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The Report of the Independent Investigation into the Care and Treatment of JW

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CHAPTER 1 EXECUTIVE SUMMARY

JW, a patient under the care of the Cambridge and Peterborough Mental Health NHS Trust, killed his grandmother, DG, on 26 December 2004. He had presented to the mental health services on 20 January 2004 and been treated in hospital from then until 23 March 2004, both as a detained and as an informal patient. He was diagnosed with bipolar affective disorder with psychotic features.

After discharge JW was followed up by the community mental health services until 24 October 2004, at which point he was readmitted to hospital after been taken to March Police Station following an attack on a neighbour. He was detained under Section 3 of the Mental Health Act 1983. Both this admission to hospital and the first one were characterised by JW escaping from the ward, being aggressive to nursing staff and being non-compliant with treatment at times.

Just before discharge from hospital in November 2004, JW was started on depot antipsychotic medication. After discharge he was seen in the outpatient department by the consultant psychiatrist and by his community psychiatric nurse at home.

At the time of his last appointment on 15 December 2004, there was no evidence of psychotic beliefs or of aggressive behaviour.

The Independent Panel found that the fatal attack on his grandmother could not have been predicted or prevented.

There were, however, issues which required further action by the NHS Trust; some of these had been identified by the Internal Inquiry which the Health Authority and the Trust had set up, and the Panel found that these had already been addressed by the Trust.

CHAPTER 2 MEMBERSHIP OF THE PANEL

Dr Brian Hanson CBE, DCL, LL.M (Chairman of the Panel)

Lawyer and Ecclesiastical Notary; reviewer for the Commission for Health Improvement 2001-4; member of the Healthcare Commission Appeals Panel since 2005. Working in London and the south of England.

Mr Trevor Barre

Registered Mental Nurse, MSc: Institutional and Community Care. Lead Nurse for the Brent Mental Health Service, Central & North West London Mental Health Foundation Trust. Has worked in a variety of mental health settings over the past 25 years, in managerial, educational and clinical roles. A reviewer for the Healthcare Commission since 2003; also a Clinical Advisor for the Healthcare Commission Complaints Team. Workplaces have been in north and northwest London.

Dr Dominic Beer

FRCPsych; MD; MA (Oxon); MBBS. Consultant Psychiatrist in Challenging Behaviour and Intensive Care Psychiatry Oxleas NHS Foundation Trust. Approved by the Secretary of State under Section 12 of the Mental Health Act 1983. Honorary Senior Lecturer Institute of Psychiatry, London. He has worked for the Ombudsman as a Clinical Advisor.

Ms Deborah Bull

MSc, CQSW, DMS, Registered Social Worker, Approved under Section 114 of the Mental Health Act 1983. Head of Social Work, Forensic Directorate, East London Foundation NHS Trust.

CHAPTER 3 INTRODUCTION

This independent inquiry was established by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (now the East of England SHA) to investigate the circumstances and actions taken in relation to the homicide of DG by her grandson, JW, on Boxing Day 2004 (for full terms of reference, see Chapter 4). At JW's subsequent trial at Norwich Crown Court, his plea of manslaughter by reason of diminished responsibility was accepted, and a hospital order was made under Section 37 of the Mental Health Act 1983, coupled with a restriction order without limit of time (Section 41).

The independent inquiry follows an internal inquiry into the incident, set up by the Cambridgeshire and Peterborough Mental Health Partnership Trust (CPFT), the West Norfolk Primary Care Trust and the East Cambridgeshire and Fenland Primary Care Trust. That inquiry was chaired by a non-executive director of the CPFT, and the Panel members were drawn from the key agencies responsible for mental health services in the area together with two external psychiatrists. It reported in September 2005, and made a number of recommendations. As a result, CPFT drew up an action plan to respond to the Report, with target dates for implementing the changes required (see Appendix 3 of this Report).

The members of the Panel wish to express their sympathy with the family and friends of DG that this tragic event occurred, especially following the happy family occasion hosted by DG the previous day. Members were grateful to those members of the family who gave evidence to the Panel and that they did so with sensitivity and complete candour which made the Panel's task the easier.

The members of the Panel also wish to thank all those who gave evidence and the staff of the Strategic Health Authority for the way in which they facilitated the work of the Panel over many months. Special thanks are due to Sandra Betterton and her team.

CHAPTER 4 TERMS OF REFERENCE

Purpose of the Inquiry

To provide an independent report into the circumstances and action taken in relation to the homicide of Mrs DG by Mr JW in December 2004. Specifically to report on the care and treatment of JW and the carer support of DG.

This review has been commissioned by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority and will have access to the report of the inquiry Panel and documents supplied to the internal inquiry.

The review will consider, at the Chairman's discretion, recommendations from similar independent mental health inquiry reports so that any significant common factors can be identified.

The review will make recommendations for the organisations involved to consider and implement as appropriate.

The Panel will conduct its work in private and be expected to take as its starting point the internal inquiry, supplemented as necessary by access to source documents and interviews, as determined by the Panel.

The Panel will give an opportunity to the family and other carers of the victim and JW to contribute to the inquiry as the Panel feels necessary.

The Panel will examine all the circumstances surrounding the care and treatment of JW by the mental health services up to the homicide of DG in December 2004. In particular:

- a. The risk assessment policies and processes, and the application of these in the case of JW.
- b. The quality and scope of his health and social care.
- c. The support given to informal carers, in particular DG.
- d. The appropriateness of his diagnosis, treatment, care and supervision in respect of the:
 - i. process of arriving at a final psychiatric diagnosis;
 - ii. assessed health and social care needs;
 - iii. assessed risk of potential harm to himself and others;
 - iv. medication regime prescribed, compliance and the interaction of substance misuse.
- e. The extent to which JW's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, and Discharge Guidance HSG(94)27 and local operational policies,

- f. The extent to which his prescribed care plans were:
 - v. effectively drawn up;
 - vi. delivered; and
 - vii. complied with by JW.

The Panel will examine whatever documentation it considers necessary and request evidence from whomever it considers appropriate in order to properly carry out its investigations

The Panel will give appropriate time and attention to the needs of the victim's family and carers, including agreeing appropriate communication arrangements with the family members involved.

The Panel will complete a timeline of the events and report on this in the report.

Membership

The Review Panel will be chaired by an independent lay person with legal experience. The other members will include:

- a. A consultant psychiatrist experienced in working with younger adults.
- b. An experienced mental health professional with experience in working with mentally ill people in the community.
- c. An approved social worker.

Reporting Arrangements

Timetable

The Panel is asked to complete the review and report within six months of starting work.

Publication

The report and action plan of the Inquiry's findings and recommendations will be published as required by NHS Circular HSG(94)27. The Strategic Health Authority will ensure that copies are given to:

- a. The relatives of DG.
- b. The Department of Health and other relevant national bodies

The Review Panel will produce a report that will be presented to the Boards of the following organisations:

- a. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority
- b. Cambridgeshire and Peterborough Mental Health Trust
- c. East Cambridgeshire and Fenland PCT
- d. West Norfolk PCT

The Review Panel report will include the findings and recommendations of the Panel, and an executive summary of the report.

The Strategic Health Authority will publish the Inquiry report and at the same time make the action plan public.

CHAPTER 5 PROCESS

Following the Internal Inquiry, the family of DG requested an independent inquiry and this was duly established in May 2006. The family was consulted about the terms of reference for the independent inquiry and these are set out in Chapter 4.

The Panel found it necessary to conduct a large number of interviews in King's Lynn over three periods in June and November 2006 (six days). It was unfortunate that a number of people to be interviewed were busy professionals who were unable to make the Panel's June dates, hence the delay to November. In addition, the Panel held fourteen day meetings in London.

Interviews were conducted in private by the Panel. Evidence was not taken under oath. Transcripts of the evidence were prepared and the text was agreed with the interviewees. The roles of the interviewees, or their relationship to JW, are recorded in Appendix 1.

The Panel had access to, and examined, all case records and other relevant documentation in the possession of the key agencies responsible for mental health services in the area (see Appendix 2). The Panel was also given transcripts of the case from the Crown Court and all witness statements.

The final draft of the Report was sent to the relevant Trusts for factual accuracy. Comments were received from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and relevant amendments to the Report were made. The Norfolk and Waveney Mental Health Foundation Trust (NWMHFT) replied that they had no records transferred to them from West Norfolk Primary Care Trust (WNPCT)* relating to the Inquiry and therefore could not comment on factual accuracy. The Report has been written in the light of the documentation examined and the evidence received and the Panel is not aware of any inaccuracies. However, because of the lack of anyone in the NWMHFT to confirm accuracy, the Panel needs to record that fact in case inaccuracies in the Report come to light after publication.

The final report including the Panel's recommendations was completed in October 2008 and was then passed to the Strategic Health Authority for presentation to the Boards of the commissioning organisations.

The Panel considered other recent reports of independent mental health inquiries and, where these were found to be relevant to this Report, reference is made to them in the appropriate chapter.

* 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust

CHAPTER 6 LOCAL MENTAL HEALTH SERVICES

The Various Trusts

The Cambridgeshire and Peterborough Mental Health Partnership Trust (CPMHPT) was formed in April 2002, and responsibility for mental health services for the Wisbech area was transferred to the Trust from the King's Lynn Hospitals Trust (KLHT). KLHT continued to provide the inpatient care for the Wisbech area, based at the Fermoy Unit of the Queen Elizabeth Hospital. However, the community mental health care was provided by the new trust, CPMHPT, from Wisbech itself. On 1 June 2008 CPMHPT was renamed as the Cambridgeshire and Peterborough NHS Foundation Trust (hereafter in the Report CPFT).

Subsequently, in 2004, the inpatient care formerly provided by KLHT was transferred to the West Norfolk Primary Care Trust (WNPCT), with care still being provided at the Fermoy Unit. This continued until 1 October 2006 when changes resulting from "Commissioning a Patient Led NHS" resulted in the dissolving of the PCT. At this point the inpatient beds in King's Lynn were transferred to Norfolk and Waveney Mental Health Foundation NHS Trust.

Thus, at the time of the incident which is the subject of this Inquiry, CPFT was providing the community mental health care for the Wisbech area and WNPCT was providing the inpatient care at the Fermoy Unit.

Community Mental Health Team (CMHT)

In 2004, the Wisbech CMHT consisted of ten full-time Care Coordinators (Psychiatric Nurses and Social Workers), two mental health support workers, three administrative staff, and sessional input from a consultant and staff-grade Psychiatrists, and a psychologist. The team manager was accountable to the service manager, who reported to the area manager. The team manager was responsible for the whole team, including social workers, although professional, rather than managerial support, was offered by the lead professionals in Social Work and Psychology. At that time, a Care Coordinator would have an average case load in excess of thirty people, and a Support Worker would have a caseload of about twenty.

Crisis Resolution Services

At the time of the homicide in 2004, crisis services in the area were embryonic. The WNPCT provided a telephone service which was based on a crisis intervention model, rather than a home treatment model. A crisis resolution home treatment team and an early intervention service covering the Wisbech area have now been established by CPFT.

In evidence it was stated that CPFT did have access to low secure/higher dependency care at the time of JW's admissions through George MacKenzie House,

Fulbourn Hospital, Cambridge. In addition Psychiatric Intensive Care units in the private sector have always been accessed where required by the Trust.

Medical Care Arrangements

Prior to 2002, effort was put into integrating Wisbech with the King's Lynn arrangements, in order that there could be good support from the academic department at Cambridge; in this way consultant appointments in King's Lynn were up to full establishment of posts. In 2002, this was thrown into reverse. It became difficult to ensure that substantive consultants filled posts, and, as a result, a series of locums shouldered the burden. The Panel received evidence that, because of the isolation of staff at Wisbech, it was difficult for senior staff to go to meetings and attend sessions for further training. In 2004 the Wisbech medical team consisted of a consultant psychiatrist and a staff grade psychiatrist. The Panel was informed in evidence that during 2004 there was no permanent appointment to the consultant post and this role was covered by a series of locums. The lines of responsibility and accountability were to CPFT and KLHT, each of which used different documentation.

Since November 2006, with beds for the Wisbech area now situated in Peterborough rather than King's Lynn, emergency cover comes from Peterborough consultants. This addressed the problem of the potential isolation of medical staff working in Wisbech. In the opinion of the Medical Director giving evidence to the Panel, it had not been possible satisfactorily to integrate medical input to the Wisbech service or to provide adequate peer support.

Early Intervention in Psychosis Service (EIS)

In Cambridge there has been EIS for some time because of the interest of the academic department in Cambridge. The most recent work has been to endeavour to extend EIS and make it available Trust-wide. Up till now there has been no EIS in the Wisbech area. In evidence, the Panel was told that the acute services were redesigned in 2003. Wisbech locality followed Department of Health guidelines, and tried to introduce Assertive Outreach Services (AOS) and EIS as a priority. In West Norfolk, the PCT successfully negotiated to have crisis resolution accepted as a top priority in 2003/04, and AOS and EIS were delayed by one year. This also resulted in a different model of acute ward care in Wisbech.

CHAPTER 7 JW BIOGRAPHY

JW was born in 1985 at King's Lynn where he lived with his parents and two brothers. He was the second child of the family. Following the divorce of his parents in 1995, he moved in 1996 with his mother, brothers and his mother's male partner to Greater Manchester. JW attended secondary school in Ashton-under-Lyne. On 5 March 2001 he was convicted at Manchester Crown Court of burglary and theft at a dwelling and sentenced to eighteen months detention in youth custody. He served a seven month sentence at Stoke Heath and the Thorn Cross Young Offenders Detention Centre, and was conditionally released in October 2001 under the provisions of Section 76 of the Crime and Disorder Act 1998. On release he completed an NVQ at the local Technical College, and then started a carpentry and joinery apprenticeship.

In April 2002 JW's mother and her partner left England to live permanently in Spain, leaving JW and his elder brother (then aged 22) living together in the family home in Manchester. The younger brother moved back to Wisbech to live with his father.

In October 2002, JW lost his apprenticeship and stayed at home, not seeking work. His elder brother was studying at Manchester University, as well as having a part-time job and, after a number of incidents, decided he could not cope with JW's increasingly hostile and aggressive behaviour. He therefore moved out of the house in December 2003. JW returned to Wisbech later that same month to live with his maternal grandmother, DG.

The following month - January 2004 - JW's mother returned to England because she was so concerned about the reports of his behaviour. Whilst staying in Wisbech, she telephoned the local mental health team, who advised her to take him to the A & E Department at King's Lynn Hospital. This she did on 20 January 2004, and he was admitted to the local inpatient mental health unit, the Fermoy.

CHAPTER 8 CHRONOLOGY OF EVENTS

c19.01.04	Concerns were noted by JW's mother about JW's behaviour and she rang the local mental health team who advised that he be taken to the A&E Department at King's Lynn Hospital.
20.01.04	JW's mother took JW to A&E at King's Lynn Hospital. JW was assessed by the duty SHO who found him to have grandiose delusions and delusions of reference. JW was admitted informally to the local mental health unit, the Fermoy. Later that day the consultant psychiatrist also found him to have delusions.
22.01.04	A drug screen on JW was clear.
24.01.04	JW broke the door open on the ward. He was placed under the provisions of Section 5(2) of the Mental Health Act 1983, but was allowed to leave the ward to reduce risk. A missing person procedure was instituted and he was returned by the police at 17.45hrs.
25.01.04	A Mental Health Act assessment took place and JW was detained under the provisions of Section 2.
26.01.04	JW poured a bottle of soft drink over his mother when she visited him in hospital.
28.01.04	JW became agitated during a visit by his mother and grandmother. He punched a nurse and absconded through the smoking room window. He climbed over the fence but was later returned to the ward.
05.02.04	JW was noted to be psychotic and hostile. He punched a staff member in the head.
16.02.04	After improvement in his mental health and behaviour, JW had his first period of Section 17 leave to go to his grandmother's house. Following this a Section 3 assessment took place but he was considered not to meet the criteria for detention.
18.02.04	A social circumstances report was prepared.
20.02.04	JW's leave had gone well; he agreed to stay at the Fermoy informally and his Section 2 Order was rescinded.
05.03.04 to 08.03.04	JW was given leave from the hospital.

23.03.04	JW was discharged to a hostel in the town of March. The discharge summary stated that the diagnosis was bipolar affective disorder. He was on semisodium valproate and olanzapine medication. Ms D care co-coordinator and support worker Ms E saw JW at the hostel and Ms D recorded that he was mentally stable.
22.04.04	JW was allocated his own flat in Wisbech.
27.04.04	JW was seen by Ms E at his grandmother's house - he was noted to have reported feeling low.
26.05.04	JW was seen by Ms E at his flat – he was well and compliant with medication
08.06.04	Ms E took JW to see a carpentry project with a view to apprenticeship.
17.06.04	JW was seen by Ms E at his flat.
18.06.04	JW was seen by Dr C who noted that he was doing well, no evidence of psychotic symptoms.
14.07.04	JW was seen by Ms E at his grandmother's house.
15.07.04	JW went on a planned holiday to visit his mother in Spain. Mother confirmed that he took no medication whilst on holiday. An argument between JW and his mother's partner led to a physical exchange which did not lead to serious injury to either party. JW went to make his own way home but was stopped by the Spanish police and, as a result, JW missed his flight to the UK.
02.08.04	Case records note that JW missed his appointment.
16.08.04	Reported by his grandmother that JW was becoming unwell and not taking his medication. JW was uncertain whether he would start the carpentry course.
19.08.04	JW seen by Dr B. DG had gone to stay with a friend because she was unable to cope with JW and needed a break. A referral was sent to the Crisis Service and the GP. JW was not looking after himself and he was losing weight. Detention under the Mental Health Act was considered but not followed up.
20.08.04	Home visit by Mr G.
24.08.04	JW was seen by Dr C who noted that he was paranoid and had discontinued his medication. It was considered that he did not meet the criteria for detention.

26.08.04	JW was visited by Ms E who found him slightly paranoid, not taking medication; she arranged further visit on 1 September. Ms E discussed her concerns with Dr C.
26.08.04	Ms E discussed her concerns with Ms H and suggested visiting in pairs as she felt uncomfortable with JW's behaviour. Ms E was withdrawn from the case.
01.09.04	There is no record of Ms E's arranged further visit to JW taking place by Ms E or anyone else.
08.09.04	JW seen in outpatients by Dr C who again noted a decline in functioning; not taking his medication. Noted that he was considered a low risk to himself and others.
21.09.04	JW failed to keep his appointment with Ms D.
22.09.04	Ms D made an unannounced visit to JW's flat - no response.
07.10.04	Recorded telephone conversation with JW's grandmother who confirmed that he was stable; an appointment was arranged for 27 October.
10.10.04	Concern was registered regarding loud music in JW's flat and damage to the flat.
24.10.04	JW had an altercation with his neighbours; JW had damaged their door. He was arrested for criminal damage, was assessed at March Police Station Both doctors noted that there were first rank symptoms of schizophrenia. He was admitted under Section 3 of the Mental Health Act. He refused medication on admission to the Fermoy Unit.
24.10.04	At 04.45hrs JW absconded via the fire door. He was returned to the ward at 13.05hrs.
27.10.04	JW expressed a wish to leave the ward.
28.10.04	JW went absent without leave again; he was on one-to-one observation at the time. He was found in March and was returned to the ward at 21.40hrs. Consideration was given to his going to a secure unit.
29.10.04	JW was being nursed in the extra care unit and was drunk; he required restraint.

01.11.04	JW was seen by Dr C who noted poor impulse control. The family was concerned because he was unable to function out of hospital. There was one-to-one supervision when at the extra care unit. The staff had to stand between him and the ward door.
03.11.04	JW ran at speed at the main security door forcing it open and ran into the main hospital. He was returned to the extra care area, ran off again and was finally returned to the ward by the police.
04.11.04	JW was seen by Dr C who noted that he had escaped twice on 3 November and was unstable; he ordered the starting of Risperdal Consta.
15.11.04	At the ward round it was noted that JW's mental state and behaviour had improved and that he was accepting his medication; there were no management problems. Discharge planning began.
18.11.04	At the ward round it was noted that JW was taking his medication; there had been no disruptive behaviour and no suicidal or violent ideas. It was agreed that he could have home leave with his grandmother to assess stability.
22.11.04	At the Section 117 meeting it was noted that JW's leave had gone well and a discharge plan was agreed.
25.11.04	Ms D made home visit. JW had contacted the Piece of MIND Workshop about work. He refused a blood test. JW's grandmother refused the offer of a carer's assessment.
01.12.04	JW had an out patient appointment with Dr C. Noted to be alert and lucid with no hallucinations or delusions. Risperdal Consta administered.
09.12.04	JW was seen by his care co-coordinator at his flat. She noted that he was well supported by his grandmother.
15.12.04	JW's depot was increased and his oral medication decreased. He was late coming to clinic but was brought by his grandmother. Another appointment was fixed for 29 December.
21.12.04	JW kept an appointment with the employment workshop "Piece of MIND"
26.12.04	JW was arrested on suspicion of killing his grandmother, DG. At 17.55hrs the Forensic Medical Examiner (FME) was called to Wisbech Police Station to carry out a Mental Health Act assessment on JW. The duty ASW telephoned the Fermoy Unit and was told by the Charge Nurse that JW was well known to the

	<p>Unit and suffered from Paranoid Schizophrenia. In the opinion of the FME, JW was suffering from paranoid delusions and he contacted the duty approved social worker, and JW's psychiatrist, Dr C, to arrange a joint assessment. This took place and a decision was made to issue a Section 3 notice which was signed at 22.10hrs. Arrangements were then put in place for JW to be transferred to a secure mental health unit.</p>
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CHAPTER 9 TREATMENT AND CARE AS AN INPATIENT

First Admission 20 January 2004 - 26 March 2004

On 19 January 2004 at 12 midnight, JW was brought to the A and E department by his mother who had rung the Crisis Team because of JW's bizarre thoughts, smoking cannabis and not relating well to his brother and friends. He was seen by the duty SHO and nurse from Churchill ward. The duty SHO discussed the case with Dr A, the locum consultant psychiatrist, who said she would see JW in the outpatient clinic the next day. It was thought that JW was psychotic but did not pose a risk to himself and was currently in a safe environment. JW's mother was told to contact the crisis team if need be.

Panel comment

The duty SHO made a thorough psychiatric and mental state examination. There was prompt and appropriate consultation with a senior doctor. Risk assessment for self harm was regarded as low, but there should have ideally been a risk assessment for harm to others. It was appropriate, given the hour, and the patient's presentation, for the patient to be kept at home and to see a consultant the next morning. The plan was discussed with JW's mother who was in apparent agreement. The Panel has concerns about how these issues were dealt with; these are discussed more in Chapter 13.

20 January 2004

JW attended Dr A's outpatient clinic. Dr A took a history and performed a mental state examination. The notes from the previous night were available. She wrote "*not willing to accept informal admission. Not willing to accept medication...Insight none – does not believe he is ill or any need for medication.*"

A detailed plan was made by Dr A namely:

1. Admission to hospital informally.
2. Detention under the Mental Health Act if JW tried to leave hospital because of risk of aggression to his mother.
3. Start olanzapine 10mg per day regularly.
4. Drug urine screen.
5. Full physical examination including CT scan head "*in view of atypical presentation of psychosis*".

Panel comment

The Panel agrees that admission was appropriate and that JW posed a risk to his mother. The notes should have been more explicit as to the process for deciding whether JW should be admitted informally or

detained under the Mental Health Act. There appeared to be good reasons for assessing JW under the Mental Health Act given his reluctance to come into hospital, poor insight, his reluctance to take treatment and the risk of aggression to his mother. The Panel has some concerns about the decision to admit JW on an informal basis. We discuss this matter further in Chapter 14. The Panel was not clear why Dr A believed this to have been an atypical presentation of psychosis as it appeared to the Panel to be a fairly typical presentation of psychosis.

Normally when a patient is new to the service a period of medication-free assessment is considered because this helps the diagnostic process. If there is a pressing need because of behavioural disturbance then treatment is given, but at this stage JW had not behaved in a way which necessitated immediate medication and it is surprising therefore that he was not observed without medication

The Panel is of the opinion that there should have been a period of medication-free assessment to help to clarify the diagnosis.

21-27 January 2004, Churchill Ward

On 23 January JW was seen by Dr A, who assessed him as being psychotic. Olanzapine was continued and she wrote that the team should continue to assess JW's mental state.

On 24 January at 3.30 am JW broke open the ward door and escaped.

The notes are not clear when and how he returned to the ward. The nursing notes record that he was placed on Section 5(2) on 24 January 2004 at 0300 after the duty SHO had consulted the on-call consultant psychiatrist. The nursing notes stated "*JW was not happy about this and broke the main ward doors open by kicking them. He roamed in the corridor for a while, being very verbally aggressive and hostile to the staff. ...manager on-call contacted. Due to patient's presentation and wish to leave the ward, JW was able to leave – to be returned by the police.*" The Missing Persons' Procedure was implemented. It was noted that the family was phoned but no reply was obtained.

At 05.45hrs, the police brought JW back to the ward handcuffed and escorted by four officers. He was taken to the Extra Care Area of the ward. Haloperidol 10mg and lorazepam 2mg intramuscularly were administered. JW continued to struggle and required two officers to remain with him continuing to hold him. A further 2mg lorazepam was given. The next entry in the notes indicates that he was asleep at 10.00hrs.

He was then placed on Section 2 of the Mental Health Act on 25 January. This was out of office hours on a Sunday. The Mental Health Act assessment performed by Dr A indicated that JW remained psychotic and that he was detained in the interests of his own health. Nursing notes indicate that he was verbally hostile and spat out

oral medication. He was given intramuscular lorazepam 4mg and clopixol acuphase 150mg. Dr A rang JW's mother to check if he had a sister or not. Nursing staff rang JW's mother later that day to explain what the plans were. The medication plan given by Dr A was to continue Olanzapine and to give intramuscular haloperidol and lorazepam intramuscularly for *"acute behavioural disturbance as required."*

Panel comment

Given JW's behaviour, mental state, large physical stature and lack of co-operation, the instructions were to let him leave the hospital and to be brought back by the police service. It is relatively unusual to have police officers restraining a patient on a psychiatric ward. The Panel was told that the police respond immediately for purposes of restraint for giving medication. In evidence one of the WNPCT Managers told the Panel that *"the police overdo their support"*. JW required a large amount of intramuscular medication to calm him down and make him manageable. This was given appropriately. There is no mention in the notes about a psychiatric intensive care (PICU) bed being sought. It is the Panel's view that this would have been good practice.

We note the comments of the Mental Health Act Commission in their 6th Biennial Report, 'In Place of Fear':

"In 1993 we expressed our concern at police involvement in clinical situations, following reports of police being called to assist in giving forcible medication. Mental health services' ward policies should set out when it is appropriate to request the help of police and should generally discourage requests for police involvement in the day to day clinical management of patients. We have heard of some hospitals requesting police assistance on a regular basis for the administration of psychiatric medication to refusing patients. This is an inappropriate use of police resources, and may raise questions of law (we understand that some police authorities are concerned as to their legal powers in such circumstances). At all events, inappropriate use of police services is an indictment of staffing and staff-training levels on the hospital wards concerned. Mental health facilities that detain patients should be staffed sufficiently and appropriately so that they are capable of ensuring the safe management of such patients without outside help.

However, it is conceivable that situations may arise where nursing staff require the help of the police to control or resolve incidents in hospital environments. In general terms, we would expect such incidents to involve serious disturbances involving dangerous behaviour that nursing staff are unable to manage and that poses a risk to patients and others if not brought under control. We understand that such situations will not always be containable by nursing staff, and that the expertise of police may

be required. We think that the use of such expertise is legitimate.

Over-reliance on the police to manage patients in hospital environments may be a result of inadequate training of hospital staff in patient management techniques and the legal framework in which they can be applied. In part, the police may have been partly responsible for encouraging some mental health units' over-reliance on police intervention, by explaining the police role in dealings with the mentally ill as if it were unique in having a potential for the use of legitimate force. In this reporting period we have suggested to the Metropolitan Police that their policy documents should be amended to acknowledge that, particularly in respect of inpatients detained in hospital under the powers of the Mental Health Act 1983, nursing staff may exercise powers of control and management that extend to physical interventions.

Hospital staff should be cautious of involving the police in relatively minor incidents, where the police may resent being asked to take charge of a situation where nursing skills could suffice. However, this should not mean that criminal behaviour by patients should go unreported to the police ... policies should provide advice on the need to consider reporting incidents to the police, with a view to investigation and possible prosecution. Whilst some criminal behaviour is so serious that there should never be any question of not reporting it, the policy should allow a certain amount of discretion over reporting to take account of the needs and wishes of victims...."

As it had become apparent that JW could not be managed informally, the decision to detain JW on Section 5(2) was properly taken. It was quite appropriate to detain him under Section 2 for further assessment and treatment. Dr A's reasons for placing him on Section 2 were well recorded. Given his history of escape and recent aggression, JW should have been detained under the criterion of "with a view to the protection of other persons" as well.

The medication was appropriate in that olanzapine had been started and it was sensible to continue it. Haloperidol and lorazepam as required were the standard medications for acute behavioural disturbance.

There appeared to the Panel to be an over-reliance by the ward on the Police Service to search for missing patients and to attend at the ward for purposes of control and restraint.

Recommendation 1

The West Norfolk Primary Care Trust¹ review its Police Liaison Policy especially with reference to requesting police to assist with controlling, restraining and giving medication to patients on the ward.

28 January 2004

JW absconded from the Extra Care Area having forced the window in the smoking room open by breaking the retainers on the window. He climbed over the fence. He was returned to the ward after a search of the nearby General hospital grounds. There is no record of a discussion amongst nursing or medical staff of whether he should be transferred to a PICU. Later that day he again refused oral medication and had to be given intramuscular medication. He believed that he was being raped.

Panel comment

JW was being very difficult to manage: he was refusing medication and escaping from a secure area. He should have been referred at this stage to a PICU.

Recommendation 2

The West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust should have formal policies with regard to the referral of a patient to a Psychiatric Intensive Care Unit.

Recommendation 3

The West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust should have access to local Psychiatric Intensive Care Unit beds.

30 January 2004

JW had a painful ear and was appropriately prescribed antibiotics for an infection of the outer ear.

He was escorted with two escorts to the Radiology Department for an MRI scan. On arrival in the department he became agitated and said he was scared to have a scan. Regular chlorpromazine 50mg was started four times a day in addition to the olanzapine.

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

Panel comment

Good physical health care was demonstrated in treating JW's painful ear.

However, taking JW to the Radiology Dept was inappropriate and not necessary to his admission. The Panel surmised from the case notes that the MRI was ordered because Dr A thought the presentation of JW to be atypical and she suspected some organic cause. It was possibly predictable that he would be frightened by the machinery given his psychosis. This could have put staff at risk if he had become aggressive. Given his recent escape, it was quite possible that he would try to abscond. Starting a second regular antipsychotic drug was best avoided given that he already had haloperidol as required plus clopixol acuphase, making in total four antipsychotic drugs. This polypharmacy is not recommended by the Royal College of Psychiatrists or the British National Formulary. Polypharmacy potentially has an adverse effect on the heart. It would have been better to have used regular haloperidol and lorazepam alone with clopixol acuphase and then prescribed clopixol decanoate after three injections of the clopixol acuphase.

Recommendation 4

The Pharmacy Department of West Norfolk Primary Care Trust¹ should ensure that best current practice advice regarding pharmacological theory and practice and the use of medication in psychiatric emergencies is issued to all prescribing clinicians.

31 January 2004 - 3 February 2004

JW was taken to the gym by the physiotherapist.

On 1 February 2004 he became agitated and had to be escorted to the Extra Care Area (ECA) using Trust approved restraining techniques.

On 2 February he attended the Gym and refused to return to the ECA and eventually had to be escorted to the ECA, again using Trust approved techniques. 100mg clopixol acuphase and 2mg lorazepam were given intramuscularly.

On 3 February he was seen in the ECA by the medical and nursing team. The plan outlined in the nursing notes, but omitted in her own notes by Dr A, was to give clopixol acuphase 150mg the following day and increase regular chlorpromazine to

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

100mg four times a day. If that proved insufficient, then regular lorazepam was to be added.

From 31 January to 3 February, 10 doses of extra haloperidol and lorazepam medication (PRN) in addition to the regular chlorpromazine and olanzapine and the clopixon acuphase were administered.

When Nurse F was asked by the Panel whether staff on the ward usually treated patients like JW who escaped and exhibited such disturbed behaviour, he replied that they did. When asked about which patients would be referred to a PICU he said a patient like JW would not normally be referred.

Panel comment

It was a measure of the team's commitment to care for JW's needs that they took him to the Gym, but this was a move which could have proved dangerous because of his aggression and might also have led to his absconding. He refused to return to the ECA and this caused difficulties in that he had to be restrained. Again, JW should have been in a PICU, where some of these needs could more easily be met.

The use of medication showed how difficult JW was to manage. The use of polypharmacy - more than two antipsychotic drugs - was putting JW at some physical risk. Any patient requiring such large doses of medication should be treated in a specialist centre PICU where such the team has expertise in managing such behaviour.

It appeared to the Panel that the ward team was managing patients who should have been managed in a PICU. It is of concern that even in retrospect staff did not think that JW should have been referred to a PICU.

4 February 2004 - 19 February 2004

JW was given the third dose of clopixon acuphase 150mg intramuscularly. He resisted and required restraint by three nursing staff using approved techniques. After this JW punched the wall, close to the head of a member of staff.

On 5 February JW was noted to have twisting of the neck which is a recognised side-effect of clopixon. When approached by a nurse, JW punched him in the head. He had refused the medication which counteracts this side-effect - procyclidine - but was later given this intramuscularly.

The following day JW was seen by Dr A and the olanzapine was increased to 15mg per day.

On 7 February JW refused to take his chlorpromazine saying he would only have haloperidol. He did not take chlorpromazine again. From 7 to 9 February he needed 13 extra doses of PRN haloperidol and lorazepam.

On 10 February chlorpromazine was stopped and haloperidol 10mg three times a day was started at the ward round. An entry was made “*?Depot injection – clopixon!*”. Clonazepam was started at 0.5 mg three times a day to alleviate anxiety and act as a calming medication. This was increased the next day to 1mg three times a day. He was noted to be “hostile and argumentative”. On 12 February he refused some of his medication and entered the office despite being asked not to.

On 13 February olanzapine was increased to 20mg; clonazepam was reduced to 0.5mg twice a day and to once a day on 14 February for three days only, then stopped. The mood stabiliser semisodium valproate was started 250mg twice a day.

After this point his behaviour improved. On 16 February he was allowed to go out on Section 17 leave to go bowling.

On 17 February, at the ward, round he was noted not to be as argumentative as before, but to be able to answer questions more directly. Dr A started assessment for detention under Section 3 of the Mental Health Act 1983 but allowed him overnight leave to his grandmother’s. He was noted to be “*demanding and at times intrusive*”.

Leave went well according to JW, and this was confirmed by his grandmother who told the nursing staff that she thought he was now well because when he was ill he was hostile, refused to listen to reason and his spiritual beliefs became excessive. He had stated to his grandmother that he acknowledged he was unwell and that he was willing to continue with treatment.

Panel comment

It was good practice to prescribe the third dose of clopixon. It is the Panel’s view that starting the depot form of the drug would have been good practice; however, there is wide variation in accepted practice on this issue. Whether to give this drug was discussed at one ward round but no indication from the notes was given as to why the depot was not started. The increase of the olanzapine to the British National Formulary (BNF) maximum of 20mg was an alternative to the depot. However, JW also required the BNF maximum of haloperidol 30mg per day so the combined dose of antipsychotic was actually double the BNF maximum. The prescription of both lorazepam (as required) together with a drug from the same class – clonazepam - was not ideal in that it is best practice to use just one drug from the same class. However, the Panel considers that it was good practice to prescribe a regular dose of lorazepam and then to reduce this over time, since it minimised both the risk of addiction and the risk of withdrawal seizures.

Regarding the granting of Section 17 leave for JW to stay at his grandmother’s, the Panel found this to be in keeping with the spirit of the Mental Health Act and the National Service Framework for Mental Health. This is accepted to be the least restrictive setting which safely manages the risk to self and others. Since JW did not pose a risk to

his grandmother or to anyone else, the Panel regarded the granting of this leave to have been appropriate.

20 February 2004 - 23 March 2004

On 20 February a Mental Health Act assessment was carried out by Dr A and the duty approved social worker. JW was not found to be liable to detention under the Act. He was noted to have *“some insight into illness and need for medication - agrees to take medication, and remain informally on the ward while seeking accommodation.”* Dr A spoke to JW’s grandmother on the phone. JW’s grandmother agreed to have JW at her home for periods of leave. Dr A emphasised to her that, if she felt this was too much of a burden or that she was unable to cope then she should let the ward know.

On 24 February JW was seen on the ward round and he told Dr A that he may have been ill on admission. The medication was changed: semisodium valproate was increased to 500mg twice a day and the haloperidol was stopped. At this point he was on olanzapine 20mg at night and semisodium valproate 500mg twice a day.

On 2 March at the ward round JW said he said his thoughts about love were part of being ill. *“I am quite a fan of philosophy and I think I was thinking too much. I know I was ill.”* Dr A noted that he was “almost well”, “willing to continue medication although does not believe they have really helped him”.

JW continued to behave appropriately on the ward and on leave, took his medication and there was no recurrence of his psychotic symptoms.

On 16 March at the ward round, JW said he was unsure if he had been unwell and requested a reduction in medication because it was *“damping him down”* and he questioned the need for it. Dr A reduced the olanzapine to 15mg at night.

On 23 March at the ward round Dr A stated her intention to reduce the olanzapine to 10mg at night. She did not record her reasons for this. On the discharge medication and in the discharge summary the dose of olanzapine was stated to be 15mg.

Panel comment

It was reasonable that JW was not detained under Section 3 of the Mental Health Act because his behaviour and mental state had improved, he was taking his medication and he had successfully had leave at his grandmother’s home. It was reasonable to reduce and stop the haloperidol while JW was still an inpatient so that his reaction to the reduction could be monitored. Since the treating team believed that JW had bipolar affective disorder it was good practice to prescribe a higher dose of semisodium valproate. Taking a serum level to check on compliance and to see if therapeutic levels had been reached would have been best practice. The Panel is of the view that beginning a reduction in olanzapine was too early at this point, given JW’s recent psychosis. It appeared to the Panel that JW was putting some pressure on Dr A for this reduction. The Panel is of the view that Dr A

should have recorded her reasons for starting this reduction. It is important to state that, had JW been diagnosed with schizophrenia or schizo-affective disorder, then he would have been prescribed depot medication for one to two years according to the Guidelines published by the National Institute for Clinical Excellence (2002).

Medication in the community

It appears that JW did not see a psychiatrist until 14 June, some three months after discharge on 23 March. His Care Coordinator and “a member of the family” also attended. He was on olanzapine 10mg at night and semisodium valproate 500mg twice a day. Dr C clearly did a thorough assessment. There were no behavioural problems or disturbances of mental state. He noted that JW was complying with medication and was not experiencing any side-effects. Dr C reduced the olanzapine to 5mg at night and stated that he might reduce this further depending on JW’s response. In the long term he wrote that the semisodium valproate could also be reduced “after a long period of stability”. Early warning signs of relapse were discussed, as were “psychosocial support and interpersonal relationships.”

Panel comment

Dr C performed a very thorough assessment and is to be commended on his attention to both the medical (mental state assessment and medication management) and the social issues. It was reasonable to reduce the olanzapine given the diagnosis of bipolar affective disorder. This diagnosis had been put in the discharge summary and Dr B stated in the summary that JW had not experienced any first rank symptoms of schizophrenia. This was not correct and must have served to confirm Dr C’s view that JW had a bipolar affective disorder rather than schizophrenia.

Second admission to hospital - 24 October 2004 to 22 November 2004

JW was detained under Section 3 of the Mental Health Act after hitting his neighbour and damaging his neighbour’s door. He was assessed by the duty specialist registrar, GP and approved social worker at March Police Station. The notes from this assessment read:

“Psychotic features - hints of thought withdrawal, hints of passivity phenomena and ideas of being controlled, hints of auditory hallucinations. Persecutory ideation – misinterprets any action of neighbour as threatening. Hit neighbour recently and threatened to kill him. Neighbour has left vicinity in fear. He completely denies or minimises these events. No understanding... (page cut off) very circular arguments... Relapsing psychotic illness possibly schizophrenia. Risk of harm to neighbour.”

He told the admitting duty SHO that he had stopped his medication. The admitting SHO could not elicit any psychotic symptoms. He was seen by Nurse F at the same

time (03.25 on 25 October) who noted that the only inappropriate thing JW said during the interview was “*about seeing a narrow image of himself and scanning*”. He concluded “*on the surface JW is not as ill as he was on his first admission.*” No care or management plan appears to have been agreed or written in the notes.

JW was offered olanzapine 10mg as prescribed but he refused this. The drug was written up on the drug chart to be given orally or intramuscularly, so it could have been enforced by means of intramuscular administration. Within two hours JW was noted to be missing. There is no evidence of any missing patient procedure being followed. At 13.05hrs on 25 October, he was returned from his grandmother’s house by two police officers: however, at 18.40hrs he again went absent from the ward. There is no evidence of any missing patient procedure being followed. He was found at 19.10hrs and told the nurses that he had forced a window in the Extra Care Area. On 26 October there is an entry saying that he would be given intramuscular medication if he refused oral medication.

On 27 October he saw the staff grade psychiatrist (Dr B) who increased olanzapine and re-prescribed semisodium valproate. Nursing notes showed that JW was suspicious, irritable, paranoid, grandiose and lacking insight into his illness and need to be in hospital. JW again went missing from the ward at 2000 that day although he was on one-to-one observations. He had gone into the garden and escaped. There is a record of the missing patient procedure being followed and all appropriate persons including JW’s grandmother being informed. Two police officers attended the ward to take details of the patient.

Panel comment

The Mental Health Act assessment correctly viewed JW as psychotic and posing a risk to his neighbour.

Allowance can be made for the admission taking place in the middle of the night, but the absence of a care and management plan constitutes poor clinical practice.

This is compounded by the fact that JW escaped from the ward three times. He managed to do this despite being on one-to-one observation which demonstrates the inadequacy of the resource to contain him. Since he was clearly posing a risk to others - though the risk to the neighbour may have diminished as he had left the area - it is surprising and concerning that JW was not transferred to a PICU. This would have prevented him escaping and made sure that he took medication - which he had been refusing - and pursued therapeutic activities in a safe environment. It was also poor practice that intramuscular medication was not administered despite being written up on the drug chart and being clinically indicated.

On the issue of policy being followed - it is unsatisfactory that the Missing Patient policy was not instituted and documented for the first and second escapes.

As mentioned before in this Report, there appeared to the Panel to be an over-reliance by the ward on the Police Service to search for missing patients and to attend the ward for purposes of control and restraint. We have commented above on the reliance on police to assist in the management of challenging behaviour.

Recommendation 5

The West Norfolk Primary Care Trust¹ should review its training and clinical practice regarding a) missing patient policy, and b) one-to-one observation and should develop a policy for devising the nursing and medical care plan in respect of emergency admissions.

Progress on the ward - 28 October to 5 November

On 28 October the consultant psychiatrist Dr C reviewed JW's care in absentia. He summarised the case and wrote a treatment plan which included stopping olanzapine and starting haloperidol 10mg three times a day and lorazepam 2mg three times a day and transferring JW to a secure unit. He also wrote that he was considering depot intramuscular medication and that if JW refused regular oral medication, then it should be given intramuscularly.

At 00.15hrs on 29 October, the police returned JW to the ward. He appeared drunk and his speech was slurred. He said he had drunk three double vodkas and a triple Bacardi. He was restrained with the help of police officers and given intramuscular medication haloperidol 10mg and lorazepam 2mg. He was deluded about a girl on 'Top of the Pops' who, he said, was "a kind of girlfriend" who he had been looking for when he had escaped. There is no record of physical observations being performed or of his being examined by a doctor.

JW was nursed in the Extra Care Area and given his medication as prescribed by Dr C before his escape. He developed some neck stiffness which was attributed to the haloperidol which was then reduced on 30 October and procyclidine given to counteract the stiffness.

On 31 October he was noted to be "*extremely frustrated in the ECA*" so was allowed a game of pool in the main ward with two escorts and the ward doors locked. He was noted to be "*overtalkative, grandiose in speech content, restless and to be showing disinhibition and flight of ideas.*" He refused lorazepam and haloperidol.

On 1 November 1 he was seen by Dr C, Dr B and Ms D and nursing staff. Dr C wrote down a summary of the case again including

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

“he has poor insight and judgment. Poor impulse control. Family is very concerned about him. Impression: If not in hospital he is at risk to others and not able to function.”

JW was placed on one-to-one observation which continued until 11 November. Dr C wrote *“If behaviour escalates or he engages in escape he will need evaluation for transfer to more secure unit.”*

Almost immediately after this plan was instituted, JW tried to walk through the ward doors on two occasions and he was verbally hostile, *“pacing the ward frantically”*. After taking medication he went to the toilet and staff suspected he had vomited the medication. The charge nurse took JW back to the ECA and agreed a care plan with JW for when he could have leave in the main ward.

On 3 November JW refused lorazepam and was observed interfering with the window hinges in the pool room. At 20.40 he ran at high speed and kicked the door repeatedly breaking the door latch. He ran out of the ward pursued by staff then ran back to the ECA before running out of the ward again. He was picked up quickly by the police in the hospital grounds and returned to the ward. He was prescribed diazepam 5mg intramuscularly - as there was no lorazepam on the ward - and haloperidol also intramuscularly after a phone call to the duty consultant psychiatrist.

On 4 November JW was reviewed by Dr C, the staff grade, ward nurse and Care Coordinator. The two escapes were noted. The plan stated *“If continued escape or other significant behaviour problem consider transfer to more secure unit.”* He was prescribed Risperdal Consta depot medication; depending on the response to this there would be a reduction in haloperidol and short term oral risperidone would be prescribed. Dr C also wrote that if he refused oral lorazepam – which he had been doing all the time since 31 October - he should be given intramuscular lorazepam. Olanzapine was reduced from 15mg to 10mg and lorazepam from 2mg three times a day to twice a day. Risperidone was started at 1mg twice a day increasing to 2mg twice a day on 5 November. He accepted his depot medication later that day. He was managed in the ECA. A television was provided for him in the ECA.

Panel comment

Dr C's care plan represented good practice. Haloperidol and lorazepam were appropriate medications for a patient in JW's condition. Dr C was correct to be looking towards managing JW in a secure ward. He was also correct in insisting on JW receiving intramuscular medication if he did not take oral medication and in thinking of starting a depot medication. This he later did. Once again the Panel are of the view that a PICU referral would have been appropriate at this point.

When JW returned to the ward, a number of areas of concern were apparent to the Panel. He was noted to be drunk and admitted to having consumed a large amount of alcohol. He was not examined by a doctor. No doctor was informed that he was back on the ward. This poor practice was compounded by JW being restrained by police

officers and being given medication with their help, contrary to acknowledged best practice. Furthermore there is no evidence of physical observations being performed by nursing staff. This could have put JW's physical health at risk e.g. by staff not noticing that medication might have suppressed his breathing.

Recommendation 6

The West Norfolk Primary Care Trust¹ should review its training for nursing staff regarding the care of physical health observations of aroused and/or intoxicated patients, particularly those who have received significant doses of prescribed medication.

When seen by Dr C on 1 November he again wrote that consideration be given to transferring JW to a secure unit. However this was not done.

Panel comment

There appears to the Panel to have been a considerable reluctance to do this by all staff despite a compelling case to do so. The Panel was told in evidence that there were no difficulties obtaining a PICU bed should one be needed.

It was good practice that JW was placed on one-to-one observations but this did not prevent him attempting to escape another three times before achieving his escape on a further two occasions. Dr C again on 4 November did not take the obvious opportunity to transfer JW to a secure unit.

Dr C demonstrated good practice by starting depot medication at this point. It was appropriate to reduce the olanzapine and start oral risperidone so that JW would not be on two different antipsychotic medications.

The duty consultant asked for intramuscular diazepam to be given because the lorazepam had run out. Lorazepam is a stock drug and it should not have run out. Intramuscular diazepam is rarely given because it is inconsistently absorbed.

Recommendation 7

The West Norfolk Primary Care Trust¹ should ensure that proper attention is given to effective stock control of essential psychiatric medication.

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

On 8 November JW was reviewed by Dr C, Dr B and the nursing staff. He was noted to be taking medication and no escape had been attempted. The improvement continued, although on 10 November he “*verbalised thoughts of smashing the place up*” to staff in the ECA. Staff explained that this “*would not be in his best interests*” and gave him extra haloperidol orally.

On 11 November JW was noted to be sedated and Dr C reduced lorazepam to 1mg twice a day and haloperidol to 5mg twice a day at the ward round. The plan was for JW to spend more time on the open ward.

On 12 November JW spent time on the open ward and the observations were reduced to every 15 minutes. He did not attempt to escape. Over the following days nursing staff spent time explaining why it was important for him to remain on the ward.

On 15 November JW was seen by Dr C, Dr B and nurses. It was noted that he had been accepting medication and had not been a management problem. His affect was noted to be “*more responsive*”. Dr C reduced the haloperidol to 2.5mg twice a day. JW was allowed to attend activities off the ward. Discharge and aftercare planning was to be discussed with the Care Coordinator.

On 15, 18 and 22 November, JW attended physiotherapy because of back pain.

On 18 November JW was reviewed by Dr C, nursing staff and Ms D, with his grandmother in attendance. He was noted to have been taking his medication. There had not been any disruptive behaviour. His affect was noted to be better and he was speaking “*better about his problems*”. He denied any violent or suicidal ideation and said he would comply with the treatment plan. JW was allowed home leave under Section 17 of the Mental Health Act. His haloperidol and lorazepam were stopped

“with risperidone liquid to anticipate discharge next week. Depending on response begin tapering oral risperidone and may need increase Risperdal Consta. JW and grandmother agreed with plan.”

JW accepted depot risperidone 25mg.

An alert form was completed and the Home Treatment Team was to be asked by ward nursing staff to ring JW over the weekend 19-20 November.

On the 22 November JW was seen at a Discharge Section 117 Meeting. Present were JW, DG, Mr G, Ms D, ward nurse, staff grade and Dr C.

Dr C wrote:

“Leave is reported to have gone well. On Friday had some side effects after injection but this cleared. No reported incidents of violence or self harm. Sleep getting better. He denies suicidal and violent ideation. He agrees to comply with medication and treatment plan. Affect positive. Impression: Good progress. Medication well tolerated now. Assessed risk for

suicidal and violent behaviour and it is low for the foreseeable future.

Plan:

- 1. Discharge today - move to Section 117.*
- 2. Continue current medication. On review likely to increase Risperdal Consta and reduce oral risperidone.*
- 3. Next injection in clinic next week. I will see him for outpatient before then.*
- 4. Care Coordinator will see him.*
- 5. Advised about emergency and crisis plan.*
- 6. He will be referred to workshop Piece of MIND in Downham Market for better activity.*
- 7. Both he and his grandmother agreed with this discharge plan.”*

JW's medication on discharge was Risperdal Consta 25mg every two weeks, risperidone 2mg twice a day; procyclidine 5mg as required (for any muscular side effects of risperidone) and semisodium valproate 500mg twice a day.

The outpatient appointment with Dr C was arranged for 1 December and JW was to see Ms D on 24 November and every two weeks thereafter.

Panel comment

JW's condition improved with medication. It is common practice in modern mental health services to treat patients in the "least restrictive environment consistent with safety" (National Service Frameworks for Mental Health). Dr C made every effort to ensure that JW's carer was fully in favour of him going on leave and then with his discharge. This was good practice. Contacting the Home Treatment Team was good practice when JW went on leave. Dr C's note-keeping was excellent in that he noted JW's improvement in mental state and behaviour and what leave and medication he was prescribing. He wrote down his assessment of JW's risk of violence to others and to self which was very good practice. The discharge plan encompassed medical as well as social components and is to be commended. The decision to discharge JW was a reasonable one which was based on clinical and risk grounds and did not appear to have anything to do with pressure of beds.

On the ward the staff made efforts to see that JW's physical needs were catered for by facilitating three visits to the physiotherapist. This good level of care may not have happened in other services where a physiotherapist might not be available. In some services a gym instructor might be employed to help meet the needs of patients. The use of a physiotherapist is viewed by the Panel as a creative way of using this service.

Outpatient treatment

On 1 December JW was seen in the outpatient clinic by Dr C with Ms D and DG. Dr C wrote to JW's GP on 3 December on note paper which included contact address, phone number and email. JW told Dr C that he was doing well since discharge and that he had been taking his medication. He denied any violent or self harm behaviour. Dr C asked his permission for him to ask his grandmother her views and he noted "*she collaborated his positive report*".

Dr C found JW to be "*lucid*" and "*his affect had a full range*". His personal hygiene, speech, activity levels were all found to be normal. He was noted to have a sense of humour. Dr C noted the absence of hallucinations, delusions, suicidal ideas or "*violent ideations, intentions or plans. He guarantees his safety as well as everyone else's. He gave firm assurances about this.*"

He was managing his time better and setting appropriate goals.

Dr C wrote "*his condition has shown excellent progress since discharge from hospital. Both mood and psychotic symptoms appear to be under good control. He also appears to be showing some progress in terms of insight. Medication is well tolerated. I assessed his risk for suicidal and violent behaviour and it is low for the foreseeable future.*"

Regarding treatment Dr C wrote: "*A goal of treatment would be to taper and eventually discontinue oral risperidone. Depending upon his response to this he may need an increase in the Risperdal Consta. For now the dose of oral depakote will remain unchanged. Further adjustments in medication will be made depending upon on going toleration and response. Although he has shown progress this is dependent upon him receiving the medication on a regular basis other wise he would likely relapse.*"

His next appointment was scheduled for six weeks 12 January 2005 but he was told that he could contact Dr C sooner if required. JW and his grandmother agreed with the plan.

Panel comment

Dr C made a thorough assessment of JW's mental state, behaviour, compliance with medication and his risk of violence to self and to others. This was good practice. He consulted with the carer and with the Care Coordinator as well as the patient JW himself. This was a good assessment. Easy contact could be made by the GP with mental health services should this be necessary.

However, given the fact that JW had only recently - nine days before - been discharged, it seems to the Panel that an appointment six weeks later was too long; one to two weeks would have been more reasonable, even allowing for Christmas and New Year. This is especially the case because of the need to adjust the medication which

Dr C had written about on discharge.

Medication: JW had received his first injection on 18 November.

Regarding Risperdal Consta - Trust Guidelines said:

“It takes three weeks following the first injection before significant release of risperidone occurs. The main release starts in week 4 and peaks in weeks 5-6. Alternative antipsychotic cover is therefore required for the first three weeks, which should then be tapered and discontinued.”

The British National Formulary Sept 2004 p.191 states:

“During initiation risperidone by mouth continued if necessary for max. 3 weeks; risperidone by mouth may also be used during dose adjustment of depot injection.”

Given that JW had only recently been on a large amount of antipsychotic medication and been very ill and disturbed, it would have been better to have given him a larger dose of oral risperidone while the level of depot risperidone was building up in the body. The issue of compliance is also important and Dr C was relying on JW's carer to reassure him that JW was taking his oral medication.

Three weeks after his first dose would have been 9 December. It would have been prudent to check on JW's progress at that point. It is possible that Dr C was thinking that JW's first admission had not been followed by intensive outpatient follow up because he appeared to have complied with oral medication without relapsing – until some months later. Given the fact that JW's admission had been difficult at times it would have been reasonable to suspect non-compliance with medication. Dr C appeared to receive confirmation from JW's carer that he was complying with prescribed medication. Even though there are no stipulated guidelines on frequency of outpatient contact it would still have been better to have seen him the following week to check on compliance and progress.

The modified instructions in the British National Formulary regarding the use of Risperdal Consta now say that oral medication should be continued for four to six weeks as it takes this long before the injection takes full effect. This was not known at the time. The Trust is to be commended in that the Medical Director notified the National Patient Safety Agency regarding this issue.

It is possible that Dr C might have detected signs of psychosis in response to specific questions had he seen JW in the outpatient clinic. However, it is equally possible that these would not have been present or, if present, that JW would have covered them up. There is evidence from police transcripts after JW's arrest that he had been concealing his symptoms. Given the fact that neither his Care Coordinator nor any

of his family detected any clear signs of relapse in his presentation, it is quite likely that Dr C would not have done either. The Care Coordinator saw JW On 9 December and did not notice any change in his behaviour or mental state. It is the view of the Panel, albeit with the benefit of hindsight, that JW was relapsing. Such a catastrophic relapse could, however, not have been predicted. Even though JW attended the clinic on 15 December, it is unlikely that any violent intent could have been elicited by professionals, although on very careful mental state examination it is possible that JW might have let slip some of his psychotic beliefs about his grandmother in which case he could have been given extra medication. In the view of the Panel it is unlikely that he could have been found detainable under the Mental Health Act since he was complying with treatment and was not behaving aggressively.

CHAPTER 10 CARE PROGRAMME APPROACH (CPA) AND CARE IN THE COMMUNITY

The CPA documentation in the JW case consists of a mixture of WNPCT and of CPFT completed forms. They have been filed together into the case record without duplication.

The Internal Inquiry recommended the development of a single CPA form which is accessible and prominently displayed in the file to record, amongst other details, violent or potentially violent incidents. The May 2006 edition of the Action Plan resulting from the Internal Inquiry notes that a CPA risk assessment screen has been in place from January 2006. In addition, a readily visible risk incident record has been completed for the East Cambridgeshire and Fenland locality.

Also as a result of the Internal Inquiry, there is now a protocol on the sharing of personal information between agencies. Sharing risk information is also part of the clinical risk training programme.

Community Care

Prior to his first admission, JW had no known contact with the mental health services. Following the disturbed behaviour which characterised the early part of this admission, by the 16 February 2004, he was considered to have sufficiently recovered to be given Section 17 leave (authorised by the Responsible Medical Officer, or RMO) to stay with DG.

Panel comment

The granting by the RMO, in communication with the multidisciplinary team and the patient/carer(s), of leave of absence from the ward, is standard practice. A 'graduated' approach to discharge aims to reacquaint the patient with the community, and to prepare him/her for leaving hospital. In this instance, the leave followed quickly on from the period of disturbed behaviour described above, which had lasted for a couple of weeks.

JW was permitted weekend leave from 24 February, after staff had confirmed with DG by telephone contact that she was agreeable to this. He had the problem, however, of not having anywhere of his own to be discharged to, apart from DG's address, so accommodation was noted to be one of his post-discharge needs.

By 24 February, he had also been allocated a Care Coordinator, who was a Community Mental Health Nurse, Ms D, working from the Community Mental Health Team, or CMHT, in Wisbech.

Panel comment

It is good practice to allocate a Care Coordinator (through the Care Programme Approach or CPA) prior to the discharge of a patient back into the community. The Care Coordinator's role is an important one, in that they have the responsibility to ensure that the Discharge Care Plan is delivered.

Further leave to JW's grandmother went well, and a temporary placement in the town of March was identified on 23 March. JW was discharged to the placement through Julian Housing Association, with follow-up by his Care Coordinator, Ms D, on a monthly basis, and with more frequent contact with a Support Worker, Ms E, (not professionally qualified), who would explore practical issues such as housing and employment with him. He was also given an Outpatient appointment with his Consultant Psychiatrist.

Panel comment

JW had been offered a reasonable and appropriate care package under the Care Programme Approach (CPA).

By 22 April, JW had been given a flat of his own in Wisbech, having spent most of the time since his hospital discharge at DG's house.

Panel comment

The Care Coordinator, local authority and housing providers, Julian Housing, are to be commended for the speed in which permanent accommodation was obtained for JW, i.e. 3/4 weeks from discharge from hospital.

JW's clinical notes provide evidence that Ms E maintained frequent and regular contact with him from April through to August 2004. She saw him at home on the 27 April, 26 May, 8 and 17 June, 14 July, 16 and 26 August. She also maintained regular telephone contact with both JW and his grandmother. In fact, she was probably the staff member who had the closest relationship with JW, and who probably knew him best.

Training courses were discussed (carpentry and joinery, drama), and initially JW seemed quite enthusiastic about the prospect, as well as spending time decorating his new flat. However, on 14 July, DG expressed concern that he needed more structure to his day, as he was tending to spend all day in the house, which she was not happy with. He was looking forward to a trip to Spain to see his mother.

Unfortunately the holiday proved problematic. DG revealed that JW had ceased taking his prescribed medication shortly before going on holiday. While on holiday he became involved in a physical altercation with his mother's partner, apparently over an argument about JW being "lazy". He missed his intended flight back to England. Consequently, temporarily estranged from his mother, JW spent a couple

of days and night in a children's home before the Spanish authorities managed to effect his return to England.

On JW's return, Ms E got in touch with DG, and she expressed concern that he was becoming unwell, "*slipping back to how he was when he was becoming unwell*" (clinical notes of 16 August 2004) and continuing to refuse to take medicine, saying there was nothing wrong with him.

DG had, in fact, made plans to visit one of her sons and his family in Derbyshire to get some respite, and requested that Ms E, the support worker visit JW before she actually went away. The visit occurred on 16 August, and Ms E shared DG's concerns, and arranged for an emergency Outpatients appointment three days later, on the 19 August. JW was at this stage spending a lot of time watching TV and listening to music late into the night – he denied taking any drugs, and although he was reported by the Support Worker as having "*an edge*" to him, he was not at that stage aggressive or overtly threatening.

Panel comment

JW and DG were given solid and consistent input from his Support Worker, who was responsive to DG's concerns, and acted on them. It could be said that she 'carried' the bulk of the work in the community care aspect of JW's case at this point, and that, at the very least, she should have been accompanied by a qualified worker on the 16 August, given DG's and her own ongoing concerns about JW's mental state. In fact, these concerns should really have been expressed in a care plan, given that the Support Worker vocalised her apprehension about lone visiting to her Team Leader on 26 August.

Recommendation 8

That the Cambridgeshire and Peterborough Foundation Trust ensure that robust systems of managerial supervision are put in place, within which difficult clinical cases are discussed.

JW was assessed both on 19 August and 20 August (at home) by medical staff and an approved social worker, but was considered at that point not to need compulsory admission to hospital, although this was considered. According to a member of the family who accompanied JW to Outpatients on 19 August, DG was not coping too well at that point in time and he "wound her up". On the visit of the 20 August, the ASW noted JW's tendency to speak about abstract, pseudo-philosophic topics, in particular relating to numbers, light and colours. He was less forthcoming when answering practical questions. It was felt that there was "no risk apparent at present to warrant extra concern".

Ms E returned from a week's leave, and saw JW on 26 August, finding him slightly paranoid and still not taking medication. For further discussion of this issue, please refer to the 'Risk Management' section of this report. DG was also seen, and was

given the phone number of the Crisis Resolution Team (CRT), and advised to contact them if she had concerns over the forthcoming Bank Holiday weekend.

Panel comment

Given the Support Worker's ongoing concerns, a better arrangement would have been to have requested that the CRT phone DG each day over the Bank Holiday, rather than advising her to call them.

On 1 September, it was decided to withdraw JW's Support Worker, Ms E, from further involvement, in the light of his non-compliance and loss of motivation. The Panel received differing accounts as to who made the decision to withdraw the Support Worker.

Panel comment

The decision abruptly to withdraw the Support Worker's input was an unfortunate one. She provided both JW and DG consistent, regular contact and support, and, although her role was primarily practical in nature, it seems probable that JW and DG felt supported by her input; the care plan involving monthly visits by Ms D would have been a poor substitute for this input. The Panel would take this opportunity to also praise both the quantity and the quality of the notes made by the Support Worker. The possibility of Ms E undertaking joint visits with Ms D, in the light of the former's apprehensions outlined above, does not appear to have been considered.

There was no face-to-face contact between JW and Ms D from 08 September (when she saw JW with Dr C) until 21 November (when he had been readmitted to the Fermoy Unit), a period of ten weeks.

Panel comment

The Panel was unable to ascertain with certainty the reason for this apparently lengthy hiatus in contact, due to the paucity of notes during this period. JW apparently failed to attend outpatients appointments and was not at home when Ms D called on him. In the view of the Panel this time-gap is excessive, especially when the recommendations of the discharge care plan of March that year are taken into account, as well as the clearly unsettled mental state JW had been demonstrating since July.

Following the assessment on 8 September, another appointment with Dr C was booked for 9 November, i.e. two months later. By this time, JW had been admitted under Section 3 of the Mental Health Act 1983, following an assault on his neighbour.

Panel comment

The two-month period until the next Outpatients appointment would have made regular community contact by the Care Coordinator even more necessary.

This second admission of 2004 lasted from 24 October to 22 November, a period of four weeks. A broadly similar pattern occurred to that of the first admission, in that the initial period was marked by difficult, aggressive behaviour, and, on settling down, leave to DG's house under Section 17 was arranged. The CPA Discharge Plan, at which DG was present, outlined a plan of fortnightly visits (rather than monthly, as before) by the CMHN, who would administer the depot injection, Outpatient appointments (the next one arranged for 1 December), and referral to a Day Centre in Downham Market to do carpentry and joinery.

Panel comment

This appeared to be an appropriate discharge plan to address JW's apparent needs, especially the increased Care Coordinator visits, although it could be said that the discharge itself occurred quite quickly after his period of disturbance - for example, he was still noted to be on one-to-one nursing observations ten days before discharge. However, there were no concerns expressed by the Consultant Psychiatrist in an Outpatient follow-up on 2 December. In fact, it was felt that at that time the *"risk for suicidal and violent behaviour ... is low for the foreseeable future"*

Records from Wisbech Housing Office indicate that there had been several days of 'erratic behaviour' prior to JW's assault on his neighbour. Housing officers had visited him in the previous week in response to complaints about loud music. After JW's arrest, it became apparent that he had also damaged his own flat. There does not appear to have been direct, contemporaneous discussion between the Housing Department and JW's Care Coordinator regarding these concerns.

The Area Housing Officer took a decision to re-house JW's neighbour and his family. He wrote to Dr C seeking reassurance that there would not be risk to anyone placed in the property vacated by the victim. He warned that any repetition of problematic behaviour would lead to the council seeking to evict JW. Dr C responded on 15 December outlining the improvement in JW's presentation and compliance and stating that he felt there was low risk that he would cause any harm to anybody whilst compliant with treatment.

Ms D made an initial home visit on 25 November, and it was decided that contact would in fact be weekly, alternating home visits with clinic appointments. This is a relatively high level of contact between a service user and CMHT Care Coordinator. It was at this visit that DG was noted to have turned down the offer of a carer's assessment, and JW refused to have a routine blood test taken.

DG was present at both the meeting on 25 November and the subsequent one on 1 December and she confirmed that JW was doing well. On 9 December, JW and his

CMHN discussed drug use, which he denied. However, he retrospectively confirmed to the police in January that he was, in fact, smoking 'skunk' during this period. In keeping with the Care Plan, he was seen again one week later in clinic at Agenoria House, where his injection was increased and his oral medication accordingly decreased. This was his last contact with the statutory services before the events of 26 December. However, he did keep an appointment on 21 December, accompanied by a friend of the family, with the employment workshop "Piece of MIND" in Downham Market, where the worker who spoke with him noted his apparent preoccupation and incongruous smiling. He denied once again any substance misuse or hearing any voices.

Overall Panel comments

JW's community care featured regular contact from the multidisciplinary team, by nurses, doctors and social care staff, apart from the period noted above in September/October, after the withdrawal of his Support Worker. Support Workers are unqualified staff, and whilst she undoubtedly did excellent work with JW, one could question whether, towards the end of their relationship, she was holding too much responsibility with regards to her face-to-face contacts with JW and DG. Her continuing input, under the active supervision of Ms D, would have offered JW and his grandmother more support and have served to monitor JW's condition. The contact after the second admission by the Ms D was much more frequent and substantial than that offered after the first admission, i.e. weekly, and this was wholly appropriate.

CHAPTER 11 DIAGNOSIS

Diagnosis in psychiatry is based on the International Classification of Diseases published by the World Health Organisation. In psychiatry, diagnosis is made on the phenomenology (experiences and symptoms which the patient has) and descriptive psychopathology (symptoms and signs which the psychiatrist observes). Sometimes patients do not readily share their experiences and it may not be easy to make a diagnosis.

JW's clinical picture during first admission

JW was brought to the A&E department by his mother on 19 January 2004 and the symptoms of psychosis were clear. JW exhibited grandiose delusions to the duty doctor *'I have the solution to the world's problems. I'm trying to help people.'* Dr A did a comprehensive assessment remarking on many features of his psychosis.

She noted that he showed *'very thought disordered responses'*. He showed bizarre beliefs: *'People try to hide inside other people to hide the evil they have done.'* She noted again *'thought disordered in trying to explain self'*. *'Two negatives make a plus so I might as well gather all the negatives in the universe to make a big plus.'* *'People snatch at him e.g. can snatch his confidence by making loud noises, can then snatch his thoughts.'* *'People try to control your body language... people try to jump on top of you and control you with their body language'*. Dr A commented that he had *'no clear evidence of passivity'*.

Dr A wrote *'thoughts like this for? some time. Brother moved out of house as couldn't handle it.'* *'He asked his mother if she has been jumping inside him and listening through his ears. Thinks everyone is doing it.'*

Dr A wrote on 20 January that the diagnosis was *'psychotic illness without affective disturbance'*. The differential (other possible) diagnoses were given as *'Drug induced psychosis (but denies recent drug history), hebephrenic schizophrenia, organic psychosis.'*

Further evidence of psychosis came over the next few days on the ward: "Mother also states that JW has been pushing toilet roll into his ears" (23 January nursing notes). He was also experiencing persecutory delusions – *'attempting to warn his grandmother not to associate with the devil; as he refers to her (his mother)* (23 January nursing notes).

On 27 January nursing notes read: *'J has stuffed tissue in his ears ... believes he has a twin sister and was rambling about this ... clearly appears to be responding to external stimuli.'*

JW told Dr A on 20 January that he believed people could snatch his thoughts. He believed nursing staff *'were controlling him'* (27 January). He told Dr A *'I am controlling his head turning to left'*. Staff also note *'... people controlling him'*.

Dr A (unsigned but similar handwriting to entry initialled by her on 29 January) wrote 'Still not clear evidence of first rank symptoms' (of schizophrenia) (30 January).

The clinical picture was then complicated when JW then developed manic symptoms. Nursing notes (1 February) said 'agitated, pressure of speech, flight of ideas, poor concentration'. On 3 February Dr A wrote 'increasingly elevated mood/overactive/racing thoughts verbally hostile/irritable/hostility to staff.'

On 6 February Dr A wrote 'No evidence of 1st Rank Symptoms. Probable diagnosis manic illness w psychotic features.'

The Panel was told by Dr B and Mr F that the picture on the ward was of over-activity, elation and grandiose beliefs. They agreed with Dr A that the diagnosis was of mania with psychotic features.

When Dr B was asked by the Panel about these symptoms, and the fact that JW's mother told staff that JW had been aggressive some two months earlier in November 2003, he agreed that schizophrenia should have been considered as a diagnosis. He agreed that the aggression could have been seen as a change in behaviour thus indicating that a mental illness had begun.

Panel comment

Diagnoses to be considered:

1. Psychotic illness

When locum consultant psychiatrist, Dr A, first assessed JW she diagnosed him as having "*psychotic illness without affective disturbance*". This means that the patient suffers from abnormal experiences such as delusions and hallucinations without changes in his mood. Delusions are unshakeable, wrong beliefs, which are not amenable to reason and which are out of their cultural context. Hallucinations are perceptions which do not have real stimuli, for instance human voices, but no visible people producing them. It is the task of the psychiatrist to establish how this rather general diagnosis needs to be changed. Early on in the clinical history of an individual patient, it can be difficult to be sure of the diagnosis, but as the contacts with the patient increase over time, the picture becomes clearer. Recognised causes of psychotic illness include drug-induced psychosis, psychoses caused by physical conditions such as head injury and infections and the major mental illnesses of bipolar affective disorder (BPAD) and schizophrenia.

2. Bipolar affective disorder

In February and March 2004, consultant psychiatrist A made the diagnosis of "*manic episode with psychotic features*". This became the diagnosis formally given by Dr B in the discharge summary written in April 2004. This diagnosis forms a sub-category of the main category of bipolar affective disorder (BPAD). This condition is the same as the older

diagnosis of manic-depressive psychosis. BPAD is characterised by a disorder of mood. This can be low mood – depression – or elevated mood, which is called hypomania or, if more severe, mania. Consultant A was of the opinion that JW's elevated mood was the primary condition and that the delusional grandiose beliefs were consistent with the mood disorder, so made the diagnosis of manic disorder. The aggressive behaviour and delusions were seen as the 'psychotic features'.

3. Schizophrenia

The other illness category which many psychotic patients are diagnosed with is called schizophrenia. This illness is also characterised by hallucinations and delusional beliefs, but these delusions are not consistent with a mood disorder. An example of delusions being congruent with a mood disorder is in the case of grandiose delusions and elated mood. In schizophrenia, the mood disorder is much less prominent than in BPAD and may not be present at all. In schizophrenia, the presence of so-called 'first rank symptoms' is usual, though not necessary, for the diagnosis to be made. These are bizarre experiences such as hearing ones thoughts echo; believing one is under the control of an external force; believing thoughts are broadcast so that a person sitting close by can hear them.

4. Schizoaffective disorder

This is a condition when both the symptoms of schizophrenia and of BPAD occur at the same time

Panel view

The Panel considers that JW had probably been ill for some time before he presented to the mental health service. Schizophrenia can come on slowly whereas mania tends to start more suddenly. It is possible for a person to have mania for two months before presenting to the services, but it is more likely that he was suffering from schizophrenia.

The Panel is of the view that JW was experiencing first rank symptoms of schizophrenia – notably passivity feelings.

The Panel is of the view that schizophrenia should have been considered formally in the discharge summary as a diagnosis at this time. This would have been either as schizophrenia itself or schizoaffective disorder.

Diagnostic issues during outpatient care

June 2004

JW's care was transferred to Dr C, consultant psychiatrist when Dr A left the Trust. JW was discharged on 26 March but was not seen in clinic until 14 June. The diagnosis given by Dr C was "Bipolar affective disorder with history of psychotic features". Dr C concluded that '*his mood appears to be under good control and there is no evidence of psychotic symptoms*'.

Panel comment

Dr C performed a thorough examination and reviewed the file. He accepted the diagnosis given by Dr A. Given that JW seemed to be well, this was a reasonable supposition. Periods of remission are more common in BPAD than schizophrenia. Nevertheless, the Panel would have liked to ask Dr C if he considered the diagnosis of schizophrenia as a possibility, given the previous symptoms and probable length of history. This was not possible as the Panel was told that he had left the country and was not contactable.

August 2004

When seen by Dr C in clinic on 25 August, JW's thinking was described as '*somewhat tangential and circumstantial*'. He appeared to be '*preoccupied*'. He '*did not verbalise overt delusions*.' The diagnosis was given as 'Bipolar affective disorder with psychotic features.'

Panel comment

Dr C maintained the same diagnosis. It is not clear if he enquired about delusions or whether their absence during conversation led him to write that JW did not verbalise overt delusions. It was not possible to ask Dr C. The presence of tangential and circumstantial thought and JW's preoccupation would seem to indicate to the Panel that a diagnosis of schizo-affective disorder or schizophrenia would have been more appropriate.

September 2004

JW again presented with tangential and circumstantial answers and preoccupation when he saw Dr C in clinic on 8 September.

Panel comment

As for August 2004 (see above).

2nd Admission: 24 October 2004 to 22 November 2004

According to the discharge summary: When seen in Peterborough Police Station after assaulting a neighbour, the on-call psychiatrist reported that JW was presenting with *'thought insertion, thought block, auditory hallucinations and delusions of persecution'*. However, at the time of admission to the Fermoy Unit the admitting psychiatrist noted that JW *'denied any forms of hallucinations, no delusions'*.

Dr C noted on 28 October that JW had been *'increasingly isolative, preoccupied and suspicious'* since stopping his medication.

Nursing notes on 27 October said that he was *'suspicious and paranoid'*, with *'evidence of paranoia and grandiosity'*.

On 29 October, *'difficult to assess for any objective psychotic features, no evidence of high mood'*. On 29 October he was *'deluded with grandiose ideas about this girl who was on TV Top of the Pops'*.

31 October *'was displaying evidence of elation, poor concentration, flight of ideas, some disinhibition noted. Grandiose in speech content.'*

2 November, *'Requested prn medication as had 'things going on in his head' giving him a headache.'*

4 November, *'Some paranoid beliefs evident' "I think all staff are liars and are laughing constantly."*

Thereafter no psychotic beliefs were noted by nursing or medical staff.

The diagnosis on discharge was given as *'bipolar affective disorder with psychotic features'*.

Panel comment

JW was becoming skilled at concealing his beliefs and this made diagnosis more difficult. There were enough symptoms of BPAD on 31 October and grandiose beliefs on 29 October for Dr C to concur with a diagnosis of BPAD. The paranoid symptoms were not particularly pronounced. The on-call psychiatrist clearly saw symptoms of schizophrenia when JW was in presumably the most severe phase of his illness at this point.

Overall Panel comments

Both consultant psychiatrists A and C diagnosed JW with BPAD. They both saw classical features of mania – elated mood, pressure of speech, flight of ideas, grandiose delusions. During the first admission there were, in the Panel's opinion, clear symptoms of schizophrenia which were insufficiently acknowledged in the discharge summary as

either being features of schizophrenia or of schizoaffective disorder.

After the second admission it would have been expected that a differential diagnosis would be given by Dr C, and then noted down by Dr B in the discharge summary. The fact that this was not done suggests that Dr C was sure about the diagnosis. The specific symptoms of schizophrenia – thought insertion and thought blocking – had been noted by the on-call psychiatrist. Either they were not experienced again by JW or he was able to conceal them. Thought insertion can occasionally occur in mania; thought blocking is very unusual.

The diagnosis of BPAD can certainly be substantiated from the clinical picture. However, the Panel believes that the possibility of schizophrenia should have been acknowledged and that it was a misjudgement not to have decided that schizo-affective disorder was more likely to be the diagnosis than bipolar affective disorder. Had the schizophrenic symptoms been given greater consideration, then it is likely that there would have been greater emphasis on compliance with medication in the weeks and months post discharge.

As to the question of whether a second opinion should have been sought, the Panel is of the view that second opinions are firstly, uncommon, and secondly, usually requested by the patient. In this case, the patient did not request one and it is not common practice for a formal second opinion to be sought by the clinical team.

CHAPTER 12 SUBSTANCE MISUSE

JW's mother reported to clinical staff that he had been a heavy cannabis user for the past couple of years preceding his first admission to the Fermoy Unit, i.e. since the age of 16 or so. She said that she knew he was using substances in 2003, when he was living with his elder brother, in Manchester. JW himself told an SHO that he was using drugs before his first admission. JW's brother told their mother that he was sure that JW had taken ecstasy, but when questioned by her, JW told his mother that he had only had half a tablet one day and the other half the following day.

A urine drug screen taken when JW was an inpatient on 22 January 2004, however, proved free of all illegal substances. Cannabis takes several days to be processed by the body, a period during which it would be detectable by a urine test, so it would seem that he had not used cannabis for at least several days before this date.

Although his previous use of drugs was known, the inpatient team considered that JW was also very unwell, so that drug misuse was one potential factor or variable amongst several that had to be considered when coming to a definitive diagnosis.

In discussion with his Care Coordinator, Ms D, JW always denied substance misuse, but his support worker, Ms E, was suspicious that he was using cannabis when JW was in the community after his first discharge from hospital.

Regarding alcohol abuse, it was noteworthy that, when JW absconded during his second admission, he was returned by the police in an intoxicated state.

After his second discharge from hospital, some members of JW's family told the Panel in evidence that they thought JW may have been using various drugs. Ms D thought she smelt cannabis in his accommodation. JW refused to give a blood test to check his levels of prescribed medication on 25 November.

In one of the interviews with the police, which took place in custody on 18 January 2005, after his arrest on Boxing Day, JW stated that he had last smoked cannabis four days before Boxing Day, having run out of his supply. He admitted that he had been smoking for two to three weeks before running out, and also intermittently before his second admission to the Fermoy Unit, claiming that it relaxed him.

Panel comment

The presence of substance misuse inevitably complicates the clinical and diagnostic picture. For example, the interaction between legal and illegal medication can be unpredictable and potentially unsafe. The effectiveness of prescribed medication can be decreased, and psychiatrists will not be able to prescribe effectively if other substances are being ingested concurrently. Substances can themselves produce symptoms of mental illness and also can exacerbate pre-existing ones.

It seems probable that JW's drug use was intermittent, perhaps due to

a lack of a substantial income to buy drugs on a regular basis or to his relative social isolation. It is likely that his admitted use of cannabis would have been likely to exacerbate his psychotic state.

What is also clear is the need for increased staff awareness of the potentially deleterious effects of drugs like cannabis on individuals with mental health problems; the Risk Assessment training that has been organised by the Trusts involved in JW's case includes in its content the impact of drugs on mental state and on prescribed medication.

Accurate assessment and planning is unfortunately made much harder when the informant either conceals the facts or under-represents their use of drugs. This may have been the case with JW. It is possible that the reason JW refused a blood test was that he thought the test would have shown the presence of illegal substances. The Panel has, however, no objective or corroborative evidence to this effect. When JW was interviewed after the homicide he was extremely unwell mentally, and the accuracy of his recall may be questionable.

Use of illicit drugs is not a criterion for compulsory admission under the Mental Health Act 1983. Thus in the view of the Panel, because the care team saw no deterioration in JW's mental state and behaviour, it would have been very difficult to justify compulsory admission to hospital even if they had good grounds for believing that JW was abusing illegal substances since such use would not, in itself, constitute grounds for compulsory admission.

Recommendation 9

The Panel endorses the recommendation of the internal Inquiry Report that staff should receive regular training on dealing with patients who use illicit substances to include the impact of such use on the patient's mental state and on the uptake of prescribed medication.

CHAPTER 13 RISK ASSESSMENT AND RISK MANAGEMENT

Panel Comment: the concept of risk assessment in clinical practice

In the 14 years since the Department of Health Circular HSG(94)27 instigated as routine the practice of establishing independent Panels of inquiry following homicide committed by people who were under the care of mental health services, numerous inquiry Panels have been asked retrospectively to consider the same important questions. Principal among these is the question of whether those professionally involved in the care of the perpetrator were cognisant of (and, if so, whether they properly considered and acted to mitigate, so far as they were able) factors which might reasonably have been anticipated to increase the risk that a potentially fatal act of violence would occur.

Following criticism that insufficient scrutiny may otherwise be applied to structural and organisational aspects of risk management, including the inevitable implications of finite resources, it has now become accepted practice also to examine actions and decisions taken by individuals in the context of the guidance and instructions provided by the organisations and agencies within which they functioned.

Recent commentators introduce a further level of contextualisation; that of the prevailing political climate associated with risk in general and in particular those risks which may be associated with mental illness. This is important because it will inevitably shape, not only the approach taken by organisations and individual mental health professionals in delivering care, but the deliberations and judgements of the inquiry Panel members who subsequently look into how that care was delivered. Within this context must be balanced a recognition of the other obligations placed upon the individuals and organisations involved in the care of the patient, primarily the requirements to meet the needs of the patient within the 'least restrictive' environment (consistent with their objective risk to self or others), to promote independence and self-determination, and the tension that may sometimes exist between such imperatives and that of risk minimisation.

Above all, inquiries are entrusted to look into the care and treatment of the individual patient; to identify examples of good practice as well as any deficiencies. This is what we have attempted to do. In this endeavour we have been keenly aware of the dangers inherent in the process of retrospective inquiry both in the Panel's own deliberations and in how our comments may be understood by the reader. While this is true of all aspects of our task, it is of particular concern in the area of risk assessment and management because of the human tendency to assume causality when events are seen to occur in a sequential way, and to look for explanations for and to identify things

that might have been done differently in order to prevent a calamitous event.

We have sought to find a way which would best render the parameters of clinical risk assessment comprehensible to the lay reader. In so doing, we have looked at how other Panels have approached this same problem and have found ourselves re-reading the full and lucid discourse by the Independent Inquiry into the Care and Treatment of Mr Anthony Hardy. While the individual personal circumstances involved in the Hardy case are very different from those associated with JW and his grandmother, the principles applied to the assessment and management of risk are of course fundamentally the same. We do not consider that we can improve upon the exposition given by the Hardy Inquiry Panel. We therefore here take the liberty of quoting that report, verbatim and at some length:

“Risk assessment in mental health care aims systematically to identify the risks of adverse outcomes, to the patient and others. The risks thus identified should be incorporated into a management plan, the main purpose of which is to minimise the likelihood of adverse outcomes occurring. Four observations crucial to risk management are summarised below.

First, while unsystematic, inadequate or flawed risk assessments may not increase the risk of adverse outcomes, satisfactory outcomes cannot be guaranteed even with detailed management plans based on thorough and appropriate risk assessments. In other words, a tragic outcome is not necessarily indicative of unsatisfactory risk management.

Second, in a retrospective review of the management of risk where very serious outcomes have occurred ... care must be taken to avoid placing too much reliance on the benefit of hindsight. Looking back, from the position of 100% certainty of an adverse event, is liable to distort the analysis of the actions that were taken before the adverse outcome occurred.

... the third important observation concerns the prediction of any rare event. In medicine in general, and in the social or behavioural sciences in particular, it is hardly ever possible to make predictions with absolute accuracy. No matter how sophisticated the method of prediction, there is always a margin of error, usually expressed in terms of ‘false positives’ (those predicted to have a particular outcome but in whom that outcome does not occur) and ‘false negatives’ (those who experience a particular outcome despite not to be at risk of that outcome). It is a property of all predictive tests that there is an inverse relationship between false positives and false negatives: if a test is designed to minimise the rate of false positives, the rate of false negatives will inevitably rise. This applies to a

putative test to predict future homicide: ideally, such a test should have as few false negatives as possible, in order not to miss any individuals who are likely to commit homicide. If a particular outcome has a very low prevalence rate (that is, rate of occurrence), as is the case for homicide committed by people with mental health problems, prediction becomes extremely unreliable because of the rate of false positives. The Confidential Inquiry into Suicides and Homicides reported that 9% of homicide perpetrators had been in contact with Mental Health Services during the 12 months prior to the homicide. Using other data from the Confidential Inquiry, it can be estimated that approximately 30 people convicted of homicide in 2001 had had an inpatient admission in the preceding 12 months. Assuming that a test to predict future homicide were available and was nearly perfect, such a test could successfully identify all individuals likely to commit homicide; but for every one of these individual correctly identified, there will be 218 people whom the test incorrectly identifies as likely to commit homicide but who do not do so (false positives). In practice, very few predictive tests perform this well, so that for each person correctly identified as likely to commit homicide, the number of people incorrectly identified as likely to commit homicide will be even greater than 218. To reiterate, this is an intrinsic property of any predictive test which aims to predict rare events.

The calculations above assume that there is a valid and reliable predictive test for homicide among those in contact with Mental Health Services. In fact, no such test exists. However, the figures clearly show that were such a test available, it would have very limited value even at its best. This is because of the fundamental problems inherent in predicting rare events, and cannot be overcome by enhancing the skills or training of mental health professionals or others...

... It therefore remains extremely difficult to predict future homicides. This is not to say that all homicides are unpredictable, but the majority remain so. This is confirmed by the Confidential Inquiry into Suicides and Homicides, which found that among those people who had been in contact with Mental Health Services prior to committing homicide, very few had been predicted as at high risk of committing homicide at their last contact with services.

Nevertheless, despite these limitations, or more particularly because of them, it is essential for mental health professionals to carry out rigorous risk assessments and formulate thorough risk management plans, because only in this way can the risks of adverse outcomes be minimised."

It follows that risk assessment is an essential part of everyday clinical practice and is fundamental to good practice in undertaking the examination and review of a patient's mental state. Although it will always be the case that clinicians use their expertise and judgement to consider risk, this is frequently not explicitly recorded in the form of a 'risk assessment'. Sometimes the clinical risk assessment will be more explicitly recorded and this is particularly the case when clinical staff weigh information and record decisions regarding certain courses of action - for example consideration of the use of compulsory powers. Additionally, it is common that clinical teams are required to document information regarding perceived risk at particular points in a patient's care pathway. For this reason, we divide the rest of our commentary on this subject into (a) discussion of the risk assessment undertaken in support of the clinical decision-making in the context of particular situations posed in the case of JW (including examination of the factors which were, may or should have been known by the services working with JW at Christmas 2004), and (b) that which was produced to meet organisational requirements.

Risk Assessment in Clinical Practice

During the period of JW's involvement with mental health services prior to his grandmother's death, consideration was given on four occasions to the use of powers under the Mental Health Act 1983 to require him to remain in hospital.

In summary, the grounds for compulsory detention under the Act are:

1. That the patient is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment/treatment.

AND

2. That the patient ought to be so detained
 - i. in the interests of the patient's own health;
 - ii. in the interest of the patient's own safety;
 - iii. with a view to the protection of others.

The Panel has considered, in detail, the clinical risk assessment associated with events from August 2004, when concerns were first raised that JW might be relapsing, to DG's death on 26 December 2004.

Ms E's notes record that DG was expressing concern that JW was not as well on his return from his holiday to Spain as he had been before he left:

“says ... he is not as well as he could be, he seems to be slipping back to how he was when he was becoming unwell, refusing to take medication as he does not believe he needs to take it ... he is ... distracted, with a slight edge to him” (16 August).

DG requested that Ms E visit the same day due to these concerns, DG was going away for a few days to stay with other members of the family. Ms E responded by discussing the concerns with Dr B and arranged an ‘emergency’ outpatient appointment for 19 August. She visited JW at 4.30pm on the same day. DG was present. Ms E thought that JW seemed less well; in particular, she noted that his conversation seemed limited and that he appeared distracted as if he were experiencing hallucinations (though he denied this) and that he seemed to have ‘a slight edge’. DG remarked that JW was up at night and sleeping during the day. He was spending all his time watching the TV and listening to music at high volume, which DG said is how he had behaved when he was becoming unwell before. Ms E noted that, although DG kept switching off the TV and music during her visit, JW kept turning it back on. He conceded that he had ceased taking his medication on a regular basis. He said he was not sure whether he would attend the outpatient appointment Ms E had arranged for him.

Ms E was due to be away from the office until 26 August. Mindful that DG was also about to go away for a brief period, she discussed contingency plans with DG and JW and gave them details of the on-call arrangements. She also discussed the case with colleagues and made notes of the current concerns, appending (with her permission) DG’s mobile telephone number to the file so that she could be advised if there had been any emergency intervention. DG said she would make arrangements for another relative to bring JW to the clinic for his appointment.

On 19 August JW was brought to the outpatients appointment by two cousins. He was seen by Dr B and Mr G (ASW). Dr B records

“Relatives worried. ... stopped taking his medication at least 2/52 ago ... feels he is not ill.

Not wanting to mix. Some self neglect. Not going out. Flat dirty.

Not getting up till late.

Poor food intake – losing weight.

Reasonably well kempt. Good rapport. Good eye contact.

? slightly elated subjectively.

Laughing inappropriately.

No insight at all.

Speech – slow to articulate ... somewhat suspicious.

Denies self harm/ suicidal ideation”.

Dr B discussed the situation with his supervisor another consultant psychiatrist. He then noted

*“not sufficient grounds for MHA yet
close monitoring
to see (Dr C) next Monday at 4.30pm.”*

An accompanying family member promised Mr G that she would check that JW had food at home when they took him back. Mr G arranged to visit the following day.

On Friday 20 August, Mr G visited JW at his flat. JW was slow to open the door but then showed Mr G in. Mr G noted that the flat was very tidy and JW agreed that he had had a recent clear up. Mr G's detailed notes describe the conversation which developed during the visit: this consisted largely of JW describing his philosophical ideas about the importance of light and colour; positive and negative numbers and how these things could give him the answer to everyday problems. It was more difficult to engage him in conversation about purely practical matters. However, the matter of his sickness certificate came up and Mr G rang the GP surgery to check when it was due to expire and to arrange its renewal. Although from Mr G's notes it is clear that he thought JW might be beginning to relapse, he concluded

“There was no risk apparent at present to warrant further/extra concern at the moment.”

He reminded JW of the need to attend outpatients to see Dr M on the following Monday. Mr G filed a detailed Crisis Alert to the Crisis team on duty over the weekend.

Panel comment

The assessment of JW on 19 August was not recorded as a formal assessment under the Mental Health Act. Dr B was not registered to act as a Section 12 approved doctor and no Section 12 approved doctor saw him on that day. Dr B consulted with the supervising consultant on-call that day (who was approved under Section 12 of the Act) and took his advice. He also involved Mr G who was on duty that day in the broader remit of duty worker for the community mental health team. Mr G took the view that he had not been asked to undertake an assessment as an ASW. We think this a rather fastidious distinction – had he sufficient concern to believe that a formal Mental Health Act assessment was required he would have been quite entitled to assert his professional view – but we accept that Mr G's actions were reasonable and were proportionate to the prevailing clinical view in that neither he nor Dr B (with the benefit of the supervising consultant's advice) believed there to be sufficient grounds to warrant JW's compulsory detention at that point. We note that Mr G was commendably assiduous in following the matter up personally the following day and in ensuring that a contingency plan was available over the weekend.

Dr B saw JW in the outpatient clinic on 25 August. JW was accompanied by DG and his cousin. It is evident from Dr C's letter to JW's GP that he conducted a very full and detailed mental state examination. JW was evidently exhibiting some signs of deterioration in his mental state in that his thinking was described as *'somewhat tangential and circumstantial'* and he seemed preoccupied. However, when asked about his beliefs JW denied any delusional ideas. JW was convinced that he was not unwell, did not need to take medication and that medication was harmful to him.

He confirmed that he had ceased to take his medication. Dr C clearly tried very hard to persuade JW to resume his treatment, offering to change the nature of the prescription if JW was finding it unsuitable, but JW would not agree.

Dr C considered risk associated with JW's presentation at the time. JW was not expressing delusional beliefs. In response to direct questioning he denied any thoughts of self harm or thoughts which might cause him to harm others:

'he guarantees his own safety as well as everyone else's'.

'...he is not presenting a danger to himself or others. He would not meet criteria for admission under the Mental Health Act. I assessed the risk for suicidal and violent behaviour and it's low but risk could increase if his condition deteriorates substantially further.'

Dr C gave advice to both JW and DG about probable relapse indicators and urged them to contact him if they had concerns about relapse. He discussed other coping strategies with JW such as the use of cognitive techniques. He discussed the crisis plan with JW and his family. Dr C notes that DG was in agreement with the treatment plan but made it clear that she would prefer it if JW would agree to take the medication. Dr C made a further appointment to review JW on 8 September

Panel comment

We have looked at whether Dr C, Dr B and Mr G paid sufficient attention to the first ground for compulsory admission; namely "*That the patient ought to be so detained in the interests of the patient's own health*". While on the one hand there were clear signs of deterioration in JW's presentation, it should be remembered that he was a young man who had thus far only a single admission to hospital. On balance, we consider that it was appropriate in the circumstances to take the approach of attempting to engage and to work with JW's co-operation while continuing to undertake frequent reviews of his mental state.

On 26 August Ms E returned from leave and visited JW at home. She noticed that, in contrast to his previous behaviour, he would not make eye contact with her. He seemed edgy and '*slightly paranoid*'. She felt uncomfortable to be with JW and cut short her visit, leaving after about fifteen minutes. On her return to the office, she discussed her concerns with the team manager, Ms H. Ms H suggested that Mr G accompany Ms E on her next visit which he agreed to do. Mr G issued an alert to the crisis team to confirm the crisis plan outlined the previous day by Dr C.

Ms E spoke to DG who said she thought JW's behaviour had deteriorated over the last 24 hours. There was discussion about what support would be available over the forthcoming Bank Holiday weekend, and Ms E confirmed that the crisis team were aware of DG's concerns. Ms E's next scheduled visit was set for 1 September.

At this point Ms E's involvement ceased. We have discussed elsewhere in this Report the abrupt cessation of Ms E's involvement and the range of explanations we have received. We were told that Ms D and Mr G visited JW on 1 September.

Panel comment

Although we are satisfied that JW was seen on 1 September, there appear to be no notes of this visit.

On 8 September JW was brought by DG to the outpatient clinic for his appointment with Dr C. Ms D was also present. Dr C noted some evidence of further deterioration in his mental state and functioning, and DG also reported deterioration in that JW was becoming more isolative and more preoccupied.

Dr C noted,

'He has a history of mood disorder with psychotic features. Symptoms have recurred after stopping medication. He is having a slow decline in his interpersonal functioning. Thus far though he has been able to maintain safety and basic standards of hygiene. I assessed the risk for suicidal and violent behaviour and it's currently low but the risk can increase if his condition deteriorates further.'

JW continued to refuse medication of any kind. He said he thought he was getting better. As before, crisis and contingency plans were discussed. The views of DG and Ms D are not recorded.

Dr C concluded:

'Currently he is not a candidate for inpatient admission or Mental Health Act assessment. However, with further deterioration this may become necessary.'

Panel comment

Dr C's concluding remarks may be read as implying that he was solely applying a criterion of risk of harm to self or others as the grounds for detention under the Mental Health Act. Because we were not able to interview Dr C, we were not able to ask him about the basis on which he might have been prepared to make a medical recommendation for JW to be admitted in the interests of his own health. From reading Dr C's notes, there is a sense that further deterioration in JW's mental health would be inevitable. We think that at this point, this could have been used as an argument for detention. Equally (though albeit with the active intervention of DG) Dr C was managing to maintain a relationship with JW and may have been concerned to maintain JW's engagement and may have felt that his future engagement would be jeopardised by too precipitate an intervention.

Recommendation 10

That the Cambridgeshire and Peterborough Foundation Trust, the West Norfolk Primary Care Trust¹ and the Norfolk and Cambridgeshire Local Authorities provide training during professional induction, together with regular refresher training, to ensure that relevant professionals (primarily psychiatrists and ASWs, but also those undertaking Care Coordinator functions) are reminded about the criteria for compulsory admission and are acquainted with current best practice guidance.

We consider a two month follow up appointment offered by Dr C to have been too remote in the context of his continuing concerns.

Ms D documents three unsuccessful attempts to see JW over the course of September. Judging by a letter of appointment sent to JW, there may have been a further attempt to see him but the outcome is not documented. On 7 October she spoke with DG who *'confirmed that J is currently stable mentally'*. She booked an appointment with DG to see JW on 27 October and sent a letter to JW.

Panel comment

The Panel is concerned that Ms E was removed from involvement at a moment of incipient crisis for JW and his carer. Her continued involvement might have made it easier to chart change in JW's presentation and this could have added much valuable information in assessing JW's risk and threshold for readmission. Of course it should be possible to argue that this continuity was present through the involvement of Ms D; however, we cannot be certain about when (or indeed whether) she saw him during the period of Ms E's involvement. Ms D's last documented contact with JW had occurred in March 2004. Aside from the joint visit with Mr G and the outpatient appointment on 8 September, documented by Dr C, we cannot be confident that she had face-to-face contact with JW again until after he was readmitted to hospital in October.

Whereas Ms E was visiting JW weekly (or more frequently in response to presenting need), Ms D's contact seems to have fallen into a pattern of attempting to establish contact on a monthly basis. While this level of contact was in accord with the care plan, she was apparently unsuccessful in her attempts at visiting JW. This did not result in a reappraisal of the care plan.

Ms D also appeared to place greater dependence on DG to monitor JW's mental health. Given the level of concern prevalent at the beginning of September when Ms E was withdrawn, in the opinion of

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

the Panel that this level of professional input was insufficient in the circumstances effectively to monitor JW's need and risks associated with a probable deterioration in his mental health. Failure to gain access to JW might have served to heighten concern but did not seem to do so.

It is not acceptable that no records were available to us of any contact Ms D may have had with JW between March and October 2004. In terms of regular monitoring of his mental state we are left to depend upon evidence from Dr C's reviews when JW attended the outpatients clinic and the detailed records of Ms E. As the professionally qualified Care Coordinator, Ms D was supposed to be taking an overview of JW's care and any risk issues. Ms D insists that she made entries in the CMHT notes of all her contacts. Were this the case, it is reasonable to suppose they would appear interspersed with the contemporaneous notes kept by Ms E and others. Thus we find Ms D's assertion, that entries were made, unconvincing.

We find the supervision arrangements in respect Ms D to have fallen below a good standard of clinical practice in that the failure to gain access to JW did not prompt reappraisal of the care plan and in that the absence of recording by Ms D was apparently not noticed.

We are concerned to have been given contradictory attributions for the decision to terminate Ms E's involvement with JW. We did not hear from any witness who said that they had made that decision. While we cannot know what lies behind these differing accounts, we think it essential that clarity is achieved as to whether the responsibility for decisions to involve or withdraw support workers resides with the team manager, with the Care Coordinator or elsewhere.

Recommendation 11

That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust institute a rigorous system of review to ensure that multi-disciplinary notes are maintained to a satisfactory standard in terms of the timeliness and quality of written entries.

Recommendation 12

That the Cambridgeshire and Peterborough Foundation Trust institutes a system to monitor frequency of contact with patients and that concerns arising from difficulties in establishing contact (such as a pattern of missed appointments) are automatically brought to the attention of the team manager.

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

Recommendation 13

That the Cambridgeshire and Peterborough Foundation Trust ensures that decisions to involve or to withdraw the involvement of support workers or other non-qualified staff in the direct care of patients are endorsed, in writing, by the team manager.

Panel comment

Ms D and Mr G both appeared to believe that the other was to record the visit of 1 September and this was not done.

In discussing contingency plans, DG does not appear to have been recognised as JW's 'nearest relative' and advised of her right to request a formal assessment of JW's mental health under the Mental Health Act 1983. We think that there were at that time reasonable grounds to have adjudged that DG was fulfilling sufficient caring responsibilities to be identified in this role. We discuss this further in the chapter on Recognition of and Support for Carers and Families.

On 24 October JW was arrested for an alleged assault on a neighbour and alleged criminal damage to the neighbour's front door. JW was then assessed in police custody by the out-of-hours Section 12 approved doctor, police surgeon and out of hours Approved social Worker. As a result of their assessment, he was readmitted to hospital under Section 3 of the Mental Health Act. Both doctors agreed that he should be so detained on all three grounds for detention (ie, in the interests of his own health; risk to self; risk to others). They noted,

He is currently suffering a relapse of his psychotic illness characterised by paranoia, possibly ideas of being controlled, ideas of thought withdrawal and persecution by his neighbour'.

JW refused informal voluntary admission. He was considered to be a particular and ongoing risk to the neighbour. JW was made subject to Section 3 of the Mental Health Act 1983 and was readmitted to the Fermoy Unit.

Panel comment

We have been unable to establish what happened in relation to the prosecution of JW for these alleged offences. It is our supposition that the matter was dropped, either in response to his compulsory detention or later, as a result of the homicide.

On 28 October JW was absent without leave from the ward. Dr C discussed JW with staff and reviewed his notes. Dr C summarised JW's week and concluded his entry in JW's notes thus:

"Impression:

- 1. Persistent psychotic state affecting health, function and safety*

2. *Poor medication compliance*

3. *Poor insight*

Not safe to be managed on this unit. Recommend transfer to secure unit to prevent escape behaviour”.

At 21.40hrs, JW was brought back to the ward by the police having been picked up in March. He appeared to have been drinking and was reported to have been incontinent of urine in the police van. He ‘begged’ to be allowed to accept oral medication but was instead restrained with the assistance of the police and intramuscular medication administered by injection. He afterwards explained that he had run away to see a friend from Top of the Pops. JW was managed overnight in the ECA.

JW remained in the ECA until a decision was taken at the ward round on 1 November that he could be given a trial on the main ward. Dr C noted that should he attempt to escape a transfer to a secure unit would be indicated. Later the same day, JW did attempt to leave the ward and physical intervention was required to prevent this. He was also suspected of spitting out his medication. JW was returned to ECA. He was said to be very unhappy about this and eventually managed to negotiate his return to the main ward where he was managed on one-to-one observation. He was noted to be extremely restless but was maintained on the ward. He was briefly returned to the ECA after refusing medication.

On 4 November JW forced his way out of the ward by kicking his way through the doors. He fled the ward with staff in pursuit, then ran back onto the ward before immediately running away again. He was picked up outside of the unit by police and brought back to the ward. He was said to be ‘extremely agitated’ and was managed on the ECA. He continued to refuse lorazepam. JW was seen by Dr C who noted his continued irritability,

‘if continued escape or other behaviour problem consider transfer to a more secure unit’

JW continued to be cared for on the ECA. On the morning of 10 November JW expressed thoughts of ‘smashing the place up’ but was dissuaded by staff. It appears that he was frustrated by a lack of money to purchase cigarettes. The following day Dr C reviewed him and decided that he could spend more time on the open ward (though he would continue to be cared for in the ECA).

JW became more relaxed and compliant over the next few days. By 15 November he was considered settled enough to be taken to off ward activities and was taken on a bowling trip which he enjoyed. He was maintained on fifteen minute observations while on the ward. It was noted that he was anticipating that he would be discharged within the week.

On 18 November, Dr C saw JW in the presence of nursing staff, his care-coordinator and DG. JW had been on Section 17 leave and was far more settled and amenable and had decided to withdraw his appeal against his detention. He reported feeling

better and felt better able to deal with problems. *“Denies suicidal and violent ideation”*. With the agreement of both JW and DG it was agreed that he could have a further short period of Section 17 leave to stay with DG.

JW returned from Section 17 leave on 22 November and was seen by Dr C and the full clinical team. DG was present. Apart from some difficulties with side effects from the medication, it was agreed that his leave had gone well. Dr C questioned JW and DG about whether violence or self harm had occurred and was reassured that she had no current concerns. He also questioned JW about any suicidal or violent thoughts and JW assured him he had no such thoughts.

“Assessed for risk of suicidal and violent behaviour and it is low for the foreseeable future”

JW was discharged with a care plan and crisis plan which was discussed with JW and DG. Dr C planned to see him within a few days and prior to his next depot injection which was due a week later. Ms D, Care Coordinator, was to have fortnightly contact and duly saw him at home on 25 November. She went over the care plan again with JW and DG.

JW was seen again by Ms D on three further appointments prior to his arrest. At no point was any substantial concern noted. In her last entry of 15 December she notes that JW was *“mentally stable”*. Her normal weekly contact was, by agreement, cancelled for the Christmas week and they were next due to meet on 29 December when JW’s depot injection was due.

Panel comment

Dr C’s entries on the ward notes over JW’s second admission demonstrate careful attention to the potential risks associated with JW’s presentation. He demonstrated evident concern of imminent risk associated with escape from the ward when in an overtly psychotic state.

As Dr C was unavailable for interview, we were not able to ask him why the initial plan to transfer JW to a secure unit was not fulfilled despite further attempts to break out of the unit and evident concern about imminent risk of harm in these circumstances. We comment further on this decision in Chapter 9.

In any event, by the third week of November, the perceived risk had diminished sufficiently for JW to be granted leave to stay with his grandmother. This leave was successful and was extended by mutual consent. A week later he was discharged. Dr C’s notes of the discharge meeting again demonstrate his attention to the views of others and care in considering and documenting possible risk. JW’s risk was seen as being associated with poor mental state typified by delusional beliefs and paranoia. At the point of discharge, the overt symptoms of his mental illness were seen as being in abeyance; he was seen as insightful, co-operative and well engaged with services.

As a result, the degree of risk he was thought to pose had dramatically reduced to 'low' in the estimation of his RMO.

We were asked by DG's family to investigate whether there was any pressure to discharge patients ahead of the Christmas holidays and, if so, whether this might have led to JW being discharged earlier than would otherwise have been considered ideal. We examined this question carefully with all relevant witnesses and considered information they gave us regarding staffing within the Fermoy Unit over the Christmas period. We were unanimously told that there was no pressure to clear beds and we accept that evidence.

One might also question whether it was reasonable to assume that so complete a recovery could be achieved in less than one month and whether a more cautious approach, involving greater use of a prolonged period of Section 17 leave, would have been a more prudent course. We think that the decision to discharge JW was taken in a properly considered way. There is evidence of good planning of his aftercare and regular review. The personal review by both the RMO and Care Coordinator within seven days of discharge meets the standard laid down as guidance by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness that face-to-face follow-up should occur within seven days of discharge. Both JW and his principal carer DG were well engaged with the aftercare plan. When, on one occasion, JW did forget to attend for his depot, this was immediately noticed by Ms D and she acted promptly to resolve the matter. JW appeared to demonstrate good compliance with medication and to be concordant with his treatment plan. It appears that DG expressed no concerns about him to Ms D or to Dr C.

Despite the dreadful events which occurred just over one month later, we have not found any substantial evidence in the contemporaneous record which should have suggested to the clinical team looking after JW that a deterioration had occurred in his mental state during December 2004. On this basis, and with the knowledge that both JW and DG were aware of how to obtain help in a crisis, Ms D's decision to postpone her weekly contact with JW until the New Year week does not appear inappropriate.

In evidence we were told that JW spent Christmas day with his extended family and seemed to be content and even slightly more forthcoming than usual. He spent some time playing with the young child of the family. With the benefit of hindsight we can say that it is probable that was concealing his delusional ideas and concerns, but that was by no means evident at the time. It seems that among those who knew him best, his immediate and extended family, nobody noticed anything particularly unusual or alarming in his behaviour.

Formal 'Risk' documentation

In the following section we deal with the formal and institutionally-required recording

regarding assessed risk that was included within JW's care planning record.

The initial formal 'Risk Assessment' document appears in the notes of JW's first hospital admission.

The document is undated and unsigned; however, events referred to in the document would suggest that it was completed on or about 24 January 2004. We think it probable that it was completed by a nurse at the Fermoy Unit, and because of the sense of immediacy it conveys and the plan to detain JW under the emergency provisions of Section 5(2) of the Mental Health Act, we think it very likely that it was completed immediately after the occasion when JW forced his way out of the unit.

The form on which the document has been completed itself appears to be draft document and is marked 'version 1'. Some of the phraseology is ambiguous and does not serve to assist the person recording the risk assessment. In places, the actual form is incomplete which further suggests that a draft document was used.

Some sections - such as that in which the author is required to summarise the nature of the risk or asked to identify factors which would reduce risk – have been left blank; other sections have been completed in an exceptionally brief manner.

JW is described as at risk of causing *'harm to himself and others if he was out of the ward'*; *'aggressive verbally towards staff'*.

JW's lack of insight and *'psychotic behaviour'* are cited as factors likely to increase risk. There is reference to him having broken the door to Churchill ward.

The risk reduction strategy outlined is to keep him on the ward in order to complete the assessment; use *'medication to calm him down'* and *'put him on a section 5(2)'*.

The document ends with a page 'risk summary' comprising a mixture of free text and 'tick box' responses which has been completed as follows:

1. Risk Summary (free text)
left blank
2. Seriousness
'extreme' (life threatening, catastrophic outcome)
3. Likelihood
'probable' (more likely than not to happen)
4. Immediacy
'immediate'
5. Manageability (extent to which risk can be reduced)
'substantial'
6. Uncertainty (how sure are you about the assessment?)
left blank
7. Brief summary of risk management plans (free text)
left blank

Panel comment

The degree of concern demonstrated in the document calls into question the decision to manage JW at the Fermoy Unit rather than transferring him to a PICU when the behaviours likely to give rise to risk continued and were not fully contained on the open ward. We discuss this matter fully in Chapter 9.

The second formal risk documentation is in the form of a 'Risk Screen' recorded as part of JW's CPA Care Plan on 31 March 2004 and the same document completed in the review of the care plan on 8 September 2004. On both occasions the documentation was completed by his Care Coordinator. Unfortunately, the two sets of CPA documentation have become conflated in the notes made available to the Panel such that it is impossible to distinguish with complete certainty on which of the two possible dates either checklist was completed. In both cases the form is signed by Ms D, but is undated.

In one version, which we presume may have been completed during March, the Care Coordinator indicates that there is no known history of 'significant violence' and no current concerns indicating a risk of violence. She notes the main risks as being associated with inadequate accommodation, recent discharge from hospital, living alone and mental illness.

In the other, which we presume to have been completed in September, the Care Coordinator highlights the following risks:

'he has a history of aggression when under the influence of illicit drug use';
'has a history of illicit drug use and this may still be the case';
'has been difficult to assess because he has disengage (sic) with services;'
'has been isolating himself';
'is able to (shop/cook/look after self) but has not been doing so appropriately;'
And selects items which suggests that JW is *'At risk of self neglect/failure to look after himself;'*
'vulnerable to abuse or exploitation';
'is in poor physical health'.

Panel comment

The risk checklists are intentionally brief documents intended to identify 'headline' issues within the Care Plan. In completing the documentation the author (usually this is a task that is undertaken by the Care Coordinator) is recording the collective opinion of the clinical team as expressed in the care planning meeting.

It is unclear to the Panel what might have led the Care Coordinator to conclude that JW had a significant history of violence when the risk checklist was completed on (we assume) the second occasion, having not drawn this conclusion when she first completed the form. JW had assaulted a nurse, thrown a soft drink over his mother and damaged the ward by breaking out of the unit during his first admission. With the

exception of the assault on his mother's partner which was alleged to have occurred in July, there were no significant episodes of reported violence or aggression between the two relevant dates. From the evidence, before us it seems possible that the Care Coordinator was at that time unaware of the assault on JW's mother's partner. It seems likely that the fuller description of risk contained in (what we presume to be) the review documentation reflects the greater knowledge of JW which the clinical team had by then developed.

It is evident that a clear association was made by the team between JW's risk of aggression and his use of illicit substances. The possible effect of his mental illness on his behaviour is not elaborated upon within the risk checklist; however, the importance of encouraging JW to continue with his maintenance medication is stressed elsewhere in the care plan.

The reference to poor physical health is not readily explicable and may represent one of the hazards of the 'tick box' system i.e. that items may be accidentally selected (or omitted) - as apparently happened in this case.

A 'Risk Assessment Review' was undertaken on 18 November 2004 as part of the process of planning JW's discharge from his second admission. The authorship is unknown as the report is unsigned. We think it is probable that the document was completed by a nurse at the Fermoy Unit. The document identifies the nature of the risk as follows,

'recent risk was that he had stopped his medication, relapsed without insight and attacked a neighbour. While psychotic he was an absconsion risk'.

The author concludes that the risk appears to be resolved with JW's acceptance of the need for medication and agreement to accept Risperdal Consta. It is intended that the risk review will be repeated in a month. JW and DG are noted to be in agreement with the plan; *'now denies suicidal or violent ideation and agrees to be concordant with medication'.*

Panel comment

This risk assessment review, though brief, appears to identify the salient factors at the relevant time - particularly the potential influence of the active symptoms of JW's psychotic illness, then considered to be in remission, upon his actions.

Panel comments on risk documentation

During the period that JW was under the care of mental health services, three different formats were used to draw together summary information regarding risk and risk planning. Only the first is identified as a 'risk assessment'. One of the forms used for the 'risk checklist' appears to have been a draft document. It is not clear whether this should have been in use at all. We consider that it would have been

preferable to have a single document rather than a range of very similar documents.

Recommendation 14

That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust ensure that a single format risk tool (linked to CPA documentation) is used within each Trust.

It is striking that risk reports were frequently unsigned and lacked a clear date to indicate when they were completed, despite both authorship and date being clearly required by the forms. It is not evident from the documents what expectations existed at the time about who should complete the various forms, when they should be completed nor when a more comprehensive evaluation of risk should be undertaken.

Since risk comprises both static (historical) and dynamic elements it is vital that all risk documentation is dated as it is pertinent to the factors known and identified at a given time. In these respects the standard of recording both at the organisational, team and individual level fell below acceptable standards.

Recommendation 15

That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust develop standards for basic requirements for recording inpatient notes and develop and employ a system regularly to audit compliance against these standards and that entries must be readily attributable to a named author and the date (and, in the case of daily entries, the time) are clearly recorded.

We acknowledge the work that the Trust has already done to improve knowledge and practice in the area of risk assessment. We recommend action to be taken so that the Trust can be assured that adequate standards are maintained. Although we are critical of the often rather perfunctory way in which it appears that risk information was recorded, in this case we are satisfied nevertheless that significant risk factors which were and could be known by the clinical team were properly considered by them. We consider that a comprehensive or better recorded risk plan is unlikely to have led to the clinical team taking a different view of risk evident at the point of JW's second discharge from hospital and in the period immediately following the discharge, or to them taking different action.

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

CHAPTER 14 RECOGNITION OF AND SUPPORT FOR FAMILIES AND CARERS

Panel comment

In this chapter we consider the contact between those offering support for JW and the mental health services, and the extent to which services engaged with the informal carers and the quality of that engagement. As it is apparent that DG rapidly became established as the principal carer for JW, we focus in particular on the contact between DG and mental health services.

The Carers Recognition and Services Act 1995 places a responsibility on the Local Authority to consider the needs of carers of persons entitled to be assessed for services under the National Health Service and Community Care Act 1990. A carer is defined as someone who 'provides, or intends to provide, a substantial amount of care on a regular basis' to that person.

Section 1(1)(b) of the Carers Recognition and Services Act states

'the carer may request the local authority, before they make their decision as to whether the needs of the relevant person-call for the provision of any services, to carry out an assessment of his ability to provide and to continue to provide care for the relevant person; and if he makes such a request, the local authority shall carry out such an assessment and shall take into account the results of that assessment in making that decision.'

JW was entitled to be assessed to receive community care services. After his second admission he also became entitled under Section 117 of the Mental Health Act 1983 to receive statutory aftercare services.

It is clear that DG provided 'substantial care on a regular basis' to JW from his first admission until the time of her death. Although JW also received support from other members of his extended family, DG was quickly recognised as his principal informal carer.

It should be noted that although the emphasis in the quotation from the Act cited above is on the carer requesting services, it is generally held to be good practice for mental health care agencies to pre-empt the need for such a request by offering such an assessment. This is undoubtedly the basis on which Ms D suggested a carer's assessment to DG on 25 November 2004.

Other duties relating to carers exist under the Mental Health Act 1983 and the Code of Practice to that Act. We consider below how these duties were discharged at various points in the chronology.

As well as considering the discharge of statutory responsibilities incumbent on services we consider that which would have represented good practice in respect of delivering care to JW. It should be understood that, while the active engagement of carers in planning the care of patients is generally considered good practice, the sharing of information with carers is always subject to the rules regarding patient confidentiality: in normal circumstances personal clinical information may only be given to others with the express consent of the patient. It is therefore important to state that we found no indication that JW had ever refused permission for any aspect of this care to be disclosed or discussed with DG.

On JW's first known presentation to psychiatric services in January 2004, he was brought to Accident & Emergency by his mother and another family member. The duty SHO who interviewed them took careful notes regarding JW's social circumstances, including his mother's move to Spain in April of the previous year, JW's failed attempt to share a house with his elder brother, and the report that his brother had moved out of the shared accommodation because he could not cope with JW's behaviour. The SHO noted that for the last month JW had been living with his grandmother in Wisbech and that all the family were becoming concerned about bizarre ideas he had started to express. His mother had temporarily returned from Spain and was also staying with DG. At the conclusion of the assessment, and after discussion with the consultant psychiatrist, the duty SHO discussed the plan to refer JW for an outpatient appointment the following morning with JW and his mother and gave them details of the crisis team should the need arise.

The following day JW was brought to his outpatient appointment by his mother. Dr B noted that JW was very argumentative towards his mother and appeared to have bizarre ideas about her: *'asked mother if she has been jumping inside him and listening through his ears'*.

Initially JW was admitted informally to the Fermoy Unit and remained as a voluntary patient for five days. It appears that he was persuaded by his mother and DG to go into the hospital to allow blood tests to be taken. He thought, and as it seems encouraged in the belief, that these tests would demonstrate the veracity of his beliefs that he was adopted and had a twin sister.

Panel comment

JW's family went along with his beliefs that the existence of a twin could be established by blood tests and used this as a ploy to persuade him to attend hospital - which he was otherwise unwilling to consider. It is regrettable that JW was brought into hospital for the first time under a false pretence. This was unlikely to improve his relationship with his family (particularly his mother, about whom he already appeared to be paranoid). We were not able to interview Dr A and cannot tell from the notes to what extent she was aware of this tactic or whether she attempted to dissuade JW's mother from it but we are aware from the notes that JW's mother expressed concern that he would be angry with her. Unfortunately, it is not unusual for families to

feel constrained to take such a course of action in order to get a patient to agree to see a doctor and no blame should be attached to JW's family for doing so.

Clearly JW was not a 'voluntary patient' in the accepted sense, as is evident from his conduct over the next few days. We think that the delay in exercising formal powers of detention was unfortunate in that JW was effectively 'tricked' by his family into being admitted to the hospital. We think that it is likely to have been apparent to Dr A that JW was not readily consenting to admission for the assessment of his mental illness. We consider that had she intervened on 20 January by requesting a formal assessment of JW with a view to detaining him in hospital at that point, the responsibility for his admission would not have been so firmly vested with the family.

Recommendation 16

That the Panel reiterates Recommendation 10 concerning compulsory admission of patients.

JW's position as a voluntary patient was not sustainable; he expressed a wish to leave the hospital and was subsequently made subject to Section 5(2) of the Mental Health Act 1983 on 23 January. He then managed to get out of the unit, was returned by the police and forcibly medicated (presumably under common law provisions).

JW's mother was advised not to visit him over that weekend because he was expressing anger towards her.

JW was then assessed for detention under Section 2 of the Act. The assessment was conducted during the weekend and so involved a duty ASW from Peterborough and Cambridgeshire County Council. Good practice dictates that the ASW will consult with recognised carers. In the case that the ASW makes an application for the patient's detention under Section 2 the ASW is also obliged to notify the 'nearest relative' of the patient as defined by Section 26 of the Mental Health Act 1983. The ASW must advise them of their rights as nearest relative, which includes the right to apply for the patient to be discharged from hospital. The rules regarding the determination of nearest relative are strictly determined by Section 26 and may sometimes lead to identification of individuals who would not be considered 'next of kin'. In this case, the ASW took the view that JW was still living in Ashton-under-Lyne (this was the view consistently recorded in the hospital notes) on his own, his brother having moved out. He did not expect him to continue to reside with DG indefinitely. JW's mother was by now resident in Spain and so could not be, in law, considered 'nearest relative' to JW, even though she was visiting the country due to her concern for him. The ASW identified JW's father as nearest relative '*address unknown*'; his lack of contact with JW did not disqualify him from the role.

In his notes of the assessment, the ASW noted the pretence adopted to get JW to go into hospital, also his mother's concern about whether they had done the right thing and her fear that she had lost JW's trust.

The following day, JW sprayed a bottle of soft drink over his mother while she was visiting him on the ward.

Panel comment

Although the identification of JW's father as 'nearest relative' may seem strange considering how little contact he had with JW in comparison to other members of the family, this was a correct interpretation of Section 26 of the Mental Health Act 1983. The ASW had no discretion to select another member of the family. The ASW consulted appropriately with JW's mother and DG and informed JW's mother of his decision to apply for his detention. This was in accord with the more general guidance within the Code of Practice to the Mental Health Act that the ASW should consult with the carers of the patient and this constituted good practice.

Over the final week of January 2004, there are numerous references to contact between JW, his family and the staff on Churchill Ward. Staff demonstrated awareness of his mother's concerns and were quick to advise her when JW was again briefly absent from the ward. They pieced together more of the story of JW's early life and of his recent disagreement with his brother. On 1 February, one of the staff nurses had a telephone conversation with JW's mother during which it became apparent that JW would need to be considered for alternative accommodation: his mother considered that he was unable to cope with fully independent living and stated that DG had been 'worn out' by her recent experience of looking after JW.

The housing notes contain a letter from DG dated 26 December 2003 but, since they refer to her discussion with the ward manager, they were more plausibly written on 26 January 2004. The letter is obviously intended to support JW's application for independent housing. DG explained that it would not be possible for JW to reside with her.

'As a pensioner I don't feel that I can cope with the responsibility of J and his problems. However if J was offered accommodation with the care in the community programme we would all be there for him in every way. He still has old school friends here and extensive family members live locally' (sic).

As JW's mother prepared to return to Spain in February 2004, DG emerged more clearly as JW's future primary carer. She was the advocate for JW, for example expressing concern that he should not be over-medicated and that he should be found enough to do to occupy himself on the ward. She asked to be kept up to date with JW's progress and invited herself to Dr A's ward round on 3 February at which the treatment plan for JW was discussed with her.

JW was visited by his mother and DG in hospital on 7 February. His mother expressed concern about the side effects of the anti-psychotic medication

administered to JW, but was reassured that the current treatment regime was not likely to be sustained when JW's mental state had resolved. She again expressed concern that she had told JW he would be able to find his sister if he came into hospital and the possible repercussions of this on their future relationship. She expressed uncertainty about whether JW was really unwell.

The following day, JW's mother reported that she had found JW much improved; greeting her appropriately and without hostility. JW joined the discussion and they spoke of his plans when discharged.

On 16 February, Mr F, on behalf of the Trust, looked into the matter of determining the responsible PCT area for JW. He noted that, although JW was registered with a GP in Ashton-under-Lyne, it was unlikely that he would be able to return there as the house was about to be put on the market. He also observed that JW would have no network of support were he to return there. In fact, his elder brother seemed likely to relocate to Wisbech to be closer to DG and the rest of their extended family. JW's younger brother was already living with DG. Mr F discussed the matter with DG who confirmed this and stated that JW did not want to return to Ashton-under-Lyne. DG made it clear that she could not accommodate JW but would support him if he were found somewhere to live locally. She stated that other members of the family would also be willing to assist.

These discussions led to the decision that JW's care would most appropriately reside with the local PCT.

Panel comment

Mr F's discussions with DG and others was carefully considered and meticulously recorded. These records provide clear evidence that the decision was taken with due regard to the clinical needs of JW and included appropriate consideration of his social care needs and the needs of DG who, it was now evident, would be his primary carer.

DG and other members of the family continued to visit JW frequently throughout the admission and their visits are recorded in the nursing notes.

At the ward round on 17 February, JW was considered for overnight leave under Section 17. Since he had no address it was proposed that, subject to her agreement, he should have leave to stay with DG. Three days later, having concluded that there were insufficient grounds to detain him under Section 3, Dr A extended JW's 'home leave' pending his assessment for independent housing. Dr A advised DG that should she have any concerns or feel unable to cope with JW, she should call the Fermoy Unit.

JW's mother wrote to the Fermoy Unit confirming that she had relocated to Spain and intended to sell the family home, which would render JW homeless.

JW continued to have weekend leave to stay with DG until his discharge from hospital. Notes suggest that there was good communication between the ward and DG at this time and that the periods of leave were uneventful and successful. Each

Monday he returned to the ward willingly, in accordance with his care plan.

Fenland District Council Housing records demonstrate that they planned JW's housing allocation to ensure proximity with DG and other supportive members of the family. JW moved out of the hostel to stay with DG while making his new flat ready. We learned from a number of witnesses, including JW himself, that he received considerable practical and emotional support from DG in equipping the flat and settling in and that he continued to take meals at her house and to look to her for help and advice on a daily basis.

As well as establishing a good rapport with JW, the support worker Ms E spent a good deal of time in discussion with DG. During her involvement DG was able to share the tasks involved in organising JW's daily life, though she continued frequently to accompany JW to appointments and was assiduous in attending care planning meetings. DG also demonstrated that she was able to mobilise the willing support of other members of the extended family when the need arose.

During the summer of 2004, JW progressively disengaged from services. Dr C continued to offer appointments and DG (with the help of other members of the family) ensured that he maintained some contact with services, even though he was increasingly unwilling to accept treatment. JW's mother and her partner were ill-prepared for JW's more truculent presentation during his visit to Spain during August, and it is clear that relations rapidly deteriorated, culminating with JW's rather bizarre attempt to leave the country using his brother's passport. JW's mother told us that she did not think that she had been given sufficient information about his illness and how best to support him in managing it. She was in some doubt about whether in fact he was unwell or just being 'difficult'.

Panel comment

We comment in Chapters 10 and 13 on the decision to withdraw the support worker from JW's care in August 2004, and register our concern that this action removed his most engaged relationship with a professional carer. Although not her primary focus, we believe that Ms E had also developed a rapport with DG and that her abrupt withdrawal removed from DG an important source of support.

It would have been good practice for the Care Coordinator to have discussed the plan to withdraw Ms E with both JW and DG. An assessment of the carer's needs at this juncture, whether or not recorded as a formal 'Carers Assessment', would have been advisable and might have led to more a considered decision regarding the cessation of Ms E's work with JW.

On 24 October JW was arrested for an assault on an adult male neighbour and for criminal damage. It is alleged that he had threatened the victim and had written defamatory graffiti on the victim's front door. A mental health assessment was conducted at March police station with the result that JW was detained under Section 3 of the Mental Health Act and admitted to the Fermoy Unit. An ASW from the out-of-hours team participated in the assessment and completed an application

stating that he believed the nearest relative, as defined by Section 26, to be JW's mother, then resident in Spain.

Panel comment

In identifying JW's mother as his nearest relative, the ASW was in error: she could not be considered as nearest relative because individuals living abroad are excluded under Section 26 from qualifying as nearest relative. Under Section 26 any relative living with the patient or providing care (of a substantial and sustained nature) to the patient would, in preference to other relatives, be considered to be the 'nearest relative'. In our opinion, DG would properly have been considered to be JW's 'nearest relative' at this point since the care she was providing was substantial (i.e. idaily emotional and practical support) and since that care was sustained and consistent. The extent of DG's involvement may, however, not have been evident to the ASW who, as an out-of-hours worker, would not have had access to the care file. Some discussion with DG as carer clearly took place during the assessment and this, at least, constituted good practice.

As nearest relative DG would have had the right to object to JW's detention or to apply for him to be discharged from detention (though there is no reason to suppose that she would have done either).

While it is unfortunate that DG's status was not fully recognised in the assessment, no adverse consequences ensued and there was unanimity about the need for JW to be detained in hospital. Nevertheless it is important that practitioners are equipped to correctly identify the nearest relative of patients so that nearest relatives can be apprised of their legal rights.

Recommendation 17

That the West Norfolk Primary Care Trust¹, the Cambridgeshire and Peterborough Foundation Trust and the Cambridgeshire Local Authorities as the responsible agencies for providing approved social work services, including out of hours services, should require that all ASWs attend annual refresher training which ensures that they are competent to identify the 'nearest relative'.

DG remained closely involved with JW throughout his second admission, and there is evidence to support generally good links between her and the staff at the Fermoy Unit.

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

On 10 November one of the staff nurses on Churchill ward contacted Ms D asking for her help for JW in accessing his bank account. The notes indicate that there had been a prior discussion with DG in which she had indicated that she would prefer not to do this in case it led to her becoming incorporated in JW's delusional beliefs. The nurse explained to Ms D that JW did not have money to buy cigarettes and that lack of cigarettes would almost certainly lead to behavioural problems. She explained DG's rationale for wishing to distance herself from the task. According to the nurse's notes, Ms D

'...informed me that she did not think it was within her remit to access'.

Shortly afterwards Ms D called back to say that she had spoken to DG who had undertaken to obtain and deliver JW's bank card to him.

Panel comment

The increased behavioural difficulties (including increased risk of absconding) that JW was likely to present if he had no access to cigarettes was a pertinent factor for consideration. Because this is a relatively common scenario, we think it likely that the ward would have had contingency arrangements to lend small amounts of money to patients on a temporary basis.

In our view, it was within the remit of the Care Coordinator to undertake this task either directly or by delegation to others. Ms D would no doubt have wished to obtain JW's explicit consent to enter his home and bring property to him. Of course, this does not mean that Ms D could reasonably have been expected to respond to this request as her utmost priority and she would have had to exercise a judgement about the practicalities of doing so as compared with the demands imposed by other work.

It is regrettable that, despite her explicit wish to remain distanced from these affairs, DG was encouraged by Ms D to provide the remedy to the problem. While we have found no evidence that these actions did in fact lead to DG's incorporation in JW's delusional system, the concern expressed by DG, that she might become incorporated in JW's delusional beliefs, was a valid one.

At the pre-discharge Care Planning meeting on 22 November, the Care Coordinator completed a 'Carers Assessment Screen' (part of the local CPA documentation). She noted that a full Carers Assessment had not been completed, but indicated that she intended to coordinate such an assessment.

This plan was pursued on 25 November. Ms D conducted a home visit and saw both JW and DG. She noted

'Mrs G denied (sic) the offer of a carers' assessment. She is familiar with the route of access for services in and out of hours'.

The following week DG accompanied JW to his outpatient appointment and saw Dr C and Ms D. JW's diagnosis was discussed and JW was given some information leaflets about it.

On 9 December, Ms D saw JW at his flat. It appears from the notes that DG was not present on that occasion. They discussed how he could become better occupied. DG's continued support was noted.

On 15 December, JW did not attend to receive his depot medication at the appointed time. Ms D telephoned DG who in turn called JW with the result that he came soon afterwards. They discussed his plans for Christmas. JW said that he would be having Christmas dinner with DG and was looking forward to Christmas. Ms D noted that she had discussed with both JW and DG how to contact services over the holiday period should they need to do so.

Panel comment

DG was described to us as a strong, caring, matriarchal figure. It was readily apparent from everything we heard in evidence that she occupied a central role within her extended family. During the course of our discussions with family members and other witnesses, it also emerged that at the same time that she was supporting JW she had assumed a significant caring responsibility for others. In this way, DG was already familiar to staff within the CMHT prior to her involvement in JW's contact with those services. While this was noted informally, the totality of the responsibility of caring for more than one person with complex needs does not appear to have been fully recognised or responded to by local services, and also may not have been apparent at the time to family members.

We were also consistently told of DG's pride in her family and her strong sense of personal dignity. While it is evident that she was dogged in her determination to achieve the best for JW, we formed a strong impression that she would have found it difficult to place a priority on her own needs; to ask for or to accept help. It is therefore no particular surprise that she declined the offer of a formal Carers Assessment when this was offered by JW's Care Coordinator. It appears that the documented offer of a Carers Assessment represents a single discussion which was not repeated.

We do not underestimate the sensitivities of working with carers; nevertheless we consider that there may have been other opportunities for the offer of a Carers Assessment to be reiterated and that the offer may have been more acceptable to DG had it been linked to the prospect of immediate, practical help or respite. In retrospect, it seems that, at times, DG did seek help in limiting her response to JW's demands: for example, in November 2004 when she requested that the care team deal with JW's demand for money to buy cigarettes. Such occasions could have presented 'windows of opportunity' to respond to JW and DG in such a way as to support the autonomy of each

whether or not this intervention followed a formal assessment of the carer's needs.

We heard from some witnesses, friends and family of DG, that they thought DG had been finding it increasingly difficult to cope with JW during the final weeks of her life. We were told that she seemed to have lost a significant amount of weight over a short period and that some members of her family were concerned for her health. We also understand that DG had other caring responsibilities and other preoccupations.

We also heard in evidence that, while DG's relationship with JW remained positive, there were occasional tensions and disagreements. We could find little to suggest that DG conveyed any concerns to those professionally concerned with JW. Instead, with apparently characteristic directness of approach, she herself attempted to try to engage JW with services which she thought would help to occupy him and reduce his isolation.

On 21 December JW attended West Norfolk MIND workshop. The appointment had been set up by DG who expressed a wish to get JW out and about as she felt he had been isolating himself over the previous four weeks. Although DG had originally intended to drive JW to the appointment, she 'did not feel up to it', and a friend of the family gave him a lift instead. The project worker explained to JW that he would need some background information before he could be accepted at the project and he attempted to contact Ms D.

The Panel of the internal inquiry recommended that carers be 'provided with written and verbal information regarding the nature of the mental illness and its likely effects'. We are not able to tell what if any written advice was offered to DG regarding JW's diagnosis, though we understand that written information would have been on display in the CMHT base.

Recommendation 18

The Panel endorses the recommendation of the internal inquiry report regarding the provision of information concerning the nature of mental illness but recommends that, as with the assessment of carers' needs, the giving of information should be treated as a process (which is responsive to the individual concerned given that the need for, and receptiveness to, information may necessarily vary over time), rather than as a single event.

CHAPTER 15 LIST OF RECOMMENDATIONS

Note: The following recommendations addressed to the West Norfolk Primary Care Trust refer to the management of inpatient beds at the Fermoy Unit. These need to be considered by the Norfolk and Waveney Mental Health Foundation NHS Trust as the successor organisation.

1. That the West Norfolk Primary Care Trust¹ review its Police Liaison Policy especially with reference to requesting police to assist with controlling, restraining and giving medication to patients on the ward. [Chapter 9]
2. That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust should have formal policies with regard to the referral of a patient to a Psychiatric Intensive Care Unit. [Chapter 9]
3. That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust should have access to local Psychiatric Intensive Care Unit beds. [Chapter 9]
4. That the pharmacy department of West Norfolk Primary Care Trust¹ should ensure that best current practice advice regarding pharmacological theory and practice and the use of medication in psychiatric emergencies is issued to all prescribing clinicians. [Chapter 9]
5. That the West Norfolk Primary Care Trust¹ should review its training and clinical practice regarding (a) missing patient policy, and (b) one-to-one observation, and should develop a policy for devising the nursing and medical care plan in respect of emergency admissions. [Chapter 9]
6. That the West Norfolk Primary Care Trust¹ should review its training for nursing staff regarding the care of its physical health observations of aroused and/or intoxicated patients, particularly those who have received significant doses of prescribed medication. [Chapter 9]
7. That the West Norfolk Primary Care Trust¹ should ensure that proper attention be given to effective stock control of essential psychiatric medication. [Chapter 9]
8. That the Cambridgeshire and Peterborough Foundation Trust ensure that robust systems of managerial supervision are in place, within which difficult clinical cases are discussed. [Chapter 10]
9. The Panel endorses the recommendation of the internal inquiry report of that staff should receive regular training on dealing with patients who use illicit

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substances to include the impact of such use on the patient's mental state and on the uptake of prescribed medication. [Chapter 12]

10. That the West Norfolk Primary Care Trust¹, the Cambridgeshire and Peterborough Foundation Trust and Norfolk and Cambridgeshire Local Authorities provide training during professional induction, together with regular refresher training, to ensure that relevant professionals (primarily psychiatrists and ASWs, but also those undertaking Care Coordinator functions) are reminded about the criteria for compulsory admission and are acquainted with current best practice guidance. [Chapter 13]
11. That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust institute a rigorous system of review to ensure that multidisciplinary notes are maintained to a satisfactory standard in terms of the timeliness and quality of written entries. [Chapter 13]
12. That the Cambridgeshire and Peterborough Foundation Trust institutes a system to monitor frequency of contact with patients and that concerns arising from difficulties in establishing contact (such as a pattern of missed appointments) are automatically brought to the attention of the team manager. [Chapter 13]
13. That the Cambridgeshire and Peterborough Foundation Trust ensures that decisions to involve, or to withdraw the involvement of, support workers or other non-qualified staff in the direct care of a patients are endorsed, in writing, by the team manager. [Chapter 13]
14. That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust ensure that a single format risk tool (linked to CPA documentation) is used within each Trust. [Chapter 13]. This has been achieved by CPFT (see appendix 3, para 1.2).
15. That the West Norfolk Primary Care Trust¹ and the Cambridgeshire and Peterborough Foundation Trust develop standards for basic requirements for recording inpatient notes and develop and employ a system regularly to audit compliance against these standards and that entries must be readily attributable to a named author and the date (and, in the case of daily entries, the time) are clearly recorded. [Chapter 13]
16. That the Panel reiterates Recommendation 10 concerning compulsory admission of patients. [Chapter 14]
17. That the West Norfolk Primary Care Trust¹, the Cambridgeshire and Peterborough Foundation Trust and the Norfolk and Cambridgeshire Local Authorities as the responsible agencies for providing approved social work services, including out of hours services should require that all ASWs attend

¹ 1 October 2006 the beds in Fermoy Unit were transferred to Norfolk and Waveney Mental Health NHS Foundation Trust. As the successor organisation they are responsible for responding to this recommendation.

annual refresher training which ensures that they are competent to identify the 'nearest relative'. [*Chapter 14*]

18. The Panel endorses the recommendation of the internal inquiry report regarding the provision of information concerning the nature of mental illness but recommends that, as with the assessment of carers' needs, the giving of information should be treated as a process (which is responsive to the individual concerned given that the need for, and receptiveness to, information may necessarily vary over time) rather than as a single event. [*Chapter 14*]

CHAPTER 16 CONCLUSIONS

Diagnosis and treatment in hospital for the first admission

The first admission of JW to hospital was characterised by challenging behaviour, aggression and escape from an open ward. The Panel is critical of mental health professionals' reluctance to refer JW to a Psychiatric Intensive Care Unit. Such a referral and subsequent transfer would have made his care more manageable. The Panel found that the diagnosis of bipolar affective disorder with psychotic features was not unreasonable, especially as it was his first admission. However, alternatives should have been formally considered, namely schizophrenia and schizo-affective disorder.

Community care after first admission

The community care following the first admission was characterised by excellent practical support to begin with, but by deficiencies in record keeping and monitoring of behaviour and mental state later on.

Care during his second admission to hospital

The care during JW's second admission to hospital showed shortcomings resulting in multiple escapes and episodes of aggression which would have probably been easier to manage had JW been admitted to a PICU.

With the benefit of hindsight, the Panel is of the view that JW was relapsing but it is unlikely that any violent intent would have been elicited by professionals, although on a very careful mental state examination, it is possible that JW might have let slip some of his psychotic beliefs about his grandmother. He could then have been given extra medication although, despite her supervision, he might not have taken this. In the view of the Panel, it is unlikely that he would have been found detainable under the Mental Health Act because he was complying with his treatment and, at that stage, was not behaving aggressively. Thus, the Panel considers that the event was not predictable.

Substance misuse

It is likely that JW abused substances before his first admission to hospital, although on admission a urine drug screen did not show the presence of drugs or alcohol. During his second admission to hospital, after he escaped from the ward, he was found to be intoxicated with alcohol. After his discharge following his second admission to hospital, there were suspicions that he was abusing cannabis but this could not be confirmed. The Panel is of the view that JW's mental illness was present even in the absence of any substance misuse.

Risk assessment and risk management

We acknowledge the work that the Trusts have already done to improve knowledge and practice in the area of risk assessment and risk management. We recommend actions be taken so that the Trusts can be assured that adequate standards are maintained. These include improvements to risk assessment documentation, additional training to clarify the parameters of the Mental Health Act 1983 in the management of a relapsing patient, and improved facilities for the safe management of patients requiring intensive psychiatric care.

Although we are critical of the often rather perfunctory way in which risk information was recorded in this case, we are satisfied nevertheless that significant risk factors which were and could be known by the clinical team were properly considered by them.

We consider that a comprehensive or better recorded risk plan is unlikely to have led to the clinical team taking a substantially different view of risk evident at the point of JW's second discharge from hospital or to his care planning at that point.

Family concerns

DG's family had a number of concerns with regard to care and service delivery issues relating to JW and, to a certain extent, those concerns are shared by the Panel as outlined in Chapters 9 to 11. With regard to the support given by the mental health services to JW's grandmother, there is evidence of good practice on the part of the support worker and by the doctor who made a thorough assessment of JW's mental state and of his risk of violence to self and others. He consulted with the grandmother and the Care Coordinator as well as JW himself.

Discharge after second admission

Family members were anxious to assert that there was no pressure from the family to release JW over the Christmas period. The Panel accepts this assertion and, having examined the case notes, is of the opinion that the decision to discharge JW was a reasonable one based on clinical and risk grounds. There is no evidence that the decision had anything to do with pressure to release beds.

The Internal Inquiry

In response to the Internal Inquiry, an action plan was drawn up by the Cambridgeshire and Peterborough Mental Health Trust and many of the recommendations of that Inquiry have been implemented. The Trust is to be commended on the swiftness of its response. The Panel has reproduced the latest version of the action plan in Appendix 3 showing the progress which has been made.

The Panel's recommendations

The Panel lists its recommendations in Chapter 15; the important matters to be addressed concern supervision arrangements of Care Coordinators, the frequency of patient visiting and the importance of making contemporaneous notes for the official

record. There is also the issue of patient access to a psychiatric intensive care unit (PICU) situated locally and the need to have a formal policy for referring patients to a PICU. In the Wisbech area there seemed to be reluctance on the part of staff to refer patients to a PICU even when there was a compelling case to do so. The Panel also considers that a review of the WNPCT's police liaison policy is urgently needed.

As stated in this Report, the Panel has identified a number of matters relating to care and service delivery which could have been improved and, indeed, this Report contains recommendations in respect of these shortcomings. However, the Panel is of the opinion having examined all the evidence available, that had these matters been addressed, it would not have prevented the tragic events which occurred on Boxing Day 2004.

The members of the Panel would wish to reiterate their sympathy with the family of DG, not only at their tragic loss, but also for the time it has taken to deal with the difficult issues arising as a result of the events.

CHAPTER 17 GLOSSARY

Affect - synonym for someone's apparent emotional state, as opposed to 'mood', which describes how someone feels subjectively.

Antipsychotic medication – medication which is given to treat patients who are psychotic. It can be given by mouth; or by short or long acting (depot) injection.

Approved Social Worker (ASW). A social worker employed as an officer of a Local Authority and appointed to act as an ASW under the Mental Health Act 1983. Such officers will have received training and demonstrated competence in the application of the formal powers conferred upon them by The Act.

Benzodiazepine – drugs such as diazepam, lorazepam and clonazepam. They have many uses and are addictive so tend to be used for short periods only. They are very effective and generally safe to treat disturbed behaviour and anxiety.

Care Programme Approach (CPA) – government policy since 1991, requiring that each patient accepted by mental health services should have: their needs for treatment and care assessed; a care plan, or package of care to meet these needs drawn up; a named mental health worker (Care Coordinator) to keep in touch with them; regular review of their needs and care plan.

Clonazepam – a benzodiazepine drug used to calm disturbed patients. It can be given by mouth or by short acting injection.

Crisis Resolution Team – provides intensive support for people in mental health crisis, by a variety of means and in a variety of settings. They stay involved until the problem is resolved, in order to prevent hospital admission and to give support to family/carers.

Delusion – strongly held false belief not amenable to reasoning and not compatible with the patient's usual cultural beliefs.

Delusion of Grandeur – a delusion that the person is convinced that they have powers and abilities which far exceed the norm.

Delusion of Reference – a paranoid symptom whereby a person feels that events/people in their environment are referring to/talking about him/her.

Depot – long-acting injection of antipsychotic drug which is released slowly into the patient's blood over some weeks.

Diazepam – benzodiazepine used to help patients who are disturbed or very anxious

Extra Care Area (ECA) – separate area of the ward where disturbed patients can be managed on an individual basis.

First rank symptoms of schizophrenia – symptoms such as passivity feelings which are regarded as characteristic of the illness.

Hallucination – perception experienced by the patient but one which does not have a real stimulus. Commonly auditory hallucinations of people's voices are heard in schizophrenia.

Haloperidol – antipsychotic medication which can be given by mouth or by short or long-acting injection.

Hebephrenic – form of schizophrenia found in younger people characterised by delusions, hallucinations, mood and behavioural disturbances.

Home Treatment – an alternative to hospital care for patients in crisis with an acute psychiatric disorder. The team is able to spend time flexibly with the patient and their social network, in the home environment, including several daily visits if required.

Lorazepam – a benzodiazepine used frequently by mouth or by short acting injection for patients who are disturbed.

Low Secure Unit - delivers intensive, comprehensive, multidisciplinary treatment and care for patients who demonstrate disturbed behaviour in the context of a serious mental disorder, and who require the provision of security. They will be detained under the Mental Health Act 1983, and may be restricted on legal grounds needing rehabilitation usually for up to two years.

MRI – Magnetic Resonant Imaging. A scan which gives images of the inside of the body.

Olanzapine – antipsychotic which can be given orally and by short acting injection.

Organic psychosis – psychosis caused by physical illnesses such as brain tumours, head injury, dementia and substance misuse.

Paranoid symptoms – ideas of persecution e.g. that the person is being followed, or that there is a plot against the person.

Passivity feelings – these are beliefs held by the patient that external powers are controlling him and are typically found in schizophrenia.

Persecutory delusions – beliefs that others are persecuting the patient

Psychiatric Intensive Care Unit (PICU) – psychiatric intensive care units are for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder.

PRN medication – medication to be taken when required (as opposed to regularly)

Psychosis – condition characterised by delusions, hallucinations and a lack of insight into the fact that the patient is ill.

Responsible Medical Officer (RMO) - the consultant psychiatrist with individual responsibility for the care of a detained patient.

Risperidone – antipsychotic medication which can be given by mouth or by depot injection (Risperdal Consta).

Semisodium valproate – mood stabilising medication used to treat bipolar affective disorder.

Section 2: compulsory admission for assessment. The order lasts for up to 28 days and is not renewable.

Section 3: compulsory admission for treatment. The order lasts for up to 6 months and may be renewed.

Section 5(2): a temporary order, lasting up to 72 hours, the effect of which is to detain an exiting patient (who has been voluntarily admitted to hospital) pending assessment of the patient for detention under section 2 or section 3.

Section 12 Approved Doctor: a medical practitioner, approved by the Secretary of State as 'having special experience in the diagnosis or treatment of mental disorder'.

Section 17 leave - leave from hospital which may be granted to a detained patient by the RMO.

Section 37/(41): Hospital order for treatment imposed by a Court as an alternative to a custodial sentence. The Section 37 order is similar in effect to Section 3. The Section 41 order is often additionally imposed by the Court where a very serious offence has been committed. The effect of this order is to restrict the power to discharge or grant leave to the patient. This power resides with the Secretary of State and is administered through a special unit within the Ministry of Justice (formerly the Home Office). The patient may also be released through the Mental Health Review Tribunal. Patients may be discharged absolutely but are more usually discharged subject to conditions ('conditional discharge').

Senior House Officer (SHO) – the most junior member of the medical team in psychiatry and one who is undergoing further training.

Skunk – an extremely potent form of marijuana, grown under specific conditions to ensure maximum potency. It is said to be much stronger than traditionally grown marijuana, and can cause hallucinations.

Specialist Registrar (SpR) – higher training doctor than an SHO, who is likely soon to become a consultant.

Staff grade psychiatrist – permanent member of staff who might have post-graduate exams and who is generally no longer training or going to become a consultant.

Tangential thinking – sign observed by psychiatrist that the patient's thoughts are not logical but 'keep going off at tangents'. Generally it is a sign of schizophrenia.

Thought block – sign observed by psychiatrist that the patient's thought stream is interrupted. Can be explained by the patient that 'someone took the thoughts out of my mind.' This is often seen in schizophrenia.

Thought insertion – experience by the patient that another person or agent put thoughts into his or her mind. This is an example of a first rank symptom of schizophrenia.

APPENDIX 1
WITNESSES AND PERSONS REFERRED TO IN THIS REPORT

Witness	Nature of Involvement	Date interviewed
JW	Interview at the Norvic Clinic by two Panel members	30 June 2006
Family Members		
Mrs DeG	Mother of JW (by telephone conference link – interviewed by the whole Panel)	30 June 2006
Mr P & Mrs LG	Uncle and aunt (by marriage) of JW	27 November 2006
Mr RG	Uncle of JW	21 June 2006
Mrs BH	Friend of the family	21 June 2006
Staff		
Dr A	Locum Consultant Psychiatrist (not possible to interview because of sick leave)	
Dr B	Staff Grade Psychiatrist	29 June 2006
Dr C	Locum Consultant Psychiatrist (not possible to interview because of living abroad)	
Ms D	Community Mental Health Nurse	27 November 2006
Ms E	Support Worker	29 June 2006
Mr F	Ward Manager Fermoy Unit	30 June 2006
Mr G	Senior Social Worker ASW	21 June 2006
Ms H	Team Manager Mental Health Team	27 November 2006
Mr I	Director of Nursing Cambridge & Peterborough MHT	27 November 2006
Ms J	Non-executive Director	28 November 2006

Ms K	Junior Staff Nurse Fermoy Unit	27 November 2006
Dr L	Medical Director	28 November 2006
Ms M	Deputy Director of Commissioning E Cambs & Fenland PCT	29 June 2006
Ms N	Area Director E Cambs & Fenland PCT	21 June 2006
Mr O	Director of Mental Health West Norfolk PCT	30 June 2006
Ms P	Social Care Lead E Cambs & Fenland PCT	28 November 2006
Mr Q	Social Worker, ASW Cambs Emergency Duty Team	29 June 2006
Mr R	Social Worker, ASW Cambs Emergency Duty Team	29 June 2006

The whole Panel visited the Fermoy Unit and spoke to members of staff on 20 June 2006

APPENDIX 2

DOCUMENTATION SUBMITTED TO AND CONSIDERED BY PANEL

Patient Records

- Patient Registration details and Medical Records, plus reports from Clinical Psychiatrist

Cambridgeshire and Peterborough Mental Health Partnership Trust

- Care File, including: Patient ID; Interdisciplinary Record; Summary Reports; Interagency Correspondence; Mental Health Act; CPA; Investigations; Pharmacy & TPR; Service Area; Inpatient nursing notes and observations, risk assessment documents
- Cambridgeshire and Peterborough Mental Health NHS Trust – Care Programme Procedural Guide for Staff
- Inquiry Report into Care and Treatment of JW by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
- Copy of Section Papers relating to JW for Cambridgeshire and Peterborough NHS Trust Inquiry
- Updated Internal Investigation report action plan

West Norfolk PCT

- West Norfolk NHS Primary Care Trust – Policies and Procedures, including Risk Assessment and Care Programme Approach
- Notes and Transcriptions of Interviews with Health Workers
- West Norfolk NHS Trust Policies: Risk Assessment; CPA; CPA Documents; CPA Supplements

External Organisations and Agencies

- Fenland District Council – Tenancy Agreement and History relating to JW, plus any contact information with this tenant, letters and Housing Policy, Housing Services Guidelines.
- Two copies of Cambridgeshire Social Services Contact
- Court Transcription and Letter from Crown Prosecutor
- Case Study – CPS – Indictment: Witnesses/Evidence; Exhibits; Recorded Interview Transcript Reports

Panel Evidence

- Documents associated with previous history – Evidence Request as a Result of Panel Interviews.
- 16 Copies of Interviews arising from Independent Inquiry into Care and Treatment of JW JW; Transcript of JW Panel Interviews, transcript of JW Panel Interviews, Summary of interviews (final transcripts)

SHA Correspondence

- JW Inquiry File: Complaint – 2005/32; Original Report; Executive Paper; RPH Notes and Correspondence; Panel Administration – Correspondence; Terms of Reference

APPENDIX 3 INTERNAL INQUIRY INTO THE CARE OF TREATMENT OF JW

Action Plan of Cambridgeshire and Peterborough Mental Health Partnership NHS Trust October 2007

KEY ISSUE	RECOMMENDATION	ACTION TAKEN OR PLANNED	LEAD AND GROUP	DUE DATE
1.Risk Assessment	1.1 To ensure that staff undertake refresher risk assessment at regular intervals.	Five day clinical risk training programme established with Anglia Ruskin University		Completed
		Arrangements for refresher training reviewed and new induction training arrangements planned		Completed
		Ensure that the risk assessment training includes reference to obtaining information from multiple family informants		Completed
	1.2 To develop a single CPA form which is accessible, prominently placed in the record and regularly updated to record violent or potentially violent incidents from first episode. This should take account of all relevant information, including social circumstances reports, discharge summaries etc and should form the basis of all risk assessments.	CPA Risk assessment screen in place as part of revised CPA policy and documentation from January 2006 New CPA process significantly redesigned in Aug 2007, incorporating risk screen and assessment and to be launched in Jan-Feb 2008. East Cambs & Fenland service has developed a risk key events pro forma to highlight significant events.	AN Adult Services DMT	Completed Jan-Feb 2008
	1.3 To make progress towards the development of an electronic CPA record accessible by staff	New Care Records System (CRS) implemented across the Trust in November 2005 Extend use of CRS to include social workers	Completed	Completed

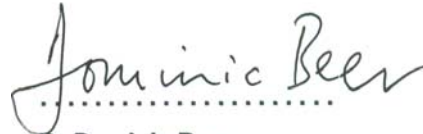
	<p>1.4 Where a decision is made not to make an application for the compulsory admission of a patient under the Mental Health Act, the following information should be recorded and shared with those involved in the patients care.</p> <ul style="list-style-type: none"> •1 The rationale for the decision not to admit. •2 The indicators that are likely to be present to trigger reassessment. •3 The risk monitoring/ management arrangements to detect changes in the patient's presentation. 	<p>Review Mental Health Act assessment recording procedure and forms</p> <p>Ensure that ASW training includes adequate coverage of risk assessment training</p>		<p>Completed</p> <p>Completed ASW training incorporates two days risk training, and includes input from Cambridgeshire Police</p>
	<p>1.5 To establish a clear protocol around referrals to voluntary and other organisations to ensure that in cases of people with serious mental illness, there is a transparent process for communicating information and sharing risks between organisations.</p>	<p>Protocol on the sharing of personal information is in place and part of Trust CPA and Risk Assessment policy</p> <p>Ensure that sharing risk information between agencies is part of the clinical risk training programme</p>		<p>Completed</p> <p>Completed</p>
<p>2. Intervention to prevent deterioration and/or relapse</p>	<p>2.1 To implement the development of an Early Intervention in Psychosis Service (EIS)</p>	<p>Service model agreed</p> <p>Funding for establishment of EIS agreed</p> <p>Implementation across the county is underway with development of the EIS in Peterborough covering Fenland and Huntingdon to be completed during 2007-08. Team being recruited.</p>	<p>AN and JR Adult Services Modernisation Group</p>	<p>Completed</p> <p>By March 2008</p>
	<p>2.2 Establishment of assertive outreach service</p>	<p>Assertive outreach services are now under the management of the Director of Adult and Older Peoples Services as part of that Directorate.</p>		<p>Completed</p>

		AOR services have been part of the Trust service transformation programme to create consistent care pathways across the Trust. All of these redesigned care pathways will be implemented by April 2008.	AN/ Adult Services DMT	By April 2008
3. Support to Carers	3.1 Carers of people with mental illness should be provided with written and verbal information regarding the nature of the mental illness and its likely effects. This should be carried out regularly as part of the delivery of a care plan for the patient. Information should include the scope and limits of the Mental Health Act where this is applicable.	'Insight' leaflets with information for carers and service users are available in all Areas of the Trust. All staff receive training on CPA Internal audits are in place to ensure that CPA reviews take place at regular intervals.	KG/AH Education and training team AN Adult Services DMT/Trust audit team	Completed Ongoing as part of ARU contract Ongoing
	3.2 The carer's willingness and ability to deliver care for someone with a mental illness should be addressed regularly by the Care Coordinator. Attempts should be made, where possible, to get assessment from other family members about the carer's situation.	Staff receive regular training in recognising the needs of carers and undertaking a carers assessment where this is indicated. Review current arrangements for training in assessing and meeting carers' needs	KG/AH KG/AH	Ongoing as part of ARU contract Ongoing as part of ARU contract
	3.3 An admission to hospital or a mental health day centre should trigger a review of the carer's needs.	Carers needs assessment section of Care Programme Approach policy reviewed as part of CPA redesign.	AN Adult Services DMT	Jan-Feb 2008
	3.4 Consideration should be given to appointing a different worker for the carer where the demands on the carer are high.	Carers support workers are available. Carers support arrangements have been reviewed as part of CPA redesign.		Completed

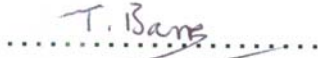
<p>7. Medication Compliance with oral anti-psychotics and awareness of action of new depot anti-psychotics</p>	<p>6.3 Continuing education for clinical staff and teams on the action/risk factors of new medications</p>	<p>Risperdal Consta issues to be included in medicines management training sessions and pharmacy inductions for medical staff</p>	<p>Completed</p>
	<p>6.4 Inform NPSA and others of the findings of the inquiry</p>	<p>Include Risperdal Consta issue in a medicines management learning the lessons seminar</p>	<p>Completed</p>
		<p>Medical Director to inform NPSA and other Medical Directors of mental health trusts</p>	<p>Completed</p>
		<p>Chief Pharmacist to email the UK mental health pharmacists group reminding them of the importance of communicating that Risperdal Consta is different to other depot injections</p>	<p>Completed</p>
		<p>Manufacturers of Risperdal Consta informed and asked to review their information to make it clearer about the differences with the formulation</p>	<p>Completed</p>



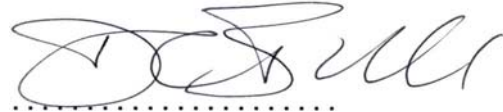
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