident occurs, such as the one dealt with by this report, there will be pressure for stricter rules and regulations: where an individual case leads to publicity condemning excessive restriction and control of a patient there will be pressure for a more liberal attitude. As is so often the case there has to be an effort to maintain

a sensible balance. The occasional failures that do occur, and it would be idealistic to believe that they can be completely avoided, give an opportunity to review that balance, which is one of the underlying aims of this report.

If those general principles are accepted, certain actions are important to try to ensure their most effective implementation.

1. Rules and procedures

Increasingly, and properly, greater attention is being paid to putting into place systems which lay down and ensure as far as possible the best practice. The recent emphasis on the Care Programme Approach is an excellent example of that. In the areas we have examined, although a considerable number of amendments to the system have been recommended, the position as we found it was by no means seriously deficient and had been under continual review.

The majority of our recommendations deal with specific weaknesses we have found. We are confident that they will be seriously considered and speedily implemented. We have noted that a number of such suggestions have already been receiving attention by the appropriate agencies.

2. Practice

The system, however, showed some real weaknesses in the implementation of the accepted practices that had been laid down. Reality does not always correspond to the assumption of the planners. An example or two might make this point clearer. The key participants - the GP, the Counsellor, the Consultant, the Named Nurse and the Community Support Nurse, for example - in general carried out their roles efficiently and effectively. Yet it is apparent that effective communications between them were often delayed or even lacking. The system was adequate for the routine, but lacked the flexibility to enable urgent or difficult cases to be identified and dealt with with urgency. Most of the reasons for this are clear and understandable. All cases cannot be 'fast-streamed' - that would defeat the object. Yet, for many reasons, there was a lack of ability to distinguish the urgent cases. One very obvious example is the placing of responsibility on individuals whose status, training and length of service makes them hesitant to press for action and unlikely to be successful promptly if they do so. For example, the role of a sole "named nurse" (or even a team if that is adopted) can only be effective if the system recognises as a whole their responsibilities and ensures that the structure enables action recommended to be taken quickly. Absence from the decision-making reviews - Multi-Disciplinary Meetings and Ward Rounds - detracts from their perceived status and must inhibit them from properly fulfilling their role, especially in the occasionally special case, such as the one we are considering. The fact that Dr CCC was job-sharing work with another consultant has to be mentioned. It appears to have had no deleterious effect in the situation we have considered but it is a complication in the chain of authority and necessitates care to ensure that it is effectively managed. The passing of information between the hospital and the G.P. is another area where potential weaknesses are apparent. In these days of telephones, faxes and E-mail, important summary details can be speedily transmitted even if the longer, more thoughtful assessments take a longer time. It is not certain that letters from G.P. to consultant on admission and in the opposite direction on release are regarded as deserving

prompt attention and despatch - there is an underlying feeling of compartmentalisation that needs to be broken down. Similar considerations arise from the experience of the CSN who visited XX and reported his worries. The system seemed to be weak and vacillating in dealing with a clear potential danger, as was the refusal by XX to accept his medication by injection.

It should be impressed on every person with professional responsibility that he or she should think deeply about each case and, as well as complying with the procedures - the boxes to be ticked on documentation - should be expected to raise any special features or problems that are felt to need attention. Once these are raised, there has to be a readiness to act speedily and in an other than routine fashion. If, as is inevitable, there is a 'false alarm', no harm is done and the system is seen to be alert.

3. Patients' rights

Finally, as we have indicated, especially in Chapter 2, there are general pressures which have a profound effect on the way in which patients are treated. These have sprung largely from a necessary and proper emphasis on the rights of individuals. Gradually, however, they have become so powerful as to induce in professionals a fear of the law to an extent that may inhibit action. This can have dangerous consequences in a small number of cases and a proper balance has to be maintained.

Many examples of this are clear from our discussions above. XX was an adult young man, living at home, but undoubtedly independent. There must have been some ambivalence as to how far the professional workers caring for him were able to involve his family, especially without his permission. Yet it is an undoubted fact (which has little to do with theories or rights) that a person with a serious psychiatric illness is under a disability which is likely to affect his judgement. In those circumstances, where safety and well-being are at stake, the health and safety of the patient must surely permit appropriate liaison with those who need to know or who can offer additional support. It would have been a great deal more satisfactory if XX had been regarded from the outset as a person who needed support from his family and its availability should have been assessed as soon as possible so that additional assistance could have been given if necessary. Similarly it must have been clear that he would have to face a considerable number of difficulties when he left hospital. Social support would not have been an infringement either of his rights or of his freedom.

* * *

The facts we have been considering are especially tragic in that all the necessary elements for its avoidance were in place. XX's illness had been quickly and correctly diagnosed, his G.P. had shown an understanding of his needs in the reference to counselling before his first rank symptoms appeared, the community psychiatric team were alerted to his release and reasonably quickly realised that he was in need of further care.

For reasons that we have indicated, no-one fully realised the extent of his illness and the urgency of the need for fuller investigation and greater control. XX himself appears to have presented as a pleasant and reasonably co-operative young man. The signs of the strength of his delusions and his resistance to medication were only tardily realised.

That said, the system markedly lacked the ability to react quickly, upon the initial recognition of the warning signs and subsequently in the reaction to them once they were clear. With hindsight, there are many concerned who would have acted differently and will deeply regret their failure to do so. No serious blame, however, can be attached to any one person but no doubt all who were concerned in the events we have reviewed will be able to see how the tragedy might have been averted and learn from the experience.

APPENDIX I

MEMBERSHIP OF THE PANEL OF INQUIRY

The following were appointed by Southern Derbyshire Health Authority, Derbyshire Family Health Services Authority and Derbyshire County Council:

Professor Sir John Wood Chairman

Mr Malcolm Ashman former Director of Social Services

Dr Cyril Davies Consultant Psychiatrist

Dr Huw Lloyd General Practitioner

Mrs Kate Lockett Director of Nursing and Quality

Mrs Jean Thornton was appointed to act as Secretary to the Inquiry.

APPENDIX II

TERMS OF REFERENCE & REMIT FOR INQUIRY

1. To examine the circumstances surrounding the treatment and care of Mr. XXX:
    1. the quality and scope of his health, social care and risk assessments;
    2. the appropriateness of this treatment, care and supervision in respect of:
        1. his assessed health and social care needs;
        2. his assessed risk of potential harm to himself or others;
        3. any previous psychiatric history, including any drug and/or alcohol abuse;
        4. the number and nature of any previous court convictions;
    3. the extent to which Mr. XXX's care corresponded to statutory obligations; relevant guidance from the Department of Health (including the Care

Programme Approach HC(90)23/LASSL(90)11, Supervision Registers HSG(94)5, and the discharge guidance HSG(94)27); and local operational policies including contractual arrangements;

4. the extent to which his prescribed care plans were
    1. effectively drawn up,
    2. delivered, and
    3. complied with by Mr. XXX;

2. The appropriateness of the professional and in-service training of those involved in the care of Mr. XXX, or in the provision of services to him.
3. To examine the adequacy of the collaboration and communication between:
    1. the agencies involved in the care of Mr. XXX or in the provision of services to him, and
    2. the statutory agencies and Mr. XXX's family.
4. To prepare a report and make recommendations to Southern Derbyshire Health Authority, Derbyshire County Council, and Derbyshire Family Health Services Authority.

* * *

At the trial of Mr. XXX, the presiding judge said;

This is clearly a case where the circumstances of this release into the community will have to be looked at with great care. I hope someone will make it their business to look at the facts and learn from them.

WE HAVE REGARDED THESE WORDS AS FORMING PART OF OUR TERMS OF REFERENCE.

APPENDIX III

CHRONOLOGY OF EVENTS

27 July 1971	xxx xxx (XX) was born. His natural father had, before then, left his mother. He has no knowledge of him.
May 1974	His mother married Mr Peter XXX. XX was thereafter adopted.
5 March 1976	XX's half-sister [..] was born.
1983	XX's half-brother [..] was born. He was generally regarded as fond of [..].
1975-1987	XX attended local schools from the age of four until he was sixteen. Nothing of concern to our inquiry occurred and he left at the appropriate time. He appears to have left school with 'average grades' in a number of CSEs. He had a reasonable relationship with others, but few friends. Towards his leaving he truanted increasingly but he was neither suspended nor expelled. He apparently shared interests in music and football with his friends.

1987-1995	YTS placement in a warehouse. XX thought the pay was low and left after six months. He felt he lacked the ability to become a van driver.
	There followed a succession of factory and largely labouring jobs, all of short duration, the longest being 15 months.
	There was during this time no significant involvement with girls.
	Membership of TA for a year or so. Some indication of enthusiasm but did not shine.
	Increasingly spending time in solitary pursuits - cycling, running and walking in the surrounding countryside.
	He was registered with a local GP practice at xxxx, xxxx.
	It is a group practice with 4 doctors. There is no rigid allocation but XX and his family have largely been seen, since her joining the practice, by Dr Yyyy.
31 May 1994	First consultation with Dr Yyyy. She saw that he had some emotional problems, associated with anxiety about physical health and referred him for counselling.
19 July 1994	First meeting with counsellor - AAA.
	There followed weekly meetings with very occasional breaks for holidays or 'cancellations' and for his period in hospital, after which meetings were resumed.
September 1994	He was seen again by Dr Yyyy, in September 1994, when antidepressants were prescribed, and in October 1994 for general medical matters. There were no overt signs detected of a major mental illness at this stage.
October 1994	Attacked at xxx xxxx Station by a group of young males. Afterwards he took a Bowie knife with him when jogging, for protection. He also changed pattern from evening to morning runs.
25 May 1995	Came to see Dr Yyyy who, because of symptoms she then elicited, referred him urgently to a consultant psychiatrist - Dr CCC.
26 May 1995	Dr Yyyy sent a referral note to Dr CCC.
14 June 1995	Seen by Dr CCC at [..] Clinic. He came alone, although Dr Yyyy had urged him to take someone with him. Instead he told his parents he was 'going to the dentist'. Dr CCC diagnosed schizophrenia and decided he needed assessment and treatment in hospital under Section if he did not agree.
	XX asked that his parents be informed. Dr CCC asked the GP to do this. Admission to Ward 34 arranged.
15 June 1995	XX, who had agreed to enter hospital as an informal patient, arrived alone at Ward 34. He was admitted by Staff Nurse EEE, who assumed the role of 'named nurse'.
	Preliminary examination by Dr DDD, Senior House Officer (SHO) to Dr CCC, who was expecting him. She had no doubt that there were symptoms of schizophrenia. XX, though not keen, accepted medication.

	XX discussed at a multi-disciplinary meeting (MDM). Appropriate medication determined and provisional assessment made of liability to detention under the Mental Health Act should he seek to leave.
20 June 1995	XX told staff he had received notice of dismissal from his work. Staff intervened and got his notice rescinded.
	XX was prescribed Temazepam as required.
21 June 1995	Seen by Dr CCC on ward round.
	Weekend leave approved. Possibility of discharge rejected. Dr CCC sent a reasonably full report of her initial outpatient assessment at Long Eaton Clinic to Dr Yyyy confirming 'a severe mental illness' requiring treatment in hospital and saying that XX had come informally but would be assessed for compulsory detention should he change his mind.
	Consultant assessment entered in his medical notes.
22 June 1995	XX's father came to pick up XX for weekend leave. His medication had been prepared and he was told to return on Sunday the 25th at lunchtime.
	A review of XX's progress was made at a multi-disciplinary meeting (MDM) by Dr ZZZ, in Dr CCC's absence. Agreed to continue his care plan.
25 June 1995	XX returned as requested. He had little to say to staff about his visit home but did indicate to a nurse that he had not got on well with his mother. He wished to discuss this with Dr CCC on her ward round on the 28th.
26 June 1995	XX was reported to have had sleeping difficulties. He had been prescribed Temazapam as required from 20 June.
27 June 1995	XX was 'allowed out' for the afternoon. It appears that a decision had been made for XX to be discharged 'in a few days time' with the setting up of the usual safeguards of after-care. (This decision was recorded in the nursing notes of 29 June.)
28 June 1995	Discharge considered for 29 June. Dr CCC spoke to XX's father at his request. He expressed considerable concern and spoke of hidden weapons and the discarding of tablets in a waste bin. XX was felt to be 'splitting up the family'. Dr CCC reported that she had told Mr XXX how important it was for the family to keep in touch with the hospital and the GP. This was apparently the first and only conversation with XX's relatives. Mr XXX indicated to the Panel that there had been a number of visits by relatives to see XX, which do not appear to have been noted.
	Dr CCC saw XX and his father together when the discussion was continued more guardedly. XX admitted to not taking the pills but there was no discussion of the hidden weapons.
	The named nurse was not involved nor informed of this discussion. Dr CCC recorded progress in his medical notes. The Community Team were reluctant to see quick discharge.
	Depot medication started with test dose. XX had a disturbed night and was reported as 'wandering around'. Discharge intended on 29 June if no

	adverse reaction to medication.
29 June 1995	Nursing notes indicate that Dr CCC had decided to change the intended 'discharge' to 'leave for a week' with the understanding that if all went well then on his return on 6 July XX was to be given a Depot injection and discharged.
	XX was collected by his father and went home on leave. Father unaware of change to leave at that time.
	MDM confirmed the week's leave and discharge if no problems had arisen.
4 July 1995	Community Mental Health Team informed of XX's impending discharge by the ward staff on standard referral form.
6 July 1995	XX returned, was seen by Dr DDD, had a further Depot injection and was discharged. He reported that there had been some difficulties but he had been offered his job back. Advised to see GP.
7 July 1995	The allocation was made by the Community Psychiatric Nurse (CPN). XX was allocated to FFF FFF, Community Support Nurse (CSN), who worked with Dr Yyyy's patients. FFF FFF took responsibility for liaison with XX.
10 July 1995	FFF FFF (CSN) telephoned XX at home to arrange the visit for an assessment and a Depot injection.
13 July 1995	Dr Yyyy certified XX fit for work.
17 July 1995	Brief period at work. Could not manage new duties. Left.
19 July 1995	Visit by CSN as arranged. Injection refused but XX promised to take the tablets. The visit went very well and was calm and relaxed. As well as advice being given to XX there was some general conversation on matters such as football in which both were interested. XX said that Sulpiride had helped his auditory hallucinations but firmly rejected the Depot injection. He reported that he had left his job. XX agreed to see Dr CCC and FFF FFF said he would visit again on 3 August.
20 July 1995	Notice of refusal of Depot medication sent by letter from FFF FFF to Dr Yyyy and Dr CCC and in her absence Dr DDD informed by telephone.
	Mother informed CSN by telephone that XX was less irritable and sleeping better. He had given up his job, which was a concern, and was isolating himself from the family, keeping to his own room.
	Mother asked CSN for an appointment to see Dr CCC. FFF FFF included this request in the above letter.
22 July 1995	Mrs XXX wrote to Dr Yyyy requesting an appointment to discuss XX. Made for 10 August.
3 August 1995	As arranged, FFF FFF visited again and Depot medication was again refused. XX indicated that the voices were less troubling, that he was sleeping better but was sleepy during the afternoons. He said the isolation was because he did not get on with his family. FFF FFF also spoke to Mrs

	XXX.
	FFF again contacted Dr CCC about an appointment for Mrs XXX. Dr CCC noted and asked her secretary to arrange it. Letter confirming appointment for 23 August, received on 8 August, the day of the tragedy.
8 August 1995	On this day XX violently attacked and killed his mother and younger half-brother. He then went to his GP's surgery and the police were alerted and took him into custody.
6 March 1996	XX appeared before the Nottingham Crown Court. He pleaded not guilty to murder but guilty to two counts of manslaughter on the grounds of diminished responsibility. After hearing medical evidence, Judge David Latham sentenced him to be detained under the Mental Health Act, without limit of time.

APPENDIX IV

SCHEDULE OF MEETINGS, WITNESSES AND VISITS

It was decided on legal advice that the hearing of witnesses concerned in the trial of Mr. XXX should be deferred until after his case had been dealt with by the Court. So as not to delay our work unduly, a decision was made to have preliminary discussions with those not directly connected, who would be able to provide background information on the structures of care involved, which we would later be considering in the context of treatment of Mr. XXX.

The meetings were held at Boden House in Derby.

The meetings featured interviews, marked *[i]* in the following list, and briefings, marked *[b]*.

1st February 1996

Introductory meeting chaired by Brian Blissett, Chief Executive and with Russell King, Corporate Services Manager, Southern Derbyshire Health Authority to indicate the steps already taken by the relevant authorities immediately following the tragedy and to consider administrative details in respect of the future work of the Inquiry.

19th February 1996
Meeting to consider the structure of the work of the Inquiry.

5th March 1996
Background briefing from:

- Mr Jim Hockenhull *[b]*-Policy & Development Officer (Community & Mental Health), Derbyshire Social Services
- Dr John Grenville *[b]*- General Practitioner, Derby representing the Local Medical Committee.

14th March 1996
Briefing on Southern Derbyshire Mental Health Trust systems and structures;

- Mr Richard Seed *[b]*- Chief Executive, Southern Derbyshire Mental Health NHS Trust
- Dr Andrew Clayton*[b]*- Medical Director, Southern Derbyshire Mental Health NHS Trust
- Mrs Trisha Treadwell*[b]*-Care Programme Approach Manager, Southern Derbyshire Mental Health NHS Trust

15th March 1996
Interviews and briefings;

- Mr EEE*[i]*- Staff Nurse, Ward Q, Derby City General Hospital
- Dr DDD *[i]*- formerly Senior House Officer, Psychiatric Unit, Derby City General Hospital
- Mrs Patricia Fitzgerald*[b]*-GP Counselling & Mental Health Advisor, Derbyshire Family Health Services Authority
- Dr CCC *[i]*- Consultant Psychiatrist, Psychiatric Unit, Derby City General Hospital

18th March 1996

- Dr Yyy *[i]*- General Practitioner [...]
- Mr AAA *[b]*- GP Counsellor, *seen by Professor Wood, Dr Lloyd & Mr Ashman*
- Visit to XX at Rampton Hospital by Dr Davies and Mrs Lockett,

25th March 1996

Briefings and interview;

- Mr John Simmons*[b]*- Head of Operations (North Sector) Lead Officer, Adult Services, Derbyshire Social Services
- Mr Timothy Lugg*[b]*- Social Worker attached to xxxx Community Mental Health Team
- Ms Gayle Meads*[b]*- Service Manager, Mental Health Services, xxxx Community Mental Health Team
- Mr FFF*[i]*- Community Support Nurse, xxxx Community Mental Health Team

26th March 1996
Discussion meeting

19th April 1996
Discussion meeting

10th May 1996
Interview;

- Mr XX - father, accompanied by Mrs Jayne Zito and Mr. Michael Howlett of the Zito Trust

23rd May 1996
24th May 1996
10th June 1996
17th June 1996
27th June 1996
15th July 1996
Preparation of a Draft of the Inquiry Report.

9th August 1996:
Interviews:

- Mr XX, father
- Mr AAA - GP Counsellor on professional placement [..]

and, consideration of Final Draft of the Inquiry Report.

APPENDIX V

SCHEDULE OF DOCUMENTS RECEIVED

Investigation report from xxx Locality Manager, Adult Services, Southern Derbyshire Mental Health NHS Trust (SDMH), 9 August 1995.

Internal Management Review Into the Circumstances of the AS Case, December 1995.

SDMH Trust's Care Programme Approach Policy (jointly agreed with Derbyshire Social Services): "People and the Care Programme Approach" Document, including Supervision Register Policy and Discharge Policies. 1994.

Joint Policy for Care Programme Approach between Southern Derbyshire Health Authority (MH Unit) and Derbyshire County Council 1994.

SDMH Trust Organisation and Business Planning Structure.

Local Organisational Chart: Erewash Locality within Adult Services.

Erewash Community Mental Health Team Operational Policy, revised August 1994.

Joint Health Service and Social Services Circular HC(90)23/LASSL(90)11: Health & Social Services Development "Caring for People".

The Care Programme Approach for People with a Mental Illness referred to the Specialist Psychiatric Services.

Health Services Circular HSG(94)5: Introduction of Supervisory Registers for Mentally Ill People from 1 April 1994.

Health Services Circular HSG(94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community.

Southern Derbyshire Health Authority/SDMH Trust: Contract for Services in 1994/95.

Guidelines for the Employment of Counsellors in General Practice (Derbyshire Counselling Scheme), July 1995.

Locally agreed Community Care Plan 1996 - 1999.

Locally agreed Joint Policy & Procedures for Community Care, December 1994.

Locally agreed Community Care Charter, November 1995.

Ward 34, Derby City General Hospital;

- Philosophy of care, November 1993
- Bed occupancy details, 15 June to 7 July 1995
- Details of staff professional training

Approved Social Workers Practice Procedures Manual, August 1993.

Article from British Medical Journal, Vol. 312, 2 March 1996 - "Case Management: A Dubious Practice"

Derbyshire County Council Social Services Management Structure - (Erewash Area), February 1995

Derbyshire County Council Social Services Management Structure, July 1995.

Community Care - Resources & Investments Supplement 1995-96, Derbyshire Social Services - July 95

Guidelines for Primary Health Care for making appropriate Referrals to Counselling & Mental Health Services

Derbyshire Community Care Plan 1995/96 - A Summary

SDMH Trust - letters dated 22/3/96 and 7/6/96 from Chief Executive to Chairman of the Panel reporting action following Internal Review

British Association of Counselling; Codes of Ethics and Practice for Counsellors, Supervisors of Counsellors and Trainers in Counselling and Counselling Skills; Complaints procedures.

Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People - Royal College of Psychiatrists 1996.

Building Bridges; Arrangements for inter-agency working for the care and protection of severely mentally ill people; HSG(95)56, Department of Health

Health of the Nation - Key Area Handbook, Mental Illness, Department of Health 1994.

Written Statement to Panel from Mr. P XXX, father, 3rd May 1996.

Report: The Victim of the Mentally Disordered Offender - The Zito Trust, March 1996

Report of the Independent Inquiry into the case of Jason Mitchell, Suffolk Health Authority, 1996.

Draft NHS Patient's Charter, Mental Health Services, Department of Health 1996.

SOURCE : ***ANONYMISED VERSION OF THE INQUIRY REPORT***
http://www.psyctc.org/cpct/as_rep/intro.htm

Adapted from the report of the inquiry supplied by Pat Fitzgerald, of Southern Derbyshire Health. Derwent Court, Stuart Street, Derby DE1 2FZ Tel.: [+44|0] 1332 626300 Fax.: [+44|0] 1332 626350

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