

**Report of the
Independent Inquiry Panel
to the Western and Eastern Health and
Social Services Boards – May 2007**

Madeleine and Lauren O'Neill



**Report Issued by WHSSB and EHSSB
on 27 March 2008**





Western Health and Social Services Board
15 Gransha Park
Clooney Road
L.Derry, BT47 6FN

Telephone: (028) 7186 0086
Fax: (028) 7186 0311

Web site: www.whssb.n-i.nhs.uk



Eastern Health and Social Services Board
Champion House
12-22 Linenhall Street
Belfast, BT2 8BS

Telephone: (028) 9032 1313
Fax: (028) 9032 4980

Web site: www.ehssb.n-i.nhs.uk

Contents

	Page
FOREWORD – Chairman, Independent Inquiry Panel	
ACKNOWLEDGEMENTS	
EXECUTIVE SUMMARY AND RECOMMENDATIONS	(i)-(xix)
1. INTRODUCTION	1-4
1.1 Summary of Events	1-3
1.2 Madeleine O’Neill	3
1.3 Lauren O’Neill	3-4
2. TRUST INVESTIGATIONS	5
South and East Belfast Health and Social Services Trust	5
Foyle Health and Social Services Trust	5
3. INDEPENDENT INQUIRY PANEL	6-11
3.1 Establishment of Panel	6-7
3.2 Terms of Reference	7-9
3.3 Methodology	10-11
4. TREATMENT AND CARE RECEIVED BY MADELEINE O’NEILL	12-33
4.1 Brief Timeline	12-13
4.2 General Practitioner	14-16
4.3 Private Counsellor	17-19
4.4 Cognitive Behavioural Therapy, South and East Belfast HSS Trust	20
4.5 Belfast City Hospital	21-23
4.6 Crisis Response Team, South and East Belfast HSS Trust	24
4.7 Family and Childcare Initial Assessment Team, South and East Belfast HSS Trust	25-26
4.8 Knockbracken Healthcare Park, Belfast	27-29

4.9	Gransha Hospital, Londonderry	30-33
5.	LAUREN O'NEILL – LIFE PATHWAY	34-35
6.	MAJOR ISSUES	36-104
6.1	Communication	36-46
6.2	Child Protection / Children in Need	46-56
6.3	Competency, Training and Education of Staff in Mental Health	57-58
6.4	Mental Health / Childcare Interface	59-61
6.5	Assessment / Risk Assessment	62-66
6.6	Supervision	67-68
6.7	Care Planning	69-70
6.8	Discharge Planning	71-72
6.9	Bed Management	73-74
6.10	Recording of Information	75-76
6.11	Interface between Statutory Services and Private Counselling Services	77-80
6.12	Next of Kin	81-82
6.13	Consultation with and Support to Families	83-87
6.14	Inter Hospital Transfer of Patients and their Records	88-92
6.15	DHSSPS Guidance (May 2004)	93-100
6.16	Trusts' Reports	101-102
6.17	Madeleine's Gransha Hospital File – Security Issues	103-104
7.	LITERATURE REVIEW	105-106
8.	COLLATED RECOMMENDATIONS	107-115

APPENDICES

1. Independent Inquiry Panel Membership
2. List of Those Interviewed by Sub-Groups of the Independent Inquiry Panel
3. South and East Belfast Trust (Knockbracken Mental Health Services-Treatment Services) – Extract from 'Protocol for the Inter Hospital Transfer of Patients and their Records (November 2006)'

4. Assessment and Management of Risk in Mental Health Services – Regional Steering Group – Terms of Reference
5. Literature Review
6. Glossary of Terms / Abbreviations
7. References

Quotations in this Report are in *italics*

FOREWORD

Throughout its work the Independent Inquiry Panel had as its focus the tragic deaths of Madeleine O'Neill and her daughter Lauren and the devastating ongoing effects of these deaths on the whole family circle. It is virtually impossible to imagine the extent of the trauma, pain and distress experienced by those relatives who were closest to Madeleine and Lauren. It is the Panel's hope that the results of its work will, in some measure, assist the family to begin to come to terms with the losses sustained.

If learning is to flow from these two deaths, then surely it must be to ensure that any failures and shortcomings identified in Madeleine's care and treatment and in the protection of Lauren from harm, are not repeated elsewhere in the province in the future. The Panel would therefore urge all those involved in the Department of Health and Social Services and Public Safety, Health and Social Services Boards, Trusts and staff in Mental Health Services and Child Protection Services, to study our report carefully, to note the findings and conclusions we have reached and, in particular, to fully and urgently implement the recommendations we have made, in a real endeavour and resolve to ensure that these sad, tragic deaths are a rare occurrence in the Health and Personal Social Services in Northern Ireland.

During its work the Panel concentrated on producing a concise, readable report which would serve as a learning process for the HPSS. From the outset the report was intended to be a public document and the Panel therefore focused on the key issues which were identified.

The Independent Inquiry Panel was aware of impending changes to Trusts and the establishment of the new Health and Social Care Authority (HSCA) from April 2008, under the auspices of the Review of Public Administration (RPA). However, the Panel's report has been prepared in the context of structures in the HPSS prior to 1 April 2007, i.e., DHSSPS, HSS Boards and HSS Trusts. Specific details of RPA changes in the HPSS emerged during the course of the Panel's work. The Panel's view was that it should not endeavour to explain the detail of all the proposed structural and organisational changes in this report. Indeed, we were concerned that to do so might only serve to deflect attention from the

main messages and recommendations in the report. The DHSSPS, HSS Boards, the new HSCA and the reconfigured Trusts must therefore liaise closely to ensure that the Panel's recommendations are picked up and dealt with urgently at the appropriate level(s) in the new structures, beyond 1 April 2007.

Finally, I wish to record my personal thanks to all members of the Panel for their dedication and professionalism in carrying out the requirements of our Terms of Reference. Their efforts went well beyond the normal call of duty and fully attained the highest standards of the public service in Northern Ireland. I am particularly grateful personally for the help and support accorded to me by the Vice-Chairperson, Secretary and Office Administrator.

**Drew Boyd, Chair
Independent Inquiry Panel**

May 2007

ACKNOWLEDGEMENTS

The Panel wishes to thank all those who provided information and briefing material which formed the basis for our investigatory work. The Chief Executives and staff of Belfast City Hospital Trust, South and East Belfast HSS Trust and Foyle HSS Trust were unfailingly co-operative and greatly assisted the Panel in making arrangements for formal interviews. Other bodies and individuals who provided information and briefing material included Madeleine and Lauren's General Medical Practitioner, Madeleine's Private Counsellor, the Police Service of Northern Ireland and the Coroner's Office.

Staff of the three Trusts above, the GP and the Private Counsellor willingly attended formal interviews at the request of the Panel. We are grateful to all those who attended and fully recognise how emotionally difficult it was.

The Northern Health and Social Services Board was most helpful in permitting the Administrator/Secretary of a previous inquiry (2003) in that Board's area, to brief the Panel at its first meeting on the approach taken in that inquiry. We are grateful to the Northern Board and the officer concerned for their co-operation and assistance.

The Western and Eastern Health and Social Services Boards which commissioned the Independent Inquiry provided contact points in their respective organisations at Director level and also at senior officer level. Close links were formed between the Chair and Secretary of the Panel and these officers during the course of the Panel's work. We are grateful to these individuals for their support and co-operation.

Dr Julia Stroud, University of Brighton was most helpful in providing advice and guidance on the 'Research Literature' section of the 'Literature Review' (Appendix 5). We are grateful to her for this invaluable expert assistance.

Finally, the Panel wishes to thank the family of Madeleine and Lauren O'Neill for their involvement with representatives of the Panel on a number of occasions during the Inquiry for briefing sessions and formal interviews. We are particularly grateful to Mr J. O'Neill (Madeleine's

husband and Lauren's father) and Mr J. Gormley (Madeleine's father and Lauren's grandfather) for the dignity and courage they showed on all these emotional occasions.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

INTRODUCTION

From evidence obtained by the PSNI which has been disclosed to the Independent Inquiry Panel, and which has not yet been subject to a Coroner's Inquest, it would appear that Mrs Madeleine O'Neill took her daughter's life and then her own life on 12 July 2005. At the time of her death Mrs O'Neill was 40 years old and her daughter, Lauren, was 9 years old.

BACKGROUND

Prior to her death Madeleine had been suffering from depression for a number of years and was receiving treatment from her GP. Although her mood fluctuated over time, it was the GP's view that Madeleine's depression was minor with reactive/situational elements. However in the period April – May 2005, following her recent separation from her husband, her condition appeared to deteriorate and on 22 April 2005 she was referred to the Cognitive Behavioural Therapy Service, South and East Belfast Trust, (SEBT), at her own request by her GP. The referral stated that she had an active depressive disorder at this time. During a further visit to her GP on 16 May 2005 there was a marked change in her demeanour and it was the GP's view that she was clearly depressed although not actively suicidal. Her medication was increased at this time and a review date was set for two weeks later.

However, on 18 May 2005, Madeleine was found unconscious in her bedroom by her mother having taken a deliberate overdose of various medications. She was taken by ambulance to the Accident and Emergency Department, Belfast City Hospital where the Consultant Physician in Acute Medicine made a diagnosis of deliberate self-poisoning.

Following treatment for her overdose, Madeleine was assessed by a Specialist Registrar in General Adult Psychiatry the next day and was referred to the Crisis Response Team, SEBT and to the Hospital Social Worker who was asked to make an urgent onward referral to the Family and Child Care Initial Assessment Team, SEBT. The Specialist Registrar asked the Crisis Response Team to refer Madeleine to Outpatient

Psychiatry at Knockbracken Healthcare Park. Madeleine was discharged from Belfast City Hospital on 19 May 2005.

Two members of the Crisis Response Team visited Madeleine at her home the next day, 20 May 2005. The team members carried out a Risk Assessment of Madeleine and decided that she did not present a high risk to herself nor did they have concerns with regard to Lauren. Following the visit the team members made a routine referral to the Consultant Psychiatrist at Knockbracken Healthcare Park, SEBT.

A Social Worker from the Family and Child Care Initial Assessment Team visited Madeleine at her home on 7 June 2005. Overall, from her assessment, the Social Worker had the impression that Madeleine had very good family support and good friends and despite her suicide attempt was now moving on with her life. The case was discussed in supervision with a Principal Social Worker on 29 June 2005 when a decision was taken to close the case.

Madeleine had been attending a Private Counsellor since late April 2005 and had a number of sessions over the next few weeks. When she attended for a session on 8 June 2005 she appeared to be extremely upset and had great difficulty in focusing. The Counsellor was very concerned that Madeleine was having suicidal thoughts and also that she made reference to taking Lauren with her, although she did not indicate a specific plan to harm the child. The Counsellor advised Madeleine's father that additional support and an emergency referral to psychiatric services was required for Madeleine due to concerns about her suicidal ideation and the possible threat to Lauren.

Madeleine's father immediately took her to her GP who was very concerned that she was actively suicidal and had expressed intention to include her daughter in a suicide attempt. Following assessment the GP contacted Knockbracken Healthcare Park with a view to admission and Madeleine agreed to be admitted as a voluntary patient. A bed could not be found for Madeleine that evening and the GP had to become involved again the following day to ensure that she was admitted to Knockbracken Healthcare Park. Madeleine was assessed by a Senior House Officer at Knockbracken Healthcare Park on the afternoon of 9 June 2005 and as a result was admitted as an in-patient because of her clinical depression, her thoughts of suicide and her thoughts of taking Lauren with her. On

the day of admission the possibility of moving Madeleine to Gransha Hospital in Londonderry was discussed and following this discussion the Consultant Psychiatrist in Knockbracken Healthcare Park contacted a Consultant Psychiatrist in Gransha Hospital with a view to arranging her move. During the course of their conversation the Consultant Psychiatrist at Knockbracken Healthcare Park described Madeleine's clinical condition and the risk of suicide but cannot recall if he made any mention of a risk to Lauren; the Consultant Psychiatrist at Gransha Hospital is adamant that there was no mention of a threat to Lauren. The Consultant Psychiatrist at Gransha agreed to accept Madeleine and on 14 June 2005 she was taken by car by her parents to Gransha Hospital. Staff at Knockbracken Healthcare Park are clear that prior to Madeleine's departure her notes were placed in an envelope and handed to her father, who was asked to deliver them to staff at Gransha Hospital. Madeleine's father is clear that he did not receive any documentation at Knockbracken Healthcare Park.

Madeleine arrived with her parents at Gransha Hospital in the late afternoon of 14 June 2005. On arrival a nursing assessment was carried out and later that evening the on-call SHO also carried out an assessment. Madeleine stayed in Gransha Hospital from 14 June until 27 June 2005 when she was discharged at her own request. Throughout her stay at Gransha staff were unaware of any threat to Lauren as this information was contained in her notes which had not arrived at the hospital. Staff at Gransha Hospital did not at any stage attempt to discover the whereabouts of Madeleine's notes or to contact Knockbracken. Madeleine's diagnosis in Gransha Hospital was that she was suffering from either a major or moderate depressive disorder with somatic symptoms, probably due to her marital situation.

On 7 July 2005 the file which had been compiled by Gransha staff during Madeleine's in-patient stay was taken from Gransha Hospital to the Cityside Community Mental Health Team offices, Londonderry. On 14 July 2005 when news of the deaths of Madeleine and Lauren was received, the file was retrieved in the Cityside Community Mental Health Team offices and when opened was found to contain the notes from Knockbracken Healthcare Park. The Independent Inquiry Panel carried out a detailed investigation to determine how these notes had been placed in the file, but was unable to reach a conclusion.

MAJOR ISSUES

The Independent Inquiry Panel identified 17 major issues in relation to this case. These were: -

- Communication
- Child Protection / Children in Need
- Competency, Training and Education of Staff in Mental Health
- Mental Health / Childcare Interface
- Assessment / Risk Assessment
- Supervision
- Care Planning
- Discharge Planning
- Bed Management
- Recording of Information
- Interface between Statutory Services and Private Counselling Services
- Next of Kin
- Consultation with and Support to Families
- Inter Hospital Transfer of Patients and their Records
- DHSSPS Guidance (May 2004)
- Trusts' Reports
- Madeleine's Gransha File – Security Issues

Communication

Multidisciplinary Professionals

There is evidence of poor communication in both Knockbracken and Gransha Hospitals between different professionals involved in Madeleine's care and there was no evidence in either hospital to demonstrate the involvement of Social Work personnel in any multidisciplinary discussions. Throughout Madeleine's stay in both Knockbracken and Gransha there is no evidence of a "joined up" "holistic" approach by multidisciplinary teams in either hospital.

Admission to the Hospitals

At the time when a bed was being urgently sought for Madeleine (8/9 June 2005) communication from the Knockbracken Healthcare Park to Madeleine's GP and to her father was very poor. It is likely that if Madeleine's GP had not made strenuous efforts to contact the hospital again on 9 June 2005, she may not have been admitted at this time of crisis. At Gransha Hospital there are concerns about the lack of communication between the accepting Consultant Psychiatrist and the SHO who carried out the initial assessment.

Consultant to Consultant

Although two telephone conversations took place between the Consultant Psychiatrist at Knockbracken and the accepting Consultant Psychiatrist at Gransha it was very concerning to note the apparent lack of information shared regarding the threat to Lauren. Within Gransha Hospital itself there was an absence of meaningful communication between the Consultant who agreed to accept the patient and the Consultant under whose care she was subsequently placed.

Hospital to Hospital

Independent Inquiry Panel members were concerned in relation to: -

- The process for transfer of documentation between Knockbracken and Gransha Hospitals.
- The lack of communication between the two hospitals to ensure and confirm the safe arrival of the patient at Gransha Hospital.
- The fact that staff at Gransha Hospital did not seek information from Knockbracken when documentation did not arrive with the patient.

Between Professionals and Family

There is little evidence of systematic communication with the patient's family either in Knockbracken or Gransha, although some collateral history was taken at the time of Madeleine's admission to Knockbracken. Neither is there any evidence of involvement of the family in discharge planning or future care arrangements. There is no evidence of involving Madeleine's husband concerning the impact which Madeleine's illness

might have on her ability to care for Lauren, nor is there any evidence that information about the threat to Lauren was shared with Mr O'Neill, with the result that he was not given any opportunity to protect her.

Overview

It was the Panel's view that neither Madeleine nor Lauren were well served by the communication process between professionals, between the two psychiatric hospitals where Madeleine was an in-patient in June 2005 or between professionals and relatives.

Child Protection / Children in Need

During the period May to July 2005 when Madeleine was in contact with services there were a number of times when professionals should have been alerted to childcare concerns and should have taken appropriate action. These issues and concerns are highlighted in the main body of the report.

It is clear from the Panel's analysis that the threats to Lauren's life were known to practitioners and staff at a number of points, but no direct action was taken to deal with or minimise the risk. It was the Panel's view that had direct referrals been made when Madeleine expressed a threat to Lauren's safety and well being, Lauren's death could have been prevented.

The Panel was also concerned by the lack of general awareness of child protection / children in need issues. It was clear that many staff lacked even basic understanding of issues such as recognition of risk, the proactive nature of the children in need concept, or the signs and symptoms of child abuse.

Competency, Training and Education of Staff in Mental Health

A common theme in this case was an apparent lack of understanding of severe mental illness and it appeared that the significance of past deliberate self-harm was missed by many staff.

Mental Health / Childcare Interface

Throughout this case the focus of mental health staff was entirely on Madeleine with no attempt made to assess risk to Lauren, even though threats to her life and well being were quite clear. No attempt was made to involve Mr O'Neill in discussions about his daughter's future welfare and care arrangements or to involve child protection services.

The Panel was particularly concerned that so many staff working in the field of adult mental health were clearly unaware of their responsibilities in relation to Child Protection Policies and Procedures and Children in Need Procedures.

Assessment / Risk Assessment

The Panel was concerned that Madeleine did not appear to have received adequate care and risk assessment at Knockbracken and Gransha Hospitals and took the view that she should have remained in Knockbracken until a more thorough assessment had been completed over a longer period of time. There were also concerns about the levels of observation of Madeleine at Knockbracken. In addition, there was little evidence of multidisciplinary working between the various community based services within South and East Belfast Trust, which had contact with Madeleine.

Supervision

The Panel was concerned to find evidence of unsatisfactory supervision in a number of situations relating to the care and treatment of Madeleine and the lack of protection offered to Lauren.

Examples included little evidence of managerial, clinical or professional supervision regarding child protection issues; poor oversight of decision making in relation to assessment / risk assessment; incomplete and inaccurate nursing care plans demonstrating lack of managerial supervision; no evidence that Madeleine's condition was discussed with line management in either Knockbracken or Gransha Hospitals.

Care Planning

The care planning process and recording of care plans in both Knockbracken and Gransha fell well short of what would be expected of professional health care staff. The nursing care plans in both hospitals were incomplete and neither hospital care plan was based on a risk assessment.

Discharge Planning

Discharge planning arrangements in both Knockbracken and Gransha Hospitals fell far short of what would be considered good practice; when Madeleine was discharged from Gransha the future care arrangements were very unsatisfactory.

Bed Management

The Panel was concerned about the difficulty experienced by Madeleine's GP in securing a bed for her in Knockbracken. There is clear need for effective bed management systems to be in place in acute in-patient mental health units in Northern Ireland.

Recording of Information

There was evidence of inaccurate recording of information relating to Madeleine at both Knockbracken and Gransha Hospitals.

Interface Between Statutory Services and Private Counselling Services

The Panel highlighted problems relating to the interface between statutory mental health services and private counselling services. The Panel was particularly concerned that Madeleine's Private Counsellor was included in care planning by both psychiatric hospitals without reference to the Counsellor. There is also an issue regarding communication and sharing of information between statutory services and private counselling services.

Next of Kin

The fact that Madeleine and her husband were separated had a direct effect on the recording of next of kin information. This meant that Mr O'Neill's role as Lauren's primary carer during Madeleine's illness was not recognised and contributed to him not being informed of the threat to Lauren.

Consultation with and Support to Families

There was a general failure to include relatives in discussions about Madeleine's care and treatment, to consult with relatives about her discharge from Gransha hospital, to provide guidance to relatives about the need to monitor behaviour in the period after discharge and to advise Mr O'Neill of the threat to Lauren. Mr O'Neill's right under Article 8 of the European Convention on Human Rights (right to respect for family life) may have been breached. There was no support offered to relatives after the two deaths occurred in July 2005.

Inter Hospital Transfer of Patients and Their Records

DHSSPS requested Trusts in April 2005 to develop protocols for actions to be followed when patients moved between HPSS organisations.

In the summer of 2005, DHSSPS asked CREST to assist in the development of a regional protocol. The views of The Royal College of Psychiatrists (NI) were requested in December 2005 as CREST was aware that there were particular issues that psychiatric hospitals need to take into consideration and that there were sensitivities regarding psychiatric notes.

A revised protocol document was published and circulated to Trusts in August 2006. In the light of the circumstances leading up to the deaths of Madeleine and Lauren it is the Panel's view that the August 2006 protocol should be reviewed urgently and updated to include guidance on child protection issues and the involvement of relatives in the process of transferring psychiatric patients and their records from one psychiatric hospital to another.

DHSSPS Guidance – May 2004

The DHSSPS Guidance ‘Discharge from Hospital and the Continuing Care in the Community with People with a Mental Disorder who could represent a Risk of Serious Physical Harm to Themselves or Others’ had not been fully implemented in either Knockbracken or Gransha Hospitals at the time Madeleine was being treated and cared for in these hospitals. This had serious implications, particularly in respect of child protection measures which might have been initiated in both hospitals and which might have prevented the death of Lauren.

Trusts’ Reports

The Panel was struck by the difference in approach adopted by South and East Belfast Trust and Foyle Trust in drawing up their reports following the deaths of Madeleine and Lauren. It was the Panel’s view that a common format would be helpful in relation to reports by Trusts on serious untoward incidents and that formal guidance should be issued on this matter.

Madeleine’s Gransha Hospital File – Security Issues

The Panel was concerned that Madeleine’s file was not properly secured by Foyle Trust following her death and took the view that formal guidance should be issued to Trusts about the need to secure all relevant documentation and files when a serious untoward incident occurs.

Literature Review

The Panel completed a Literature Review which utilised relevant inquiry reports, guidance, research and academic literature to underpin the work of the Inquiry and its learning objectives. The Literature Review highlights the need for further research.

RECOMMENDATIONS

Communication

1. Belfast City Hospital, South and East Belfast Trust and Foyle Trust should review their arrangements for multidisciplinary working and information sharing focusing

on: -

- roles
- the nature of services
- treatments and interventions
- structures
- accurate targeting of referrals
- formal and informal processes
- internal and external communication
- recording of information
- case co-ordination/key working
- training
- unit/professional culture

2. South and East Belfast Trust should review its arrangements for admitting patients for in-patient care, with particular reference to a daily waiting list management and bed management system and an ongoing contact system with patients and their carers when beds are not available. There is a need to ensure that systems are in place within Knockbracken which track a request for admission and assist in the management of risk and patients until a bed is allocated.

3. Foyle Trust should review its arrangements for admitting patients for in-patient care to Gransha to ensure in particular that SHOs obtain all relevant background information from the referring GP or hospital and collateral information from the patient's family, as far as is practical, on the day of admission.

4. The DHSSPS and the Boards should instruct Trusts to draw up and implement policies regarding consultation by staff with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

5. Trusts should ensure that there is clarity in the role and function of Crisis Response Teams, Home Treatment Services and Community Mental Health Teams.

6. Trusts should ensure that there are sound arrangements for clinical supervision within Community Teams in general and specialist advice/support in Community Home Treatment and Crisis Response Team services. In constructing these arrangements Trusts should be aware that increasing specialisation of services is likely to make it more difficult for individual practitioners to fulfil a keyworking / co-ordinating role across a care plan.

7. Trusts should ensure that protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient.

Child Protection / Children in Need

8. All Boards and Trusts should review the child protection training and awareness of all staff, including access to policies and procedures.

9. DHSSPS in conjunction with Boards' ACPCs should review the content and uptake of child protection training delivered to GPs and should consider making such training mandatory for all relevant staff and practitioners.

10. Counselling bodies should make child protection training including refresher training a mandatory component of ongoing registration.

11. Counselling bodies should require counsellors registered with them to follow the Department's Child Protection Policy 'Co-operating to Safeguard Children' and Regional ACPC Policies and Procedures.

12. DHSSPS should review Co-operating to Safeguard Children and the four ACPCs should review their Child Protection Policy and Procedures to ensure that both documents provide consistent and specific guidance for counsellors and psychotherapists, particularly those working in a private capacity.

13. The DHSSPS should, in conjunction with the Department of Employment and Learning and education providers, review all undergraduate and post graduate training for relevant professions to include a core understanding of child protection issues.

Competency, Training and Education of Staff in Mental Health

14. Trusts should ensure that all SHOs new to Psychiatry should have an induction course covering role clarification and a basic knowledge of common psychiatric disorders, their treatment and management.

15. Trusts should ensure that multidisciplinary staff are aware of the nature of therapeutic relationships and the concepts of transference and counter-transference.

16. Trusts should ensure that staff working in the field of mental health have continuous professional development plans which include in-service training and evidence based practice refresher courses.

Mental Health / Childcare Interface

17. DHSSPS and Boards should ensure that each Trust puts in place a joint protocol designed to manage the interface between mental health and child care services, addressing and facilitating the co-working of cases where there are concerns that adult mental health problems may impact on the care of children.

18. The four ACPCs should jointly commission multidisciplinary training across the region for mental health and child care staff, focused on working together in cases where there are adults with mental health issues who have dependent children. This training must explicitly deal with child in need issues as well as child protection matters. The ACPCs should make use of the Crossing Bridges (1998) training resource produced by Department of Health.

19. DHSSPS should ensure that consideration of parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children. (Understanding the Needs of Children in Northern Ireland).

Assessment / Risk Assessment

20. South and East Belfast Trust should review the assessment models used by CRT and FCC IAT in cases where a parent with dependent children has attempted suicide or made a serious threat of self-harm.

21. DHSSPS should develop guidance that would lead to the implementation of consolidated assessments in mental health. Consolidated assessment would underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning which all feature in other recommendations in this report. It would also include assessment of the impact of mental illness on carers and on children and the adequacy of support arrangements for them.

Supervision

22. Boards and Trusts must ensure that supervisory policies are in place which require that: -

- Arrangements are in place to monitor and audit assessment, case management, effectiveness of interventions, record keeping and discharge planning of individual cases.
- Staff understand and adhere to ACPCs' Child Protection Policy and Procedures.
- In all situations where there are concerns relating to children there is an appropriate multi-agency assessment of risk.
- There is a named nurse and named doctor with clearly defined responsibilities to provide a lead role for child protection within mental health services.

Care Planning

23. DHSSPS should review guidance in relation to care planning. The review should ensure that care plans are designed in conjunction with a model of care and include consideration of risk assessment and management, multidisciplinary working, verifying information provided by

the patient, and objective, evidence based approaches to care plan changes.

Discharge Planning

24. Both SEB and Foyle Trusts should undertake urgent reviews of their systems for developing discharge plans for patients leaving their hospitals. In addition DHSSPS should consider providing guidance in relation to discharge planning. The basic elements which should form part of future discharge planning would include: -

- Comprehensive Multidisciplinary Team input.
- Identified planned date of discharge.
- Clear discharge pathway to cover all aspects of discharge.
- Professionals or services named in discharge plans must have been contacted and provided informed agreement to their inclusion in the plan.
- Discharge and leave destinations should be known and associated risk assessed, including contingency planning.
- Where there is a parenting role, risk assessment and plan must be recorded.
- Discharge plans should include provision for engagement with follow-up services.
- Consideration should be given to carer involvement.
- A relapse prevention plan should be drawn up, with carers' involvement.
- Parents with serious mental illness should be prioritised for follow-up after discharge.

Bed Management

25. Boards and Trusts must ensure that each in-patient unit has a bed management policy in place, which outlines the bed management system and identifies an accountable named individual.

Recording of Information

26. Both South and East Belfast and Foyle Trusts should have in place as part of their governance arrangements a system to monitor and audit case records within Mental Health services to ensure: -

- Accuracy
- Assessment and management of risk
- Care planning
- Effectiveness of treatment
- Discharge planning
- Correct patient identification

Interface Between Statutory Services and Private Counselling Services

27. DHSSPS in co-operation with responsible Departments in Great Britain should implement its commitment to the statutory registration and regulation of psychotherapists and counsellors as outlined in the 2006 consultation on standards. The associated guidance to psychotherapists and counsellors should aim to improve communication between statutory services and private counselling services, leading to a culture in both sectors where the benefits of co-ordinated care are promoted to patients/clients/service users. The guidance should also take account of Recommendations in the section on Child Protection/Children in Need in this Report.

Next of Kin

28. DHSSPS and Boards should ensure that Trusts have a policy in relation to identifying and recording 'Next of Kin' information. Trusts should also consider the extent to which staff training and/or refresher training should be provided for front-line staff involved routinely in taking personal history details from patients, particularly in situations where patients have family issues relating to divorce, marital separation and dependent children.

Consultation with and Support to Families

29. Whilst acknowledging the planned benefits in 'Protect Life – A Shared Vision' – The Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011 launched in October 2006, including its stated intention to provide support and assistance to families bereaved by suicide, we take the view that some of the proposed 'Actions' in the Strategy document need to be brought forward more quickly than planned. We

recommend that the DHSSPS should review this matter urgently and consider whether or not earlier implementation would be possible.

If this proves to be impossible we further recommend that Trusts should be required to urgently establish interim arrangements to provide support and assistance to families bereaved by suicide, in order to temporarily fill the gap in service provision clearly identified in relation to the lack of support provided to the O'Neill and Gormley families.

Inter Hospital Transfer of Patients and Their Records

30. In light of the circumstances leading up to the deaths of Madeleine and Lauren, the DHSSPS should request CREST or its successor organisation to urgently review its August 2006 Protocol relating to inter-hospital transfer of mental health patients, with a view to including: -

- A section dealing with Child Protection issues (perhaps along the lines of the Child Protection section in the Protocol document drawn up by South and East Belfast Trust [Knockbracken Mental Health Services – Treatment Services] in November 2006) (Appendix 3).
- A specific statement that if transfers of patients are carried out by or with relatives and their personal transport, the patients' records must be transferred separately from the patient and relatives, by secure means.
- A specific statement that transfers of patients must always require pre-move written data setting out core features of the illness, diagnosis and reasons for the transfer, to be faxed or emailed in keeping with approved confidentiality arrangements, in advance to the receiving hospital, and agreed in writing by the accepting Consultant, prior to the actual move.
- Guidance to Trusts on definition and use of the words 'transfer' and 'discharge' in the context of movement of a patient from one psychiatric hospital to another in the province with no intention of the patient returning to the referring hospital, given the apparent interchangeable use of the two words in relation to the movement of Madeleine O'Neill from Knockbracken to Gransha Hospital.

When this further updated CREST protocol is available it should be issued by the DHSSPS to Trusts for implementation as a standard protocol throughout the service in Northern Ireland, rather than as guidance for the preparation of protocols by each individual Trust.

In addition, within 6 months of issue of CREST's updated protocol, the DHSSPS should require Trusts to provide evidence of specific action undertaken to make relevant staff aware of the updated protocol, the need to adhere to it strictly and the need to formally review the working of the updated protocol at regular intervals of not more than one year.

DHSSPS Guidance – May 2004

31. DHSSPS should ensure that when guidance is issued for implementation by the HPSS on particular service issues, an audit mechanism is included to ensure that the required action is taken within a specified timescale.

32. There are clearly continuing issues of understanding and interpretation of some aspects of the 2004 Guidance apparent within Trusts and the medical profession, (as expressed by the NI Branch of the Royal College of Psychiatrists), which contributed in some measure to the handling of the care and treatment of Madeleine. We note the action taken recently by DHSSPS to establish a Regional Group to review assessment and management of risk in mental health services and the timescale involved but would nevertheless recommend that the DHSSPS takes urgent action to specifically review and update the 2004 Discharge Guidance, in conjunction with Boards, Trusts and the relevant professions.

Trusts' Reports

33. Steps should be taken by the DHSSPS, in conjunction with Boards, Trusts and other relevant bodies such as the Mental Health Commission and ACPCs, to draw up and issue guidance regarding the production of initial investigation reports by Trusts, in situations where there has been a serious incident such as a suicide or homicide, involving a patient or client. Such guidance should, at least, include draft terms of reference for such an investigation, proposed model format of a report and proposed timescale.

Madeleine's Gransha Hospital File – Security Issues

34. We fully endorse and support the recommendation of the Inquiry Panel (McCleery) and the guidance in 'Co-operating to Safeguard Children'. In light of events in this case, the DHSSPS should issue further formal guidance / instructions to all Trusts in relation to the need to secure all relevant documentation and files in such circumstances, as a matter of urgency.

Literature Review

35. DHSSPS in collaboration with corresponding Departments in England, Wales and Scotland should commission UK wide research into all aspects of child killing to ensure that attention is given to increasing the understanding of cases involving parents who are mentally disordered but where there are no pre-existing child care concerns. This work should build on the existing international literature and seek to resolve the problems with definition that have made it difficult to translate research findings into practice guidance that would inform risk assessment. DHSSPS and its partner Departments in this research should ensure that this work is integrated with Child Death Review arrangements and with the work of the new Safeguarding Board for Northern Ireland.

36. When commissioning inquiries DHSSPS and Boards should ensure that inquiry panels have early access to research and similar inquiries of which DHSSPS and/or Boards are aware. This would avoid duplication of effort and support the learning objectives of inquiries.

1. INTRODUCTION

1.1 Summary of Events

Mrs Madeleine O'Neill first registered with her GP in 1995. In March 1999 she presented to her GP with sustained low mood, loss of interest and weepiness. This was attributed to memories of sexual abuse as a child and to the fact that the perpetrator was being tried at that time. The perpetrator subsequently received a jail sentence. Over the following five years her mood fluctuated and she visited her GP on a number of occasions to be treated for depression.

On 22 April 2005 her GP referred her to South and East Belfast Trust's Cognitive Behavioural Therapy service, at her own request. Although an appointment was subsequently made for her, she did not in fact attend.

On 16 May 2005 Madeleine visited her GP accompanied by her brother. The GP noted a very marked deterioration in her mood associated with her marital break-up and surrounding issues. Although she was depressed at that time he felt that she was not actively suicidal.

On 18 May 2005 Madeleine was admitted to Belfast City Hospital, Accident and Emergency Department following an overdose of mixed medication and stayed overnight; she had been found by her mother and had written a suicide note. On 19 May 2005 she had a psychiatric assessment in Belfast City Hospital and at that time said that the overdose had been impulsive and she denied any other plans for self-harm. The Specialist Registrar in General Adult Psychiatry (Specialist Registrar) who carried out the assessment referred Madeleine to the Crisis Response Team in South and East Belfast Trust for Madeleine to be assessed in the community and for onward referral to Outpatient Psychiatry at Knockbracken Healthcare Park. The Specialist Registrar also referred Madeleine to the Hospital Social Worker to facilitate onward referral to family and child care services as Madeleine was a parent with responsibility for a child. Madeleine was assessed by a Social Worker from Belfast City Hospital on 19 May 2005. The Social Worker made a referral to the Family and Child Care Initial Assessment Team in South

and East Belfast Trust for family support, marked as high priority. Madeline was discharged from Belfast City Hospital on 19 May 2005.

On 20 May 2005 two members of South and East Belfast Trust's Crisis Response Team visited Madeleine in her home. At that time she confirmed that she had no further thoughts of suicide and was looking forward to the future. Following the assessment the team contacted a Consultant Psychiatrist's secretary at Knockbracken Healthcare Park and made a referral.

On 7 June 2005 a member of South and East Belfast Trust's Family and Childcare Initial Assessment Team visited Mrs O'Neill in her home. Again it was the view that she had no further thoughts of self-harm and there were no indications that she would pose a risk to her daughter.

On 8 June 2005 at the request of Madeleine's Private Counsellor, Madeleine's father contacted her GP as a matter of urgency. When her GP spoke to her, he found that she was actively suicidal and was very concerned especially as she had expressed thoughts of taking her daughter with her in a suicide attempt. While the GP referred her to Knockbracken Healthcare Park her admission was deferred to the following day. On 9 June 2005 Madeleine was assessed by the Senior House Officer (SHO) at Knockbracken Healthcare Park and the Consultant decided that admission to hospital was required. It was noted that at this time she was suicidal, had expressed thoughts of wanting to take her daughter with her and had accessed internet suicide sites. She remained in Knockbracken Healthcare Park until 14 June 2005 when she was discharged/transferred * under the care of her parents to go to Gransha Hospital. During this period she stated on some occasions that she wished to get well for her daughter's sake.

On the afternoon of 14 June 2005, Madeleine arrived at Gransha Hospital accompanied by her parents and was admitted for assessment and treatment. Whilst the assessment noted the recent overdose it was the view that there was no immediate threat of suicide and there was no mention of any threat to her daughter. Madeleine was discharged on 27 June 2005. It appears from evidence obtained by the Police Service of

** There is an issue as to whether, in technical terms, Madeleine was transferred or discharged from Knockbracken . South and East Belfast Trust has stressed that in its view she transferred from Knockbracken to Gransha Hospital. This issue is dealt with in detail later in this Report in the section headed: 'Inter Hospital Transfer of Patients and their Records'.*

Northern Ireland (PSNI) which has been disclosed to the Panel, and which has not yet been subject to a Coroner's Inquest, that she took her daughter's life and then her own life on 12 July 2005.

1.2 Madeleine O'Neill

Madeleine, the eldest child of John and Anne Gormley, was born on 13 September 1964. Her parents subsequently had three other children, two boys and a girl. Madeleine grew up in Derry and attended primary and secondary school there. She appears to have enjoyed her time at school and when she left at the age of eighteen with 10 'O' Levels and 2 'A' Levels she went on to the local North West Institute of Further and Higher Education where she obtained a HND in Computer Studies. Subsequently she joined the Civil Service and moved to Belfast where she met her husband, John O'Neill. Madeleine appears to have been a very quiet, reserved, private type of person who suffered from repeated episodes of depression over a number of years. Staff at Belfast City Hospital, Knockbracken Healthcare Park and Gransha Hospital recall her as a lovely person who appeared happy to engage with them and a number of staff were clearly very distressed during their interviews with Panel members, when they recalled Madeleine and particularly when they remembered the occasions where Madeleine and Lauren were together on the ward.

1.3 Lauren O'Neill

Madeleine and John O'Neill's only child, Lauren, was born on 5 February 1996. Lauren was a delightful child, always bubbly, full of life and blessed with a kind and gentle nature. She grew up and went to school in Belfast where she touched the hearts and lives of many people there. She enjoyed school, particularly her art and poetry classes and had lots of friends there. She was a natural at many sports, loved swimming and was an active member of the local ballet and gymnastics clubs. She was also talented musically, singing in the school choir and learning to play the piano. Towards the end of the school year in 2005 Lauren went to school in Strabane for two weeks in preparation for her move there, following Madeleine and John's separation in March 2005. Lauren had adjusted well to these new circumstances and was looking forward to starting her new school in September 2005 and living close to her

cousins there. Mr O'Neill continued to play a significant role in his daughter's life, sharing joint caring responsibilities with his wife and having daily contact with her. He showed photographs of Lauren, taken in the weeks before her death, to some members of the Panel. These photographs confirm Mr O'Neill's description of Lauren as a happy, healthy and well-adjusted child. Had events turned out differently, Lauren could have looked forward to a long, happy and productive life. Sadly, this was not to be, and she was just nine years old when she died in tragic circumstances on 12 July 2005. In her memory book one of her teachers writes *When I think of Lauren, I see sparkling eyes, a smiling face and I hear laughing.* Another friend wrote *Lauren brought us joy, that was her gift.* These memories are a fitting tribute to a very special little girl who is sorely missed by all those who knew and loved her.

2. TRUST INVESTIGATIONS *

Following the deaths of Madeleine and Lauren on 12 July 2005, the Western and Eastern Health and Social Services Boards agreed that Foyle Health and Social Services Trust and South and East Belfast Health and Social Services Trust should be asked to undertake separate multidisciplinary reviews.

South and East Belfast Trust's review which was completed in October 2005, followed closely the format recommended by the Mental Health Commission. Foyle Trust's report completed in January 2006 also met the Mental Health Commission requirements but followed a more investigative approach. Both Trusts' reports proved extremely valuable to the Independent Inquiry Panel in terms of providing background information.

** See also section headed 'Trusts' Reports' under 'Major Issues' later in this Report*

3. INDEPENDENT INQUIRY PANEL

3.1 Establishment of Independent Inquiry Panel

Following the tragic deaths of Madeleine and Lauren at their home in Carryduff, Co. Down in July 2005, an Independent Inquiry Panel was established by the Western and Eastern Health and Social Services Boards, in consultation with the DHSSPS. The Panel was asked to carry out a composite Inquiry taking account of the relevant DHSSPS policy/guidance documents – ‘Co-operating to Safeguard Children’ (May 2003) and ‘Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others’ (May 2004).

The Independent Inquiry Panel was chaired by Mr. Drew Boyd. Mr Boyd retired from the Health Service in 2005, following a career which spanned senior management posts in Policy and Planning, Personnel, General Management, Hospital Commissioning and Primary Care.

The Panel included medical, nursing, social work, voluntary sector, legal professional and service user representatives. A list of members of the Panel is attached (Appendix 1). Panel selection ensured an appropriate mix of mental health and child protection expertise.

In broad terms, the Panel was asked to examine the care received by Madeleine in relation to her mental health needs and the child protection issues affecting Lauren.

The Western Health and Social Services Board acted as the lead Board in establishing the Independent Inquiry Panel because Madeleine received her last hospital care in Gransha Hospital, Derry which is managed by Foyle Health and Social Services Trust. The Eastern Health and Social Services Board was also involved because Madeleine had been a patient in Belfast City Hospital, a client of the Community Services in South and East Belfast Health and Social Services Trust, and a patient in Knockbracken Health Care Park, Belfast also managed by the South and East Belfast Trust, before moving from there to Gransha Hospital.

At the outset the Panel Chairman, Drew Boyd, stressed that this Inquiry and Report had been jointly commissioned by the Western and Eastern

Health and Social Services Boards. Both Boards recognised that the Panel was independent and should carry out its work and formulate its findings and recommendations accordingly. He also gave a firm commitment to keep the family informed of the work of the Panel throughout the inquiry process. The key aims were to carry out a thorough investigation and to highlight any lessons which arose from the work of the Inquiry Panel.

The Western and Eastern Health and Social Services Boards having commissioned this Report, have the primary responsibility for ensuring that the Recommendations are actioned appropriately. The role of DHSSPS in securing Province-wide action is critical in enabling this.

3.2 Terms of Reference – Independent Inquiry Panel

The Western and Eastern HSS Boards jointly produced 'Terms of Reference' for the Independent Inquiry with input from and the agreement of their respective Area Child Protection Committees. The Terms of Reference were issued with a Press Release by the Boards on 30 March 2006. At the request of the Panel, the two Boards agreed, in August 2006, to revise the Terms of Reference to enable the Panel to consider some events subsequent to the deaths of Madeleine and Lauren O'Neill.

The revised Terms of Reference are set out below.

To review and examine the circumstances surrounding the referral, admission, treatment and discharge of Madeleine O'Neill to Knockbracken Health Care Park and Gransha Hospital and subsequent events with particular reference to: -

- *The quality, range and delivery of care in respect of the mother; the assessment of risk, including the assessment of risk in relation to the risk of significant harm to the child and related child protection issues*
- *The level of care she received and its suitability in the light of her previous history and assessed needs*
- *The care she was receiving at the time of the incident*
- *The processes surrounding admission to and transfer between the hospitals and whether these complied with existing*

statutory and professional obligations, current guidance and local operational policies which were extant at that time

- *The adequacy of her referral assessment, care plan, monitoring and care co-ordination*
- *Communications and co-operation between professionals and organisations and the adequacy and appropriateness of these*
- *Communications with and involvement of family and carers*
- *The processes surrounding her discharge from hospital*
- *The effectiveness of records management*
- *The extent to which care planning addressed the needs of and risks to the child*
- *The adequacy of the risk assessment and risk management undertaken for the child*
- *The adequacy of communications and co-operation within and between the Health and Social Care system and with others involved*
- *Identification of any issue which requires review and examination*
- *To make recommendations on operational policy and any related managerial arrangements, arising from the deliberations of the Inquiry Team. Such recommendations should include any identified actions*
- *To make recommendations which identify what lessons need to be learnt, how they will be acted upon, and what should be changed as a result so as to improve working within and between disciplines/programmes and agencies and thus provide better safeguards for children.*

To prepare a report on the composite findings and recommendations. To provide a final draft version of the report to the Western Health and Social Services Board and the Eastern Health and Social Services Board and to subsequently present a final report to the Boards, their respective Area Child Protection Committees and to DHSSPS for further dissemination across Northern Ireland.

The form of the report should enable it to be widely circulated so that all lessons can be fully learnt and take account of Freedom of Information, Data Protection and Human Rights legislation.

3.3 Methodology

A Press Release, together with Terms of Reference and Membership of the Independent Inquiry Panel was issued jointly by the Western and Eastern Health and Social Services Boards on 30 March 2006.

Preliminary Work

During March and April 2006 the Chair, Vice Chair and Secretary of the Panel held a number of preliminary meetings to become acquainted with the basic factual material supplied by the two Boards, including reports prepared by the South and East Belfast and Foyle Health and Social Services Trusts, and to plan for the first meeting of the Panel. An Independent Inquiry Panel office was established in March 2006 in a secure room provided in the Western Health and Social Services Board Headquarters, Londonderry, together with secretarial support.

Initial informal meetings were also held separately with Madeleine's father, Mr J. Gormley and husband, Mr J. O'Neill in the first half of April 2006.

The Chair also had initial informal meetings with the Chief Executives of the South and East Belfast and Foyle Trusts towards the end of April 2006, and the Chair and Vice Chair met with representatives of the PSNI early in May 2006.

Independent Inquiry Panel Meetings

The Panel held its first meeting on 4/5 May 2006 and held 12 meetings in total during the course of its work in addition to interviews and to preparatory and advisory work carried out by individual members in preparation for meetings.

Work Carried out by the Panel

The main areas of work carried out by the Panel, in roughly chronological order but recognising that there was overlap from time to time, were: -

- Study of basic material provided by the two Boards, including reports prepared by the two Trusts.
- Identification of major issues for investigation.

- Identification and acquisition of further documentation required.
- Identification of staff of the two Trusts, relatives and others to be interviewed by the Panel. (Appendix 2)
- Establishment of the process for conducting interviews.
- Identification and collation of issues arising from interviews, conclusions and recommendations.
- Establishment of methodology for preparing the Panel's report.
- Establishment of action plans (in conjunction with the two Boards) for handling the Panel's report when finalised.

Throughout the whole period of the Inquiry, close liaison was maintained with relatives and with the senior officers nominated by the two Boards as 'lead contacts'.

Data Protection

The Independent Inquiry Panel was registered under the Data Protection Act 1998 and all information given to the Panel was treated as confidential.

4. TREATMENT AND CARE RECEIVED BY MADELEINE O'NEILL

4.1 Timeline: 22 April 2005 – 14 July 2005

This brief timeline is intended to assist readers of the Report to identify significant issues / events over the period 22 April 2005 to 14 July 2005.

Date	Contact / Service	Issue / Event
22-4-05	General Practitioner	Madeleine referred to Cognitive Behaviour Therapy Service, South and East Belfast Trust.
16-5-05	General Practitioner	Assessed as depressed.
18-5-05	Belfast City Hospital	Admitted to hospital following serious overdose.
19-5-05	Belfast City Hospital	Assessed by Specialist Registrar in General Adult Psychiatry (Specialist Registrar) and by Hospital Social Worker prior to discharge.
20-5-05	Crisis Response Team, South and East Belfast Trust	Visited at home by Crisis Response Team members.
2-6-05	General Practitioner	Assessed. Mood remained low.
7-6-05	Family and Childcare Initial Assessment Team, South and East Belfast Trust	Social Worker visited Madeleine at home.
8-6-05	Private Counsellor / General Practitioner	Madeleine admitted to thoughts of self-harm and alluded to taking Lauren with her.
9-6-05	Knockbracken Healthcare Park, Belfast	Assessed by SHO and admitted by the Consultant Psychiatrist as voluntary in-patient.
14-6-05	Knockbracken Healthcare Park → Gransha Hospital	<ul style="list-style-type: none"> i. Travelled by car from Knockbracken to Gransha accompanied by her parents ii. Assessed at Gransha and admitted as a voluntary patient.
27-6-05	Gransha Hospital, Londonderry	Discharged from hospital. Went to parents' home in Londonderry.

6-7-05	Private Counsellor	Assessment session.
10-7-05		Returned to Carryduff home.
12-7-05	PSNI	Bodies of Madeleine and Lauren discovered at their Carryduff home.
14-7-05	Community Mental Health Team, Cityside, Londonderry	Notes and the Nursing Transfer Form from Knockbracken Healthcare Park discovered in file in Community Mental Health Team Office, Cityside, Londonderry.

4.2 General Practitioner

Madeleine first registered with her GP in 1995 when she became pregnant with Lauren. She subsequently had a normal uneventful pregnancy and delivered a healthy female infant, Lauren. Madeleine rarely sought medical help or advice up until March 1999, when she presented with sustained low mood, loss of interest and periods of weeping. She was treated with anti-depressant medication and responded well to the therapy. By September 1999 her mood had improved considerably, her outlook was much brighter and she was coping well in all aspects of her life. She continued to be well and was able to discontinue anti-depressant medication in the summer of 2000. In July 2001 she presented with further symptoms attributable to depressed mood and her anti-depressant treatment was recommenced. Initially there was a good improvement but following a further dip in mood towards the end of 2001 her treatment was changed. She continued to make a progressive recovery and by July 2003 was noted to be in good form. Her mood was stable and she was very well once again. In view of her past history however the GP was reluctant to stop anti-depressant medication immediately and Madeleine was agreeable to continue treatment. In July 2004 she remained well and was keen to reduce medication with a view to discontinuation.

Despite some personal domestic difficulties, Madeleine remained well throughout 2004 although she continued on the reduced level of medication. However, over the period that the GP was treating Madeleine, he also considered other methods of treatment rather than medication. Cognitive Behavioural Therapy and other supports were offered on a regular basis but Madeleine refused them. The GP viewed Madeleine's depression, for the majority of the time he was treating her, as minor with reactive / situational elements.

On 22 April 2005 Madeleine was eventually referred to the Cognitive Behavioural Therapy service at her own request by the GP. The referral stated that she had an active depressive disorder. She was given an appointment for 27 June 2005 but did not attend as events had overtaken the waiting period and that was in fact the date on which she was discharged from Gransha Hospital.

The GP again assessed Madeleine on 16 May 2005 when she attended with her brother. On this occasion the GP noted a marked change in her demeanour. Her mood was described as very flat with poor eye contact and rapport and it was the GP's view that she was clearly depressed at this time but not actively suicidal. Her medication was increased and the GP suggested that the family might increase input and support. He also agreed to review her in two weeks time or sooner should the need arise.

The GP next assessed Madeleine on 2 June 2005 following her stay in Belfast City Hospital due to a deliberate overdose taken on 18 May 2005. Although her mood remained low and withdrawn at this time, her eye contact had improved and she described regretting the act and denied any further thoughts of self-harm.

The final time the GP saw Madeleine was on 8 June 2005 when he was contacted by her father who advised that Madeleine's Private Counsellor was very concerned about her state of mind. He arranged to see Madeleine at the 'Out of Hours' centre shortly after 6.00 pm that day and at the time of assessment found her to be actively suicidal. The GP was very concerned, particularly as Madeleine had expressed intention to include her daughter in a suicide attempt.

Following assessment the GP contacted the duty SHO at Knockbracken Healthcare Park with a view to admission and Madeleine agreed to be admitted as a voluntary patient. A bed was not available at this time but the GP was told that it was likely that one would be available the next day following the Consultant's ward round. The GP discussed the matter with Madeleine and her father and they all agreed that this would be an acceptable solution. The hospital was to contact Madeleine and her father the following morning with a view to admission as arranged. However, the GP was contacted shortly after lunch time the following day, 9 June 2005, by Madeleine's father, who informed him that he had not yet heard from the hospital regarding Madeleine's admission. The GP then contacted a Consultant Psychiatrist at Knockbracken Healthcare Park by telephone and discussed the situation with him. As a result the Consultant Psychiatrist agreed to see Madeleine that afternoon with a view to admission.

The GP had been treating Madeleine for depression for a number of years, and it was his view in June 2005 that she was now suffering from a

major depressive illness. He expressed this view to the Consultant Psychiatrist during the course of their telephone conversation on 9 June 2005.

The GP surgery was informed by Gransha of her admission and her discharge from Gransha Hospital to an address in Derry but the GP was not aware of her return to the Belfast area.

4.3 Private Counsellor

Madeleine attended an initial assessment session with a Private Counsellor on 26 April 2005. The primary focus in this first session was on Madeleine's marital breakdown and her desire to achieve reconciliation with her husband. An initial contract was entered into at this first session for private individual counselling focused on relationship problems.

Madeleine attended two further relationship counselling sessions in May 2005 and then on 1 June 2005 she attended a further assessment session following her attempted suicide on 18 May 2005. At this session she talked about her goals of moving closer to her family, making new friends and making plans for the future. She also spoke of her regret about upsetting people and about her desire not to leave Lauren. She was very articulate at this session, appeared realistic in her outlook and hopeful about the future.

She did not however make it clear to her Counsellor that she had been on medication for a number of years for depression. Madeleine told the Counsellor that a social worker and a community psychiatric nurse had visited her following her suicide attempt. The Counsellor had the impression from Madeleine that she had ongoing contact with appropriate services and as a result concluded that there was no need to make contact with other services. There was no indication that Madeleine posed a risk to her child. She was calm and articulate at this session and indicated that she wanted to resume relationship counselling and was keen to talk about reconciliation with her husband.

The Counsellor was not aware at this point that she had been mentioned in Belfast City Hospital documentation.

At the 1 June 2005 assessment session, Madeleine also discussed the impact of her suicide attempt on Lauren. Madeleine was concerned about the impact of her actions on her daughter. The Counsellor noted that Madeleine appeared to want Lauren to have a *perfect childhood*.

On 8 June 2005 when Madeleine again attended her Counsellor she was extremely upset and had great difficulty in focusing. The Counsellor was very concerned that Madeleine was having suicidal thoughts and also

that Madeleine made reference to taking Lauren with her. Madeleine's remarks in relation to Lauren had been barely audible and could not be clarified once she had made them, as she was crying and incoherent and would not respond. The Counsellor was very concerned that Madeleine appeared to be at risk of harming herself and was particularly concerned that Lauren might find her mother dead. Madeleine made reference to hanging or cutting herself. She did not indicate a specific plan to harm Lauren.

The Counsellor's primary concern in relation to Lauren at this point was Madeleine's ability to provide daily care for her; she was so concerned that she did not consider it appropriate for Madeleine to leave the session alone and took the view that Madeleine required an emergency referral to psychiatric services. Madeleine informed the Counsellor that her father was waiting for her and gave permission for him to join the session. The Counsellor advised Madeleine's father that additional support and an emergency referral to psychiatric services was required for Madeleine due to concerns about her suicidal ideation and her reference to taking Lauren with her. Madeleine's father agreed to take Madeleine to her GP and, if he was unavailable, directly to Knockbracken Healthcare Park. Madeleine said during the course of this session that she wanted to go into hospital. Madeleine's father assured the Counsellor that he would advise the GP of the reasons for the emergency psychiatric referral including the threat to Lauren.

The Counsellor was aware that Madeleine had a very good relationship with her GP.

Following an unsuccessful attempt to contact Mr Gormley on 9 June 2005, the Counsellor succeeded in making telephone contact with him on 10 June 2005. Mr Gormley informed the Counsellor that he had taken Madeleine directly to her GP and that she had subsequently been admitted to Knockbracken Healthcare Park on 9 June 2005. Madeleine's father also confirmed that the GP had been advised of Madeleine's thoughts of suicide and her reference to taking Lauren with her.

Madeleine attended a further assessment session with her Counsellor on 6 July 2005 at which time she reported a generally improved sense of wellbeing and was calm, clear and articulate. She acknowledged her need for hospitalisation in June 2005 and stated that she had told

hospital staff about her suicidal thoughts and her thoughts of taking Lauren with her. Although her recent hopes for reconciliation with her husband had been dashed, Madeleine felt that she had turned a corner and whilst things might be difficult for a while she could cope. She denied having any current suicidal thoughts, stated that she would never have harmed Lauren and talked about how much she loved her. She spoke of her plans to move house and ask for a transfer in work.

Madeleine's Counsellor was very concerned that she had been included in Hospital Discharge Planning/Documentation both from Belfast City Hospital and Gransha Hospital; she stressed that she had not been consulted in any way about this. She was contacted by both South and East Belfast and Foyle Trusts at a later stage regarding internal investigations into the deaths of Madeleine and Lauren.

4.4 Cognitive Behavioural Therapy, South and East Belfast HSS Trust

As noted previously, Madeleine was referred by her General Practitioner to the Cognitive Behavioural Therapy (CBT) service on 22 April 2005. This referral was an attempt to address her long standing psychological issues. He referenced that Madeleine had an active depressive disorder.

The referral was received by the CBT Service on 9 May 2005. A screening interview appointment for 27 June 2005 was sent to Madeleine on 11 May 2005. The purpose of that interview was to determine her suitability for CBT. Madeleine telephoned the CBT Service on 16 May 2005 to confirm she would be attending her appointment. She did not, however, attend her appointment on 27 June 2005. It was on that day she was discharged from Gransha Hospital.

The records of Belfast City Hospital, Knockbracken and Gransha reflected that there were different levels of awareness of the existence of a CBT referral. There was no evidence that anyone from the three hospitals or the GP had attempted to contact CBT staff to advise them of the change in Madeleine's circumstances.

In discussion with the Panel, CBT staff felt that Madeleine would probably not have been suitable for this service at this time, as she appeared to have too much going on in her life to enable her to engage in any meaningful way.

4.5 Belfast City Hospital

Madeleine was taken by ambulance to the Accident and Emergency Department in Belfast City Hospital on 18 May 2005, having been found unconscious in her bedroom by her mother. She had taken an overdose of various medications and left a suicide note. The diagnosis made by the Consultant Physician in Acute Medicine was that this was a case of deliberate self-poisoning.

The next day, 19 May 2005, a detailed psychiatric assessment of Madeleine was carried out by the Specialist Registrar in General Adult Psychiatry (Specialist Registrar). Madeleine was very tearful, emotional and regretful but very firm in her statement that she would not attempt self-harm again. The Specialist Registrar had the impression that Madeleine had found her recent marital separation overwhelming and stated that she had not seen it coming despite some difficulties. The possibility of admission to hospital as a voluntary patient to allow further assessment and for her to get away from the immediate causes of stress was discussed with Madeleine. However, she declined this suggestion. A collateral history was taken by the Specialist Registrar from Madeleine's mother who gave details of her recent marital difficulties. The Specialist Registrar also contacted Madeleine's GP who gave details of her ongoing history of depression. In view of the fact that Madeleine stated that the overdose had been impulsive and that she had no further thoughts of self-harm, it was the view of staff that she could not be detained. Her family were clearly supportive and she was willing to engage with Community Services. However, the Specialist Registrar was concerned about the seriousness of Madeleine's suicide attempt and was also concerned that her thought content included the effect that her suicide would have on the other members of the family. In the course of her assessment the Specialist Registrar did ask Madeleine if she had thought of harming Lauren, a question she would routinely ask where a parent with dependent children has attempted suicide. Madeleine said that *she would never hurt her*.

Accordingly, following her assessment, the Specialist Registrar established a clear care plan which included: -

- Referral to the Crisis Response Team (CRT) by the Specialist Registrar herself

- Referral to the Hospital Social Worker for the Social Worker to organise an urgent referral to the Family and Child Care Initial Assessment Team, (FCC IAT), South and East Belfast HSS Trust.

The Specialist Registrar did not include the more concerning aspects of Madeleine's suicidal ideation in the summary letter to the admitting Consultant Physician in Acute Medicine, as this would be a document which would be generally accessible on the ward. Madeleine had no previous history of self-harm, there was no suggestion that she had made threats against Lauren or sought to harm her previously, and the collateral history from Madeleine's mother suggested no concerns with regard to the care of Lauren, which led the Specialist Registrar to believe that it was reasonable not to include any of this thought content in a record that had wider circulation. She recognised with hindsight however that it was possible to see that these were significant thoughts and comments and that it would be helpful to examine how such information could be passed on to other mental health professionals (e.g., GP, CRT, Knockbracken) in future given the systems for sharing information that existed. However, the CRT referral makes it clear that the Specialist Registrar did mention Madeleine's concerns about losing her daughter, i.e. Lauren being taken away from her in the context of her overdose and separation from her husband. CRT was also informed of the referral to FCC IAT by the Specialist Registrar.

Madeleine was also seen and assessed by the Hospital Social Worker on 19 May 2005. Again Madeleine's marital difficulties and her recent separation from her husband were identified as significant stress factors relating to her depression. Both the Social Worker and the Specialist Registrar recorded that Madeleine also spoke about her experience of childhood sexual abuse in the context of her history of depression. The Social Worker has a clear record of a telephone conversation on 19 May 2005 with the Specialist Registrar in which parenting issues are explicitly discussed (i.e., no concerns regarding either parent's capacity to parent and no indication that Madeleine intended any harm to Lauren). The records of both the Specialist Registrar and the Social Worker provide evidence of a prompt multidisciplinary response to the issues surrounding Madeleine's imminent discharge from BCH.

Following assessment the Specialist Registrar discussed the case with the Consultant Psychiatrist. A written referral which was described as *High Priority* was made by the Hospital Social Worker to the Family and Child Care Initial Assessment Team and Madeleine was provided with contact details for relevant support groups. The referral from the Hospital Social Worker did not make reference to the Specialist Registrar's referral to CRT. The line for 'Level of urgency' on the 'Referral from Hospital' completed by the Hospital Social Worker on 19 May 2005 is clearly marked as *High*. Madeleine was discharged from Belfast City Hospital that same day, 19 May 2005.

4.6 Crisis Response Team, South and East Belfast HSS Trust

Madeleine was referred to the Crisis Response Team by the Specialist Registrar following her psychiatric assessment at Belfast City Hospital. Information regarding her recent overdose was conveyed to the team at the time of referral. Two team members visited Madeleine at her home the next day, 20 May 2005. The team carried out a Risk Assessment of Madeleine and following discussion it was decided that at that time she did not present a high risk to herself. Information was taken from Madeleine only at this time. Madeleine's parents were present in the house at the time of the visit but the team members did not speak to them.

The team members did not have any concerns with regard to Lauren's wellbeing at this time and did not think of her as a child in need as Madeleine did not give them any cause for concern in this respect. It was felt that her overdose was a result of a build up of pressures, particularly with regard to her marital situation. She appeared to team members to be very remorseful about her overdose and did not appear to want any further support from them.

Following this visit the Crisis Response Team closed the case and Madeleine was referred on to a Consultant Psychiatrist at Knockbracken Healthcare Park for an out-patient appointment as requested in the referral from the Specialist Registrar in Belfast City Hospital. This was regarded as a routine, rather than an urgent, referral. Madeleine's GP was advised of this referral by letter dated 24 May 2005 by the Crisis Response Team.

4.7 Family and Child Care Initial Assessment Team, South and East Belfast HSS Trust

Madeleine was first contacted by the Social Worker from FCC IAT on 6 June 2005 to check if she still required assistance. This was confirmed and the Social Worker visited Madeleine at her home on 7 June 2005. Madeleine's father was present in the house at the time of the visit but the Social Worker did not speak to him. The referral to the Initial Assessment Team had been made by the Social Worker at Belfast City Hospital at the request of the Specialist Registrar following Madeleine's assessment there on 19 May 2005. The referral was clearly marked with a *High* level of urgency. The referral notes the intentional overdose, a link to Madeleine's recent separation and her request for information about additional support. The referral does not indicate that Madeleine was also referred to the Crisis Response Team.

In situations where a child of Lauren's age is involved, it is the normal practice in line with the protocol operated by Belfast City Hospital, that this type of referral would come to the Initial Assessment Team.

Although marked *High Priority* it was not considered an urgent referral as it appeared to be a referral for family support and the length of time between referral and assessment would be fairly normal. On the basis of the information available to the team member it was not considered necessary to contact Madeleine's GP.

During the course of the interview the team member discussed with Madeleine the range of services she had received or was offered. She understood from Madeleine that she had been referred to the Cognitive Behavioural Therapy Team and was seeing a Private Counsellor. She was also aware of Madeleine's ongoing visits to her GP. Madeleine was very open about her problems and discussed the range of support she had, particularly within her own family. Madeleine did not identify any further services which she felt she might require at this time.

Overall the team member was left with the impression that Madeleine was a person who had taken an overdose as a desperate response to the pressures caused by her marriage breakdown. However, she seemed to have very good family support and good friends and was now moving on, in that she was coping with day to day issues and had made

arrangements to sell her house in Belfast and move with Lauren to the Strabane locality.

The team member felt that Madeleine was on the road to recovery and did not feel any need to make contact with Mr O'Neill at this time. It was also not felt necessary to consider the needs of Madeleine's parents as carers, as it was felt that any such need would have been identified through the hospital. It was the view that Madeleine's parents were there for her as an emotional support within the home setting.

The Social Worker discussed Lauren's needs with Madeleine in terms of health, contact with Lauren's father, and Madeleine's capacity to overcome her mental health issues as a result of her separation.

The case was discussed in supervision with a Principal Social Worker on 29 June 2005 when the decision was taken to close the case as Madeleine appeared *to be moving forward with her life despite a very difficult past.*

4.8 Knockbracken Healthcare Park, Belfast

When Madeleine's Private Counsellor became aware of the extent of her illness and of the threat to Lauren on 8 June 2005 she immediately alerted Madeleine's father who took her to her GP. When the GP assessed Madeleine he found her to be actively suicidal and was very concerned particularly at the possibility that she would include Lauren in a suicide attempt. He contacted the duty SHO at Knockbracken Healthcare Park with a view to admission and Madeleine agreed to be admitted as a voluntary patient.

A bed was not immediately available but the GP was informed that it was likely that one would be available the next day following the Consultant's ward round. He discussed the matter with Madeleine and her father and it was agreed that this would be an acceptable solution. As far as the GP was concerned Madeleine and her father were due to be contacted by the hospital the following morning with a view to admission.

However, the GP was contacted after lunch on the next day by Madeleine's father who informed him that he had not yet heard from the hospital regarding Madeleine's admission. The GP contacted the Consultant Psychiatrist at Knockbracken by telephone and he agreed to see Madeleine that afternoon with a view to admission.

On arrival at Knockbracken, Madeleine was assessed by the SHO assigned to the Consultant Psychiatrist who had been contacted by the GP. The SHO saw the GP's referral letter but did not speak to him directly. The SHO's assessment involved taking a history from Madeleine and examining her mental state. The SHO believed that Madeleine should be admitted because of her clinical depression, her thoughts of suicide and her thoughts of taking Lauren with her. The SHO noted that Madeleine had accessed internet suicide sites. The actual decision to admit Madeleine was taken by the Consultant Psychiatrist.

Following assessment Madeleine was placed on general observation in Knockbracken, which meant that she was routinely checked every hour between 7.30 am and 10.00 pm and every half hour from 10.00 pm until 7.30 am. In addition all new admissions are nursed in the main Admission Bay of the Ward which has a higher concentration of staff and

which is in close proximity to the nursing station. Madeleine had free movement within the ward environment.

Staff were aware of the threat to Lauren during Madeleine's stay at Knockbracken but no protective measures were put in place as Lauren was always accompanied by at least one adult on her visits to the ward.

The possibility of moving to Gransha Hospital was discussed on the day of Madeleine's admission. The Consultant Psychiatrist, the SHO and Madeleine's father were all present during the course of this discussion.

It was agreed that it would be appropriate for Madeleine to move to Gransha Hospital as she had a number of plans in place including the purchase of a home in the Strabane locality near her sister, the transfer of Lauren to a school in Strabane and a proposal to obtain a transfer in her work. It was also the view that she would have more continuous support there from her family members once she moved from hospital into the community. A further factor which influenced the decision at this time was that if Madeleine was to move it would be better to do so at an early stage so that she could have hospital treatment and then be discharged into the community within the same locality where she would then have her outpatient treatment.

Following this the Consultant Psychiatrist in Knockbracken telephoned a Consultant Psychiatrist in Gransha Hospital on 10 June 2005 in an endeavour to have Madeleine accepted as a patient there. He recalls that he informed his counterpart in Gransha Hospital of Madeleine's intention to move to the Strabane area and of plans for Lauren to go to school there. He also recalls that he described Madeleine's clinical condition and the risk of suicide but does not recall if he made any mention of a risk to Lauren. Later that day in a further telephone conversation the Consultant Psychiatrist at Gransha Hospital agreed to accept Madeleine as a patient, although a bed was not available on that particular date. The Consultant Psychiatrist at Knockbracken was left with the impression that a bed would be found for Madeleine in Gransha Hospital early the following week.

The Consultant Psychiatrist at Knockbracken was of the view that Madeleine was capable of making rational decisions at this time. She had come into hospital as a voluntary patient and her behaviour

demonstrated that she was willing to engage in treatment which meant that staff did not consider formally detaining her. However, the Consultant Psychiatrist confirmed that if a bed had not been found in Gransha Hospital at this time and if Madeleine had asked to leave hospital, he would definitely have detained her on a compulsory basis for assessment. The interim plan for Madeleine whilst she was awaiting the move to Gransha Hospital was to continue on her current antidepressant medication.

On 13 June 2005 the Consultant Psychiatrist at Knockbracken again made telephone contact with his counterpart at Gransha Hospital and it was agreed that Madeleine could be transferred the next day. Madeleine left Knockbracken on the afternoon of 14 June 2005 and was taken by car by her father and mother to Gransha Hospital. Prior to leaving Knockbracken, staff are quite clear that a copy of Madeleine's notes were placed in an envelope and handed directly to Madeleine's father, who was asked to hand them over to staff when they arrived at Gransha Hospital. Madeleine's father is equally clear that he did not receive any documentation at Knockbracken and so did not and could not have handed over any documentation when he arrived at Gransha Hospital.

4.9 Gransha Hospital, Londonderry

Initially there appears to have been an assumption that Madeleine would be under the care of the Consultant Psychiatrist who had accepted her transfer from Knockbracken, as he covered the Strabane locality to which Madeleine would be moving on her discharge from hospital. However, on her arrival at Gransha Hospital on 14 June 2005 it became clear that Madeleine would in fact be residing at her parent's home on the Cityside of Londonderry for some time after discharge and so the decision was taken to transfer her care to the Consultant Psychiatrist who covered the Cityside. Another factor in reaching this decision was that the Consultant Psychiatrist who had initially accepted Madeleine as a patient was due to go on leave a few days later, on 16 June 2005.

Decisions regarding the placement of patients within the hospital are usually based on geographical considerations, i.e., where the patient will be living on discharge. This is designed to facilitate any community follow up of services which may be required.

On arrival at Gransha the family members were met by the Ward Manager, Clinic B, and the admitting nurse. A nursing assessment was carried out. The on-call SHO who carried out the initial medical assessment of Madeleine was coincidentally a member of the team covering the Strabane patch at that time. It was his view that as a patient Madeleine seemed very intelligent and compliant; information on medication was based on what she told him at that time but he could not recall if Madeleine showed him actual medication. When interviewed the SHO was not sure if there was a transfer letter at that time, nor could he recall if he checked back with Knockbracken regarding medication. In normal circumstances if there were difficulties with a patient he would contact the GP who referred her or if relatives or parents were on hand he would discuss the matter with them, but in Madeleine's case she seemed extremely co-operative, reasonable and knowledgeable about her medication.

This on-call SHO does not recall if the Consultant Psychiatrist who had accepted her transfer was present at the time of Madeleine's admission or if he discussed the case with him. When the on-call SHO arrived on the ward on the evening of Madeleine's admission he was told that a patient had presented for admission from Knockbracken. There were no

Knockbracken notes available to the admitting SHO. With hindsight he felt that he had inadequate information about the patient and believed that if previous notes had been available they would have helped him greatly.

The on-call SHO did not see Lauren at any stage nor was he aware of any threats to her and so in the circumstances he had no reason to consider her a child in need. Overall, at the time of assessment, Madeleine seemed to him *a relatively normal case* and so, following discussion with nursing staff, he recommended general ward observation.

Madeleine was seen briefly by the accepting Consultant Psychiatrist at the end of his ward round on 15 June 2005, the day after her admission. At this time he explained to her that she would in fact be under the care of the Consultant Psychiatrist heading the Cityside team. The Cityside Consultant Psychiatrist said that he had been informed by the accepting Consultant Psychiatrist that Madeleine was depressed and passing through a crisis but that she was now recovering. He also understood that she was buying a house in Strabane and would be moving there after a period of rehabilitation. As such he felt that her move to Gransha Hospital was in many ways for social reasons and he was happy to welcome her as a patient. He was also informed at this stage of Madeleine's previous overdose but there was no mention of any possible threat to Lauren. Neither the accepting Consultant Psychiatrist at Gransha nor the Cityside Consultant Psychiatrist had access to the Knockbracken notes either at the point of admission or during Madeleine's in-patient stay. The Cityside Consultant Psychiatrist was also not aware that Madeleine had researched Internet sites dealing with suicide.

The Cityside Consultant Psychiatrist stated that he believed that Madeleine's diagnosis at this time was either a major or moderate depressive episode with somatic syndrome (ICD / 10 Diagnosis Category F32.11) associated with her marital situation. He did not think that this was recurrent. He agreed that Madeleine required hospitalisation at that period to help her to readjust to her changed life circumstances. It was also his view that she was not psychotic. Her overdose had not been a planned act in that she had taken it at a time when her parents were in the house and when she might subsequently be discovered. She was positive and was making plans for her new life. As far as he was aware

Madeleine's sister was looking after Lauren whilst Madeleine was in hospital and when Madeleine eventually requested discharge it was understood it was to enable her to go back to Belfast to complete the sale of her house.

Madeleine was allocated to the care of the Cityside team following her assessment and admission. The Cityside SHO felt that she was capable of making rational decisions at this time because of the plans she was making and because of her apparent optimism about the future. It was not felt that her condition warranted detention and the issue was never discussed. Initially Madeleine was very private and quiet but over time she became more outgoing and felt good on her return from two periods of weekend leave.

During the course of Madeleine's stay in Gransha Hospital there is no evidence that staff had any discussion with her family nor did they actively seek any notes from Knockbracken.

Madeleine's discharge from Gransha Hospital on 27 June 2005 was at her own request and this was discussed by the Cityside Consultant Psychiatrist, the SHO and nursing staff. Following these discussions her request was granted on the basis that she was making continuous progress and making rational plans for the future. When a patient is being discharged from Gransha Hospital it is normal for contact to be made with the family but this did not happen in this case.

The medical staff stated that there was no evidence available to them which would have warranted Madeleine's compulsory detention for assessment or treatment.

She was offered an outpatient appointment with her Consultant Psychiatrist for four weeks after her discharge, as she wanted to complete the sale of her house in Belfast. At the time of her discharge she was offered Community Nurse support and day hospital treatment but she preferred to continue her sessions with her Private Counsellor.

Following Madeleine's discharge an initial hand written discharge summary was completed by the Cityside SHO on 3 July 2005 and forwarded to her GP in Belfast.

On 7 July 2005 the SHO took Madeleine's file from Gransha Hospital to the Cityside Community Mental Health Team offices in line with the protocol in place at that time. On 14 July 2005 when news of the deaths of Madeleine and Lauren was received the file was retrieved in the Cityside Community Mental Health Team offices and when opened was found to contain the copied notes from Knockbracken.

As part of Foyle Trust's investigation into the death of Madeleine O'Neill it attempted to determine how these notes had been placed in the file but, despite an intensive inquiry and interviewing all relevant staff, was unable to reach any satisfactory conclusion. The Independent Inquiry Panel also looked at this matter in detail, including in-depth interviews of Knockbracken and Gransha Hospital staff, but again was unable to reach any definite conclusion as to how or by whom the notes had been placed in the file, but recognises that the Coroner's Inquiry through the PSNI may elicit this information.

The Independent Inquiry Panel found no evidence of any event which additionally impacted on Madeleine's mental health subsequent to her discharge from hospital.

5. LAUREN O'NEILL – LIFE PATHWAY

It is important that the Independent Inquiry into the deaths of Madeleine and Lauren O'Neill places appropriate emphasis on the life of Lauren O'Neill. It is also important that it examines any involvement statutory agencies may have had with Lauren. Section 10 of 'Co-operating to Safeguard Children' suggests that any inquiry should review assessments undertaken, services offered to the child, services provided to the child and any other actions taken.

During the course of this Inquiry the Panel found that Lauren O'Neill was a normal, healthy, happy child cared for by loving parents. Her life events took a normal course until her mother's mental health had such a devastating impact.

Lauren was born in the Jubilee Maternity Hospital on 5 February 1996 to Madeleine and John, both civil servants. Lauren was born at thirty nine weeks gestation following a planned caesarean section, and weighed 3060 grams(25th centile) at birth.

Health Visiting records for Lauren between her birth and 10 March 2000 indicate a normal healthy child who was meeting all her milestones with all assessments recording satisfactory progress. Records refer to Lauren *sleeping and feeding well, of evidence of books and nursery rhymes and evidence of good progress and stimulation*. GP records relating to Lauren paint a similar picture of a normal healthy childhood with nothing of concern to report.

Lauren began Primary school in Belfast in September 2000. School Health records indicate normal child development with the health appraisal outcome carried out by School Nursing on 15 March 2001 recorded as satisfactory. Lauren enjoyed school and seemed particularly interested in art and poetry. She was also talented musically, singing in the school choir and learning to play the piano. There were no issues of note relating to Lauren's presentation or attendance at school. Lauren left the Belfast Primary school two weeks before the end of the school year in June 2005 and attended a local primary school in Strabane in preparation for her move there in the new school year.

During the period of Mr and Mrs O'Neill's separation from March 2005, Lauren continued to live with her mother, however Mr O'Neill continued to play a significant caring role with Lauren, sharing things such as the school run, homeworks, weekends and overnights. All significant family members report no issues relating to the arrangements for Lauren at this time.

Following the marital breakdown Mr and Mrs Gormley, Lauren's maternal grandparents, continued to offer high levels of support to their daughter. When Madeleine first attempted to take her own life with an overdose on 18 May 2005 her parents were staying with her at the time. They continued to provide this support to Madeleine and Lauren during the next three weeks, at times commuting between their home in Derry and Madeleine's home in Belfast. They were present in the family home during visits from the Crisis Response Team and a member of the Family and Childcare Initial Assessment Team although they were not involved in any discussions during these visits. The quality of the social work assessment of Lauren's needs is dealt with elsewhere in this report. Madeleine's parents were staying with her when she was admitted to hospital on 9 June 2005.

At the time of Madeleine's hospitalisation in Knockbracken Lauren stayed full time with her father, who continued to try to keep life as normal as possible for her in terms of attending school and other activities. When Madeleine moved to Gransha Hospital on 14 June 2005, Lauren then moved to stay with a maternal aunt in Strabane, to be close to her mother in hospital and to facilitate her introduction to the local primary school in the last two weeks of term. When Madeleine was discharged from Gransha Hospital on 27 June she was reunited with her daughter at the maternal grandparents' home. Madeleine and Lauren returned to their home in Belfast on 10 July 2005, two days before Lauren's death.

The Inquiry Panel found nothing of concern relating to the development or parenting of Lauren O'Neill during her short life. She was obviously much loved by both her parents and the wider family circle, all of whom were keen to help out at the time of her parents' separation. During her mother's most recent illness and subsequent hospitalisation all care arrangements for Lauren were based on planning for the future, where Lauren would live with her mother and go to school in Strabane, but continue to have significant contact with her father.

6. MAJOR ISSUES

6.1 Communication

Throughout our inquiry the issue of Communication has emerged as a common theme in a number of different contexts, some of which we set out below as particular examples: -

6.1.1 Multidisciplinary Professionals

There is evidence to suggest poor communication between the acute sector and primary care in relation to Madeleine's treatment. There is no evidence to suggest co-ordination of Madeleine's care between the various agencies involved: -

- Madeleine's GP was not informed that a bed had not been found for her on the morning of 9 June 2005 until Mr Gormley contacted him at lunch time that day.
- CBT service was not aware of Madeleine's admission to Knockbracken.
- FCC IAT was not aware of Madeleine's referral to Crisis Response Team.
- Madeleine's GP was not personally aware of her transfer to Gransha.

It is the Panel's view that the identification of a key/link worker to co-ordinate cases between acute and primary care and to encourage more effective collaboration between professionals would benefit parents who suffer from mental illness and their children.

There is also evidence of poor communication in both Knockbracken and Gransha hospitals between different professionals involved in Madeleine's care. While some nurses report on discussions between nursing and medical staff, this does not seem to have been done in a systematic and structured way. While many staff in Gransha referred to multidisciplinary ward rounds, there was very little evidence of these and an absence of any documentation, minutes or even decisions and actions associated with these. As a result it was difficult to ascertain who knew what and when. There is no evidence of either Knockbracken or Gransha involving social work personnel in multidisciplinary discussions about

Madeleine. There is little evidence of professionals communicating in a systematic way. There is in fact evidence of professionals working contrary to one another; for example, allowing Madeleine assigned leave which clashed with an occupational therapy assessment meeting in Gransha Hospital. The fact that the Occupational Therapy Department had been unable to complete an assessment on the patient had never been shared with any other members of the team. There was some suggestion from KHCP staff that multidisciplinary discussion involving the social worker would have taken place on Thursday morning at the multidisciplinary ward round, had the patient remained in their care. This however suggests that multidisciplinary working is viewed as something that only happens at a formal meeting or on ward rounds, rather than something which is embedded into the everyday work practices and culture of the team. Throughout the patient's stay in hospital there is no evidence of a 'joined up' 'holistic' approach by the multidisciplinary teams in either hospital.

This contrasts sharply with the communication between professionals within BCH which was generally timely and effective. The GP was also contacted. Information which was in the Specialist Registrar's notes regarding Madeleine's suicidal ideation and her thoughts and concerns about family members has already been highlighted. A hindsight test does have to be applied in this case as it is difficult to see how the Specialist Registrar could have reasonably placed more weight on what Madeleine had said. The actions of the Specialist Registrar and the Hospital Social Worker demonstrate the seriousness they attached to Madeleine's suicide attempt and her ideation. The Specialist Registrar has agreed on reflection that it probably would have been better if her notes had been copied to the Crisis Response Team although this would not have been normal practice. Equally it would have been helpful if Madeleine's GP and Knockbracken had access to this information but systems did not really exist to allow easy information sharing. Taken from another perspective neither Knockbracken nor Gransha in their assessments sought additional information from BCH and such action would have greatly assisted their understanding of Madeleine's condition.

The Hospital Social Worker at BCH did not include in her referral to FCC IAT that Madeleine had also been referred to CRT. Had she done so the FCC IAT Social Worker or her supervisor might have considered liaising with CRT. Both the CRT and FCC IAT acted in a completely independent

manner and did not consult with any other professional agency which contributed to the poor standard of assessment in both cases.

The interviews with the Cognitive Behavioural Therapy Service and other staff highlighted that there is a need to generate a better understanding of the role and function of CBT and when it is appropriate. There were communication issues which were similar to those relating to the Private Counsellor, where CBT was included in plans without reference to the service or a critical analysis being made of the appropriateness of this form of treatment once Madeleine had attempted suicide.

RECOMMENDATION 1:

Belfast City Hospital, South and East Belfast Trust and Foyle Trust should review their arrangements for multidisciplinary working and information sharing focusing on: -

- **roles**
- **the nature of services**
- **treatments and interventions**
- **structures**
- **accurate targeting of referrals**
- **formal and informal processes**
- **internal and external communication**
- **recording of information**
- **case co-ordination/key working**
- **training**
- **unit / professional culture**

6.1.2 Admission to the Hospitals

Knockbracken Healthcare Park

When the GP contacted the SHO on call in Knockbracken Healthcare Park on 8 June 2005 he was told that unfortunately no bed was available for the patient but that she would be placed on a waiting list overnight and contacted the next day. Subsequent enquiries by the panel however in relation to the bed state at that time have revealed that there were in

fact two pass * beds in the hospital that evening. It is not clear if the SHO was up to date with the bed situation in the hospital or if there was a robust bed management system in place in the hospital for managing such requests. Following the request for admission there was an expectation from the GP and the patient's carer that Madeleine would be contacted the next day. This however did not happen and the GP made a second request to the hospital when the patient and her family made contact with him on 9 June 2005. This chain of events would indicate that within the hospital there was no robust waiting list management and no clear protocol for ensuring that the patient's needs were to the forefront of the staff's actions the next day as arranged. The fact that the patient was not contacted the next day highlights a risk that a seriously ill patient might not receive treatment he/she clearly needed.

There is evidence of good communication between the admitting SHO in Knockbracken and the admitting Consultant Psychiatrist. In Knockbracken the SHO meticulously shared all her notes, observations and information with the Consultant, who then made a diagnosis of *severe depression* and admitted the patient to hospital. The Consultant also had good written and verbal communication from the GP.

RECOMMENDATION 2:

South and East Belfast Trust should review its arrangements for admitting patients for in-patient care, with particular reference to a daily waiting list management and bed management system and an ongoing contact system with patients and their carers when beds are not available. There is a need to ensure that systems are in place within Knockbracken which track a request for admission and assist in the management of risk and patients until a bed is allocated.

*'Pass Beds' are beds already allocated to patients who are receiving treatment in a ward and who, as part of their care plan, are on home trial. Some pass beds cannot be used as the patient may require to return to hospital if their mental health deteriorates.

Gransha Hospital

In relation to the admission process at Gransha Hospital the SHO who assessed Madeleine had no information from any source other than the patient. No information from the assessment process was shared with the accepting Consultant at the point of admission or at any time after that. At the time of admission the SHO believed that the Consultant had good reason to admit and never queried why. This raises a significant issue of supervision of junior staff which we shall return to later.

RECOMMENDATION 3:

Foyle Trust should review its arrangements for admitting patients for in-patient care to Gransha to ensure in particular that SHOs obtain all relevant background information from the referring GP or hospital and collateral information from the patient's family, as far as is practical, on the day of admission.

6.1.3 Consultant to Consultant

There are clear differences in recollection between the Consultant Psychiatrists in Knockbracken and in Gransha about what information was shared when a bed was being sought for Madeleine in Gransha Hospital. Whilst some information relating to previous history and diagnosis was shared, it is the Panel's view that no information about threats to Lauren was given.

The Consultant Psychiatrist at Gransha Hospital is adamant that no mention was made of any potential risk to the child during telephone conversations.

This situation was exacerbated by the fact that neither Consultant made a note of the two conversations. The accepting Consultant at Gransha did not communicate with the admitting SHO and the SHO therefore did not know why the Consultant was admitting the patient. The SHO was

therefore unaware of Madeleine's previous history, diagnosis, the threat to herself and of course the threat to her child. One tragic consequence of all this was that the initial diagnosis of *severe depression* was not communicated to the Gransha staff and a diagnosis of *situational crisis* was recorded by the SHO. This then set hospital staff on a pathway of treatment and care planning not in keeping with the patient's needs or actual condition. This indicates a failure of Consultant leadership in Gransha Hospital in the form of written diagnosis and treatment plan. In essence, there was an absence of meaningful oral or written communication between the Consultant who agreed to accept the patient to Gransha Hospital and the Consultant under whose care she was subsequently placed. *

6.1.4 Hospital to Hospital

Madeleine moved from Knockbracken to Gransha Hospital on 14 June 2005. While Knockbracken endeavoured to ensure that the correct information went with the patient, the process of sending copies of the patient's notes with the patient and her relatives is inherently flawed. Firstly, the patient's parents dispute the hospital's account of the transfer of documentation and the Inquiry team was unable to resolve the contradictory views. Secondly, unsecured transport of a patient's information does not comply with data protection provisions. Thirdly, it is unreasonable to place responsibility for taking the patient's notes from one hospital to another on either an ill patient or their carers at a stressful time. It is also questionable practice given that the notes contained both relevant and sensitive information about the patient. Whilst a member of nursing staff at Knockbracken telephoned Gransha to confirm that a bed was still available and advised that the patient was on her way in the care of her parents, there was no contact between the two hospitals to confirm safe arrival of the patient or the notes. The staff admitting the patient to Gransha are clear that they did not have access to the patient's notes from Knockbracken. However it is incumbent upon the professional staff admitting a patient and starting an assessment process to seek information from the referring hospital. One professional suggested at interview that it would have been a breach of confidentiality to seek information from the previous hospital. This indicates a significant lack of understanding of the crucial role played by good communication and information gathering in assessing and treating the patient. *

* See Recommendations later in this Report in the section headed: 'Inter Hospital Transfer of Patients and their Records'.

6.1.5 Between Professionals and the Family

There is little evidence of systematic communication with the patient's family in either Knockbracken or Gransha hospital although some collateral history was taken at the time of Madeleine's admission to Knockbracken. In Gransha Hospital there is no evidence of involving the family in discussions about home leave or day visits. In addition, staff in Gransha Hospital failed to get collateral history, a description of pre-morbid personality and level of functioning during her two periods of leave from Gransha. Neither is there evidence of involving the family in discharge planning or future care arrangements. There is no evidence of involving Madeleine's husband in discussions about the impact of her illness on her ability to share in the care arrangements for Lauren, or about the potential impact of her mother's illness on Lauren. There is no evidence that anyone considered sharing information regarding the threat to the child with the child's father and as a result the father, the main carer of the child at that time, was given no opportunity to protect his child from very real danger.

RECOMMENDATION 4:

The DHSSPS and the Boards should instruct Trusts to draw up and implement policies regarding consultation by staff with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

6.1.6 Crisis Response Team / Home Treatment Service

The introduction of Crisis Response Teams and Home Treatment services is to be welcomed as an alternative to hospital admission in some cases and as a means to provide a more flexible and responsive service to those who suffer from mental health problems.

The Bamford Report – 'A Vision of a Comprehensive Child and Adolescent Mental Health Service (July 2006)' - would suggest a need to expand the range of services and support available in the community in

order to engage users and support carers as part of the philosophy of care.

It would seem that Trusts are at different stages in introducing these alternative approaches. A number of models have been adopted at locality level and it is not therefore possible to recommend one particular approach. It is however vital that there is a clear understanding of roles and responsibilities both within the service and with the public in general. In situations where a Home Treatment Service is integrated with a Crisis Response Team the remit of each service needs to be clear as does the role of the Community Mental Health Team.

Those making and receiving referrals must be aware of the need to provide all relevant information. Consideration should be given to the need to contact other relevant professionals, e.g. keyworker / GP / Consultant, so that a full history can be made available as part of any assessment.

In the case of Madeleine, a psychiatric assessment at BCH outlined the need for further follow-up. It is clear that the nature of this follow-up indicated the need for more than a crisis visit; the input felt to be necessary included monitoring and support for Madeleine, encouraging compliance with medication and facilitating contact with other relevant agencies.

RECOMMENDATION 5:

- **Trusts should ensure that there is clarity in the role and function of Crisis Response Teams, Home Treatment Services and Community Mental Health Teams.**

RECOMMENDATION 6:

- **Trusts should ensure that there are sound arrangements for clinical supervision within Community Teams in general and specialist advice/support in Community Home Treatment and**

Crisis Response Team services. In constructing these arrangements Trusts should be aware that increasing specialisation of services is likely to make it more difficult for individual practitioners to fulfil a keyworking / co-ordinating role across a care plan.

RECOMMENDATION 7:

- **Trusts should ensure that protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient.**

6.1.7 Overview

This whole section has highlighted a significant problem of communication in the events which are the subject of this inquiry. It is also disturbing to note that this is a recurring theme in virtually all similar published inquiries in Great Britain and Northern Ireland in recent decades. The Panel has discovered clear evidence of professionals making assumptions about what others knew or that others would pick up issues both from mental health and child protection perspectives. In some instances, for example in the telephone conversations between the two Consultant Psychiatrists at Knockbracken and Gransha Hospital, information conveyed about Madeleine's medical diagnosis and condition was not recorded by either Consultant, and in the Gransha Hospital situation no information was therefore available for the admitting SHO's initial assessment of Madeleine.

This contrasts sharply with both Belfast City Hospital and the GP. At Belfast City Hospital both the Specialist Registrar and the Hospital Social Worker spoke to Madeleine's mother as part of their assessment. Unfortunately this same standard of practice was not carried forward into

the community where both CRT and FCC IAT failed to speak to Madeleine's parents even when they were present for the one-off visits of both teams. The GP was both clear and diligent in his communication with Knockbracken. He ensured that important information in relation to Madeleine and Lauren was shared with appropriate urgency. The GP demonstrated a high standard of advocacy for his patient in following up the allocation of a bed.

It can only be concluded that neither Madeleine nor her daughter Lauren were well served by the communication process between professionals, between the two psychiatric hospitals where Madeleine was an in-patient in June 2005, or between professionals and relatives. Had this communication process been better and up to the professional standards patients and relatives are entitled to expect, it is possible that the deaths of Madeleine and Lauren could have been prevented.

6.2 Child Protection / Children in Need

The respective duties and legal responsibilities for HSS Boards and Trusts for children are set out in The Children (NI) Order 1995 and its associated Regulations and Guidance. The Trust's specific legal duties for children are defined by Part IV of The Children Order for children in need and Parts V and VI for the protection of children.

In May 2003 the DHSSPS issued guidance 'Co-operating to Safeguard Children'. This guidance replaced previous guidance 'Co-operating to Protect Children' which was issued in November 1996 as Volume 6 of the Regulations and Guidance to the Children Order.

The stated purpose of the guidance was to *assist the Area Child Protection Committees (ACPCs) to develop strategies, policies and procedures to safeguard children assessed to be at risk of significant harm.*

Section 1.13 of 'Co-operating to Safeguard Children' identified a number of key principles which are fundamental to the protection of children. The first four principles are of particular relevance to this inquiry: -

- *The child's welfare must always be paramount and this overrides all other considerations.*
- *A proper balance must be struck between protecting children and respecting the rights and needs of parents and families; but where there is a conflict, the child's interests are paramount.*
- *Children have the right to be heard, to be listened to and to be taken seriously. Taking account of their age and understanding they should be consulted and involved in all matters and decisions which may affect their lives.*
- *Parents/carers have a right to respect and should be consulted and involved in matters which concern their families.*

Sections 1.14, 1.15 and 1.16 of 'Co-operating to Safeguard Children' refer to the *shared responsibility* of everyone involved with the child including parents and professionals: -

- *Primary responsibility for safeguarding children rests with their parents, who should ensure that children are safe from danger in the home and free from risk from others. Some parents cannot always ensure this degree of safety and it may be necessary for statutory agencies to interfere to ensure that the child is adequately protected.*
- *Safeguarding children depends upon effective information sharing, collaboration and understanding between families, agencies and professionals. Constructive relationships between individual workers and agencies need to be supported by senior management in each agency.*
- *For those children who are suffering, or who are at risk of suffering significant harm, multidisciplinary/agency working is essential to safeguard them. The staff of all agencies should:*
 -
 - *Be alert to potential indicators of abuse, neglect or failure to thrive;*
 - *Be alert to the risks which individual abusers, or potential abusers, may pose to children;*
 - *Share, and help to analyse information so that informed assessments can be made of each child's needs and circumstances;*
 - *Contribute to whatever actions are required to safeguard the individual child and promote his welfare;*
 - *Regularly review the outcomes for the child against specific shared objectives; and*

- *Work in co-operation with parents, unless this is inconsistent with safeguarding the child.*

Section 3.7 of 'Co-operating to Safeguard Children' has also particular relevance to this inquiry. This section refers to the concept of children in need: -

- *Trusts have a general duty to safeguard and promote the welfare of children which should be fulfilled by social services staff providing directly or arranging for others to provide, services designed to meet children's assessed need. Provided it is consistent with the child's welfare and safety, these services should enable parents to bring up their own children. The planning and provision of these services should be done in partnership with parents, taking into account the child's age, gender, stage of development, religion, culture, language and race.*

Following on from the DHSSPS Guidance 'Co-operating to Safeguard Children', in March 2005 the four Area Child Protection Committees issued a new and uniform set of regional policies and procedures. The policies and procedures incorporated the learning from the Victoria Climbié Inquiry Report (2003), the DHSSPS Multi-Professional Audit (2003), the Independent Review Report into the case of David and Samuel Briggs (2003) and the Bichard Inquiry (2004).

The new policies and procedures were distributed widely throughout the region during March 2005 with an expectation that all staff working within the HPSS would be given access to them and training on their use and implementation. Each of the four ACPCs held information seminars in each of the Trusts prior to the implementation date to ensure that senior staff and professionals were aware of the new procedures prior to implementation. The policies and procedures are the key documents referenced in Child Protection Training Level 1 for statutory staff and the Keeping Safe training for voluntary organisations.

Sections 3.65, 3.66 and 3.67 of the policies and procedures refer specifically to the responsibilities of professionals working in Mental Health settings (Children and Adult Services) and clearly outline the steps

which should be taken in situations where the psychiatric condition of a parent may have consequences on his/her ability to provide adequate and appropriate care for children within the family.

Analysis of practice

The Inquiry Panel approached its analysis of Madeleine and Lauren's care and treatment using Chapter 10 of 'Co-operating to Safeguard Children' policy and the Regional Child Protection Procedures as the framework for standards in practice. The Panel approached its analysis taking account particularly of Chapter 10 in the 'Co-operating to Safeguard Children' policy.

During Madeleine and Lauren's pathway through the system there were a number of times when professionals should have been alerted to childcare concerns and should have taken more appropriate action.

When Madeleine was admitted to BCH on 18 May 2005 following a serious overdose, staff recognised that Madeleine had a dependent child, that she was finding life difficult to cope with, that she was suffering from severe depression and that she was experiencing some trauma as a result of her separation from her husband. Madeleine and Lauren were then quite rightly referred to the Social Work Department at BCH for assessment. This department made an onward referral to South and East Belfast Trust Family & Child Care Initial Assessment Team.

Earlier sections of this report deal more specifically with the details of the intervention of the Initial Assessment Team. While the Inquiry Panel is satisfied that the referral from BCH regarding Lauren was not of a child protection nature, it is equally clear that the assessment of Lauren as a child in need was not given adequate weight by this community team. In fact it is difficult to see what purpose was served by the social worker's visit. The nature of the assessment appeared to take the form of a one-off visit to check out the level of Madeleine and Lauren's support. However this visit did not involve an assessment of any depth, not least cross referencing Madeleine's account with anyone else, including the child or the child's father. Had this been done perhaps the needs of Lauren may have been highlighted to both parents and grandparents at this vulnerable time. This highlights the need for professionals involved in this type of work to be clear on their roles and responsibilities and to be

diligent in their assessment processes to ensure that a thorough picture of the needs of the child and family are obtained. The nature of this assessment would suggest children in need assessments are given a lower priority. However, as the Climbie Inquiry emphasised such assessments are a statutory requirement and should be afforded appropriate priority. It should be emphasized that at this point there was no suggestion of any threat to Lauren and on the basis of the information available at that time the professionals concerned could not have predicted the tragic events to come.

It is also noted in other sections of this report that the CRT was aware of the FCC IAT referral but at no point was it considered necessary to discuss the case with colleagues in family and child care. There was no evidence that the CRT gave any consideration to Lauren as a child in need given that she was the dependent child of a mother who had recently taken a serious overdose and left a suicide note.

The next opportunity for professionals to pick up on childcare concerns was when Madeleine attended her appointment with her Private Counsellor on 8 June 2005. At this time Madeleine first alluded to thoughts of taking Lauren's life. Although the Counsellor acted swiftly and appropriately in alerting Madeleine's father to the danger and insisted that he take her to her GP with a view to admission to hospital, the Panel is of the view that the Counsellor should have made a referral to Child Protection services at that time and should also have spoken directly to the GP. While the Regional Child Protection procedures do not specifically refer to the role of the private sector in this regard, they do contain a section on the role of the general public at Section 3.133: -

- *Any member of the public concerned about a child who may be at risk of abuse should refer the matter to Social Services, NSPCC or the police.*

The threat to Lauren was raised again when Madeleine attended her GP later on 8 June 2005. At this point the GP made immediate and appropriate attempts to have Madeleine admitted to hospital. While the delay in this process until the next day did cause the Panel some concern, the GP was satisfied that the protection arrangements

discussed with Madeleine's father were adequate. This overall action ensured that the immediate concerns about Madeleine's mental health and the impact of that on Lauren were dealt with in the short term.

Whilst it is clearly a judgement call for the individual professional practitioner, we would incline towards the view that Madeleine's GP should also have made a child protection referral at the time he referred Madeleine to Knockbracken. The roles and responsibilities of medical staff including GPs is clearly outlined in the Regional Child Protection Policy and Procedures at Section 3.71: -

- *Where there is clear evidence of abuse or if an allegation has been made of abuse there should be no delay in referring the child immediately to social services.*

His assumption that the issue would be picked up in the hospital setting appears reasonable, but there is a key child protection message from inquiry after inquiry – don't rely on other people to pass information on or to take child protection action. The GP also had a dilemma about informing Lauren's father about the threat to her. Lauren, Madeleine and Madeleine's husband were all patients of the GP and while he owed Madeleine a duty of patient confidentiality whether or not she was separated from her husband, the threat to Lauren meant that her father should have been informed. The GP was concerned about making the marital situation worse and / or compromising his role as family practitioner with both adults, but these considerations should have been outweighed by the welfare of the child being paramount and Mr O'Neill's ongoing personal parental responsibilities and rights. It must be emphasised that there would be nothing wrong or inefficient with Social Services receiving a number of referrals in a case like this. This would in fact emphasise the gravity of the situation and immediately identify key people who should be contacted in order to clarify information, contribute to assessment and be included in any planning.

The next time the threat to Lauren was articulated to professionals was when Madeleine was assessed for admission to Knockbracken on 9 June 2005. The records of both the medical and nursing staff clearly refer to Madeleine's thoughts of taking her own life and taking Lauren with her. It

is not clear what weight this threat was given by the staff concerned other than it appears to have been viewed as a symptom of Madeleine's mental illness/severe depression, which was then to be treated within the safety of a hospital setting. Although it is clear that all of the nursing and medical professionals who came into contact with Madeleine during her stay in Knockbracken had access to this information, there is no evidence that anyone discussed this issue to highlight its significance or gave consideration to referring the matter on. On this issue the Child Protection procedures Section 3.71 apply, as do Sections 3.65, 3.66 and 3.67 which specifically outline the steps which should be taken by mental health professionals: -

- *Where a professional in Mental Health services has concerns that a patient may present a risk to a child, he should consult with his line manager. If there are child protection concerns the line manager will make a verbal referral to the social work manager in the family and child care team and inform the hospital social worker.*

It is clear from our inquiries that no steps were taken by Knockbracken staff to specifically assess the risk to Lauren from Madeleine or to pass on the information of the threat to Lauren to the hospital social work staff or the community family and child care team.

The Panel is of the view that had anyone either in the hospital or in the community who knew of the threat to Lauren alerted the child protection services a chain of events relating to the child protection procedures process would have occurred. This would have ensured that at the very least the child's father would have been informed of the threat. A multidisciplinary case conference would probably have been held and it is highly likely that a child protection plan would have been put in place. It is therefore reasonable in these circumstances for the Panel to conclude that had direct child protection referrals been made by the GP, the Private Counsellor and Knockbracken when Madeleine first expressed a threat to Lauren's safety and wellbeing, Lauren's death might have been prevented.

The Panel is particularly concerned that none of the professionals involved with the care and treatment of Madeleine O' Neill considered it appropriate to inform Mr O' Neill of the threat to his daughter. This was in spite of the fact that Mr O' Neill had shared parental responsibility and continued to play a significant caring role for his daughter. Mr O' Neill believes that had he known of the threat he would have ensured appropriate child protection plans were put in place. This failure to consult with Mr O' Neill is contrary to the principles outlined in 'Co-operating to Safeguard Children' which states: -

- *Parents/ carers have a right to respect and should be consulted and involved in matters which concern their families .*

The next opportunity for professional staff to assess Lauren's needs came when Madeleine was treated in and subsequently discharged from Gransha Hospital. Although it is clear that Gransha staff were at no time made aware of the threat to Lauren, they were aware of the fact that Madeleine had a dependent child for whom she had significant caring responsibilities. There is no evidence that staff made any attempt to consider the needs of Lauren in the context of Madeleine's ongoing mental health needs. The Panel is of the view that this is a glaring omission in terms of the Gransha discharge planning arrangements for Madeleine. Section 3.65 of the Child Protection procedures states: -

- *Children of parents who have a psychiatric condition may be considered as vulnerable and in need of additional support.*

Child Protection Training

Throughout the Panel's analysis of the child protection issues in this case the Panel was concerned by the lack of general awareness of child protection/children in need issues. It was clear that staff lacked even basic understanding of issues such as recognition of risk, the proactive positive nature of the children in need process, or the signs and symptoms of child abuse. The majority of staff at interview stated that they had never received any formal training about Child Protection, which

is clearly reflected in their lack of understanding of the seriousness of the threat to Lauren.

This raised a concern for the Panel that these professionals and their respective organisations did not comply with the policy in Section 10 of 'Co-operating to Safeguard Children' which clearly states:-

Everybody who works with children should be able to recognise and know how to act upon, concerns that a child may be at risk. They should know: -

- *When and how to make a referral to social services*
- *That emergency action should never be delayed, if it is needed to safeguard a child*
- *That a written record should be kept of any concerns they have about a child considered to be at risk and the investigation conducted; that details of further action taken should also be recorded and the basis for a decision not to act further should be recorded and countersigned by a senior officer of the agency; and*
- *That a written record should be kept of discussions within their own agency or with others about a child's welfare*

A further concern of the Panel relates to implementation of the Regional Child Protection Procedures. These revised procedures had an implementation date of 1 April 2005, over three months prior to the deaths of Madeleine and Lauren. Very few of the staff were aware of these procedures at the time Madeleine was in their care; some indicated that they have had access to and training on them since then. This lack of knowledge of crucial and potentially life saving procedures is reflected in the failure of staff involved in Madeleine's care at Knockbracken to recognise the risk to the child from the parent and to take appropriate action to safeguard the child. While this issue is most stark in Knockbracken where the staff had been made aware of the threat to the child, the lack of training on Child Protection issues and the lack of awareness of Child Protection procedures was also reflected in the interviews with Gransha Hospital staff.

Another issue of concern is the non-prioritisation of child protection training by GPs. Madeline's own GP had received training and had been involved in arrangements for GP training. However, in discussion with the Panel he observed more generally that as GPs were not regularly required to make use of child protection knowledge and training, other types of training took priority and would continue to do so.

Protection of children is the responsibility of all practitioners. GPs are often the first contact with services for parents who are mentally ill. They must take a broad view of the family in order to best understand individual and family needs, including the need for child protection. Therefore it is fundamental that GPs have up to date knowledge of Child Protection procedures and view child protection training as an equal priority with other training.

RECOMMENDATION 8:

- **All Boards and Trusts should review the child protection training and awareness of all staff, including access to policies and procedures.**

RECOMMENDATION 9:

- **DHSSPS in conjunction with Boards' ACPCs should review the content and uptake of child protection training delivered to GPs and should consider making such training mandatory for all relevant staff and practitioners.**

RECOMMENDATION 10:

- **Counselling bodies should make child protection training including refresher training a mandatory component of ongoing registration.**

RECOMMENDATION 11:

- **Counselling bodies should require counsellors registered with them to follow the Department's Child Protection Policy 'Co-operating to Safeguard Children' and Regional ACPC Policies and Procedures.**

RECOMMENDATION 12:

- **DHSSPS should review Co-operating to Safeguard Children and the four ACPCs should review their Child Protection Policy and Procedures to ensure that both documents provide consistent and specific guidance for counsellors and psychotherapists, particularly those working in a private capacity.**

RECOMMENDATION 13:

- **The DHSSPS should, in conjunction with the Department of Employment and Learning and education providers, review all undergraduate and post graduate training for relevant professions to include a core understanding of child protection issues.**

6.3 Competency, Training and Education of Staff in Mental Health

A common theme throughout this case was an apparent lack of understanding of severe mental illness. There was evidence that staff were deficient in their knowledge of severe depressive illness. The significance of past deliberate self-harm in such a context was clearly missed by many staff.

The Crisis Response Team had a very mechanistic approach to the assessment of Madeleine's mental condition and circumstances. This would suggest a need for training.

The Social Worker from FCC IAT had insight into the potential inappropriateness of a Cognitive Behavioural Therapy referral following Madeleine's suicide attempt, however this did not prompt action e.g. a discussion with colleagues in Cognitive Behavioural Therapy or the Crisis Response Team. The Social Worker acknowledges the limits of her mental health expertise but this also did not prompt her to speak to colleagues with the necessary expertise. Once again this suggests a need for training.

This apparent lack of understanding also manifested itself in Knockbracken when there was a failure to question the objectivity of a seriously ill patient. The patient seemed to be making major life changing decisions at a time when she was suffering from a severe depressive illness which is known to distort perceptions and cloud judgement. Consideration was not apparently given to the risk of further burdening a seriously ill patient with unnecessary choices and decisions. It is questionable whether staff at Knockbracken should have been enabling or promoting a major life change at that time without contact with the GP and without an initial multidisciplinary assessment.

In Gransha, staff appeared to over identify with the patient and focused on the *understandability* of the symptoms as a *situational crisis*. The FCC IAT adopted a similar approach, focusing on the understandability of the depressive symptomatology in relation to the current circumstances and failed to display a real understanding of the patient's severe mental illness.

The Panel was concerned at the apparent reluctance of inexperienced SHOs to readily liaise with an appropriate senior, i.e. Consultant on call, in relation to lowering observation levels of a seriously ill patient (Knockbracken), and in relation to a new admission (Gransha). In Gransha, staff seemed unaware of the importance of rigorously double-checking patient subjective reports regarding alleged *success* of leave and accurately recording objective accounts and their sources. The Panel was also concerned that some staff rationalised their failure to record patient interviews, failing to see that health care records are a form of communication to facilitate the care, treatment and support of the patient.

RECOMMENDATION 14:

- **Trusts should ensure that all SHOs new to Psychiatry should have an induction course covering role clarification and a basic knowledge of common psychiatric disorders, their treatment and management.**

RECOMMENDATION 15:

- **Trusts should ensure that multidisciplinary staff are aware of the nature of therapeutic relationships and the concepts of transference and counter-transference.**

RECOMMENDATION 16:

- **Trusts should ensure that staff working in the field of mental health have continuous professional development plans which include in-service training and evidence based practice refresher courses.**

6.4 Mental Health / Childcare Interface

Professionals working in adult and child and adolescent mental health services may become aware of children suffering, or likely to suffer significant harm. They should be aware of their responsibilities for safeguarding children and their contribution to the child protection process.

(‘Co-operating to Safeguard Children’ DHSSPS May 2003)

In an organisation or system as vast and as complex as the Health and Personal Social Services there will be many boundaries and interfaces which professionals have to negotiate and work across. The interface between Adult Mental Health and Family and Child Care services is particularly important as a parent’s mental ill health and resulting behaviour can have a significant adverse effect on their capacity to parent.

To this end, multidisciplinary working and shared decision making among professionals working in both mental health services and family and child care services is crucial in safeguarding the needs, safety and rights of children and their carers.

Mental Health services are generally delivered on a multidisciplinary basis, including Social Work, Nursing, Medicine, Occupational Therapy, Psychology and others. It is important that roles, responsibilities, skills and knowledge merge to an extent that the client/family experience and journey is as seamless as possible. It is also important that everyone in the multidisciplinary team is able to raise concerns about a child for whom their patient may have caring responsibilities or a child who they believe to be at risk of significant harm.

Mental Health services in this context need to work within a framework which respects the advocacy role of staff working with the adult client group, but also makes explicit that the child’s welfare is paramount.

It is therefore important that relationships between professionals in both Mental Health and Family and Child Care services are well established and sufficiently transparent and mutually supportive to facilitate frank discussion on particular issues/cases and remain focused on child protection issues and shared statutory responsibilities.

In all interactions with Mental Health personnel it is clear that their focus was entirely on the patient. When the patient made clear her intention was to kill herself and take her child with her, none of the Mental Health professionals or Family and Child Care services involved attempted to formally assess the current risk to the child. No special arrangements were made to monitor her interaction with the child while on the ward. There was no attempt made to follow up on this statement to assess how real it was. Had she said this before to her family or to the child? There was no assessment of the risk the patient posed to the child now or in the future and no attempt was made to involve the child's father in discussions about the future welfare and care arrangements for the child. While some staff indicated that it would not be their role to conduct such an assessment, at no time did any professional give consideration to informing the social worker attached to their team or seeking advice from a child protection nurse advisor. No professional at any time gave any consideration to involving child protection services within their own Trust. This lack of a *holistic* response to the needs of an entire family of a mentally ill patient meant that the professionals working with the patient maintained a narrow focus on her situation, choices and feelings excluding the needs of a vulnerable child for whom the patient was a significant carer.

The Panel was concerned that so many adult mental health staff were clearly unaware of their responsibilities in relation to ACPCs' Child Protection Policy and Procedures and local Children In Need Procedures. It is of the view that assessment tools relating to adults should automatically include details of any children and their care arrangements. Similarly child care assessments should automatically include details of current or past parental mental health problems. The Panel believes that all child care staff should receive ongoing training in adult psychiatric illness, its potential impact on children and indicators for referral for appropriate supports. Training needs should be reviewed as part of the supervision process.

RECOMMENDATION 17:

- **DHSSPS and Boards should ensure that each Trust puts in place a joint protocol designed to manage the interface between mental health and child care services, addressing and facilitating the co-working of cases where there are concerns that adult mental health problems may impact on the care of children.**

RECOMMENDATION 18:

- **The four ACPCs should jointly commission multidisciplinary training across the region for mental health and child care staff, focused on working together in cases where there are adults with mental health issues who have dependent children. This training must explicitly deal with child in need issues as well as child protection matters. The ACPCs should make use of the Crossing Bridges (1998) training resource produced by Department of Health.**

RECOMMENDATION 19:

- **DHSSPS should ensure that consideration of parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children. (Understanding the Needs of Children in Northern Ireland).**

6.5 Assessment / Risk Assessment

Madeleine was formally assessed by doctors on the three occasions when she was admitted to hospitals, i.e., by a Specialist Registrar when she was admitted to Belfast City Hospital in May 2005 following her overdose and by SHOs in both Knockbracken and Gransha Hospital in June 2005.

Assessment involves the acquisition of all relevant information which should ideally be taken from the referring agent, (usually a GP or another hospital), the patient and the patient's family in addition to an examination of the patient's mental state. This information should then be shared with the Consultant who will make the diagnosis and agree the treatment plan. In this case the quality of this initial assessment varied between the three hospitals. The psychiatric assessments in BCH and Knockbracken were comprehensive and informative, whilst the assessment in Gransha Hospital was incomplete. The supervision of this process and the analysis of the information gathered also varied between the three hospitals.

In Knockbracken the information was analysed very carefully by the Consultant who then agreed with the diagnosis of severe depressive illness and decided to admit Madeleine to hospital. In Gransha Hospital the decision to accept her was made by a Consultant acting on limited information he received from the Consultant at Knockbracken before she arrived at the hospital. The information disclosed at that time was not recorded or shared with the staff whose responsibility it was to develop a care plan. The admitting SHO had no information as to why Madeleine was being admitted, other than a Consultant had agreed to admit. He had no information from the referring hospital and no information from the GP. The SHO subsequently recorded his impression at this point as *situational crisis*. This impression was never validated by the patient's Consultant in Gransha Hospital although he informed the Panel that his diagnosis was a major or moderate depressive disorder with somatic symptoms (ICD – 10F32.11) probably due to her marital situation. In fact this diagnosis was never recorded in Gransha Hospital during Madeleine's in-patient stay. The SHO did not pursue any further information from Knockbracken at that time nor did he seek advice, guidance or supervision from a Consultant-on-call. When Madeleine was subsequently seen two days later by the Consultant responsible for her

care during her stay in Gransha he too appeared to assume that her primary issues were relationship difficulties and social problems and that she was in recovery.

This flawed process led to a chain of events whereby Madeleine may have been able to mask her true state of mind. She was assessed as being of low risk and allowed to leave the hospital for periods of time. She was subsequently discharged from hospital with no convincing recorded evidence of significant improvement and an inappropriate care plan.

There was no evidence that staff utilised any training they may have received in risk assessment and there was no evidence of any risk assessment tools in use. This is reflected in the absence of any risk assessments in the documentation of either Knockbracken or Gransha Hospital. In the Knockbracken setting there is evidence of a threat to harm a child and active suicide planning through researching the Internet, yet this information was not analysed in terms of risk nor was any action taken to manage that risk. There is evidence that the patient's movements were initially restricted in Knockbracken when she was put on general observation. However, the patient was subsequently given access to the hospital grounds three days later with no recorded evidence that the risk factors had decreased. There is no recorded rationale for reducing a high risk patient to low risk in such a short time. It is not acceptable to rationalise such a step on the basis of her compliance with ward procedures.

There is also evidence of poor co-ordination of assessment information and no consolidation of information in an overall assessment in Knockbracken or Gransha. This process would have been assisted by multidisciplinary case discussions and by a key worker / case co-ordinator with responsibility to pull information together. Communication with other professionals to check and share information might also have prompted some professionals to produce their own consolidated assessment. A consolidated assessment could have pulled together various headline information which when added together might have prompted concerns about risk or at least prompted further questions: -

- Major recurrent mental illness.
- History of depression.
- Serious suicide attempt with suicide note.

- Continuing suicidal ideation.
- Relevant family history.
- Threat to child.
- Inclusion of family members in thinking about suicide.
- History of childhood sexual abuse.
- Recent relationship problems.
- Relevant family and personal issues.
- Accessing internet sites dealing with suicide.

It is the Panel's view that Madeleine should have remained in Knockbracken until a more thorough assessment had been completed over a longer period of time. She should not have moved until there was evidence that she was stable and that Lauren's needs had been properly assessed and met and the relevant procedures followed. Had Gransha Hospital known about the threats to Lauren it is unlikely that Madeleine would have been accepted as a patient at that time. Any move to Gransha should have been the subject of much greater planning and taken place over a longer timeframe. There are concerns as to whether Madeleine received adequate care and risk assessment at Knockbracken and Gransha. There is also concern about the levels of observation of Madeleine at Knockbracken. The role of consumerism, i.e., an overemphasis on patient choice, is another relevant factor in relation to decision making at Knockbracken. It is reasonable to ask if Madeleine was able to make informed choices about the best place for her ongoing treatment and care at this time. Medical practitioners have an ethical responsibility not to offer choice without establishing that it is in the patient's best interests.

It should be noted again that there was a sharp contrast in the quality of multidisciplinary assessment practice at BCH compared to Knockbracken and Gransha. The Specialist Registrar at BCH produced a very thorough assessment which elicited important information and led to clear planning and timely action.

The Specialist Registrar was alert to the potential risks for dependant children and their needs. The family was included in the assessment. The standard of supervision by the Consultant Psychiatrist was high. The Panel noted that BCH had a group of staff that worked collaboratively across departments and disciplines. An appropriate sense of urgency

was evident throughout, from the psychiatric referral by the Consultant Physician in Acute Medicine to the onward referrals from the Hospital.

Unfortunately the high standards of multidisciplinary working and assessment present in BCH were not reflected in community services within South and East Belfast Trust. Both the assessments of the CRT and FCC IAT failed to go beyond the surface presentation of the patient/client and were largely dependent on self report of the patient/client. Relatives were not consulted despite being present in the house. Neither team considered it necessary to contact Mr O'Neill in the context of the needs of a dependent child whose mother had recently taken a very serious overdose. FCC IAT gave some consideration to Lauren's needs but neither team considered the impact on Lauren of her mother's overdose. CRT was made aware at referral that Madeleine was concerned about losing Lauren. Other professionals were not consulted. In the CRT's case this was despite the inclusion of CBT and the Counsellor in their care planning. The FCC IAT social worker clearly recognised that CBT might not be appropriate but there is no consideration of following this up with any other professional, e.g. CRT or the Counsellor. CRT was aware at the point of referral that a referral had been made to FCC IAT but there was no attempt to share assessment information. FCC IAT were not aware of CRT involvement at the point of referral but the file notes say that Madeleine informed them (incorrectly) that she was seeing Community Mental Health. Once again there is no attempt to share information with other professionals. The CRT appeared to have an absence of supervisory oversight of the decision making in this case. Supervision in the FCC IAT lacked rigour and did not go beyond the surface presentation in the case. FCC IAT did not respond to the referral with an appropriate level of urgency. The Panel was concerned that the staff from both teams who were interviewed did not appear to have insight into the deficiencies in the response and practice of their respective teams.

RECOMMENDATION 20:

- **South and East Belfast Trust should review the assessment models used by CRT and FCC IAT in cases where a parent with dependent children has attempted suicide or made a serious threat of self-harm.**

RECOMMENDATION 21:

- **DHSSPS should develop guidance that would lead to the implementation of consolidated assessments in mental health. Consolidated assessment would underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning which all feature in other recommendations in this report. It would also include assessment of the impact of mental illness on carers and on children and the adequacy of support arrangements for them.**

6.6 Supervision

Supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence; assume responsibility for their own practice; and enhance consumer protection and safety of care in complex clinical situations.

Supervision is an integral component of staff support and professional development, which in turn raises the standards of service delivery. It is central to the process of learning and should be seen as a means of encouraging self-assessment, analytical and reflective skills. It is a requirement of all professions and underpinned by the principles of Clinical and Social Care Governance.

Supervision includes: -

- (i) Management Supervision
- (ii) Clinical Supervision (of which child protection supervision forms a part), and
- (iii) Professional Supervision

Although child protection supervision and management supervision are complementary, they are separate functions.

Area Child Protection Policy and Procedures (2005) recognise that supervision within the child protection arena varies according to organisational/professional arrangements and local implementation may be determined by the needs of each professional group. However each agency represented on an Area Child Protection Committee must have in place a policy for the formal supervision and management of cases where there are child in need/child protection issues. The Panel found little evidence of managerial, clinical or professional supervision relating to the issues within this case.

As noted in the section on Assessment/Risk Assessment the CRT appeared to have an absence of supervisory oversight of the decision making in this case. While there was evidence of supervision within the FCC IAT it lacked rigour and did not go beyond the surface presentation in the case.

Nursing care plans in both Knockbracken and Gransha were incomplete and inaccurate demonstrating a lack of managerial supervision. Also there is no evidence to suggest that Madeleine's condition was discussed with line management in either Knockbracken or Gransha. This issue is also relevant on consideration of the child protection concerns and the lack of understanding any of the staff displayed of signs and symptoms of child abuse.

The solitary role of the SHO in the admission process in Gransha also highlights the issue of supervision of staff working with extremely ill and vulnerable patients.

This issue is particularly relevant when the junior staff have little or no experience of mental health and mental illness. Perhaps a supervision process involving staff on a busy ward might have triggered some discussion around the reasons for the patient's admission and the risks associated with her remaining at home. It might also have highlighted the poor recording and the lack of assessment and inadequate care planning arrangements.

RECOMMENDATION 22:

Boards and Trusts must ensure that supervisory policies are in place which require that: -

- **Arrangements are in place to monitor and audit assessment, case management, effectiveness of interventions, record keeping and discharge planning of individual cases.**
- **Staff understand and adhere to ACPCs' Child Protection Policy and Procedures.**
- **In all situations where there are concerns relating to children there is an appropriate multi-agency assessment of risk.**
- **There is a named nurse and named doctor with clearly defined responsibilities to provide a lead role for child protection within mental health services.**

6.7 Care Planning

Care planning is an essential part of health care and social care in the HPSS in Northern Ireland and must be viewed as a positive use of professional knowledge and time. Without a specific document delineating the plan of care, important issues are likely to be neglected. Care plans provide a structured framework to guide all who are involved in a patient's care. The care plan has traditionally been associated with models of nursing and the domain of the nurse. This is a view which can be detrimental to the patient as it does not take into account the multidisciplinary approach required to deliver optimum care to the patient.

To be effective and comprehensive the care planning process must involve the whole multidisciplinary team which will provide care for the patient. The first step in care planning is an accurate and comprehensive assessment of the individual and, in mental health, a validated Risk Assessment in the areas of harm to self, others and property. It is essential that the initial assessment is reassessed and decisions are based on evidence of progression towards health or ill health.

Assessment must be based on a structured framework within a model of care. However, not every model of care can adequately cover the full range of complex situations health care professionals are faced with. It is essential that within the structure of assessment there are key factors or triggers built into the process such as risk to self and others, child care protection issues, sharing of information and past history with other organisations. Concerns in the initial assessment must be followed up and action recorded in the evaluation of care.

Once initial assessment is completed a comprehensive list of problems is identified . This list is then incorporated into a model of nursing or care and therapeutic input is identified to resolve the problem in partnership with the patient. Any nursing intervention is to be related to a problem and clearly documented and measured in an objective way in the evaluation of outcomes of care.

As the patient's condition improves the degree of intervention by the team should reflect this. An objective measurement can be demonstrated by

the reduction of problems which should significantly decrease or be of lower intensity.

Changes in patient care should be based on evidence based care or clinical judgment after reassessment and agreement that this is the appropriate action to take in the best interests of the patient. Agreement with care and change in care must be sought and communicated to the patient.

Care planning is a process which records the input and outcomes of care and as a tool demonstrates the validity of care. The care plan must be subject to scrutiny within the multidisciplinary team to ensure agreement and validity. It is also essential that care plans conform to a standard to ensure that high quality appropriate care is being delivered by a team to the patient. The care plan should be audited on a regular basis by the ward manager to ensure optimum care is received by the patient.

In the case of Madeleine the care planning process and recording of care plans fell well short of what would be expected of professional health care staff. The nursing care plans in both Knockbracken and Gransha were incomplete. Neither hospital care plan was based on a risk assessment which would have identified risk factors. Had this been done the clear risk to this mother and child could have been more appropriately managed and professionals might have been more focused on this significant issue.

Mental illness can affect people's parenting ability and impacts on their children in variable ways. A skilled, comprehensive and holistic assessment which includes the needs of dependent children is an essential element to all care plans.

RECOMMENDATION 23:

- **DHSSPS should review guidance in relation to care planning. The review should ensure that care plans are designed in conjunction with a model of care and include consideration of risk assessment and management, multidisciplinary working, verifying information provided by the patient, and objective, evidence based approaches to care plan changes.**

6.8 Discharge Planning *

The discharge planning arrangements in both Knockbracken Healthcare Park and Gransha Hospitals fell far short of what would be considered good practice. This contrasts sharply with Madeleine's brief stay in BCH where medical, psychiatric and social work staff worked quickly and collaboratively to produce a discharge plan based on rigorous assessment. Following her stay in Knockbracken Madeleine was transferred to Gransha Hospital without any multidisciplinary assessment of her needs. In Knockbracken there was also some confusion as to whether this patient was being 'transferred' or 'discharged' to be readmitted to another hospital. In either case the movement of a seriously ill patient and the proposal to transfer her copied notes by a relative to another hospital has inherent risks which were not fully recognised and taken into account. A phone call to the receiving hospital to ensure that the patient and notes had arrived safely could well have led to a better outcome for both Madeleine and Lauren. The fact that the Consultant at Knockbracken recognised that this patient would have met the criteria to be formally detained had she not agreed to receive medical treatment in hospital voluntarily, should have alerted staff at Knockbracken to the risk of such a move to Gransha.

When the patient was discharged from Gransha Hospital the arrangements were very unsatisfactory. The evidence suggests that the patient had requested to be discharged, which was then facilitated without consultation with her family and main carers. The follow up care plan was not appropriate for a patient suffering from major depression with a history of self harm. In fact the hospital's discharge plan depended to a large extent upon the involvement of a Private Counsellor with whom no hospital staff had any contact. Indeed, while the Counsellor was referred to by a number of professionals as significant in the discharge planning arrangements for the patient, no one was clear as to the role of the Counsellor or what they expected her to provide. The Consultant in charge of Madeleine's care in Gransha Hospital informed the Panel that the patient had been offered other services from the day hospital and the community mental health team and an earlier out-patient appointment,

** It should be noted that this section is intended to cover routine discharge planning. A separate section dealing with the DHSSPS guidance document 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others' – May 2004, is included later in this Report.*

but this offer had been refused. However, there was no record made of this. He stated that her reason for declining these services and an earlier outpatient appointment was that she was returning to Belfast to finalise the sale of her house. Although the GP Surgery was informed on the day of discharge that Madeleine had been discharged, the GP was not informed that she was returning to Belfast. A subsequent fax sent on 8 July 2005 to the GP surgery indicated that Madeleine was in fact living in Derry.

RECOMMENDATION 24:

Both SEB and Foyle Trusts should undertake urgent reviews of their systems for developing discharge plans for patients leaving their hospitals. In addition DHSSPS should consider providing guidance in relation to discharge planning. The basic elements which should form part of future discharge planning would include: -

- **Comprehensive Multidisciplinary Team input.**
- **Identified planned date of discharge.**
- **Clear discharge pathway to cover all aspects of discharge.**
- **Professionals or services named in discharge plans must have been contacted and provided informed agreement to their inclusion in the plan.**
- **Discharge and leave destinations should be known and associated risk assessed, including contingency planning.**
- **Where there is a parenting role, risk assessment and plan must be recorded.**
- **Discharge plans should include provision for engagement with follow-up services.**
- **Consideration should be given to carer involvement.**
- **A relapse prevention plan should be drawn up, with carers' involvement.**
- **Parents with serious mental illness should be prioritised for follow-up after discharge.**

6.9 Bed Management

The current resource of acute admission beds for mental health is under continuous pressure to provide immediate admission for those deemed to require hospitalisation. This is not unique to one area of the province, with many of the admission units accepting out of area or out of Board admissions in and out of hours.

This pressure on beds has been experienced by acute general hospitals for the past decade and every general hospital has put in place a bed management system to ensure that the demand has been managed effectively and safely.

Currently the experience in Northern Ireland for acute mental health in-patient beds is similar to the pressures experienced by acute general hospital services. It is imperative that those Trusts which provide in-patient mental health services have an operational system that manages their bed resources effectively and assists in the safe management of those awaiting admission.

An effective bed management system comprises: -

- A live record of beds available for use
- Management by a named individual who is accountable
- A clear Bed Management Policy
- The utilisation of any vacant bed or pass bed to optimum capacity
- The tracking of patients after request for admission and safe alternative care e.g. admission on a certain date or transfer to an appropriate community based care option
- The management of patients returning from leave to appropriate accommodation
- The planning of admissions based on a prioritisation system in managing risk of harm to the patient or others

- The production of validated information on the resources utilised and any shortfall
- An identifiable resource to assist in sound decision making for those needing urgent admission

It is essential that every in-patient unit has in place a bed management system which ensures the optimum use of all beds and that there are clear records which identify usable resources when a request for admission is received, thus reducing the risk to the patient and the community.

If there is no access to a bed at the time of request the system should be able to track the patient and find a suitable alternative such as an admission to another unit or an admission inside a defined timeframe. The system needs to keep the patient and referring agent informed of the progress towards admission and the need for the referring agent to monitor the patient and identify any increasing risk to the hospital.

RECOMMENDATION 25:

- **Boards and Trusts must ensure that each in-patient unit has a bed management policy in place, which outlines the bed management system and identifies an accountable named individual.**

6.10 Recording of Information

The Panel found evidence of inaccurate recording of information relating to Madeleine.

Some information gathered by nursing staff at Knockbracken was inconsistent, with inaccurate timescales for Madeleine's overdose in May 2005 recorded as *three weeks previously* and then *three months previously*. Some clinical recording was also poor; for example, a record states that a TPR (temperature, pulse and respiration) is completed but only pulse and blood pressure are recorded. Temperature and respiration are not recorded. Although the ward sister was clear that she checked the care planning documentation on a daily basis, these discrepancies were not identified and rectified.

When Madeleine left Knockbracken a 'Patient Referral to Other Hospitals' form dated 14 June 2005 contained factually incorrect information that she had a catheter insitu, which she clearly had not, and that she required full assistance with personal cleansing, which she clearly did not.

Madeleine on occasions appears to have been confused, in the minds of staff, with other patients. At Gransha blood tests were mixed up and a Serum Lithium level was attributed to Madeleine in error. This mistake was not recognised by staff. However, this did not affect her treatment and care.

Whilst human error in situations where information has to be recorded can never be entirely ruled out, it is clearly of the utmost importance to ensure that the recording of information relating to patients in both community and hospital settings is carried out within the parameters of policies, procedures and systems which minimise human error through robust checking and supervisory processes.

RECOMMENDATION 26:

Both South and East Belfast and Foyle Trusts should have in place as part of their governance arrangements a system to monitor and audit case records within Mental Health services to ensure: -

- **Accuracy**
- **Assessment and management of risk**
- **Care planning**
- **Effectiveness of treatment**
- **Discharge planning**
- **Correct patient identification**

6.11 Interface Between Statutory Services and Private Counselling Services

The Inquiry has highlighted problems relating to the interface between statutory mental health services and private counselling services. The GP, BCH, Knockbracken and Gransha were all aware that Madeleine was seeing a Private Counsellor. Any information they had in relation to the service provided was on the basis of self report from Madeleine. Records and interviews with staff indicate that there was not a consistent report of this work from Madeleine. This lack of clarity was further compounded by the absence of a consolidated assessment by Knockbracken and Gransha which would have suggested the need to clarify the role of the Counsellor directly with the Counsellor herself. In this context it is particularly worrying that the Private Counsellor was included in care planning by both psychiatric hospitals without reference to the Counsellor. At no point was the Counsellor contacted by any other professional to discuss the nature of her work with Madeleine or to co-ordinate Madeleine's care. This was unsatisfactory and particularly poor practice where the Counsellor was included in care/discharge planning. South and East Belfast Trust and Foyle Trust both contacted the Counsellor as part of their own investigations after Madeleine's death.

The Panel has also considered the role of the Private Counsellor with regard to her communication with other services. At no point did the Counsellor initiate direct contact with any of the other services involved in Madeleine's treatment and care but she did ensure that Madeleine was taken to see her GP on the first indication of her suicidal ideation. It is clear that there is variation in practice between different Private Counsellors. There was a letter on the GP file from a previous Private Counsellor in 1998 advising the GP that he was working with Madeleine. It is acknowledged that communication between a private sector provider and the GP is not a straightforward issue and making contact can only be initiated with the client's consent, unless the client poses a risk to self or others. At present there is no process in place to facilitate communication or to confirm the qualifications or remit of a private sector provider. While an argument for client privacy/confidentiality may have been appropriate at the beginning of the Private Counsellor's work with Madeleine, this can not be sustained once it became clear that Madeleine's GP had been treating her for depressive illness and becomes unacceptable following Madeleine's attempted suicide on 18

May 2005. The Private Counsellor was also depending on Madeleine's self report of the involvement and interventions of other professionals and the Panel's interview with the Counsellor indicated that Madeleine had presented her with an inaccurate picture.

These failings on both sides of the statutory-private sector divide were further aggravated by the child protection failings outlined in the section on Child Protection/Children in Need. The Counsellor did take steps to ensure that Madeleine was taken to the GP at the first sign of a threat of suicide. The Counsellor also passed on the threat to Lauren to Madeleine's father and asked him to make sure that this information was passed on to the GP. The Counsellor did make follow up phone calls to Madeleine's father to ensure that Madeleine had been taken to appropriate services. However, it is the Panel's view that the apparent reticence on the part of the Counsellor to share information with statutory providers in relation to Madeleine informed her approach to the child protection issues in relation to Lauren, i.e. she did not make direct contact with the GP or child protection services.

Communication between private and statutory services is in the patient/client's interest to improve the co-ordination of care and ensure that treatment and other services are appropriate or complementary. A failure to engage in appropriate professional consultation due to an over-emphasis on confidentiality exposes both the professionals involved and the patient/client to the risk of inappropriate, unnecessary, contradictory and/or potentially dangerous interventions. Sharing of information is in the patient/client's interest in terms of future recovery. When the issues relate to patient/client safety or the safety of others, particularly children, then it is imperative that information is shared.

In the latter stages of the Inquiry the Panel became aware of a report 'Standards of Good Practice for Counselling Services in Northern Ireland' issued for consultation by DHSSPS in November 2006. Several sections of these draft standards are of direct relevance to the issues discussed in this section.

Section 4.30

Where an organisation is providing counselling for people with associated health-related needs (e.g. mental health needs) the counsellor should, with the agreement of the service user, advise

the service user's family doctor that the person is receiving counselling.

Section 4.31

The organisation should have a protocol to ensure that service users with mental health and physical health-related needs are appropriately referred to other services, including for further assessment, particularly where there are identified risks, including the risk of suicide.

Section 5.3

Organisations must ensure that service users understand the limitations of confidentiality within the service user-counsellor relationship and are clear under what circumstances exceptions in confidentiality may occur. Certain circumstances can require confidentiality to be breached for example:

- if the service user is considered to of danger to themselves;*
- if the service user is perceived to endanger others;*
- under the Children (Northern Ireland) Order 1995;*
- if required by the order of a court of law;*
- if acts of terrorism are threatened;*
- under the Drug Trafficking Act 1994;*
- under the Road Traffic Act 1988;*
- under the Proceeds of Crime Act 1995.*

In the report the term *organisation* includes individual counsellors who practice alone. It should also be noted that the review which preceded these standards (Counselling in Northern Ireland – Report of the Counselling Review, DHSSPS May 2002) recommended statutory registration for counsellors.

RECOMMENDATION 27:

DHSSPS in co-operation with responsible Departments in Great Britain should implement its commitment to the statutory registration and regulation of psychotherapists and counsellors as

outlined in the 2006 consultation on standards. The associated guidance to psychotherapists and counsellors should aim to improve communication between statutory services and private counselling services, leading to a culture in both sectors where the benefits of co-ordinated care are promoted to patients/clients/ service users. The guidance should also take account of Recommendations in the section on Child Protection/Children in Need in this Report.

6.12 Next of Kin

The circumstances of the marital separation of Madeleine and John O'Neill appear to have impacted on considerations relating to the recording of information of Madeleine's next of kin in her admission to the three hospitals, i.e., Belfast City Hospital in May 2005, and Knockbracken and Gransha Hospital in June 2005.

The Panel was advised by both nursing and medical staff that in relation to Madeleine's admission to Belfast City Hospital, Madeleine's next of kin was originally recorded as her husband, John O'Neill. This was an emotive issue for Madeleine and her parents and eventually Madeleine's father's name was added as next of kin and Mr O'Neill's name was also recorded on the documentation. At the time, given her state of mental health, it was felt best to go along with the wishes of Madeleine and her parents.

At Knockbracken the next of kin details on Madeleine's admission documentation give her father as next of kin, with his address and contact details. Mr O'Neill's name and phone number also appear on the documentation as next of kin. It should be noted that Mr O'Neill continued to play a significant role in Lauren's life and was the primary carer for her whilst Madeleine was hospitalised in Knockbracken.

At Gransha Hospital, Madeleine's father is the named next of kin, with his address and contact details. Mr O'Neill's details do not appear on the documentation.

Mr O'Neill has expressed concern about this whole situation and feels that it impacted on the fact that he was not advised at any time between May 2005 – July 2005 by the GP or statutory hospital and community services about the threat to Lauren by her mother. This was, in his view, compounded by the fact that Madeleine's father was aware of the threat but did not communicate this to him.

The Panel's concern here is that despite the marital separation, issues of confidentiality and possible implications for child contact arrangements, Mr O'Neill was entitled, as Lauren's father and parental carer, to have been advised of the threat to her safety and wellbeing. There is a basic requirement in child protection situations that the interests and welfare of

the child are paramount and take precedence over any other sensitivities there may be for relatives and other adults involved. It is, at the very least, unfortunate that these principles were not adhered to in this case. If they had been, the outcome for Lauren in particular might have been different and better.

RECOMMENDATION 28:

DHSSPS and Boards should ensure that Trusts have a policy in relation to identifying and recording 'Next of Kin' information. Trusts should also consider the extent to which staff training and/or refresher training should be provided for front-line staff involved routinely in taking personal history details from patients, particularly in situations where patients have family issues relating to divorce, marital separation and dependent children.

6.13 Consultation with and Support to Families

In its analysis and conclusions relating to 'Communication', the Panel has highlighted the lack of systematic communication with the patient's family in either Knockbracken Healthcare Park or Gransha Hospital.

Our direct discussions with both Mr O'Neill (Madeleine's husband) and Mr Gormley (Madeleine's father) only served to heighten our concerns about this issue.

In relation to Primary Care and Community Services in Belfast, Mr O'Neill indicated that whilst he accepted that generally the GP's input had been very good, he was concerned that the GP had been aware of a threat to Lauren but had not communicated this threat to him as Lauren's father. He pointed out that all three of them – Madeleine, Lauren and himself – had been patients of the same GP. When two different sets of Community staff of South and East Belfast Trust had visited Madeleine after her discharge from Belfast City Hospital following treatment for her drugs overdose, no contact was made with him.

In relation to Madeleine's in-patient episodes in the three hospitals, Mr O'Neill advised that when Madeleine was admitted to Belfast City Hospital following her overdose, he had gone to the hospital but no member of staff at the hospital had talked to him. He had also visited Madeleine on a number of occasions when she was in Knockbracken Healthcare Park, but again there had not been any contact with hospital staff apart from a brief introduction to an SHO and no information was given to him. He did not visit Madeleine during her stay in Gransha Hospital, at her request.

Mr Gormley also stated that when Community staff of South and East Belfast Trust had visited Madeleine in her home following her discharge from Belfast City Hospital, both he and his wife were present in the home, but no members of staff had shared any information with them. Both he and his wife had felt that no-one was interested in talking to them.

In relation to Madeleine's in-patient stay in Knockbracken Healthcare Park, Mr Gormley described communication with him as *non-existent*, after talking to the Consultant Psychiatrist on Madeleine's admission to

Knockbracken Healthcare Park, he had no further discussion with medical staff, either there or at Gransha Hospital.

Mr O'Neill was particularly aggrieved that at no time during Madeleine's in-patient episodes had anyone contacted him to advise him of his wife's threat to harm their daughter. Indeed, it was not until November 2005 – some four months after the deaths of Madeleine and Lauren – that he was advised of the threat to harm Lauren by officers of the PSNI. He took the view that had he known about this threat prior to the two deaths he would have taken any necessary action to ensure Lauren's safety.

Mr Gormley advised us that when he was initially told of Madeleine's threat to Lauren, the seriousness of the threat did not register with him. He felt that a professional should have talked to him at that time. He was now tormented because he had not taken the initiative to talk to doctors about the threat. Mr Gormley also confirmed that he did not communicate the threat to Lauren to Mr O'Neill and was not aware as to whether others had told Mr O'Neill of the threat. Indeed, he had not communicated the threat to Lauren to anyone else.

There is no doubt in the Panel's view that Mr O'Neill, as Lauren's parent, should have been informed of the threat to Lauren through the involvement of Children's services under a child protection referral. The requirement for the welfare of the child to be paramount (Children NI Order 1995 and ACPCs' Policy and Procedures) was not considered. The primary protectors for children should be their parents. Even without child protection considerations, Mr O'Neill should have been involved as someone with parental responsibility and as part of Lauren's child in need assessment. Mr O'Neill's right under Article 8 of the European Convention on Human Rights (right to respect for family life) may have been breached.

*Overall, the Panel is left with a clear view that the general failure to include relatives in discussions about Madeleine's care and treatment, to consult with relatives about her discharge from Gransha Hospital, to provide guidance to relatives about the need to monitor behaviour in the period after discharge, and to advise Lauren's father of the threat to Lauren from her mother, constituted a poor and unacceptable standard of care which must be addressed with vigour and determination to ensure that such shortcomings do not occur again.

**See Recommendation earlier in this Report in the section headed: 'Communication – Between Professionals and the Family'.*

The Panel also looked carefully at the issue of provision of support for relatives after the deaths of Madeleine and Lauren. In essence, there was none.

Mr Gormley was incensed that he had not received any communication – *not a phone call, a note or a card* – from either Trust, following the two deaths. In August 2005 he had contacted the accepting Consultant Psychiatrist at Gransha Hospital and requested a meeting, as he thought that Madeleine had been under his care during her in-patient stay. He was firmly of the view that if he had not taken the initiative and contacted the Consultant Psychiatrist, no further action would have been taken.

Mr O'Neill was also angry that there had not been any communication with him by HPSS after the two deaths. The first contact he had was in February 2006 from a Director of the Eastern Health and Social Services Board. In the autumn of 2006 he had met senior officers of both South and East Belfast and Foyle Trusts when he had received from them copies of the investigation reports prepared by the Trusts; at that time he had forcibly expressed his concern that neither Trust had offered any apology or acknowledged the deaths of Madeleine and Lauren in case it might compromise them in any way.

When Panel members interviewed the Chief Executive of South and East Belfast Trust she advised that at the time this incident took place the Trust did not have a formal policy in place covering support to families bereaved by suicide. She indicated that staff were aware at the time of Madeleine's stay in Knockbracken Healthcare Park that Madeleine and John O'Neill were separated and pointed out that there were practical issues involved at this time as the Trust did not have a contact address for Mr O'Neill and therefore had no way of contacting him. This is not consistent with the fact that Mr O'Neill's name and telephone number was recorded on Madeleine's admission documentation to Knockbracken. The Chief Executive also stated that in situations where the issues are clearer, for example if a long term patient in Knockbracken Healthcare Park should die, she would personally write to the family and members of staff would attend the funeral and offer appropriate support.

The Chief Executive of Foyle Health and Social Services Trust when interviewed also confirmed that at the time this incident took place the

Trust did not have a specific policy in place regarding support for families bereaved by suicide. He stressed that at the time of Madeleine's stay in Gransha Hospital, staff did not have any knowledge of the threats to Lauren.

The Suicide Awareness Co-Ordinator, Westcare Business Service was interviewed by Panel members. He talked about his role and referred to 'Bereaved by Suicide' document, produced due to lack of information on bereavement both from an emotional and practical point of view. He indicated that in his view it was essential to provide an immediate response to families bereaved by suicide, including those who may not have had any previous contact with statutory services. The Co-Ordinator advised that the Gormley family had been offered support in January 2006, following an approach by a family member, but the offer was not taken up.

In October 2006 the DHSSPS launched 'Protect Life – A Shared Vision' – The Northern Ireland Suicide Prevention Strategy and Action Plan 2006 – 2011. One of the principles set out in the document reads: -

- *Engagement – support for, and commitment to, continued consultation with bereaved families, survivors, carers and their representatives.*

In the Strategy's Action Plan there are 'Actions' to support families in times of distress and to ensure that accessible information and timely support is available to all bereaved by suicide, both at community / voluntary and statutory level.

It is the Panel's view that both Trusts should have contacted relatives quickly after the deaths of Madeleine and Lauren and offered support and assistance. Sensitivities about the marital situation and next-of-kin should not have delayed or prevented such an initiative. The absence of any such initiative significantly added to the grief and distress of relatives and is still a significant issue in their grieving process. Implementation of the new Suicide Prevention Strategy should however address this issue in the future.

RECOMMENDATION 29:

Whilst acknowledging the planned benefits in ‘Protect Life – A Shared Vision’ – The Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011 launched in October 2006, including its stated intention to provide support and assistance to families bereaved by suicide, we take the view that some of the proposed ‘Actions’ in the Strategy document need to be brought forward more quickly than planned. We recommend that the DHSSPS should review this matter urgently and consider whether or not earlier implementation would be possible.

If this proves to be impossible we further recommend that Trusts should be required to urgently establish interim arrangements to provide support and assistance to families bereaved by suicide, in order to temporarily fill the gap in service provision clearly identified in relation to the lack of support provided to the O’Neill and Gormley families.

6.14 Inter Hospital Transfer of Patients and Their Records

An important issue identified by the Panel was the ‘transfer’ of Madeleine O’Neill from Knockbracken to Gransha Hospital on 14 June 2005, with her medical records, in the care of her parents.

The sequencing of the ‘transfer’ was: -

- Knockbracken staff advised that the medical records (in a sealed envelope) were handed to Mr Gormley to take to Gransha.
- Mr Gormley states that he was not given any records.
- Gransha staff advised that they did not receive any records.
- Gransha staff were therefore unaware of Madeleine’s threats to Lauren O’Neill’s life.
- Madeleine was in Gransha from 14 June until her discharge on 27 June 2005.
- During that time Gransha staff did not contact Knockbracken seeking Madeleine’s records.

The sad outcome was that had Gransha staff been aware of threats to the life of Lauren, her death might have been prevented.

There is some query as to whether or not this was a transfer or a discharge (at Knockbracken) and a new admission (at Gransha). In the South and East Belfast Trust Report, the term *transfer* is used in various paragraphs. It also indicates that Madeleine was *discharged* on 14 June 2005. In the Foyle Trust Report, ‘Background Summary’, the term *transfer* is used twice in the first paragraph, but in the second paragraph it states that Madeleine was *admitted* to Gransha.

Subsequently, South and East Belfast Trust has made it clear that in its view Madeleine was transferred to Gransha Hospital, rather than discharged. Had Madeleine been discharged from Knockbracken the Trust has stressed that its discharge policy requirements would have been implemented.

The Panel has noted this clarification, despite the use by both Trusts of the terms *transfer* and *discharge* in their documentation. However, the Panel is also clear that the evidence existed to have justified Madeleine’s compulsory detention at Knockbracken for assessment and treatment, if she had stated an intention to leave hospital care.

Apart from looking in detail at the specific issues surrounding Madeleine's transfer / discharge from Knockbracken to Gransha, the Panel also decided to look at the policy guidance available to staff in such situations.

A letter dated 25 April 2005 from a Principal Medical Officer and the Chief Pharmaceutical Officer, DHSSPS to HPSS Trusts advised that it was becoming increasingly common for patients to be transferred between HPSS organisations and that the HM Deputy Coroner for Greater Belfast had highlighted in a recent case where a patient death had occurred that systems should be in place to indicate what medical and nursing staff should do in cases where a patient is transferred between hospitals with the notes not accompanying them. He had also asked that proper procedures should be put in place across all hospital Trusts in Northern Ireland. The Department's letter also advised that it was necessary for every Trust to develop protocols for actions that should be followed when patients are moving between organisations. Trusts were asked to confirm completion and implementation of protocols by 30 June 2005.

During the summer of 2005 the Principal Medical Officer, DHSSPS convened a small sub-group of CREST (which had agreed to help with development of a regional protocol) and this sub-group produced a draft 'Protocol for the Inter Hospital Transfer of Patients and Their Records'. On 30 December 2005 the Principal Medical Officer wrote to the Chairman, Royal College of Psychiatrists (NI) advising that the CREST sub-group was aware that there were particular issues that psychiatric hospitals need to take into consideration and that there were sensitivities surrounding psychiatric notes. A considered view was requested from the Royal College of Psychiatrists (NI). (CREST – Clinical Resource Efficiency Support Teams – was established in 1988 under the auspices of the DHSS(NI) Medical Advisory Structure. It comprises some 20 health care professionals from the health service in Northern Ireland, with a key aim to promote clinical efficiency whilst ensuring that the highest possible standard of clinical practice is maintained).

By this time (December 2005) the Eastern Health and Social Services Board (EHSSB) was aware of the issues arising from the deaths of Madeleine and Lauren. The DHSSPS had been informed by Trusts in the summer of 2005 that the guidance issued in April 2005 had been implemented. A follow-up audit carried out by a Consultant in Public

Health Medicine, EHSSB in the autumn of 2005 in the EHSSB area indicated that this was not the case. In February 2006, Clinical Directors of Adult Mental Health Services in the EHSSB area advised that almost all Trusts were developing protocols relating to document transfer, but many Clinical Directors had not seen the April 2005 DHSSPS guidance. The Clinical Directors were asked to keep progressing the development of protocols within their Trusts.

In May 2006 the Consultant in Public Health Medicine, EHSSB provided to the Clinical Director of each Mental Health Unit in the EHSSB area, a draft CREST Protocol as revised by input from the Royal College of Psychiatrists (NI) and requested further information and assurances from Trusts by 30 June 2006 as to the extent to which protocols had been developed and were being implemented.

The draft CREST Protocol, as revised and expanded by input from the Royal College of Psychiatrists (NI) covered, inter alia, professional (Medical and Nursing) roles, documentation to be transferred with patients and specific guidance in relation to Mental Health transfers. However it indicated that patient transfers would be carried out by ambulance transport and specifically stated that staff should not normally transfer patients, clients or their records using their own cars, unless there are very exceptional circumstances. It also specifically stated that the referring unit remains responsible for the provision of care until the patient arrives and is accepted by the receiving unit. There was no mention in the draft CREST Protocol about a patient transferring from one hospital to another, with their medical records, in the care of relatives and using relatives' personal transport.

The responses received by EHSSB to its request for further information in May 2006 from the six Mental Health Units in Trusts in its area were provided to the Panel in August 2006.

South and East Belfast Trust (Knockbracken Mental Health Service), which had provided in-patient care to Madeleine in June 2005 until her move to Gransha, advised in July 2006 that the Trust was in the final stages of updating its current transfer protocol and that the updated protocol had been discussed with staff and would be formally circulated within the Trust. A copy of the final draft was forwarded. This final draft had followed the draft CREST Protocol to a large extent, but had also

included additional requirements covering Child Protection issues and relevant specific statements – *Staff must not transfer Patients/Clients using their own cars, patients cars or the cars of relatives and under no circumstances should the Patient or the Relatives be given the responsibility of Transfer or management their own notes (sic) or other relevant documentation.* At the Panel's request the Trust forwarded a copy of its final protocol document in November 2006.

Of the responses from the other five Trusts, two had protocols which did not mention Child Protection issues or transfers by or with relatives. One Trust had an updated protocol which included specific Child Protection issues and precludes transfers by or with relatives. One Trust expected to have an updated protocol in place by the end of September 2006 but did not forward the document. Another Trust which has a hospital dealing with Learning Disability Psychiatry advised that transfers to other Psychiatric Units rarely if ever occur and there was therefore no separate protocol in place.

Following correspondence from the EHSSB there is evidence that Trusts in the EHSSB's area had put or were in the process of putting updated protocols in place, taking account of the revised CREST Protocol. However, this revised Protocol – published and circulated to Trusts in August 2006 – did not include references to either Child Protection issues or the involvement of relatives in the process of transferring psychiatric patients and their records from one psychiatric hospital to another.

RECOMMENDATION 30:

In light of the circumstances leading up to the deaths of Madeleine and Lauren, the DHSSPS should request CREST or its successor organisation to urgently review its August 2006 Protocol relating to inter-hospital transfer of mental health patients, with a view to including: -

- **A section dealing with Child Protection issues (perhaps along the lines of the Child Protection section in the Protocol document drawn up by South and East Belfast Trust**

[Knockbracken Mental Health Services – Treatment Services] in November 2006) (Appendix 3).

- **A specific statement that if transfers of patients are carried out by or with relatives and their personal transport, the patients' records must be transferred separately from the patient and relatives, by secure means.**
- **A specific statement that transfers of patients must always require pre-move written data setting out core features of the illness, diagnosis and reasons for the transfer, to be faxed or emailed, in keeping with approved confidentiality arrangements, in advance to the receiving hospital, and agreed in writing by the accepting Consultant, prior to the actual move.**
- **Guidance to Trusts on definition and use of the words 'transfer' and 'discharge' in the context of movement of a patient from one psychiatric hospital to another in the province with no intention of the patient returning to the referring hospital, given the apparent interchangeable use of the two words in relation to the movement of Madeleine O'Neill from Knockbracken to Gransha Hospital.**

When this further updated CREST protocol is available it should be issued by the DHSSPS to Trusts for implementation as a standard protocol throughout the service in Northern Ireland, rather than as guidance for the preparation of protocols by each individual Trust.

In addition, within 6 months of issue of CREST's updated protocol, the DHSSPS should require Trusts to provide evidence of specific action undertaken to make relevant staff aware of the updated protocol, the need to adhere to it strictly and the need to formally review the working of the updated protocol at regular intervals of not more than one year.

6.15 DHSSPS Guidance – May 2004

In October 2004 the DHSSPS issued a guidance document 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others', (dated May 2004). This guidance replaced previous guidance issued in 1996.

The stated purpose of the guidance (Para. 1) was that all service users, in whatever setting, should have a care plan appropriate to their needs. The specific aim was to ensure that people with a mental disorder who are being discharged from hospital, and who could represent a risk of serious physical harm to themselves or others, receive appropriate continuing support in the community.

In its covering letter dated 19 October 2004 the Department stressed the importance of the guidance being widely circulated and made available to all professional staff and managers responsible for mental health in-patient provision. The Department also advised that the guidance should form a framework for the development of local policies and procedures.

In the published 'Executive Summary and Recommendations from the Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board', presented to the Eastern Board in May 2006, that Panel concluded that implementation by Trusts of the Department's 2004 guidance *would go a long way towards addressing many of the issues identified during the Inquiry*. The Panel made two specific recommendations: -

We recommend that the Department put in place a robust audit of each service provider's implementation of the May 2004 Guidance...

While we believe that much of the 2004 Guidance could be implemented without significant additional resources, we recommend that the Department should consider providing whatever resources prove necessary for the re-training of staff in new responsibilities outlined in the Guidance, such as those of the Care Co-ordinator.

The Independent Inquiry Panel supports these views and recommendations.

So what had happened since the Department's revised Guidance was issued in May 2004, particularly up to the time of the deaths of Madeleine and Lauren in July 2005?

Madeleine was an in-patient in Knockbracken from 9 June 2005 until her move to Gransha Hospital on 14 June 2005. The Trust responsible for her care during this period was South and East Belfast HSS Trust.

Madeleine was an in-patient in Gransha Hospital from 14 June 2005 until her discharge on 27 June 2005. The Trust responsible for her care during this period was Foyle HSS Trust.

In October 2005, (3 months after the deaths of Madeleine and Lauren), Eastern HSS Board carried out an audit of implementation of the 2004 Guidance with relevant Trusts in its area, as part of the Board's monitoring of Key Quality Issues for 2005-2006.

In the response of the SEB Trust to the Eastern Board's audit, the Trust's Chief Executive stated that the Guidance had been widely circulated and had been discussed on a number of occasions within the Trust. The Chief Executive went on to say that several areas of concern had been raised, relating to the range of professions involved in implementing the guidance, i.e., medical, social work, nursing and psychology. The Eastern Board was also advised that the Trust had received a copy of a response to the Guidance from the Royal College of Psychiatrists (NI) dated July 2005 and that the Trust concurred with the issues raised by the Royal College.

In effect, the 2004 Guidance had not been fully implemented by the SEB Trust at the time of the deaths of Madeleine and Lauren in July 2005, and indeed that remained the situation for some time to come.

The outcome of the Eastern Board's audit in October 2005 was conveyed to a Deputy Secretary, DHSSPS on 11 May 2006 by the Board's Chief Executive. On 9 May 2006 the Deputy Secretary, DHSSPS wrote to the Chairs and Chief Executives of all HSS Trusts, (copied to the Chairs and Chief Executives of all HSS Boards), stressing the Department's clear

expectation that the 2004 Guidance is implemented in full by the HPSS. Assurances were requested from each Trust that the Guidance was being implemented. Where this was not the case, Trusts were asked to take immediate steps to secure its full implementation. Written assurances were requested by 30 May 2006.

In the SEB Trust's reply to the Department dated 14 June 2006, the Chief Executive advised that the Guidance had been circulated to all clinicians and was being implemented as far as possible. Whilst the Trust had no difficulty with the general principles within the Guidance, there remained concerns amongst clinicians about some of the details in the Guidance; this information had been forwarded to the Department through the Royal College of Psychiatrists (NI). In the meantime the Trust would continue to work within the Guidance, as far as possible.

In the Foyle Trust's reply to the Department dated 30 June 2006, the Chief Executive advised that a group comprising Senior Managers and Consultant Psychiatrists had met to review the Trust's compliance with the 2004 Guidance. The group had identified a series of steps which needed to be taken to ensure full compliance and these steps were being addressed by the Trust. In addition, the Chief Executive suggested that additional guidance should be issued by the Department, in relation to some aspects of the 2004 Guidance.

At the end of June 2006 the Foyle Trust's Chief Executive also advised the Independent Inquiry Panel that insofar as application of the 2004 Guidance to Madeleine's case was concerned, the information available to Foyle Trust at Madeleine's admission and during the course of her in-patient care and treatment period, did not fall within the scope of the Guidance and as a result the Guidance was not applied in this particular instance. This seems to refer to the problems surrounding the transfer of Madeleine's medical records from Knockbracken to Gransha and the lack of information therefore available to Gransha staff regarding threats to the life of Lauren, an issue which is dealt with in detail elsewhere in this Report.

It is clear that the Department's 2004 Guidance was not fully implemented by either the SEB Trust or the Foyle Trust between its issue in October 2004 and the deaths of Madeleine and Lauren in July 2005. Indeed, it is also clear that neither Trust had fully implemented the

Guidance by May 2006 when the Department requested information on the extent of implementation by that time. Whilst there were issues raised about the 2004 Guidance, mainly through views expressed by the Royal College of Psychiatrists (NI), it is the Panel's view that action should have been taken by the Department much earlier than May 2006 to ensure that the 2004 Guidance was either implemented in full, or amended having regard to the views expressed by the Royal College of Psychiatrists (NI) and Trusts.

If the 2004 Guidance had been fully implemented by July 2005, would it or could it have helped to prevent the deaths of Madeleine and/or Lauren?

The 2004 Guidance states clearly (Para. 3) that for it *to apply, the person must have a mental disorder and also be considered to represent a risk of serious physical harm to themselves or others.*

In the Panel's view, Madeleine clearly came within this definition during her in-patient stay in Knockbracken. She had a mental disorder, and, having already attempted suicide, continued to threaten suicide again and had also threatened the life of her child, Lauren, in the process. The Guidance indicates that assessments of those at-risk prior to discharge should include, inter alia, risk factors such as previous suicide attempts, serious depressive illness, recent adverse life events, e.g., relationship problems, which all applied to Madeleine. It also states that where a multidisciplinary team assessed a significant risk, a care plan must be drawn up. Development of such care plans should include the involvement of relatives and should also *take particular account of the needs of children...of people with mental health problems.* A 'Key Worker' and 'Care Co-ordinator' should also be nominated.

None of these actions were taken during Madeleine's in-patient stay in Knockbracken. If they had been, Child Protection measures could have been put in place which might have prevented the death of Lauren.

The SEB Trust Report relating to the deaths of Madeleine and Lauren notes that if Madeleine had remained in Knockbracken a Child Protection Case Conference would have been arranged involving the Family and Child Care Team. It could be argued that having regard to the reasons for Madeleine's admission to Knockbracken for treatment and, in

particular, the identified risk to Lauren, this action should have been taken in any case. Had this been done, the risk to Lauren should have been passed to the Child Care Team in Foyle Trust when Madeleine was admitted to Gransha Hospital and, in turn, this risk should have been passed to Gransha staff, despite Madeleine's medical notes from Knockbracken not being available. Indeed, this might have stimulated action by Gransha staff to acquire Madeleine's medical notes from Knockbracken.

Again, if these actions had been taken, Child Protection measures could have been put in place which might have prevented Lauren's death.

As indicated previously, the view of Foyle Trust is that the information available at the time of Madeleine's admission to Gransha Hospital and during her period of in-patient care, did not place Madeleine within the scope of the 2004 Guidance and therefore the Guidance was not applied in this particular instance. Whilst this is true in relation to possible risk of serious physical harm to others, nevertheless some of the risk factors set out in the Guidance relating to self-harm do appear to be applicable and are recorded in Madeleine's medical and nursing notes in Gransha, e.g., previous suicide attempt, serious depressive illness, recent adverse life events.

It could therefore be argued that preparation of a care plan, under the 2004 Guidance, should have been undertaken in Gransha Hospital and this may have alerted the multidisciplinary team to ensure that Lauren's needs were also taken into account.

However, it is perhaps not unreasonable to draw attention to the particular events and circumstances which influenced the thinking of both SEB and Foyle Trusts. Given the relatively short period of time that Madeleine was a patient in Knockbracken (9-14 June 2005) and that it was known quite early in her stay in Knockbracken that she might soon be moved to Gransha Hospital, Londonderry, it was felt that it was better not to develop a care plan while she was there, but rather to leave it to Gransha Hospital staff to plan and implement her treatment. Had Madeleine's medical records reached Gransha Hospital staff at the time of her move to that hospital on 14 June 2005, including the documented risk to Lauren, Gransha Hospital staff might well have determined that Madeleine did come within the scope of the 2004 Guidance and planned

her treatment accordingly, including implementation of measures to protect Lauren.

In summary however, the Panel takes the view that, whilst taking account of the particular sequence of events and circumstances during Madeleine's in-patient stay in both Knockbracken (9-14 June 2005) and Gransha Hospital (14-27 June 2005) and the consequent absence of formal care planning for Madeleine in both hospitals, more might have been done by Knockbracken to ensure that the documented risk of harm to Lauren was specifically brought to the attention of child care staff in Foyle Trust when Madeleine moved to Gransha Hospital, and by Gransha Hospital to approach Knockbracken to obtain information about Madeleine's previous care and treatment, which would have identified the risk to Lauren.

Had these actions been taken, the death of Lauren, and perhaps even the death of Madeleine, could possibly have been prevented.

On 4 October 2006 the Panel Chair wrote to the Deputy Secretary, DHSSPS advising that the Panel would wish to reflect any views the Department may have on the implementation of the May 2004 Guidance in its report and requesting information on the following points: -

- (i) *The extent of response from Trusts to your letter of 9 May 2006, i.e., did all Trusts respond by 30 May 2006 as requested and are any responses still outstanding?*
- (ii) *Can you give any indication of the general 'state of play' regarding implementation from the responses received from Trusts?*
- (iii) *What action has been taken by the Department since 30 May 2006, taking account of responses from Trusts?*
- (iv) *What further action is envisaged / planned from this point on?*

(v) *What timescales are attached to any action envisaged / planned by the Department?*

The Panel Chair also indicated that the Panel would be interested in any other more general points that the Department would wish to make and that, as drafting of the Panel's report was likely to commence in October, the Panel would be grateful for a response as soon as possible.

On 15 December 2006 a new Deputy Secretary, Social Policy Group, DHSSPS wrote in response to the Panel's letter of 4 October 2006 advising that she now had responsibility for the issues referred to in the correspondence.

The response noted that all relevant HSS Trusts had replied to the Department's letter of 9 May 2006. With the exception of one Trust which had wrongly considered that the Guidance did not impact on its services, all Trusts stated that they were implementing the Guidance, although four Trusts had indicated that further work was needed, either to update their policies and procedures or to improve their procedures to ensure full compliance. Three Trusts had indicated that their policies were being reviewed.

Several Trusts had raised concerns about implementing the Guidance. The main issues related to definition of patients who should be covered by the Guidance and resource implications of implementing the Guidance.

The Deputy Secretary went on to say that the responses from Trusts had helped to inform the terms of reference and proposed work plan for a regional group on assessment and management of risk in mental health services, which had recently been established; the first meeting of the group was at the end of October 2006. A review of existing policies and procedures to be carried out by the group, through self- assessment by Trusts and follow-up visits by the Regional Quality and Investigation Authority, will include the 2004 Discharge Guidance. This will give the Department a more in-depth picture as to how the Guidance has been put into practice and what needs to be done to facilitate full compliance. The proposed timescale of the regional group's project work runs until July 2008.

A copy of the regional group's Terms of Reference and Work Plan are attached to this report (Appendix 4).

RECOMMENDATION 31:

- **DHSSPS should ensure that when guidance is issued for implementation by the HPSS on particular service issues, an audit mechanism is included to ensure that the required action is taken within a specified timescale.**

RECOMMENDATION 32:

- **There are clearly continuing issues of understanding and interpretation of some aspects of the 2004 Guidance apparent within Trusts and the medical profession, (as expressed by the NI Branch of the Royal College of Psychiatrists), which contributed in some measure to the handling of the care and treatment of Madeleine. We note the action taken recently by DHSSPS to establish a Regional Group to review assessment and management of risk in mental health services and the timescale involved but would nevertheless recommend that the DHSSPS takes urgent action to specifically review and update the 2004 Discharge Guidance, in conjunction with Boards, Trusts and the relevant professions.**

6.16 Trusts' Reports

Following the deaths of Madeleine and Lauren on 12 July 2005, the two Trusts involved – South and East Belfast HSS Trust and Foyle HSS Trust – prepared internal reports.

The South and East Belfast Trust report was dated 7 October 2005 and was submitted to the EHSSB later that month. The Foyle Trust report was dated 26 January 2006, but a draft report was submitted to WHSSB in November 2005.

Both reports were provided to the Independent Inquiry Panel by the two Boards at the outset of our work, together with papers such as medical, nursing and other clinical notes, and various policy documents, protocols and guidance issued by the DHSSPS, Board and Trusts.

The Panel was struck early in its work by the difference in approach used by the two Trusts in preparing their reports. The South and East Belfast Trust report was prepared on the basis of guidance issued in 2005 by the Mental Health Commission, i.e., using a review meeting approach with representatives present from various departments which had previous contact with Madeleine in both South and East Belfast Trust and Belfast City Hospital Trust. The Foyle Trust report was prepared following an investigative approach, which included individual interviews with a number of Trust staff, and had a number of specific sections on conclusions, recommendations and a timeline of events.

Both reports provided good background information about the care and treatment of Madeleine and the various associated significant events. However, we found the Foyle Trust report much easier to use generally, in terms of accessing specific information and following the sequence of events.

The DHSSPS Guidance paper (May 2004) is silent on the format and contents of an initial investigation report by a Trust, where there has been a serious untoward incident such as a suicide or homicide. The Chief Executives of the two Trusts and the senior Trust officers responsible for producing the two reports were interviewed to obtain their views as to whether or not it would be useful to have guidance on a standard approach to producing such reports in similar situations in the future.

They were unanimously of the view that this would be welcomed and the Panel has drawn up an appropriate recommendation.

RECOMMENDATION 33:

- **Steps should be taken by the DHSSPS, in conjunction with Boards, Trusts and other relevant bodies such as the Mental Health Commission and ACPCs, to draw up and issue guidance regarding the production of initial investigation reports by Trusts, in situations where there has been a serious incident such as a suicide or homicide, involving a patient or client. Such guidance should, at least, include draft terms of reference for such an investigation, proposed model format of a report and proposed timescale.**

6.17 Madeleine's Gransha File – Security Issues

The Panel obtained a copy of the Foyle Trust's 'Serious Incident Policy' (March 2006), which sets out the framework and operational arrangements for the management of serious adverse incidents within the Trust. In paragraph 4.1.3 of this policy it states that in the event of a serious incident*all patient records / notes must be secured as soon as possible and only be made available for any subsequent investigation.*

In the 'Report of the Inquiry Panel (McCleery) to the Eastern HSS Board' (January 2006), the Panel commented on the issue of securing records for the purposes of inquiry and made the following recommendation: -

In order to maximise confidence in and to protect the integrity of, any investigation (whether internal or external) the Panel recommends that the Trust should make it standard practice for all papers relevant to a patient's care (from whatever source and from first contact with services) to be secured immediately after such a serious incident and stored at one site. We recognise that papers may be required for a number of purposes, including internal reports, but this can be managed from the central site, and copies, rather than original documents, can be used. We further recommend that the responsible Board should satisfy itself that papers have indeed been secured in a timely fashion.

Section 10.15 of 'Co-operating to Safeguard Children' provides useful guidance in terms of securing files following the death of a child and this could equally apply to all individuals known to Social Services: -

Immediately upon the death of a child known to social services, or once it is known that a case is being considered for review, each involved agency should immediately secure its records relating to the case to guard against contamination, loss or interference until the case management review process is complete. Where access to secure records is required by a member of staff involved in the case from any individual agency it should only occur under the supervision of an independent senior member of staff. Such

access must be recorded and signed and dated by those involved.

Whilst there was no specific policy in place in July 2005 in Foyle Trust in relation to securing of records following a serious untoward incident, the Programme Manager, Mental Health Services advised at interview that on hearing on 14 July 2005 of the deaths of Madeleine and Lauren, he instructed that Madeleine's file should be retrieved for safekeeping in the Cityside CMHT office. Whilst this was done, it is clear that the file was not 'secured'. Rather it was moved from an open shelf in the office to another part of the office where it could still have been accessed by any member of staff in the office. In addition the file was given later that day (14 July 2005), on request, to the Consultant Psychiatrist and SHO to read through and prepare a final discharge letter to Madeleine's GP. The file was returned to Medical Records Department, Gransha Hospital on 15 July 2005 and the final discharge letter was typed and issued to the GP on 19 July 2005. This letter, although written after the deaths of Madeleine and Lauren, made no reference to the fact that Mrs O'Neill was now deceased.

It is clear that Madeleine's file was not 'secured' on 14 July 2005, that it was accessed later that day by medical staff and that it was taken away to Gransha Hospital. Senior Trust Officers accept that this should not have happened and that the file should have been locked away for safekeeping.

RECOMMENDATION 34:

We fully endorse and support the recommendation of the Inquiry Panel (McCleery) and the guidance in 'Co-operating to Safeguard Children'. In light of events in this case, the DHSSPS should issue further formal guidance / instructions to all Trusts in relation to the need to secure all relevant documentation and files in such circumstances, as a matter of urgency.

7. LITERATURE REVIEW

To guide and underpin the work of the Independent Inquiry Panel, the Chair and one other member of the Panel undertook a necessarily limited review of two areas of the available literature: -

- i. Previous inquiry reports and literature focusing on learning gained from inquiries generally, including how successful they have been in impacting on policy and practice in the health and social care fields and preventing further tragedies.
- ii. Literature and research in relation to parents who kill their own children, particularly where the parent has a mental disorder and has taken their own life.

The literature review can be found in full at Appendix 5 and the Panel hopes that it will be used as a stand alone resource to promote evidence based practice improvement in treatment, risk assessment and child protection. The literature review has also informed the first recommendation below.

During the late drafting stages of the Inquiry Report the Panel became aware of research and guidance which it would have been helpful to have had access to at an earlier stage and this has informed the second recommendation in this section.

RECOMMENDATION 35:

- **DHSSPS in collaboration with corresponding Departments in England, Wales and Scotland should commission UK wide research into all aspects of child killing to ensure that attention is given to increasing the understanding of cases involving parents who are mentally disordered but where there are no pre-existing child care concerns. This work should build on the existing international literature and seek to resolve the problems with definition that have made it difficult to translate research findings into practice guidance that**

would inform risk assessment. DHSSPS and its partner Departments in this research should ensure that this work is integrated with Child Death Review arrangements and with the work of the new Safeguarding Board for Northern Ireland.

RECOMMENDATION 36:

- **When commissioning inquiries DHSSPS and Boards should ensure that inquiry panels have early access to research and similar inquiries of which DHSSPS and/or Boards are aware. This would avoid duplication of effort and support the learning objectives of inquiries.**

8. COLLATED RECOMMENDATIONS

The work of this Independent Inquiry has identified major issues in respect of processes, procedures and systems in Trusts involved, which are probably indicative of more systemic HPSS issues in other Trusts. A mechanism should be established by the two Boards which commissioned the Inquiry working alongside DHSSPS to ensure that the learning and recommendations of the Report are systematically actioned regionally with progress on implementation monitored.

Communication

1. Belfast City Hospital, South and East Belfast Trust and Foyle Trust should review their arrangements for multidisciplinary working and information sharing focusing

on: -

- roles
- the nature of services
- treatments and interventions
- structures
- accurate targeting of referrals
- formal and informal processes
- internal and external communication
- recording of information
- case co-ordination/key working
- training
- unit / professional culture

2. South and East Belfast Trust should review its arrangements for admitting patients for in-patient care, with particular reference to a daily waiting list management and bed management system and an ongoing contact system with patients and their carers when beds are not available. There is a need to ensure that systems are in place within Knockbracken which track a request for admission and assist in the management of risk and patients until a bed is allocated.

3. Foyle Trust should review its arrangements for admitting patients for in-patient care to Gransha to ensure in particular that SHOs obtain all relevant background information from the referring GP or hospital and

collateral information from the patient's family, as far as is practical, on the day of admission.

4. The DHSSPS and the Boards should instruct Trusts to draw up and implement policies regarding consultation by staff with patients' families during an in-patient stay, in particular at admission, discharge and where the patient has a dependent child or children.

5. Trusts should ensure that there is clarity in the role and function of Crisis Response Teams, Home Treatment Services and Community Mental Health Teams.

6. Trusts should ensure that there are sound arrangements for clinical supervision within Community Teams in general and specialist advice/support in Community Home Treatment and Crisis Response Team services. In constructing these arrangements Trusts should be aware that increasing specialisation of services is likely to make it more difficult for individual practitioners to fulfil a keyworking / co-ordinating role across a care plan.

7. Trusts should ensure that protocols for discharging patients from a service should be clear and should include the principle of informing the referral agent, the patient's GP and other professional colleagues involved in the care of the patient.

Child Protection / Children in Need

8. All Boards and Trusts should review the child protection training and awareness of all staff, including access to policies and procedures.

9. DHSSPS in conjunction with Boards' ACPCs should review the content and uptake of child protection training delivered to GPs and should consider making such training mandatory for all relevant staff and practitioners.

10. Counselling bodies should make child protection training including refresher training a mandatory component of ongoing registration.

11. Counselling bodies should require counsellors registered with them to follow the Department's Child Protection Policy 'Co-operating to Safeguard Children' and Regional ACPC Policies and Procedures.

12. DHSSPS should review Co-operating to Safeguard Children and the four ACPCs should review their Child Protection Policy and Procedures to ensure that both documents provide consistent and specific guidance for counsellors and psychotherapists, particularly those working in a private capacity.

13. The DHSSPS should, in conjunction with the Department of Employment and Learning and education providers, review all undergraduate and post graduate training for relevant professions to include a core understanding of child protection issues.

Competency, Training and Education of Staff in Mental Health

14. Trusts should ensure that all SHOs new to Psychiatry should have an induction course covering role clarification and a basic knowledge of common psychiatric disorders, their treatment and management.

15. Trusts should ensure that multidisciplinary staff are aware of the nature of therapeutic relationships and the concepts of transference and counter-transference.

16. Trusts should ensure that staff working in the field of mental health have continuous professional development plans which include in-service training and evidence based practice refresher courses.

Mental Health / Childcare Interface

17. DHSSPS and Boards should ensure that each Trust puts in place a joint protocol designed to manage the interface between mental health and child care services, addressing and facilitating the co-working of cases where there are concerns that adult mental health problems may impact on the care of children.

18. The four ACPCs should jointly commission multidisciplinary training across the region for mental health and child care staff, focused on working together in cases where there are adults with mental health

issues who have dependent children. This training must explicitly deal with child in need issues as well as child protection matters. The ACPCs should make use of the Crossing Bridges (1998) training resource produced by Department of Health.

19. DHSSPS should ensure that consideration of parental mental health is integrated into all stages of the new Northern Ireland Assessment Framework for Children. (Understanding the Needs of Children in Northern Ireland).

Assessment / Risk Assessment

20. South and East Belfast Trust should review the assessment models used by CRT and FCC IAT in cases where a parent with dependent children has attempted suicide or made a serious threat of self-harm.

21. DHSSPS should develop guidance that would lead to the implementation of consolidated assessments in mental health. Consolidated assessment would underpin improvements in risk assessment, key working/case co-ordination, multidisciplinary working, care planning and discharge planning which all feature in other recommendations in this report. It would also include assessment of the impact of mental illness on carers and on children and the adequacy of support arrangements for them.

Supervision

22. Boards and Trusts must ensure that supervisory policies are in place which require that: -

- Arrangements are in place to monitor and audit assessment, case management, effectiveness of interventions, record keeping and discharge planning of individual cases.
- Staff understand and adhere to ACPCs' Child Protection Policy and Procedures.
- In all situations where there are concerns relating to children there is an appropriate multi-agency assessment of risk.

- There is a named nurse and named doctor with clearly defined responsibilities to provide a lead role for child protection within mental health services.

Care Planning

23. DHSSPS should review guidance in relation to care planning. The review should ensure that care plans are designed in conjunction with a model of care and include consideration of risk assessment and management, multidisciplinary working, verifying information provided by the patient, and objective, evidence based approaches to care plan changes.

Discharge Planning

24. Both SEB and Foyle Trust should undertake urgent reviews of their systems for developing discharge plans for patients leaving their hospitals. In addition DHSSPS should consider providing guidance in relation to discharge planning. The basic elements which should form part of future discharge planning would include: -

- Comprehensive Multidisciplinary Team input.
- Identified planned date of discharge.
- Clear discharge pathway to cover all aspects of discharge.
- Professionals or services named in discharge plans must have been contacted and provided informed agreement to their inclusion in the plan.
- Discharge and leave destinations should be known and associated risk assessed, including contingency planning.
- Where there is a parenting role, risk assessment and plan must be recorded.
- Discharge plans should include provision for engagement with follow-up services.
- Consideration should be given to carer involvement.
- A relapse prevention plan should be drawn up, with carers' involvement.
- Parents with serious mental illness should be prioritised for follow-up after discharge.

Bed Management

25. Boards and Trusts must ensure that each in-patient unit has a bed management policy in place, which outlines the bed management system and identifies an accountable named individual.

Recording of Information

26. Both South and East Belfast and Foyle Trusts should have in place as part of their governance arrangements a system to monitor and audit case records within Mental Health services to ensure: -

- Accuracy
- Assessment and management of risk
- Care planning
- Effectiveness of treatment
- Discharge planning
- Correct patient identification

Interface Between Statutory Services and Private Counselling Services

27. DHSSPS in co-operation with responsible Departments in Great Britain should implement its commitment to the statutory registration and regulation of psychotherapists and counsellors as outlined in the 2006 consultation on standards. The associated guidance to psychotherapists and counsellors should aim to improve communication between statutory services and private counselling services, leading to a culture in both sectors where the benefits of co-ordinated care are promoted to patients/clients/service users. The guidance should also take account of Recommendations in the section on Child Protection/Children in Need in this Report.

Next of Kin

28. DHSSPS and Boards should ensure that Trusts have a policy in relation to identifying and recording 'Next of Kin' information. Trusts should also consider the extent to which staff training and/or refresher training should be provided for front-line staff involved routinely in taking personal history details from patients, particularly in situations where

patients have family issues relating to divorce, marital separation and dependent children.

Consultation with and Support to Families

29. Whilst acknowledging the planned benefits in ‘Protect Life – A Shared Vision’ – The Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011 launched in October 2006, including its stated intention to provide support and assistance to families bereaved by suicide, we take the view that some of the proposed ‘Actions’ in the Strategy document need to be brought forward more quickly than planned. We recommend that the DHSSPS should review this matter urgently and consider whether or not earlier implementation would be possible.

If this proves to be impossible we further recommend that Trusts should be required to urgently establish interim arrangements to provide support and assistance to families bereaved by suicide, in order to temporarily fill the gap in service provision clearly identified in relation to the lack of support provided to the O’Neill and Gormley families.

Inter Hospital Transfer of Patients and Their Records

30. In light of the circumstances leading up to the deaths of Madeleine and Lauren, the DHSSPS should request CREST or its successor organisation to urgently review its August 2006 Protocol relating to inter-hospital transfer of mental health patients, with a view to including: -

- A section dealing with Child Protection issues (perhaps along the lines of the Child Protection section in the Protocol document drawn up by South and East Belfast Trust [Knockbracken Mental Health Services – Treatment Services] in November 2006) (Appendix 3).
- A specific statement that if transfers of patients are carried out by or with relatives and their personal transport, the patients’ records must be transferred separately from the patient and relatives, by secure means.
- A specific statement that transfers of patients must always require pre-move written data setting out core features of the illness, diagnosis and reasons for the transfer, to be faxed or emailed in

keeping with approved confidentiality arrangements, in advance to the receiving hospital, and agreed in writing by the accepting Consultant, prior to the actual move.

- Guidance to Trusts on definition and use of the words ‘transfer’ and ‘discharge’ in the context of movement of a patient from one psychiatric hospital to another in the province with no intention of the patient returning to the referring hospital, given the apparent interchangeable use of the two words in relation to the movement of Madeleine O’Neill from Knockbracken to Gransha Hospital.

When this further updated CREST protocol is available it should be issued by the DHSSPS to Trusts for implementation as a standard protocol throughout the service in Northern Ireland, rather than as guidance for the preparation of protocols by each individual Trust.

In addition, within 6 months of issue of CREST’s updated protocol, the DHSSPS should require Trusts to provide evidence of specific action undertaken to make relevant staff aware of the updated protocol, the need to adhere to it strictly and the need to formally review the working of the updated protocol at regular intervals of not more than one year.

DHSSPS Guidance – May 2004

31. DHSSPS should ensure that when guidance is issued for implementation by the HPSS on particular service issues, an audit mechanism is included to ensure that the required action is taken within a specified timescale.

32. There are clearly continuing issues of understanding and interpretation of some aspects of the 2004 Guidance apparent within Trusts and the medical profession, (as expressed by the NI Branch of the Royal College of Psychiatrists), which contributed in some measure to the handling of the care and treatment of Madeleine. We note the action taken recently by DHSSPS to establish a Regional Group to review assessment and management of risk in mental health services and the timescale involved but would nevertheless recommend that the DHSSPS takes urgent action to specifically review and update the 2004 Discharge Guidance, in conjunction with Boards, Trusts and the relevant professions.

Trusts' Reports

33. Steps should be taken by the DHSSPS, in conjunction with Boards, Trusts and other relevant bodies such as the Mental Health Commission and ACPCs, to draw up and issue guidance regarding the production of initial investigation reports by Trusts, in situations where there has been a serious incident such as a suicide or homicide, involving a patient or client. Such guidance should, at least, include draft terms of reference for such an investigation, proposed model format of a report and proposed timescale.

Madeleine's Gransha Hospital File – Security Issues

34. We fully endorse and support the recommendation of the Inquiry Panel (McCleery) and the guidance in 'Co-operating to Safeguard Children'. In light of events in this case, the DHSSPS should issue further formal guidance / instructions to all Trusts in relation to the need to secure all relevant documentation and files in such circumstances, as a matter of urgency.

Literature Review

35. DHSSPS in collaboration with corresponding Departments in England, Wales and Scotland should commission UK wide research into all aspects of child killing to ensure that attention is given to increasing the understanding of cases involving parents who are mentally disordered but where there are no pre-existing child care concerns. This work should build on the existing international literature and seek to resolve the problems with definition that have made it difficult to translate research findings into practice guidance that would inform risk assessment. DHSSPS and its partner Departments in this research should ensure that this work is integrated with Child Death Review arrangements and with the work of the new Safeguarding Board for Northern Ireland.

36. When commissioning inquiries DHSSPS and Boards should ensure that inquiry panels have early access to research and similar inquiries of which DHSSPS and/or Boards are aware. This would avoid duplication of effort and support the learning objectives of inquiries.

APPENDICES

1. Independent Inquiry Panel Membership
2. List of Those Interviewed by Sub-Groups of the Independent Inquiry Panel
3. South and East Belfast Trust (Knockbracken Mental Health Services -Treatment Services) – Extract from ‘Protocol for the Inter Hospital Transfer of Patients and their Records (November 2006)’
4. Assessment and Management of Risk in Mental Health Services – Regional Steering Group – Terms of Reference
5. Literature Review
6. Glossary of Terms / Abbreviations
7. References

Independent Inquiry Panel Membership

Panel Membership

- | | | |
|-------------------------|---|--|
| Mr Drew Boyd | - | Chairman, Independent Inquiry Panel |
| Ms Bernie McNally | - | Vice Chairperson, Independent Inquiry Panel and Director of Children / Social Work and Mental Health Services, North & West Belfast Health and Social Services Trust |
| Mr Avery Bowser | - | Area Children's Services Manager, NSPCC |
| Dr Mary Clarke-Finnegan | - | Consultant Psychiatrist, Killarney, Co.Kerry |
| Mrs Stella Cunningham | - | Chief Officer, Southern Health and Social Services Council |
| Mr Trevor Fleming | - | Assistant Director of Nursing, Homefirst Community Trust |
| Ms Judith Lees | - | Senior Nurse, Safeguarding Children Homefirst Community Trust |
| Ms Mairead McCrea | - | Patient Advocate, Holywell Advocacy Services, Holywell Hospital, Homefirst Community Trust |
| Ms Cathy McPhilips | - | Assistant Director of Mental Health Services, Armagh/Dungannon Trust |
| Mr Mervyn Morrow | - | Queen's Counsel |

Administrative Support

- Mr John Mulkeen - Secretary, Independent Inquiry Panel
- Mrs Sheila Lafferty - Administrative Support

<p>List of Those Interviewed by Sub-Groups of the Independent Inquiry Panel</p>
--

Belfast City Hospital

- Specialist Registrar in General Adult Psychiatry
- Consultant Psychiatrist
- 2 Staff Nurses

Community Staff, South and East Belfast Health and Social Services Trust

- 2 members of Crisis Response Team
- 2 members of Cognitive Behavioural Therapy Team
- Social Worker on Family and Childcare Initial Assessment Team
- Principal Social Worker on Family and Childcare Initial Assessment Team

Knockbracken Healthcare Park

- Consultant Psychiatrist
- Senior House Officer (duty SHO when a bed was being sought for Madeleine)
- Senior House Officer (responsible for carrying out Madeleine's initial assessment)
- Ward Manager
- 2 Staff Nurses

Gransha Hospital

- Medical Director (accepting Consultant Psychiatrist)
- Locum Consultant Psychiatrist (responsible for Madeleine's care and treatment)
- Senior House Officer (responsible for carrying out Madeleine's initial assessment)
- Senior House Officer (responsible to Locum Consultant Psychiatrist)

- Ward Manager
- Ward Clerk
- Occupational Therapist
- 2 Staff Nurses

Foyle Health and Social Services Trust

- Chief Executive
- Programme Manager for Mental Health Services
- Team Manager, Cityside Community Mental Health Team
- Suicide Awareness Co-ordinator (Westcare Business Services)

South and East Belfast Health and Social Services Trust

- Chief Executive
- Director of Planning and Performance

Others

- General Medical Practitioner
- Private Counsellor

SOUTH AND EAST BELFAST TRUST
KNOCKBRACKEN MENTAL HEALTH SERVICES
TREATMENT SERVICES

Extract from ‘Protocol for the Inter Hospital Transfer of Patients and their Records (November 2006)’.

2.0 Child Protection issues

2.1 Where Child Protection concerns have been identified a referral must be made to the appropriate Family and Childcare team in the receiving Trust.

2.2 The referral must be made prior to the transfer and followed in writing within 5 days of transfer.

2.3 The time and date of the referral must be recorded in the notes.

2.4 The name of the Staff member in the receiving Trust who accepts the referral must also be recorded in the Medical and Nursing Notes.

2.5 Whilst it is good practice to inform the Patient and if appropriate nearest relative regarding the referral any decision to do so will be made by the Multidisciplinary Team. Sharing information in such circumstances is not deemed a breach of Professional conduct and is in keeping with the Child Protection Policies and procedures.

2.6 If there are child protection concerns identified a referral should be made to the Family and Child Care team where the child is resident. If the patient is transferred but the child remains at the address stated in the referral then the receiving Trust is made aware of the nature of the concerns and that a referral has been made. The family and child care team to

where the referral has been made should be made aware of the changes in the patient's circumstances. However if the family have moved address and this is the reason for transfer the family and child care teams in both Trusts must be notified.

2.7 The Mental Health Team in the receiving Service must be notified in writing that contact has been made with the family and child care team in their area.

ASSESSMENT AND MANAGEMENT OF RISK IN MENTAL HEALTH SERVICES

REGIONAL STEERING GROUP

TERMS OF REFERENCE

Background

Mental Health Services continually face the challenge of determining and managing the risk that some people may pose either to themselves or others. In the vast majority of cases Mental Health Services provide safe and effective care, minimising such risks through good professional practice. Inevitably however some adverse incidents will occur. Understanding and practice of good risk assessment and management is becoming increasingly important, not least as our local Mental Health Services continue to move towards more community based provision. Equally where serious adverse incidents do occur we must ensure that, where possible, learning from these incidents is shared.

The McCleery Inquiry Report, from which the Executive Summary and recommendations were made available by the Eastern Health and Social Services Board in May 2006, relates to such an incident. This Inquiry Report made 48 recommendations, mostly directed at the HSSPS, and which the Department endorsed as good practice recommendations to be implemented. These recommendations covered a broad range of areas including policy and procedures around admission and discharge, assessment and management of risk, in-patient observation and leave, integration across hospital and community services, use of the Mental Health Legislation, awareness and compliance with existing good practice guidance, management of untoward incidents, report writing and record keeping.

Although the McCleery Report refers to one unfortunate case it occurs against a background of a considerable number of serious

adverse incidents being reported by local mental health services to the Department. There are also other ongoing and past Independent Inquiries and Northern Ireland specific data collected by the Confidential Inquiry into Suicide and Homicide by people known to mental health services. Northern Ireland is not unique in regard to concerns over the assessment and management of risk in mental health services. The National Patient Safety Agency (NPSA) has recently published its first analysis of patient safety in mental health services and is also carrying forward work to address issues identifying safety in acute wards, management of aggression and violence, safer use of psychotropic medication, aggregate root cause analysis of suicides and a review of recent independent inquiries. The Department of Health has also commissioned a review of risk management, including the evidence framework, information sharing and training for professionals, and the Care Programme Approach. All of these initiatives will provide useful information and recommendations which will assist this project.

Aim

A programme, taking account of the McCleery Report recommendations and with full involvement of service users, carers and professionals, to review the management of risk for people with a mental disorder including those with dual diagnosis. The objective is to develop standards, processes, policies and training strategies to enhance services.

Scope

This initial programme will focus on statutory general Adult Mental Health Services, across both hospital and community settings, including services for people with a dual diagnosis of co-morbid substance misuse and also the functionally ill elderly but not dementia services. Learning disability and specialist Mental Health Services e.g. CAMHS, brain injury, specialist substance misuse services, will not be included in the initial phase of this work.

Objectives

1. *Establish baseline of current practice*

A. Review existing Policies / Standard Operating Procedures for the assessment and management of risk in relevant Trusts and how these (including the extant Discharge Guidance) are being implemented. This should include the investigation, follow-up and reporting of Serious Adverse Incidents. This review will be done against the relevant criteria within the Quality Standards for Health and Social Care 2006 and the recommendations of the McCleery Report. The review would be carried out through a self assessment exercise by Trusts, followed by review visits by RQIA, both of which should take account of the views of service users and carers.

B. Review of currently available information on adverse incidents in general Adult Mental Health Services including good practice recommendations. Potential sources include the Mental Health Commission, Trust Serious Adverse Incident Reports to DHSSPS, Independent Inquiries or other Serious Adverse Incident Reviews and the National Confidential Inquiry into suicide and homicide.

2. *Identify good practice and challenges in risk assessment and management by mental health services and explore potential models/opportunities for improvement.*

This will require close involvement of service users, carers and mental health professionals and be taken forward by a series of stakeholder workshops and consultations.

3. *Draft, consult and agree multidisciplinary regional standards for good practice in Risk Assessment and Management in general Adult Mental Health Services.*

The standards should improve the service provided to service users and carers, reassure public concerns, provide a

supportive framework for professionals, facilitate regional reporting of adverse incidents and dissemination of learning and also inform the methodology for conducting future Independent Inquiries.

4. Implementation of Regional Standards

This would include production of material to support awareness raising and staff training, including the potential for new ways of working, and promote continuous self improvement through services reflecting on their performance together with the views of users and carers.

Once implemented the future monitoring of the Regional Risk Assessment and Management Standards would occur as part of thematic quality reviews.

Other Issues

Need to align with:

- Departmental Standards and Guidelines Unit's Programme*
- Regional Mental Health Policy (Future Service Framework)*
- Regional Quality Improvement / Inspection*
- Current reporting mechanisms for Adverse Incidents*
- Development of Supervision Standards for Nursing Practice*

Working Arrangements

The Steering Group will meet quarterly to oversee this project. Agenda and supporting papers to be sent out 7 days prior to each meeting and formal minutes recorded. The confidential nature of some of the information available to the group must be respected. This does not prevent members taking soundings from interested

colleagues and peers who will reasonably expect to be told broadly the way in which the project is progressing.

ASSESSMENT AND MANAGEMENT OF RISK IN MENTAL HEALTH SERVICES
PROJECT OUTLINE

Objective	Jan-March 2006	April- June 2007	July-Sept 2007	Oct-Dec 2007	Jan-Feb 2008	Mar-April 2008	May-July 2008
1a	Governance review of Risk Assessment and Management in Adult Mental Health Services						
	Self Assessment	Review Visits	Final Report				
1b	Review of local Adverse Incidents and emerging issues						
2			Stakeholder workshops and consultation				
3			Draft local standards and issue for Consultation			Issue agreed final standards	
4							Training and Implementation

LITERATURE REVIEW

Introduction

Previous Inquiries

'The Age of the Inquiry: Learning and Blaming in Health and Social Care'

Stanley and Manthorpe (2004) analyse some of the key inquiries in Great Britain from the early 1990s onwards. It was interesting to note that previous published inquiry reports had identified as problem areas some of the major issues which we identified in our inquiry and have highlighted in this report.

In Chapter 7 of this book (contributed by Andrew McCulloch and Camilla Parker) there is a list, (in roughly descending order of importance or frequency), identifying 12 key issues arising from a study of 14 major homicide inquiries in the period 1988-1998: -

- * 1. Poor risk management.
- * 2. Communication problems.
- * 3. Inadequate care planning.
- * 4. Lack of inter-agency working, (not just across health and social care but also more widely, e.g., with the independent sector).
- * 5. Procedural failures, (both administrative and legal).
- 6. Lack of suitable accommodation.
- 7. Resources.
- 8. Substance misuse.
- 9. Non-compliance, (with medication).
- * 10. Involvement with carers.
- 11. Ethnic minority issues.
- 12. The need for reform (of Mental Health policy / legislation).

The issues marked with an asterisk * are also major issues in our Inquiry into the deaths of Madeleine and Lauren O'Neill and have been dealt with in detail elsewhere in this report. This does perhaps raise questions about how learning from inquiry reports is brought to the attention of government, statutory and voluntary organisations, and particularly to

practitioners and staff who deal with patients and clients on a daily basis, both in hospitals and in the community.

Set out below are some relevant quotations from the book which also strike chords with aspects of the Panel's Inquiry and some of the conclusions reached: -

- *Too little attention is paid to the importance of vulnerability in the assessment and management of risk; that is, of not placing patients and offenders back into situations which may promote the commission of further disastrous actions and the completion of what the late Dr. Murray Cox (1979) called 'unfinished business'.*
- *The roles played by, and support for, family and other close carers have not been adequately addressed – sometimes with tragic consequences.*
- *The inquiry into the care of Anne Murrie (Williams and Hennessey 1999) who killed her nine-year-old daughter found that services had responded to her as an individual rather than seeing her 'within the context of her family'. Professionals were judged to have failed to take account of the impact of Anne Murrie's ex-husband's new relationship on her state of mind and to have been unaware of the vulnerability of her daughter in relation to these feelings. In these cases, it appears that professionals saw these women primarily as users of mental health services. This identity excluded consideration of other roles such as survivor of abuses, single mother or rejected wife and mother.*
- *A failure on the part of services to acknowledge an individual's multiple roles can have particularly serious consequences for women who are mothers. A number of these inquiries ... found a lack of communication and co-ordination between adult mental health services and children's services. Falkov's (1996) review ... found a*

similar lack of co-ordination between services characterised child deaths where parents had mental health problems. Stanley et al's (2003) study identified particular problems in inter-professional work between adult psychiatrists and child care social workers which included failures in co-ordination and difficulties concerning confidentiality. Problems in communication between these two professional groups are likely to limit the capacity of either service to assess risks to women and children.

'Community Care Tragedies: A Practice Guide to Mental Health Inquiries'

Reith (1998) also highlighted issues which emerged in the Panel's Inquiry: -

- *Arrangements for the transfer of information contained in clinical notes between hospitals should be improved to satisfy the requirements of both transferring and receiving hospitals.*
- *When a patient is referred for the first time, or transferred from another team, there should always be a new clinical assessment, which should include an appraisal of risk of violence.*
- *Clinical assessment should always include a direct search for thoughts about harming others.*
- *The nurse admitting the patient to the new ward should have available the nursing / medical notes prior to making their own admission assessment.*
- *The information and social histories gathered following admission should always consider the views of other family members, carers, and persons close to the patient. Their views should also be sought when Care*

Programme Approach plans are made before discharge and when they are reviewed after it.

- *The current importance given to confidentiality was considered one of the factors that adversely influenced professional practice (Smith 1996). As a consequence of this practice the Smith Inquiry recommends that whenever someone is admitted to hospital suffering from a severe mental illness and whose history is not known, a social work assessment should be completed before the patient is discharged from hospital.*
- *It is most important to understand the patient's view of the world, and to recognise that 'professionals need to be trained to trust the experienced judgement of close family, rather than rely on their own impressions made at one isolated assessment'. (Blom-Cooper, 1995).*
- *Effective risk management requires a recognition of the need and right for relatives who are often also the main carers to be involved in care and treatment plans. In those very common circumstances where the patient is receiving substantial emotional and practical support from relatives, they surely have a right to know sufficient details about the mental disorder, its likely course, warning symptoms of relapse and how and when to summon help, to enable them to discharge their responsibilities effectively. The key task in working with relatives is to engage them in the overall care plan so that they become partners with the clinical team in their relative's care. (Blom-Cooper, 1995).*

'Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness'

The above report was published towards the end of the Panel's work in December 2006. The confidential inquiry report covers England and

Wales and focuses on current and recent mental health patients. The overall work of the confidential inquiry is done on a UK wide basis and data covering Northern Ireland is to be disseminated separately.

In relation to 'Progress on Suicide' the report notes: -

Forty-nine percent of the patients who died had been in contact with services in the previous week, 19% in the previous 24 hours. At final contact, immediate suicide risk was estimated to be low or absent in 86% of cases.

We identified a group of 'most preventable' suicides, consisting of 1,108 cases, 18% of the [five year] total, or 233 per year. These are the cases most clearly related to service failure.

Previous Inquiry recommendations have been adopted well by services overall. Previous data collection has highlighted a number of patient groups at risk [in-patients; post-discharge; under enhanced Care Programme Approach; missed last contact; non-compliance in last month] – the number of suicides by patients falling into one of these 'priority groups' has fallen most. There has been a rise in suicides by patients outside the priority groups.

In relation to 'Progress on Homicide' the confidential inquiry notes: -

Twenty-nine per cent of patients who committed homicide were seen by mental health services in the previous week. At final service contact, immediate risk was judged to be low or absent in 88% of cases.

We have calculated the number of 'most preventable' cases to be 34 cases, 14% of all patient homicides, or 7 per year. These are the cases most closely related to service failure.

The victim of a homicide by a mentally ill patient is nearly always a family member.

The confidential inquiry goes on to address the issue of prevention including potential solutions: -

- I. In relation to absconding from in-patient wards the report makes comments which are relevant to this Inquiry – *In mental health services we have to balance patient autonomy and patient safety and at times this can be difficult. But the current situation, in which patients admitted for their own protection can leave a ward within a few hours or days, cannot continue.*
- II. The report highlights the high level of risk of suicide during the transition from in-patient ward to the community: -
 - 15% of post-discharge suicides occurred in the first week after discharge
 - 22% of post-discharge suicides occurred before the first follow-up in the community
 - 34% of in-patient suicides occurred during the period of discharge planning towards the end of an admission
 - 25% of all suicides by current or recent mental health patients *occurred during the transition from ward to community, making this the period of maximum suicide risk.*
 - 8% of all suicides in the study occurred just before or just after discharge

The report emphasises the following measures to manage transition safely: -

- *regular assessment of risk during the period of discharge planning and trial leave*
- *agreed plans to address stressors that will be encountered on leave and discharge*
- *the patient to have ways of contacting services if a crisis occurs during leave or after discharge*
- *early follow-up on discharge, including telephone calls immediately after discharge for high risk patients and face-to-face contact within a week of discharge for anyone receiving 'enhanced' care under the Care Programme Approach (CPA)*

- *support arrangements for people who discharge themselves from wards*
- iii. The report identifies that the CPA approach is under utilised and says that risk management can be improved by *jointly reviewing the management of the most high-risk patients with other clinical teams, through local clinical governance*
- iv. The report had important remarks to make in relation to attitudes to prevention – *A feature of the cases we have investigated is the low proportion that clinicians regarded as preventable – only 19% of suicides and 21% of homicides. To an extent this reflects the recognition that mental health patients overall are a high risk group – it is therefore unrealistic to expect services to prevent all suicides or homicides. However, there is a danger in going from recognising risk in patients as a whole to accepting the inevitability of individual deaths...It is time to change the widespread view that individual deaths are inevitable – such a view is bound to discourage staff from taking steps to improve safety. It may be a reaction to the criticism of services and individuals that can happen when serious incidents occur. Therefore, if mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame.*

Research Literature

Violent deaths of children are rare, infrequent events. (Stroud 1996). Stroud and Pritchard (2001) note the substantial decline in child homicides in England and Wales over the past 20 years and attribute this to improved social services practice and inter-agency collaboration. *This has been tacitly acknowledged in NSPCC advertisements that report a death per week rather than a death per day as in their earlier reports* (Stroud and Pritchard, 2001). Child homicide committed by someone outside the family (extra-familial) is *especially rare*. Given the success in reducing child deaths due to the improvements in child protection during the last two decades it is not surprising that the literature on child homicide committed by a parent (filicide) has tended to concentrate on parents and families where there was abuse in the family and concerns about child welfare prior to the death of a child. The result of this has been a neglect of issues relating to mental health and mental disorder in parents who kill their children. In some respects this reflects the gaps between child services and adult mental health services that are regularly cited in the literature and appeared in this case. Research suggests that mental disorder is a significant factor in filicide so Stroud (1997) concludes that *an understanding of the association between mental disorder and child homicide could assist in preventing violent assaults on children.*

Hetherington et al (2002) take a different view about the research base but end with a very pertinent point – *Broadly we are looking at a picture where about one third of mentally ill parents have dependent children, and where over a quarter of children who are placed on the child protection register have a mentally ill parent or carer. These are substantial numbers, but parental mental illness appears in the child protection literature as one sub-category of parental problem among many. There are more studies concerned with parental mental illness and child homicide than with parental mental illness and child abuse in general. It takes murder for these children to become visible.*

Before continuing it is important to reiterate the word of caution in Stroud and Pritchard (2001) – *at the outset, we would stress that the majority of individuals experiencing mental health problems pose a*

far greater risk to themselves than to other people. Indeed, the situation is similar to 'poverty'. The vast majority of people living in poverty do not neglect their children, only poverty places greater difficulties on them; so too with mental disorder.

Stroud and Pritchard (2001) are at pains to contradict an assertion in the Department of Health resource document 'Crossing Bridges' (Falkov, 1998) which says *it is debateable as to how many fatalities of individual children can be prevented*. As Stroud (1996) says in her earlier article - *While it is important to counteract popular, alarmist fears about the incidence of child homicide by being clear that it is an infrequent occurrence, the real point for consideration is the fact that the violent death of any child is one death too many and efforts at understanding and preventing such deaths must continue*. It would be easy to fall into the pessimism of the 'Crossing Bridges' view particularly in a case like the one covered by this Inquiry. The situation outlined in this Inquiry is at the less likely end of a rare phenomenon i.e. filicide. There are limits to the helpfulness of the literature in looking at this case for just as the child protection literature has not addressed parental mental disorder so the literature that does cover child homicide tends to focus on cases where there is pre-existing child abuse. Where there is consideration of parental mental disorder it tends to focus on the more acute or florid psychotic presentations. The case considered by this Inquiry clearly depicts a mother with a long standing recurrent (probably mild) depressive illness with associated *reactive / situational* elements who in a relatively short space of time developed more severe symptomatology resulting in a diagnosis of major depressive illness associated with a significant suicide attempt and threats to her child. Apart from the direct threat, at no point were there any concerns about the child's welfare and no involvement from child services. The literature would suggest that prior to the threat this was a hard to spot case and parts of the literature must therefore be treated tentatively. The extracts and discussion set out here are intended to promote further consideration of these issues, taking a cue from aspects of this case. It should in no way be viewed as definitive. It is clear from a consideration of some of the available literature that there is a need for more research in this area.

Stress

Stroud (1996) states that *perpetrators of child murder experience significant levels of psycho-social stress* and draws attention to d'Orban's (1979) finding in relation to the role of multiple adversity e.g. marital, financial and housing problems; bereavement. These factors are also noted as being of *aetiological significance in depression*.

A stress factor that resonates with this case can be found in Cassell and Coleman (1995) with particular reference to depression - *A crisis may be precipitated when their child approaches the age at which the parent experienced major traumatic events*.

Where there is marital separation this can often represent the removal of a mediating factor between the child and the mental illness of the parent who remains the primary carer for the child. At the milder end of the spectrum this would be about the emotional and developmental impact of the illness on the child or children. At its most extreme, as it is in this Inquiry, this can involve the death of a child.

It would seem that a message from the literature to all practitioners is not to underestimate the significance of such psycho-social stressors in these situations.

Mental Illness

Reder and Duncan (1999) identify that there is a high incidence of depression in mothers who kill their children. A study by Resnick (1969) suggests that it was as high as 71% in the cases reviewed. The rate was half that for fathers but still significant at 33%. Reder and Duncan (1999) report Wilczynski's (1997) finding that *concern about parental mental health had been the commonest reason for any prior contact between families and professional agencies*. They cite McGrath (1992) who warned practitioners to *bear in mind the risks to the child of a mother with a family and personal history of mental illness, who is herself showing signs of illness, and who is preoccupied with the physical or spiritual well-being of the child*.

Assessment

Reder and Duncan (1999) write: -

General Practitioners – i.e. ‘family doctors’ – are ideally placed to integrate issues relating to different family members since they hold knowledge about each individual. They have the potential to commission services that meet the needs of the entire family, if necessary by referring to both child and adult resources and liaising between them. As regards child protection, general practitioners have the potential to provide invaluable contributions to multidisciplinary training events and child protection conferences.

It is our contention that professionals will be able to help individuals better if they consider wider relationships and influences in addition to individual needs. All this can be summed up in the phrase: ‘think family’. Reder and Duncan (1999).

They add the following ‘practice issues’: -

- *Liaison between adult and child services is essential so that children of parents with mental health problems can have their needs recognised and addressed*
- *Parallel assessments are necessary when a parent shows evidence of mental health problems: one, of the risk to the child from the parent’s behaviour; the other of the appropriate intervention for the parent*
- *Practitioners should consider the problems of individuals in the context of their family and wider relationships*

The early detection and adequate treatment of psychiatric disorder is another crucial measure for preventing filicide. This should include training of mental health professionals to ensure they always address the issue of homicidal potential when examining patients. Wilczynski (1997).

The recent inspection of child protection services in Northern Ireland (DHSSPS, 2006) has application to the understanding and assessment of Lauren’s needs but the general points are equally applicable to the mental health issues in the case: -

5.2.13 Social work reports and assessments did not always take a 'child centred' or 'analytical' approach but tended to focus on the adult perceptions of their family's needs or on the relationships between adults. Hence they often failed to consider the impact of the behaviour and level of functioning of adults on the child's shorter and longer term psychological development and emotional wellbeing.

5.2.14 Many of the case files examined did not demonstrate the use of a theoretical base to conceptualise the risks for children. This was particularly evident in cases characterised by domestic violence, mental illness, learning disability and drug/alcohol dependency.

Risk

Cassell and Coleman (1995) deal with the risk to the child primarily in the context of psychosis however it is clear that their observations are relevant in a case where a direct threat has been made arising from a depressive illness - *If the child is included in the content of the parent's delusions, the risk to the child's emotional development and the potential for physical harm are much greater (Rutter and Quinton 1984). The parents altered beliefs can include any facet of the child.*

If the parent shows florid psychotic symptoms, some assessment of dangerousness must be made... Many of these killings are 'altruistic' in that the parent believes they are protecting the child from other dangers... Murderous violence can occur in those with no previous history of maltreatment and hence it is essential to consider the content and nature of any delusions.

Wilczynski (1995) clarifies two meanings of 'altruistic' – *In 'altruistic' filicide, the parent (usually the mother) perceives the killing to be in the child's best interests. 'Primary' altruistic killings are what have been termed 'mercy killings', in which there is a real degree of suffering in the victim (for example disability or disease) and an absence of secondary gain for the parent. The much more*

common 'secondary' altruistic killings involve no real degree of suffering in the child, and typically occur in the context of depression in the parent (virtually always the mother).

Cassell and Coleman (1995) go on to say that risk to the child is greatly enhanced where the *child is incorporated into the psychotic ideation. Similarly, if a psychotic parent is suicidal, or mentions harm occurring to the child, assessment is needed of the content of the delusions.*

In contrast Green (2002) writes – *The issue of whether psychosis poses more risk than, say, depression is a typically complex one within this field and, as with many issues, best treated with caution. For instance, Cassell and Coleman (1995) posit that children are at increased risk if incorporated into parental psychotic ideation; conversely, other research (see Dore, 1993) showed no differences in outcomes between children of psychotic and depressed parents.*

'Crossing Bridges' (Falkov, 1998) states at the end of the section on depression: -

Children's physical safety may be of more obvious and immediate concern when psychotic symptoms are present in a parent, especially if the children have been actively incorporated into the parent's symptoms. Where thoughts and intentions about suicide are explored, it is important to also inquire about homicidal ideas, especially where the individual has responsibility for young children.

Following admission of a parent subsequent to an overdose or self-harm, seek information about :-

- *the presence and whereabouts of any dependent children*
- *any agencies involved with parents and/or children*
- *the support required for a parent to meet the needs of the children, including their safety; for parents with responsibility for*

young children, questioning about homicidal as well as suicidal thoughts is necessary

Stanton et al (2000) observe – *Having to live with having killed one's own child is a considerable burden for someone already struggling with a major mental illness. Thus the role of the mental health clinician in managing risk with a mentally ill mother need not differentiate between the interests of the mother and that of the child. Preventing any possibility of the mother harming her child is strongly in her own interest... Thus for the clinician attempting to predict risk of maternal violence this study indicates a number of potentially confusing and misleading issues. Evident devotion to the child and parenting is not likely to be a protective factor. The mentally ill mother is likely to have difficulty monitoring her parenting effectiveness and level of risk. However, it does point to the importance of the identification and early and effective treating and monitoring of major psychiatric illness.*

Professional Response

Reviewing the literature on the response of professionals and agencies to parental mental illness and child welfare Green (2002) writes – *Essentially all argue that the key to good service provision is the integration of services and a 'holistic' approach – one in which the needs of all family members can be considered. Recent cross-national comparative research (Hetherington et al, 2001) suggests that some problems, i.e. keeping a clear focus on the child and co-ordinating services, are not exclusive to this country. However, England does seem to have specific problems 'derived from the system' such as risk avoidance, professional pessimism and a shortage of resources. He then identifies from the literature the many barriers to integrated and effective service provision in the UK. These are, in summary: -*

- *The burgeoning specialization of services and rigid demarcations between adult and children's services*
- *Differing professional perspectives congruent with narrow professional interest and perceived remit*

- *Family life is not co-terminus with agency boundaries*
- *The relative lack of formal structures to consider children's needs and the mentally ill parent's needs outside of the child protection conference*
- *Legal frameworks which are unconnected and do not address family need; on top of this the impact of the Children Act (1989) has probably been to raise thresholds of intervention*
- *Access to services as lack of funding has led to cutbacks in preventative services and a lack of co-operation unless high statutory thresholds are crossed*
- *Lack of co-ordination of services. In some cases the problem is **not** lack of inputs but the converse - a lack of co-ordination at strategic and operational levels. This can be counter-productive, producing dependency and confusion within the family, struggles for control amongst professionals and a lack of clarity as to who bears responsibility for what.*

Rustin (2005) utilising a psychotherapeutic approach in a compelling article on the inquiry into the death of Victoria Climbié, considers how professional thinking and actions including the inquiry itself were shaped by their own anxieties in relation to what had or might have happened. The request from the inquiry that *The concept of 'respectful uncertainty' should lie at the heart of relationships between the social worker and the family is not easily achieved.*

I think it is helpful to bear in mind that many of the actions (or moments of inaction) described in the report as obvious evidence of incompetence relate to the desire of professionals to keep a distance from the intense feelings stirred up by exposure to human cruelty and madness.

Professional and agency responses that lead to fragmented information can be viewed as defence mechanisms which 'mirror' the condition of the patient. Avoiding thinking about potentially difficult or frightening subject matter, for instance a severely depressed mother who may be thinking of killing herself and her child, is in many ways a natural human response to such anxiety provoking information or circumstances. This can lead to a 'mindless' practice by individuals and agencies in which the integrity of

the professional and agency personae disintegrate in parallel with that of the client/patient.

The feelings aroused in doing this difficult work are hard to make space for. They are uncomfortable, and they are liable to cause trouble in the sense of demanding more thought and more work if they are taken seriously. They are the 'gut feelings' referred to by one witness who spoke about how these feelings got put to one side rather than be subject to reflection and evaluation. This fact is closely linked to the much noted absence of any useful supervision of the work undertaken, and in similar vein the absence of adequate detailed written notes at many crucial points. Not talking about and not writing down disturbing observations are examples of the avoidance of thought.

The report causes one to ponder on the infantile anxieties which the tasks of child protection evoke in staff. Feelings of helplessness, of dependence and deference to authorities, of not knowing enough, of sticking to the rules mindlessly like a terrorised child, of fear and wanting to return to the 'normal' world as soon as possible predominate.

Rustin (2005) also notes – *It has been widely observed that staff trained to deal with adult mental health problems often pay virtually no attention to the impact on the children of their clients of long-term exposure to disturbed and disturbing behaviour. Sometimes even the existence of dependent children in the household is ignored.*

The solution to this professional mindlessness lies for Rustin in the nature of training and ongoing supervision and consultation – *Unless workers have a theory and practice which allows them to perceive such levels of distress and have a context in which they can assess its impact on them, instead of being pulled into identifications and counter-identifications [with the client/patient], the casework required cannot be done.*

Rustin's contention is echoed by comments in The Observer newspaper (3 December 2006) by Prof. Louis Appleby in his role as Director of the Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. He cited *a culture of 'desensitisation' in which psychiatric staff become used to dealing with very high-risk patients and so fail to notice the warning signs when one is becoming dangerously ill.*

Conclusion

This literature review shows that many of the issues we have highlighted in our Report have been identified elsewhere in a number of previous inquiries, some of them many times. The themes of inquiry after inquiry – communication, assessment, working together, support and supervision, training – are captured well in 'Crossing Bridges' (1998) which is available now as a resource to agencies and practitioners. This review of some of the available literature demonstrates that in the same way there was a need to bring together the available knowledge in relation to Madeleine and Lauren in a consolidated assessment that would have guided future action, so there is a need at government department level to bring together the available research and inquiry knowledge in a format that will meaningfully assist practitioners, particularly in the assessment of risk and strategies to deal with risk. Similar calls are repeated regularly throughout the literature reviewed. There is then a need to build on our existing knowledge through effective monitoring of statistical trends by government and the commissioning of research into areas where existing research is inconclusive or non-existent (e.g. filicide by mentally ill parents or carers).

See Recommendations earlier in this Report in the section headed: 'Literature Review'.
--

GLOSSARY OF TERMS / ABBREVIATIONS

ACPC	Area Child Protection Committee (of a Health and Social Services Board).
Belfast City Hospital	BCH; Belfast City Hospital Trust.
CBT	Cognitive Behavioural Therapy Service, South and East Belfast Health and Social Services Trust.
Community Mental Health Team, Cityside	Part of Foyle Health and Social Services Trust, Londonderry.
Consultant Psychiatrist	Consultant; a senior doctor responsible for care and treatment of mentally ill patients.
CREST	Clinical Resource Efficiency Support Teams, established in 1988 under the auspices of the DHSS (NI) Medical Advisory Structure.
CRT	Crisis Response Team, South and East Belfast Trust.
DHSSPS	Department of Health, Social Services and Public Safety; the Department.
Eastern Board	Eastern Health and Social Services Board, Belfast; EHSSB.
FCCIAT	Family and Childcare Initial Assessment Team, South and East Belfast Trust.
Foyle Trust	Foyle Health and Social Services Trust, Londonderry.
Gormley, (Mr.)	Mr. John Gormley, Madeleine O'Neill's father and Lauren O'Neill's grandfather.

GP	Madeleine O'Neill's General Medical Practitioner.
Gransha	Gransha Hospital, Foyle Health and Social Services Trust, Londonderry.
HPSS	Health and Personal Social Services, Northern Ireland.
Initial Assessment Team	Family and Childcare Initial Assessment Team, South and East Belfast Health and Social Services Trust.
Knockbracken	Knockbracken Healthcare Park, South and East Belfast Health and Social Services Trust; KCHP.
Lauren	Lauren O'Neill.
Madeleine	Madeleine O'Neill.
Multidisciplinary	Professional officers, (e.g., doctors, nurses, social workers, etc), working in a team setting, providing care and treatment to a patient.
O'Neill, (Mr.)	Mr John O'Neill, Madeleine O'Neill's husband and Lauren O'Neill's father.
Panel	Independent Inquiry Panel.
Police Service of Northern Ireland	PSNI
Private Counsellor	Counsellor; an independent professional counsellor working with Madeleine O'Neill on marital issues / difficulties.
SHO	Senior House Officer; a junior doctor in a hospital.
Social Services	Social Services Directorate or Department in a Mental and Social Services Board and/or Trust.

South and East Belfast Trust	South and East Belfast Health and Social Services Trust; SEBT.
Terms of Reference	The tasks given to the Independent Inquiry Panel by the Western and Eastern Health and Social Services Boards.
Voluntary Patient	Patient voluntarily receiving care and treatment when admitted to a hospital ward, i.e., not subject to a detention order.
Westcare Business Services	A shared Services organisation which provides a range of administrative, professional and technical support to the HSS Trusts in the Western Area and to the Western Health and Social Services Board.
Western Board	Western Health and Social Services Board; WHSSB.

REFERENCES

Bamford Review of Mental Health and Learning Disability (Northern Ireland) (July 2006) 'A Vision of a Comprehensive Child and Adolescent Mental Health Service'

Cassell D. and Coleman R. (1995) 'Parents with psychiatric problems', in Reder P. and Lucey C. *Assessment of Parenting: psychiatric and psychological contributions* London: Routledge

Department of Health and Social Services (Northern Ireland) (1995), 'The Children (NI) Order (1995) inc. Regulations and Guidance.

Department of Health and Social Services (Northern Ireland) (November 1996) 'Co-operating to Protect Children' [Vol. 6 of Regulations and Guidance, The Children (NI) Order (1995)]'

Department of Health, Social Services and Public Safety (May 2002) 'Review of Counselling Services (Counselling in Northern Ireland – report of The Counselling Review)

Department of Health, Social Services and Public Safety (May 2003) 'Co-operating to Safeguard Children'

Department of Health, Social Services and Public Safety (May 2004) 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others'

Department of Health, Social Services and Public Safety (April 2005) 'Area Child Protection Committees' Regional Policy and Procedures'

Department of Health, Social Services and Public Safety (2006) 'Regional Multi-Agency Procedures to be followed in cases of Sudden or Unexpected Child Deaths from Birth to 18 years – A Consultation Document'

Department of Health, Social Services and Public Safety – CREST (Clinical Resource Efficiency Support Team) (August 2006) 'Protocol for the Inter Hospital Transfer of Patients and their Records'

Department of Health, Social Services and Public Safety (October 2006) 'Protect Life – A Shared Vision' – The Northern Ireland Suicide Prevention Strategy and Action Plan 2006 – 2011

Department of Health, Social Services and Public Safety (October 2006) 'Assessment and Management of Risk in Mental Health Services', Regional Steering Group – Terms of Reference, Membership and Project Outline

Department of Health, Social Services and Public Safety (2006) *Our Children and Young People – our shared responsibility*

D'Orban P. (1979) 'Women who kill their children' in *British Journal of Social Work* 134 pp. 560-571

Dore M.M. (1993) 'Family preservation and poor families: when 'home-building' is not enough' in *Families in Society* 74(9) pp. 545-556

Eastern Health and Social Services Board (January 2006) 'Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board'

Eastern Health and Social Services Board (May 2006) 'Executive Summary and Recommendations from the Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board'

Falkov A. (ed) (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children* London:Department of Health

Foyle Health and Social Services Trust (January 2006) 'Final Report (Version 4) into the Death of Madeleine O'Neill'

Foyle Health and Social Services Trust (March 2006) 'Serious Incident Policy'

Foyle and Sperrin Lakeland Forums on Suicide / Westcare Health Promotion 'Bereaved by Suicide; A Guide to the Feelings and Services' – Second Edition

Green R. (2002) *Mentally ill parents and children's welfare*
London: NSPCC Practice Development Unit
(http://www.nspcc.org.uk/Inform/OnlineResources/InformationBriefings/MentallyIllParents.asp_ifega26025.html)

Hetherington R., Baistow K., Katz I., Mesie J. and Trowell J. (2002) *The Welfare of Children with Mentally Ill Parents: Learning from inter-country comparisons* Chichester, England: John Wiley and Sons

McGrath P. (1992) 'Maternal filicide in Broadmoor Hospital: 1919 – 1969' *Journal of Forensic Psychiatry* 3 pp. 271-297

Reder P. and Duncan S. (1999) *Lost Innocents: a follow-up study of fatal child abuse* London: Routledge

Reder P., McClure M and Jolley A. (eds) (2000) *Family Matters: Interfaces between child and adult mental health* London: Routledge

Reith (1998) 'Community Care Tragedies: A Practical Guide to Mental Health Inquiries'

Resnick PJ. (1969) 'Child murder by parents: a psychiatric review of filicide' *American Journal of Psychiatry* 126 pp. 325-334

Rustin M. (2005) 'Conceptual analysis of critical moments in Victoria Climbié's life' in *Child and Family Social Work* 10 pp. 11-19

South and East Belfast Health and Social Services Trust (October 2005) 'Report of the Serious Untoward Incident Meeting held in the Boardroom, Trust Headquarters, Knockbracken Healthcare Park on 14 September 2005'

Standley N. and Manthorpe J. (2004) 'The Age of the Inquiry: Learning and Blaming in Health and Social Care' Routledge

Stanton J., Simpson A. and Wouldes T. (2000) 'A qualitative study of filicide by mentally ill mothers' in *Child Abuse and Neglect* 24 pp. 1451-1460

Stroud, J (1997) 'Mental disorder and the homicide of children: a review', *Social Work & Social Sciences Review* 6(3) pp. 149 – 162

Stroud, J. and Pritchard, C (2001) 'Child Homicide, Psychiatric Disorder and Dangerousness: a review and an empirical approach in *British Journal of Social Work* Vol 31 pp. 249 – 269

University of Manchester (2006) *Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness*

(http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths_full_report.pdf)

The Victoria Climbié Inquiry (2003) Report of an Inquiry by Lord Laming Stationery Office

Wilczynski, A. (1995) 'Child killing by parents: a motivational model' in *Child Abuse Review* 4 pp. 365-370

Wilczynski, A. (1997) *Child Homicide* London:Greenwich Medical Media