



An independent investigation into the care and treatment of Daniel Gonzales

A report for
NHS South East Coast (formerly Surrey and Sussex SHA) and Surrey County
Council

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1. Introduction

1.1 The independent investigation is commissioned by NHS South East Coast (formerly Surrey and Sussex SHA) and Surrey County Council with the support of Surrey Police and Surrey Probation. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27 *The Discharge of Mentally Disordered People and their Continuing Care in the Community*.

1.2 On Wednesday 15 September 2004 Daniel Gonzales, 24, caught a train from London to Portsmouth and got off at Southsea. He approached an elderly couple, Peter and Janice King, and attacked Mr King with a knife. Mr King defended himself, and Mr Gonzales ran off. Later that day he killed Marie Harding, 73, in Southwick, Brighton. He stabbed her in the back, cut her throat and stole her purse.

1.3 Just after 5am on Friday 17 September 2004, Mr Gonzales killed Kevin Molloy, 46, on Tottenham High Road, North London. He stabbed him in the face, neck and chest. At about 6.50am, Koumis Constantinou was woken by the sound of Mr Gonzales breaking into his house in Hornsey, North London. Mr Constantinou was stabbed several times before his wife came to his aid and Mr Gonzales ran away. At about 8am the same day, Mr Gonzales killed Derek and Jean Robinson at their home in Highgate, North London. He stabbed them in the throat. At the time he committed the murders and attempted murders he was 24.

1.4 On the 27 March 2006, Mr Gonzales was given six life sentences for the murders of Marie Harding, Kevin Molloy, Derek Robinson and Jean Robinson and for the attempted murders of Peter King and Koumis Constantinou.

1.5 We consider that Mrs King and Mrs Constantinou, although not named on the indictment, should also be considered as primary victims of Mr Gonzales as both were present when their husbands were attacked and both had reason to be in fear for their lives.

1.6 Since the age of 17, Mr Gonzales had received inpatient and outpatient care from the NHS trust which, under different names and in different configurations, provided specialist mental health services to the people of Woking, Surrey. An independent investigation was set up to examine all the circumstances surrounding

Mr Gonzales' care and treatment as required where homicides are committed by people being treated by specialist mental health services. This is the report of the investigation.

1.7 We started taking evidence on 25 September 2006 and took our final oral evidence on 11 September 2007. Many of the witnesses provided us with records and documents that supported and added detail to what they told us.

1.8 We would like to thank Mr and Mrs King, and Mr Molloy's sisters, Theresa Norris and Ann Noonan, who generously agreed to speak to us even though this meant reliving past horrors. We would also like to thank the staff at the organisations with whom we dealt. They were entirely helpful and provided us with written material, much of it relating directly to Mr Gonzales, but including national and local policy documents and other relevant material. We invited people we thought could help the investigation to give evidence. They all agreed to do so and spoke to us freely and openly. We would like to thank them for their cooperation and candour. The witnesses included Mr Gonzales, his parents and his maternal grandmother all of whom provided us with an important perspective for which we are grateful. Service- users from the Woking area gave us illuminating information about their experiences of the services available to them.

1.9 We were also helped by the publication in March 2006 of Dr Tony Maden's *'Review of homicides by service-users with severe mental illness'*, and in December 2006, of *"Avoidable deaths - the five-year report of the national confidential enquiry into suicide and homicide by people with mental illness"*, both of which allowed us to place Mr Gonzales' care and treatment in a wider context.

1.10 Mr Gonzales died in Broadmoor Hospital in August 2007 as a result of an apparent suicide¹ when we were well advanced in drafting our report. We reviewed our findings and recommendations and concluded that they are unaffected by the manner of Mr Gonzales' death. We have added at appendix A some comments on Mr Gonzales' mental state following conviction, as we believe it may cast light backwards onto the events that led to the homicides. We hope that our report will also help to provide a context in which to understand the tragedies Mr Gonzales

¹ Outcome of inquest will be included if known before publication.

caused, and that this may help all those affected by his actions.

1.11 This investigation was chaired by Lucy Scott-Moncrieff, a solicitor specialising in mental health, who was supported by James Briscoe and Granville Daniels. Project management was supplied by Tariq Hussain, a senior consultant at Verita. Verita is a consultancy specialising in the management and conduct of investigations, reviews, and inquiries in public sector organisations. Biographies for the panel appear at appendix F.

2. Terms of reference

2.1 To examine all circumstances surrounding the care and treatment of Mr Gonzales, in particular:

- The quality and scope of his health, social care and risk assessment
- The circumstances relating to treatment including:
 - The suitability of the care in view of Daniel Gonzales' assessed health and social care needs, and clinical diagnosis
 - The clinical and operational organisation, and the quality of care provided in the community
 - Assessment of the needs of carers and family
- The suitability of his treatment, care and supervision in respect of:
 - His assessed health and social care needs
 - His assessed risk of potential harm to themselves or others
 - Any previous psychiatric history, including drug and alcohol abuse
 - Previous forensic history
 - How the service met his health and social care needs
- The extent to which his care corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health and local operational policies
- The extent to which his prescribed care plans were:
 - Effectively delivered
 - Complied with by Daniel Gonzales
 - Monitored by the relevant agency
- The history of Daniel Gonzales' treatment, care and compliance with the service provided.
- The internal investigation completed by Surrey and Borders Partnership NHS

Trust and the actions that arose from this.

- Consideration of his connections with the criminal justice system, and examination of interagency communications.

2.2 To consider the adequacy of both the risk assessment procedures applicable to Daniel Gonzales and the relevant competencies and supervision provided for all staff involved in his care.

2.3 To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Daniel Gonzales, or in the provision of services to him, including Surrey and Borders Partnership NHS Trust and GP services.

2.4 To make recommendations so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.

2.5 To prepare a written report that includes recommendations to the strategic health authority and county council.

3. Executive summary and recommendations

“The possibility that Daniel Gonzales was ill may have disappeared over the horizon and been lost to well-meaning attempts to provide more practical support and engage with him in the areas that were most important to him.”

(Mark Girvan)

Executive summary

Our terms of reference are detailed and specific. Some of them, relating to risk assessment and management, clearly require us to consider whether clues to Mr Gonzales’ eventual extreme violence were missed. The subtext of these terms of reference is to ask us to consider if the homicides (or other extremely violent acts) were predictable and therefore possibly preventable. We think it is important to confirm at this early stage that we have found nothing to suggest that evidence of Mr Gonzales’ potential for extreme, or even significant, violence was overlooked.

However the terms of reference also require us to look at the totality of the care offered to Mr Gonzales, and here we believe that the subtext requires us to consider if there was anything at all that could and should have been done that might have prevented or reduced the likelihood of the murders. Whilst we are clear that it was not possible to predict what Daniel Gonzales did we recognise that good practice, effectively delivered, by its very nature reduces risk of harm to self or others.

In writing our report we have given full attention to both these elements of our terms of reference.

3.1 We found that this was a case full of general and specific missed opportunities caused by:

- human error, on a sliding scale of culpability
- lack of resources, covering both lack of a particular service and lack of funds within a particular service
- system failure, covering both poor systems and good systems used badly
- bad luck
- a combination of two or more of these factors

3.2 We know that in the months and years before Mr Gonzales committed his crimes he was ill, unhappy, and lonely. The onset of mental illness may mean the loss of certain hopes and expectations, but it does not have to be the end of all hope for the future and it is possible to have a fulfilling life with mental illness; even with schizophrenia. Treatment in the context of successful engagement could have helped with many of Mr Gonzales' problems and made his life satisfactory. An ordinary understanding of human nature suggests that someone is less likely to go down the path of destruction and self-destruction if his life feels good enough.

3.3 Our investigation finds that overall, Mr Gonzales was not successfully treated. We cannot say with certainty that he could have been, but we can and do say that the way he was treated was not likely to succeed and did not succeed. The proper application of CPA, risk assessment and management, strategies for engagement and contingency planning, would have produced more effective care.

3.4 However, the underlying triggers and motives for Mr Gonzales' crimes are unknown, and now forever unknowable, so it is not possible to say that any action or inaction by another person could have averted disaster.

3.5 This was a case where things went wrong early on and did not recover. Responsibility for this has to be shared by many of those who worked with, or were responsible for, Mr Gonzales, not just those working with him at the end.

3.6 For the reasons set out in the body of our report, we are satisfied that Mr Gonzales suffered from schizophrenia, a severe and enduring mental illness, from the age of 17 when he was first admitted to hospital in February 1998, to the time of his death at the age of 27 in August 2007. His illness was atypical, and the lack of acute episodes or consistent and positive signs and symptoms after his discharge from hospital in 1999 made diagnosis difficult.

3.7 Many witnesses told us that, before the events of September 2004, Mr Gonzales was entirely unremarkable in his presentation and the nature of his contacts with services. It was suggested that there might be 40 people receiving services from the community mental health team (CMHT) whose profiles would match his. We accept the findings of the internal inquiries which took place soon after the offences and concluded that there were no missed clues that Mr Gonzales would suddenly exhibit such extreme and catastrophic violence. One cannot say,

therefore, even with the benefit of hindsight, that Mr Gonzales should have been recognised as exceptionally dangerous. Although this may be a relief for those who worked directly with Mr Gonzales, it should be an uncomfortable finding for those providing services to people with this profile, as it makes it clear that something more than improved risk assessment is needed to reduce the likelihood of actions of this kind from people with this profile.

3.8 The evidence available to us, including the various Healthcare Commission reports about trust services², suggests that service provision in this trust is standard. We think the services offered to Mr Gonzales could and should have been better. As a result of our interviews we have concluded that there may be difficulties across the country in offering the right services to people like Mr Gonzales; difficult to engage, mentally ill young men involved in drugs and petty crime. The vast majority of people with this profile are never violent, except perhaps to themselves, but most mental health service-users with schizophrenia who commit homicide have this profile.³

3.9 One way in which Mr Gonzales was far from typical of subjects of statutory homicide inquiries was in his loyalty to the place of his birth. Effectively his home was in Woking for the whole of his life, although he spent periods in detention and visiting his father in Spain. Throughout his life he was under the care of a single local authority and, except for a few months in 1998/99, a single health care provider, albeit in a number of transformations. This gives an added edge to the evidence of missed communications, unshared information and lack of continuity of care that we have identified in this case. These features are common in reports of this type, but the reason usually given, that the service-user had a chaotic and itinerant life so that responsibility was spread between a number of trusts and local authorities, is not available here.

² In 2004/5/6/7 the trust and the predecessor trusts were generally assessed as fair. Evidence from the national patient survey, in regard to CPA in 2007 showed that the trust scored above the national average in 9 out of 10 indicators relating to CPA.

³ We note from “Avoidable Deaths, December 2006, The University of Manchester” that, of those with schizophrenia who carried out a homicide and had been in contact with mental health services, 91% were men, 64% were not currently married, 71% were unemployed and 72% had a history of drug misuse. Across the board, for all homicide perpetrators who had been in contact with services, immediate risk was judged to be low or absent at final service contact in 88% of cases. Mr Gonzales fitted all these categories, which suggests that for public safety reasons, as well as in the interests of good clinical practice, a better way of working with this easily identifiable group needs to be found.

3.10 This report does not detail all the contacts and decisions made about Mr Gonzales' care as this would make it difficult to separate key events and decisions from less important ones. We created a chronology of Mr Gonzales' contacts with all statutory and voluntary services, including police, probation and prison services. The chronology has been compiled from the evidence we gathered either through the interviews or documents supplied to us. A version of the chronology, limited to Mr Gonzales' care programme approach (CPA) history and contact with psychiatrists, is given at appendix B. The full chronology, which runs to 49 spreadsheet pages, shows that:

- Between his first admission to hospital at the age of 17 in February 1998 and his last contact with services before the crimes, six years and five months later in July 2004, Mr Gonzales spent a total of two-and-a-half years in hospital, in prison, or in Spain
- In the three years and ten months he spent in the community in Surrey he saw:
 - a GP 18 times (and missed three appointments)
 - a psychiatrist 16 times (and missed nine appointments)
 - another member of the CMHT 24 times, seven times without an appointment (and missed 11 appointments)
- In 2001 he attended 22 of 26 appointments with the probation service on time; attended late but was still seen on one occasion; twice attended too late to be seen; and had an acceptable excuse for the one time he did not attend at all.
- In 2002/3 he attended seven of 26 appointments with the probation service on time, attended late but was seen on six occasions and had acceptable excuses (sick notes) for only two of the 13 times he failed to attend.
- He was stopped or arrested by the police on many occasions, and although he was thought to be in possession of, or under the influence of, street drugs many times was found in possession of street drugs (cannabis) only once. On one occasion he was found in possession of a white powder which he claimed was ketamine, although it turned out not to be a controlled substance.

3.11 In our view, despite the amount of time spent and appointments made; despite the number of forms filled in and letters sent; despite (or, quite possibly, because of) the number of people involved, the specialist services frequently failed to deliver a service to Mr Gonzales that he valued or that met the standards of good practice. Notwithstanding this general assessment, we also find that there were occasions when Mr Gonzales was provided with a service he did value and that did meet good practice standards. These occasions are set out in the body of the report.

3.12 Having read the papers and heard from all the witnesses, we started drafting our report from the position that those who had provided care and treatment to Mr Gonzales were well intentioned and, generally, suitably skilled for the tasks they were given. However, as it was equally clear to us that the care and treatment offered to Mr Gonzales was often inadequate, we decided that it was important not only to report on the failings that we found, but to try and identify the underlying reasons for these failings.

3.13 We concluded that the individual failings of individual health and social care workers largely stemmed from the system of delivery of services. Modern specialist mental health care and treatment is delivered through a variety of specialist functional teams as well as catchment-area based community teams. In theory care is provided through a jigsaw puzzle of interlocking services with everything fitting together and no pieces missing. In reality, there are gaps, overlaps, and disjunctions in the different parts of the service that make up the whole, and because the services are operated by fallible human beings there are endless opportunities for mistakes, misunderstandings and miscommunications. However, even if this were not so, even if the jigsaw had all its pieces and worked as expected, we do not consider that it is the right system for people like Mr Gonzales. Service-users who are difficult to diagnose and difficult to engage with are not well served by this type of system unless it is accompanied by assertive care coordination and a commitment to full engagement. A jigsaw of services can all too easily be experienced as a fragmentation of services.

3.14 As requested in the terms of reference, we have identified the extent to which Mr Gonzales' care corresponded to statutory obligations, the Mental Health Act 1983 and other relevant guidance from the Department of Health and local

operational policies. The relevant authorities have, of course, already carried out their own internal inquiries and many (but not all) of our findings have already been identified in those earlier investigations and acted upon.

3.15 Inquiries such as this are expensive, and it is important that they add value. We do not consider that we would add value by telling people what they already know: that they should comply with guidance and their terms of employment, etc. Therefore in our conclusions and recommendations we have tried to build on the recommendations of the internal inquiry and the multi-professional review and also to look at the underlying reasons why the efforts of health and social services staff were so unsuccessful in engaging effectively with Mr Gonzales.

3.16 We do not deny the difficulty of delivering a service to someone with Mr Gonzales' combination of difficulties, attitudes and behaviours, but as we were told many times by trust staff that Mr Gonzales was typical of a large group of service-users, perhaps 8% of the total caseload of the CMHT, it must be obvious that finding a way to provide effective help to this group is urgently needed.

3.17 Much time and effort was spent on Mr Gonzales, as can be seen from the information above and also from the chronology at appendix B. Generally, the people we spoke to seemed well aware that Mr Gonzales did not seem to want what was offered to him, but did seem to want something, because he kept coming back. Unfortunately, the service providers did not seem to be curious about what might be causing this ambivalence, or that they might reconsider the service he was being offered in the hope that it would be more valuable to him.

3.18 The foreseeable consequences of this kind of mismatch between what is offered and what is wanted are that those affected are more likely to try and rely on their own resources, which will have been seriously compromised by their illness, and are at greater risk of being:

- Unemployed and unoccupied by other useful or pleasant activities
- Disengaged from ordinary daily life
- Involved in petty or not so petty criminality
- Involved in the drugs sub-culture.

All of these applied to Mr Gonzales.

3.19 The national service framework for mental health⁴ identified twelve guiding values and principles to help shape decisions on service delivery. People with mental health problems can expect that services will comply with the following values and principles.

1. Involve service-users and their carers in planning delivery of care.
2. Deliver high quality treatment and care which is known to be effective and acceptable.
3. Be well suited to those who use them and non discriminatory.
4. Be accessible so that help can be obtained when and where it is needed.
5. Promote their safety and that of their carers, staff and the wider public.
6. Offer choices which promote independence.
7. Be well coordinated between all the staff and agencies.
8. Deliver continuity of care for as long as this is needed.
9. Empower and support their staff.
10. Be properly accountable to the public, service-users and carers.

3.20 We consider that points 1-9 were all lacking to a greater or lesser extent in this case, for the reasons set out. We have more difficulty with point 10, because we are not sure what this means in this context. We are satisfied that the trust management is and was open and transparent in its activities, but if accountability incorporates providing good value for money, it was not achieved in this case.

⁴ National service framework for mental health: modern standards and service models
Department of Health, 30 September 1999

Note on Mr Gonzales' court verdict

3.21 We have found that Mr Gonzales was suffering from schizophrenia for many years before he committed his offences, but this should not be seen as a challenge to the verdict of the jury that he was guilty of murder rather than manslaughter by reason of diminished responsibility. The test for diminished responsibility is quite specific, and the mere fact that someone has a mental disorder at the time that he commits a homicide does not necessarily mean that responsibility for his crime is diminished in the sense required by law.

Recommendations

Introduction

3.22 We have identified many failings, but have decided not to make a large number of recommendations. Many were failures to comply with existing policies, procedures and good practice guidance and recommendations from us that staff should comply with their contractual obligations seem superfluous. It was clear to us that the guiding philosophy of care provision for service-users such as Mr Gonzales lacked a determined commitment to understand his needs and to engage with him to meet those needs. Consequently most of the attempts that were made were ineffective. We consider engagement to be such an essential part of the successful treatment of people like Mr Gonzales that our principal recommendation supports the adoption of a way of working such as the recovery model (as described in chapter 11) that puts engagement at the heart of practice. We are told that the trust has developed its *Vision and Values* framed around a central theme of *Capturing hope and building on dreams*. This approach is consistent with our recommendations.

3.23 We have also made a number of other recommendations to help ensure compliance with good practice. We hope that our recommendations, if followed, will cost no more than the service we examined, since they involve a culture shift rather than a reorganisation of services or injections of cash.

Recovery model and the care programme approach

R1 We recommend that the trust review and address its culture of engagement with service-users, their families and carers. We do not believe that extra policies or more detailed procedures and protocols will result in improvements in practice but, rather, that a new approach to practice is needed.

R2 We recommend the trust adopt an approach such as the recovery model to address the shortcomings identified in this report. We believe the recovery model (or a similar philosophy such as the trust's *Vision and Values*) should underpin the practice of care professionals. It should also form the basis of a debate among professionals as to how the service should be taken forward. Compliance with the care programme approach will still be needed within the recovery model to provide the structure for mental health care to be properly and safely delivered. Formal risk assessment, including the completion of risk assessment forms, will still have a place, but the skills needed to assess risk must expand to include thoughtful curiosity. The recovery model (or a similar philosophy) requires the professional to be curious about what drives the service-user, what is meaningful to him, and why. Understanding what makes a person tick illuminates risk assessment and management and makes it more likely that the right boxes on the inevitably necessary forms are ticked.

If the goal of full engagement is pursued rigorously, within the framework of the care programme approach, it should ensure that:

- A diagnosis or working formulation is confidently made and acted upon
- Allegations of falsifying symptoms will be sorted out and contextualised
- The interrelationship between illness and drugs will be clarified
- The most appropriate person to offer full engagement will be identified
- Someone will have a coherent body of knowledge about the service-user
- There will be no responsibility gaps between referrals being made and

picked up by other professionals.

Follow-up letter

R3 We recommend that every significant contact between a service-user and a service-provider, or between service-providers about a service-user, is followed up by a letter to the service-user. “Significant contact” is any contact that results in a decision being made (including a decision not to do something). The letter would set out what decision had been made; why it had been made; what would happen next; and when the service-user could next expect contact. Copies should be sent to appropriate professionals and, if the service-user consents, to family and informal carers. If the service-user does not consent, advice should be taken on whether the refusal to consent should be overridden, in line with national and local confidentiality policies.

Referral vacuum

R4 We recommend that the trust clarify whether a referring consultant keeps responsibility until the referred-to consultant sees and assesses a service-user, or whether the responsibility transfers on the date of referral. The point when transfer of responsibility between consultants happens could have far-reaching consequences if a vacuum exists and neither consultant accepts responsibility in a crisis. It is important that it is always clear which consultant holds clinical responsibility for each service-user.

Allocation of care coordinators

R5 We recommend a review of the criteria used when allocating care coordinators. They should be allocated against objective criteria such as their experience, case load and the complexity of the case to be managed. The review should also consider what additional supervision is required when recently qualified professionals are appointed as care coordinators.

Police response

R6 We recommend that a review of customer contact processes at police station front desk is undertaken so that members of the public are clear as to what they can expect from the police and the police are clear what is expected of them.

R7 We recommend that if the police, or any other agency, are to be part of a care plan, including crisis planning, they must be informed of this, so that an action plan may be agreed in the event of contact being made.

Recommendations identified by the multi professional inquiry

3.24 We support the recommendations of the multi-professional inquiry which are found at appendix D. We particularly emphasise our support for the following recommendations.

- *That where patients have involvement with a range of services a chronology of care is maintained which will provide details of the history and staff ensure that all information is sought and shared with the relevant parties.*
- *That the trust and social services review their policies on providing a service to people who disengage to build in contingency plans within the care planning, together with an age appropriate service.*
- *That all handovers of patients between professionals should be fully documented in that individual's case notes.*
- *That the trust should undertake an examination of clinical notes, their coordination and availability to professionals.*
- *That the trust and social services review their policies on providing a service to people who disengage, to build in contingency plans within the care planning, together with an age appropriate service.*
- *That carers' views should be sought and taken into consideration when completing treatment and care planning.*
- *That all threats of harm to others should be taken seriously and consideration given to discuss with the individuals concerned, in order to properly manage risk.*

- *That transition procedures between CAMHS and adult services are reviewed and that care planning for that individual is jointly set between the two services.*

Service changes since 2004

3.25 Since the events that this report relates to, a number of important changes in policies, systems, programmes and personnel have been put in place by the trust and the county council. The trust has informed us⁵ that amongst other changes they have implemented the following:

- *“Using enhanced CPA effectively with this type of patient*
- *Pursuing engagement/disengagement proactively*
- *Tackling dual diagnosis having proper crisis plans*
- *Taking a longitudinal view*
- *Using risk assessment to inform and guide risk management rather than as an activity in its own right*
- *Re-assessing the situation if the carers are more worried than the professionals”*

The county council has informed us⁶ that it has *“...reviewed the criteria standards of the care coordination role and set clear standards for social work staff taking of this role.”*

We welcome the changes put in place by the trust and the county council.

⁵ Letter dated 7 April 2008

⁶ Letter dated 3 April 2008

DETAILS OF THE INVESTIGATION

4. Biography of Mr Gonzales

“Generally over a period of time his mental health really deteriorated, so much that his level of functioning was very poor” (John Humphreys - youth justice worker)

Childhood and education 1980 -1997

4.1 Mr Gonzales was born on the 21 June 1980 at Frimley Park Hospital in Surrey. His mother, Mrs Lesley Savage, is English, and his father, Mr Julian Gonzales, is Spanish.

4.2 Mr Gonzales was an only child. He went to a local nursery and primary school in Woking where his parents lived. In 1986 his parents separated. Mr Gonzales continued to live with his mother, but had frequent contact with his father, which continued throughout his childhood and into adulthood.

4.3 In 1991 he went to Gordon’s School; a grant maintained school in Woking, where his mother worked. There were concerns about his educational attainment, and he was assessed by an educational psychologist. He was found to have dysgraphia, a specific learning difficulty affecting his ability to write. Further assessments during his time at the school found he had an above average IQ.

4.4 In 1994 he took Spanish GCSE a year early and gained an A grade. He never lived in Spain, only visiting on family holidays, but he was fluent in Spanish and effectively bilingual.

4.5 In 1995 Mr Gonzales was excluded from school for bad behaviour shortly before GCSE exams. He was allowed back to take them, and gained a further seven GCSE’s at grades A* to C. He started taking cannabis during this year. In September 1995 he started at Brooklands College, Weybridge to study drama and Spanish at A level. During 1995, Mr Gonzales also joined the Surrey Youth Theatre, and was offered a major role.

First criminal offence - 1996

4.6 Mr Gonzales dropped out of college at the end of his first year. Shortly after this, in July 1996, he first came to the attention of the police, when he punched a bus driver in a dispute about a fare (this was later recorded as him having bitten the driver's ear). He admitted the offence and was formally cautioned. In November 1996, Mrs Savage was concerned about his mental health. The family GP referred him to the Frimley Children's Centre, where he was assessed by a senior social work practitioner who referred him to the ACORN drug unit.

Foster care & early signs of mental health symptoms - 1997

4.7 In early 1997 Mr Gonzales had a job in a bank, found by his mother, but only lasted a few days. In April he was arrested for shoplifting. His mother asked social services to find him a foster placement, as she was finding it difficult to cope with him. He was placed in supported lodgings with Mr and Mrs Soane, and remained with them for over a year. During this time, he was frequently in trouble with the police for impulsive crimes of theft and criminal damage. In October 1997 he was placed on a two-year probation order and directed to attend drug counselling. Shortly before this he went on holiday to Canada with his mother and grandmother, where he had no access to street drugs. His mother said he had become paranoid on the holiday. The Soanes had also noticed him displaying psychotic behaviour. His drugs counsellor wrote to the local drug and alcohol team consultants to report that Mr Gonzales thought people were talking about him, and that the television talked to him.

4.8 Mr Gonzales went back to Brooklands College briefly while on probation and then took a job at Blockbuster video store which he kept for a week. A Christmas holiday in Spain, with no access to street drugs, produced further symptoms of mental illness.

First psychiatric hospital admission - 1998

4.9 In February 1998, when Mr Gonzales was 17, he was admitted to the Abraham Cowley unit, an open psychiatric unit, for an assessment under section 2 of the Mental Health Act 1983 (MHA), after harming himself by punching a window. He was discharged by the Mental Health Review Tribunal before the assessment

was complete, and returned to live with the Soanes. He continued to get into trouble with the police, and caused concern in all those dealing with him professionally, who believed that his mental health was deteriorating. Although he was living with the Soanes, he was spending a lot of time at his mother's. She told them he was talking loudly to himself at night.

Strategy meeting and second psychiatric hospital admission 1998 - 1999

4.10 In July 1998 Mr Gonzales became 18 and had to leave the Soanes. He moved to live with a new carer, Steve Price. He continued to cause concern to those working with him, through his apparent symptoms of illness, drug taking, lack of engagement and continued involvement with the police. On the 14 September 1998 representatives of social services, children's services, youth justice services, CMHT, aftercare accommodation services, and Mr Price had a senior strategy meeting. The meeting identified his potential high risk of violence and/or suicide, and concluded that Mr Gonzales might never be able to live independently.

4.11 On the 28 September 1998, Mr Gonzales was admitted to the Oaktree clinic, a low secure psychiatric hospital, following a highly charged incident. His youth justice worker, John Humphries, saw him self-harming by hitting himself on the head with a saucepan and behaving in a threatening way towards Mr Price. He also caused criminal damage in the street before behaving threateningly towards the police, who restrained him and took him to hospital under section 136 of the MHA. Mr Gonzales stayed in hospital until April 1999, detained initially under section 3 of the MHA, then section 35, then section 38 and finally section 37. Dr Annear, the psychiatrist who cared for him during his first four months in the hospital was clear that he suffered from schizophrenia having given him a medication free trial.

Visits family in Spain May 1999 to August 1999

4.12 While Mr Gonzales was in hospital his parents decided that a change of scene would give him the opportunity of a fresh start. So his father returned to live and work in Spain. He moved to Minorca. His son joined him in May 1999, returning to England in August 1999.

Deteriorating mental health and prison 1999 - 2001

4.13 Mr Gonzales returned to live with his mother and her partner, Stephen Harper. He was under the care of Dr Kidd, consultant psychiatrist in Woking. He was taking medication but suffered a severe dystonic⁷ reaction. As a result his medication was changed in February 2000. He continued to hear voices; to take street drugs, although to a lesser extent; and to get in trouble with the police. In March 2000 he moved out of the family home, at his mother's request, and became homeless. In April 2000, shortly before his twentieth birthday, he was arrested on charges of burglary and street robbery and remanded in custody to HMP Reading. In December 2000 he was given a two-year prison sentence for these and other, lesser, offences, which he served at Dover Young Offenders Institution. A report was prepared by Dr Ward Lawrence before the sentence. He observed no current symptoms of illness. He reported that Mr Gonzales had admitted manipulating the symptoms of his illness in an attempt to avoid being sent to prison on remand during an earlier assessment by Dr Lawrence in April 2000.

4.14 Personal and professional visitors were concerned that Mr Gonzales appeared to be mentally ill while he was in custody. He received anti-psychotic medication from the healthcare centre while he was on remand at HMP Reading. No evidence of mental illness was found while he was serving his sentence in Dover.

Released from prison, new diagnosis of no mental illness - 2001

4.15 He was released from prison on 30 April 2001 and remained on licence, supervised by the probation service, until 30 October 2001, initially living with his mother and Mr Harper. His offending behaviour improved considerably during this period on licence. His family continued to have concerns about his mental health, although when Dr Lawrence saw him in outpatients he felt that he did not suffer from any mental illness. Mr Gonzales was evicted by his mother in June 2001, slept rough for a period and was then found accommodation in a hostel.

⁷ Abnormal tonicities of muscle, characterized by prolonged, repetitive muscle contractions that may cause twisting or jerking movements of the body or a body part

Returns home, assessed at A&E, becomes homeless, hostel place 2002

4.16 By January 2002 he was back home with his mother and Mr Harper. Mr Gonzales and his mother spent months seeking help, until finally Mr Gonzales was seen by his catchment area consultant psychiatrist, Dr Norman Weinstock, on 25 June 2002.

4.17 In July 2002 the police were called to an incident at the family home. They took Mr Gonzales to A&E at St Peter's Hospital, as he said that he felt unwell and needed accommodation because he could no longer live at home. He was not admitted to hospital, despite concerns expressed by staff at A&E. He was then homeless, living rough or with friends, until a hostel place was found for him in October 2002.

Caught shoplifting: supervision orders November 2002 to April 2003

4.18 Despite these difficulties Mr Gonzales kept out of trouble with the police during 2002 until November when he was arrested for shoplifting.

4.19 In January 2003 he was sentenced for the shoplifting, and given a six-month community rehabilitation order (CRO), under the supervision of the probation service. The probation officer was very concerned about his mental health. But Mr Gonzales was assessed by members of the community mental health team who thought that he was not particularly ill. The probation service continued to try and get him into work or education. Mr Gonzales continued to commit minor offences. He was given a 40-hour community punishment order (CPO) on 29 April 2003, again for shoplifting.

Returns to Spain May 2003 - December 2003

4.20 Before completing either the CRO or the CPO, Mr Gonzales went to stay with his father who was now living and working in Malaga. His family felt a change of scene would be helpful and might allow Mr Gonzales to find work.

4.21 He stayed with his father for two months, and then went to stay with his aunt in La Corunna, where he remained until late November 2003. He had no

access to street drugs, but was clearly mentally ill. Mr Gonzales and his extended family believed that it was best for him to return to England to seek treatment. While he was still in Spain, on 26 October 2003 he wrote, but did not send, a long letter to his GP, Dr Kuzmin, expressing despair about his circumstances and asking for help. He acknowledged that he suffered from severe schizophrenia and asked to be admitted to hospital.

Cry for help letter and consequences December 2003 - April 2004

4.22 Mr Gonzales returned to England in November 2003. His mother and grandmother gave Dr Kuzmin's locum the letter Mr Gonzales had written in Spain. The locum sent a copy, with a detailed two-page referral letter, to Dr Kidd, requesting an appointment for Mr Gonzales.

4.23 Mr Gonzales was seen in outpatients in January, March and April 2004 but was not offered an inpatient bed, despite his request to be admitted. It was not until April 2004 that he was allocated a care coordinator, Aloysius Kizza, who first wrote to him, offering an appointment, on 21 April 2004.

Broken leg, attending raves, arrested for non-completion of community orders January to August 2004

4.24 Mr Gonzales broke his leg in January 2004 and was in plaster. He was more or less dependent on his family to get about until March. When the plaster was removed, his way of life was to remain quietly at home during the week, then go to raves in London at the weekends.

4.25 During this time, in the spring and summer of 2004, Mr Gonzales made contact again with a young man, Charles Sadler, who had been a friend at Gordon's School and Brooklands College. Mr Sadler and his friends used to meet up on Friday evenings in Woking town centre. They met Mr Gonzales by chance on one occasion, and then started including him in these social gatherings. Mr Gonzales told Mr Sadler he was trying to improve his situation by giving up drugs. Mr Sadler noticed that he appeared to be having some success with this in the few weeks before the offences, although one consequence was that he appeared to be depressed.

4.26 He had no contact with the police from the time he returned from Spain in November 2003 until 22 July 2004, when he was arrested on the warrant issued in June 2003 for failure to complete his CRO and CPO. He was remanded on bail. This prevented him going to Spain to see his father as arranged because the bail terms required him to surrender his passport and not seek other travel documents.

4.27 In court on 16 August he was fined £50 for breaching the CPO. There was no penalty for breaching the CRO, reflecting the relatively trivial nature of the original offences.

The murders and attempted murders September 2004:

September 11 Mr Gonzales went to a rave in London, returning home the following day

September 13 He gave himself black eyes by punching himself in the face then tried to harm himself by jumping down a flight of steps. He ran naked through the streets of Knaphill, Woking, before returning home.

September 14 He stayed at home

September 15 He travelled to Portsmouth and attempted to murder Peter King. He then went to Brighton and murdered Marie Harding before returning to Woking for the night.

September 16 He went to London

September 17 He murdered Kevin Molloy, Derek Robinson and Jean Robinson and attempted to murder Koumis Constantinou in North London. He was arrested.

Subsequent history: September 2004 - August 2007

23 September 2004 He was remanded to HMP Belmarsh

- 15 October 2004 He was transferred to Broadmoor high security psychiatric hospital
- 27 March 2006 He was sentenced to six life sentences for the murders of Marie Harding, Kevin Molloy, Derek and Jean Robinson and for the attempted murders of Peter King and Koumis Constantinou.
- 9 August 2007 He apparently committed suicide at Broadmoor Hospital, aged 27

5. Diagnosis and treatment and the involvement of psychiatrists

“...in the absence of a clear diagnosis, treatment options were not actively pursued, in particular the possibility of taking medication.” (Mark Girvan)

5.1 Two key themes emerge from our review of the work of the psychiatrists: the lack of a clear diagnosis of schizophrenia for Mr Gonzales for most of the time he was in contact with the services; and, when a clear diagnosis was made, it did not last and so did not shape the services he received. Responsibility for his psychiatric medical care was shared by a large number of doctors. This, combined with the inadequate operation of CPA, contributed to the failure of doctors and others to understand and engage with him effectively.

Non medical views

5.2 Mr Gonzales' mental health was commented on by a number of non-medical professionals. Mrs Soane, who fostered Mr Gonzales from April 1997 to July 1998, said:

“You'd had to have known Daniel before all this happened to try and get an understanding of what we're saying. He was not the same boy, by the time he was 19, 20 he was not the same boy. There was still no violence or anything but he was just different.”

5.3 John Humphries, youth justice officer, was in contact with Mr Gonzales from October 1997 until 21 January 1999. He told the investigation:

“Generally over a period of time his mental health really deteriorated, so much so that his level of functioning was very poor. If anything there... seemed to be an increase in the deterioration in his mental health... It was general lack of personal care and lack of self-awareness.”

John Humphries was also present when Mr Gonzales was admitted to the Oaktree clinic and observed the level of his disturbance on the day of his admission and described his behaviour *“like a wild animal in a cage”*.

5.4 Charlotte McGregor, a social worker, was in contact with Mr Gonzales from October 1999 until March 2003. She described the difficulty of assessing his diagnosis and mental health difficulties. She said that when she took on his care coordination she understood his diagnosis to be drug-induced psychosis or query schizophrenia, although *“he didn’t really come across as having a mental illness or anything.”* She said his mother told her that when he came off street drugs you *“...see the paranoia.”* Later, when she saw him in prison, she started to believe the diagnosis of drug induced psychosis. Later still, she started to move towards the suggestion of personality disorder being put forward by others working with him.

5.5 Daniel Anderson and Sarah Cannon, probation officers, were in contact with Mr Gonzales from September 2000 until August 2004.

“...since our involvement with Mr Gonzales and since 2000 there has always been a clear theme running through, that everybody who has been involved with him has been quite convinced that there has always been an underlying mental health problem...Because he’d always been an active case with the community mental health team, we would always be relaying those concerns, always asking for assessments, always asking what can be done on that side.”

5.6 Mother Lesley Savage and grandmother Brenda Cutmore:

Mrs Cutmore: *“All the evidence seems to us to point to the fact and we are convinced that Daniel had a mental problem that he took drugs either because of this mental problem or just socially, found that they helped him and then they became a prop, so it helped his mental outlook.”*

Mrs Savage: *“Certainly when we knew 100 per cent that he didn’t have access to drugs - when he went on holiday, for example - he was completely bizarre, scary. We were frightened to death. In Canada at one time we took him on holiday and I know now - I didn’t know at the time - he was definitely psychotic.”*

“He never denied the illness as a whole. As an example, if I was in another room and he was in the living room but I could see him in the mirror, so he wasn’t aware I could see him, I could see him doing all these things [demonstrates grimacing] and I knew he was talking; he could see someone

because he was looking at them and talking and doing all these things. I would go in and say, 'Daniel, what were you doing; who were you talking to?' 'I wasn't talking to anybody, it was a joke I remembered.' He would always deny it. It was a moment of denial, it wasn't a denial of the whole thing. I can't explain it."

Mrs Savage: *"What it boils down to in the end is he did not want to talk about his voices. That was basically it. We just didn't go there. Everywhere else was fine but we didn't go there."*

Involvement of psychiatrists

Overview

5.7 Mr Gonzales' contact with psychiatrists began formally on 9 December 1997 when he was assessed by Dr R Garcia. He was referred by Mike Blank, director, Surrey alcohol drug advisory service (SADAS). He had previously been referred by his GP on 28 November 1996 to a child & adolescent psychiatrist (Dr E. Crutchley), Frimley children's centre, but he did not have a psychiatric assessment at that time, instead being seen by a social work practitioner

Comment

We do not criticise the decision to have another professional carry out the 1996 assessment, but we wonder if a psychiatric assessment might have picked up the first signs and symptoms of Mr Gonzales' schizophrenia.

5.8 Between 9 December 1997 and 20 July 2004, his final attendance at an outpatients' clinic before he committed the offences, Mr Gonzales was under the care of eight consultant psychiatrists.

5.9 His last contact with his consultant psychiatrist at a CPA review was on 22 February 2000 with Dr Kidd. Two months later he was arrested for robbery and remained in custody for a year, after which his care planning never really recovered.

5.10 His last consultant contact before the offences was at an outpatients' clinic with Dr Weinstock on 25 June 2002. This was his only direct contact with Dr Weinstock who was his consultant psychiatrist from that date until the offences over two years later. Dr Weinstock's only other involvement was when he was consulted by Dr Dada about Mr Gonzales after the appointment on 22 January 2004.

5.11 From 13 September 2002 until his last appointment on 20 July 2004, Mr Gonzales was seen by four junior doctors (of staff grade or associate specialist status). All were locums. Mr Gonzales attended only five appointments. Three of the junior doctors saw him only once and one, Dr M Joyce, saw him twice.

Comment

The involvement of consultant psychiatrists and their medical teams with Mr Gonzales' CPA was sometimes (but not always) poor and in breach of policy and good practice. The details of the involvement of consultant psychiatrists with CPA are set out in chapter 9 which deals with CPA in detail.

Significant contacts and involvement by psychiatrists

Dr M. De Ruiter (9 December 1997 to 6 February 1998)

<p>"...there is a risk that if he continues taking drugs he might develop a drug-induced psychosis..." Dr Garcia</p>
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5.12 Mr Gonzales was referred to Dr M De Ruiter, consultant psychiatrist, Windmill drug and alcohol team, by Mike Blank on 19 November 1997. He was assessed by Dr De Ruiter's senior house officer (SHO), Dr Garcia, on 9 December 1997. Dr Garcia prescribed an antipsychotic medication (thioridazine) having discussed Mr Gonzales' presentation with Dr De Ruiter. In a letter to Mr Gonzales' GP following the consultation, he said "*...there is a risk that if he continues taking drugs he might develop a drug-induced psychosis...*" It is impossible to tell whether thioridazine was prescribed as a prophylactic against the possibility of a psychosis developing, or to alleviate non-psychotic symptoms associated with drug misuse. It can be prescribed for either.

Dr Hennessy (6 February 1998 to 26 February 1998 admission to the Abraham Cowley unit (ACU))

Dr Hennessy described him as having a *“prolonged drug induced psychotic illness”*.

First hospital admission

5.13 Dr Hennessy was the first consultant psychiatrist with responsibility for Mr Gonzales who had personal contact with him. He had a 20 day admission to the ACU from 6 February 1998 until 26 February 1998. In her report to the Tribunal she said he had a *“prolonged drug induced psychotic illness”*. Dr Hennessy expressed concern at Mr Gonzales’ discharge by the mental health review tribunal (MHRT) which was against her recommendation.

5.14 Following Mr Gonzales’ discharge from ACU, he was not made subject to CPA. On 27 February 1998, Dr Hennessy’s SHO referred Mr Gonzales back to Dr De Ruiter. An appointment was made for 17 March 1998 and then 6 April 1998 with Dr Williams, senior clinical medical officer, Windmill drug and alcohol team, but Mr Gonzales did not attend.

Dr Kidd 15 June 1998 to 28 September 1998

5.15 Michaela Richards, CMHT coordinator faxed a message to Dr Kidd on 7 May 1998 requesting a psychiatric assessment as Mr Gonzales *“looks to be deteriorating again”*. A letter containing background information was sent to Dr Kidd on 1 June 1998 before Mr Gonzales’ appointment with Dr Kidd on 16 June 1998. In fact, Mr Gonzales saw Dr Kidd’s SHO, Dr O’Brien. She noted Mr Gonzales as having *“...serious illicit drug misuse...”* and *“...evidence of psychotic disorder...”* but did not make a definitive diagnosis.

Dr O’Brien noted Mr Gonzales as having *“...serious illicit drug misuse...”* and *“...evidence of psychotic disorder...”*

However, she prescribed olanzapine, a drug then licensed only for use in schizophrenia.

5.16 Following the referral by Dr Hennessy on the 28 February 1998 Mr Gonzales was not seen until the appointment with Dr O'Brien. It is not clear who held consultant responsibility for Mr Gonzales during the period 27 February 1998 to 15 June 1998.

Comment

We have been unable to ascertain whether a referring consultant keeps responsibility until the referred-to consultant sees and assesses a service-user or whether the responsibility transfers on the date of referral. If this 'consultant vacuum' exists it could have far-reaching consequences, should neither consultant accept responsibility at a time of crisis. This needs clarifying by the trust one way or the other. See recommendation 4.

5.17 At his second appointment on 14 July 1998, Mr Gonzales was discharged from outpatients by Dr O'Brien after refusing help from the Windmill drug and alcohol team. She wrote:

"I don't see the point of him coming to outpatients as he is not going to co-operate with any treatment. The only thing we can do is keep an eye on him by his key worker Kay Preston....I have not made another outpatients appointment therefore."

5.18 Dr Kidd was the consultant responsible for Mr Gonzales from 15 June 1998 to 28 September 1998. Mr Gonzales was not personally seen by Dr Kidd until he first assessed Mr Gonzales on 23 September 1998 at Abraham Cowley unit to prepare a psychiatric report for Woking Magistrates Court.

5.19 In his report to Woking Magistrates Court, dated 29 September 1998, following his assessment of Mr Gonzales on 23 September 1998, Dr Kidd's opinion reflected how he was subsequently to view Mr Gonzales' illness and behaviour. He stated:

"I felt that Mr Gonzales was probably psychotic as I was interviewing him, but with sufficient insight and control over himself to be able to make quite rational judgments about himself and the future...I did not think he was sectionable because of his degree of lucidity and his apparent lack of a

delusional system which might be influencing his behaviour.”

5.20 In his report Dr Kidd concluded that Mr Gonzales *“probably has a personality disorder”* and his use of *“large doses of LSD and sometimes Ketamine over recent years...is almost certainly responsible for his current state of mild psychosis”*.

Dr Kidd concluded that Mr Gonzales <i>“probably has a personality disorder”</i>

Detained at Oaktree clinic

Dr Annear 28 September 1998 - 9 January 1999

5.21 On 28 September 1998, five days after Dr Kidd’s assessment, Mr Gonzales was taken to Oaktree clinic by police under section 136 and detained, initially under section 2 and then section 3 of the Mental Health Act 1983 in the care of Dr Annear, consultant psychiatrist. After speaking to Mr Gonzales’ mother Dr Annear agreed to recommend a treatment order to the court in relation to the various criminal offences outstanding at the time of Mr Gonzales’ detention under the MHA, as well the offences committed on the day he was detained. This was agreed by the court and his detention continued under section 38 of the MHA.

5.22 Dr Annear was responsible for Mr Gonzales for four months inpatient treatment and assessment from 28 September 1998 until he stopped working at the hospital on 9 January 1999. This was the longest period of continuous assessment that Mr Gonzales received prior to his admission to Broadmoor.

5.23 To establish Mr Gonzales’ diagnosis before his court appearance, Dr Annear took Mr Gonzales off medication to see whether or not he relapsed. He told the investigation:

“...because there was some doubt historically about whether this was so-called drug-induced psychosis or whether it was a schizophrenic illness, we put him on sulpiride and then sulpiride with pipothiazine injections, and then discontinued medication whilst he was on a Section 38, because I made a recommendation to the court for a 38 as an interim hospital order to see

whether he would respond to treatment. This was treatment where you remove the treatment as part of treatment to ascertain whether indeed this was a schizophrenic illness. He didn't relapse after three weeks but he had by four or five weeks, so we put him back on, and John Humphries managed to bring the court case forward to get a 37."

5.24 Dr Annear had a working diagnosis of "continuous paranoid schizophrenia" for Mr Gonzales. He came to this conclusion after observing the effect on him of withdrawing treatment while he was at the Oaktree clinic. This diagnosis was supported by two other assessing doctors for the section 37 hospital order that was imposed on 21 January 1999.

Dr Annear had a working diagnosis of continuous paranoid schizophrenia and thought that his drug use was symptomatic of schizophrenia rather than causing symptoms.

5.25 Dr Annear started Mr Gonzales on antipsychotic medication in the form of a depot, pipothiazine palmitate 25mg IM every two weeks, and an oral antipsychotic, sulpiride 200mg tds. Mr Gonzales was also prescribed procyclidine tablets because of the severe side effects he experienced from this medication.

5.26 Given Mr Gonzales' known misuse of street drugs, the investigation team questioned Dr Annear about the possible impact this might have had on his mental illness.

"I thought then - and I think I recorded it somewhere - that his drug use was symptomatic of schizophrenia rather than causing symptoms. I thought that because there were all these other symptoms that were described. I think it was said that even when he wasn't taking drugs he was still getting symptoms, and I think even then I attributed the drug use to somatic over-arousal, and that he was trying to treat his over-arousal. I would say that even more eight years later in similar cases, but that is what I thought and recorded at the time."

"...It became clear to me - and it is even clearer now eight years later - that many patients who end up with a diagnosis of schizophrenic illness have been called variously drug-induced psychosis, personality disorder, acute psychotic episode, drug-induced, etc, the merry-go-round, and then end up

with a continuous schizophrenic illness.”

5.27 Dr Annear was clear in his evidence to the investigation that he would have kept Mr Gonzales on medication had he remained under his care. He said:

“I would not have had him off medication. That is with hindsight. This is somebody I wouldn’t have wanted to see off medication.”

5.28 Dr Annear said it had taken persistence and perseverance to make the diagnosis. He said he understood the diagnostic difficulties that Mr Gonzales posed for clinicians involved later. He was asked how frequently such a diagnosis loses its validity:

“Very common, I’m afraid. Whether I give a short report or a long report, it is still very common.”

Transfer to Farnham Road Hospital

Dr Ahmad 12 January 1999 to 16 March 1999

5.29 Mr Gonzales was transferred from Oaktree clinic to Farnham Road Hospital on 12 March 1999 as a “swap” with another service-user as his mental state was stable and it was thought that he did not need treatment in secure conditions. The discharge summary dated 12 May 1999 and prepared by Dr Dekalu-Thomas, locum SHO to Dr Cripps, stated Mr Gonzales’ diagnosis as “paranoid schizophrenia”. This summary, written two months after Mr Gonzales was discharged from the Oaktree clinic, was for some reason addressed to Dr Lawrence although Mr Gonzales was the responsibility of Dr Kidd. The summary gives no reason for Mr Gonzales admission save to say that he was brought to the Oaktree clinic by the police under section 136 of the Mental Health Act. It also gives no description of his behaviour prior to admission (there is a reference to him hitting himself on the head with a saucepan, but this is merely something that happened “at the age of 18”). The only description of his behaviour on admission was that “on admission he remained psychotic, deluded, disinhibited and out of touch”. John Humphries, Mr Gonzales’ youth justice worker, has a vivid recollection of the events of that day, both before the police arrived and subsequently:

“Daniel was like a caged animal and the police van was shaking. When he arrived at the Oaktree clinic it was almost like howling in the van and the shaking was like a wild animal in a cage. That went on for some time before Daniel could be taken out of the police van.”

Comment

We do not believe that anyone who simply read the discharge summary would have any idea what led to Mr Gonzales’ admission to a secure unit, rather than to the admission ward of the ACU. We do not know why the discharge summary was written two months after Mr Gonzales left the Oaktree clinic, a delay which amounts to poor practice. We also consider the quality of the discharge summary to be inadequate, as it gave no proper description of Mr Gonzales’ behaviour on the day of admission and therefore no reason why he had needed to be admitted to a secure unit. The failure to include in the discharge summary an accurate description of the reasons for Mr Gonzales’ admission to the Oaktree clinic (particularly relevant as he was just so young; just 18) had important consequences for how he was viewed by professional staff subsequently.

Transferred to Abraham Cowley unit (ACU)

5.30 On 15 March, three days after his arrival at Farnham Road Hospital, Mr Gonzales was discharged from the section 37 order by his RMO, Dr S. Ahmad, consultant psychiatrist, and was transferred to ACU on 16 March 1999 as an informal patient.

5.31 An undated discharge summary from Dr A. O’Brien stated Mr Gonzales’ diagnosis as paranoid schizophrenia. At the time of his transfer he was receiving pipothiazine depot 50mg every fortnight and procyclidine 5mg three times daily.

Diagnosis...paranoid schizophrenia, Dr O’Brien
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Discharged from ACU

Dr Kidd 16 March 1999 to 26 April 2000

5.32 Mr Gonzales was an inpatient informally in the ACU from 16 March 1999 until his discharge on 14 April 1999. He was then an outpatient until he was remanded in custody on 26 April 2000. During this time he was under the care of Dr Kidd, consultant psychiatrist. He voluntarily remained on depot antipsychotic medication until February 2000, and on oral anti-psychotics from then until he went to prison.

5.33 Mr Gonzales was discharged from the ACU without the knowledge of the youth justice team. The team had attended all his CPA reviews except the last one (Mr Humphries mistakenly believed the CPA meeting was on the 30th when it was on the 29th, and attended a day late) and should have been consulted as Mr Gonzales was a care-leaver with a continuing right to services arising from his mental health status. John Humphries told us:

“Then suddenly we had a phone call to say that Daniel had been discharged from hospital. Sue Piscoe the leading care worker was very upset at the time because she had expected a planning meeting to take place with the various agencies, including social services of which she was a representative, and I thought possibly myself because I had previous background information, where a care plan would be arranged.”

“Prior to him going into hospital he’d been accommodated by social services in supported lodgings, and at the senior strategy meeting there had been agreement to continue funding that for a certain period of time. He went from being in a supportive setting to being discharged in the community without any of those agencies being involved in any planning meetings...”

5.34 The discharge summary dated 28 April 1999 from Dr Kotze to Dr Rumball, Mr Gonzales’ GP, gives Mr Gonzales’ diagnosis as schizophrenia and past poly-substance abuse.

Diagnosis: schizophrenia and past poly-substance abuse. Dr Kotze

5.35 This summary repeats the failure to give a comprehensive account of the reason for his admission to Oaktree clinic and simply says that he was admitted “after assaulting a police officer”. It then says he was admitted to the ACU “in order to sort out his housing problems.” It says that “for detailed past psychiatric history, drug, forensic and personal history, I refer you to the medical report prepared by Dr Kidd on 29 September 1998”. This report was produced prior to Mr Gonzales’ admission to Oaktree clinic. The rest of the summary deals entirely with Mr Gonzales’ stay at the ACU.

Comment

It seems as if Dr Kotze felt there was nothing significant or even relevant to be learned from Mr Gonzales’ six-month stay on the secure unit. He also makes no reference to the five court reports written during this time by Dr Annear and two other consultant psychiatrists. It was unhelpful that the staff at the Oaktree clinic failed to provide a timely and comprehensive discharge summary. The court reports and, probably, the Oaktree notes could easily have been obtained and, as far as we can see, were not.

Changed diagnosis

5.36 Dr Kidd’s evidence to the investigation panel was that Mr Gonzales did not have schizophrenia:

*“All this debate about whether he is mad or not is probably irrelevant. The fact is he was disturbed underneath, but he may not have had a delusional - this is what makes me think it is not a process schizophrenia. He hadn’t had a developed paranoid delusion thing; he had dissociative symptoms, he heard occasional voices, which were mostly in his head telling he was no good, or ‘f**k you’ or that kind of spontaneous aggressive little outburst in his head which he was trying his best to control.”*

It is not a process, schizophrenia. Dr Kidd

5.37 Dr Kidd appears to have favoured the possibility that Mr Gonzales' substance misuse was more significant in explaining his behaviour than his diagnosis of schizophrenia. That is despite the compelling evidence from his stay in Oaktree clinic that he did have a diagnosis of schizophrenia and despite the fact that Dr Kidd was maintaining him on depot injections. Also, the diagnosis used at this time was one of paranoid schizophrenia.

Managing his medication

5.38 Following a GP referral dated 3 September 1999, after two missed appointments, Mr Gonzales attended an outpatient appointment with Dr Kidd's SHO, Dr Tolliday. Dr Tolliday notes:

“He complains of drooling and stiffness if he misses a single dose of procyclidine and there is a degree of akathisia which he complains of and is evident today”.

5.39 When Mr Gonzales was reviewed on 7 December 1999, Dr Kidd made it a condition of his receiving an atypical antipsychotic medication (olanzapine) that he *“stopped cannabis and any other illicit drug entirely”*.

5.40 In his care plan dated 7 January 2000, signed by Mr Gonzales and prepared after a CPA review on 23 December 1999 attended by Dr Kidd, his diagnosis is given as *“paranoid schizophrenia”*. In a letter dated 30 December 1999 to Mr Gonzales' GP, Dr Kidd writes *“I told him firmly that while he is persisting in imbibing illicit drugs he would have to continue the injection...”*

5.41 Mr Gonzales refused his depot injection on 7 February 2000 and started taking olanzapine on 9 February 2000. Following an outpatient's appointment Dr Kidd wrote to Mr Gonzales' GP on 2 March 2000 stating:

“I am not sure what medication he is actually taking at the moment but it would be appropriate if he were taking Risperidone 1mg bd or Olanzapine 5mg nocte”.

5.42 The impression is that in March 2000 Dr Kidd believed that Mr Gonzales did have some form of psychotic illness (perhaps paranoid schizophrenia, perhaps drug-

induced psychosis), and that he needed continuing antipsychotic medication. But there is no clear acceptance that he had schizophrenia or that the psychotic illness he had could be separated from his drug misuse. Regarding Mr Gonzales' drug taking, he told the investigation:

“At around 1999 my view of the importance of psychological trauma hadn't fully developed. Looking back, I can see this is the vital part of him and many other schizophrenic or psychotic people. If you take proper trauma histories, 50 percent of them have significant trauma and, as we know, psychosis can develop from psychological trauma, plus drugs, and I think he fits that bill....He fits the criteria of disturbed adolescent who is taking drugs.”

5.43 He was then asked whether Mr Gonzales had a severe and enduring mental illness:

“This is the thing. At what stage do you decide that they are severe and enduring, because in between times he was perfectly lucid, normal, charming in fact, but of course, underneath he still harboured the drivers for his psychosis. After five years of trying to persuade him into treatment, you can say it is severe and enduring.”

5.44 Mr Gonzales was not identified in the notes as having a personality disorder, but Dr Kidd did refer to this possibility in his evidence to the investigation:

“We are normally talking about borderline personality disorders, and underneath I think he is the sort of underlying personality disorder, complicated by drugs.”

I think he is the sort of underlying personality disorder, complicated by drugs. Dr Kidd

5.45 Mr Gonzales did not attend his appointment with Dr Kidd on 28 March 2000. Dr Kidd commented:

“His mother had ejected him quite understandably and he was living with friends no doubt in a state of hand to mouth chaos. This is quite sad but

there is not much to be done...I will not send him another appointment 'til I hear that he wants to see me. A CPA meeting might be in order".

5.46 It is clear that Dr Kidd's approach to managing Mr Gonzales was to:

- Attempt to bring about modification of his drug taking behaviour
- Negotiate with him about alternative antipsychotics with conditions attached (to stop taking illicit drugs)
- Leave the responsibility regarding attending appointments to him.

5.47 Dr Kidd explained to the inquiry the frustration he felt at managing Mr Gonzales, saying:

"...the worry about him was because he was so chaotic and there didn't seem to be a means of really getting him, except by sectioning him, and the grounds for sectioning him were never very great at any one time.... We want to encourage autonomy and so on, and he was able to put on this façade of sensible, charming, independent and so on, and he had this side of him which was quite misleading. He might even fall into the category of multiple personality disorder; he was able to switch into this charming way of being, which is slightly misleading, but people always look on the bright side and say, 'Good. All right then, what are you going to do?'"

5.48 Dr Kidd criticised the lack of stricter boundaries for Mr Gonzales. He told the investigation he was surprised that the MHRT removed his section and felt that remaining on the section would have had *"...more coercive value."*

5.49 Dr Kidd believed that Mr Gonzales was taken off his section 37 *"by the sectioning RMO"*, but this was not the case. The consultant (Dr Ahmad) who took him off his section 37 had known him for all of three days and the day after his discharge from section he was transferred to ACU as an inpatient under the care of Dr Kidd.

5.50 Dr Kidd arranged CPA reviews in late 1999 and early 2000, but these did not result in a satisfactory action plan based on Mr Gonzales' presentation or behaviour. Dr Kidd delegated responsibility for his medication to his GP:

“I am not sure what medication he is actually taking at the moment but it would be appropriate if he were taking Risperidone 1mg bd or Olanzapine 5mg nocte”

5.51 On 28 March 2000, when Dr Kidd decided not to send him another outpatient’s appointment, he stated *“a CPA meeting might be in order”*. Before any CPA could be organised Mr Gonzales was arrested.

Dr Lawrence April 2000 to 3 October 2001

5.52 Mr Gonzales was arrested on 26 April 2000. He was assessed in the custody suite of Woking Magistrates Court by consultant psychiatrist Dr Lawrence. Dr Lawrence prepared a court report dated 4 May 2000 and wrote to Dr Kidd on 5 May 2000 saying that Mr Gonzales was not *“appropriate for hospitalisation today”*. Mr Gonzales was remanded in custody to Reading youth offenders institute (YOI). He remained continuously in custody until 30 April 2001.

5.53 There is no evidence of any documented handover to Dr Lawrence and his team after the assessment, though Dr Kidd told the panel that there was telephone discussion with Dr Lawrence. Charlotte McGregor, the social worker in Dr Kidd’s team who had been Mr Gonzales’ care coordinator, visited him in prison although her involvement appears to have ended before the end of his sentence.

Comment

Although Dr Kidd involved himself with Mr Gonzales’ care planning more than subsequent consultants, the failure at the beginning to involve the youth justice team with the discharge, and at the end to hand over formally to Dr Lawrence’s team, undermined the continuity that is meant to be at the heart of care planning.

5.54 Dr Lawrence assessed Mr Gonzales again on 23 November 2000 to provide a psychiatric report to his solicitors. He saw him as an outpatient on 20 June 2001 and discharged him from outpatient follow-up on 3 October 2001.

5.55 Dr Lawrence’s view, given in evidence, was that Mr Gonzales did not have a severe mental illness. He told the investigation:

“...Clearly at the time I saw him I didn’t think he had a severe mental illness...”

5.56 However, in his court report of 4 December 2000 he stated that Mr Gonzales:

“Has a history of specific learning difficulties, conduct disorder and early onset of polydrug misuse...the possibility remains that he suffers from paranoid schizophrenia”.

...the possibility remains that he suffers from paranoid schizophrenia”. Dr Lawrence

5.57 He told the investigation:

“My initial conclusion when I saw him was - and I think I put it in the record - that he probably didn’t have schizophrenia but it was unclear”.

5.58 Dr Lawrence’s view was that if Mr Gonzales had schizophrenia or another psychotic illness he would probably have represented to mental health services. His view was that Mr Gonzales’ use of illicit drugs would increase the likelihood of relapse.

5.59 Dr Lawrence did not have Mr Gonzales’ inpatient records from the Oaktree clinic, although he could have obtained them. He read the discharge summary but discounted the possibility that he had schizophrenia. Asked *“...what weight did you give to the fact that he’d been in the Oaktree clinic for about six months?”* he answered:

“I gave it some weight. Clearly he’d received a diagnosis of paranoid schizophrenia from the Oaktree clinic. I read the discharge summary. I didn’t read the original notes because those weren’t available, but having read the discharge summary it wasn’t convincing to me that he had a diagnosis of schizophrenia from the information contained within the discharge summary. The Oaktree clinic didn’t have the best of reputations with the health service, but he had been diagnosed by another consultant as having schizophrenia, so I did give that some weight”.

Comment

It seems that Dr Lawrence did not consider the possibility that the lack of supporting information in the discharge summary might have been because of inadequacies in the summary, rather than inadequacies in the original diagnosis and formulation. We do not understand why anyone whose opportunities to observe a service-user were as limited as Dr Lawrence's would not wish to consider the inpatient notes in detail to help his own diagnosis and formulation. We find it even more surprising that Dr Lawrence would rely so heavily on his own assessment when he believed, with good reason, that Mr Gonzales had not always been honest with him. The investigation team considers that it must be good practice for those seeking a diagnosis to take into account the best-available historical information. Obtaining and reading old notes is an essential part of good practice. The fact that it can be so time-consuming and tedious as to be neglected is a matter that clinicians and managers need to address when looking at ways of recording and sharing information.

5.60 In his December report Dr Lawrence claimed that Mr Gonzales had:

“Consistently failed to comply with treatment as an outpatient, although the brief periods that he has been on injections he does appear to have been more stable”

5.61 The records show that Mr Gonzales voluntarily accepted fortnightly depot injections from November 1999, after his return from Spain, until February 2000 and he then accepted oral medication until he was remanded in custody in April 2000. He also seems to have accepted medication for at least some of the time between his two hospital admissions in 1998.

Comment

Dr Lawrence's report gives a misleading impression of the extent to which Mr Gonzales cooperated with treatment, in particular the injections, which were recorded as giving him unpleasant side-effects.

It is regrettable that Mr Gonzales' prison inmate record has been lost by the prison service. We know that he was prescribed Risperidone on 15th August 2000. In his December report Dr Lawrence says Mr Gonzales had not taken antipsychotic medication for two months before their meeting on 23 November. That leaves a period of between one and two months when Mr Gonzales had apparently been taking medication but then stopped. Medical records from that time would have shown if there had been evidence of relapse before or during those weeks. Dr Lawrence mentions in his report that prison staff told him that Mr Gonzales reported hearing voices. But Dr Lawrence does not quote from the prison medical records, so we cannot know the circumstances.

5.62 Dr Lawrence was aware of Mr Gonzales' use of illicit drugs. Asked if some of his symptoms could have been related to drug use he said:

"My impression was that they could well have been related to drugs."

5.63 Dr Lawrence thought Mr Gonzales was fabricating symptoms. In his December report he comments:

"On a previous occasion when I have seen him in the Court Diversion Service he complained of auditory hallucinations. He told me today that he wasn't hearing voices when I saw him and told me that he had invented these in order to avoid being sent to prison".

5.64 The previous occasion is described in his May letter to Dr Kidd:

"...he did describe "hearing voices" and these were described in a manner that I often see in imprisoned young men i.e. hearing voices which are clearly a reflection of their own thoughts but they fail to recognise as such. For instance, he told me that when I had sat down he heard a voice saying "punch him", meaning me. Phenomenologically, whilst these could obviously be considered part of a psychotic illness they are probably part of a dissociative state"

5.65 Even when Dr Lawrence believed what Mr Gonzales told him, he did not think this "symptom" of hearing voices was evidence of a psychotic illness.

Comment

In his December 2000 court report Dr Lawrence writes:

“Mr Gonzales admits on occasion to manipulating his symptoms in order to remain in hospital rather than prison, which further complicated the assessment”.

“On occasion” sounds like more than once, but there can only have been one occasion. Mr Gonzales was not an inpatient when he made the original claim to hear voices and there was no question of him “remaining” in hospital. The expression “manipulating his symptoms” leaves it unclear whether:

- Dr Lawrence believed Mr Gonzales did hear voices but not on the occasion of his first meeting with Dr Lawrence in April 2000, or*
- Dr Lawrence believed Mr Gonzales never heard voices and made them up entirely, or*
- Dr Lawrence thought Mr Gonzales was truthful on the first occasion but tried to minimise the claim at the second meeting. This could be because he no longer wanted a hospital order if he believed he would get out sooner with a prison sentence.*

Whatever Dr Lawrence meant, later readers all seem to have assumed that the second possible meaning was the correct one, even though Dr Lawrence never suggested in his second report that Mr Gonzales had fabricated symptoms.

5.66 This issue of manipulated symptoms was addressed in Dr Lawrence’s evidence to the investigation:

“If a patient tells you [he had fabricated symptoms] that, it is a significant thing and, whatever your view of it, that has to be recorded in some form or another. What sense you make of that is difficult.”

“Working within the criminal justice system, you need to be aware that people do present symptoms for specific reasons in order to evade custodial

sentences. And one has to bear that in mind in terms of his clinical presentation at the time, where he had not been on medication, he had been in prison, which is a good time to test someone's mental state. If they are going to relapse they often relapse soon after imprisonment, and he hadn't relapsed. Then you have to try to make some sense of his previous presentations in terms of what you see before you and what he is saying, and that was simply an attempt to make some sense of that".

5.67 It is important to emphasise that Mr Gonzales told Dr Lawrence that he “manipulated” symptoms “in order to remain in hospital rather than prison”. This was an odd, and perhaps noteworthy, way of putting it since he had been out of hospital for about a year when he first met Dr Lawrence. This was the specific context of his “fabrication”. He did not manipulate symptoms to obtain psychotropic drugs or pretend to be ill when he was not. However, “manipulated” symptoms became “fabricated symptoms” in the minds of subsequent psychiatrists.

Comment

Dr Lawrence's reports had much greater staying power than those of Dr Annear. His two page report, written in December 2000 purely to assist the court in deciding if Mr Gonzales should be placed on a hospital order, seems to have been taken subsequently as the definitive description of him as un-cooperative and an unreliable historian. We note that the Oaktree clinic was run by a different trust, but it has not been suggested to us that this might have adversely affected communication, nor should it have done.

5.68 After Mr Gonzales left Dover YO1 on 30 April 2001, he was reviewed by Dr Lawrence in outpatients and was not taken back under the care of the CMHT at Bridgewell House.

5.69 On 1 August 2001, Dr Lawrence wrote to Mr Gonzales' probation officer:

"I see little point in sending him another appointment given his poor attendance and his current mental state...if you have any concerns about his mental state I would be happy to see him".

5.70 In fact, Mr Gonzales should still have been on enhanced CPA as he was on enhanced CPA when he was arrested and his care coordinator, Charlotte McGregor, had written to HMP Reading to organise aftercare on 7 September 2000. So decisions about discharge from outpatients should have been made via the CPA process, but it appears Dr Lawrence was unaware of this.

5.71 On 22 August 2001, Dr Lawrence was notified of Mr Gonzales' contact with the Crisis Response Team. He wrote a note for a follow-up appointment to be arranged in the "next 10 days" but we have found no evidence that such an appointment was offered during this time. Mr Gonzales did not attend his next appointment with Dr Lawrence and as a result he was discharged from out follow-up on 3 October 2001.

5.72 When Mr Gonzales was discharged by Dr Lawrence on 3 October 2001 he was discharged from psychiatric services entirely. (See chapter 9 paragraphs (9.18 & 9.19)

...he did not suffer from a mental illness. Dr Lawrence

5.73 We asked Dr Lawrence why he discharged Mr Gonzales. He said that Mr Gonzales did not suffer from a mental illness and he was managing him under standard CPA:

"My perspective when he was in prison was that he was rejecting all help and I arranged to see him in order to try to motivate him to accept some help. I saw him on one occasion and not subsequently. My expectation, having looked at the information I had, was that we would be unlikely to engage him in any further treatment at that stage, given what I'd seen of him, and that he would be re-presented and could be picked up again subsequently."

5.74 That is a reasonable strategy if it is based on all relevant information, but it can only be successful if there is good coordination between agencies and teams and a response that results in a meaningful and helpful assessment. As it happened, Mr Gonzales did represent (on 22 August 2001) but this did not result in him being "picked up".

Comment

Dr Lawrence did not review Mr Gonzales' Oaktree clinic notes. He did not meet with his mother. He had limited access to past notes. He did not organise a CPA. His view was that Mr Gonzales did not warrant complex CPA and he seemed unaware that Mr Gonzales had not been discharged from CPA earlier. His comments that Mr Gonzales had fabricated symptoms and his view that he had no severe mental illness prevailed and appeared to carry more weight in informing subsequent opinion than the previous diagnosis of schizophrenia made after an inpatient admission of over six months.

Last consultant psychiatrist

Dr Weinstock 25 June 2002 to 17 September 2004

5.75 After Mr Gonzales' discharge from outpatients by Dr Lawrence on 3 October 2001, his next assessment by a psychiatrist was on 25 June 2002 when he saw Dr Weinstock. Dr Weinstock was the last consultant psychiatrist who had responsibility for him. It is difficult to know on what date he became, or should have become, Mr Gonzales' consultant. The possible dates are:

- when Mr Gonzales was re-referred to Bridgewell House via a letter written by his mother on 12 March 2002
- when Mr Gonzales' mother was interviewed by Teresa Vines on or about 2 April 2002
- when Mr Gonzales saw Dr Weinstock on 25 June 2002.

5.76 Mr Gonzales' mother wrote to "Head of Department, Bridgewell House" on 12 March 2002 requesting a follow-up appointment for him. Three months later, on 25 June, he was assessed in person by Dr Weinstock at an outpatient's appointment.

Comment

It was good practice that Mr Gonzales was seen by his new consultant in person, but regrettable that the meeting did not take place for three months. Striking while the iron is hot would be good practice when someone is known to the CMHT as a hard-to-reach individual.

5.77 Dr Weinstock's contemporaneous notes read:

"...Complains of low stress tolerance. Mother picks on him for small things. Mother calls police if he gets exasperated. Raises his voice, e.g., if she goes naked into his room repeatedly. Needs counselling to tolerate mother. Living with mother last one year complains of low stress tolerance".

"...No illicit drugs since November 2001. Lives with mother and stepfather. Draws. Plays football by himself. Reads. Computer. Goes for walks. Can't get work because if gets stressed and loses it because [employers] can't accept [him] when angry / exasperated..."

"...Emotionally vulnerable. Didn't want to finish [the consultation] because angry, saying I was doing a bad job, had constantly interrupted him. Wants to see a different psychiatrist".

5.78 At that point Mr Gonzales left the consultation. Dr Weinstock did not write to his GP. He told the investigation team:

"Yes. I did not do one. I should have done. Rarely over the years, I have not done a letter. Probably occasionally it happens and it just happened to have happened on this particular occasion"

He did not contact the CMHT after this consultation, or arrange for a CPA review. He did not consult with Mr Gonzales' mother to check the claim that "...she goes naked into his room repeatedly." If he had, Mrs Savage would have told him it was untrue. He did not assess whether this claim was part of Mr Gonzales' mental illness symptoms, and Mrs Savage's response might have led to him doing so.

5.79 Dr Weinstock told the investigation team he thought he would have had at least some of Mr Gonzales' notes with him at the time of his assessment. He said he arranged for Mr Gonzales to have another appointment with his staff grade doctor. The notes reveal that Mr Gonzales was due to see Dr Weinstock's locum staff grade, Dr J Gore on 10 September 2002, but failed to attend. It was only after he attended Bridgewell House "*abusive and disruptive*" on 13 September 2002 that he was assessed by Dr Gore at the ACU.

Comment

The appointment with Dr Gore was not until September - nearly three months after the meeting with Dr Weinstock. Given Mr Gonzales' distress, the fact he walked out of the meeting (a rare occurrence that anyone who knew him could have told Dr Weinstock), his alleged peculiar behaviour and his request for a different consultant, one would have expected Dr Weinstock to arrange a follow-up appointment much sooner.

Last medical staff involvement

5.80 In the meantime, on 10 July 2002, Mr Gonzales presented at A&E and was seen by the duty psychiatrist, Dr Lazarova. The crisis response team (CRT) "feedback information form" specified Dr Lawrence as the "psychiatrist" and under the "plan" specified "*FAO Dr Lawrence please send him an appt for a review etc*". As agreed with the crisis team, Mr Gonzales attended Bridgewell House the next day and there is a note dated 29 July that he was discussed at the meeting of Dr. Weinstock's team (Patch 3) when Joyce Winstone was allocated as his care coordinator. We found no evidence that the CRT suggestion of a review by his consultant psychiatrist was ever followed up.

5.81 The appointment with Dr Gore took place on the 13 September 2002. Dr Gore carried out a comprehensive assessment of Mr Gonzales. In her detailed letter of 1 October 2002 to his GP, Dr Hendry, Dr Gore stated that there was "*No evidence of enmeshed psychiatric disorder*". Mr Gonzales failed to attend his next appointment on 7 November 2002 and Dr Gore wrote to his GP stating:

"I have asked his CPN...and Social Worker...to ask Daniel to make a further appointment if he wishes to be seen again."

5.82 Joyce Winstone's view, expressed in a letter to Mr Gonzales on 7 March 2003 and to his GP on 7 April 2003, was that he was "closed" to outpatients as "he has not attended appointments."

5.83 Dr Gore's letter theoretically left the way open for a further outpatient appointment, but there was no suggested involvement of a psychiatrist in Mr Gonzales' care until 7 April 2003. Mr Gonzales went to Bridgewell House to ask for an appointment with a psychiatrist. Joyce Winstone wrote a letter to his GP, copied to Dr Weinstock, suggesting a re-referral to Dr Weinstock. This letter did not result in an appointment being made. Nor did an urgent referral letter from Mr Gonzales' locum GP, dated 1 December 2003, following Mr Gonzales' return from six months in Spain produce a timely response.

5.84 It was not until 22 January 2004 that Mr Gonzales was finally assessed in outpatients, again by a locum staff grade doctor, Dr T Dada. Afterwards, Dr Dada discussed Mr Gonzales with Dr Weinstock. This means there was no psychiatrist contribution to his care from 13 September 2002 until 22 January 2004 (almost 15 months but including 6 months when he was in Spain). This covered the period in the first half of 2003 when probation records suggest he was not managing at all well and was causing considerable concern about his mental health.

5.85 Dr Dada wrote to Dr Hendry on 23 January 2004 following the outpatients' appointment:

"I discussed [the case] with Dr Weinstock who suggested the Day Hospital for a period of further assessment and observation...I called Mr Gonzales at home but he declined the suggestion of coming in to the Day Hospital...I was told that he has been off medication for almost two years as he stopped taking it due to side effects... He described as significant the side effects when taking the antipsychotic medication.... I checked through his notes and noted there were issues of drug abuse and a history of fabricating psychiatric symptoms....His Mum reported that recently he has been speaking to himself and appeared to be responding to visual hallucinations, and stays in bed all morning...During this period of assessment I could not detect any symptoms of mental illness"

5.86 This was an important assessment as Dr Dada weighed up Mr Gonzales' presentation, the history from his mother and his review of the notes available to him. It would appear that Dr Dada was sceptical about his experience of side effects. This is despite comments from the Oaktree clinic and Dr Kidd's SHO about Mr Gonzales' severe extra-pyramidal side effects to typical antipsychotic medication. The references to "*drug abuse*" and "*fabricating psychiatric symptoms*" and his inability to detect any symptoms of mental illness had a greater influence on Dr Dada's opinion than the histories of Mr Gonzales and his mother. Nevertheless, an offer for him to attend the day hospital was made. It appears there was no further contact after the telephone call in which Dr Dada "*agreed...to get back to [Mr Gonzales] as soon as possible*" regarding the possibility of an in-patient admission".

Comment

It seems likely to us that Mr Gonzales and his family would have found this visit and its aftermath somewhat discouraging, particularly the lack of promised contact after the telephone call.

5.87 Another locum doctor, Dr M Joyce, saw Mr Gonzales on two occasions (10 March 2004 and 22 April 2004). Dr Joyce referred him back to the CMHT. Despite stating that he suffered "*chronic schizophrenia*" and that "*at the moment it is the negative symptoms that are most prominent*", Dr Joyce did not mention his CPA status or that a CPA review might be appropriate as part of the referral back to the CMHT.

5.88 Finally, Mr Gonzales saw Dr Wagaine-Twabwe, locum associate specialist to Dr Weinstock on 20 July 2004. Dr Wagaine-Twabwe wrote to Mr Gonzales' GP to provide feedback. The letter is reproduced in appendix E *as it demonstrates the sense of therapeutic helplessness that seem to be brought forth by Mr Gonzales' sense of hopelessness.*

5.89 This was his last contact with a member of the trust before he committed his crimes.

Broadmoor assessments following arrest

5.90 The purpose of this section is to gain an important prospective on Mr Gonzales' diagnosis from Broadmoor Hospital consultants who were able to observe him in a controlled environment. The only other time this quality of information was available was when Mr Gonzales was in Oaktree clinic under the care of Dr Annear.

5.91 Mr Gonzales was detained and treated in Broadmoor Hospital from September 2004 until his death in August 2007. The investigation heard evidence from both treating psychiatrists who carried out detailed assessments of his mental state. Dr Petch had initial responsibility on admission. When Mr Gonzales was transferred to Isis ward Dr Das took over responsibility. Dr Petch resumed responsibility when Mr Gonzales was moved from Isis ward to Henley ward.

Dr Das told us:

“Immediately on coming in, the view of Dr Petch, the admitting consultant, was that this is a psychotic illness, given the bizarreness of the offences, given the bizarreness of the self-harm, given that there is a clear history of him having presented with psychotic symptoms in the past, so he was started on an depot antipsychotic. Historically if you look into Danny’s history he has never really done very well on a typical depot antipsychotic, which is the old-fashioned depot antipsychotic, he always had a lot of side effects. What we saw with the antipsychotic was that it brought down the agitation, it brought down the arousal, but we saw a man who had extrapyramidal symptoms: he was stiff as a board, it was quite a sight. When he came on Isis we thought this was not on, we had to do something; the side effects were so bad.”

5.92 In reply to a question about whether he was given the standard doses Dr Das said:

“No. It was 600 of Clopixol, which you will appreciate is a very high dose; 600 Clopixol a week is a mega dose. We decided that we would change over to a new antipsychotic, quetiapine, which has a very good side effect

profile, and we started him on quetiapine. Around the time he was on the quetiapine he self-harmed and my concerns were that he was on a conventional dose of quetiapine, which is 750 mgs a day. It was not just the self-harm; the other problem was that he was unpredictable, hitting out at other patients and staff. Everything was fine and the next moment he would punch someone or, for example, he was having his dinner, he took the fork and went for another patient's eyes. It was very lucky that he only managed to graze, otherwise he would have caused a lot of damage.

We then decided to go on an unusual strategy of treating him on double the normal dose of quetiapine... I think some rationale we felt was that, given he was self-harming, was there a depressive element, so we also started an antidepressant along with that, venlafaxine. We then started a mood stabiliser as well, sodium valproate. All these changes happened between August and October 2005. What we saw, I think it was with the quetiapine going up to 1500 that it temporarily correlates with a very dramatic improvement. From about September of last year [2005] Danny is a changed man....”

5.93 Commenting on the effect of the changed medication Dr Das said:

“The changes we have seen in him is that he began to talk with his primary nurse, he began to verbalise as to what was happening around the index offence, how he was feeling. We could relate to him in the sense that it was like coming out of a shell, he was warmer, it was like talking to somebody who was more normal, more warmth and smiles. He began to interact with other patients on the ward, he began to get into his usual interests of listening to music, watching videos....”

5.94 Dr Das was asked whether Mr Gonzales could be fabricating or concealing symptoms and whether someone who was not mentally ill could function on the high doses of medication that he was receiving.

“We had this discussion within the team, just to expand on this point, is this improvement in him just spontaneous, is this attributable to medication, is it that we are just medicating someone who doesn't need to be medicated,

for example. Talking to his parents, this is the best he's ever been; they have not seen Danny so well since the age of about 15 to 16. This is a Danny they can relate to, they can talk to, a person who is organised in his thought process, able to talk about how he feels. Clearly there is improvement. There is indication that his presentation is better than how he was at about 16 to 17 years of age. That's one thing which would probably lead us to think that the medication is doing something.

The second point is the change in his mental state over a period of three months, from being extremely disturbed to a dramatic change, correlates very well with the initiation of medication treatment."

"I think 1500 mgs of quetiapine would be extremely sedating, and if we were to give it to somebody, say, with normal dopamine levels in the brain, I think it would knock that person out."

Dr Petch told us:

"I think undifferentiated schizophrenia probably is a more accurate diagnosis than paranoid schizophrenia - although one could be forgiven for thinking that it was paranoid schizophrenia.

The reason for that is that the picture is being so predominantly one of gradual deterioration of the negative symptoms from late puberty, and the positive symptoms seem to me to be fleeting, changing and interspersed with periods of possibly drug misuse... He doesn't really come over as a typical man with schizophrenia; he comes over much more as personality disorder - a disorganised and rather anti-social man who was in and out of the criminal justice system committing offences not necessarily related to psychotic symptoms, or indeed drug misuse.

The picture was extremely complicated, but now looking back, he is an undifferentiated schizophrenia - okay, with personality disorder, and drug misuse."

5.95 Both Dr Das and Dr Petch acknowledged how Mr Gonzales' drug misuse interfered with his diagnosis of schizophrenia being accepted. Dr Das stated:

“The issue of him having taken substances seems to have clouded everything. In my reading of his history, having gone through his notes extensively, it appears that over a period of time quite a bit has been attributed to substance misuse and there appears to be some degree of reluctance to call a spade a spade

There is an emphasis on drug-taking because it is one easy way to explain the rapid changes in his mental state. In the family where I have spoken to them they say he was changing very rapidly, and again it was the mood that was changing. Irritability was changing, and the overall picture was just of a very gradual decline - so gradual if you just saw him as a one-off you would not pick it up, you would need to see him a number of separate times.”

5.96 Dr Petch gave the investigation his interpretation of the difficulty the mental health team had making an accurate diagnosis and formulation of Mr Gonzales' mental illness:

“There were times when services and indeed we felt that he was perhaps not being completely open with us, which complicated matters as well. He is quite capable of calculating his own advantage if he thinks you are going to admit him or do something he doesn't want. He is quite capable of attempting to pull the wool over your eyes. He has not done that particularly here, although I am sure he is very capable of doing it.

...normally you can take a decent mental state out of somebody half competent in five minutes or maybe 10, and work out at least a preliminary review of whether you think they are psychotic or not. With him I walk away and I am terribly confused. I am none the wiser as to whether I think he has psychosis or not, and it is only really taking examination of the longitudinal picture that it emerges. I hope that came out in my report, because seeing this man in out-patients is not going to help you, if you see what I mean - in terms of a one-off.”

5.97 He was asked whether he agreed that the attempts by previous doctors to arrive at a diagnosis were reasonable.

“And understandable. I can’t see that they were not doing the best they could with what they had in front of them, which was a changeable picture. You get somebody in a busy clinic in an afternoon, you’ve got four or five before, you’ve got four or five after in the middle of the afternoon, you do what you can in half an hour. It is inadequate for what we do, but if someone is not really eloquent, is not really answering, he is totally chaotic, he has a very long history, you can only find half the notes, the other half is with the CPN or wherever, it is all over the place. In that sort of chaos that appears to me to be local services overall - without picking on them, just generally - it is going to be very difficult to identify this one amongst all the people. I wouldn’t have thought he would really stand out from the crowd.”

5.98 He accepted they were still finding diagnosis difficult even with the advantages of Mr Gonzales being with them for so long.

“Indeed, and we have some of the best diagnosticians in terms of nursing staff and psychologists and social workers and the multi-disciplinary team putting their all into this and with regular CPAs, and we are still not sure. That I hope is not because of incompetence but because we have an open mind and because his presentation is so atypical.”

Comment

Mr Gonzales was clearly diagnosed with “continuous paranoid schizophrenia” after his admission to Oaktree clinic from September 1998 to March 1999 under section 37 of the Mental Health Act 1983. The evidence for this diagnosis at that time is compelling. However, the diagnosis did not appear to “stick” and only one year later, he was discharged from the outpatients’ clinic. The diagnosis of schizophrenia was referred to at times in later correspondence, but never shaped his care in the way it should have. Subsequent diagnosis in the absence of the evidence obtained from the Oaktree clinic admission was undeniably difficult and it is regrettable that that evidence did not have the presence in these later attempts to reach a diagnosis that it should have done. The absence of a diagnosis should have led

to a formulation upon which an effective care plan could have been based

The failure to take more account of the Oaktree evidence must, in part, have been due to the lack of proper handovers, either face to face or in writing, between those who worked with him before and during his admission to Oaktree clinic and those who did so afterwards. We do not criticise Dr Annear, as he left the clinic over two months before Mr Gonzales. Nor do we criticise John Humphries or Sue Piscoe/Withers, who attended all or most of the in-patient CPA's and who would have been able to provide valuable information to his subsequent treating team.

Much of Mr Gonzales' early contact with psychiatrists (from his referral to Dr De Ruiter on 19 November 1997 until his discharge from outpatients by Dr Lawrence on 3 October 2001) included comments about his drug-taking. It would appear, though, that he was never formally recognised as having a "dual diagnosis" (broadly defined as being the coexistence of mental illness and substance misuse problems). Mr Gonzales' drug-taking behaviour became less prominent after 2001. When Dr Weinstock assessed him on 25 June 2002 he noted that he had taken "no illicit drugs since Nov 2001". Other evidence suggests he continued to take "recreational" drugs, particularly at raves, until the time of the offences.

There are only two contemporaneous references to the possibility of Mr Gonzales having "personality problems": Dr J Gore, 13 September 2002 and Dr Kidd's court report, 23 September 1998. No diagnosis of personality disorder was made until after he committed his offences.

Mr Gonzales' diagnosis was infrequently mentioned in the notes so it is difficult to know if the responses to his behaviour from the psychiatrists involved were based on an understanding that he had schizophrenia. If there was a tacit acknowledgment that he had schizophrenia, was it appropriate for him to be discharged from outpatient care, losing the input from a consultant psychiatrist? We doubt it is ever appropriate to discharge a service-user with schizophrenia and with the needs and behaviour shown by Mr Gonzales, either from outpatients or from the CMHT. If he was not thought to have a mental illness, then an explanation for his behaviour and his deterioration over the years, and how his needs were to be assessed and managed should have been

sought. In the absence of a clear diagnosis a formulation should have been made that included all the evidence, including the Oaktree material. The absence of either clear diagnosis or robust formulation seemed to result in many of the clinicians treating Mr Gonzales relying to an unhelpful extent on the way that Mr Gonzales presented at interview.

There is a line to be drawn between respecting service-users' rights to accept or reject services, and neglecting their needs. There is no doubt that those who were responsible for Mr Gonzales found him confusing. The lack of a clear diagnosis led to uncoordinated, snap-shot assessments that lacked understanding of the history of his illness, his contact with services, and how these might have affected the nature of his presentation. If Mr Gonzales had been seen clearly as a service-user with a severe and enduring mental illness, whose behaviour was significantly influenced by his illness, there might have been a more tolerant and sophisticated approach to his psychiatric care. Unfortunately there was no continuity between psychiatrists, or between psychiatrists and the CMHT, after his arrest on 25 April 2000.

Mr Gonzales was discharged from outpatient follow-up, or not sent further appointments, on four occasions. He continued to have some contact with his care coordinator or the duty worker at Bridgewell House. But he was discharged entirely from the psychiatric service from 3 October 2001 until 25 June 2002 despite attempts from his mother and GP to have him reassessed.

It is difficult to understand the role that Mr Gonzales' outpatient appointments had, or were meant to have, in managing his condition and behaviour, particularly since on a number of occasions he failed to attend seemingly because he never received the appointment letter or was too disorganised. There was little or no coordination between the doctors seeing him in outpatients, his GP and the CMHT at Bridgewell House. An example of this is the attempted re-referral of him to outpatients in April 2003 by his then care coordinator, Joyce Winstone. Ms Winstone wrote to his GP on 7 April 2003 suggesting he be referred to Dr Weinstock and copied the letter to Dr Weinstock. Why Ms Winstone, as care coordinator, could not have liaised directly with Dr Weinstock and booked him in is unclear. The letter did not result in an appointment being made. Overall, the psychiatric element of Mr

Gonzales' care was uncoupled from the CMHT input.

The junior doctors who saw Mr Gonzales in outpatients knew he had a diagnosis of psychosis or schizophrenia, but they appeared unaware of how the care programme approach could and should have been used to manage him as none of them made reference to it. We believe that the lack of consultant psychiatrist leadership in using the care programme approach from 2000 was a significant failing.

Dr Dada's assessment reflects how recorded information influenced later assessments. It is clear from the notes from Mr Gonzales' treatment in Oaktree clinic and ACU from 1998 to 2000, as well as from evidence given to the investigation, that he had severe extra pyramidal side effects to prescribed medication and had experienced "genuine" psychotic symptoms in the past. However from his review of the notes, Dr Dada picked out the statement from Dr Lawrence about fabricating symptoms and his previous drug abuse. He interpreted Mr Gonzales' request for "anti-side effect" drugs as evidence that he might misuse them. This is despite the fact that he had not been misusing drugs at that time and his mother gave a clear description of his abnormal mental state with manifestation of psychotic behaviour.

When Mr Gonzales was prescribed antipsychotic medication he took it despite the severe side effects he experienced. In early 2000 he refused his depot because of the severe side effects that he was experiencing and was prescribed oral medication. It is perhaps understandable that he would want reassurance that any new treatment would not cause him similar side effects. Part of that reassurance could have involved providing him with a small supply of "anti-side effect" tablets "just in case".

We conclude that Mr Gonzales should have been considered to have a dual diagnosis, defined in its widest context, because he had a mental illness and admitted to using illicit drugs. His care plan should have specified that his substance misuse required assessment and management. The investigation team conclude that at the very least, Mr Gonzales should have been managed as an individual with a severe psychotic mental illness, such as schizophrenia. Despite Mr Gonzales' irregular attendance at outpatient appointments, the investigation team conclude that he should not have been discharged from out-

patient follow-up. If an individual with severe mental illness is prone to miss appointments, it is the duty of the psychiatrist to find a way around the problem. For example, if the care programme approach is in place, attendance at outpatients might be unnecessary because psychiatrists can have alternative input through regular CPA reviews. If an outpatient consultation is deemed essential, psychiatrists should be creative in ensuring the consultation takes place (as is done in assertive outreach teams). Common sense suggests that a service-user is less likely to value appointments when he is likely to see a different person every time.

Between 20 June 2001 (when he was last seen by Dr Lawrence) and the time of the offences in September 2004, Mr Gonzales was only seen once by a consultant psychiatrist, when he was seen by Dr Weinstock on 25 June 2002. This means that for that for over three years, with one brief exception, the professional most equipped to diagnose and formulate his presentation, the consultant psychiatrist, was not involved directly in Mr Gonzales' care, despite all the contact Mr Gonzales had with other members of the CMHT and his GP. Mr Gonzales' assessments after 25 June 2002 were by locum junior doctors, who, although they were able to undertake thorough assessments, were seemingly unable to take an overview and be curious as to what might be underlying his presentations and behaviour.

Mr Gonzales' input from psychiatrists should have been part of an overall care plan that identified his needs and specified the role that outpatient appointments played in addressing them. His consultants should have played a leading role in ensuring that he was subject to the enhanced care programme approach.

In the Royal College of Psychiatrists council report CR140 dated August 2006, roles and responsibilities of the consultant in general adult psychiatry one of the key skills required for consultants in general adult psychiatry to fulfill their roles is stated as being: "Care plan and treatment plan formulation; within in-patient and community settings and in emergency and non-emergency situations. This includes discharge planning and community care plans. These plans are drawn up in close collaboration with the multidisciplinary team and other agencies."

The Royal College of Psychiatrists council report CR96 dated April 2001, Consultants as Partners in Care: The roles and responsibilities of consultant psychiatrists in the planning and provision of mental health services for people with severe mental illness states in relation to consultant's core skills, that:

- *“Core skills are to develop relationships with service-users and to assess need and appropriate treatment and service provision.*

These core skills are also to provide appropriate treatment and services, involving:

- *familiarity with mental health legislation and the relevant Mental Health Act*
- *understanding of the provisions of the NHS Plan (Department of Health, 2000) and National Service Framework (Department of Health, 1999a; see appendix), the care programme approach (CPA) and the ability to implement the use of such procedures appropriately and in the service-user's best interests*
- *ability to accept the leadership role, where appropriate, in the clinical team and the responsibilities of that role so as all the disciplines involved in service-user care can be coordinated and used effectively to pursue the major objective of the best treatment of the individual service-user, according to the nature of the clinical setting.”*

We could find no evidence that there had ever been a proper handover, including discussion and careful reading of all the notes, on any of the occasions that responsibility for Mr Gonzales' care moved from one consultant to another after he left the Oaktree clinic. We find this to be poor practice, and a contributing factor to the diagnostic confusion around him.

Dr Weinstock's involvement as Mr Gonzales' consultant

5.99 This section of the report is included because in taking evidence we were made aware that a number of witnesses thought Dr Weinstock was not managing

his community workload effectively. We have already recorded that he saw Mr Gonzales at outpatients on 25 June 2002. Apart from being consulted by his staff grade doctor about Mr Gonzales, he had no further dealings with him.

5.100 Dr Weinstock told the investigation he was appointed as consultant psychiatrist in November 2000 having worked for the predecessors of the trust since November 1985.

5.101 We received the following evidence from members of the trust regarding Dr Weinstock.

Lorraine Reid

“I think he wasn’t much of a team player. I didn’t really know him personally but from what I heard...I think he didn’t regularly attend the CMHT and he seldom had CPA reviews.”

Dr Hennessy

“...he wrote to me to say that he was finding difficulty in managing his workload. I think this would have been in about 2001. On paper his job was not excessive in terms of Royal College standard but I believe he was struggling on an administrative level in trying to cope. He has some obsessional traits, which can be very helpful, but I felt, after discussing with the senior secretariat, that he wasn’t using the support available. I felt that was one reason he was getting into trouble in managing his workload, so I put in some informal help through the medical secretariat route. He was also complaining of not having enough junior medical support...he shared a staff grade doctor...I identified money available and made that post up to a full-time staff grade post.

He continued to say that he was struggling to cope with the workload. I did ask Dr Lawrence to look at that and, although objectively it did not seem that the workload was excessive, an opportunity arose to give him additional medical support at a senior level. I hoped that with that, and by that time Dr Lawrence was working with me on this, that that would give Dr Weinstock an opportunity to look at his managing of his workload with some additional medical support at a senior level.”

Dr Lawrence

“I had a number of conversations with Dr Weinstock about his workload since he became a consultant, both through appraisal and through peer support. Looking at his catchment area and his patch, I didn’t think he had a particularly unfair and unequal caseload to any other consultant.”

“He had a tendency to take a great deal of time in preparing written material and to check it endlessly, so we encouraged him to check it once or twice and for his secretary to encourage him not to endlessly check and repeat.”

“He gave the impression of not being someone who perhaps had time to sit and reflect and take a little bit of time out. I certainly wasn’t under the impression that he was in any way neglecting his clinical workload”.

5.102 The panel put these views to Dr Weinstock and he was quite open with the investigation team about his difficulties. In notes made by Dr Weinstock and sent to the investigation team following his interview with them, he made these comments about his involvement with the CMHT:

“I actually went to Bridgewell House twice weekly on a regular basis following my appointment as consultant. Once was to the CMHT meeting, the other to one of my out-patient clinics. I’d often have discussions with staff about patients other than those seen when I held the out-patient clinic; and CMHT staff would sometimes be present when the patient was seen. CPA meetings were mainly held after the CMHT meeting at Bridgewell House...

...I facilitated and participated in the work of CMHT staff in the CPA with inpatients, frequently initiated CPA meetings, attended CPA meetings as required, initiated and attended network meetings. At meetings I actively participated in discussion concerning assessment and planning...

If it was considered that the CPA was a low priority with me by my managers, it was never mentioned to me; and given the Bridgewell House management arrangements it could not have escaped their attention”

5.103 Both Dr Weinstock and Joyce Winstone acknowledged to the investigation team that they had a difficult working relationship. Dr Weinstock also told the investigation team that working with the community mental health team at Bridgewell House was not a pleasant experience:

“What I do remember, just to give you the background of the CPA team, it was not for me a very pleasant working environment. I have worked in other CMHTs that were very different. It was not pleasant for me. Simply, I think, personalities; it was just one of those things that happened.”

and, in his notes submitted post-interview:

“As far as I was concerned [the CMHT] was part of the not always so wonderful world of work, but obviously problematic with respect to burnout in respect of years of fitting in a social environment which didn’t suit me, latterly the somewhat overbearing managers, and the sense of having no control over one’s work environment.”

5.104 In notes sent to the investigation team after his interview, Dr Weinstock refers to the issue of communication at the time Mr Gonzales was reassessed in September 2003. Despite a lack of formal documentation, or communication between the locum staff grade doctor and the CMHT, he believes that communication was taking place even though it was not formally under the framework of CPA. He refers to the letter dated 14 November 2002, from Dr Jacqui Gore in which she:

“asked his CPN, Henry Conteh, and Social Worker, Joyce Winstone, to ask Daniel to make a further appointment if he wishes to be seen again”:

“What happened in this case was that there wasn’t an initial multidisciplinary CPA to assess needs and plan, but rather one with only Joyce Winstone and Mr Gonzales; and doubtless part of that plan was that Mr Gonzales attended outpatients. I don’t see the matter as described as one of departments not communicating, but rather individuals in the team. For reason unknown there was never a multidisciplinary CPA meeting from the time a care coordinator was appointed, to which the staff grade doctor

would be invited. The staff grade doctor though was apparently aware of the care plan which had been produced for she involved the CPN and social worker in the management of Mr Gonzales.”

5.105 We are not convinced that asking another professional to ensure a service-user makes another appointment represents adequate multidisciplinary communication or collaborative working.

5.106 We were told many times that Dr Weinstock had a tendency to be obsessional at work. Co-workers said that affected his ability to manage his case load and reduced his attendance at patch team meetings. Regarding note-taking and written work Dr Weinstock was again open. He said:

“There are many things in my life in which I am not at all obsessive, not the slightest bit obsessive. But when it comes to work, things like written material and getting that right, I would say more than average, absolutely. I would agree with that. I do not regard that as a drawback.”

5.107 Dr Weinstock indicated that he had been under considerable workload pressure:

“The situation of a chap like me, whatever the truth of the matter about whether it was me and the way of my work practice or whether I really was short staffed, I felt pressed.

I have always been very careful about clinical matters. I took longer than other people, I think, concerning diagnosis, treatment, getting things right, educating myself about patients. That seems to me an extremely important part of my practice, a core part of my practice.

...I would say I had become quite demoralised during the time I was doing my job and I think I was a bit more irascible in the situation than I would have liked to have been - no question about that. But as far as I am aware that was not with everybody. I got on very well with people on the ward, if you speak to people on the ward you will hear a totally different story. If you

...speak to people from the day hospital, you will hear a completely different story.”

5.108 He was asked if he felt he had been fulfilling his role as a consultant effectively and if he had been supported in his difficulties managing his work. He said:

“Well no, I didn’t. That was the problem.”

“Looking back I was irascible at times when I shouldn’t have been and I regret that now: and it was a function of burnout....However too much shouldn’t be made of this irascibility: I wasn’t so generally.”

5.109 He told us that he had told both Dr Hennessy and Dr Lawrence, who had appraised him, that he *“found things very difficult”*. He gave written evidence that he was experiencing symptoms of “burnout”:

Comment

We conclude that there was evidence, for whatever reason, that Dr Weinstock was becoming overwhelmed with his work and that it was affecting his health. During 2004 he felt he was beginning to suffer from “burnout”. This was affecting his ability to carry out his responsibilities as a consultant and RMO. From March 2004 the trust agreed that Dr Weinstock could reduce his attendance at patch meetings from weekly to fortnightly. The records of patch meetings show that:

- *Dr Weinstock attended 13 out of 26 meetings in the six months from March to September 2004 for patch 3*
- *Dr Lawrence attended 22 out of 30 for patch 1*
- *Dr Hennessey attended 17-19 out of 24 (two of the meeting minutes did not record attendance) for patch 2*
- *Dr Kidd attended 21 out of 26 for patch 4.*

If attendance at these meetings was important, which presumably it was, Dr Weinstock's inability to manage this task should have prompted concern as it must have been affecting his work.

Through burnout or otherwise, with regard to Mr Gonzales he:

- Failed to liaise appropriately with the CMHT and Mr Gonzales' care coordinator.*
- Failed to plan his care and write up his notes adequately after the outpatient assessment on 25 June 2002.*
- Did not appear to be sufficiently aware of the role of CPA in managing Mr Gonzales' care.*

He was proud of his clinical thoroughness and carefulness, but he did not manage to apply these principles to his care for Mr Gonzales. Neither did he ensure that his subordinates followed suit as far as Mr Gonzales was concerned. The "extremely important" and "core part" of his practice "concerning diagnosis, treatment, getting things right, educating myself about patients" was, unfortunately, lacking on this occasion.

The supervision and appraisal systems in place did not enable him to deal with his workload difficulties and his acknowledged difficulties of burnout. It is notoriously difficult for people to recognize that they are burning out, and we do not criticize Dr Weinstock for not having done so. It is one of the functions of supervision and appraisal to pick up on these issues, and, although some problems were recognized, it seems the systems failed to pick up, or effectively deal with, the extent of the problem.

The problematic working relationships between him and some of the staff at Bridgewell House were not addressed as they should have been by line managers.

Findings

Diagnosis and treatment

5.110 It is clear that many of the clinicians involved with Mr Gonzales had difficulty in making a clear diagnosis due to his atypical presentation and that this included the clinicians at Broadmoor Hospital. Nevertheless we believe that better engagement with him, combined with improved communication when he was transferred to different teams, might have assisted the diagnosis that was made at the Oaktree clinic to better shape the services he received.

5.111 The evidence for the diagnosis of “continuous paranoid schizophrenia”, made during his admission to the Oaktree clinic from September 1998 to March 1999 under section 37 of the Mental Health Act 1983, was compelling at the time.

5.112 Mr Gonzales’ admission to Oaktree clinic, and in particular the diagnosis made by Dr Annear, did not appear to influence the actions or formulations of subsequent consultant psychiatrists, starting with Dr Kidd. Dr Annear’s formulation was based on four months of close observation while Mr Gonzales was an inpatient, and there was a drug-free trial to help make the formulation, so we consider the failure either to accept Dr Annear’s formulation, or give reasoned argument why it should not be accepted, was poor practice. Failure to mention the five court reports in the discharge summary and discharge letters suggests these were not considered useful or relevant, which we find to be unjustified.

5.113 The diagnosis of schizophrenia, although referred to at times in subsequent correspondence, did not shape Mr Gonzales’ subsequent care in the way it should have; for example he was discharged from outpatients only one year after the diagnosis.

5.114 It was difficult to ascertain from the notes if the responses to Mr Gonzales’ behaviour from the psychiatrists involved were based on an understanding that he had schizophrenia.

5.115 The apparent lack of a clear diagnosis led to uncoordinated, assessments based on presentation that lacked an understanding of how the history of his

illness, and his contact with services, might have affected the nature of his presentation.

5.116 If Mr Gonzales had been seen clearly as a service-user with a severe and enduring mental illness, whose behaviour was a result of his illness, there might have been a more tolerant and sophisticated approach to the management of his psychiatric care.

5.117 At the very least, Mr Gonzales should have been managed as an individual with a severe psychotic mental illness, such as schizophrenia.

5.118 Mr Gonzales should have been considered to have a dual diagnosis, defined in its widest context, because he had a mental illness and admitted using illicit drugs. His care plan should have specified substance misuse as requiring assessment and management.

5.119 The lack of consultant psychiatrist leadership from 2000 in using the care programme approach was a significant failing. The junior doctors who saw Mr Gonzales in outpatients knew he had a diagnosis of psychosis or schizophrenia, but they appeared unaware of how the care programme approach could and should have been used in managing him as none of them made reference to it. Although the consultant is ultimately responsible for the actions of his junior doctors, junior doctors working in psychiatry themselves should be familiar with the care programme approach and its role in the management of people with psychiatric illness. The locum doctors were senior juniors, not part of a training programme, and would have been expected to have the requisite experience and knowledge that would allow them to work with less supervision than would be the case with a training grade doctor. The frequent turnover of locum doctors meant that there was a responsibility on Dr Weinstock to become familiar with and supervise their competence. However we do not strongly criticise Dr Weinstock for the individual junior doctors' failure to use the care programme approach because the doctors involved had a duty to use it and would have been expected to use it in their clinical practice, and to a certain extent Dr Weinstock should have been able to assume that they were doing so. We do not know whether the lack of references by the locums to the care programme approach with Mr Gonzales was an unfortunate aberration or a result of earlier failures in training, and as we have not

spoken to the doctors concerned we do not criticise them for these failures. However, we do believe that the apparent unawareness displayed in the records made by the junior doctors of how the care programme approach could and should have been used in managing Mr Gonzales reflects a lack of leadership from Dr Weinstock.

5.120 After Mr Gonzales' arrest in 2000 the psychiatric element of his care was uncoupled from the CMHT input and that this damaged the service offered to him. There was little or no coordination between the doctors seeing him in outpatients, his GP, and the CMHT at Bridgewell House. We found it difficult to understand the role that Mr Gonzales' outpatient appointments had in managing his condition and behaviour, particularly since on a number of occasions he failed to attend, seemingly because he never received the appointment letter or was too disorganised.

5.121 The lack of consultant involvement was not good practice. The lack of continuity of care caused by the changes of locum junior doctors must have hindered the possibility of engagement with Mr Gonzales. This was not the responsibility of any of the junior doctors concerned.

5.122 Insufficient familiarity with Mr Gonzales' history resulted in some poor decision-making on his medication, which we consider affected Mr Gonzales' ability to engage with services.

5.123 Mr Gonzales should not have been discharged from outpatient follow-up, despite his lack of attendance at outpatient appointments. If an individual with severe mental illness is prone to miss appointments, it is the duty of the psychiatrist to find a way around the problem. For example, if the care programme approach is in place, attendance at outpatients might be unnecessary because psychiatrists can have alternative input through regular CPA reviews. If an outpatient-type consultation is deemed essential, psychiatrists should be creative in ensuring the consultation takes place, as happens in the assertive outreach service, for example.

5.124 Between 20 June 2001 (when he was last seen by Dr Lawrence) and the time of the offences in September 2004, Mr Gonzales was only seen once by a

consultant psychiatrist when he was seen by Dr Weinstock on 25 June 2002. This means that for that for over three years, with one brief exception, the professional most equipped to diagnose and formulate his presentation, the consultant psychiatrist, was not involved directly in Mr Gonzales' care, despite all the contact Mr Gonzales had with other members of the CMHT and his GP.

5.125 Mr Gonzales' input from psychiatrists should have been part of an overall care plan that identified his needs and specified the role that outpatient appointments played in addressing them.

5.126 Mr Gonzales' community consultants failed to participate effectively in the operation of the care programme approach. Neither did they fulfil their role in ensuring he was subject to the enhanced CPA.

5.127 There was evidence that Dr Weinstock was becoming overwhelmed with his work and that this was having a tangible impact on his ability to carry out his responsibilities as a consultant: he failed to liaise appropriately with the CMHT and Mr Gonzales' care coordinator; he failed to write up adequately, and plan, Mr Gonzales' care after the outpatient assessment on 25 June 2002; he did not appear to be sufficiently aware of the role of CPA in managing Mr Gonzales' care.

5.128 The supervision and appraisal systems in place did not enable Dr Weinstock to deal adequately with his workload difficulties. It is possible that he was becoming unwell during 2004 and systems did not appear to be in place to address this effectively.

5.129 The problematic working relationship between Dr Weinstock and some of the staff at Bridgewell House was not addressed as it should have been by line managers.

6. Clinical risk assessment

“When I reviewed the case I did not feel he was getting any less worrying, there was just less evidence of contact with the police or going to prison. After all, he was in Spain for quite a period and we heard what the mother said about his time in Spain and it did not sound like he was terribly well when he was in Spain. So if you go by someone is well because you do not have a lot of contact with them, that’s not a good barometer” - (Lorraine Reid - chief executive of the trust 2002/2005)

6.1 Clinical risk assessment is a fundamental part of mental health practice. Much guidance exists as to best practice. Within North West Surrey Mental Health Partnership NHS Trust there was an operational policy within their care programme approach assessment/reassessment procedure.

6.2 Most organisations consider clinical risk under three specific headings:

- risk to self (suicide/self harm)
- risk to others (violence)
- risk of self neglect (mental or physical health deterioration).

6.3 Fiona Edwards, current chief executive of the Surrey and Borders Partnership NHS Trust, described the situation in respect of risk when she joined the merged trust in December 2004:

“All three trusts had a very good report on risk. Managing risk at different levels, so I was not having any messages about having to watch out for risk management or risk assessment in any of the founding organisations. Indeed, CHI review said it was very good.”

6.4 Lorraine Reid is the former chief executive of North West Surrey Mental Health NHS Partnership Trust, the transitional organisation bringing together three Surrey mental health trusts. She told us that risk assessment was checked on every reported serious untoward incident and she kept a personal involvement with the process:

“The serious untoward incidents were all collated for themes... I wrote an annual letter to all members of staff about the findings of all the serious untoward incidents...the sorts of things that would come out would be adherence to CPA policy - that’s why the CPA group was quite important - risk assessment, because risk assessment hadn’t been being done properly.”

6.5 Jill Jarvis, former seconded director of nursing of North West Surrey Mental Health NHS Partnership Trust, also thought there was no indication of significant concerns in respect of risk. She said in evidence:

“We had a corporate risk register and some of the outcomes of SUIs⁸ are included in that, so that it was monitored by risk and clinical governance.

...we did have a lot of discussion about risk versus choice and risk versus whether people engage, and I think we were clear that risk took priority. Having said that, from what I have read about the internal review - and I didn’t know him and I wasn’t involved in the internal review - this would not be somebody who would ring alarm bells.”

6.6 However Dr Rachel Hennessy, former medical director acknowledged that the trust was ‘struggling’ with risk assessment, but she believed this was in keeping with most other organisations. She said:

“I think the approach we adopted was very reasonable, which was that every patient accepted by mental health services would have a risk screening document that had been provided with it, and that a more detailed risk assessment document was developed for those people who scored anything other than low on the risk screening document. I am aware that other trusts required very comprehensive assessments of every patient that were different, but I think that was a reasonable approach.”

6.7 Risk assessment training at the trust was carried out by Joe Dunne, in conjunction with Teresa Vines, within the Woking community mental health team. This was part of a package of training, which included the revised care programme approach documentation. Mr Dunne’s evidence was particularly helpful. He told us

⁸ Serious untoward incidents

there was an electronic register of people on enhanced CPA but there was no central system for monitoring the register. He said that the trust had a CPA lead manager but she left and wasn't replaced. He was asked how robust he thought risk assessment was and said:

“The SUIs were showing that there wasn't always a risk assessment on the case notes, at least it was not dated. People were doing it as something that needed to be done, a piece of paperwork, but weren't considering risk. They weren't using it as a tool to affect their practice.”

6.8 In reviewing both pro-formas and documentation, there was much to support Mr Dunne's view that clinical risk assessment was a paperwork exercise rather than an information gathering exercise that would be used to influence a care plan. See recommendation 2.

6.9 Mr Gonzales' notes show that the first formal mental health risk assessment recorded was following his admission to the Oaktree clinic in September 1998 under section 3 of the 1983 Mental Health Act. A pro-forma entitled RAMAS (risk assessment management and audit system) was used. This indicated a history of aggression and a risk to self and others.

6.10 In November 2000 a clinical risk assessment form was completed, which described his risk to self and others as medium. It gave no indication about action to be taken, but did note poor engagement with services and refusal of medication.

6.11 Danny Jones, forensic team coordinator, told us that when violence or aggression was considered an issue they would offer assistance with risk assessments, as they had particular expertise in finding information and intelligence. This assistance was available even if the service-user did not meet the criteria for the forensic service, and would have been available to those caring for Mr Gonzales. It was not requested.

6.12 Two further risk pro-formas were completed on Mr Gonzales by his care coordinator Joyce Winstone. The first one, in September 2002, identified a medium risk of self neglect or accidental self harm and a medium to high risk of abuse by others. This concluded that Mr Gonzales should be managed under enhanced CPA. The resultant care plan focused purely on accommodation, and there was nothing

to address the specific risk factors.

6.13 Ms Winstone was clear that she considered there was a significant risk of violence to others from Mr Gonzales. She told us:

“I did worry about his level of aggression and the very last time I went to see him, I took a student nurse who was on placement at Bridgewell House.”

“Yes, I did take somebody with me. Actually Charlotte had said, “Don’t see him on your own.” and I said, “I’ll see him down here at Bridgewell House,”, so there were other people around. Probably instinctively I kept myself safe.”

6.14 She was clearly concerned about his behaviour:

“Mainly because of the way he behaved towards me and because of the way the interview room was structured then at Bridgewell House... Also later on Charlotte McGregor did say that she had no doubts that he was capable of killing somebody.”

6.15 We asked Ms McGregor if she recalled saying or feeling this and she told us she had no such recollection. Despite Joyce Winstone’s serious concerns about the risk of working with Mr Gonzales we found no record of those concerns and no record of a risk plan to address these.

6.16 Charlotte McGregor carried out a reassessment in March 2003 and identified all the risk issues as low. However, it was still decided that the appropriate level of CPA was enhanced.

6.17 The last “formal” risk assessment was done by Aloysious Kizza on 11 May 2004. This was established to have been done by telephone, although the pro-forma did not say so.

6.18 Dr Lawrence told us he thought there might be some merit in standardising risk assessments using the historical clinical risk management tool (HCR20) to

identify high-risk service-users. But he thought Mr Gonzales' score would not have identified him as high risk.

6.19 The risk reported by his mother was never fully assessed or addressed. Mrs Savage was sent a carers assessment form in May 2004. She reported that she was worried about her own safety “a lot” and would like help in dealing with risk or safety issues. She received no feedback regarding the form and no additional assistance.

Comment

Throughout his contact with the mental health services Mr Gonzales was occasionally subject to risk assessments, which often identified a risk to himself or others. This did not usually materialise into any form of care plan to address the identified risk.

There appears to have been a belief based on the fact that his offending behaviour was apparently decreasing that his risk to others was lessening. There was little evidence that any risk associated with his possible deteriorating mental health state was being assessed.

We conclude that risk assessments were, in general, poorly formulated and very rarely considered when planning care. The lack of a clear diagnosis may have made this worse since it led to a view that his problematic behaviour was not always related to, or influenced by, an underlying mental illness.

We were struck that witnesses from the trust were not, as far as we could see, defensive about their role in service delivery. They seemed confident (and we agree with them) that the level of violence shown by Mr Gonzales could not have been predicted and that there were no missed clues that he would suddenly exhibit such extreme violence. They seemed to infer from this that his treatment, based on these risk assessments, was therefore satisfactory, which is not an inference the evidence supports.

The fact that the extreme violence was not predictable does not mean that it could not have been averted. In considering whether these crimes could have been averted, we found ourselves scrutinising the place that risk assessment is

given in the care and treatment of people with mental disorders.

While we were drafting our report the Department of Health published “Best Practice in Managing Risk; Principles and Guidance for Best Practice in the Assessment and Management of Risk to self and others in Mental Health Services”. We welcome the guidance.

It is clear from the guidance that research into risk assessment and management now gives a much clearer understanding of what works. But over-reliance on risk assessments creates its own risks, since it can be forgotten that they can never be totally accurate however expert the assessors. We note that the Department of Health guidance accepts there can never be perfection in this area.

An inaccurate assessment of low risk that lulls service providers into a false sense of security may lead to inadequate delivery of services and inadequate or unsuitable services being offered, which, in turn, may lead to the already underestimated risk that the person poses to themselves or others increasing.

We agree with the guidance when it emphasises that risk assessment is not an end in itself, but a tool to inform risk management. Whether filling out CPA or risk assessment forms, the recording of information is never a satisfactory substitute for acting on it.

If it is accepted that risk assessments may be inaccurate, part of risk management must be to have a contingency plan in case the assessment is incorrect. A number of our witnesses emphasised that the best way to reduce the risk of violence when somebody is at high risk, is a good and trusting relationship with a professional, to whom they will turn when in crisis. It therefore seems obvious to us that meaningful engagement, as part of a contingency plan, is as important when the service-user is assessed as low to medium risk, as it is when someone is assessed as high-risk.

Findings

6.20 Risk assessments were, in general, poorly formulated and very rarely considered when planning care.

6.21 Risk management was, to all intents and purposes, absent.

7. Inter-agency collaboration and communication

“Sometimes trying to get our concerns about somebody’s mental health across is definitely not always taken seriously” (Sarah Cannon - probation officer)

7.1 Communication, both within an organisation and externally, is often a significant feature in success or failure when reviewing health and social care. In particular, the issue of record keeping and sharing is vital to ensure information from informed and knowledgeable sources is available as appropriate. This is critical in terms of specific issues like risk assessment.

7.2 In the case of Mr Gonzales, the amount of written information and personal knowledge held across a number of health, social care and criminal justice system agencies was considerable. At an early stage we tried to map out all the agencies involved and where information on Mr Gonzales was held. The main agencies involved were health and social services, probation, police, the youth justice service and the prison service.

7.3 This information was in theory available for sharing, but in reality there was a lack of sharing between services (with the exception of the probation service). This was not a deliberate withholding of information or a decision not to seek information by the various people and agencies involved, but there appeared to be a failure of genuine multidisciplinary working.

7.4 The same problem arose within the trust, where clinical records were maintained by different professionals on a number of sites. This was made worse by the information systems in place when the trust was established.

7.5 Fiona Edwards, the current trust chief executive, said:

“Certainly where we are at, we have sixteen different computer systems across South, and that excludes the county councils, the two Local Authorities that we work with, and I think we are probably one of the worst trusts for that kind of legacy problem with information technology.”

7.6 Even when information systems are ‘state-of-the-art’, human factors such as interpersonal relationships, holding effective meetings and sharing information are critical in underpinning care, treatment planning and implementation. The

care programme approach is used within mental health services for such treatment planning. A full analysis of the use of the care programme approach is covered in chapter nine of this report.

7.7 One of the critical inter-agency relationships was between the supervising probation officer, and the CMHT. There was ad-hoc contact, but there was a lack of systematic care and treatment planning.

7.8 Ms Cannon from the probation service was asked by the panel whether she had received a copy of Mr Gonzales' care plan or if she was aware what his care plan was. She said:

“No. I know I never attended a CPA. No, I never received one.”

7.9 She was also asked if she knew from the mental health service what Mr Gonzales' diagnosis was. She said:

“If I remember at the time, it seemed to be ever changing. The one thing I remember quite clearly, which is what concerned me at the time, was that sometimes I felt my concerns about Daniel's behaviour were not being taken seriously. The one time he did come in quite distressed and I phoned Joyce and we arranged for Daniel to go straight from the office down to see Joyce, and her response was very much, ‘There's nothing, he's fine.’ I remember a clear term she used was, ‘Just a silly little boy, he's fine’ and I had over-reacted.”

7.10 When the issue of the relationship between probation and the CMHTs was explored further Mr Anderson from the probation service said:

“It's a very difficult one because when it works well it works well. It is often almost down to personalities in some ways.”

7.11 He was asked to give a rough percentage of the times the working relationship worked well and stated:

“Probably 40/60. In 40 percent it works well, in 60 percent it doesn't work so well.”

7.12 We found that the probation record demonstrated confused communication systems at Bridgewell house. Mr Gonzales attended at probation on the 6 March 2003 and was recommended to go to Bridgewell House to “*explain how he feels*”. His probation officer, Sarah Cannon, asked Bridgewell House if he had attended and was told he had not. Mr Gonzales, described as depressed and agitated, insisted that he went to Bridgewell House and received an appointment with Dr Weinstock. Probation called to check and were told again that no appointment was made. Ms Cannon then notes in her records:

“...it appears that Mr Gonzales does not have an appointment with doctor which confirms my concerns as I believe Mr Gonzales made up the fact he had seen staff at Bridgewell House”

7.13 Yet the Bridgewell House records show that on 6 March 2003 Mr Gonzales contacted the duty manager, and was seen by Charlotte McGregor. He asked her to arrange for him to see a psychiatrist. This is confirmed by Joyce Winstone who wrote to Mr Gonzales on 7 March 2003. She referred to his wish to see a psychiatrist and explained this wasn’t straightforward since he had been discharged from outpatients for failing to attend appointments.

Comment

By the time the probation officer was wrongly told that Mr Gonzales had not been to Bridgewell House, Joyce Winstone had heard from Charlotte McGregor and had written to Mr Gonzales. It does not take much imagination to work out how damaging this mistake was. The probation officer records her lost trust in Mr Gonzales. It can be assumed that Mr Gonzales felt bad about not being believed, and felt let down by Bridgewell House. We conclude that this was one of the 60% of occasions when the relationship between the trust and the probation services did not work so well.

7.14 A further significant failure of communication took place after Mr Gonzales returned from Spain in November 2003. The records show that the CMHT were aware of his return by 2 December 2003, when his grandmother telephoned the duty officer and asked for an assessment to be made.

7.15 The CMHT knew that a warrant had been issued the previous summer because Mr Gonzales failed to complete his community penalties before he left for Spain. The CMHT should have informed probation of Mr Gonzales' return from Spain, and if it had done so the warrant would have been executed immediately.

7.16 In the event, Mr Gonzales was not arrested on the warrant until July 2004, when the police were alerted by members of the public who recognised him. He was bailed but had to hand in his passport, and was unable to travel to his family in Spain a few days later, as planned.

Comment

Mr Gonzales' visits to his family in Spain were very important to him. The disruption of his plans must have been a disappointment to him and this cannot have helped his mood or mental health in the weeks preceding the murders.

7.17 The other critical inter-agency relationship was with the local police force, which had significant intelligence, contact and records involving Mr Gonzales. Detective Superintendent Brian Boxall confirmed that there were protocols in place for sharing information. He was asked what formal documents, policies and procedures for information-sharing existed at that time.

"The main piece of documentation - I was checking this morning whether all four mental health trusts had signed up to it - was the Surrey information-sharing protocol, of which I have a copy. I don't know whether you've seen it.

That's the main one for all sorts of agencies, and I understand that certainly three, possibly all four, of the trusts were signed up to that at that particular time."

"At that particular time I would suggest it was very much a matter of if people within the trust felt there was an issue then they would inform the Police. The protocol itself is the information-sharing protocol."

7.18 As also experienced by the probation service we were unable to find any evidence of involvement at a structured level. There was ad-hoc contact, usually involving an incident in which the police had been contacted. For example, on 28 September 1998 police used section 136 of the 1983 Mental Health Act to remove Mr Gonzales to a place of safety within the mental health services.

7.19 Another significant incident, on 13 September 2004 when Mr Gonzales was reported by his family to be running around the locality naked, is dealt with in chapter 12 of this report.

7.20 We were informed on a number of occasions that multi-professional meetings known as ‘network meetings’ could be convened, in addition to the care programme approach meetings. These were ad-hoc multi-disciplinary meetings called to address a specific issue or concern. We found there was no procedural guidance on how these meetings would be instigated.

7.21 Teresa Vines, nurse team leader, explained the purpose of network meetings:

“If one of the nurses came in to me and said, ‘I’ve this man on an enhanced CPA and he’s not engaging but I’m getting all these calls in, et cetera’, my advice would be to get all the agencies involved and call a network meeting and see who is going to do what to get this guy engaged. That’s what I mean, somebody would have to come and tell you that it’s not happening.”

7.22 We found that no such network meeting was ever convened for Mr Gonzales. Between July 2002 and May 2003, when he went to Spain, his care coordinator was social worker Joyce Winstone. She accepted that Mr Gonzales leaving to go to Spain should have triggered a network meeting since he was on enhanced CPA. She told us:

“The network meeting hit me in the face when I was writing up my statement. I thought I should have done that.”

Comment

Throughout his contact with services we could only establish full care programme approach meetings taking place on two occasions while he was in the community, on 23 December 1999 and 22 February 2000, while he was under the care of Dr Kidd.

7.23 We explored the issue of communication with the general practitioners responsible for Mr Gonzales' primary care. Dr Kuzmin from the Southview practice told us:

“Occasionally they invited GPs to case conferences and things like that, although that might not have happened in this case. Very often we are very busy and we just submit a report, if it is such short notice, and a report seems to suffice. That was the situation roughly then. There was communication by letter, but we may never have met the individuals involved, you may never have met any of the people you have dealings with in that way. That was the situation, not really very satisfactory.”

7.24 Dr Kuzmin was asked for his view on the relationship between primary and secondary care in Woking at the time. He said:

“Not brilliant. At that time I think the culture was very much you refer a patient to the community mental health team, they coordinate the care, we do the prescriptions and may be see them for physical ailments. Very often, if they have a severe mental health problem, the coordination of the care tends to be the psychiatrists and the CPN. Now if there are minor mental health issues, we hardly ever involve the psychiatric services and we manage them ourselves. There was very much a big divide.”

Communication with family

7.25 The final important issue on communication involves Mr Gonzales' family and carers. This was a major deficit according to his main carer over many years, his mother Mrs Savage. On two occasions she completed the lengthy carer's assessment requesting information and support but received none.

7.26 She told us:

“Not once ever has any psychiatrist said to me, ‘Can I have a word with you’ or, ‘Can I ask you anything about Daniel’, or after an appointment, ‘Can I speak to you as well?’ Never ever. That’s made me cry now because I’m so angry about that.”

7.27 This was not connected with confidentiality as we clarified with Mr Gonzales that he would have had no issues about his care and treatment being discussed with his mother.

7.28 The evidence seems to show that no one from the CMHT contacted any other relative, foster carer or friend to discuss or clarify issues.

Comment

We did see some good examples of information sharing. There was a comprehensive assessment and communication from the community psychiatric nurse, Mark Stephenson, who assessed Mr Gonzales at Dover young offenders institute. This was not, though, used as an opportunity to review or plan an integrated mental health/probation service care package when he was released from Dover YOI. At that point he was theoretically still on enhanced CPA although he did not have a care coordinator and his consultant, Dr Lawrence, was apparently unaware of his CPA status.

Despite individual initiatives and some ad-hoc communication, inter-agency collaboration and communication was not effective and resulted in lost opportunities to review services being offered. The wealth of information available within the respective organisations, and from the family and carers, never became the shared knowledge that would have allowed a proper understanding of Mr Gonazales’ many problems.

We were particularly struck by the apparent lack of involvement with carers and the token assessments undertaken with Mrs Savage. Mr Gonzales signed one CPA form, but we believe neither he nor his carers ever received a written care-plan, or knew of some care plans which existed.

Findings

7.29 There were some good examples of information sharing such as the comprehensive assessment and communication from the community psychiatric nurse, Mark Stephenson, who assessed Mr Gonzales at Dover youth offenders institute (YOI). However, this was not used as an opportunity to review or plan an integrated mental health/probation service care package when he was released from Dover YOI.

7.30 Despite individual initiatives and some ad-hoc communication, inter-agency collaboration and communication was not effective and resulted in lost opportunities to review services being offered.

7.31 There was a lack of useful involvement with carers. The carer's assessments undertaken with Mrs Savage were tokenistic and neither Mr Gonzales nor his carers ever received a written care plan, or, knew of a care plan when one existed.

7.32 The youth justice service did a good job with Mr Gonzales. The probation service, at least up until 2003, did a better job of engaging with Mr Gonzales than did the specialist services.

7.33 The prison service at fault for losing Mr Gonzales' inmate records which would have provided helpful information about his mental state.

7.34 From what we were told by Mark Stephenson, and the documents he provided, we find that Mr Gonzales was thoughtfully and consistently managed at Dover YOI.

7.35 The police dealt with Mr Gonzales appropriately except for the comments we make about the events of 13 September 2004 set out in chapter 12.

7.36 Mr Gonzales' GPs tried hard to ensure that the specialist services were aware of their and the family's concerns about his mental health. It is implicit in our findings in relation to the specialist services that the message did not get through but we have no criticism to make of the GPs efforts. If specialist services accept responsibility for a service-user, primary care must be able to assume those services know what they are doing.

7.37 We are told, and are pleased to hear, that work continues on strengthening the communication between these various services so that information is shared when that is more important than an individual's right to confidentiality.

8. Trust management arrangements

“The trust was only ever set up for a year, so the structure it started with was enough to take the trust through a year. Another year might have been manageable - there would not have been big financial problems in the second year - but a third year just was not manageable. A flat structure would have been fine for a year or 18 months, not for three years” - Lorraine Reid - chief executive 2002/2004

8.1 Like those in many parts of the country, the mental health services in Surrey were in the process of considerable restructuring in 2002 to 2004. We heard from many witnesses how these transitional arrangements were affecting services.

8.2 This was graphically described by Lorraine Reid, who was chief executive from 2002 to 2004:

“Can I give you a bit of context because I think that would help? I was appointed in 2002 as chief executive for the transitional organisation that was only expected to last for a year and then the trust was going to be reconfigured. What actually happened was the decisions weren’t made about reconfiguration, which meant the trust continued for three years. The final year of the trust was a real struggle. On the one hand everyone knew what direction the trust was going to go in and that all the trusts in Surrey would come together as one, but North West Surrey had never really been set up to be a viable trust in the long-term. By the third year we had a significant financial deficit, the finance director had left and we were in a real mess. Various other directors were leaving because they didn’t see a future for themselves in the trust, so it wasn’t a year where we had the capacity to have any significant amount of change. We also had a Healthcare Commission inspection, which I think was around the time of the incident. That last year was a very rough year in the organisation, although the heads of service remained the same, so the operational management wasn’t terribly adversely affected by the changes like the directors leaving.”

8.3 Many witnesses told us that the protracted transitional arrangements had negative effects on issues such as recruitment and support service provision. For example, there was no clinical audit department in the trust. This was contracted in on a service level agreement basis from a primary care trust.

8.4 Jill Jarvis, the then director of nursing, gave evidence about clinical audit. She said:

“As I say, it was set up as an interim trust and there was an expectation that a lot of things were provided by shared services that didn’t come to pass, particularly that (clinical audit). There was a person who was designated to us, that person went on long-term sick and, despite regular discussions and trying to negotiate, it was, ‘That’s your person, they’re off sick, you don’t get a service.’ We did what we could and we prioritised, so I had a small team, but I lost my team as well towards the end because the financial situation was worse. Joe Dunne worked for me for a time as lead nurse, but we then had to move him to manage a CMHT. We prioritised CPA as being the thing we needed to audit, so we did that and we audited around our child protection, so we had to be very selective. The majority of anything you could describe as audit work was around Essence of Care because that was very much home-grown and could be done locally.”

8.5 She also said that despite the issues of limited services and the capacity of staff to undertake all roles, there were some advantages to being a small trust. She was asked to describe the team that was working at a senior level to manage the trust at that time:

“Very positive, very focused on clinical provision, overstretched, but worked together very well as a team. There are some advantages to small - small can be beautiful. Communication was very good, it was very easy to get information around. Probably the parts where it all started getting very difficult was when they expected us to meet various standards that an interim trust was never set up to do: stuff like CNST, RPST, Healthcare Commission. When you are having to do that on top of everything else, that was when it became apparent that we were overstretched.”

8.6 It was apparent that much senior management energy at that time was directed towards essential 'must dos' such as the preparation for, and involvement with, the Healthcare Commission visit. There was little capacity for creativity or staff development.

8.7 The 'transitional' period was clearly a difficult time for the organisation, and may have resulted in some service deficits such as the absence of a robust audit team and limited planning for the future. Nevertheless the senior management team received little evidence that this was having a significant impact on clinical services. In fact, the impression was that clinical services were being maintained safely and to appropriate standards. But the absence of any effective audit or control systems, including eventually the absence of a care programme approach coordinator, was in reality giving false assurance on the robustness and safety of services being delivered.

Findings

8.8 Much senior management energy at that time was directed towards essential 'must dos' such as the Healthcare Commission visit and there was little capacity for creativity or staff development.

8.9 The absence of any effective audit or control systems and the absence of a care programme approach coordinator gave the trust false assurance on the robustness and safety of services being delivered.

9. The care programme approach

“When you look at Daniel’s case, clearly the CPA was not being enacted entirely according to the policy, for example, Daniel was on an enhanced CPA, went to Spain and we did not pick it up when he came back” - (Dr Rachel Hennessey - medical director of the trust 2002/2005)

Background to the care programme approach

9.1 The care programme approach (CPA) was implemented in mental health services in England in April 1991. At that time there were four key components:

- systematic arrangements to be put in place for assessing the health and social needs of people accepted by the specialist mental health services
- the formation of a care plan to address the identified health and social care needs
- the appointment of a key worker to keep in touch with the service-user and monitor the care plan
- undertaking regular reviews and implementing agreed changes to the care plan, if required.

9.2 In 1999 Department of Health undertook a review to revise and modernise the CPA. It also confirmed that the CPA would continue to be the key systematic approach to assessing and delivering mental health services to people of working age in contact with specialist mental health services.

9.3 The key changes set out below were introduced in 1999.

- The integration of the CPA and care management. This was to address the issue of lead roles between health services and social services being somewhat blurred.
- Health and social services would appoint a lead officer to work across both agencies.

- The term care coordinator would replace the previous title of key worker.
- There would be two levels of CPA - standard and enhanced.
- Reviews of care plans would be ongoing with meetings being set as required (replacing fixed six monthly meetings).
- Risk assessment/management to be part of the CPA. Service-users on enhanced levels to have a crisis and contingency plan.
- The supervision register to be abolished from 2001 - subject to robust CPA arrangements being in place.
- Systematic audit to be established in respect of the implementation of CPA.

9.4 Subsequently, CPA has featured as part of performance management within trusts, as well as in Healthcare Commission reviews.

9.5 In November 2006 the Department of Health announced a review of CPA. Following consultation new policy and practice guidance was issued in March 2008⁹.

The CPA and Mr Gonzales

9.6 In terms of the CPA chronology of the care and treatment of Mr Gonzales, his first significant contact with mental health services was in February 1998 when he was detained under the Mental Health Act and as such was subject to CPA. At this time, his RMO was Dr Hennessey, and he was an inpatient in the Abraham Cowley unit (ACU). He was discharged by a Mental Health Review Tribunal on 26 February 1998. There was a multidisciplinary meeting that day which included his mother and father as well as all professionals involved with his care and treatment but no formal CPA plan was recorded in his notes.

9.7 There is no record of any subsequent CPA meeting until Mr Gonzales' next admission under the Mental Health Act, in September 1998, to the Oaktree clinic. But Mr Gonzales had remained under the care of specialist mental health services. He kept two outpatient's appointments with Dr Kidd's SHO, Dr O'Brien, but missed two. Dr O'Brien wrote to his GP in July advising that Mr Gonzales was being

⁹ Refocusing the Care Programme Approach, Policy and Positive Practice Guidance, DH, March 2008

discharged from outpatients as he was not cooperating. There was a senior strategy meeting involving the youth justice team and mental health services on 14 September 1998, when it was recorded that *'Daniel will never be able to live independently...'* We assumed this related to mental health concerns.

9.8 Records indicate there were three CPA meetings during the inpatient admission at the Oaktree clinic. All were attended by John Humphries and Kay Preston, and two were attended by Sue Piscoe. These three had been at the senior strategy meeting in September. John Humphries had been with Mr Gonzales before and during his admission on 28 September 1998 and had witnessed his extreme level of disturbance.

9.9 The last of the Oaktree CPA meetings took place on 16 February 1999. Records indicate a meeting was scheduled for 17 March 1999, but we are unable to ascertain that this meeting did take place because there is no minute in the records. The notes indicate it was cancelled, which seems likely as by this time Mr Gonzales had been transferred out of the Oaktree clinic to the Abraham Cowley unit (ACU) via Farnham Road Hospital.

Comment

This period at the Oaktree clinic was considered by his family to be one of the more helpful involvements of mental health services, and his consultant at that time (Dr Annear) was seen as helpful and engaged.

9.10 There were CPA meetings during ward rounds at the Abraham Cowley unit on 22 and 29 March and Mr Gonzales was discharged from ACU on 14 April 1999 with the knowledge that he planned to live with his father in Spain. His RMO (Dr Kidd) is recorded as happy for him to go to Spain after clarification with probation services that his probation order had been discharged. This was confirmed by John Humphries (youth justice worker). Mr Gonzales' diagnosis on discharge was given as schizophrenia with drug abuse. The notes indicate that CPA was to be arranged when he returned, but not how this would be coordinated, or by whom. We could not establish that there were any administrative systems in place to review this situation. Mr Gonzales was also entitled to section 117 aftercare after discharge. He would have been entitled to it on his return from Spain as he had not been discharged from aftercare in the meantime.

Comment

None of the records provided to us give any evidence that any of the people who attended the senior strategy meeting 6 months earlier were consulted before Mr Gonzales was discharged from hospital, and it is clear from the records that the youth justice team expected that he would be discharged to residential accommodation locally in due course. We have already reported the concerns of John Humphries and his colleagues over this failure, which amounted to poor practice in itself. It must also have contributed to the different view of his problems after his stay in a secure hospital to the one which prevailed before that admission.

9.11 Mr Gonzales was in Spain from April to August 1999. He took two months' medication and a prescription to allow medication to be prescribed by a local doctor. Records indicate that Charlotte McGregor was allocated as his key worker when he returned in September 1999, with a CPN also involved to help with medication. There had been no CPA planning for his return, so his care and treatment between September and December did not take place in the context of a formal care plan under CPA.

9.12 After an outpatient appointment with Dr Kidd's locum SHO on 2 November 1999 Mr Gonzales was seen by Dr Kidd on 25 November 1999, with a CPA arranged for 23 December 1999. This took place as planned and there was a good attendance, including his mother and key worker. An enhanced CPA care plan was drawn up. The care plan gave the diagnosis as paranoid schizophrenia and arranged the next CPA for 22 February 2000. This review meeting also took place as planned.

9.13 Mr Gonzales failed to attend his appointment with Dr Kidd in March 2000. His records show that Dr Kidd would not send him another appointment until he 'hears that he wants to see him' but indicates 'a CPA meeting might be in order.'

9.14 Mr Gonzales was arrested on 25 April 2000 and remanded in custody with Dr Ward Lawrence now being involved for assessment purposes and court reports.

9.15 In August 2000 Dr Kidd wrote to Mr Gonzales suggesting he should contact the drug and alcohol team and Dr Kidd or the CMHT when he was released. Mr Gonzales was released from Dover YO1 on 30 April 2001 and he returned to his

mother's home.

9.16 At the time Mr Gonzales went to prison he was on enhanced CPA. There is no recorded decision to take him off it. Charlotte McGregor continued to be involved while he was in prison, to the extent that she visited him there. There was no formal handover from Dr Kidd's team to Dr Lawrence's team. Dr Lawrence apparently took over because he had prepared a pre-sentence report while Mr Gonzales was on remand and it was thought that, as the consultant psychiatrist with the forensic team, he was the right person to continue with the case. There is no evidence that Dr Lawrence understood that Mr Gonzales had not been taken off enhanced CPA or that he had ever been on it, though this would have been clear from the notes.

9.17 Dr Lawrence wrote to Vivienne Cameron (probation officer), following an outpatient appointment on 20 June 2001. He said that in his opinion Mr Gonzales probably did not suffer from any form of severe mental illness. Before forming this opinion, Dr Lawrence did not review Mr Gonzales' Oaktree clinic notes or meet with his mother. He commented that Mr Gonzales had told him he had 'fabricated symptoms'. (It is not clear if this is a different conversation to the one they had in November 2000 when Dr Lawrence described an admission of "manipulating symptoms".) It seems that this, and his view that Mr Gonzales had no severe mental illness, carried more weight in informing subsequent opinion than the previous diagnosis of schizophrenia which was based on an inpatient stay of over six months.

Comment

Based on Dr Lawrence's opinion, enhanced CPA would not have been justified.

9.18 Dr Lawrence discharged Mr Gonzales on 1 August 2001 after he failed to attend outpatient appointments, but did advise he would be happy to see him again if considered appropriate.

9.19 On 22 August following concerns expressed by his mother the crisis response team referred Mr Gonzales back to the CMHT/Dr Lawrence. A risk assessment done at the time indicated he was at medium risk of violence/harm to others. A hand written note by Dr Lawrence on the crisis form advised "*FU appt with me next*

10/7". The follow up appointment did not take place, and there is no indication one was offered. On 3 October Dr Lawrence wrote to Dr Kuzmin (GP) discharging him from his outpatient clinic.

9.20 On 1 November 2001 there is a letter from Dr Rumball (GP) to Dr Lawrence requesting an appointment. There is a long gap then until 12 March 2002 when Mrs Savage writes to Bridgewell House asking for help. A post-it on the letter written by Dr Lawrence states - "*Southview patient. No contact with me since summer 2001. Only saw following probation request - back to catchment area.*"

Comment

It appears Dr Lawrence believed that when he discharged Mr Gonzales in October and wrote to the GP informing him, that this amounted to a referral back to the catchment area and discharge from outpatient attendance. There is no explanation as to why Dr Rumball's letter in November achieved nothing, or why the follow-up appointment suggested by Dr Lawrence after the assessment in August was not offered.

9.21 In addition to the failure to provide an appointment after the risk assessment and the failure to respond to Dr Rumball's letter in November, there was then a long delay between Mrs Savage's request to the CMHT (Teresa Vines) for help on 12 March 2002, and the actual appointment on 25 June 2002. Between those dates, Ms Vines had discussed the request for help with Dr Weinstock.

9.22 The CPA status at this time is unclear, but there is no evidence that he had ever formally been taken off enhanced CPA. Correspondence on 9 July 2002 from Teresa Vines to Mr Gonzales indicates he was to be allocated a care coordinator as soon as possible.

9.23 On 10 July 2002, Mr Gonzales presented at A&E, having been taken there by the police following a row at home. He was seen by the duty psychiatrist, Dr Lazarova, and other members of the crisis response team (CRT). Following discussion with Dr Lazarova and the CRT, Mr Gonzales attended Bridgewell House on 11 July 2002 and was assessed by Charlotte McGregor. On the CPA and risk status summary she ticked that CPA was "N/A". The explanation for N/A is "i.e. if that person has been assessed but not accepted by service".

9.24 On 16 July 2002, Teresa Vines wrote *“Daniel has refused engagement with the CMHT...”* On 18 July 2002, a letter from Jackie Rampling, assertive outreach worker, Omni outreach team to Emma Fenton, Woking CMHT stated:

“...I am writing to confirm that the risks surrounding Danny at this time seem to be minimal and as he appears to be well engaged with your team, we will not be taking him on to our caseload”.

9.25 On 22 July 2002, Emma Fenton took a telephone call from Mr Gonzales about his referral to Link Lodge. This resulted in the allocation of community psychiatric nurse, Henry Conteh, as care coordinator but this did not generate a CPA review as it should have done. On 27 July 2002, Joyce Winstone became Mr Gonzales’ care coordinator. Further confusion is revealed in a letter dated 15 August 2002 from Henry Conteh to Mr Gonzales, saying he is the new care coordinator, although there is no indication in later notes that Mr Conteh undertook this role. This was discussed with Joyce Winstone when she gave evidence. She said:

“The only thing is that from the outset of my involvement, Mr Gonzales was verbally aggressive towards me. I may have fed that back to the Patch 3 team and my hypothesis is that they may have decided that it would be better for the two of us to co-work him. However, I know that Henry went off on a CPN degree course for a year and I have a feeling that was around the end of 2002. I have not been able to check that, but his involvement could have been quite short lived.”

Comment

If the confusion and muddle from August 2001 to August 2002 was obvious to the investigation team from the documents, we think it must have been equally obvious to Mr Gonzales and his family, which can hardly have encouraged them to believe the CMHT was on top of the situation.

9.26 Joyce Winstone completed the risk status/CPA summary assessment tool and drew up an enhanced CPA plan. This was agreed by Dr J Gore, a locum staff grade to Dr Weinstock, who saw Mr Gonzales at the Abraham Cowley unit on 13 September 2002.

9.27 On 14 November 2002, following more missed outpatient appointments Dr Gore wrote to Mr Gonzales' CPN and social worker saying he should request a further appointment if he wished to be seen again.

9.28 There is no indication what this means in respect of enhanced CPA status and no suggestion that a review should take place.

9.29 The next mention of the CPA is 6 March 2003, when the risk status/CPA summary assessment tool is completed by Charlotte McGregor. She ticked the box to indicate Mr Gonzales should remain on enhanced CPA. The following day Joyce Winstone wrote to Mr Gonzales about him seeing a doctor. She told him she would have to ask Dr Weinstock if he would see him again as he has been discharged from the outpatient's clinic.

9.30 On the basis of the papers provided to us, Mr Gonzales was still on Dr Weinstock's list, and on enhanced CPA, from November 2002 to March 2003. There is no record to show he had been discharged.

9.31 Correspondence on file dated 7 April from Joyce Winstone to Mr Gonzales' GP (Dr Rumball and copied in to Dr Weinstock says she had seen Mr Gonzales, and he intended to go to Spain. There is no mention of his enhanced CPA status. There is a further letter confirming that he has gone to Spain from Joyce Winstone dated 3 June 2003. Again, there is no mention of CPA status. As Joyce Winstone states the case is now closed, it is possible that she believes he is not now on enhanced CPA.

9.32 In evidence, Dr Rachel Hennessey, the then medical director, told us:

"It's difficult. When you look at Daniel's case, clearly the CPA was not being enacted entirely according to the policy, and the internal inquiry has indicated, for example, Daniel was on an enhanced CPA, went to Spain and we did not pick it up when he came back. Clearly if we knew when he came back he should have been on enhanced CPA until a decision was made and clearly documented about a change, and if that was not needed, a decision made about the reason he was moved to a standard CPA. Clearly in that case there were deficiencies."

9.33 The next contact with specialist mental health services appears to be on 22 January 2004 when a locum staff grade doctor (Dr Dada) sees Mr Gonzales in the outpatient clinic. This followed a request from his GP, dated 1 December, in response to a letter written by Mr Gonzales on 26 October 2003. This was supported on 2 December when his grandmother also requested an assessment for him.

9.34 Dr Dada's letter back to the GP indicates he had found no symptoms of mental illness and, after discussions with Dr Weinstock, had offered Mr Gonzales a place at the day hospital. Mr Gonzales declined but agreed to consider inpatient care and treatment. Dr Dada stated he would discuss this with Dr Weinstock and get back to Mr Gonzales, but there is nothing in the records to suggest this happened.

9.35 The next contact is at the outpatient clinic on 10 March 2004 when Dr M Joyce, locum associate specialist, reviews Mr Gonzales and reports there being 'no symptoms or signs of the chronic schizophrenia from which he suffers'. A further appointment was offered for 20 April, and CMHT were asked to consider an assessment by the community support worker.

9.36 This was discussed at the patch 3 meeting on 22 March, when it was decided to allocate Christine Evans (CSW) to care coordinate with Dr Joyce. There is no record of Christine Evans actually becoming his care coordinator.

9.37 The planned outpatient appointment on 20 April took place. Mr Gonzales was accompanied by his mother. After this, a letter dated 22 April from Dr Joyce to his GP advised that an EEG¹⁰ had been requested and a referral made for community support.

9.38 On 11 May 2004 Mr Aloysius Kizza (SW), saw Mr Gonzales for the community support referral and partially completed a risk status/CPA summary assessment tool. There is no indication of CPA status or even if he is to be accepted by the service. As previously noted, there is no indication he has ever been taken off enhanced CPA status.

¹⁰ A diagnostic test which measures the electrical activity of the brain using recording equipment attached to the scalp with fine electrodes. Helpful for diagnosing epilepsy.

Comment

At this point three health and social care professionals were involved in Mr Gonzales' care. This would, with his diagnosis of schizophrenia, meet the criteria for enhanced CPA in force in the trust at that time. What can be said with certainty is that there was no clear care plan for his contact with specialist mental health services in 2004.

9.39 The notes indicate Mr Gonzales failed to attend appointments with Mr Kizza in July, although he did attend for the EEG on 30 June. On the 21 (or 20) July 2004 he attended his outpatient appointment with yet another locum, Dr Wagaine-Twabwe. The resulting letter to his GP was uninformative about his mental state and advised that he would review in about two month's time, but no date was given. This was his last contact with a psychiatrist before committing the offences.

Comment

We acknowledge the potential for different opinions in clinical/professional judgements. What the CPA was intended to achieve, when implemented in 1991, was the clear identification of a key worker/care coordinator responsible for ensuring that a well understood care plan with timely reviews was in place and that handovers were formal, effective and documented. These simple goals were rarely achieved by the care coordinators during Mr Gonzales' contact with services from 2000-2004.

There were two changes of consultant while Mr Gonzales was at the Oaktree clinic, and on those occasions the consultants were able to draw on the knowledge of the existing team which was familiar with Mr Gonzales. Any subsequent good practice did not survive consultant changes as there were no proper handovers after Mr Gonzales left the Oaktree clinic.

As we heard from witnesses it became clear that there was uncertainty about the CPA process in respect of Mr Gonzales. We consider that the trust policies and procedures, in conjunction with social services, were sensible and appeared well thought through, but the systems in place to review or audit them were virtually non-existent.

Staff knowledge/trust systems

9.40 The former medical director Dr Rachel Hennessey considered that staff were generally familiar with the CPA but acknowledged that there were issues in respect of system auditing. She said:

“By that time (2003/4) the CPA process had been going for quite some time. I think staff were on balance generally familiar with the process. It continued to be paper-based at that time rather than electronically operated, and staff were becoming more familiar with the enhanced and standard CPA.”

9.41 In her evidence, Helen Wood, general manager said that because there was not a clinical audit department within the trust, auditing CPA *“fell predominantly to the heads of service and directors.”* When asked who would take the lead in ensuring designated reviews of those on enhanced CPA took place she said *“That would be within the team.”*

9.42 Lorraine Reid confirmed this was an issue. She also said that towards the end of the life of the trust there was no central CPA coordinator in post and that:

“Most of the medical notes were kept in two places: at the Abraham Cowley unit and then further still some sectors at the Ashford base.”

9.43 This was an issue Mark Girvan, Woking CMHT manager also commented on:

“The CPA system was a bit chaotic. What had happened there was a paper trail of CPA and a sense of what the team are driving at with their assessment, and then there’s this e-CPA from the year before that was still on the system. To be honest, people didn’t have enough training to know exactly to close the electronic care plan.”

9.44 The issue of staff training in respect of CPA policies was discussed with Joe Dunne, who had been allocated responsibility as lead nurse for this. He carried this out within the Woking patch with Teresa Vines. He said of the training that:

“It worked on the assumption that people knew about CPA but then they clarified the issues and the changes as required as part of the new policy.”

9.45 He was asked about his understanding of the implementation of the CPA within the trust. He confirmed the view of others that there wasn't any central auditing/overview of those on enhanced CPA.

9.46 Teresa Vines was asked how the CPA operated within their area and who was responsible overall for CPA at that time. She confirmed that this was undertaken by supervisors within the CMHTs.

9.47 On the more specific issue of how the CPA was implemented with Mr Gonzales, we had significant problems in identifying from the available papers and documents how decisions were reached. We found similar difficulties as we interviewed some witnesses. We have to conclude that staff must have made clinical decisions based on incomplete information.

9.48 We discuss elsewhere Dr Lawrence's involvement with Mr Gonzales and his apparent lack of knowledge of his CPA status. He told us that in the time he was involved with Mr Gonzales he thought his CPA status would have been standard. But he went on to say:

“If the treating team were making a diagnosis of schizophrenia, and he was non-compliant with medication, and concerns were being raised to them by family about his mental state, yes he should have been on enhanced CPA. If those were the factors they were dealing with at the time and they believed those factors, yes he should have been.”

9.49 As previously mentioned, the earlier enhanced CPA had not been formally amended or discharged when Dr Lawrence was responsible for Mr Gonzales,

Family's view

9.50 Mrs Savage, Mr Gonzales' mother, was particularly concerned about the absence of any real involvement with her in drawing up care plans. She twice completed the lengthy carer's assessments, as part of the CPA. She told us she had received them in the post. She was asked if she queried why they had been sent to

her and she said:

“No, because in my mind it was obligatory, they’d had to send me one of those forms they don’t do anything with!”

9.51 Following further questions about how many CPA meetings she attended, Mrs Savage mentioned reviews with the Surrey youth justice team, one review in the ACU and one or two with Dr Annear. She was then asked if she had ever received a written care plan and said:

“No. I didn’t even know what that was.”

9.52 Mrs Savage’s mother, Mrs Cutmore, who attended the interview with Mrs Savage, said:

“We didn’t even know it existed. We knew of the reviews but that was before he was 18. It wasn’t until we had all the papers and we found out so much from those.”

9.53 Lorraine Reid thought Mrs Savage could have helped the team caring for her son if she had been asked to do so. She said:

“I would have said one of the shortcomings was not engaging with the mother. I think the mother would have been engageable with, even if he was difficult, and sometimes you have to work through someone like the mother or the carer to get a picture of what’s going on with the patient because he wasn’t ever going to keep appointments. He did when he was working with Charlotte McGregor, but I think his mother used to help getting him to the CMHT and things. The mother had a lot of information that wasn’t even in the case notes. I think that would have helped.”

9.54 We discussed with Mr Gonzales his perception of the CPA process and whether anyone had discussed with him the plan for the help and care he was going to be given. He said:

“Not really, no. There were no big meetings like this at all, no CPAs or anything like that. While I was on the outside no CPAs at all or anything like that, never once.”

9.55 Though Mr Gonzales stated that that he had never been given a given a written care plan, the records show that in addition to the CPA’s that were held when he was an inpatient at Oaktree clinic, he also attended a CPA meeting with his mother on 23 December 1999 and signed a complex care plan form on the 7 January 2000. We cannot find evidence of any other care plan having been given to him, or for his permission being sought for copies of care plans to be given to his mother. In the knowledge of Mr Gonzales’ chaotic lifestyle, copies of his care plan should have been physically handed to him and explained to ensure he was fully aware of their contents.

9.56 Daniel Anderson and Sarah Cannon from Surrey probation service told us they were concerned about his mental health but had never been involved with a CPA meeting or aware of any care plan.

Ms Cannon

“My main concern from the time I was physically seeing Daniel was the engagement with the CMHT. If perhaps the relationship between him and his care coordinator could have been addressed, because the refusal by Daniel to engage was one of the main sticking points. He really didn’t want to talk.”

9.57 Joyce Winstone was his care coordinator from 29 July 2002. She stopped on 3 June 2003 when Mr Gonzales when to Spain. She told us:

“By then he had gone to Spain and I discussed the situation in supervision with Siobhan O’Hallorahan, my supervisor. We felt that we could close the case and take no further action. Daniel was saying that he was going to go to Spain, live with his father and not come back. In fact he did come back, as we know.”

Comment

There should have been a CPA meeting before Mr Gonzales was taken off CPA as he was on the enhanced level.

9.58 Joyce Winstone recounted a difficult time as care coordinator for Mr Gonzales. She considered that he would have preferred a younger worker and also described some difficulties she experienced with Dr Weinstock (referred to in the chapter on diagnosis and treatment). She was asked whether discussion should have taken place with Dr Weinstock about him going to Spain and acknowledged:

“That is the point at which we should have had a network meeting.”

9.59 She was then asked if there an operational policy for networking meetings and said:

“There is no written policy in the way that there is for CPA, but it is a useful meeting to have when you are floundering a bit. If you get a professional plan that you can then present to the client and say, “We’re sorry you are not wanting to work with us. As a group of professionals, this is what we feel should be happening.”

Comment

In the absence of clear operational policy for ‘network meetings’ we consider that what was needed at that time was a CPA review. The use of ad-hoc meetings apparently outside the CPA system was potentially confusing to the existing CPA policy.

9.60 Discussing her working relationship with Dr Weinstock Joyce Winstone told us:

“He would not do CPAs. He did not see them as a necessity”

9.61 This statement was put to Dr Weinstock. He acknowledged that his working relationship with Joyce Winstone ‘*was not the best*’, but said: ‘*it is simply not true. I attend CPA meetings all the time*’.

Comment

Ms Winstone told us that she felt that her problematic relationship with Dr Weinstock influenced the way in which she undertook her role as care coordinator. This was something that should have been dealt with through their line managers.

9.62 Aloysius Kizza took over care coordinator responsibility as described in the chronology above. He did seem poorly briefed, and with hindsight, there were concerns as to whether he was appropriately experienced for the role. He was asked if he had noticed from reading the file whether Mr Gonzales was on enhanced CPA. He said:

“I remember looking out for the enhanced CPA. I can’t remember finding the CPA. I cannot remember if by the time when I took over the case I looked at it and if it was on there. I cannot say I saw it.”

9.63 He was asked if he knew how someone is taken off CPA and said:

“I don’t know. I don’t know if somebody could be taken off a CPA. CPA is just a care plan, setting out objectives which we should do to support and maintain the welfare, minimise the risk of this person. I can’t remember the sort of CPA which was on the form. I cannot remember seeing that on the file.”

9.64 He was asked if it would have surprised him to find that Mr Gonzales’ file was no longer active. He said:

“No, it wouldn’t. When I was engaging with Mr Gonzales I had this thought about his past and, given the nature of his presentation and given the information his mother was giving to me, and given the information he was giving to me, and given the information I was getting from the psychiatrist, it didn’t reflect much of the past behaviours.”

9.65 He was asked whether Mr Gonzales was discussed at any other patch meetings after he had been allocated to him.

“No. He didn’t come up. Even in my supervision I didn’t discuss Daniel Gonzales.”

“The cases which were discussed were cases which were a risk which requires intervention, referral to the psychiatrist and monitoring, cases which were of a high risk. From the time before it was allocated to me and the time when he was allocated to me he did not present any of that sort of risk that required to be discussed in patch meetings, going to talk to Dr Weinstock to request for assessment or any further input during that time.”

9.66 Mr Kizza told us that the key areas he was pursuing in working with Mr Gonzales were that *“He was lonely and isolated and not engaged, and he had had accommodation concerns.”* He also told us that his aim was to *“...develop a relationship and, on the back of that, to gain willing cooperation and engagement and perhaps an insight to do certain things that previously he would not be too keen upon.”* We accept that he was making an effort to establish a rapport with Mr Gonzales.

9.67 Lorraine Reid considered Mr Kizza was too inexperienced to be allocated care coordinator for someone with a history like Mr Gonzales’. When questioned about this she told us:

“I think he was too inexperienced. I was surprised that the care coordinator was even a social worker in that case.”

“He had a forensic history, he had been in youth custody, he had been in custody, he had case notes that size [indicates thick]. He had been on section, and he shouldn’t really have been off the enhanced CPA, he should have been on enhanced CPA all the time. If you think someone with that history was allocated to someone who was a fairly newly-qualified social worker, that doesn’t quite fit.”

“He should at least have been an ASW or an experienced CPN”

Comment

There were significant failures identified in the organisation regarding the delivery of the CPA. The CPA was introduced in 1991 with guiding principles to address many of the issues and failures seen in delivering specialist mental health services to Mr Gonzales. We saw examples of good practice and individuals striving to both understand and assist Mr Gonzales, but we conclude that the failure of CPA to be implemented effectively seriously compromised the care Mr Gonzales was entitled to expect from the trust. Delivering an effective service to someone with Mr Gonzales' combination of difficulties will never be easy, and can only happen if willingness to help is backed up by high levels of professionalism. Personal skills and qualities are very important, but are unlikely to be effective unless they are being used properly within the carefully constructed local and national CPA protocols.

Findings

9.67 There were examples of good practice and individuals striving to both understand and assist Mr Gonzales.

9.68 The CPA systems in place had many weaknesses, including poor management control and audit, as well as individual failures in following policies.

9.69 Decision-making was often isolated and fragmented and not relayed to other key people or recorded appropriately.

9.70 For much of his contact with the services there was no clear care plan which was understood and communicated with Mr Gonzales, his carers and other professionals involved.

9.71 Carer assessments were not followed through, and the engagement with his mother was generally poor.

9.72 Key components of the care plan, such as risk assessment and risk management, were often poorly informed and formulated.

9.73 There were never any properly developed crisis or contingency plans.

9.74 After his return from Spain there was little consideration given to the skill set and experience required of the allocated care coordinator.

9.75 The centrality of the CPA as the 'cornerstone' of delivering mental health services was at times evident and at times absent.

9.76 The importance of historical records as a valuable source of information was not consistently recognised.

10. The Mental Health Act

“I can’t find anything that would suggest he would have warranted bringing in for assessment or treatment at any particular time” (Dr. Rachel Hennessey)

10.1 We considered whether there is evidence that Mr Gonzales should have been detained under the Mental Health Act other than on the occasions when he was, in 1998 and 1999.

10.2 The Mental Health Act allows someone to be detained in the interests of their own health as well as in the interests of their own safety or for the protection of other people. It is tautological to say that Mr Gonzales’ health was adversely affected by his mental illness. The question was whether the other criteria for detention under the Mental Health Act were met, namely:

“...that his mental illness was of a nature or degree which made it appropriate for him to receive medical treatment in hospital and that it was necessary that he should receive such treatment and that it could not be provided unless he were detained”

We did not think that they were.

10.3 At no time after he left hospital was it suggested to him that he should go in as an informal service-user, to allow those caring for him to obtain further information about diagnosis and treatment. Our reading of the records shows that the only suggestions of inpatient treatment came from Mr Gonzales - in July 2002 when he was taken to A&E and asked to be admitted; and again in early 2004, when he suggested to Dr Dada that he should go in as an informal service-user. Nothing came of either of these suggestions. It seemed to us that if Mr Gonzales needed diagnostic and other assessments, more effort would have been needed to engage with him voluntarily in the community before there could be justification for hospital detention.

10.4 The one exception to this relates to 13 September 2004 (which is dealt with in chapter 12 of this report). Mr Gonzales’ behaviour was bizarre and out of character, and caused great concern to his family. It is possible that if he had received a Mental Health Act assessment, he would have been admitted to hospital. No such assessment took place but we think a MHA assessment should

have taken place following the efforts of Mrs Savage and Mr Harper to alert the authorities. If it had been thought that Mr Gonzales had needed inpatient treatment, we do not know if he would have been willing to be admitted as an informal service-user. If he had been willing to be so admitted, it is not possible for us to say that the Mental Health Act could have been used in this occasion.

Findings

10.5 There is no direct evidence that the MHA should have been used at any point but was not. Nor do we find evidence that those responsible for Mr Gonzales' treatment felt hampered by a lack of power to impose medication while Mr Gonzales was living in the community.

11. Engagement

Regardless of whether he was ill or not ill, if someone commits suicide or they go and do really dramatic things, the one thing I believe prevented them from doing it is the quality of a relationship they have with someone. It seems clear to me that probably he did not have the quality of relationship with a particular worker that might have made him think, I am starting to have bad thoughts and I want to tell someone. That's the biggest thing" (Mark Girvan - manager, community mental health team 2004)

11.1 There is agreement that there was a lack of engagement between Mr Gonzales and the statutory and voluntary services there to help him. The 1999 National Service Framework for Mental Health is clear about the importance of engagement even when the service-user is thought to be of low risk of causing harm to self or others. The framework confirms that successful long term treatment and management of mental illness in the community will nearly always be based on good engagement between service-providers and service-users.

11.2 Mr Gonzales understood the value of engagement:

"Well, if I was seeing someone two or three times a week, that's at least something. Someone's at least lifted a finger and tried to help me, which is good. I'd have been able to identify myself with the person."

Mark Girvan reinforced the importance of engagement:

"In general terms it would also be ideal for services to be configured around people's skills rather than GP alignments. Ultimately I have people who will engage. There are young guys who take drugs and frankly they're difficult, maybe ill, may not be ill, and we're not going to be able to see them lots, but the quality of their sense of our service is key - I believe it and I still believe it. Maybe support work, outreach, going out and having a coffee every month, going to the gym with him. In a sense there's an outreach service that's not outreach, three times a week that we could try and do with people like Daniel."

11.3 It became clear from the witnesses that people approached the notion of engagement in a number of different ways. The first idea was that if a service-user was in contact with services, however erratically, this was engagement. It was not claimed to be good engagement, but for the purposes of ticking boxes to comply with the policy on assessment it met the definition.

11.4 Teresa Vine was asked what services would be available for someone with a dual diagnosis of mental illness and substance abuse in 2004:

“The first line, which is always the most difficult, is engagement. That is always the most difficult one, and once you’re able to establish that, whether it’s through Omni, it can take a long time because if the person is not going to engage they’re not going to engage. You’re interfering with what they’re doing, you’re telling them to stop taking drugs... We didn’t have it then but we do have it now, we have access to three outreach workers who are employed by social services. They are in a house down the road from us in Link Lodge and if we find we need people to bring them for appointments and be a bit more proactive, we can refer them to them, but we didn’t have that before the last year or year-and-a-bit.”

“...one of the things that Woking was probably better at than many other teams is that they were very responsive. Even if it wasn’t assertive outreach to somebody who was difficult to engage, they were very responsive to people who came to them. There are some teams who think they don’t want to engage with us so there’s nothing we can do. What Woking have always been quite open to is if someone knocks on our door we’ll respond to that. It’s a small bit of the jigsaw but they were good at that.”

11.5 It is clear that Woking CMHT’s view of engagement was to be responsive to those who asked for help. The evidence we received from witnesses was that Woking CMHT was responsive and this was supported by the panel’s review of documentation.

11.6 Joyce Winstone described the approach to engagement very succinctly:

“Our duty is to monitor them and provide what we can for as long as they will engage with us”.

11.7 Mr Anderson from probation described the value of probation orders for those not engaging with mental health services:

“Therefore it’s quite a good process in some ways to try and assure a level of engagement, because the individual knows that if they don’t there are going to be consequences to that.”

11.8 Ms Cannon reinforced this:

“Also it’s a routine. He was quite chaotic. If they know it’s on this day and that time, it brings in some boundaries and routine to their lives.”

11.9 The approach to engagement taken by professionals towards Mr Gonzales was mostly based on responding to him or his family. Stanley Riseborough identifies the dilemma faced by staff:

“He seemed to be engaging, predominantly when his mother brought him along, and the services still have very much this legacy of if people don’t choose to come when we set the appointment, then how actively do we pursue and chase them.”

Comment

In our view, this kind of contact should not be described as engagement without a qualifier, as it might conceal the lack of real engagement. We suggest that such contact should be referred to as “superficial engagement”, or even, at the risk of adding to jargon, “pre-engagement contact.”

11.10 The other forms of engagement described to us, all of which we considered to be true engagement, broadly adopted one of three approaches:

- The service approach of trying to give the service-user what s/he wants
- The paternalistic approach of trying to get him/her to understand what the professionals can see s/he needs
- The recovery approach of trying to help him/her understand how to make the best of a difficult situation.

11.11 Most witnesses supported a mixture of these approaches, but in each case one or other predominated. This influenced whether the emphasis was on the service-user being responsible for engaging with the services, or on the service-providers being responsible for engaging with the service-user.

The service model

11.12 Helen Wood said:

“With Daniel what transpired was tragic, but there was a question as to how ill or not he was, and if you make the threshold too low you are going to be absolutely overwhelmed with people who perhaps don’t need that level of service.... However, for example a number of referrals were made over the years to drug and alcohol services, and Daniel simply didn’t engage, and at times he said he wanted to and at times he indicated that it was a lifestyle choice and he very positively stated ‘I don’t want to give up this lifestyle’. So, however the service had been organised I don’t think in every case it would have made a difference.”

11.13 Joyce Winstone picked up on this theme:

“He only gave you the information that he wanted you to have. You have flashback memories of certain situations and I have a vivid memory of two things. One is of him walking round the interview room at Bridgewell House, literally with his hand on his heart, saying, “I will cooperate. I will see the

CRES team. I will keep all my appointments with you. I will behave myself. I will stick to the tenancy agreement.” Once he got into Link Lodge, he metaphorically shut the door and he was very difficult to make contact with.”

11.14 Andy Bell, director of public affairs, Sainsbury centre for public affairs and Kathryn Pugh, project leader, Young Minds, gave the panel evidence about engagement and service-user choice:

“...time and time again families are saying, ‘I’m telling you he’s not well’, and the service is saying, ‘It’s his choice.’ It’s at what point is the voice of the families who are living with somebody heard.”

Comment

Our impression is that the service model is likely to be prominent when the service-user is seen as low risk for harming himself or others, and not very needy. The consequences of such a person not taking up the offered services are seen to be relatively unimportant. However, it seems it is all too easy to underestimate the needs of those with chronic schizophrenia who do not have acute episodes. This is borne out by the report of the Confidential Inquiry into Suicide and Homicide, published on 4 December 2006. The result is that, even if matters do not end as tragically as they have here, the mentally ill person slides into living a diminished, hopeless, and restricted life.

It is crucial to have a pre-illness baseline, so that someone's deterioration from that point can be assessed, and a proper assessment made at every stage of their continuing ability, or otherwise, to engage. If each assessment is simply compared to the previous one, then in the case of a person with no acute episodes for years, gradual deterioration of mental state and the ability to engage properly may be missed. In particular, if someone with a diagnosis of schizophrenia attends appointments sporadically, usually when brought by someone else, and agrees to programmes but does not follow them up, then there should be consideration that s/he is displaying the negative symptoms of the illness, rather than choosing not to engage.

The paternalistic model

11.15 The paternalistic model (and we do not use the phrase negatively) was clearly articulated in this case, and particularly eloquently by the consultants with the most clinical experience. They had different ideas about how to persuade someone to accept what they needed but a shared view of what those needs were.

11.16 Dr Annear described to the panel in some detail how he would try to educate a service-user about their illness. He outlined how it might take three months before they would relapse after stopping their medication and how illicit drugs increase the dopamine levels temporarily and therefore make their illness worse. He made the important statement:

“The second half is that if you can somehow empathise with the experience rather than list the symptoms, you have a much better dialogue.”

11.17 Dr Kidd described his approach as follows:

“I would have loved him to be able to go straight to a secure hostel, and I would have loved to have the power to say, ‘You will go to that hostel where they’re going to look after you’ - like a bail hostel. I have had one or two successes with patients who have gone from prison to a bail hostel run by the Probation Service in liaison with psychiatric services. Good success because they draw the boundaries, they are therapeutic, but there are very few of these places around, they are extremely rare and it’s a great shame.”

11.18 Mr Kizza was asked whether he saw his role a bridge between a service-user and the psychiatrist or the CPN:

“Yes. And to enable the client to accept the services you have identified as the need for this person. Even if he may not have the insight, you see he requires at least to be supported in this way, then you try, you negotiate... It was just befriending him, to see me as another young man, just try to befriend him, try to give him hope and probably he’ll begin to engage with the services, begin to be able to access the available services in the community. It was just a starting point. There is not any other way you can do it. It’s just trying to show them what is available.”

11.19 This was also the favoured approach of Mr Gonzales and his mother whose desperate efforts to obtain treatment for her son are well documented.

11.20 Evidence from Mrs Savage was telling:

“I know a lot more now, but at the time it seemed wherever he went and came back from he came back with leaflets and the leaflets just said the pros and cons. It was all about getting leaflets. Now it all makes perfect sense to me, that it was much easier to blame everything on the drugs and change diagnoses because then they don’t have to treat him, which is what I’m really angry about.”

11.21 Mr Gonzales described his own approach to his illness as follows:

“If I’m going to be in the mental health system my treatment should come first above everything else. My treatment should be paramount and I shouldn’t be having to face things like that myself without knowing things and that. At the end of the day I’m not going to give myself in. I was feeling very unwell, I needed the help, I wasn’t going to get it because I wasn’t even going to go out and tell them I was ill because I was scared of being sectioned. It was obvious I was ill because my mum could see it and my mum told them loads of times. Once or twice I went to the Abraham Cowley unit asking to get in. Even then that’s a self-contradiction but I did feel so unwell that I had to, but I know that’s a self-contradiction. My treatment is paramount and it should have been dealt with all the way through.”

The recovery model

11.22 There was wide acceptance by many of those we interviewed of the recovery model, but less agreement about what it entailed and how it was being used within the trust.

11.23 Mark Girvan told us that in 2004 the trust was moving to engage with service-users in line with the recovery model. This was of particular interest to us, as it became apparent this may have influenced the approach to care and treatment offered to Mr Gonzales.

“...we tried to promote the idea of what the customer wanted. That’s what we do. He came along, he said, ‘I’m bored, I want a bit of help with employment’, and we tried to engage him along the lines he presented with. In a way that’s pretty much what the recovery models and the training we’ve given staff promotes the idea of them doing.”

11.24 There was further evidence that the trust believed it was working to the recovery model and that this belief was a factor in influencing how care and treatment was delivered. Teresa Vines stated:

“We work very much to the recovery model, and it’s quite new, but we always have worked in a very holistic way, and you can tell by the team members that we have.”

11.25 When Jill Jarvis, the then director of nursing, was asked about the recovery model she described the balance between risk management and service-user choice:

“The reality is that people have to prioritise. We have a limited resource, and assessing that risk is a risk. It is two separate things. One is that you have to make a conscious decision that you’re looking at risk rather than necessarily patient choice, and making sure you are keeping them and others safe. Equally, it may well be that sometimes people are using choice and recovery model and things like that as a way of managing their own anxiety about the fact that they have to prioritise.”

11.26 She also said there had been no implementation strategy or study days regarding the recovery model which she could remember. She said:

“It probably was an organisational philosophy, but I wouldn’t see it as something that was implemented”

11.27 Mark Girvan told us the model did not have the full support of medical staff. As the approach needs a change of attitude to be effective, it would have been important to engage such key members of the team. He said:

“I think they think its rubbish. I think they think it’s a vague thing that doesn’t say anything. It’s not rubbish and I think they’ve missed the point of it somehow.”

“The recovery model is a bit of a vague concept. People go for training and they come away thinking, I don’t quite know what I’m going to do now.”

11.28 Having considered the ways service-providers attempted to engage with Mr Gonzales, we were not sure that the trust had properly understood the recovery model as the descriptions given to us made it sound more unhelpful than otherwise. We decided we needed more information to get a better sense of the model, both theoretically and as it was used in the trust around 2004.

11.29 The panel received a written paper on recovery from Dr Julie Repper¹¹ and had the opportunity to discuss her views, and using the model in practice, when she gave evidence.

11.30 The recovery model was a relatively new concept in mental health services in England in 2004 when the National Institute for Mental Health in England (NIMHE) published a document entitled ‘*Emerging Best Practices in Mental Health*’. It recognised that there was no one definition of the term recovery. To help develop the model in line with emerging best practices, recovery was defined as ‘a personal process of overcoming the negative impact of diagnosed mental illness/distress despite its continued presence’.

11.31 We consider this statement from Dr Repper to be a particularly illuminating and helpful insight into how the recovery model can be understood:

“Probably the most useful way of understanding recovery is linking it to our own experience because it is something that is common to all of us; it is not

¹¹ Dr Repper is currently associate professor for Mental Health Nursing and Social Care at Nottingham University and is co-author of a book entitled *Social Inclusion and Recovery. A model for Mental Health Practice* (Baillere Tindall 2003)

specific to mental health problems. Any of us, who have been through a divorce, being made unemployed, a major illness or bereavement, know that that changes us; there is no way to going back to how we were before that event. We have to incorporate that into our way of living and we learn from that and move on with that, which is exactly what we are talking about in terms of recovery from mental health problems.

Very importantly, recovery is about taking back control over your own life and your own problems, about not seeing your problems as being uncontrollable, or that their control is just the province of experts. It is about understanding yourself what is possible and what you can do to help yourself.”

11.32 Any developed care plan would then be focused around the service-users’ wishes and ambitions, but Dr Repper said this should not be seen as a *laissez-faire* approach. She told us:

“Our aim is to promote inclusion and reduce stigma and discrimination, and we are not helping a person if we allow them to return to their home or to work, or we push them into relationships and activities before they are ready. That can destroy those relationships. We are not helping them to get involved in activities if they are very disturbed or deluded or angry because that will make things harder for them in the long-term.

We need to carefully assess when and how to help them to resume or commence activities. To do that we have to go back to having a trusting relationship, we need to help them to tackle issues as they arise, we need to help them to manage their drugs to allow them to get up in time, we need to help them to explain things to potential employers. We need to not just help the individual to fit into their environment; we also need to do work with the environment to help them to understand mental health problems. That is another part of recovery.

One of the greatest barriers to recovery and inclusion is the pessimism within services. Increasingly research is showing that service providers have very low expectations of people using services, they don’t have a lot of hope

for them, which is one of the biggest barriers to getting out there and living a meaningful life.

In conclusion, we can promote recovery by helping everyone to lead a meaningful life that they value. This involves providing treatment, support, information and opportunities within carefully assessed boundaries. It is about helping people to set limits on themselves but also about knowing when they need us to impose limitations. It's not about letting people do exactly what they want, nor is it about us deciding what's best for them."

11.33 Dr Repper acknowledged that the recovery approach is hard work and difficult to put into practice as it requires considerable skill and commitment.

11.34 We were reassured that the recovery model, if followed properly, would not compromise appropriate intervention in line with evidence-based practice. The quality of engagement should, in fact, facilitate this. Dr Repper said:

"The second part of our model of recovery is helping facilitating control; it is not about letting people passively sit back and have things done for them. It is about helping them to take control of their life, of their future, of their problems, and of the help and support they receive. Part of that is the treatment of symptoms, and it is moving away from us telling people what they need to them telling us what they want and coming to some kind of balance between that, because even once we have decided what they need, there are lots of choices and decisions that can be made. We might decide that somebody needs to have medication, but they have a lot of experience of taking medication and they know what feels right in terms of when they take it, where they take it, how they take it, how often they take it. It is about setting boundaries but giving choices and helping them to make decisions within those limits."

11.35 An investigation team member attended a conference on the recovery model. This included a number of presentations by service-users, emphasising the positive aspects of the recovery model. We noted that it is the intention of the Department of Health to produce a policy statement on how the recovery approach fits into mental health services.

11.36 We received a report from the National Advice Service of Rethink¹², published in January 2005, on the work of their recovery learning sites. Rethink recognise the difficulties of incorporating recovery practices into clinically orientated services, but the charity has embraced the philosophy. We were told in January 2007 that it planned to ensure all Rethink services were using recovery practices by March 2008. We also received evidence about the trust’s adoption of ‘*Vision and Values*’ from the chief executive and this was reinforced in a letter to us stating that:

“At its inception the trust developed and articulated in partnership with service-users and carers its ‘Vision and Values’. The ‘Vision and Values’ framed around a central theme of ‘Capturing hope and building on dreams’ and the trust’s commitment to values-based practice provides the context in which the philosophy and practice of recovery can be further considered and implemented.”

We believe the trust’s ‘*Vision and Values*’ are consistent with the principles of recovery. However when we spoke to service-users in 2007 they did not describe a recent transformation in service delivery, so at that time it seems that implementation was not yet complete.

Mr Gonzales’ attendance record

11.37 In view of the different models of engagement, and because we heard much about the difficulties for staff in Mr Gonzales’ erratic attendance at meetings, we analysed Mr Gonzales’ contact with services.

11.38 As previously mentioned, after his first admission to hospital in 1998 Mr Gonzales saw:

- A GP 18 times (and missed three appointments)
- A psychiatrist 16 times (and missed nine appointments)

¹² Rethink is a charity which works to help those affected by severe mental illness recover a better quality of life.

- Another member of the CMHT 24 times, seven times without an appointment (and failed to keep 11 appointments)
- He had two periods of contact with the probation service: for six months when he came out of prison in 2001, and for six months from December 2002 until he went to Spain in May 2003
- In the first contact period with probation he attended 23 of 26 appointments (late once); he turned up but was too late to be seen on two occasions, and had an acceptable excuse for the one occasion he failed to attend at all
- By contrast, in his second period of contact, in 2002/3, he attended 13 times out of 26 (late six times) and failed to attend on 13 occasions with sick notes for only two of them.

Comment

Many people told us that one of the reasons Mr Gonzales was difficult to engage was because he did not keep appointments, so we were surprised to see that his attendance rate was as good as it was. We felt strongly that conversations between him and service-providers about this attendance record might have allowed both him and the service-providers to get a better understanding of what might work. For example, why was his contact with probation successful in 2001 and unsuccessful in 2002/3? Why did he go to Bridgewell House so many times without an appointment? Why did he keep so many GP's appointments as compared to outpatients? Mr Gonzales was an intelligent young man, despite the ravages wrought by his illness, and his willingness to persist, however intermittent, could have been built upon. However, without an analysis of his attendance pattern, such conversations could not take place, or even be contemplated.

Adverse factors

11.39 It did not seem to us that the recovery model had been in operation in Mr Gonzales' case, and as the other models we identified had not succeeded in achieving long term and meaningful engagement with him, we looked at the factors which might have got in the way of this desirable outcome.

Lack of continuity of care

11.40 Continuity of care was an obvious issue, Mr Gonzales was asked about who he saw, and whether he would have liked to see a doctor more regularly than a nurse. He said:

“If I had been able to see the same doctor regularly“

“For example, I spent one day speaking to the prosecution doctor for 30 minutes and suddenly he went to school with me and he knows exactly who I am and we were best mates and everything and he knows all my family and he knows everything about me. No, that’s impossible. To have proper care you need to have a doctor to have followed your path for a little while and to cross-examine you thoroughly over the course of a few months, not just one day for 30 minutes. That is absolutely impossible. Even may be for once a week for two months that is still completely ridiculous. You need to have someone to have been sitting there and watching you to see the changes in your personality, to look at anything in your behaviour that might be there that shows them. I don’t think you can cross-examine a patient in such a short period of time, that’s absolutely ridiculous.”

11.41 He was asked which of the doctors he saw knew him best. With some prompting he said that he knew Dr Kidd and Dr Annear quite well. He then made this telling statement:

“It’s the psychiatrist, and the absence of one, still to this day. It’s mind blowing. Why? Why was there an absence of psychiatrists? People need to see a psychiatrist because otherwise you can’t tell if they’re ill. It’s absolutely ridiculous. If I go in there and I act like I’m not ill and I put on a

smiley face and pretend to be happy - and he's not even qualified anyway - how are they going to know what's happening? That's probably the reason I deteriorated into such a bad state of mind."

11.42 Charlotte McGregor reinforced the value of continuity:

"He obviously did feel a bit more comfortable talking to us because we knew him; we didn't have to go through things again. For example, when I saw him in the corridor he was more pleasant to me than he might be to the worker that he had at that time. He would talk to me a little bit more, be a little more open with me and a bit more co-operative, so I think consistency in workers probably did pay off even though it didn't pay off that much. It helped a little bit, it helped oil it along a little bit."

11.43 Dr Hennessy described the value of the early intervention of psychosis services in ensuring continuity:

"In terms of early intervention in psychosis, where people are followed up by those services that are effectively functioning, so these young people with perhaps unclear diagnosis at least to start with, have a specific service in which people remain in that service for a reasonable amount of time, whether the diagnosis becomes a certainty, and it is probably that type of area of the expansion or proper implementation of early intervention in psychosis. Daniel was psychotic and that type of service, with family interventions, might have been something that would have helped."

Comment

We have already described in considerable detail the lack of longitudinal assessment in Mr Gonzales' case. Continuity of care is not the only way to carry out such assessment. But in a culture which did not reinforce the need to read old notes, continuity of care would have allowed the service-provider to have a long-term view of Mr Gonzales, and allowed a relationship to grow between Mr Gonzales and his clinical team. Continuity should be provided by the most appropriate member of the team. If there is diagnostic uncertainty, this is most likely to be the consultant.

Lack of agreed diagnosis and medication regime

11.44 The lack of a clear and accurate diagnosis led to varying opinions over time and amongst those working with him at any one time about Mr Gonzales' need for medication, his mood, behaviour, character and eligibility for services. This had a knock-on effect on his relationships with the people working with him.

11.45 Mr Gonzales had clear views about the effect on him of taking, or not taking, the right medication:

“When I was first released from the psychiatric hospital I had a couple of psychiatric nurses - I can't remember their names - and they used to look after me quite well, when they were giving me depot and that. I was on the depot between 1999 and 2000 and when I went to prison I stopped taking the depot, and from then on everything went bad, but between that time when I was on the depot there was absolutely nothing wrong with me at all, I was fine.

They helped me with everything except my mood - I wasn't on a mood stabiliser - but they seemed to make me elated anyway so I never really felt like [demonstrates lethargy] I always felt [demonstrates elation] brilliant, good day. That was one thing. I liked it, it was good; it was better to feel that way than to feel down. The chlorpromazine is a tried and tested antipsychotic and it worked on me quite well. It stopped me having any hallucinations and that and it made me have more of a point of view. I seemed to be more of a person, I seemed to be able to speak up for myself a lot more. The depot was basically helping that as well and I felt confident. As I say, it did make me go a bit up the wall, a bit elated, but generally it was helping me. All it was doing was giving me the Largactil shuffle which we all know about, but I was quite happy to take it besides all that. I wasn't really bothered about the side effects.”

Comment

Many of the people who spoke to us complained of how difficult it was to get through to Mr Gonzales. The above comments seem to suggest that lack of medication may be an explanation. This is supported by evidence, already

quoted, from Broadmoor Hospital.

11.46 Joe Dunne described the value of having a comprehensive look at someone whose diagnosis is uncertain:

“When you say uncertain diagnosis, it often pitches up that it might be personality disorder. If it’s personality disorder, chasing somebody can have the wrong effect because the person becomes more dependent. I’ve seen many cases where somebody has been chased and the more we chase the faster they run away and they become more and more dependent on the system and structures that are in place. Again I don’t know much about Daniel Gonzales, but if there’s a mixed diagnosis maybe someone needs to sit down and pull it all together, look at the history, what’s happening here and then decide what is the diagnosis, because that’s where everyone gets confused and it creates a lot of tension between staff as well.”

11.47 Dr Annear also reinforced the need to get the diagnosis right as soon as possible:

“I am constantly told, that I keep patients for too long in the PICU, (psychiatric intensive care unit) because there is a ceiling of three months on the PICU. I would rather keep somebody for longer than that to get the medication right - after all you can only try two changes of medication in three months, and if you go on to clozapine it’s another two months - and get the psycho-education right, and then say this is the recipe for a long and happy life out of hospital. That is what I would rather do, than do a rapid turnover.”

Comment

Engagement, continuity, diagnosis and correct medication are interlinked and any one of them could start the process that allows all to be achieved. A situation where, after six and a half years of contact with a single trust, not one of these elements was even close to being achieved, suggests that something went badly wrong in the way the trust’s resources were used.

Lack of flexibility

11.48 We start from the position that it is the service-providers who have to take the lead on engagement as it is an essential part of the job they are paid to do. This means flexibility of approach is likely to be important. Mrs Savage told us:

“Visiting at home is very important. Nobody ever visited him at home apart from Sue Withers and Gavin Barker, who were marvellous. When you see these people at home and you’ve made them a cup of tea and all that sort of thing, they seem more like part of the family rather than someone you go and see in an office who doesn’t have much time for you. And you have to be there at a specific time when your illness dictates that you can’t get out of bed.”

11.49 John Humphries said the youth offending team recognised that flexibility was key with young people:

“I visited him. That’s another area may be I can talk about, the nature of the way we work. In the youth offending team we are quite different from adult services in the sense that we would recognise we’re working with young people whose level of maturity is at times quite low, their motivation is quite low. When I first met Daniel I realised that I had to very quickly adapt the way I supervised him, otherwise he would have been in breach of his order in no time and would have been brought back to court. My priority was to establish a relationship with him and engage him before I did any work. I always did home visits, I never asked him to come and see me at my office. I always did them late afternoon or early evening when I knew he would be up. I generally checked with his carer that he was at home, that he was up and he was ready, because it would have been so easy for me to have asked him to come and see me at noon at my office, and I knew I would be setting him up to fail. I felt the priority for Daniel was to have someone to engage with him first of all.”

11.50 Lorraine Reid said home visits and flexible engagement was more the role of the assertive outreach team than the CMHT:

“The CMHT can do home visits, but he’s the sort of person that may be a more assertive outreach - meet him in different places other than home and don’t always expect him to come into the CMHT because he was never going to do that”.

11.51 Teresa Vine said:

“As I say, the most difficult part is engagement, and if you were able to have dedicated staff to work specifically with getting these people engaged it would cut down a lot of work and a lot of worry, and a lot of anxiety within the community from other professionals and relatives.”

11.52 Dr Kidd also commented on assertive outreach:

“Twenty years ago the old-fashioned community nurse would just say, ‘Right, I think I’ll go and see that patient; I’ll track them down and see what’s happened.’ Now it has to be on a timed and scheduled basis and a lack of flexibility has crept into the system. The nurses were overwhelmed with systems without being able to respond to what they felt was perhaps desirable in a more flexible way. Do you see what I am driving at?

To me it is a big thing, and more time ought to be allocated for more psychotherapy - not just watching the situation and hoping for the best - more time for assertive outreach, meaning developing a relationship and getting to the root of the matter. Psychological-wise, I don’t think assertive outreach in itself is enough; people are not trained enough.”

11.53 A wider perspective was provided by Andy Bell and Kathryn Pugh:

“Services are not constructed to meet young people’s needs by and large... The fact that somebody won’t come to you doesn’t mean to say that you should stop trying to engage with them. I know there are difficulties around choice and lifestyle, and part of your choice should be to say, ‘No, I don’t

want this.’ One of the difficult things about giving people choice is that sometimes they don’t make the choices we want them to make. That is a very difficult thing for any service to deal with and accept and run with, but that doesn’t mean to say you don’t keep trying and you don’t keep engaging with people.”

11.54 Dr Repper also emphasised the need for flexibility in approach:

“What we need to say is, ‘Where would you like to meet us, when would you like to meet us?’ and if necessary meet him at a pub on a Friday night, or at least at a Wimpey Bar at six o’clock at night and have a cup of tea or some egg and chips with him. Something that enabled him to find an acceptable way of doing it that wasn’t stigmatising and automatically associated with mental health, but was about hearing his story in a way he felt he could tell it in a place that he could. That makes sense to me. Recovery model or not, it’s something good practitioners have been doing for a long while.”

Comment

We wonder why more services are not already organised in this way, so as to catch all those who are both difficult to engage with and in need of services

11.55 Kathryn Pugh told us:

“We used to say when I was commissioning that we had four categories. Category one is will we be sued if we don’t do; category two is what the targets say we must do; category three is what should we do, and category four is what would we like to do. I don’t think I ever got to category three because we were always focused on categories one and two because that was the financial reality.”

11.56 We were puzzled that a need for flexibility could be recognised but still rejected. Mr Kizza told us:

“The majority of the patients presented themselves in the same way. Most of the patients of that age will misuse drugs probably, will take alcohol. Appointment is one of the last things they want to do, so when I was over

there we keep on trying to make another appointment, try to see when we are able to see them. It is a common thing, and I don't think it was posing any frustration. Some of them come up to attend but there are others who don't."

Comment

It may not have been frustrating for staff when service-users kept missing appointments, but it can hardly have promoted engagement.

11.57 Daniel Anderson and Sarah Cannon described the approach taken by probation services:

"Following on from what John Humphries' was obviously saying, we do notice quite a significant difference, specifically with young people we get going through the transition from the youth offending team into probation, because the onus of responsibility is firmly placed on that offender, even if they have just turned 18. So it is appointments, they are expected to come to the office. We will do one visit that counts as an appointment but we wouldn't be going out every week or two weeks to see them at home to try and engage them.

Interestingly enough, we do have a performance target at the moment that's in place to show have we done everything we possibly can do to maintain an offender coming into the office and to maintain a level of engagement, but that still doesn't go as far as going out to do regular home visits. That's to do with things like did we telephone the offender the day before or the morning of their appointment to remind them; have we looked at all the different options we can of how they can remember appointments. Again, going back to the earlier point, there is a large percentage of very chaotic individuals and we have to look at some fairly creative means as best we can to try and get a full sense of engagement.

My experience within the probation service, when I started we were given the flexibility within the work we did to do all kinds of things like that, almost along the lines of what the youth offending teams do. Unfortunately, as things have changed - and we've gone through dramatic

amounts of change, certainly towards more public protection, towards enforcement, being a law enforcement agency - all that side of things seems to have reduced quite significantly.”

Comment

We found it interesting that the probation service, bound as it was by nationally set rules, bent over backwards to engage with its service-users whereas the CMHT, which had more flexibility, did not seem inclined to use it.

Difficulties in managing referrals

11.58 There seems to be a particular problem around first appointments. It is similar to the issue of consultant responsibility that can take place when a service-user has been referred to a new consultant, but the new consultant has not yet taken the service-user on. It is probably unreasonable to expect agencies to chase people who have not signed up to their service. But in such cases the referring body, particularly if it is part of a statutory service, would seem to have a responsibility to investigate the failure to make contact. For example, to make sure it was not a result of the person’s negative symptoms of illness, anxiety about change, or fear of the unknown.

11.59 The investigation team asked a number of witnesses their response to un-kept initial appointments.

11.60 Darren Ayres from Project 18 stated:

“If we had a cancellation, we would send a letter out to the referrer, letting them know the situation. In the same way, if we had someone who did not turn up, we called that a DNA (did not attend) and we would send another letter. We would give someone maybe three chances before we would ask for another re-referral.”

11.61 He also confirmed that he would advise the referrer if the person did not attend.

11.62 Mike Klein described his attempts to make contact with Mr Gonzales:

“A letter went out that he did not attend, a 14 day letter went. It is pretty much standard practice, but then we heard that it went to the wrong address. The secretary to the team alerted us to that, and so we sent a new letter out with a new appointment to the Guildford address, Vaughan House, and just in case, to his old address as well in the hope that he didn’t miss it. On 22/6 unfortunately again he did not attend, which is not uncommon, so another 14 day letter went out.”

11.63 He was asked if at that point he closed the case:

“No. I got a phone call from Hayden Morris from the Omni outreach, this is the team that work with SADAS and they care for people with dual diagnosis and difficult-to-engage clients. He said that he understood Mr Gonzales had problems getting in so he said he was more than happy if we could give him the date and the time and venue that he would give Mr Gonzales a lift in, so I put that in the letter and copied it in to Hayden Morris. That appointment was offered for 20/7, but again unfortunately on that day he did not attend, and he was then discharged from the services.”

Effectiveness

11.64 We merely state the obvious when we say that engagement is more likely if the service-user feels that he or she benefits from it.

11.65 Mr Gonzales told us:

“They wouldn’t help me with things like claiming benefits, and they wouldn’t help me with things like housing. When I left mental hospital I was on the street, no benefits and no hostel, nothing. That was why I had a poor relationship with the team, because they refused to pull their weight when I was on the outside basically.... I just couldn’t handle it any more so I gave up on the team really because my social worker wasn’t doing anything....”

“I said to my social worker, ‘I need a place to stay and I’m not feeling very well. Is there a chance you could get me into a hostel?’ She said, ‘I don’t know, let’s ask the housing officer.’ So I spoke to the housing officer with her and then the housing officer said, ‘Oh yes, we’ll sort a place out where you can lodge.’ All that was done, I found out, she told me, ‘I turned up and I told them not to give you a place.’ I said, ‘Thank you very much.’ I wasn’t very chuffed about that, to say the least. I went back to the housing officer, spoke to the housing officer behind my social worker’s back and then the housing officer said, ‘Okay, you can move in tomorrow and everything will be sorted because I can tell that you’ve got problems and you need to sort yourself out.’ I couldn’t live with mum at the time because I was very ill and I needed to be looked after.”

And, later

“In 2003 I was almost on the brink of suicide and I went to see my dad in Spain thinking that that step would put me on the route to recovery. Anyway, I did that and I had a very bad time over there which wasn’t getting any better, so I asked my mum if she would pick me up and come back. Of course, my mum was saying, ‘We can’t have you living with us Dan, you’re too ill, things have got to change.’ So I wrote a letter to the Abraham Cowley unit saying please give me a bed, I feel very ill, suicidal, I need help, and nothing happened with it.”

Mr Gonzales’ strategies

11.66 Mr Gonzales confirmed to the panel that he was very good at covering up how ill he was feeling. He said it was because “...no one really wants to get sectioned, do they?” and that “a lot of people who are ill won’t admit it.”

11.67 The following quote from Mr Gonzales is illuminating:

“I knew I was ill, but then again I thought by covering it up I could handle it. I was a bit different, not being able to tell her I was ill - I knew I was ill but I was playing a game with the system.”

Comment

When we remember that he spent a fortnight on an adult acute admission ward when he was 17, and six months in a secure unit when he had just turned 18, perhaps it is not surprising that he was afraid of being sectioned and was ambivalent about mental health services. Such ambivalence is commonplace and professionals should take it into account when trying to engage with someone, particularly if that person never had the chance to develop an adult personality before his illness took hold.

11.68 The evidence of Andy Bell and Kathryn Pugh reinforced the view that Mr Gonzales' attitude to adult mental health services was common:

"We know that young people particularly are less likely to engage in the early stages because they are much more concerned about a stigma, they are worried about what their friends will think, they don't necessarily want to go to an NHS trust where they are going to be with "mad people" as they put it, or if they become ill they are in a ward with people up to the age of 65. ...In consequence, they don't seek help early, they wait until they are almost in crisis point, at which point they have to have a much more aggressive intervention, which is also a much more expensive intervention, which has to then be provided.

For me, the other issue when you are talking about 16 and 17-year-olds, we feel very strongly that they shouldn't be on an adult ward unless that is the right place for them. Unless there has been an assessment that says this is where they need to be, and if that isn't where they need to be, they need to be on a specialist ward where people are used to engaging with young people, where they will be with other young people, because inpatient wards are scary places."

Comment

Daniel Gonzales had a part to play in the failure to engage meaningfully. He frequently took medication when it was prescribed for him and kept more meetings with members of the team than he missed, but because he was highly motivated to keep out of hospital (at least before the end of 2003) and as he

generally believed he could manage his illness, he persistently, but not consistently, played down both his symptoms and his needs. As Andy Bell and Kathryn Pugh commented, this is a common strategy for young people with mental illness.

11.69 There is evidence that, even without the support he had hoped for, Mr Gonzales was trying to sort himself out. Charles Sadler, who had been at school and college with him and who works for the trust, described to us how he had made contact again with Mr Gonzales in early 2004. He said he and friends included Mr Gonzales in their Friday evening socialising, sometimes spilling over into the weekend. It seems that there was a change in Mr Gonzales in the weeks before the offences and that he was trying to avoid breaking the law. Charles Sadler was asked if he knew why this change had occurred:

“All I know is that he was really trying to fix his life at that time. I remember him telling me he had kept off the drugs and as I said in that seven or so weeks we never saw him take a single pill in our presence or smoke a single spliff. He had told us that his doctor had said it was really bad for him to do drugs, so we knew how serious it was and that he had to remain off drugs, although he was drinking alcohol.”

Comment

The primary task of specialist mental health services, in whatever setting, is to engage with the service-user. This is sometimes difficult, sometimes impossible, but the goal should always be the same. The NSF points out that if services engage effectively with an individual it improves that person’s quality of life and life chances, allows more accurate and personalised risk assessments to take place, and reduces risk generally. It is difficult to see why it should be otherwise as people with mental health problems are the same as everybody else in that the quality of their personal relationships are an important element in their sense of well being. For somebody with serious mental health problems, a good, trusting, mutually respectful, relationship with a skilled and knowledgeable professional is likely to provide the securest possible basis for successfully managing their illness.

We realise that this creates a difficulty. The NHS, like most public services, is beset with policies, initiatives, guidance and targets. Ensuring compliance and delivery requires a superstructure and rigidity that does not fit easily with client-centred engagement.

In our view, many of the current targets and requirements set within the NHS have been chosen because they are measurable: responding to requests for help within a certain time, sending fresh appointments when appointments are missed, holding regular meetings, completing risk assessment and CPA forms. These are all useful but none of them says much, or anything, about the quality of the help being offered or its effectiveness.

The failure to engage with Mr Gonzales, exemplified by individual and system failures, was influenced by the negative attitude about his care and treatment which existed throughout his contact with the service after he left the Oaktree clinic. To succeed, the approach must be one of determined therapeutic optimism. Goals need to be achievable rather than unattainable dreams, and failures need to be treated as correctable mistakes. Service-providers should not punish themselves for making mistakes, but see them as an opportunity to find out why the plan did not work and to make a better one. If the next attempt fails, it again needs to be rectified by analysing the failure and trying something else. And so on until, if necessary, all the creative and professional resources of the trust have been brought to bear. Front line staff should be given the resources to work in this way.

Formal risk assessment still has a place but when assessing risk in the context of successful engagement, staff should ask such questions as:

- What is the risk that I will not be able to engage with this person?*
- What could the consequences be if I do not engage?*

The consequences need to relate to what is likely to be important to the individual as well as to society. The risk that someone will be condemned to a marginalised and unhappy life if they are not engaged with services should be an important consideration. If it is thought this risk is likely, the risk assessment should become an important driver in making every effort to

engage with that person. Assuming the worker is able to engage, and to discuss ways in which meaningful help can be offered the risk assessment would address new issues such as those set out below.

- How likely is it that this intervention, if delivered, will achieve what the service-user wants?*
- How likely is it that this intervention can be delivered? Will this intervention keep the service-user safe?*
- If I believe the service-user needs something that he doesn't want, do the risks of being persistent outweigh the risk of disengagement?*
- If I have to persist, how do I minimise the risk of disengagement and maximise the chance of acceptance?*
- Would it be better to use primary care as the front-line service with specialist services providing close support?*

A likely benefit of following the recovery model, or a similar model, is that the professional who engages with the service-user will have to have a proper understanding of the service-user's personal and psychiatric history. This understanding would be from the service-user's point of view, and from the point of view of service-providers, family and carers. The coherent body of knowledge created will help mitigate the problems caused by the current system in which specialist services are delivered from different locations by different organisations, agencies, and teams.

The sort of engagement described in the discussion of the recovery model, would clearly improve the quality of life of mental health service-users. This is not simply because they may accept interventions they would otherwise reject, but also because mutually respectful and trusting relationships are good in themselves. Remaining in society, or finding a way back into it, is a better outcome for any mental health service-user than being isolated and cut off. The emotional consequences of mental disorder are often the most difficult to deal with and anything that militates against unhappiness and

despair is good treatment.

Engagement is the foundation of successful treatment. Engagement following a model such as the recovery model, set within the framework of the care programme approach, will allow treatment to be delivered in a systematic way that will be available for audit but will protect the primary task of treatment from being smothered by the undoubted need to audit the use of public funds.

From the evidence we heard, we believe that the management and staff working in the specialist services would be able to adopt the recovery model and develop the understanding necessary to work in this way.

Among those working directly and indirectly with Mr Gonzales were thoughtful, experienced professionals with the skills and abilities to engage with him successfully or to ensure that successful engagement took place. We hope this is clear from these extracts.

Despite assertions from staff, we are not convinced they were working with the recovery model in 2004, or anything like it. In particular, we do not consider the level of engagement with Mr Gonzales was in line with recovery model principles. We saw no evidence of training or development to bring about the required attitudinal shift in approach.

We believe the recovery model, as described to us, would have had much to offer the care and treatment of Mr Gonzales. The fact that it requires a strong commitment to meaningful engagement and working with the service-user would have altered the approach to Mr Gonzales. We think that it would be useful to the trust to evaluate how its adoption of its Visions and Values would have altered the way in which Mr Gonzales' care was offered.

We see much value in mental health services following the philosophy behind the recovery model, particularly putting engagement at the centre of the therapeutic relationship. But failure to understand the rigour of the recovery model carries considerable risk. The emphasis on user-acceptance may cause professionals to slide more easily into lack of action than is likely in the

paternalistic or even service, models. With these, providers are, at the least, aware that a person needs their services even if he does not want to accept them.

Full engagement could not have guaranteed that Mr Gonzales would not have committed his offences, but it would, possibly, have made it less likely. The prospect of full engagement receded with every missed opportunity and miscommunication but it had a real possibility of being achieved right up to the end of 2003 as Mr Gonzales was then actively asking for help. Full engagement would not necessarily have prevented Mr Gonzales' recreational drug taking in 2004, but if it had been in place it would have allowed:

- *a proper diagnosis*
- *the prescription of effective medication*
- *a relationship of mutual trust and respect between a service-provider and Mr Gonzales.*

Findings

11.70 Among those working directly with Mr Gonzales and elsewhere in the trust were thoughtful, experienced professionals with the skills and abilities to engage with him successfully, or to ensure that successful engagement took place.

11.71 There was lack of engagement between Mr Gonzales and the statutory and voluntary services that were there to help him.

11.72 The trusting relationships that follow full engagement may deflect people from behaving dangerously. In a case such as this, where the crimes were apparently not committed in response to command hallucinations or other psychotic symptoms, or for rational reasons such as personal enmity or financial gain, the lack of any such relationship seems important.

11.73 Mr Gonzales' needs arising from his illness were underestimated. He was not given the help he needed to avoid living a diminished, hopeless, and very restricted life.

11.74 The level of engagement with Mr Gonzales was not in line with the principles of the recovery model, despite the assertions made to us that this model was used.

11.75 The recovery model, as described to us by Dr Repper, would have had much to offer the care and treatment of Mr Gonzales. The fact that it requires a strong commitment to meaningful engagement and working with the service-user would clearly have altered the approach to Mr Gonzales. We saw no evidence of training or development taking place to bring about the required attitudinal shift in approach. Any other model with the same priorities and philosophy would also be satisfactory.

11.76 A failure to understand the rigor of the recovery model carries considerable risks, as the emphasis on user acceptance may give rise to unacceptable inaction by professionals.

12. Events of 13 September 2004

12.1 Two days before the first murder, Mr Gonzales engaged, very publicly, in bizarre and out-of-character behaviour. Mr Gonzales described it to us:

“The day before I committed the offences I was seen running round Knaphill estate completely naked, round the shops, past all the pubs and everything, back down the road and all round the estate, completely naked. Yet I wasn’t arrested, no social workers or doctors came to see me or anything like that. Nothing was done to prevent that at all...I don’t know why I did it, to be honest. I’ve absolutely no idea. That morning I was punching myself in the face trying to give myself black eyes, and I did have one black eye....I was just going mad. I’ve never been that ill before, not even when I committed my offences.... I think it was a mode of self-harm but in a different type of way. I wanted to degrade myself, self-degradation to feel better. That’s the reason why I did that. I tried to break my nose by jumping face down on the dustbin; I threw myself down the stairs about three or four times. Anyway, I was running round the estate naked and everyone saw this. My step-dad called the police, the police didn’t come.”

12.2 In looking at the way this incident was handled, we considered that we should limit ourselves to an examination of those parts of the response that intersected with the mental health services. The police was the main agency involved in responding, and when Mr Gonzales’ family made a formal complaint about the way they had done so, the police voluntarily referred the matter to the Independent Police Complaints Commission (IPCC), which decided that the investigation would be managed by them using Surrey police resources. When looking at the subsequent report, we have only commented on the police actions that can be directly linked to the mental health services through their advice to Mr Gonzales’ family that the police should be contacted in an emergency; we have not commented, for instance, on the actions that the police took when members of the public alerted them to a naked man running around the area. We have received evidence that the police deployed three officers in response to the reports from the public. The IPCC report concluded that “Given all the circumstances it does not appear that Surrey Police have acted inappropriately” We have not taken the same view in relation to the small part of the circumstances with which we are concerned.

12.3 On 13 September 2004 Steven Harper, Mrs Savage's long-term partner, had a day off. He told us:

"I can tell you exactly what happened because I still remember it like it was yesterday. I woke up in the morning; it was one of my rest days. My sister has four children and I was going to go to my sister's, which is about a mile-and-a-half away, and help her out with the kids, see my nephews and look after them while she takes them to school or whatever. I went downstairs, had a cup of tea, went out to the driveway and got into my car. I heard movement upstairs; I knew Daniel was awake. He would quite often wear headphones and you could hear the music. I sat in my car facing out of the drive, and I was just rolling a cigarette because I smoke roll-ups, and the next thing I knew Daniel came running up the drive. My car was parked facing out to the road, Lesley's car was parked [next to it], and he went up the steps from the house, sprinting straight past me without any clothes on."

"This was at approximately ten past eight in the morning, and there are quite a few schools where I live so there were people about and it was quite a busy time. I thought I would drive to see where he was going and what was going on. I went where I thought he would go, which was Knaphill village, which is just half-a-mile up the road from me. I couldn't find him, so I drove round the village for a bit and then I phoned Lesley at work from a phone box, because I didn't have any credit left on my phone. I told her what happened and she said to go back home and check if he's back at home. I went back, opened up the front door. I knew he was at home when I drove back - I can't remember exactly what time that was, it might have been nine or half-past, but it's in my statement anyway - because I could see through the living room window. The kitchen is at the back and I could see him pacing up and down."

"I walked into the front door and there was no sound at all. He had obviously heard me come in and it went quiet. I said, 'Daniel, I've been looking for you in Knaphill.' He said, 'I wasn't in Knaphill, man' in a really strange voice that I'd never heard before. I thought, something's wrong here, so I shut the door and went straight out. I didn't want to go in; I could

just sense that something wasn't quite right, seeing him run out like that. I thought the only thing I can do is to go down to the police station. I could have rung them straightaway, but I don't think that would have achieved an awful lot, because probably so did 50 other people ring the police. I thought, if I go down to the police station they'll take me more seriously, I can give them a lot more information: paranoid schizophrenic, not taking any medication, just fill them in a bit about the details. That's what I did."

12.4 We had the opportunity to review the papers connected to the family's complaint about the police actions/inactions. There is a disagreement about exactly what was said at the police station so we have relied not only on what Mr Harper said to us but also on the extracts from the recorded conversation between the front desk clerk who spoke to Mr Harper and the force contact centre operator which are given in the IPCC report. The civilian clerk made notes while she was speaking to Mr Harper, but threw these away before their importance became clear.

12.5 It is agreed that Mr Harper identified Mr Gonzales as the man who had been running naked in Knaphill, but was now at home, confirmed that Mr Gonzales was diagnosed with paranoid schizophrenia and wanted to be of assistance in providing this information. The tape recording shows that the civilian front desk clerk then gained the impression that Mr Harper did not want the police to attend at the family home.

12.6 Mr Harper has always insisted there was never any point at which he asked the police not to attend the house. His expectation was that they would do so. The misunderstanding may have arisen as a result of Mr Harper explaining at the police station that he did not wish Mr Gonzales to know that he had been there, as he thought it would cause problems. For this reason he did not wish to give his personal details including his surname, or make a formal complaint. He assumed that the police would be able to trace Mr Gonzales through their records, and, indeed, the police have confirmed that this information was on their system, and that Mr Gonzales' address was identified by the contact centre operator that day. While Mr Harper was still at the police station the civilian clerk phoned the contact centre operator to report the conversation. We have a transcript of the conversation, which shows that the decision not to take any action on the

information provided by Mr Harper seems to have been very much influenced by the view taken that Mr Harper did not want the police to go to the house. It also seems to be the case that this decision was made while Mr Harper was still at the police station, but that he was not informed of it before he left.

12.7 The IPPC report showed that relevant information about Mr Gonzales (including warnings for 'weapons' and 'mental health') was held on the Surrey crime information system (CIS) and on the police national computer. It found that these systems were not accessed on that day but we were told by Surrey police that their investigations show that the contact centre operator accessed the Surrey CIS on two occasions. We were told that the markers for 'weapons' are predominantly for officer safety reasons, and would not be relevant in this situation when there was no information that Mr Gonzales had threatened any form of violence. Mr Gonzales' weapons markers were placed on the system in 1997 and 1999/2000 which would have been seen by the operator, as would the fact that the last time the police called at his home address was in 2002, twenty months earlier. We were also told that the 'mental health marker' is only there to advise the police that they will need an appropriate adult if an interview is required. The police also told us that if the police had been alerted by the mental health services to a potential risk they would have put a 'location of interest marker' on his address and as a consequence there would have been a response to his home.

Comment

It seems there was a significant misunderstanding between Mr Harper and the civilian front desk clerk. Mr Harper knew that Mr Gonzales was well known to the police. He also knew that the CMHT advice was to contact police if there were any serious problems, as had happened in September 2001, May 2002 and July 2002. The civilian front desk clerk, on the other hand, did not know Mr Gonzales or Mr Harper, and did not know that contacting the police was the only crisis response plan the family had been given. If the specialist services wish to include the police as part of a crisis plan, it is incumbent on them to ensure that the police are aware of this and have an agreed action plan in the event that they are contacted. If this had been done on this occasion, the control room operator would have seen the "location of interest" marker when she checked the Surrey CIS and we have been assured that in such circumstances police would have been deployed to visit the house.

The IPCC report is critical of Mr Harper for not making his wishes clearer, and insisting that some action was taken if he was so concerned about Mr Gonzales. We consider such criticism to be unfair. Mr Harper had no more reason than anybody else to know what was to come. He cannot be blamed for not understanding that no action would be taken when he went to the police to identify the naked man. We assume that the police have already tightened up their procedures. If they have not, we strongly suggest that in future, those receiving details of concerns from members of the public should establish exactly what those members of the public are expecting the police to do and should ensure that the member of the public knows what will be done, if anything.

We also consider that, whatever the police thought Mr Harper wanted, they had a duty to formulate and carry out their own assessment to ascertain whether to deploy officers. It seems that the accessing of the Surrey CIS did not lead to any assessment being undertaken to determine whether to deploy officers, for none is recorded, nor is there any record that consideration was given to visiting Mr Gonzales for the purpose of interview or to referring the matter to the duty mental health team. We have been told that police decision-making procedures are now much more robust, so that decisions on what action to take are made in accordance with nationally agreed standards, and that cases can only be closed by staff who have received special training. We are advised that, if current systems had been in place at that time, some action would probably have been taken, which would have been either immediate deployment or deployment within 48 hours. In the absence of the "location of Interest" marker which would have guaranteed an immediate response we cannot know what deployment decision would have been taken, but we have been told that there was only a slim possibility that a 48 hour response would have been thought appropriate.

It is clear, both from Mr Harper and from Mr Gonzales himself that Mr Gonzales was in an unstable state on that Monday, and it subsequently was revealed that Mr Gonzales had also self-harmed that morning, as he had before his first and second admissions to hospital in 1998, though Mr Harper did not know this when he went to the police station.

We have no way of knowing what would have happened if professionals had gone to assess his mental state. In particular we do not know if Mr Gonzales would have answered the door, although we believe Mrs Savage and Mr Harper would have done so when they returned home that afternoon at about 4pm. We recall the level of disturbance Mr Gonzales displayed when he was first sectioned. Remembering also the Broadmoor doctor's view that his mental state had been seriously destabilised by his use of drugs, we think it at least possible that Mr Gonzales would not have been able to maintain his composure in the face of professional assessment, and the extent of his inner turmoil would have been revealed.

12.8 After leaving the police station Mr Harper stayed away from the house until Mrs Savage returned from work. They then found that Mr Gonzales was out. Mr Harper told Mrs Savage what he had seen and what he had done, and it is accepted by all that Mrs Savage then spoke to Mr Kizza about the events of the day. There is further dispute here about what was actually said. Mrs Savage has always insisted that she rang Mr Kizza because she was worried about her son's behaviour, and that she told him everything that she had been told by Mr Harper. Mr Kizza, on the other hand, insists that he was simply told that Mr Gonzales had left the house after some kind of an upset. Unfortunately, Mr Kizza did not make a note of the conversation, but Mrs Savage's telephone records show that the conversation lasted for 11 minutes which suggests that it was fairly detailed. In the absence of any contemporaneous note to the contrary, we have concluded that Mrs Savage's account is more likely to be the correct one. We cannot see why Mrs Savage would have rung Mr Kizza other than to let him know what had been going on that day and ask for help. It is not in dispute that Mr Kizza took no action on 13 September as a result of the telephone call he received from Mrs Savage.

Comment

At the very least we think that Mr Kizza should have contacted the crisis team to let them know of Mrs Savage's concerns. We cannot say what the crisis team would have done.

12.9 The then chief executive of the trust, Lorraine Reid commented on this dispute:

“I met with Daniel’s mother twice and they were pretty difficult meetings. Her story about what happened three days before the [murders] didn’t tally with what Kizza said had happened that day,...”

“I can’t imagine anyone who was as worried as she was about her son - and she came over as someone who had been worried for a long time about her son, and there is documentary evidence for that as well. There is a carer’s assessment that said whatever happened to the diagnosis of schizophrenia. I couldn’t understand why someone like that would have held back the information about him running naked and not tell him. I found it quite hard to believe what he (Mr Kizza) said.”

Comment

The importance of professionals making and keeping contemporaneous notes is highlighted by the disagreements about what was said between the police and Mr Harper, and between Mr Kizza and Mrs Savage.

12.10 Mr Kizza had obviously formed the opinion that Mr Gonzales didn’t have a serious risk profile and described him to us in the following way:

“Personally, having met him, I would think he was probably like the other guy next door, just staying in his house, playing loud music, and there was not a big difference because he was running on the streets joking, which they normally do”

12.11 This suggests that Mr Kizza was unaware that alarm bells should start to ring when a person with mental health problems starts behaving out of character. Being naked in public may be a typical symptom of illness in some people, but it was not one that Mr Gonzales had previously displayed. As such, it was at the least evidence of some instability in Mr Gonzales’ mental state.

12.12 It is impossible to say what would have happened if the police or a member of the community mental health team had visited Mr Gonzales to assess the situation. It is clear that he was in a disturbed mental state and it is possible that he would not have been able to contain himself if confronted by experienced professionals, and signs of mental illness justifying an emergency hospital admission might have been revealed. Mr Gonzales said to us:

“If someone makes a phone call to the mental health team and says, ‘My son’s running round the estate naked and he’s jumping down the stairs and he’s trying to fall flat on his face to see if he can break his nose.’ If I’m running round the estate naked they should - he called the police and I didn’t get arrested for it. That would easily have prevented those crimes because I was in a very bad way.”

It is difficult to disagree with this.

12.13 Whether it would have been thought Mr Gonzales should go to hospital, whether he would have been willing to go voluntarily, or whether he would have met the criteria for detention under the Mental Health Act, is impossible to say. What is clear is that this was a very big missed opportunity to assess Mr Gonzales’ mental state and it was directly attributable to failures in the care planning provided for him.

Findings

12.14 Even allowing for Mr Kizza’s inexperience, we find his assessment of the situation fell short of the standard expected of a recently qualified social worker.

12.15 There was greater failing in the selection of an inexperienced care coordinator for an individual with a forensic history and difficult family relationships.

12.16 A serious shortcoming was the lack of a robust crisis management plan to follow in the event of an emergency. The failure by the specialist services to ensure that the police knew that they had a place in Mr Gonzales’ crisis planning was confusing and unhelpful.

12.17 The only people who come out of these events with any credit are Mrs Savage and Mr Harper. We find the evidence that they alerted the professionals as to Mr Gonzales' bizarre behaviour compelling, and the failure of the professionals contacted to clarify why they were being contacted, to keep the initial written record of the contact, or to take any effective steps to follow up the contacts to be poor practice.

13. Review of internal investigations

“There were themes and issues that I would have liked to see much more tightly followed through and taken more seriously” - Fiona Edwards (chief executive of the trust December 2004 - present)

13.1 A full management report was prepared in accordance with the trust’s policy in relation to serious untoward incidents. This review was carried out by Mark Girvan, community services manager Woking, with a chronology prepared by Danny Jones, mentally disordered offenders team manager. The report is dated 5 November 2004 and was based on an examination of documents and a clinical review meeting held on 13 October 2004 involving staff from mental health services who had significant contact with Mr Gonzales.

13.2 A multi-professional internal review was set up in January 2005. It aimed to examine the care and treatment provided to Mr Gonzales; to find out if there were lessons to be learnt from the events that took place; to minimise the possibility of a similar event, and to make recommendations for the future delivery of local mental health services. The review took evidence from a wide range of witnesses including Mr Gonzales’ mother and grandmother. The review took into account the report of the multi-agency public protection arrangements (MAPPA) “Initial Review” which involved the trust, police and probation. We have also read this report. We note that Joyce Winstone did not give evidence to the multi professional internal review. She told us she was not invited to do so. We do not know the reason for this, and find it odd, as it was important to hear what she had to say. The findings and recommendations of the multi professional review are at appendix C. (The findings and recommendations are set out in its original format.)

13.3 In our view, the full management report was thorough and professional, and reached a number of conclusions with which we agree.

- That people found Mr Gonzales to be a spasmodic attendee and very difficult to engage.
- That attempts to use the Mental Health Act would have been hard to justify on the available information.

- That, in the absence of a clear diagnosis, treatment options were not actively pursued, in particular the possibility of taking medication.
- That the possibility that Mr Gonzales was ill may have been lost to well-meaning attempts to provide more practical support, and engage with him in the areas that were most important to him.
- That carers, particularly his family, expressed a variety of concerns about his very challenging and sometimes frightening behaviour.
- That there was no clarity about Mr Gonzales' CPA status and comprehensive risk assessments were not evident.

13.4 The main recommendation of the full management report was that there should be a full internal review, involving the police and probation services, in accordance with the trust's serious untoward incident policy. The report also proposed an action plan to prepare for this review, and to review systems for:

- formulating risk assessments
- prioritising engagement with young substance misusers with mental health and offender histories
- ensuring that formulation of diagnosis, needs assessments and treatment plans are at the forefront of discussions within multi disciplinary teams.

We agree that all these action points were necessary and appropriate.

13.5 We think the conclusions of the multi-professional inquiry are less satisfactory, as the following two examples show:

“During Mr Gonzales’ first admission to hospital in 1998 he had a successful appeal against his section. The Mental Health Tribunal disregarded his consultant psychiatrist’s opinion that he should remain in hospital for a fuller assessment of his mental health needs. Consequently he never received a full assessment of his mental health state”.

13.6 In fact, later in 1998, Mr Gonzales' was again detained at the Oaktree clinic and received a full assessment which concluded he had schizophrenia, a diagnosis which was not accepted by those subsequently responsible for his care.

“The changes in the move to patch management in part compounded the situation whereby Mr Gonzales was seen by several different consultants and care coordinators with also their changing leadership and management within the trust’s structure. This did result in a lack of “ownership” of his care and treatment”

13.7 The patch system certainly caused difficulties, but we have not received any evidence that these had any significant impact on the “ownership” of Mr Gonzales' care. Mr Gonzales was the responsibility of Dr Weinstock and his team from June 2002 or even earlier, over two years before the offences were committed. That was quite long enough for ownership to be established even though Mr Gonzales was in Spain for six months in 2003.

13.8 The multi-professional review did, though, identify a number of failings and problems with which we fully agree.

- The lost opportunities to undertake full assessments.
- The use of several different sets of case notes.
- The difficulties in recruitment and retention of staff in patch three and the reduced attendance of the consultant psychiatrist at patch three meetings.
- The lack of engagement with Mr Gonzales from specialist services and the fact their work was carried out in isolation from other services.
- The failure to formally involve his mother and to support her.
- The absence of a formal handover from the community child and adolescent service to adult services.

13.9 The formal findings and recommendations of the multi-professional review are, in the main, uncontroversial and we agree with the recommendations to review policies, improve and integrate systems and improve and integrate record keeping. However, we are left with the uncomfortable impression that the review was too willing to blame system failure rather than human error. It also identified reasons for poor practice which were not really justified. For example:

“A lost opportunity early on in his contact with the services in 1998 occurred when the Mental Health Act Tribunal disregarded the advise of our consultant psychiatrist to remain in hospital under section to have a fuller assessment of his mental health state”. (Paragraph 8.7)

13.10 This is factually true but irrelevant because a detailed mental health assessment took place later that year which is not referred to at all. This is deeply misleading. It gives the impression that the trust was never able to carry out an in-depth inpatient assessment, which is not the case.

13.11 The report also places some responsibility for failures on the frequent changes of consultants.

“During Mr Gonzales’ contact with the service, because he moved residence, the patch system meant that he was seen by several different consultants, their medical teams and care coordinators”. (Paragraph 8.8)

13.12 Again, this is factually true. But Mr Gonzales was under the care of Dr Weinstock from at least June 2002 until the time that he was arrested and Joyce Winstone, who was his care coordinator from July 2002 until May 2003 continued to be part of Dr Weinstock’s team. So she could have been his care coordinator in 2004. Consequently, the lack of continuity during 2004 was nothing to do with the patch system.

Findings

13.13 The full management report was a thorough and professional piece of work.

13.14 The conclusions of the multi-professional inquiry were less satisfactory. Its formal findings and recommendations are, in the main, uncontroversial but we are

left with an uncomfortable impression that the review was too willing to blame system failure rather than human error. The report identified reasons for poor practice which we do not believe were justified, and it failed to make recommendations that were obviously needed.

Suicide

Subsequent to Mr Gonzales' death by suicide, the investigation team revisited the verbal evidence provided to the investigation by the two consultant psychiatrists responsible for his care in Broadmoor Hospital. The investigation team deems it appropriate to relay the possibilities explored by the Broadmoor specialists as to the reason for the crimes committed by Mr Gonzales and the interpretation of his suicide attempts prior to our interview with him. It is not the function of this section to second guess the outcome of the coroner's inquest. We believe the evidence we received from the Broadmoor Hospital consultants helpful in understanding Mr Gonzales' mental state following his conviction as it casts light backwards on to the events that led to the homicides.

There is no doubt that during Mr Gonzales' incarceration in prison and throughout the first few months at Broadmoor Hospital, indeed up until he received high doses of antipsychotic and mood stabilising medication, Mr Gonzales' mental state was a cause of extreme concern. Mr Gonzales acted in a violent and aggressive manner towards others but he also made three concerted attempts at suicide.

Dr Das told the investigation:

“In prison there was a dramatic change in his mental state. He was aggressive, lunging at prison officers, so much so I think he needed a six-man unlock. He was very disturbed, very upset about what he did, saying that he would kill himself or kill someone. He then carried out quite a serious act of self-harm, very bizarre and very unusual; I have never encountered that level of self-harm before. He bit himself in his cubital fossa and I think he ruptured an artery or a vein and he bled a few litres. That was in prison. He was lucky that he was found in time or he would have died, and he needed blood transfusions. That was the state he was in when he came in. He was unpredictable, he was lashing out at people, numerous incidents. When he came on to Luton Ward, the admissions ward, that was probably the most disturbed patient we have seen in a few years. That was the level of disturbance.”

“On Luton Ward he needed continuous seclusion, observation round the clock. It was just not possible to have any rational discussion with him. He wouldn’t talk, he was withdrawn. For no reason he would just punch a member of staff. We really could not understand the psychopathology for what is going on underneath. Eventually there was another incident of self-harm on Luton - again he bit himself in his cubital fossa - and Luton felt they were not able to manage him, and that is when he came on Isis Ward. On Isis Ward he went on the highest level of observation possible, which is arm’s length, which means he is next to a member of staff within arm’s length 24 hours a day. However, it happens at times - it is very difficult when you observe a patient 24 hours; there can be lapses of concentration - Danny turned round and under the bed sheet he again bit his arm, so that was the third episode. He was very lucky. He lost about a couple of litres of blood and it was very fortunate that an experienced member of staff noticed something was wrong and was able to rush him out.”

Dr Das was asked whether these were suicide attempts.

“Yes. At that point in time when he carried those out he did not say anything, but subsequently when we spoke to him he said he was just desperate, he wanted to die, he wanted to do something. The seriousness of his self-harm is not that he is harming himself to cause himself damage, it is more the intent is suicidal, so that is even more grave.”

Dr Petch told the investigation:

“...he would attack at random. He would take a chance. We asked him what it was about and he hadn’t really been able to tell us whether it was delusional misidentification or some sort of delusional psychotic thing going on, he just lashed out at whoever...There were a couple of incidents where there was some minor provocation in that sort of way, but he would just generally lash out and was very impulsive and unpredictable. He was so unpredictable in terms of whether it was one particular time of day, one particular day of the month, day of the week, it was purely random. We tried to look at the pattern, whether it was any particular members of staff, black, white, male, female, but we couldn’t identify any function of the

staff, rank or anything, it just seemed to be that those people who were nearby got it, so the more you nursed him the more likely you were to be hit because you were with him longer. It was really very difficult.”

“In that first year the intensive care team did really very well indeed in keeping him alive, that was the thing. I was convinced he wouldn’t make it, at that point. He very, very nearly did die in a serious untoward incident here relating to a time when he managed to self-harm under his blankets. He still has to keep his arms above the blanket at night, which isn’t very comfortable for the poor chap, but we can’t manage that in any other way. That was a problem of observation, and it is in the care plan that his arms are showing and it was missed one day, and he took his opportunity to bite his arm, bite his artery under the covers, and by the time anybody noticed there was a pool of blood.”

It is clear from the evidence from Dr Das and Dr Petch that at the time of his admission to Broadmoor, Mr Gonzales was a highly disturbed and mentally ill man. However, eventually Mr Gonzales responded to treatment such that he was fit to attend trial and further exploration of the circumstances prior to committing the offences was possible.

Dr Das told the investigation about Mr Gonzales’ use of Methamphetamine (Crystal Meth):

“What we saw after he improved, it helped us in exploring some aspects of incidents prior to the index offences. It is quite clear that he did use methamphetamine, which is crystal meth, as you know, prior to the index offence. He says he was in a rave about a few days before the index offence. He used crystal meth. There is a degree of ununderstandability about the index offence, although Danny himself had mentioned previously that he wanted to become a famous mass murderer like Freddie Kruger in Elm Street, for example. Although this has been amplified quite a bit in the press media, it is very difficult to understand why he went on to do what he did....”

“Looking at his forensic history compared to our other Broadmoor patients, he doesn’t seem to have a very remarkable forensic history of being extremely violent...In his notes I only found one instance when he said he was going to kill someone...That was in September 1999 when he said he had thoughts of killing people. So, nothing very unremarkable except to say that it appears somebody with a history of a revolving door patient was coming in and out of psychiatric services. And then something happens in September 2004 that tips this man over. But what does appear is Danny prior to that always had ideas of killing people. This is something that appears to be emerging, that he did have ideas that he wanted to do something horrendous, he wanted to kill people like Freddie Kruger, as I said, but he never had any plans to act on those. Something happened around that time that dramatically changed his behaviour, and this happened over a period of a few days when he describes what was like a dream-like state over the period of four days when he went on to carry out his index offences.”

“We know there is evidence that people with a pre-existing history of schizophrenia who then go on to misuse something like crystal meth, amplifies the symptoms, modifies the symptoms for a period of time. It is very difficult to say, I am only speculating, but I wonder what role crystal meth played in that because there is a lot of evidence emerging in the literature now about the association of crystal meth with violent behaviour. It doesn’t take much, just an intake of crystal meth on a day... Clearly something happened that led to this dramatic worsening in his mental state, which then contributed to the offending. There is a large degree of un-understandability about the index offences because it appears to be fairly motiveless. Apart from that, probably that desire to go and kill people, but that doesn’t appear like a strong motive at all; he is just going and indiscriminately killing strangers.”

“Looking at the overall history, our impression was that here is a man who had a history of schizophrenia, who was misusing substances, who goes on to use crystal meth, and then suddenly tips over into a state when he goes and kills a few people. It is very difficult to understand what happened exactly because he was not, for example, having command hallucinations telling him

to go and kill people. It was not like he identified those potential victims, it wasn't like that. It was not driven by symptoms."

"Formulating this case...a man who has a pre-existing mental illness goes on to have crystal meth, which does a surge of dopamine into the brain and leads to thoroughly disorganised bizarre violent behaviour. So yes, a pre-existing mental illness amplified ten or 20-fold by a substance like crystal meth."

Dr Petch told the investigation:

"...methamphetamine that he allegedly took on the last offence...was a new drug which he had not taken before, and it seemed to have a different effect on his mental state which as yet is unquantified.. It is more than a coincidence that within a week he was killing people, but actually how that affected his mental state we have not been able to fathom, because he had not explained it. I still don't fully understand the offences...."

"There are reports of people having homicidal ideas on [Methamphetamine], and so obviously one cannot discount the impact that that drug had on his mental state at the time, given that he allegedly took the drug during that period. It just seems that he never killed before. He had taken methamphetamine which is thought to have that effect on people, and you have to link the two."

Dr Petch also commented on the link between the homicides and Mr Gonzales' suicidal state of mind during the offences:

"...I didn't pick up that there was an acute suicidality at the time of the offences. I presume that during the offences themselves he was very suicidal, because he could quite easily have turned the knife on himself at that point. It didn't happen but it was only a hair's breadth....He could easily have ended up killing himself during the spree...he was called a "serial killer" in the court, but he is more of a mass killer because it is like a spree killing, it is all in one go, in one episode. It was not one and then a couple of months later another one...if you look at the history of mass killings a very

large number of them end up killing themselves at the scene or very soon afterwards...We can all think of well-known examples...so I would say this is a job that has not yet been finished...for him....He's got no idea why he did it, I am quite sure..I think the jury is still out on why he did it."

Thus, at the time the investigation team interviewed Dr Das and Dr Petch, they both expressed an "un-understandability" of why he committed the offences. The working hypothesis was that he had an underlying undifferentiated schizophrenic illness and the ingestion of methamphetamine at the weekend immediately prior to the first of the offences precipitated a bout of violent, impulsive and random homicidal behaviour that could have culminated at that time in Mr Gonzales' suicide.

Both Dr Das and Dr Petch commented on Mr Gonzales' future risk of suicide. They expressed this risk as being present both as a product of mental illness (and linked to the "unfinished business" with regard to Mr Gonzales not killing himself immediately after the homicides) and the very real suicide threat posed by Mr Gonzales' future acknowledgement of the consequences of receiving a whole life sentence without parole:

Dr Das:

"What we are concerned about though is Danny's very unrealistic view of the future. We think that Danny has a long-term risk of suicide, and I think that risk would probably never go away...We worry more about self-harm suicide, not related to mental illness but something more rational, someone who realises where he or she is and tries to kill himself. That is certainly the long-term worry, and those sort of acts of self-harm would be difficult to prevent. That is the long-term prognosis we are extremely worried about.

Dr Petch:

"I think chronically the risk of self-harm is really very, very high and it will go up. It won't go down.

Dr Petch commented on Mr Gonzales' suicide intent following the commission of the offences stating that he had:

“A drive to kill self, which I have never encountered to such an extent. He would do anything to kill himself at that stage”.

When asked whether that drive *“still might be there?”* he replied *“It still might be there”*.

Appendix B

Consultant/CPA chronology

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
28/11/96			Referred by GP to Dr Elaine Crutchley, Consultant Child and Adolescent Psychiatrist, Frimley Children's Centre		Not assessed by Consultant Psychiatrist, but was assessed by Belinda Bray, Senior Social Work Practitioner. Referred to ACORN drug unit. Missed opportunity? - if had been assessed by Consultant Psychiatrist, mental illness may have been detected at this stage. If Early Intervention for Psychosis available, might have been utilized
19/11/97			Letter to Dr M De Ruiter, Consultant Psychiatrist, Windmill DAT from Mike Blank		
9/12/97	DR DE RUITER Dr R Garcia, SHO	"...there is a risk that if he continues taking drugs he might develop a drug induced psychosis..." Thioridazine 50mg	Seen by Dr R Garcia, SHO to Dr M De Ruiter, Windmill Drug and Alcohol Team		Discussed with Dr De Ruiter. Did Dr De Ruiter have Consultant Responsibility to institute CPA given that antipsychotic medication was prescribed? Was the medication to avert a possible drug-induced psychosis or to alleviate non-psychotic effects of drug misuse?
6/2/98	DR HENNESSY	Chlorpromazine 25mg tds	ADMITTED to ACU under care of Dr Hennessy. Detained under 5(2) on 12/2/98, converted to Section 2 MHA		
24/2/98	DR HENNESSY		Discharged from Section 2 by MHRT		
26/2/98	DR HENNESSY	"Drug-induced psychosis" Chlorpromazine 25mg tds	Discharged from ACU	No CPA formally recorded on discharge despite there being a multidisciplinary meeting on the day of discharge that included his father, mother, carer, aftercare social worker, accommodation & sports worker, probation officer. Stated that would receive "follow-up treatment from the Drug and alcohol team"	Inpatient for 20 days
27/2/98	DR HENNESSY		Letter from Dr Hennessey's SHO to Dr Marian De Ruiter requesting an appointment		He never got to see Dr De Ruiter. Is this a missed opportunity?
17/3/98				Did not attend outpatient's appointment	
6/4/98				Did not attend outpatient's appointment	
7/5/98	?		Referred to Dr Kidd, Consultant Psychiatrist by Michaela Richards, WCMHT		It is not clear whether he remained under Dr Hennessy's care between February and June 1998. There was no psychiatrist input during these months.
15/6/98	DR KIDD Dr O'Brien SHO	"If anything, things worse when stops taking drugs" Diagnosis not specified. "...serious illicit drug misuse..." "...evidence of psychotic disorder." Olanzapine 10mg daily	Assessed by Dr Kidd's SHO, Dr O'Brien	Attended with mother, grandmother and Sue Withers	
21/6/98				DG turns 18	
14/7/98	DR KIDD Dr O'Brien SHO		2 nd appointment with Dr O'Brien. Discharged from outpatient follow-up		Not seen by Dr Kidd in person
14/7/98	Dr O'Brien, SHO Dr De Ruiter's SHO			Discussion between Dr O'Brien and Dr De Ruiter's SHO "Dr O'Brien is following up in OPD. Still chaotic, takes drugs as he did previously. Evidently	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				<i>psychotic. Doesn't want to attend DAT appointment. Refused help offered by them with a view to specialist input"</i>	
14/9/98				Senior strategy meeting attended by, amongst others, John Humphreys and Sue Piscoe from the Youth Justice Team, and Kay Preston from the CMHT. One identified need was "Daniel will never be able to live independently.....". Agreed that there would be a further meeting in a few months time.	
23/9/98		<i>"...probably has a personality disorder...large doses of LSD and sometimes Ketamine... is almost certainly responsible for his current state of mild psychosis"</i>	Assessed by Dr Kidd for report to Woking Magistrates Court		1 st personal contact by Dr Kidd.
28/9/98	DR ANNEAR	<i>"Continuous Paranoid Schizophrenia"</i> Sulpiride 200mg tds Pipothiazine Palmitate 25mg IM every 2/52 Procyclidine	ADMITTED to Oaktree Clinic under S. 136 MHA. Under care of Dr Annear.	DG admitted to Oaktree Clinic. During his admission there were 3 CPA meetings - 24 th November 1988, 5 th January 1999 and 16 th February 1999. John Humphreys was present at the senior strategy meeting, was present when DG was taken to the Oaktree Clinic and detained, and attended all 3 CPA meetings at the Oaktree Clinic. Kay Preston was present at the senior strategy meeting and attended all 3 CPA's. Sue Piscoe, if she is the same person as Sue Withers, attended the senior strategy meeting and the first 2 CPA's. Dr. Annear, the responsible medical officer, was not involved in DG's case at the time of the senior strategy meeting, but observed him on the day that he was admitted, and attended the first 2 CPA's. He had left the Trust before the CPA on the 16 th February. There was therefore excellent continuity provided by John Humphreys, Dr Annear and Kay Preston, and pretty good continuity provided by Sue Withers/Piscoe. John Humphreys, Sue Withers/Piscoe and Kay Preston were all invited to the CPA due to be held at the Oaktree Clinic on the 17 th March 1999. Based on past attendance, it seems likely that at least 2 of them would have attended. NB this CPA did not take place because DG had been transferred to Farnham Rd and then ACU. There was a CPA scheduled for 30/3/99, noted in the Oaktree clinic inpatient notes on 8/3/99. On 6/3/99 it is noted in the nursing notes "CPA will be arranged from tomorrow and this will be co-ordinated by Oaktree clinic". On admission to ACU it is noted in the	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				medical notes "...A CPA has been arranged for Daniel on 17/3 which has now been cancelled..."	
30/9/98	DR ANNEAR		Detained under S3 MHA		Dr Annear initially filled out a medical recommendation for S2. Dr Kidd was contacted and suggested S3 was more appropriate. Dr Annear was reluctant to recommend a S3 but agreed after he had obtained collateral history from DG's mother.
9/1/99	DR CRIPPS	Discharge summary from Dr A.O. Dekalu-Thomas, locum SHO to Dr Cripps "Diagnosis: Paranoid Schizophrenia"	Dr Annear leaves Oaktree clinic on 9 January 1999		As far as Dr Annear was concerned, DG had Paranoid Schizophrenia (continuous) and should remain on antipsychotic medication.
21/1/99	DR CRIPPS		Section 37 MHA imposed		
				DG transferred to Arc Ward at the Noel Lavin Resource Centre (page 334).	
12/3/99	DR AHMAD		Transferred to Noel Lavin Resource Centre, Farnham Road Hospital as inpatient		
15/3/99	DR AHMAD		Taken off S37 by Dr Ahmad	Discharged from Section 37 by RMO on Arc Ward	Dr Kidd thought that DG had been taken off his section by "the sectioning RMO". In fact, Dr Ahmad did so, despite his very brief contact with DG.
16/3/99		F20 Paranoid Schizophrenia Pipothiazine 50mg every 2/52 Procyclidine 5mg tds	Transferred to ACU	Transferred to ACU as informal patient	
16/3/99	DR KIDD		ADMITTED to ACU		
29/3/99				Dr Kidd's Ward Round/CPA meeting on the ward in ACU noted in in-patient notes but no CPA documentation completed.	
30/3/99				In-patient notes state "John Humphries turned up today for Daniel's CPA from yesterday...He will liaise with all agencies and arrange another 117/CPA as he feels te support last discharge was not appropriate".	
12/4/99				ACU in-patient notes state "Would like to go to Spain for 1-2/12 on Saturday. Will have to enquire with probation if OK. ...Dr Kidd happy to go to Spain...would be discharged and CPA arranged when he returns..."	
13/4/99				In-patient notes state "I have contacted Kay Preston - she has said that another keyworker will be nominated this week and that Bridgewell House will notify the ward."	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				<i>I have contacted John Humphries... who has informed me that the probation order was discharged when Daniel was detained under Sec 37 - since Sec 37 ended, John Humphries has not legal powers over Daniel - and hence there is no problem with him going to Spain".</i>	
14/4/99	DR KIDD	1. Schizophrenia 2. Drug abuse (past poly-substance abuse) [3-202], [4-34] Pipothiazine 50mg every 2/52 Procyclidine 5mg tds	DISCHARGED from ACU <i>"Discharged today with 2 months of TTAs including report and doctor's letter - going on holiday to Spain for two months. Kay Preston (Keyworker was aware of this as informed by myself 12-4-990.</i>	Discharged from ACU with a primary diagnosis of schizophrenia and a secondary diagnosis of past drug abuse. There appears to have been no CPA meeting after the one at the Oaktree Clinic on the 16 th February 1999. None of the records that have been provided to us give any evidence that any of the people who had attended the senior strategy meeting, been there when DG was first detained, or who had attended the CPA meetings at the Oaktree Clinic, were consulted before DG was discharged from hospital.	No follow-up appointments in outpatients department. ?No CPA reviews
April 1999/August 1999				DG in Spain with his father and his father's family, having been sent with a 2 month supply of medication and a prescription to allow his medication to be given by a local doctor.	
3/9/99	DR KIDD		GP writes to Dr Kidd for an appointment. A handwritten note to Bridgewell House requests: <i>"This chap apparently has 2 weekly Pipothiazine 50mg. Would you please do this for him...P.S. Would you please check with Dr Kidd what he plans?"</i>		There is no coordination between Bridgewell House and Dr Kidd and clearly no communication with DG's GP
17/9/99				<i>"Seen as Duty Assessment- mother and Daniel reporting deterioration - increase in voices...Discussed with Dr Kidd." .the rest is unreadable because of photocopying.</i>	
21/9/99	DR KIDD		DG misses appt		
29/9/99				Nicki Haines allocated (for injections) Charlotte Macgregor allocated DG's Social Worker and Keyworker	
12/10/99	DR KIDD		DG misses appt		
2/11/99	DR KIDD Dr J Tolliday, Locum SHO	Not mentioned in correspondence Pipothiazine 50mg every 2/52 Procyclidine 5mg tds	Attends appt with Dr J Tolliday, locum SHO to Dr Kidd. Dr Tolliday suggests seen by Dr Kidd at next appt		

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
25/11/99	DR KIDD	Not mentioned in correspondence Pipothiazine 50mg every 2/52 Procyclidine 5mg tds	Seen by Dr Kidd	Seen by Dr. Kidd, consultant psychiatrist	
23/12/99	DR KIDD	Not mentioned in GP correspondence CPA Care Plan states " <i>Diagnosis Paranoid Schizophrenia</i> " Pipothiazine 50mg every 2/52 Procyclidine 5mg tds		CPA with DG, Mrs Savage, Charlotte McGregor, Nikki Haines (CPN) and Dr. Kidd. Complex CPA care plan drawn up. Next CPA listed for 22 nd February.	
7/2/00	DR KIDD	Refuses depot		Meeting between DG, Dr Kidd Charlotte Macgregor and Nicki Haines	
9/2/00	DR KIDD	Starts Olanzapine			
22/2/00	DR KIDD			CPA with DG, Mrs Savage, Charlotte McGregor and Dr. Kidd	
29/2/00	DR KIDD	Not mentioned in correspondence ?medication. " <i>Appropriate if he were taking Risperidone 1mg bd or Olanzapine 5mg nocte</i> "	OPA with Dr Kidd		
9/3/00	DR KIDD	GP prescribes Risperidone 1mg bd			
28/3/00	DR KIDD	Not mentioned in correspondence	Misses appointment with Dr Kidd. No further appointment sent " <i>'til I hear that he wants to see me</i> "	DG did not attend appointment. Dr. Kidd said "I will not send him another appointment until I hear that he wants to see me. A CPA meeting might be in order" (Volume X page 77)	Was this the right approach? How much responsibility should DG have been deemed to have for his behaviour? If he had been managed overtly as having schizophrenia, would this have made a substantial difference? Is this a missed opportunity given what Dr Annear said about DG's likelihood of relapsing after 4/52 untreated?
25/4/00			ARRESTED	Arrested and remanded in custody	
5/5/00		Not mentioned in correspondence	Letter from Dr W. Lawrence, Consultant Psychiatrist, to Dr Kidd following Dr Lawrence's assessment at Woking Magistrate's Court requesting " <i>fairly urgent follow-up</i> " but bail refused and DG remanded to Reading Prison		
8/8/00		Started taking Risperidone in Prison		Dr. Kidd wrote to DG in prison suggesting that as soon as he is released he "should contact the drug and alcohol team to let them help you stay off the drugs, and contact myself or the community mental	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				health team for general support in getting you to get on positively with your life and leave all this dreadful time behind you".	
15/8/00					
7/9/00				Letter from Charlotte McGregor to H M Prison Reading, trying to organise aftercare (copy to Dr. Kidd).	
23/11/00		<i>"He has been treated on a number of occasions for a psychotic illness, which may be drug-induced, although the possibility remains that he suffers from paranoid schizophrenia...[He] admits on occasion to manipulating his symptoms in order to remain in hospital rather than prison...He has no current symptoms of mental illness and does not require current treatment in hospital"</i>	Assessed in HMYOI Forbury Road, Reading by Dr Lawrence to prepare Psychiatric Report at request of DG's solicitor		<p>Dr Lawrence's notes read <i>"Seen at Reading YOI. On ordinary location till recently - moved to seg ?he has been bullying. Poorly motivated. Poor personal hygiene"</i></p> <p><i>Seen: "When I saw you I was putting it on because I didn't want to go to prison. "People back stabbing me" e.g. disgusting habits, difficult cell mate. "I don't listen to them" - "try to wind me up". Made a complaint about a member of staff - staff ??? him. Now on discipline "because stayed in bed for 2/52" - following alleged punch from Prison Officer. "Not the best of times"...</i></p> <p>Dr Lawrence's reference to DG <i>"manipulating his symptoms"</i> was purely in the context of DG doing so <i>"in order to remain in hospital rather than prison"</i>.</p> <p>Did manipulated symptoms become fabricated illness?</p>
30/4/01			Released from Dover YOI	Released from prison and returned home to mother Seen by Dr. Lawrence at Bridgewell House.	
2/5/01				At the time DG went into prison he was on enhanced CPA. No decision was made to take him off it, and Charlotte McGregor continued to be involved while he was in prison. There was no hand over from Dr. Kidd's team to Dr. Lawrence's team. Dr. Lawrence apparently took over because he had prepared a pre-sentence report while DG was on remand, and it was thought that he was the right person to continue with the case. There is no suggestion that Dr. Lawrence understood that DG had not been taken off enhanced CPA, or, indeed, that he had ever been on it.	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
20/6/01				DG seen by Dr. Lawrence. Dr. Lawrence felt that DG "probably does not suffer from any form of severe mental illness" and DG agreed to see him again to try and ensure that he was not indeed suffering from a mental illness. Dr. Lawrence made it clear that he was seeing DG "as part of his probation order".	
27/6/01	DR LAWRENCE	<i>"My opinion is that Mr Gonzalez probably does not suffer from any form of severe mental illness...[he] has agreed to continue to attend outpatients with me to review his mental state in order that we will be sure that he does not indeed suffer from a mental illness"</i>	Letter to Ms V Cameron, Probation Officer, from Dr Lawrence following outpatient appointment		In forming this opinion, Dr Lawrence did not review DG's Oaktree Clinic notes. He did not meet with DG's mother. He had limited access to past notes. He did not organise a CPA (his view was that DG did not warrant complex CPA). His comments that DG had fabricated symptoms and his view that DG had no severe mental illness prevailed and appeared to carry more weight in informing subsequent opinion than DG's previous diagnosis of schizophrenia.
20/6/01	DR LAWRENCE	<i>"Well and free of psychotic symptoms"</i>	Outpatient appointment with Dr Lawrence		
1/8/01	DR LAWRENCE	<i>"...current stable mental state..."</i>	Letter to Ms V Cameron, Probation Officer, from Dr Lawrence following outpatient non-attendance: <i>"I see little point in sending him another appointment given his poor attendance and current stable mental state ...if you have any concerns about his mental state I would be happy to see him"</i>	Dr. Lawrence writes to Viv Cameron, probation officer, saying that DG had failed to keep an appointment and that he felt there was little point in sending him another appointment giving his poor attendance and his current stable mental state. However he said that he would be happy to see him again if Ms Cameron thought that he should.	Effectively, DG was discharged from outpatient and Psychiatrist follow-up but was he? Was he "open to outpatients" or not? What was Dr Lawrence's policy. He states that he would have been happy to see DG if DG's probation officer requested it.
22/8/01	???	Not mentioned in correspondence	Feedback information form from Crisis Response Team addressed to Duty CMHT/Dr Lawrence with Plan... <i>"Duty and Dr Lawrence to be aware of client and to support parents as needed"</i> . Dr Lawrence has handwritten on the form <i>"FU appt with me next 10/7"</i> [5-41]	Crisis response team referred DG to duty CMHT/Dr. Lawrence as a result of Mrs Savage's concerns. A risk assessment was carried out showing him to be at medium risk of violence/harm to others and at medium risk to property.	Should this have prompted a CPA Review? This incident occurs 21 days after Dr :Lawrence writes that he would have been happy to see DG "if you have any concerns about his mental state" but the follow-up appointment did not take place. Why not? Was it a system error? This is a missed opportunity. It may have been that Dr Lawrence would have formed a different view of DG's behaviour had he personally reviewed him after this presentation to the Crisis Response Team.
24/8/01				DG not accepted by SADAS because <i>"he was not ready"</i> [3-16]	
3/10/01	DR LAWRENCE	Not mentioned in correspondence	Letter from Dr Lawrence to DG's GP <i>"Mr Gonzalez failed to attend his recent appointment with me. I</i>	Dr. Lawrence writes to Dr. Kuzmin to say <i>"Mr Gonzales failed to attend his recent appointment</i>	Discharged from Outpatient follow-up

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
			<i>see little point in sending him more. I am therefore discharging him from clinic</i>	with me. I see little point in sending him anymore. I am therefore discharging him from clinic". It therefore seemed to be the case that Dr. Lawrence discharged DG from the CPA without a discussion with other members of the team, perhaps because he did not know that DG had never been taken off enhanced CPA.	?Role of CMHT - seems to be just "duty alert". Thus, DG was effectively discharged from psychiatric services from 3/10/01 until 25/6/02 when DG is seen in outpatient by Dr Weinstock despite the attempts from his GP and mother to get him seen (see below)
1/11/01				Dr. Rumball (GP) writes to Dr. Lawrence asking that he be given an appointment The records then show a long gap until:	
12/3/02				Mrs Savage writes to Bridgewell House asking for help. Post-it on the letter signed by Dr. Lawrence saying "Southview patient. No contact with me since summer 2001. Only saw following probation request - back to catchment area". It therefore appears that Dr. Lawrence believed that when he discharged Mr Gonzales in October, and wrote to Dr. Kuzmin informing him of this, that this amounted to a referral back to the catchment area. There is no explanation as to why Dr. Rumball's letter of 1 st November achieved nothing, nor why it is that Bridgewell House did not seem to be aware that the case had been referred back to the CMHT.	
25/3/02			Letter from DG's mother to "Head of Department, Bridgewell House" requesting " <i>any assistance you could afford Daniel or myself in this matter...</i> ". Dr Lawrence has handwritten on the letter " <i>Southview patient. No contact with me since summer 2001. Only saw following probation referral → back to catchment area</i> "		
26/3/02			Teresa Vines speaks to DG's mother..." <i>appointment for next Tuesday...case to be discussed at next Patch 3 meeting...suggest OPA Dr Weinstock for psychiatrist assessment</i> "		
27/3/02			Teresa Vines " <i>Spoke to Dr Weinstock - he will send Daniel and outpatients appointment</i> "		
2/4/02	DR WEINSTOCK	Not mentioned in correspondence	A letter from Teresa Vines, Nurse Team Leader, Bridgewell House, to DG's GP is also copied to Dr Weinstock, Consultant Psychiatrist. " <i>Dr Weinstock is aware and is sending Daniel an outpatients</i>	Mother attends Bridgewell House and sees Teresa Vines asking for DG to see a psychiatrist Letter from Theresa Vines to Dr. Hendry, GP, saying	The letter from TV was generated following the meeting with DG's mother's visit to Bridgewell House.

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
			appointment”	Dr. Weinstock is aware and is sending Daniel an out patient’s appointment.	For some reason, there is a significant delay in DG being offered an appointment to see Dr Weinstock or one of his junior doctors. Another missed opportunity.
29/5/02			“Phone call from Daniel’s mother Mrs Lesley savage. She has not seen or heard from Daniel since last Saturday and is greatly concerned. I phoned Heidi at Omni. Left a message on the answer phone for her to contact me. Teresa Vines -		
30/5/02			“Phone call from Gary at OMNI. Daniel has been turning up at the OMNI office for the past 3 mornings...appears well but unkempt...intends to return home today...Gary said if you send an OMNI referral they will pick him up. Mother informed.	Nothing in the records until:	
25/6/02	DR WEINSTOCK	No mental state examination, no diagnosis or formulation stated.	Seen by Dr Weinstock in outpatients. Dr Weinstock’s notes read: “complains of low stress tolerance; mother picks on him for small things; mother calls police if he gets exasperated; raises his voice eg if she goes naked into his room ?repeatedly? Needs counselling to tolerate mother. Living with mother last 1 yr No illicit drugs since Nov 2001 Living with mother + stepfather Draws, plays football ?by himself?, ?reads?, computer - goes for walks. Can’t get work because if gets stressed + loses it ?because? can’t ?accept? when angry, exasperated. Beaten physically as child Emotionally vulnerable Didn’t want to finish, because angry saying I was doing a bad job, had constantly interrupted him. Wants to see a different psychiatrist.		No letter following this consultation. No plan set out in the notes.
2/7/02				Telephone call from Joyce Winstone to Dr Weinstock’s secretary to arrange an outpatient appointment after DG did not attend a “meeting”	
9/7/02				Theresa Vines wrote to Mr Gonzales to advise him that the CPN who assessed him had left the CMHT and that he would be allocated a care coordinator	When was this assessment?

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				as soon as possible	
10/7/02	DR WEINSTOCK	<i>"He told CRT that he had paranoid schizophrenic illness but his description was more like drug-induced psychosis...there was no obvious acute symptom in his presentation"</i>	Feedback information form from Crisis Response Team includes in the Plan <i>"...FAO Dr Lawrence: Please send him an appointment for review of his mental health needs in your outpatient [clinic]."</i>	DG taken by the police from home to A&E where he asked for admission and was referred to the CMHT	This did not result in an outpatient's appointment CPA review This is a missed opportunity
12/7/02				<p>Risk status and CPA summary tool completed by Charlotte McGregor identified DG was of medium risk of severe self-neglect, accidental self-harm, risk of violence/harm to others. Identified that he was sleeping rough, but said that he should not be accepted by the service on to enhanced or standard CPA.</p> <p>The form says that "If any risk category is rated medium or high then proceed with Trust clinical risk assessment. If this is felt to be inappropriate, the reason(s) must be stated". There is a small note that may be a response to this requirement saying "Did bite bus driver's ear when 15 years old but no known violence since".</p> <p>If this was the reason given for not putting DG on to enhanced or standard CPA, it was clearly wrong. He "almost assaulted" his mother on his first admission to hospital; he had threatened garage staff when stealing from the garage in 1997, he allegedly scratched and bit a police officer when arrested on 23rd July 1998, and his detention at the Oaktree Clinic took place after he had smashed a car window, threatened his foster carer, Steve Price, and either bitten, or threatened, a police officer. On the 23rd March 2000 he was alleged to have kicked and head butted a shop manager who challenged him when he was stealing items from the shop and on the 25th April he was remanded in custody after allegedly threatening a 14 year old boy and stealing his phone. If this information was not available to the CMHT, it should have been. The information was available to the Probation Service, and although DG's supervision from the Probation Service under licence expired in October 2001, there should have been communication between the Probation Service and the CMHT prior to that time to ensure that the CMHT was fully aware of DG's criminal, violent and threatening</p>	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				history.	
18/7/02			"Telephone call from OMNI. Jackie from OMNI called regarding the referral for Daniel. She did not know what we wanted them to do. I explained that now Daniel was engaging with services it was important this continued and as he is well known to OMNI it would be another source to keep him engaged. Jackie said she would speak to her manager and get back to me". E Fenton (SW)		A letter from Jackie Rampling, Assertive Outreach Worker dated 18/7/02 states "As per our conversation today I am writing to confirm that the risks surrounding Danny at this time seem to be minimal and as he appears to be well engaged with your team, we will not be taking him on to our caseload"
22/7/02				Duty contact form from CMHT "Daniel needs a care coordinator as he is currently engaging for support with housing needs". This suggests that, despite the decision on the 12 th July that DG should not be accepted by the service onto enhanced or standard CPA, there was a change of mind because DG was willing to engage.	
29/7/02				"Discussed at Patch 3 Meeting agreed for Joyce Winstone to Care Co-ordinate. CMHT Manager	
15/8/02				Letter from Henry Conti to DG saying that he is the new care coordinator. This does not make sense given Joyce Winstone was appointed Care Co-ordinator on 29/7/02. Did DG have 2 Care Co-ordinators?!	
10/9/02	DR WEINSTOCK Dr J Gore, Locum Staff Grade		Misses appointment with Dr J Gore, Locum Staff Grade to Dr N Weinstock		
12/9/02				Letter to DG from Dr. Jacqui Gore, regretting that he had not attended an outpatient appointment on the 10 th September, and offering another appointment for the 7 th November. Risk status/CPA summary tool, plus enhanced CPA plan drawn up by Joyce Winstone, suggesting DG was at medium risk of severe self-neglect or accidental self-harm; low to medium risk of violence/harm to others; medium to high risk of abuse by others; and at medium risk to property "currently homeless". She suggested that he should be on enhanced CPA. The risk management form shows "bit bus driver's ear at age 15" as the only "risk of violence/harm to others" with "can be verbally and/or physically threatening when drinking alcohol" as the only "current indicator"	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				under risk of violence/harm to others. Risk accelerators were shown as "increased/return to previous level drug use" and "ongoing homelessness"; and the "action to manage identified risk and accelerators" is simply given as "needs housing - has been linked to CRB WBC for place at Link Lodge".	
13/9/02	DR WEINSTOCK Dr J Gore, Locum Staff Grade	<i>"No evidence of enmeshed psychiatric disorder...there may be personality issues"</i> <i>"No medication is necessary at this stage"</i>	Assessed at ACU by Dr J Gore, Locum Staff Grade to Dr N Weinstock and H Conteh (CPN and ?Care Co-ordinator) after DG <i>"presented to Bridgewell House today abusive and disruptive"</i>		This was a thorough assessment accompanied by a lengthy letter. There is no suggestion that a CPA Review might be in order.
1/10/02				Dr. Gore wrote to Dr. Hendry, GP, following a mental state assessment carried out on 13 th September at ACU. She felt that he did not have an enmeshed psychiatric disorder, but that he had accommodation needs and that he had agreed to attend Bridgewell House two to three times a week to ensure that he was engaging with services. The letter was copied to Joyce Winstone ASW and Henry Conteh CPN, suggesting that it was still thought to be appropriate that he should be on enhanced CPA.	
7/11/02	DR WEINSTOCK Dr J Gore, Locum Staff Grade		Missed outpatient appointment with Dr J Gore. Dr Gore writes <i>"I have asked his CPN...and Social Worker...to ask Daniel to make a further appointment if he wishes to be seen again."</i>		Effectively discharged from outpatient follow-up. Missed opportunity? Demonstrates lack of ability to engage with DG
14/11/02				Dr. Gore wrote to Dr. Hendry (GP) saying that Mr Gonzales had failed to attend an appointment on the 7 th November so she has asked his CPN and social worker to ask him to make a further appointment if he wishes to be seen again. "Although he also failed to attend a previous appointment, he had been seen in the meantime, usually concerning his request for accommodation". This letter was copied to the CMHT. Dr. Gore did not say that DG was being discharged from Dr. Weinstock's clinic.	
6/3/03				Risk status/CPA summary tool completed by Charlotte McGregor, showing DG at low risk on all	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				<p>criteria, but comments "As assessed today, although rise higher when taking drugs. Currently says not on illegal drugs. Denies self-harm or harm to others". Ms McGregor ticked the box to say that DG should continue to be on enhanced CPA.</p>	
7/3/03				<p>Letter from Joyce Winstone to Daniel Gonzales, "I have checked with staff at the out-patients' department at Abraham Cowley Unit, you have been discharged as you did not attend appointments that were offered to you. I will therefore need to discuss with Dr. Weinstock when he can see you again".</p> <p>When Jacqui Gore carried out the mental health assessment in September 2002, she copied her letter to Joyce Winstone and Henry Conteh, social worker and CPN. Clearly, enhanced CPA was appropriate at that time because there were 3 specialist mental health professionals involved in the case. The day before Joyce Winstone wrote to DG in March 03, it seems that Charlotte McGregor had still felt that enhanced CPA was the correct level. On the day that Joyce Winstone wrote to DG, she said that she would need to discuss with Dr. Weinstock "when he can see you again". This suggests that she had every intention of arranging an appointment for him, which would mean that there would still be 2 specialist professionals involved in his care, so he would still be eligible for enhanced CPA.</p> <p>There is no record of any correspondence or communication between Dr. Weinstock and Joyce Winstone immediately following that letter, nor indeed, of any communication between Joyce Winstone and the ACU, confirming that DG had been discharged as he had not been keeping appointments. On the basis of the papers provided to us, which may be incomplete, DG was still on Dr Weinstock's list between November 2002 and March 2003; there is no record to show who told Joyce Winstone that he had been discharged, and no record that Joyce Winstone asked Dr Weinstock to offer DG a further appointment.</p>	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
7/4/03	DR WEINSTOCK		Letter from Joyce Winstone, Approved Social Worker to DG's GP and copied to Dr Weinstock <i>"Daniel has been closed to Psychiatric Outpatients as he has not attended appointments. I did suggest that if he feels he needs to see a psychiatrist he could be re-referred through your service. He as not taken prescribed medication for some months now, as far as I am aware"</i>	<p>Joyce Winstone wrote to Dr. Rumball, GP, to say that she had seen him on 1st April, when he had indicated that he was planning to go to Spain "He feels that he will never get anywhere in Woking, as people are not prepared to help him. He did allude to feeling ill, but when I attempted to elicit symptoms from him, he became irritable and would not give me any information". The letter goes on to say "Daniel has been closed to psychiatric out patients as he has not attended appointments. I did suggest that if he feels he needs to see a psychiatrist and could be re-referred, through your service". This letter was copied to Dr. Weinstock and to Helen Russell of the Crest Team.</p> <p>On 7th March Joyce Winstone said she would talk to Dr. Weinstock about getting a further appointment. On 1st April it seemed, Joyce Winstone told DG that if he wanted to see a psychiatrist he should go to his GP and ask for a re-referral. What happened here? Did JW misremember what she had agreed in March? Did she speak to Dr Weinstock and he refused to offer an appointment and nothing was recorded?</p> <p>There was then a long gap in the records, but in the chronology drawn up for the multi professional review, on:</p>	<p>No outpatients appointment is forthcoming</p> <p>Another missed opportunity</p>
29/5/03				"Siobhan O'Hallorhan informed Joyce Winstone that DG had gone to Spain.	
3/6/03				<p>Joyce Winstone telephones Sarah Pill (probation officer) informing her that DG has gone to Spain. Discussion between Joyce Winstone and Siobhan O'Hallorhan. Gonzales case closed".</p> <p>Under the Trust's protocol, a CPA meeting has to be held before someone can be taken off enhanced CPA. Siobhan O'Hallorhan had not been involved in DG's care programme, and it therefore seems doubtful if the procedure followed on the 3rd June amounted to the correct procedure. However it also seems likely that Joyce Winstone was not aware that DG was still on enhanced CPA, because she appear to believe that she was the only person who was meant to be dealing with him.</p> <p>What had happened to Henry Conteh? If he had gone off (somebody suggested that he went off for study leave) why was he not replaced? What was the</p>	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				situation with the Dr Weinstock and his juniors?	
1/12/03	DR WEINSTOCK	The Letter from DG's GP starts "I would be very grateful if you could see this 23 year old man with known schizophrenia..."	Letter from DG's GP addressed to Dr Kidd at ACU requesting APPOINTMENT-URGENT. "He is hearing voices and very depressed. He denies any drugs and has been off treatment since [aged] 18. I would be very grateful for any help with this untreated schizophrenic" Dr Kidd has handwritten on the referral "Dr Weinstock"	Dr. Taylor-Barnes, locum to Dr. Kuzmin, wrote to Dr. Kidd, heading "Appointment - Urgent" enclosing a copy of a letter asking for help written by DG on the 26 th October 2003, and describing DG as "hearing voices, very depressed and an untreated schizophrenic". The letter had a hand written note on it presumably put there when the letter was received, saying query "Dr. Weinstock ?".	This comprehensive and accurate letter from DG's GP (a locum) does not result in an outpatients appointment being made Another missed opportunity
2/12/03	DR WEINSTOCK	"longterm schizophrenia"	Duty Contact Form following telephone call from DG's Grandmother "He is well known to our service, suffering the effects of longterm schizophrenia"	CMHT Duty contact form shows a referral by Mrs Cuttmore, DG's grandmother, asking if a member of the team could offer an assessment "says he got on poorly with JW. Could someone else see him".	No outpatient appointment is made after this contact from DG's grandmother Another missed opportunity
22/1/04	DR WEINSTOCK Dr T Dada, Locum staff Grade	"I was told that he has been off medication for almost two years as he stopped taking it due to side effects... He described as significant the side effects when taking the antipsychotic medication. I checked through his notes and noted there were issues of drug abuse and a history of fabricating psychiatric symptoms. His Mum reported that recently he has been speaking to himself and appeared to be responding to visual hallucinations , and stays in bed all morning". "During this period of assessment I could not detect any symptoms of mental illness"	Seen at outpatients clinic by Dr T Dada, Locum Staff Grade to Dr N Weinstock. He "discussed [the case] with Dr Weinstock who suggested the Day Hospital for a period of further assessment and observation...I called Daniel at home but he declined the suggestion of coming in to the Day Hospital. However he would like to come in as an in patient in the future if offered. I therefore agreed to discuss this further with Dr Weinstock and get back to him as soon as possible"		Finally, DG is seen in outpatients, 9 months after the letter from Joyce Winstone requesting an appointment. It is interesting that the points that Dr Dada picked up from his "check" through the notes were "issues of drug abuse and a history of fabricating psychiatric symptoms" There is no further note about the possibility of an in-patient admission. DG does not attend the Day Hospital. This was a missed opportunity.
23/1/04				Dr. Dada (locum staff grade to Dr. Weinstock) wrote to Dr. Hendry (GP) to say that he had seen DG on the 22 nd , and had not been able to detect any symptoms of mental illness. Dr. Dada discussed the case with Dr. Weinstock who suggested the day hospital. Dr. Dada called DG at home but he declined the suggestion of going to the day hospital. He said he would like to come in as an in patient in the future if offered. Dr. Dada said that he would	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				discuss this with Dr. Weinstock and get back to DG "as soon as possible". There is nothing on the records to suggest that Dr. Dada did get back to DG on this.	
10/3/04	DR WEINSTOCK Dr M Joyce, locum Associate Specialist	<i>"In the mental state exam today there were no symptoms or signs of the chronic schizophrenia from which he suffers"</i>	DG and mother seen at outpatients clinic by Dr M Joyce, Locum Associate Specialist to Dr N Weinstock	Letter from Dr. M Joyce (locum associate specialist to Dr. Weinstock) to say that he saw DG that day. Dr. Joyce identified negative symptoms of schizophrenia. He said he would review DG on the 20 th April, and refer to CMHT to consider an assessment by a community support worker. On the same day he wrote to the CMHT, asking for an assessment by the community support workers.	
22/3/04				<i>"Discussed in Patch 3 meeting as a result of letter from Dr Joyce, Associate Specialist to Dr Weinstock. To be allocated to Christian Evans CSW + Dr Joyce to Care Co-ordinate. T/c to Christian Evans to inform - left message on voicemail. Joyce Winstone"</i>	
20/4/04	DR WEINSTOCK Dr M Joyce, Locum Associate Specialist	No diagnosis stated in correspondence	DG and mother seen at outpatients clinic by Dr M Joyce, Locum Associate Specialist to Dr N Weinstock		
21/4/04				Aloysius Kizza wrote to DG at Link Lodge offering him an appointment for the 28 th April.	
22/4/04				Dr. M Joyce, following seeing DG at a clinic on the 20 th April, referred DG for an EEG, and also wrote to the community support worker at Woking CMHT, asking for the referral. Dr. Joyce also write to Dr. Hendry, setting out his thoughts.	
11/5/04	DR WEINSTOCK		DG's mother states on her Carers Assessment Form <i>"Since Daniel was released from a Secure Psychiatric Unit the word 'Schizophrenia' has not been mentioned by anyone except myself when referring to Daniel's condition- everybody seems very cagey and guarded. I appreciate that labeling is not nice but how do we care for Daniel without knowing specific details?"</i>	Risk status/CPA summary tool completed by A Kizza, showing DG at low risk across the board, with no comments, and no indication of whether DG should be on enhanced CPA, standard CPA or not accepted by the service. This document is the first CPA document to be completed since Dr. Taylor-Barnes wrote to Dr. Kidd on the 1 st December 2003, and since Mrs Cuttmore contacted Bridgewell House asking for an assessment by the team on the 2 nd December 2003. The risk assessment form of 11 th May is followed by an undated (perhaps because I only had the first page) CMHT assessment form and an undated	This is borne out in the correspondence where there is no reference to a diagnosis or formulation of DG's presentation.

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				<p>referral form to Project 18. This form shows that the referral was made by Mr Kizza, and that the professionals involved with DG were Dr. Weinstock, Mrs Kizza and Christian Evans, CSW. On this basis, DG was on enhanced CPA at that time, although no CPA forms had been completed other than the risk assessment form.</p> <p>11-05-04 Carers assessment completed by Mrs Savage, in which she asks for help and advice on Daniel's condition and illness and on motivation and on the diagnosis and for information about mental illness and its effects "this most of all" and to be involved in planning his treatment and care and in obtaining support and for help for Daniel to get to appointments and for support in monitoring Daniel's condition. It ends "Daniel is a young man who is stagnating. His illness prevents him from being able to concentrate very well, communicate very well or have any direction in his life. Just lately he has moods which are becoming quite depressing to him and worrying to me. If Daniel's condition is caused by chemical imbalances in the brain, then it is obvious that without medication nothing will ever change. If Daniel does not or cannot be persuaded into taking medication then the only other alternative is to make the life he is presently living more friendly and motivating so life can be a little more pleasant for him".</p> <p>DG was not prescribed any medication during 2004.</p>	
24/6/04	DR WEINSTOCK Dr M Joyce, Locum Associate Specialist		Due to see Dr Joyce, Locum Associate Specialist to Dr N Weinstock, but mother phoned "this morning 5 minutes before I was due to see Daniel to say he had 'gone walkabout'		
28/6/04				Dr. Joyce wrote to Dr. Hendry to say that Mr Gonzales had not attended his clinic on the 24 th June, and offering him a further appointment for 20 th July	
1/7/04				Mr Kizza wrote to DG regretting that he had not attended the previous appointment and offering him one on the 15 th July.	
9/7/04				EEG report for test that took place on the 30 th June - Dr. Weinstock given as the referring physician.	

DATE	RESPONSIBLE CONSULTANT	DIAGNOSIS AND MEDICATION	SITUATION	CPA	COMMENTS
				Document suggests that it was received at the ACU on the 16 th July.	
20/7/04	DR WEINSTOCK Dr D Wagaine-Twabwe, Locum Associate Specialist	No diagnosis stated in correspondence	DG and grandmother seen at outpatients clinic by Dr D Wagaine-Twabwe, Locum Associate Specialist to Dr N Weinstock		An appointment was made for 2months' time but this was the last contact DG had with a psychiatrist before committing the offences
21/7/04				Dr. Wagaine-Twabwe, locum associate specialist to Dr. Weinstock, wrote to Dr. Hendry to say that he had seen Mr Gonzales in his clinic on 20 th July who attended with his grandmother. The letter is uninformative as to mental state, but says that Dr. Wagaine-Twabwe was unable to find the results of the CT scan which Mr Gonzales and his grandmother were both concerned about. Dr. Wagaine-Twabwe said that he would review Mr Gonzales in about 2 months time, but no date was given. Clearly, no proper CPA procedure was followed after DG returned from Spain. There was no formal care plan, there was no decision as to what level of CPA he should be on, he did not have reviews of his care plan.	

Investigation interviews

- Daniel Anderson - probation officer, probation service
- Dr John Annear - forensic consultant psychiatrist
- Darren Ayres - Project 18 employment adviser
- Salvador Barbato - service-user, Mind, Woking
- Andy Bell - director of public affairs, Sainsbury Centre for Mental Health
- DS Brian Boxall - professional lead for public protection, Surrey police
- Sarah Cannon - probation officer, probation service
- Brenda Cutmore - grandmother of Mr Gonzales
- Dr Das - forensic consultant psychiatrist, Broadmoor Hospital
- Joe Dunne - Runnymede community mental health team manager
- Fiona Edwards - chief executive, Surrey and Borders Partnership Trust
- Mark Girvan - Woking community mental health team
- Daniel Gonzales
- Julian Gonzales, father of Mr Gonzales
- Stephen Harper - partner of Mr Gonzales' mother
- Dr Rachel Hennessy - consultant and former trust medical director
- John Humphries - youth justice worker
- Jill Jarvis - former director for nursing, Surrey and Borders Partnership Trust
- Danny Jones - forensic team coordinator
- Dr Kidd - consultant psychiatrist
- Janice King - partner of Peter King
- Peter King - victim of attempted murder
- Mr Aloysious Kizza - duty social worker, Guildford social care and sensory disability team

- Mike Klein - drug specialist
- Lucy Koca - service-user, Mind, Woking
- Dr Kuzmin, GP, Southview surgery
- Dr Ward Lawrence - forensic consultant, Surrey and Borders Partnership Trust
- Charlotte McGregor - social worker, Woking community mental health team
- Noeleen Molloy - sister of victim
- Theresa Norris - sister of victim
- Dr Ed Petch - forensic psychiatrist, Broadmoor Hospital
- Kathryn Pugh - project leader, Young Minds
- Professor Julie Rapper - Sheffield University
- Lorraine Reid - former chief executive, Surrey and Borders Partnership Trust
- Stanley Riseborough - director of nursing, Surrey and Borders Partnership Trust
- Charles Sadler - friend of Mr Gonzales
- Ms Lesley Savage - Mother of Mr Gonzales
- Bernadette Soanes - foster carer of Mr Gonzales
- Michael Soanes - foster carer of Mr Gonzales
- Mark Stephenson - community psychiatric nurse, Dover mental health centre
- Mary Teasdale - Rethink
- Teresa Vines - nurse team leader
- Dr Norman Weinstock - consultant psychiatrist
- Joyce Winston - former Surrey social worker
- Helen Wood - general manager of trust
- 23 service-users at Woking Mind

Transcribed copy of multi-professional review into the care and treatment of Mr DG: North West Surrey Mental Health Partnership NHS Trust June 2005

8. Findings and recommendations

8.1. It was noted from the Chronology, 21st September 1998, during Mr DG's admission to hospital (Oak Tree Clinic) that the second doctor who was due to complete the Section 2, MHA documentation did not arrive. It appears that there was no investigation as to why this happened, nor any written explanation.

Recommendation

It is recommended that the Trust complies with the legal requirements when applying Sections of the Mental Health Act 1983.

8.2. There was a great deal of background information available on Mr DG which all professionals involved in his care had access to.

Recommendation

It is recommended that where patients have involvement with a range of services a chronology of care is maintained which will provide details of the history and staff ensure that all information is sought and shared with the relevant parties.

8.3. Throughout his history a pattern had emerged of disengagement and compliance which could well have been exacerbated by his use of illicit drugs. From the records there was no clear plan as to how Mr DG was to be engaged to use the services arranged for him or whether they were the most appropriate, given his presentation and his age.

Recommendation

It is recommended that the Trust and Social Services review their policies on providing a service to people who disengage to build in contingency plans within the care planning, together with an age appropriate service.

8.4. It appeared that there were dysfunctional operational issues within the CMHT relating to the lack of clear objectives, local interpretation and implementation of policies and procedures.

Recommendation

It is recommended that both the Trust and Social Services review their policies, objectives and procedures to which the CMHT work in order to ensure they are integrated and jointly owned and implemented.

8.5. The absence of integrated case files and data collection systems hampered the availability of information and the ability to fully appreciate need and potential risk.

Recommendation

It is recommended that the Trust working in partnership with Social Services, Surrey County Council should set out a programme to fully integrate both case files and data information.

8.6. It was found that on examination of the records and oral evidence received that patient and carer contact, including face to face, telephone conversation for example, were either not written up within the one day working standard or not written up at all.

Recommendation

The Trust has a standard requiring all patient and care contracts to be recorded in the care notes within one working day. It is recommended that a regular audit takes place which monitors compliance with this standards and that the Trust develops systems of dealing with non-compliance.

8.7. A lost opportunity early on in his contact with the services in 1998 occurred when the Mental Health Act Tribunal disregarded the advice of his consultant psychiatrist to remain in hospital under Section to have a fuller assessment of his mental health state.

During Mr DG's contact with the service, because he moved residence, the patch system meant that he was seen by several different consultants, their medical teams and care coordinators.

Recommendation

A review of the organisation of the Mental Health Services using the Patch System is undertaken to address concerns regarding the continuity of care.

8.8. There was no evidence of an effective handover between the professionals and this seemed to have resulted in a lack of ownership of his care and treatment.

Recommendation

All handovers of patients between professionals should be fully documented in that individual's case notes.

8.9. CPA has been highlighted as providing the cornerstone of mental health services and should form the basis of all care planning and case review. However the implementation and use of CPA by the CMHT was not robust and coordinated resulting in poor ongoing communication across professionals and agencies.

Recommendation

It is recommended that the implementation of CPA is reviewed within the Trust to ensure that the benefits of using this approach are secured through effective policies and training programme.

8.10. Substance misuse is increasing in the younger population with the resulting mental health problems such as drug induced psychosis. Although Mr DG was referred to the Drug and Alcohol Service there was limited input from this service as MR DG was non-compliant particularly regarding attending appointments and receiving treatment. There appears to have been a lack of a risk assessment with regard to the use of drugs and effect this could have, and was having, on his mental state.

Recommendation

Until recently Drug and Alcohol Services were not required to adhere to CPA. It is recommended that participation in CPA is extended to this service to include the identification of risk and management for those individuals who are deemed as having a dual diagnosis as they are seen by both services.

8.11. It was reported several times that his mental state appeared to worsen when he was supposedly off of illicit drugs. However this was never explored taking into account that this might have been his way, through self medication, of controlling the voices in his head and other symptoms he was experiencing.

8.12 There were several sets of case notes relating to Mr DG's care. These did not appear to have been examined in totality. Again this resulted in a lost opportunity to appreciate the full picture of Mr DG's mental state and the risks he posed. The consultant professional staff changes resulted in presentation to the services being treated in isolation.

Recommendation

The Trust should undertake an examination of clinical notes, their coordination and availability to professionals.

8.13. The patch system implemented by the Trust presented a number of problems: -

- A too small team which therefore resulted in a lack of staffing skill mix and experiences.
- inability to adequately cover leave or the rapidness of staff turnover.
- other patches picking up clients when Patch 3's caseload numbers were at a maximum. This negated the whole ethos of having a patch system and knowledge of the clients was lacking.
- inadequate management time as it was diluted across three areas.
- identification of suitable and age appropriate care coordinators.
- lack of peer support.

Recommendation

It is recommended that the Patch System operated by the Trust is reviewed in light of the above findings and that serious consideration is taken of whether this system is sustainable.

8.14. Clinical leadership is an important element of effective CMHT working. It was reported that the consultant psychiatrist working with Patch 3 team rarely attended weekly team meetings, or participated in CPA and was not based with the team. In addition none of his medical team had attended CPA training. This compounded the difficulties of communication across and between the professionals.

Recommendation

In line with the recommendations 8.9 and .8.12 further consideration should be taken of ensuring the Consultant Psychiatrists becoming fully functioning members of the CMHT participating in team meetings and CPAs.

8.15. The CMHT is made up of Social Services and Health staff each working to different policies, procedures, structures and processes. There were no agreed common service objectives between the two employing agencies resulting in some confusion for staff and lack of synergy.

Recommendation

It is recommended that the Trust and Social Services review their policies on providing a service to people who disengage, to build in contingency plans within the care planning, together with an age appropriate service.

8.16. Although there were two attempts to undertake a Carer's Assessment these were never completed nor therefore acted upon. Mr DG's mother was very active in her son's care and made regular contact with the services and encouraged him when possible to participate in his treatment. The services however, did not take this into consideration nor involve her in his treatment or care planning.

Recommendation

Carer's views should be sought and taken into consideration when completing treatment and care planning.

8.17. Likewise it was reported that Mr DG had been experiencing difficulties in regard to his mental state whilst in Spain and there was no attempt to contact either his relatives or services to ascertain the difficulties. In fact his case was closed and no contingency plan was developed for his return to England.

Recommendation

Carer's views should be sought and taken into consideration when completing treatment and care planning.

8.18. It was reported that Mr DG had made several threats to harm his mother. However these threats did not appear to have been considered serious enough to assess the risk to his mother and subsequent actions. It is unclear whether these threats were ever discussed with his mother or whether she felt at risk from him.

Recommendation

All threats of harm to others should be taken seriously and consideration given to discuss with the individuals concerned, in order to properly manage risk.

8.19. There appeared to be a lack of procedure and handover from child and adolescent (CAMHS) to adult services, the latter depending on referral from Mr DG's GP. As the CAMHS services were more successful in engaging Mr DG than the adult service might have been able to adopt some of their approaches to ensure a consistent care pathway.

Recommendation

It is recommended that transition procedures between CAMHS and Adult Services are reviewed and that care planning for that individual is jointly set between the two services.

8.20. When Mr DG initiated contacts with the services it was usually due to his perceived need for alternative accommodation. Although alternative placements were offered they regularly broke down and there was no evidence as to why they failed nor what kind of support he needed to ensure their success.

Recommendation

It is recommended that an exploration of the reasons why placements fail and an identification of the support mechanisms to be put into place is included within the CPA process.

Letter from Dr Dan Wagaine-Twabwe

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21st July 2004
(Clinic: 20th July 2004)

Direct Line: 01932 722449

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Dear Dr Hendry

Daniel Gonzales – d.o.b. 26 06 80
20 Southwood Avenue Knaphill Woking GU21 2EY

I saw Mr Gonzales in the outpatient clinic at Bridgewell House on 20th July 2004. He attended with his grandmother.

Mr Gonzales was reluctant to talk, answering questions with the minimum of words, mostly with 'o.k.'. He said his appetite was 'o.k.', his weight was 'o.k.', concentration was 'o.k.', sleep was alright. He told me he was on no medication and that he does not need help. However, when I reminded him about help with housing, he said 'yes'. He told me he spends his time watching T.V., and that sometimes he goes to a gym. His grandmother told me that sometimes things are quite difficult; he has low motivation and that she that currently he is unable to live independently. She also told me that he will shortly be going to live with his grandmother in Spain for three weeks. This is to give his mother some respite.

Both Mr Gonzales and his grandmother asked me about the results of the CT scan he had about two weeks ago, but after checking through the notes, I told them the results were still awaited. They appear keen to know the results.

I have arranged for Mr Gonzales to be reviewed in about 2 months time.

Yours sincerely

Dr Dan Wagaine-Twabwe
Locum Associate Specialist to
Dr N Weinstock, Consultant Psychiatrist

Cc Woking C.M.H.T.

Panel biographies

Lucy Scott-Moncrieff

Lucy qualified as a solicitor in 1978, and has worked in the fields of mental health and human rights law ever since. She is a member of the Law Society's Mental Health & Disability Committee and its Access to Justice Committee, having previously chaired both committees. In 2005 Lucy was awarded the Mental Health Legal Aid Lawyer of the Year award, and two years later her firm was short listed for the Law Society's award for Excellence in Innovation. Lucy is a director of Edge Training Limited, a company that offers training on the law to the purchasers and providers of health and social care, and a member of the QC Appointments Panel. Lucy is on the editorial boards of the *Community care law reports* and the *Mental health law journal* and has written and broadcast regularly on legal issues over the years.

James Briscoe

James was appointed an NHS consultant with Northern Birmingham Mental Health Trust (NBMHT) in 1997. Whilst with NBMHT he set up a nationally acclaimed integrated primary care liaison service, recognised as an NHS Beacon Site in 2000. He was an honorary senior clinical lecturer at the Interdisciplinary Centre for mental health, University of Birmingham from 2002 to 2005. He has written a number of peer reviewed academic papers and book chapters. He has undertaken project management roles advising NHS trusts on the development of modern mental health services. James has worked as an independent consultant since 1997. He left the NHS in 2002 to develop a career in private psychiatry and became medical director at Woodbourne Priory Hospital in October 2003. In November 2005 he set up Midland Psychiatrist Partnership, a limited liability partnership of independent consultant psychiatrists specialising in medico-legal and occupational health work.

Granville Daniels

Granville Daniels is a registered nurse with over 40 years NHS experience - the last 20 years being in executive director posts in provider services in mental health and learning disability services at an operational level. For the last 18 years he has been based in NHS trusts in Nottinghamshire, working in mental health and learning disability services. Granville's most recent post was executive director for Nottinghamshire Healthcare (NHS) Trust, one of the largest mental health providers in the country. His remit included operational management responsibility for all adult mental health services and executive director for nursing. Granville has significant experience of undertaking service reviews and has undertaken a number of external inquires and homicide reviews, including being appointed by the Secretary of State to the public inquiry into the personality disorder unit at Ashworth Hospital (Fallon inquiry). Granville is a clinical adviser to the Health Service Ombudsman for mental health and forensic nursing issues.

Tariq Hussain

Tariq is a senior consultant at Verita - a consultancy specialising in the management and conduct of investigations, reviews, and inquiries in public sector organisations. He is a former nurse director who has experience of leading change management in the fields of learning disability and mental health services. Tariq served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting (now the Nursing and Midwifery Council).