

An independent inquiry into the care and treatment of Y and X

A report for
NHS South East Coast

May 2008

Chair

Anthony Harbour

Panel members

Dr Tim Amor

Linda Bolter

Project manager

David Watts

Contents

Abbreviations and references	5
1. Introduction	6
2. Overview of the report	9
3. The inquiry and prosecution of Y for the murder of X	11
4. Y - his background	16
5. Y - in-patient and out-patient care and treatment	21
6. Y's contact with probation service	34
7. X - her background	41
8. The healthcare provided to X between February 1995 and January 2003 (excluding psychiatric admissions)	49
9. Psychological services input in the care of X	53
10. X's care and treatment between October and December 2002 under the care of the South London and NHS Trust	64
11. X's inpatient care and treatment in Shelley Ward from 15 January to 30 March 2003	82
12. Medway Maritime Hospital - X's in-patient care and treatment from 31 March to 4 April 2003	98
13. A comparison between the care and treatment that X received in 2002 and 2003	111
14. X - risk assessment and management	116
15. X - the application of the CPA	124
16. The management and treatment of persons with personality disorders	135
17. The response of West Kent NHS and Social Care Trust following the homicide	141
18. Psychiatric services in Medway from 2002 to the present day	150
19. Conclusions	160
20. Recommendations	165

ANNEX		172
Annex 1	Terms of reference	172
Annex 2	Schedule of witnesses	174
Annex 3	Documents considered by inquiry team	176
Annex 4	Excerpt from discussion with Pol 1 (2 October 2006)	181
Annex 5	A chronology of X's healthcare	183

Abbreviations and references

This report refers to Y and X respectively. These were the convenient short forms adopted during the inquiry process and the anonymised short forms adopted for this report. Otherwise it generally refers to people by name unless we considered it necessary to maintain their anonymity, when initials appear, e.g. MM. We refer to X's sister, brother-in-law and mother as A, C and E respectively.

The subject matter is complex, so the report refers throughout to the names of many health and social care professionals. The job titles of these professionals can be found both in the text and in annex 2.

Footnotes refer to transcripts of meetings with witnesses. For example, the reference "Man 1 2" refers to the second page of the transcribed evidence of Man 1.

References and quotations relate to documents listed in annex 3. For example, D10 refers to file E page 10 of the GP records concerning X.

ASW	Approved Social Worker
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution and Home Treatment Team
GP	General Practitioner
MAPPA	Multi-Agency Public Protection Panel
MASST	Medway Assessment and Short-term Treatment Team
MHA	Mental Health Act
PCT	Primary Care Trust
RMN	Registered Mental Nurse
SOAD	Second Opinion Appointed Doctor
SHA	Strategic Health Authority
SHO	Senior House Officer
SLaM	South London and Maudsley NHS Trust

1. Introduction

- 1.1 On 4 April 2003 Y killed X. He pleaded not guilty and was convicted of her murder. He was sentenced to a minimum term of 19 years on 11 March 2004.
- 1.2 Guidelines issued by the Department of Health in circular HSG (94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community* and the updated paragraphs 33-36 issued in June 2005 require an independent inquiry to be undertaken when a person in contact with mental health services commits homicide. Both Y and X received care and treatment from specialist mental health services. This inquiry was commissioned by the Kent and Medway Strategic Health Authority (SHA) in January 2006. On 1 July 2006, this body merged with Surrey and Sussex SHA to form NHS South East Coast.
- 1.3 The inquiry was conducted by Anthony Harbour (chair), Dr Tim Amor and Linda Bolter.

Anthony Harbour is a solicitor and partner in a London practice specialising in health and social service law. He has chaired other inquiries of this nature. He is a legal member of the Mental Health Review Tribunal and the Family Health Service Appeal Authority.

Dr Tim Amor is a consultant psychiatrist. He now works with a community based mental health team in Central London, and worked in a forensic inpatient setting. He is a medical member of the Mental Health Review Tribunal.

Linda Bolter is a Mental Health Act Commissioner, an independent mental health consultant/supervisor and has been a panel member on a number of independent mental health inquiries, including homicide inquiries. She was an Approved Social Worker (ASW) and mental health service manager with a local authority.

- 1.4 The inquiry panel started work at the end of March 2006. Management of the inquiry was originally co-ordinated by Louise Riley and Valerie Hayes from the Kent and Medway SHA. In September 2006 David Watts took over on behalf of Verita.
- 1.5 The terms of reference of the inquiry are attached (annex 1). A draft report was delivered to NHS South East Coast in July 2007. This report was based on the testimony of a number of witnesses (annex 2) and relevant documentation (annex 3).
- 1.6 The recall of witnesses was inevitably incomplete. Important documentation was no longer available. For example, the medical records relating to Y's care and treatment are lost. This meant that in some cases matters were raised about which it was not possible or expedient to come to a firm conclusion. The text makes clear where this is the case.
- 1.7 The terms of reference of the inquiry were to consider the treatment and care provided both to Y and X. Y withdrew his consent (after much of the material concerning his care and treatment had been considered) to disclosure of documentation concerning his case. He also declined to meet with us. The effect of this is that this report on the treatment and care provided to Y is not as complete as we would wish.
- 1.8 We could not have completed this report without help from many individuals; David Watts and the team at Verita; Louise Riley and Valerie Hayes from the Kent and Medway SHA, who initially managed the inquiry. Agencies not directly involved in the care and treatment of Y and X went out of their way to help, in particular Kent Probation Service and Kent Police. We also thank all those who attended and provided information about Y and X.
- 1.9 Tim Amor and Linda Bolter met X's sister and her husband at the end of the inquiry. We are grateful for their help in understanding X. We met X's

adoptive father. This report refers throughout to E as X's father. This is because he adopted both X and her sister.

2. Overview of the report

- 2.1 On 4 April 2003 Y murdered X by injecting her with heroin. Y and X had arranged for this to happen while they were both informal patients in Shelley Ward which is an acute psychiatric ward at Medway Maritime Hospital.
- 2.2 Y had a long history of substance misuse and offending behaviours. He was admitted to Shelley Ward on 27 March 2003 in response to his suicidal ideas and depression. He discharged himself from the ward on 30 March 2003.
- 2.3 Y's background, his contact with services and his prosecution for murder are reviewed in chapters 3 - 6 of this report.
- 2.4 X had been in contact with out patient psychiatric services in West Kent since the age of 15. She had a diagnosis of personality disorder. In October and December 2002 X was admitted to the Bethlem Royal Hospital. On each occasion, X was admitted under section 2 of the Mental Health Act 1983 after threats of suicide. X was discharged from the Bethlem Royal Hospital on 31 December 2002 after failing to return from leave. On 15 January 2003 she attended the Accident and Emergency Department at Medway Maritime Hospital seeking admission to hospital because she felt depressed and unable to cope. She was then admitted to Shelley Ward.
- 2.5 X's background along with her care and treatment are reviewed in chapters 7 - 15 of this report.
- 2.6 X was diagnosed as suffering from a personality disorder. Chapter 16 of this report considers the care and treatment of a person with this diagnosis.
- 2.7 The responses of the trust in the aftermath of the murder are reviewed in chapter 17 and there is a review of the psychiatric services in Medway from 2002 to the present day in chapter 18.

2.8 Chapters 19 and 20 of the report deal with the conclusions and recommendations.

3. The inquiry and prosecution of Y for the murder of X

Background information

- 3.1 Y met X when they were both inpatients on Shelley Ward, an acute psychiatric ward based on the site of the Medway Maritime Hospital.
- 3.2 On 26 March 2003 Y was seen by a specialist social worker for mentally disordered offenders and a probation officer and talked about feeling stressed and depressed and in need of psychiatric help. They initiated a referral to the Accident and Emergency Department at Medway Maritime Hospital, advising that he should present there immediately. In the event, he delayed his visit until the following evening. Following an assessment by a nurse and doctor Y was admitted to Shelley Ward on the night of 27 March 2003. He was assessed as suffering from depression and 'significant suicidal ideas' and drug abuse.
- 3.3 X had been an inpatient since the middle of January 2003. She was an informal patient, although she had been treated in the Bethlem Royal Hospital under section 2 of the Mental Health Act (MHA) in both November and December of 2002. On 28 March 2003 X was seen by a member of staff, talking with Y in the ward lounge. The nurse was concerned about the relationship as he was a known drug-user and she was considered to be particularly vulnerable.
- 3.4 Y discharged himself from Shelley Ward, without discussion with any doctor, on 30 March 2003.
- 3.5 On 31 March 2003, X reported to her primary nurse that to her regret she had made a pact or arrangement with a patient for him to purchase £80 worth of heroin for her and inject her as she wished to die. She had agreed to pay him £1000 for his help. X had not used heroin before and Y told her that the amount of heroin she could buy for £80 would kill her. She initially refused to identify the name of the patient to ward staff, but the following day, after

some persuasion by another nurse, she admitted that the fellow patient was Y. He had by this time discharged himself from hospital and she was advised to have no further contact with him. Other measures were put in place to lessen the likelihood of her carrying out her arrangement with Y.

The day of the incident

- 3.6 On Friday 4 April 2003, X, with permission from staff, spent much of the day away from the hospital. During the day she had contact with her father and had lunch with her mother in a pub. She returned to the hospital by taxi at about 4pm, having stopped en route at a cash point to withdraw £400 from her Woolwich Building Society account. The nurse in charge of the ward gave her some of her prescribed medication (Carbamazepine and Promazine). At 4.14pm she received a call from a telephone kiosk in Gillingham High Street on her mobile phone. She left the ward, saying she was going to the League of Friends shop. No member of staff saw her again.
- 3.7 Meanwhile, Y accepted a lift to the hospital from a friend, H. There is some discrepancy about when H thought this took place (he initially thought it was about 7pm, but later told police it might have been significantly earlier). A CCTV camera recorded Y getting into H's car at 4.17pm. They collected X from the hospital a few minutes later. Two calls to the same number were made on X's mobile phone at 4.24pm and 4.29pm. Shortly after 4.30pm, H reported that Y carried out a drugs deal in Canterbury Street, having met two women there. H then states that he drove them to a house in Milton Street, where Y used to stay. A few minutes later he drove them back to the hospital and dropped them at the Marlborough Road entrance. H was recorded on CCTV as returning home at 4.52pm. Another verifiable incident was the report by a female (subsequently identified as X herself) of the theft of her Woolwich Building Society card at 5.03 pm. Witness MM recalls going to the cash point with Y late that evening and the card being 'swallowed'. This was verified by a CCTV record at 11.58pm.

The discovery of the body

- 3.8 None of the witnesses reported anything about the whereabouts that evening or the next morning of X. At about 1.30pm on Saturday 5 April 2003 a member of the public, J, was walking along the Great Lines, a footpath behind the hospital. He discovered a young woman whom he believed to be dead. He alerted police and ambulance on his mobile phone. A syringe and needle were found nearby. Two nurses from Shelley Ward attended the scene at 3.15pm and one of them identified the body as that of X. X's father later formally identified the body of his daughter.

Post mortem examination and its outcome

- 3.9 The examining Consultant forensic pathologist formed the opinion that X had died from an injection of heroin, as three small puncture wounds were found in her arm. He could not rule out her having taken the drug orally or intranasally. Subsequent laboratory tests, however, provided little or no support for the possibility that heroin (or morphine) was taken orally or intra-nasally and the concentration in her blood was found to be within the normal range seen previously in cases where death had resulted from opiate poisoning.

The case against Y

- 3.10 A number of witnesses, friends and acquaintances of Y, testified that he had confessed to them that he had carried out the act which had led to the death of X. There appeared to be some confusion among witnesses about times of day and, on occasions, dates when they had met him.
- 3.11 H, who is mentioned above in relation to driving Y on the evening in question, further testified that Y visited him the following afternoon in a distressed state and said *"I've done a terrible thing. I haven't slept all night. I killed the girl with an injection"*. He added that he had done it by the wall on the Great Lines. Y's girlfriend, K, had visited H subsequently, also in a distressed

state, and said Y might have committed the offence to help her with her rent arrears.

- 3.12 K's own evidence to police appeared contradictory. She claimed to have spent most of the evening in question with Y, drinking in local pubs and at a friend's house. The owner of the house, RG, testified, however, that, on Saturday 5 April 2003, he overheard a lengthy, and at times heated, conversation between K and another woman, MM, who were later joined by Y. He heard K say Y had admitted he had killed someone, whom he described as a WPC and that he had been paid to do it. MM testified that Y had admitted to them that he had met a girl on Shelley Ward who was:

“a policewoman, or Special Constable and she had asked me to bang her up with heroin. She was begging me to kill her to inject her, she wanted to die. She wanted to pay me to do it to her.”

- 3.13 On Sunday 6 April 2003 Y paid an early morning and an afternoon visit to a friend, N, who was also a family friend. According to N, Y was *“very flustered and quite agitated”* hence he realised something was wrong. N said Y had admitted:

“I killed a girl. I OD'd her, I was in Shelley Ward with her....She gave me £500 to do it and I put it in her....She asked me not to leave....I didn't leave till she closed her eyes and then I walked off...It's just sinking in. I've just started to realize what I've done. I've told X and she's run off, she's disgusted with me.”

The arrest of Y

- 3.14 Y was arrested on Wednesday 9 April 2003, at a house in Milton Road Gillingham *“on suspicion of the murder of X, between 4-5 April 2003”*. Under caution he said *“She owed me money”*. He later said *“I knew her she ripped me off”*. Later, en route to Chatham Police Station he said *“She was going to get some gear, but didn't have the money, she gave me her cash card but*

she only had £40 in her account, the machine kept her card, she even wrote the PIN number on my hand.” He said the card had been retained by the Woolwich Building Society in High Street Gillingham. At the station, he stated *“stupid cow topped herself”*. When Y was in custody he was interviewed by the police but made no admissions. He gave a detailed defence statement, which he subsequently changed during his oral evidence

The outcome

3.15 Y was tried for the murder of X. He pleaded not guilty. He was convicted and on 11 March 2004 was jailed for at least 19 years.

4. Y - his background

Introduction

- 4.1 This chapter provides background information about Y from his early childhood until April 2003, when he murdered X.
- 4.2 We were unable to interview Y, as he was unwilling to meet with us. We decided consequently it was not appropriate to contact members of his family because it was unlikely that they would cooperate given his antagonism to the inquiry. Hence this narrative has been obtained largely from records from his general practitioner (GP) surgery and psychiatric and addictions service records, made available by the West Kent NHS and Social Care Trust as well as probation service records. Some information has also been obtained from witness statements, given by friends and acquaintances, in relation to his prosecution for the murder of X.

The childhood and adolescence of Y

- 4.3 Y was born on 29 November 1976 in the Medway area. His mother apparently suffered from asthma and his father from diabetes. He had two siblings, a brother four years older and a sister three years older.
- 4.4 By his own admission, Y was breaking the law from about the age of eight when he started to go around with a group of older boys. He was sent to two different residential schools, apparently as a result of his disruptive behaviour, from the age of 13. He said he was expelled from boarding school and left with no qualifications. Medical records show that in 1991 he had two overnight admissions to Medway Maritime Hospital for overdoses of tranquillisers, taken in conjunction with cannabis. He was referred to a child psychiatrist.
- 4.5 He told probation officers that he started using heroin when he was 14. His GP records show that, from November 1994 (aged 18), he was attending

Manor Road, the Medway Addictions Service and he had admitted to workers there that he had been a heroin addict since the age of 14.

- 4.6 Y became a father for the first time at 14. A subsequent child died and his partner left to live abroad. He seems to have had no contact with his child. He told probation officers his drinking started to become problematic at this time.
- 4.7 His offending came to the formal attention of the police in 1989, when he was convicted of vehicle offences and subjected to a two-year conditional discharge. In 1991, he was convicted of aggravated burglary and possession of controlled drugs and received a two-year supervision order. In early 1992 he was sent to a young offenders' institution for six months, following conviction for a number of offences, including assault occasioning actual bodily harm, thefts and burglaries.
- 4.8 Y's addiction problems caused him to have two inpatient admissions to Shelley Ward, for the purpose of opiate detoxification in 1994 and 1995. He was discharged from the later admission as he was unable to keep to his contract, having left the ward without agreement. At this time he was diagnosed as suffering from Dissocial Personality Disorder and Opiate Dependency Syndrome. He began an outpatient methadone opiate detoxification course in February 1996, but it appears that he was finally discharged from Manor Road in November 1996, after a period of non-attendance.

The early adulthood of Y

- 4.9 Y continued to offend and between 1992 and 2003 was subject to most sanctions available to the courts, including probation orders, community service orders, community punishment, imprisonment and fines.
- 4.10 Records show that Y was in touch with psychiatric services again in 1998, when he had taken a cocaine overdose and, in 1999, he was referred to the

psychiatrist, Cons 1, suffering from depression, insomnia and an inability to control his temper. In December 2000 he attended Medway Maritime Hospital Accident and Emergency Department twice in two days, due to his heavy drinking and/or him having taken an overdose. He was, however, not referred to psychiatric services.

- 4.11 His GP records from August 2002 show he was again referred to psychiatric services, while he was an inpatient at Medway Maritime Hospital. A doctor was concerned as he had written a suicide note, but he discharged himself before he could be seen and assessed by medical staff. In October that year, he was referred to a psychiatrist as he indicated to his GP that he was suffering from depression and insomnia, having, he claimed, witnessed his friend seriously assaulted by his brother-in-law and also having been left by his girlfriend. Y did not attend the consequent outpatient appointment. In January 2003 he visited his GP and requested a medical certificate to explain why he had been unable to attend court that day. He was abusive and threatening towards the GP and said he would have to return to prison, from which he had only recently been discharged, if no certificate was provided.
- 4.12 This links to probation records, which show that at this time he was being referred back to court having breached a Community Rehabilitation Order, made in June 2002, with a condition attached that he was to address his alcohol misuse. The outcome of this hearing was that he was made subject to a Community Punishment Order, to run concurrently with the original Community Rehabilitation Order above.
- 4.13 Again, it would appear that Y failed to comply with this order. However, on 24 March 2003, he was told he was in breach of his order. He spoke with a probation officer saying he was feeling low and had thoughts of self-harm. He was due in court concerning the breach in two days time, and as a consequence of the concerns of probation officers, an appointment was made for him to see the specialist social worker for mentally disordered offenders immediately after the hearing. In view of this appointment, the court adjourned the hearing until 16 April 2003.

4.14 Y presented as distressed and allegedly suicidal during his interview with SW 1 and Prob 1. He said it was because he had witnessed a serious assault. As a consequence, he was referred to the Medway Maritime Hospital Accident and Emergency Department which he agreed to attend immediately. The probation officer telephoned to alert the department of his imminent arrival. In the event, Y failed to attend until late the following evening. He was admitted to Shelley Ward after an emergency assessment. He met X while on the ward. She was also a patient at this time. They made a plan for her to pay him to buy heroin and inject her with it, as she apparently wished to die. This plan was executed a few days later, on the night of 4-5 April 2003, a few days after Y had discharged himself.

Information gained from friends and acquaintances

4.15 A number of friends and acquaintances gave evidence to the police in relation to Y's prosecution for the murder of X. We extracted from these statements some information to expand a picture of Y, having been unable to meet him. Initials appear throughout this section to maintain anonymity.

4.16 Y had a girlfriend, K, with whom he had been in an "on-off" relationship for the previous four-and-a-half years. She described their relationship as "volatile a lot of the time" and indicated that at times he had been both physically and verbally violent towards her. They had been living apart for the previous year, as K was concerned that his drug use, particularly heroin, had caused significant difficulties in their relationship and contributed to its volatility. She said she had recently been resisting his attempts for them to live together again as she did not wish things to go back to how they had been. She described how Y had recently admitted himself to Shelley Ward to "get himself off the drugs". K spent a lot of time with Y over the weekend the offence was committed and provided an alibi for him during much of this period.

- 4.17 Y spent some time when he was not with K staying at the house of a friend, O, in Gillingham. He said he had known Y for less than two years and had met him in Gillingham. Y was also a frequent visitor to another house owned by RG and also occupied by a couple and another woman, woman Q. Y apparently spent a significant amount of time at this house during the weekend of the offence, with K and the others, especially Q. She described how she had known Y for a few months and he had lodged with her for a few weeks while recovering from a physical assault. She too was involved in drugs and indeed had apparently supplied them to Y a few days before the offence.
- 4.18 Y had another friend, N, who said that he had known Y and his family for 15 years. Y had chosen to visit this friend after committing the offence and had admitted what he had done, appearing to show disgust and remorse. Another friend, H, had driven Y on the day he bought the heroin used to kill X. Y had visited him in a distressed state the following day. He was crying and admitted that he had injected X.
- 4.19 Almost without exception, the above friends and acquaintances accepted that Y could be less than pleasant at times, but were shocked that he had committed the offence and did not believe this was in line with his normal behaviour.

5. Y - in-patient and out-patient care and treatment

Introduction

5.1 This chapter is in two parts. Part one deals with Y's care and treatment, both as an inpatient and as an outpatient, from 1991 to his admission to Shelley Ward on 27 March 2003. Part two deals with this admission until he discharged himself on 30 March 2003.

Part one - Y's care and treatment, both as an inpatient and as an outpatient, from 1991 to his admission to Shelley Ward on 27 March 2003.

5.2 Y's main problems were difficulties associated with multiple substance misuse and an anti-social personality.

5.3 From the account he gave when first admitted for detoxification from heroin in January 1994, Y had started misusing illicit substances from the age of 13 (*i.e.* late 1989 or 1990). This began with cannabis and "pills" (probably amphetamines), but progressed to smoking heroin at the age of 14 (1990/1991) and to injecting heroin and crack cocaine by the age of 15 or 16 (1992). By 18 (1995) Y claimed to have used a wide range of drugs including cannabis, amphetamines, LSD, cocaine, crack cocaine, heroin, methadone and benzodiazepines. He was probably dealing in drugs to afford his own habit by the time he was 16.

5.4 This history is probably related to his unstable upbringing and disturbed behaviour as a child, which led to him being sent to at least two specialist boarding schools as well as leading to him taking several overdoses in 1991. It is also linked in time to his offending history, with his first conviction being in February 1989 for theft and taking a vehicle without the owner's consent.

5.5 GP records show that he was first openly disclosing with GPs his addiction to opiates in December 1992, but that the contacts were mainly centred on Y's

requests for medical sickness certificates. Y first mentioned that he was attending the Manor Road substance misuse service in November 1993 and he was later admitted by that service to Shelley Ward at the then Medway Hospital on 6 January 1994 for detoxification from opiates. He took his own discharge from Shelley Ward on 9 January 1994.

Comment

Y's assessment and care during the admission to Shelley Ward in January 1994 was of a good standard. He was physically examined and tests were planned to check his HIV and hepatitis status. There was no evidence that Y was suffering from any form of mental illness. A lofexidine detoxification programme was discussed with Y as he said he would prefer not to be given methadone. That programme began immediately and included regular physical checks on his blood pressure and pulse rate before and after the administration of lofexidine. Other medication was also used to control withdrawal symptoms, in keeping with acceptable medical practice. Y was encouraged to attend a relapse prevention group. Despite this good standard of care, Y took his own discharge three days after admission. He was offered follow-up through the Manor Road substance misuse service a few days later, but we do not know if he attended. The GP was informed of this admission and his early self-discharge.

5.6 Following this admission, Y reported to his GP in September 1994 but then attended fairly regularly as well as attending Manor Road substance misuse service. Y was prescribed a maintenance dose of methadone 40mg per day by the Manor Road service between November 1994 and March 1995 and was then meant to reduce the dosage to 35mg per day. It is unclear what happened between this date and his second admission for opiate detoxification on 22 August 1995.

1995 admission to Shelley Ward

5.7 On 22 August 1995 Y was admitted to Shelley Ward for opiate detoxification. Y was still taking 40mg methadone per day, which had been started on 7

November 1994. He also admitted taking extra street methadone and heroin. He was taking cannabis, abusing alcohol and gave a history of using LSD, amphetamine, cocaine and benzodiazepines in the past. He admitted to drug dealing to support his habit. Y said he had never been tested for HIV or Hepatitis and he denied needle-sharing. He later refused blood testing. He told the admitting doctor he was due in court in September for criminal damage and handling stolen goods. There was no sign of mental illness and physical examination was normal. On 25 August 1995 he discharged himself. He did not wait to see Cons 7 (registrar) but was given an appointment to go to the Manor Road substance misuse service on 30 August 1995.

Comment

Y received a good standard of care during the second admission for detoxification and was fully assessed physically. He was offered HIV and hepatitis testing, but later refused blood tests. He demonstrated no evidence of mental illness. Y again chose not to be given methadone, expressing a preference for lofexidine and a standard detoxification programme was commenced immediately. Three days later he asked to be switched to a methadone detoxification regime, but before nursing staff could arrange for him to see the consultant or junior doctor to discuss this, Y had again decided to discharge himself. The GP was again informed of this admission and his early self-discharge.

5.8 Y was given an appointment to see someone from the Manor Road substance misuse service on 30 August 1995, but we do not know if he attended. However, that service discharged him for non-attendance in December 1995. By February 1996 Y had returned to Manor Road and had been started on an outpatient methadone detoxification, aimed at reducing from a dosage of 40mg per day to zero in 5mg steps every two days. It does not seem likely that Y adhered to this regime and he was again discharged from Manor Road in November 1996 for non-attendance.

- 5.9 Y was sentenced to two years at a young offenders' institution in March 1997 and there is a corresponding gap in his GP records.
- 5.10 In May 1998 he presented to the Accident and Emergency Department at Medway Hospital after a suspected fit due to high cocaine, alcohol and temazepam use and was admitted overnight. He does not appear to have been referred to psychiatry at this time. He did not attend an appointment at the Manor Road substance misuse service in July that year. Thereafter, there is no reference to Manor Road, suggesting that Y completely disengaged from substance misuse services despite his continued use of drugs.
- 5.11 In April 1999 Y requested a psychiatric referral from his GP because he was having difficulty controlling his temper. The referral was sent, but there is no record of him attending an appointment.
- 5.12 In December 2000 Y presented to the Medway Maritime Hospital Accident and Emergency Department twice in two days, having been drinking heavily and/or having taken an overdose. No referral to psychiatry was made.
- 5.13 In August 2002 Y was admitted to a medical ward at Medway Maritime Hospital, having written a suicide note. He discharged himself before he had been psychiatrically assessed. The psychiatrist telephoned the GP to inform him of this, but no follow-up arrangement was made.
- 5.14 In October 2002 Y was urgently referred to psychiatric outpatients by his GP after complaining of feeling depressed and suicidal. His girlfriend had left him and he had apparently witnessed a serious assault. He failed to attend the outpatient appointment.
- 5.15 In January 2003 Y was aggressive and threatening to his GP. He again demanded a letter excusing him from attending court the next day. Y was afraid that without the letter he would be sent back to prison.

Comment

The various GPs involved in Y's care dealt with his needs appropriately, at times in difficult circumstances. They appear to have frequently discussed with Y his use of the substance misuse services and he reassured them he was attending the Manor Road service. He did not require a referral from the GP to attend there.

The communication from the Manor Road service to the GP was reasonable, if intermittent. Between March 1995 and his second admission for detoxification, the GP had no communication from the Manor Road service and would therefore have been unsure what dosage of methadone Y was receiving. There was a similar lapse between February and November 1996 when Y had been advised to reduce methadone to zero, but there was no communication during this time to update the GP on progress until Y was discharged for non-attendance. This lack of communication is regrettable, but probably made little difference to Y's overall care.

The GPs also responded appropriately to Y's requests for psychiatric referrals in 1999 and 2002, but Y failed to attend the arranged appointments. Communication between his GP and the hospital about his failure to attend was good.

Part two - Medway Maritime Hospital from 27 March 2003 to 30 March 2003

Chronology

- | | |
|-----------------|---|
| 26/3/03 (Wed) | Y was seen by SW 1 and Prob 1 and was asked to go to the Medway Maritime Hospital Accident and Emergency Department for psychiatric assessment. |
| 27/3/03 (Thurs) | Y was admitted to Shelley Ward via the Accident and Emergency Department with depression and "significant suicidal ideas", plus heroin and cocaine abuse. He was assessed by SHO 1 on call, and Nurse 1 at 9.30pm and his |

case was discussed with Cons 2 (11pm) prior to admission. Y's GP was recorded as GP1.

He said he had witnessed a serious assault eight months earlier and recently broken up with his girlfriend. He felt depressed and had not been sleeping well for the "*last few weeks*". He disclosed a previous history of self-harm and reported that he had tried to harm himself several times in the last few weeks, including a deliberate overdose of intravenous heroin and temazepam.

Y tested positive for cocaine, morphine and cannabis. He said he was being prescribed diazepam 10mg and temazepam 40mg at night (there is no record of this in his GP notes) and had been taking buprenorphine 8mg twice per day but this was unprescribed (this is a drug sometimes prescribed as substitution therapy for patients with a moderate opiate dependence, with a maximum BNF dosage of 32mg per day). He had four 8mg tablets with him.

Y gave a history of admission to a "*high secure prison*" and an interest in boxing. He was recognised to be at "*high risk of violence towards others*" and a "*contingency plan*" was made to call the police to the ward if he became verbally or physically aggressive. An "*urgent review of management plan by [Cons 7] team*" and further risk assessment was recommended in view of his history of violence.

A note was made of the need to obtain further information from the probation service. Prob 1's details were given to SHO 1 by Y on admission. However, no

probation information was available in the Accident and Emergency Department.

SHO 1 prescribed diazepam 10mg and temazepam 40mg at night plus buprenorphine 8mg twice per day on a regular basis, in addition to “as required” promazine (a sedative antipsychotic used to reduce anxiety/agitation in low dosage) 25mg up to three times per day for agitation and metoclopramide 10mg up to three times per day for nausea or vomiting.

28/3/03 (Fri) After admission, Y was given 8mg Subutex (buprenorphine) at 2am. The nursing record by Nurse 1 states that he ‘settled straight away when he was admitted to the ward’. He was placed on 30-minute nursing checks and was noted to have slept for only two hours. She reiterated that Y *“needs to be reviewed by the nursing and Cons 7’s team ASAP regarding management plan”* and that the staff *“need to call probation officer (Prob 1)”*.

The nursing record by Nurse 2, stated she had discussed with Cons 2 the appropriateness of Y’s admission because of his *“addiction issues”* and his history of violence. Y complained that he had not been prescribed diazepam in the morning. Nurse 3 recorded that Y was given diazepam 10mg at night and was later due to be given temazepam 40mg.

29/03/03 (Sat) Nurse 4, acting charge nurse, recorded that Y received a letter from Prob 1. Y asked nursing staff to contact the probation service on Monday 31 March 2003 to ensure they knew he was in hospital.

He later left the ward with his mother and then his cousin. He smelled of alcohol on his return. He appeared anxious in the evening and was given promazine 25mg. It was later recorded that evening that he was abrupt, rude and interfering.

30/3/03

Nurse 5 recorded that Y was annoyed that doctors had not divided the diazepam dosage between morning and evening. He insisted on being allowed off the ward with a friend in the afternoon and only returned at 7pm.

In the evening Y requested to discharge himself. The duty doctor was informed but did not see Y before he signed the required form and left the hospital.

Comment

We believe that the risks Y posed to other patients on Shelley Ward mean he should either not have been admitted or, once admitted, should have been reviewed by a senior psychiatrist (preferably the consultant) and a senior ward nurse the following day. In retrospect it is likely that Y was exaggerating his depressive symptoms to engineer admission to hospital and thus reduce the likelihood of a custodial sentence for failing to comply with his Community Punishment Order. However, at the time of his assessment in the Medway Maritime Hospital Accident and Emergency Department, SHO 1 and Nurse 1 had to make a decision based entirely on what Y told them about himself. They did not have information from the probation service or SW 1. They could not contact Y's GP or access the archived hospital records because of the time of his admission (9.30pm).

Although he may have exaggerated Y was open about his risk of violence to others. Despite this risk he persuaded SHO 1 and Nurse 1 that he was experiencing "significant suicidal ideas" and had tried to harm himself by deliberately overdosing on intravenous heroin and temazepam in the previous

week. Both professionals seemed to acknowledge that admitting Y was a risk, but one that could be managed on Shelley Ward. SHO 1 appropriately sought the advice of the consultant on call, Cons 2, who happened to be the same doctor who would subsequently take charge of Y's inpatient care. Cons 2 said she at first refused to admit him on the basis of his history of drug addiction. She was persuaded by SHO 1 who told her:

“The patient is very suicidal, the patient is very depressed, if I don't admit him now he is going to do some harm to himself.”

It is recorded that Cons 2 then agreed that the admission was appropriate. Trust admission criteria also suggest that Y's admission was appropriate: he was thought to have acute and severe symptoms of mental illness (depression) and to be at high risk to himself and lacked effective 24-hour care in a home environment. There is no mention in the criteria of the need to consider the safety of other patients or of staff.

SHO 1 prescribed medication based on Y's own reported intake of benzodiazepines and buprenorphine. This was appropriate in the short term, despite the relatively high dosage of temazepam (and was probably done at Y's insistence) but would have required review by the inpatient team as soon as possible, based on further information obtained from the Manor Road substance misuse service, Y's GP and the probation service.

Nurse 1 was sufficiently concerned about Y's risk of violence to record a contingency plan to call the police if he became verbally or physically aggressive on the ward. She also appropriately recognised that further information needed to be sought from the probation service the following day and that Y would require “urgent review by Cons 7's team” and a further risk assessment.

5.16 From the next morning (Friday 28 March 2003), the nursing team were already beginning to raise doubts about Y's admission. Nurse 1 recorded that Y “settled straight away when he was admitted to the ward”. Nurse 2 recorded that she had discussed the appropriateness of Y's admission with

Cons 2 in view of his “*addiction issues*” and his history of violence. She also recorded that Y had begun to complain about his prescription and wanted diazepam made available in the morning as well as at night.

5.17 Despite these concerns there is no record of Y being re-assessed by a senior doctor or nurse. The absence of medical notes for Y’s admission hampered the inquiry in this regard. Cons 2 suggested, during the post incident review that she:

“had attended the ward on the 28th to review Y. However, the nursing staff advised her that Y was settling and requested that she postpone seeing him.”

5.18 When Cons 2 gave evidence she amplified her reasons for not seeing Y:

“Knowing the patient is so manipulative and knowing the patient is so arrogant, and knowing the patient is settling down right now, I decided to let him settle during the weekend and we decided to see him on the Monday ward round so that there will be other nursing staff around.”

5.19 She chose not to see him despite the fact that she was unhappy about the range and type of medication that had been prescribed by SHO 1. She had also been told on the morning after his admission that he was no longer showing any evidence of depressive symptoms or suicidal thoughts and plans.

Comment

We consider that Cons 2 failed in her clinical responsibility in choosing not to review Y. It was unlikely that nursing staff would have advised her not to see Y, given their concerns about his history and his behaviour. No time limits were in force for patients being assessed by a consultant psychiatrist after admission.

5.20 By Saturday 29 March 2003, Y insisted on leaving the ward with friends and family, as he was aware of his informal status. He consumed alcohol on one

of these occasions, but was not breathalysed “owing to the ward situation” or asked to submit to urine drug screening. The next day he went out for a long time with a friend and again was not tested on return.

Comment

During his previous admissions in 1994 and 1995 for detoxification, Y had been asked to sign a behavioural contract, limiting his contact with visitors to a few nominated people agreed with nursing staff and restricting his time off the ward to escorted trips with staff. Since then, the inpatient service had been reconfigured and there were no nominated detoxification beds on Shelley Ward. However, patients with substance misuse problems were still being admitted to the ward and some, including Y, would have required detoxification. We do not know if a behavioural contract was still in use for such patients on Shelley Ward at this time, but if Y had been asked to agree such a contract, his ability to leave the ward unescorted would have been regulated and so he would have been better observed during his brief admission. Also if he had agreed to such a contract he could have been breathalysed and his urine tested for substance misuse on return from time off the ward. Any refusal would have led to a decision as to whether or not he should be discharged.

Y expressed a wish to discharge himself on Sunday 30 March 2007. He was appropriately asked to sign a form to this effect and to see the duty doctor, but declined to wait until he could be seen. No attempt seems to have been made to arrange community follow-up after discharge either in psychiatric outpatients or with the substance misuse service, despite the recorded concerns about his potential self harm on admission.

Y's Care Programme Approach (CPA) status

5.21 There is no record of Y's eligibility for CPA being assessed. If he had been assessed it is unlikely that he would have satisfied the criteria for enhanced CPA. This was confirmed at interview by CPA 1, who was at the time the trust CPA lead. There is a suggestion that at the end of the third day of assessment, Y was not thought to be significantly depressed or suicidal and that his main problems were thought to be a combination of substance misuse and personality issues. He appears to have chosen to leave the ward in order to continue his substance misuse. Our conclusion is that Y was not offered follow-up because of that assumption about his diagnosis, which would have made him ineligible for CPA at the time. However, no explicit statement concerning this was recorded in the nursing notes and the medical notes are missing. To our knowledge, no attempt was made to inform Y's GP about this admission or his early discharge and there is no reference to this in his GP records.

Comment

If SHO 1 and Nurse 1 had decided not to admit Y they could have considered giving Y an urgent outpatient appointment for the next day. Given their evaluation of the likelihood that he would harm himself they decided in favour of admission. It is not this decision to admit that causes most concern. Rather it is the failure to adequately reassess Y's mental state and risk factors the following day, with the benefit of senior medical and senior nursing staff expertise and having gained further information about him from the probation service and the GP.

There should have been an attempt to offer Y a follow-up outpatient appointment soon after his discharge. Y's GP should have been informed of the admission and his decision to discharge himself.

We have considered the trust's current admission criteria. If Y was to be assessed today and his threats of self-harm/dangerous behaviour were genuine then a further diagnostic assessment could be justified. This type of assessment could potentially be done in the community with the Crisis Resolution Home Treatment Team now in operation.

The current trust operational policy concerning admissions provides that:

“The Nurse in Charge retains the right to refuse admission of any service user to the Unit if the health and safety of other service users and staff are compromised.”

As far as we are aware, no such policy was in existence at the time of Y's admission in 2003. Cons 2 said she did not take into account the impact that the admission of someone with Y's characteristics could have had on other patients in the ward to which he was admitted. Nurse 2 (charge nurse) considered health and safety issues at the time of Y's admission, for example she considered Y's propensity to violence, and his current drug use. In the absence of explicit guidance, however, it would have been more difficult for Nurse 2 to refuse Y's admission. It may be that this policy, coupled with increased capacity to assess in the community perhaps makes it less likely that a patient with Y's characteristics would now be admitted to Shelley Ward.

6. Y's contact with probation service

Introduction

6.1 Y's contact with the probation service, and in particular the circumstances surrounding his referral to Medway Maritime Hospital for treatment is covered in this chapter. Two probation experts helped prepare it. Both said this was a well managed case according to the National Probation Service National Standards for the Supervision of Offenders in the Community 2000. We also heard evidence from probation officers Prob 1 and Prob 2 as well as from community service officer CSO 1.

Types of order

6.2 During the period relevant to the inquiry Y was subject to two types of community order, Community Rehabilitation Order and Community Punishment Order.

Community Rehabilitation Order

6.3 This can be imposed for between six months and three years and can reflect both the seriousness of the offence and the needs of the offender. Offenders will expect to report under National Standards and to tackle the difficulties that have led to their offending. They may be required as a condition of their order to attend an accredited programme to address specific aspects of their behaviour. The Community Rehabilitation Order made on 20 June 2002 at Medway Magistrates Court required Y to address his alcohol misuse. Practical help can also be given in relation to housing or benefit issues. This type of order can be managed by probation service staff or staff from organisations that work in partnership with the probation services. Such organisations include, for example, drug/alcohol agencies. In this case the Community Rehabilitation Order was supervised by a probation officer.

Community Punishment Order

6.4 This is a community sentence where offenders are expected to carry out unpaid work. They incorporate a “*skills for life provision*” which can improve educational skills. It is clear from the records of contact that Y failed to attend his Employment, Training and Education appointments. The number of hours imposed ranges from 40 to 300 and the duration can have some relation to the seriousness of the offence. Community Service Orders were replaced by Community Punishment Orders under the Criminal Justice Act 2003.

Y’s criminal record and his contact with probation service prior to 2002

6.5 Y had a number of criminal convictions:

6	Offences against the person	(1992-1998)
3	Offences against property	(1996-2002)
13	Theft and kindred offences	(1989-2001)
3	Public order offences	(1993-2000)
3	Offences relating to police/courts/prisons	(1997-1998)
4	Drugs offences	(1991-1993)
2	Miscellaneous offences	(1998)

6.6 He received a number of custodial sentences, the longest sentence in 1997 of two-and-a-half years for intimidating a witness and blackmail.

6.7 He also received probation and community orders prior to 2002. Prob 1 said that during the period before 2002 “his reporting to me was ... sufficient, regular and acceptable”. This contrasts with the “chaotic reporting” described by Prob 2 who was supervising him when he was subject to the Community Rehabilitation Order in 2002.

Chronology - 2002 to 2003

- 20/6/02 Community Rehabilitation Order for 12 months with a condition to address his alcohol misuse; made at Medway Magistrates Court for various offences including theft.
- 6/2/03 Community Punishment Order for 200 hours made at Thanet Magistrates Court for offences of excess alcohol and breach of his Community Rehabilitation Order. In the pre-sentence report Y is identified as having a high risk of reconviction and risk to the public at medium level. The author does not consider that Y is suitable for supervision by the probation service. The report states that a community based disposal would be of *“little benefit”*. Despite this, the court made a community punishment order, with the chair of the bench observing:
- “This is an unusual case. There are certain elements that we have had to consider carefully.”*
- 3/3/03 Y was suspended from his Community Punishment Order
- 24/3/03 Y saw Prob 1 and CSO 1. Y was described by CSO 1, who had not met him before, as *“distressed”* and *“very agitated with himself”*. Because of his presentation, an appointment was made for him to see SW 1 on 26 March 2003. CSO 1 reflected on the possibility that Y fabricated his condition to engineer the referral and concluded that that was not an issue.
- 26/3/03 Y appeared in court in relation to the breach of the Community Punishment Order. His case was adjourned until 16 April 2003 *“as requested due to his appointment with SW 1 due to his mental health issues”*.

26/3/03 Y was interviewed by Prob 1 and SW 1 at the probation service offices in Chatham. Prob 1 thought that he was seen about 4pm.

Risk assessments undertaken by the probation service

6.8 There are a number of risk assessment documents on the probation file. The context in which the documents were prepared was in relation to the various offences for which he fell to be sentenced and therefore the documents do not have direct relevance to this inquiry. The author of the Offender Assessment System form completed before he received the Community Rehabilitation Order in June 2002 notes:

“Very extended pattern of offending - could be a challenging participant in terms of attitudes & lack of remorse & poor consequential thinking.”

Comment

The Offender Assessment System completed on 19 March 2003 does not mention Y’s drug use and the probation report completed on 19 June 2002 refers to his abstaining from heroin use. Given that other sources during these periods identified him as a heroin user, he is likely to have been giving false information.

The interview on 26 March 2003

6.9 Y was seen by SW 1 and Prob 1. Prob 1 was satisfied that Y was not “pulling the wool over their eyes” in requesting a hospital appointment to prepare to mitigate his circumstance in anticipation of the breach proceedings before the criminal court. It was put to Prob 1 that Y’s symptoms may have been fabricated. He responded:

“I did not perceive from what he said and the way he said it, from the way he behaved, and from the way he looked, that he was in any way

dissembling. Yes, he had a very complicated history and he had a known history of alcohol abuse and drugs abuse and he had a history of very unpleasant behaviour. But nevertheless he was presenting on that occasion as being himself personally distressed.”

6.10 SW 1 described Y as being very distracted and very anxious at “*risk of suicide or self harm*”. She concluded that:

“He really needed to go to the A&E liaison service immediately in order to have a clinical assessment in relation to treatment and/or admission.”

6.11 Prob 1 described Y as being very open and honest and noted that he may (underlined in notes) be suffering from post-traumatic stress concerning an assault he witnessed. “*SW 1 has taken the clear view that Y is very unwell.*”

Comment

We were so concerned that Y had manipulated the professionals into arranging to refer him to psychiatric services that it reflected on their experience as assessors. Prob 1 was an experienced probation officer, having qualified in 1979. CSO 1 had worked in Young Offenders Institutions for a year and a half before joining the probation service about five-and-a-half years earlier. Both their supervision and management arrangements appeared robust and they expressed no concerns about this aspect of their work.

SW 1 qualified in social work in 1993 and trained as an ASW. She brought to our attention concerns about her management and supervision. She told us she specialised in working with mentally disordered offenders. Her job description contained no details of this function. She developed a liaison role with the probation service. Prob 1 was complimentary about her work. Despite her concerns, we were satisfied she had sufficient experience as an assessor to perform her role, particularly as she conducted the assessment of Y with another experienced professional.

All three assessors concluded that Y appeared genuinely distressed at their meeting in March 2003; CSO 1 and Prob 1 on 24 March 2003 and Prob 1 and SW 1 on 26 March 2003. We accept therefore that the joint decision by Prob 1 and CSO 1 to refer Y to SW 1, and then the joint decision by Prob 1 and SW 1 to refer Y for psychiatric assistance was reasonable in the circumstances.

With hindsight it seems clear that Y manipulated his admission to Shelley Ward to serve his own ends. There is little evidence about Y's involvement in an assault in June 2002 where he claimed he was a victim and suffered post-traumatic stress as a consequence. His need for emergency psychiatric assessment has to be viewed in the light of his having lied to SW 1 and Prob 1 when he said he would go straight to the Accident and Emergency Department; in fact, he went the next day at about 11pm. His behaviour on the ward showed a manipulative and cynical approach to the treatment offered.

The admission to the Medway Maritime Hospital Accident and Emergency Department

6.12 SW 1 was clear that the route to a psychiatric assessment for a person with Y's presentation was via the Accident and Emergency Department. She described meeting with Liaison 1, and on the basis of information given to her by Liaison 1, SW 1 concluded that the way to access care for Y was via a referral to the Accident and Emergency Department. According to Man 1, inpatient services manager/modern matron and Man 2 area services manager this referral route was not correct;

"She wasn't clear about the pathway but I don't think that's just her; there was an awful lot of sending people to A&E going on."

6.13 Man 1 said the intake assessment function at that time rested with the Community Mental Health Team (CMHT) but that the service was available only between 9am-5pm. She described the function of the Accident and Emergency Department liaison psychiatry service as limited to people with primarily physical problems.

Comment

In early 2003 some of the procedures for assessing people with mental health problems were not clear (the Accident and Emergency Department's liaison psychiatry service has now been disbanded and a different model is in operation). This was also identified by clinical governance manager Man 3 when he conducted his clinical and practice review. Given this uncertainty we do not criticise SW 1 and Prob 1 for following the procedures they considered to be in place at the time. The following points give grounds for concern:

- a. The absence of clear criteria for the admission of someone with Y's problems.*
- b. The failure to assess Y following his admission by an experienced clinician.*
- c. The fact that someone with Y's difficulties could still be admitted today.*

7. X - her background

Introduction

- 7.1 This report seeks now to provide a description of the background of X, from her early childhood until her death in April 2003. Initials appear throughout this chapter to maintain anonymity of family members who gave information. These relatives have provided both factual information and their impressions of X at various stages in her life as well as their thoughts about the care she received. They have also told of their feelings about the impact the murder of X has had on them.
- 7.2 The inquiry has had access to a wealth of written material on X, largely from her medical, nursing and other healthcare notes, but also from a number of people who gave verbal evidence to the inquiry, including her sister, brother-in-law and father, as well as from many of those involved in her care. We also received copies of witness statements given to the police in relation to the prosecution of Y for the murder of X. These included a statement from her mother, who died in 2005.
- 7.3 Both the mother and sister of X provided “victim impact statements” to the Crown Prosecution Service, in February 2004, in preparation for the trial of Y for her murder.

The childhood and adolescence of X

- 7.4 X was born in Gillingham Kent on 3 July 1979, the second of two children of E and F. F left the family home, after four years of marriage, when X was eight months old and her sister, A, nine months older. In 1983 X’s mother married a former friend of her first husband, E, and their son, M, was born in late 1985. The family moved to Rainham and remained there throughout X’s childhood. X and her sister were adopted by E and hence used his surname and were brought up as his children.

- 7.5 According to her family, X experienced extremes of mood from an early age, ranging between being moody and confrontational to intensely loving, both with family and friends. Her sister A described X as like a little child, who loved attention, but also liked to mother people and have them as “hers”. Apparently unknown to her mother, both X and her sister were sexually abused by their father from about the age of seven to 12 or 13. According to A, she and her sister eventually decided to tell their mother of the abuse and she said she would discuss it with their father. He said he was upset they had gone to their mother about this rather than to him. A and X reacted differently to their father’s response, A being angry and X feeling guilty that they had upset him. Their mother, according to A, started drinking heavily from this time and continued to do so until she died in 2005. The family decided to take no further action. A said the abuse ceased a year later. E said it ceased at the time of the revelation.
- 7.6 X’s mother said that when she was 13, X was taken to Medway Maritime Hospital, having taken an overdose of paracetamol, following an argument with her. Medical records indicate that X was first seen by the Child and Adolescent Mental Health Service in early 1995, at the age of 15, as a result of an overdose and consequent short hospital admission. According to her mother and sister the overdose was a result of her feelings for a boy being unreciprocated. In 1996 X’s mother sought help to find X somewhere else to live, in view of difficulties in their relationship. X was seen by the Kent County Council Children and Families Team after a further admission as a result of an overdose. Follow-up appointments were offered, but X apparently failed to attend and so the file was closed about six weeks later, although professionals recognised that she remained vulnerable.
- 7.7 X left school with ten GCSEs. Shortly before her 16th birthday, she met a man and moved in with him, living some of the time in London. The relationship was highly volatile. X became pregnant during this 18 month relationship but according to her mother the man forced her to have an abortion, to which she reacted badly.

- 7.8 From the age of 13, X's life was characterised by a number of overdoses and other acts of self-harm, including severe cutting to her arms, face and legs, and on one occasion, she walked in front of a lorry. According to her sister, these acts of self harm were directly related to the sustained abuse she suffered as a child. Her father also acknowledged that the abuse X suffered, which he now regrets, was central to her psychiatric illness.

The adulthood of X

- 7.9 In 1999, X's new GP referred her to psychiatric services based at Medway Maritime Hospital, because she was again experiencing depression. She was seen by SHO 2 on Cons 3's team, who assessed her to be actively suicidal, suffering from a severe depressive episode, post-traumatic stress and an adjustment disorder. He noted that she had a history of sexual abuse and that her mother was an alcoholic. Subsequently, X was referred to a clinical psychologist, Psychologist 1 who saw her regularly at the Christina Rossetti Day Hospital. She was subsequently seen by a gestalt therapist, GT 1, from December 2000 onwards. He then retained contact with her, albeit on occasion intermittently, until shortly before her death in 2003. Her sister said she valued his input above all the other help she was offered.
- 7.10 The involvement with psychological services in 2001 apparently coincided with the time that X and her sister came to the decision to tackle again the matter of the sexual abuse they had suffered from their father. With the support of A's husband, the three confronted E at the family home. This resulted in him going voluntarily to the police the next day, but, according to A, not before their mother had threatened a suicide pact with their father in an apparent attempt to deter them from pursuing the issue. In the event A, with the support of her husband, followed through her decision to cooperate with a prosecution against her father. X ultimately declined to give evidence, apparently not wishing to upset her mother by depriving her of her husband's support, especially as she had recently been diagnosed with cancer. According to E, these differing decisions in relation to pursuing a prosecution led to friction between the sisters. E told the inquiry he asked the police

officer in charge of the prosecution against him if he could still be charged with offences against X, as he thought this might help her healing. He was told this was not possible. E was subsequently prosecuted and pleaded guilty at Maidstone Crown Court on 7 December 2001 to six counts of indecent assault on his daughter A. He was jailed for 30 months. He was released in March 2003. Reporting restrictions to protect the identity of A remain in place during her lifetime because of the nature of the offences.

- 7.11 From the time she left school in 1995 to 2001 X had a number of jobs including working in Medway for a recruitment agency and employment in London with a bank. In 2001, she started work for the Metropolitan Police in the control room. Her brother-in-law said she performed this role well and was “*a natural*” at it. She had some relationships while she was there, one with a married officer. This followed a now-familiar pattern, with her becoming over-involved and dependent, which in turn caused the man to withdraw from the relationship. Subsequently, she pursued the officer at home in a threatening manner, which ultimately led to her suspension from her job and then to her appealing against her suspension.

X’s admissions to the Bethlem Royal Hospital

- 7.12 After the incident with the married officer in 2002, X developed a relationship with another man with whom she lived in the Croydon area. This relationship became untenable after about five months, as X was, according to her mother “*smothering him with love*”. When he ended the relationship X reacted badly and took an overdose. This led to her being admitted to the Bethlem Royal Hospital on section 2 of the MHA on 18 October 2002. She was diagnosed by the consultant psychiatrist in charge of her treatment, Cons 4, as having a borderline personality disorder. On 29 October 2002, she was discharged from her section, but remained in hospital until 13 November 2002, when she was discharged with a letter to take to the Homeless Person’s Unit and a follow-up appointment with a community psychiatric nurse (CPN).

- 7.13 On 7 December 2002, she was again admitted under section 2 to Bethlem Royal Hospital, after further overdoses and a consequent short stay at Mayday Hospital. Shortly before this, a friend she had met during her previous hospital admission had committed suicide by jumping off a multi-storey car park. This had affected X greatly, as apparently she had made a pact with this patient to kill herself too, but had lost her nerve. X later admitted that she admired the resolve of her friend and felt guilty that she had not carried through her side of the pact.
- 7.14 On 23 December 2002, she was given leave to return to her mother's house for Christmas, but did not return as planned on 31 December 2002 and was discharged in her absence. In the event, she spent a few days at her sister's in Nottingham and then, with the hope of a fresh start, went to Newcastle although she did not stay. A explained that this was a familiar response to difficult situations, when X would imagine that a change of location would make things better.
- 7.15 It is not known where X was living after she left Newcastle. She did however have contact with the GPs with whom she had been registered in Purley. She contacted the psychiatric liaison team at Mayday Hospital in Croydon before attending the Accident and Emergency Department at Medway Maritime Hospital on 15 January 2003.

The admission of X to Shelley Ward

- 7.16 On 15 January 2003 X went to the Accident and Emergency Department at Medway Maritime Hospital. She was seeking admission to a psychiatric ward because she felt depressed and unable to cope. She was admitted informally to Shelley Ward, the acute psychiatric ward for patients from the Gillingham/Rainham area.
- 7.17 X was treated with medication and was re-referred to GT 1, whom she had seen previously. She was also referred to the local CMHT, with a view to planning for her future. Her need for accommodation was a particular issue.

During her stay on Shelley Ward, X was assessed as presenting a risk of harming herself. This risk was re-assessed at intervals. She once more took an overdose during her time on Shelley Ward. She was allowed leave from the ward, usually accompanied either by staff or relatives. On one occasion she absconded from the ward when she was feeling particularly anxious, but returned several hours later, having taken a train back to Croydon.

- 7.18 X met another patient, Y, while she was an inpatient. He discharged himself soon after. It transpired that they had made an arrangement for her to pay him to buy heroin and inject her, as she wanted to die. X had spoken to staff after this plan was made. On the afternoon of 4 April 2003, X returned from an outing with her mother at about 4pm and left the ward shortly afterwards, saying she was going to the League of Friends shop. The next afternoon a passer-by found her body on nearby waste ground known as the Great Lines. She was pronounced dead, having apparently received a fatal overdose of heroin.

The victim impact statement made by E (mother of X) in February 2004

- 7.19 E said in her statement how shocked and devastated she felt when told of the death of her daughter. She had initially assumed it was suicide, as her daughter had tried to commit suicide a number of times before, but she described these efforts as cries for help or attention. She always made sure that she would be found and that the harm she had done herself was not life-threatening. When she learned that X had been murdered, she described herself as feeling *“so much worse. I was so angry at the man for his callousness at injecting heroin into X”*. As a fellow patient:

“He must have known that she could not make such a decision to end her life. He was preying on her vulnerability for profit.”

- 7.20 She had been unaware that her daughter had been feeling suicidal on that day, but stressed:

“If she had confided in me about the plan I would have been able to talk some sense into her and she would still be alive.”

- 7.21 As a result of her daughter’s murder, E described herself as losing the will to live, losing so much weight that she was unable to walk and she drank to excess, leading to liver damage. She was prescribed antidepressants and was signed off work from her job as a secretary to a firm of accountants, where she had been for 13 years and consequently was claiming incapacity benefit. She valued the support of her husband, but said:

“The rest of the family seem to blame E for the situation and I am caught in the middle.”

The victim impact statement made by A (sister of X) in February 2004

- 7.22 A described the relationship with her sister as “very close”. She told of past overdoses, or X cutting herself, as being cries for help and not life-threatening. She always made sure others were aware of what she was doing. A described an acute sense of loss and felt that her sister had been looking forward to future events, such as a holiday with a friend and a visit from herself that weekend.
- 7.23 A valued the great support provided by her husband, which enabled her to progress in her career against the odds. Her relationship with her parents had suffered, leading to her seldom speaking to her mother and not at all to her father, whom she held responsible for her sister’s troubles. Her contact with her brother had also been troubled. Before the court case she agonised over unanswered questions and dreaded the actual event, which she knew would stir up distressing memories.

The views of A and her husband C

7.24 Linda Bolter and Dr Tim Amor met A and C in February 2007. As indicated above, they provided much useful material which informed the contents of this chapter.

7.25 A and C strongly believe that X's mental health problems were directly related to the abuse she suffered as a child, and may have been compounded by the fact that initially *"nobody believed her when she came forward and told it the first time round"*. In relation to her suicide attempts, which they considered to be cries for help, they were frustrated that nobody was able to do anything to change the way X felt. A described conversations with staff at Medway Maritime Hospital, when her sister had thrown herself in front of a lorry, and her frustration that they would not admit her, the implication being that her actions were not sufficient to warrant admission. With reference to her admission to the Bethlem Royal Hospital, A indicated that X resented the fact that she was told she could leave, when she did not feel any different from how she had been when she was admitted. During her admission to Shelley Ward A described her sister feeling that nothing had changed and that she was being *"kicked out"*. She felt she needed:

"a relationship with someone who she could ring all the time, whenever she felt she was going to do something, rather than having to do it and then go to hospital".

7.26 In relation to her admission to Shelley Ward in January 2003, both A and C independently drew attention to the inappropriate mix of patients on the ward. A said:

"She was clearly vulnerable ... I can't believe they put her in a ward with people who would take advantage ... it's quite obvious to anybody that you just wouldn't mix people like that together."

Comment

The views of A and C helped the inquiry greatly. We share their concerns about the risk to vulnerable patients inherent in admitting somebody with Y's background to an acute inpatient psychiatric ward. Chapter 5 of this report discusses the admission of Y. Specifically to seek reassurance about this issue we have asked the trust if a patient with X's characteristics could now be cared for and treated in a protected single sex inpatient environment.

7.27 We met E on 9 March 2007. He also provided background information on X and his perceptions of her as a child and young adult. He acknowledged:

"I know that the abuse that she suffered by me was central to her psychiatric illness. I feel as much to blame for her death as Y and I live with that guilt daily. X is always in my thoughts. Not only did I destroy her and A's childhood, but I also decimated the whole family unit both close and extended."

Comment

We met E primarily to seek his views on details about his responsibility for the assaults on X being contained in a report that could become public. He appeared open with us and provided helpful information. He wrote a letter dated 11 March 2007 amplifying and clarifying some of the areas he had discussed. He then wrote another letter dated 22 March 2007 saying he did not agree to allow "details of the abuse to be published in the final report for public viewing".

Our view is that X's death cannot be understood unless both the abuse she suffered as a child and the identity of the abuser are known. In other words, the public interest in X's "story" being told outweighs the rights of her father to privacy.

8. The healthcare provided to X between February 1995 and January 2003 (excluding psychiatric admissions)

Introduction

8.1 X's contact with psychological services based at Medway Maritime Hospital is described in chapter 9 and her admissions to the Bethlem Royal Hospital in 2002 are described in chapter 10. This chapter focuses on the primary healthcare she received from 1995 until her admission to Shelley Ward in January 2003, her assessments at Medway Maritime Hospital Accident and Emergency Department, her psychiatric outpatient care and the communication between the services involved.

Primary health care

8.2 X was appropriately referred to mental health services by GPs in 1996 and in 2002, but otherwise presented via the Accident and Emergency Department at Medway Maritime Hospital and was cross-referred. All GPs involved appear to have responded appropriately to outpatient letters from psychiatrists regarding her antidepressant medication.

8.3 The Hurley Clinic GPs (Kennington Lane, London SE11) with whom she was registered between June 2001 and July 2002 were told by X that she was seeing GT 1 and psychiatrists at Medway Maritime Hospital. We do not know why her GPs did not contact Medway Maritime Hospital. It may be that X asked them not to do so. The psychiatrists continued to believe she was registered with GP2 in Rainham and therefore sent letters to his surgery. GP2 did not write to correct this error. If there had been contact with psychiatric services based at Medway Maritime Hospital the GPs would have been aware that X was missing appointments and was also facing disciplinary action at work. Given this information, they could have chosen to refer her to a local service. We suspect, however, that X would have resisted this at the time and are therefore not convinced it would have made any difference to the care she received.

- 8.4 The GPs from the Keston House Surgery in Purley acted diligently in referring X to the local CMHT in September 2002, to the psychology department in November 2002 and to the local CMHT again in January 2003. When X presented to them on 14 January 2003, they appropriately responded to her request for urgent help while she was waiting to be given an outpatient appointment, by giving her the telephone number for the local “*crisis line*”. X called this service the next day and the psychiatric liaison service at Mayday Hospital then contacted her previous CPN, CPN 1, who made an appointment to see X on 17 January 2003. However, X went to the Accident and Emergency Department at Medway Maritime Hospital later that day and was admitted.
- 8.5 The GP surgery in Purley held X’s primary care notes from the date of her registration with them in July 2002 until August 2003 when the notes were requested by the primary care trust (PCT). The surgery received no request for information on X from the staff on Shelley Ward during this time and was not informed of her death.

Comment

It is doubtful if any of the GPs could have picked up potential warning signs of child sexual abuse earlier than 1999 (when X first revealed this to SHO 2 to Cons 3). X had presented between the ages of 14 to 16 with what may have been, in retrospect, attempts to alert them of her psychological distress. In 1995 she complained about her weight, eventually seeking slimming tablets (which were not prescribed) in 1997. She also sought advice about HIV and AIDS in 1996. All these could have been linked to her history of sexual abuse, leading her to develop problems related to her sexual identity and causing her confusion or anxiety about sexual relationships. However, it is also possible that these consultations were unrelated to her abuse and were simply common teenage anxieties. It is perhaps not surprising therefore that the GPs dealt with them at face value and did not try to explore them in depth. In brief, there is little

evidence of anything but reasonable or good care provided by the GPs involved with X over the years.

Secondary Health Care

8.6 X was able to obtain psychological treatment speedily from Psychologist 1 and then GT 1, and there was reasonable co-ordination between the professionals involved during the period 1999-2002. The psychiatrists who saw X in outpatients were less aware of what GT 1 was doing than they were when Psychologist 1 was involved. However, none of the doctors requested information from GT 1 and we have no doubt he would have responded if such a request had been made, as he did to the Purley GPs in 2002.

8.7 The various changes in antidepressants were appropriate and well communicated to the GPs. When X failed to attend appointments, reasonable efforts were made to contact her or to give further appointments before she was discharged from either outpatient or day hospital services and she was never refused re-assessment if she re-presented.

Comment

As with the GPs involvement with X, there is little evidence of anything but reasonable or good care provided by the hospital-based services.

9. Psychological services input in the care of X

Introduction

9.1 X had contact with psychological services from 1999 onwards. This chapter details her contact with these services. During this period she was treated by two therapists, Psychologist 1, a consultant clinical psychologist, and GT 1, a gestalt therapist. Gestalt therapy is a therapeutic technique, used on a one-to-one or group basis, which focuses on gaining an awareness of emotions and behaviours in the present rather than in the past.

Involvement of Psychologist 1

9.2 X was initially referred to Psychologist 1 by SHO 2, SHO to Cons 1 at Medway Maritime Hospital, on 8 April 1999, after revealing her history of sexual abuse. That referral was made on the assumption that X would be a suitable candidate for a “*childhood sexual abuse group*”, but this group was not operating at the time. Psychologist 1’s main role was working with psychotic patients within the Community Care Psychology Service, based at Medway Maritime Hospital. She recorded that she had made ‘an exception’ to see X at the insistence of the psychiatric team because of her previous experience of childhood sexual abuse work.

9.3 Psychologist 1 first saw X on 4 June 1999 (X had not attended an earlier appointment) and began an agreed course of 20 one-hour, weekly sessions on 8 July 1999. The purpose of these sessions was said to be ‘disclosure work’. Psychologist 1’s aim was to support X and therefore the psychiatric team during her period of crisis, which involved attempts at self harm, while keeping the intervention relatively short in order to maintain X’s independence and prevent her developing “*a patient role*”. Psychologist 1 also recommended to X that she should contact two voluntary agencies, the “*Sanctuary*” and “*Fairbridge*” for support outside the hospital system, but it appears X never did so. She was living at home with her parents at this time and working for a recruitment agency.

- 9.4 The sessions with Psychologist 1 were generally well-used by X. She failed to attend only two of them. As time progressed, she became concerned about the sessions coming to an end, but was able to discuss with Psychologist 1 the possible use of the Day Hospital from November 1999, with a view to recommencing weekly psychotherapy in January 2000 if she attended the day hospital regularly and did not harm herself or others during this time. Psychologist 1 also discussed the need for X to consider moving away from her parents' home before further psychological work was planned. The work with Psychologist 1 in fact ended after 19 sessions, not 20, on 18 November 1999, as both Psychologist 1 and X had miscalculated.
- 9.5 X was initially assessed at the Day Hospital on 27 October 1999 and offered weekly attendance at "*diversional groups and relaxation*" in order to "*provide support and prevent deterioration*" plus "*mental state monitoring*". It was planned to establish her attendance at the Day Hospital before the sessions with Psychologist 1 ended.
- 9.6 X then failed to attend the Day Hospital after 1 December 1999. She presented to the Medway Maritime Hospital Accident and Emergency Department twice in January 2000. On 13 January 2000 she was meant to have attended an appointment with Psychologist 1, but went instead to the Accident and Emergency Department, where she was described as distressed. X sought admission on this date, but was instead given an outpatient appointment. On 21 January 2000 she took an overdose of paroxetine (an antidepressant), was assessed at the Medway Maritime Hospital Accident and Emergency Department and was again given an outpatient appointment for 23 February 2000 to see Cons 1, consultant psychiatrist.
- 9.7 X saw Psychologist 1 on 3 February 2000 and was told their sessions would not continue. Psychologist 1 put it to X that her inability to attend the Day Hospital and her overdose were not 'failures', but perhaps an indication that X was protecting herself from undertaking psychological work for which she was not yet ready. Psychologist 1 then re-referred X to the Day Hospital and

closed her case. She sent a detailed letter to consultant psychiatrist Cons 3 explaining her case closure decision.

- 9.8 X took an overdose and was treated in the Medway Maritime Hospital Accident and Emergency Department on 21 February 2000. She failed to attend her appointment with Cons 1 on 23 February 2000 which had been made on 21 January 2000. Cons 1 then reviewed her notes and referred her back to Psychologist 1, discharging her at the same time from his outpatient clinic. Psychologist 1 subsequently wrote to X and Cons 1 on 7 March 2000 to reaffirm her decision to close the case and confirmed that X had been referred to the Day Hospital.
- 9.9 From 27 March 2000 to 18 May 2000 X attended the Day Hospital for one-to-one supportive psychotherapy sessions with her keyworker DH1 who at the time was an acting charge nurse.
- 9.10 X took an overdose of paracetamol and diclofenac (an anti-inflammatory) on 30 May 2000 and was admitted to a medical ward at Medway Maritime Hospital for three days. She then attended the hospital as an emergency on 10 June 2000 “*demanding admission*”. She was instead seen by the duty SHO and made an appointment to see Cons 1 on 26 June 2000. She also attended the Accident and Emergency Department on 13 June 2000 with “*suicidal intent*”. She did not attend the appointment with Cons 1 on 26 June 2000, but did attend a subsequent appointment four days later.
- 9.11 X was discharged from the Day Hospital for non-attendance on 13 July 2000.
- 9.12 On 25 September 2000 Cons 1 referred X to Psychologist 2, clinical psychologist and head of the psychotherapy service at the psychology department, St Bart’s Hospital in Rochester. On 23 October 2000, Psychologist 2 suggested that it might be better for Cons 1 to approach Psychologist 1 again as she had previously established a therapeutic relationship with X, but Psychologist 1 then wrote to both Psychologist 2 and Cons 1 on 8 November 2000 declining the referral. This decision was based on

the fact that Psychologist 1 felt that X required a “long-lasting, containing, continuing therapy, not a series of crisis contacts” and that Psychologist 1 was no longer in a position to offer this service. We assume it was as a result of this letter that Psychologist 2 then asked GT 1 to take the referral instead.

Comment

Psychologist 1 acted effectively throughout her contact with X. She offered time limited psychotherapy, focused on X’s history of sexual abuse and its impact on her self-image, her relationships with men and her propensity to self-harm when she felt abandoned. She recognised at the outset that she would not be in a position to continue an open-ended therapeutic relationship with X because her main professional role was within the “psychosis service”, but responded to pressure from the psychiatric team to help them support X, who was in crisis after revealing her sexual abuse for the first time. Psychologist 1 used the allotted sessions with X well and prepared her for the ending of those sessions. She then supported Day Hospital staff when they tried to engage with X.

Psychologist 1 also communicated well with X’s GP, Day Hospital staff and the consultant psychiatrists involved in X’s care. When the issue of childhood sexual abuse was discussed and Psychologist 1 appreciated that X’s younger brother was still living at home, she appropriately sought advice anonymously from social services.

Psychologist 1’s decision not to accept a re-referral of X was appropriate as she worked in the “psychosis service” and could not offer the long-lasting, continuing therapy that both she and Cons 1 felt X required.

Involvement of GT 1

9.13 X was first seen by GT 1 on 21 December 2000. GT 1 first trained and worked as a registered mental nurse (RMN) and then as a charge nurse at Medway Hospital. He later trained in gestalt psychotherapy and was appointed as a nurse therapist in the psychology department. The psychotherapy team was

based in St Bart's Hospital in Rochester, but GT 1 worked in the psychiatric department on the site of the Medway Maritime Hospital. He had worked on the site in his different capacities since 1991.

9.14 According to his notes he saw her on the following occasions:

21/12/00 Initial session, after which he planned to meet X weekly. The expectations and desired outcome of therapy were recorded as:

- a. *“Wants more control over her mood states.*
- b. *Wants to experience herself as autonomous and self regulating.*
- c. *Wants to be able to support mobilization [it is assumed this meant leaving her parents' home] and attain goals.”*

9.15 GT 1 felt X probably had a diagnosis of borderline personality disorder:

“There appears an apparent competence in most areas of living until a man becomes involved (who somehow probably resembles relationship with stepfather).”

9.16 He recognised that before exploring her history in detail X would need to learn to recognise times of increased risk to herself and be able to work out ways of protecting herself e.g. by seeking the support of her sister.

29/1/01, 5/2/01

26/2/01, 5/3/01

During these sessions he began to explore aspects of X's personality, how she viewed herself and how she related to others (including him). This included a focus on the split between her *“capable, resourceful, competent self”* and the *“incompetent, depressed, helpless”* self *“which*

stays at home”, in addition to the recurrent theme of repeated attachment/separation in her life. He was setting her homework tasks as a means of encouraging X to continue the psychotherapeutic work between sessions.

9.17 Then there is a gap until:

15/8/01 GT 1 made telephone contact with X. He recorded that they had not met since May, but there is no record of meetings after March. X had started work with the police and promised to send him her shift pattern so he could work out an appointment time.

11/9/01 He wrote to X as he still had not heard from her, suggesting that he would have to discharge her if she made no contact in the next week.

12/9/01 He received a letter from X dated 30 August 2001 detailing her shift pattern.

1/10/01 X discussed the fact that her sister had decided to press charges against their stepfather, but X had refused to make a statement. GT 1 explored an *“attachment to an unavailable man”* (a colleague at work) and ways of trying to get X to *“slow down her responses”* to situations. He encouraged her to keep a journal with this in mind. He also planned to explore her beliefs about being wanted and liked and her feared consequences of that.

8/10/01 This appointment focused on countering her impulsiveness, especially with regard to her self-harming and her attachments to unavailable others who then

abandon her. GT 1 linked this behaviour to her past history of abuse and her relationship with her stepfather. He planned to see her again in four weeks.

3/1/02 This appointment focused entirely on the relationship X had developed with a colleague. They explored likely practical and emotional outcomes, with an emphasis on the risks to X. GT 1 recorded that she was “*blinking out anything but the intense feeling of being ‘loved’ - it’s like nothing else matters*”.

7/2/02 The session was dominated by X recounting the story of how she had got drunk and then created a disturbance at the home of the colleague she was having a relationship with, in front of his wife, who until then did not know of their affair. X was afraid she would lose her job. GT 1 explored her belief that ‘men are not responsible for something she has done to them’. They planned for her to telephone on 7 February 2002 with a view to meeting again on 11 February 2002.

9.18 There are no more records from GT 1 after this, other than correspondence to the police in their capacity as X’s employer or to the GP in Purley. However, according to the information Psychologist 1 sent to the inquiry, he is listed as having appointments with X again on the following dates:

13/5/02

20/5/02 DNA

27/5/02

5/6/02 CANH

10/6/02 CANP

13/6/02

24/6/02

1/7/02

22/7/02	CANP
31/7/02	CANP
6/8/02	DNA
19/8/02	CANP
2/9/02	DNA

9.19 We do not know if the recorded contacts up until 1 July 2002 were face-to-face or by telephone. It is therefore unclear exactly how many times GT 1 and X met in total, but there are 17 recorded contacts between 21 December 2000 and 1 July 2002.

9.20 GT 1's plan of action for X is contained in a letter sent to the Purley GPs on 13 September 2002. This plan reflects what is recorded in the individual sessions above, but also includes a newer focus: *"to look at the relationships she does not form with women, who tend to become competitors"*. GT 1 wrote to X on the same day, explaining his reasons for closing her case now she had moved out of the area and permanently registered with a new GP.

9.21 X was referred to GT 1 again on 31 January 2003 when she was admitted to Shelley Ward. GT 1 told us that it was unusual for an inpatient to be referred to him or the service in which he worked, but he agreed to see X in order to assess whether she was amenable to psychotherapy at that time.

9.22 GT 1 saw X on four occasions between 20 February 2003 and 13 March 2003, but also attended meetings and had telephone conversations with other professionals involved in her care outside of those times.

20/2/03 At the initial meeting he concluded that *"therapy not going to be able to address desired focus - other needs pressing that if met could begin to free attention to engage in therapy"*. In his opinion, those needs were *"a stable and secure home base with clarity about employment situation"*. He suggested seeing her weekly *"as preparation for engaging fully when full support in*

place". Until then he planned to remain as "*background figure*".

27/2/03 GT 1 engaged X in planning for the forthcoming CPA meeting, asking her to focus on what she felt were the important issues to address.

5/3/03 GT 1 attended a CPA meeting on Shelley Ward.

6/3/03 GT 1 saw X. She was concerned there was a plan to discharge her imminently, though she did not feel ready. She did not feel anything had changed during her 'long and unproductive stay in hospital.' GT 1 then made representations on her behalf to the ward staff, asking them to reconsider the timescale for discharging X. In his interview GT 1 said that he believed X might have benefited from a discharge plan focused on resolving her housing and employment problems, suggesting "*that could have happened over a couple of months*".

13/3/03 X described a "*row*" she had with the ward manager over her discharge date and how she had subsequently left the ward. GT 1 felt this event had "*a damaging effect on the working relationship with X that might support movement outwards*". However, after his intervention, a discharge-planning meeting scheduled for 19 March 2003 was postponed pending a decision on who X's new consultant would be (she had requested not to see Cons 6, locum consultant psychiatrist at this point). GT 1 did not see her again.

Comment

GT 1 acted professionally and competently throughout his contact with X. His assessment and treatment plan was appropriate and X seems to have valued his

involvement. Many professionals would have chosen either to discharge X or have been required to do so by practice guidance because of her periods of non-engagement. In GT 1's words:

“Sometimes I have mixed views and the field seems to have mixed views. Sometimes you can say, ‘either you stick to this pathway or I discharge you’, but that is not everybody’s view in borderline personality disorder. Sometimes there is a case for keeping an open door, the requirement for you and the service may re-emerge typically when things go wrong.”

The fact that X was held on GT 1's case-load throughout 2001 and 2002 was important in keeping her reasonably stable after she joined the police service and moved away from the Medway area.

GT 1 did not communicate regularly with X's GP or consultant psychiatrist by letter in the way that Psychologist 1 had done. When X's new GP in Purley asked him to summarise his involvement he responded promptly and in a way that would have helped inform another professional considering her suitability for psychotherapy.

It was reasonable for GT 1 to discharge X from his case-load once he had written to her new GP in Purley in September 2002. He expected her to be referred to a local psychology service, which is what happened.

We consider that when X was re-referred to GT 1 after her admission to Shelley Ward in 2003, he correctly formed the view that she was not capable of engaging in a psychotherapeutic programme until her basic needs had been addressed. He appropriately fed this back to the inpatient team, arguing that discharge planning should take place over a longer period and be structured around helping her to address her accommodation and employment issues. He appropriately felt that he should remain “a background figure” until that work had been done, but was prepared to increase his involvement in the future if X became more able to engage in psychotherapeutic work.

Psychological treatment is one of the recommended therapeutic interventions for people diagnosed with personality disorder. It is not always easily available on the NHS. We are critical of some aspects of the treatment and care that X received but believe that she received effective treatment from the psychological services based in Kent. X valued the treatment and the psychology department were flexible about keeping contact with her and they stepped in when she came back to Kent in January 2003.

10. X's care and treatment between October and December 2002 under the care of the South London and NHS Trust

10.1 X was admitted to Gresham 2 at the Bethlem Royal Hospital on 19 October 2002. She was discharged on 13 November 2002. She was then re-admitted to Gresham 1 on 7 December 2002 and discharged on 31 December 2002.

Introduction

10.2 This chapter reviews the care and treatment provided to X between October and December 2002 and in particular comments on the care and treatment she received as an inpatient at the Bethlem Royal Hospital.

First admission 17 October 2002 to 13 November 2002

17/10/02 (Thurs) X went to Mayday Hospital Accident and Emergency Department after claiming to have taken an overdose of 100 x Sertraline 100mg tabs, 60 x paracetamol 500mg tabs, 28 x zopiclone 7.5mg tabs and perhaps other unknown medications late the previous evening. When she said she was known to psychiatric services in the Medway area a summary of her history was requested from them. It was faxed to Mayday Hospital Accident and Emergency Department that day. According to that summary, she had taken several previous overdoses and her diagnosis was "*a depressive episode in the background of Post Traumatic Stress Disorder*", with the PTSD being related to childhood sexual abuse by her stepfather. Suicide notes to friends and family dated 16 October 2002 are filed, but it is uncertain at what stage during her admission these were made available to clinical staff.

She had recently broken up with her boyfriend, R, effectively making her homeless and this was thought to be the main cause of her self-harming. However, other past and current problems including childhood sexual abuse, her mother's cancer, her stepfather being in prison, her previous substance misuse and her concerns about her employment with the police were also recorded in the notes. X's address at this time was in Wallington where she was sharing a flat with a friend, who made it clear she could not return there.

She was initially admitted to a medical ward and treated with Parvolex. This was to protect her from liver damage after a paracetamol overdose. She was also observed to experience cardiac arrhythmia (a supra-ventricular tachycardia causing a fast pulse rate of 130) but this spontaneously resolved. She was assessed by the psychiatric liaison service and a first medical recommendation for her detention under section 2 of the MHA was completed.

18/10/02

The second medical recommendation was obtained and she was formally detained that day. SW 3 was the ASW. The purpose of her detention under the MHA was described by Sp/R 1, SpR in psychiatry at Mayday Hospital, to be:

“respite, containment and to link (her) into (a) formal psychiatric service”.

19/10/02

X was transferred to Gresham 2 Ward at the Bethlem Royal Hospital under the care of Cons 4. Cons 4 accepted responsibility for X's care because she was of no fixed address and because Cons 4 was the on-call consultant for

the day of X's admission. It is not known whether staff at Bethlem Royal Hospital searched the hospital database and discovered that her GP had referred X to the Purley Resource Centre on 11 September 2002, which would have meant that X should have been admitted under a different consultant.

The admitting doctor recommended:

“risk assessment, close obs (nursing observations), drug chart (i.e. that he should complete a prescription chart for ward use) and r/v (review) by team after w/e”.

He completed a brief risk screen. X was then assessed by a nurse (Nurse 6) who explained to her the meaning of section 2 and began *“maximum close observations”* (which we believe means one to one, within arm's reach). X was prescribed Promethazine 10-20mg at night on a PRN basis. Promethazine is a sedative antihistamine, often used to avoid prescribing benzodiazepines to patients at risk of physical or psychological dependency on them. It was used 12 times in total throughout her stay on the ward.

21/10/02 At a ward round with Cons 4 her observation levels were reduced to 15-minute checks.

23/10/02 X was observed to be calling and texting R many times. She became 'hysterical' when her phone went missing and accused staff of taking it. Staff called R to confirm that he considered the relationship was over. He planned to visit the ward to emphasise this to X.

- 24/10/02 R visited and told X their relationship was over (although he visited more than once in the end).
- 26/10/02 X was noticed displaying obsessional/compulsive behaviour, moving the door knob to her room to a specific angle before feeling able to enter her room.
- 28/10/02 X attended “*relaxacise*” with the occupational therapist and expressed interest in attending the gym and Aikido in future.
- 29/10/02 X attended “*breakfast club*”, *i.e.* cooked herself breakfast. She later attended the ward round with Cons 4 and agreed to remain on the ward informally. She was then discharged from section 2 and started on venlafaxine (Efexor) XL 75mg every morning (a sustained release antidepressant formulation, allowing a once per day dosage). She was later reported not to be happy with the ward round as she “*didn’t feel safe on her own*”.
- 30/10/02 Entries in the notes suggest that as soon as X was an informal patient, she began to spend long periods off the ward and the primary nurse had difficulty arranging to see her.
- 01/11/02 X was said to be planning to “*organise her furniture and begin looking for accommodation*”.
- 05/11/02 At the ward round with Drs SG 1 (staff grade) and SHO 3. X was angry about plans for discharge as she still did not feel ready and was effectively homeless, having previously lived with her boyfriend. Staff were planning for discharge “*next Tuesday*” (12 November 2002). They were also planning to arrange counselling, but it is not

known who was to take responsibility for this (Cons 4 was not able to clarify this in her interview). In the notes there is simply a list of possible agencies that might provide counselling (police, MIND and private) with question marks alongside them. Accommodation arrangements are also unclear but it is recorded that bed and breakfast hotel (B&B) accommodation “*may be needed*” if nothing else organised.

- 06/11/02 X spoke with the ward manager and asked for clarification of her “*aftercare planning*”. She reported other patients were arranging drug deals on the ward. The manager promised to speak with the primary nurse about the discharge plans. The primary nurse promised to speak with her about this on 8 November 2002. Sue White (ASW) from Westways Resource Centre telephoned the ward to report a complaint by X’s ex-landlady (and, we believe, friend), that X had been sending threatening texts warning her to stay away from R. This friend had reported the texts to the police.
- 08/11/02 X apparently told her mother that she was thinking about taking a further overdose. She told nursing staff that she felt hopeless and negative about ever feeling better.
- 11/11/02 She became disturbed during the night and the on-call doctor suggested she be detained under the MHA if she tried to leave the ward. X said she did not feel ready to be discharged.
- 12/11/02 A ward round with Drs SG 1 and SHO 3 was held and X and her mother attended. X asked to stay until accommodation was sorted on 29 November 2002, but was told she would be discharged on 13 November 2002

or could leave earlier if she wished. A plan was made for B&B accommodation to be arranged if necessary and “early CPN involvement” in addition to an outpatient appointment with a psychiatrist.

13/11/02

X was discharged. She was given a letter to take to the Homeless Persons’ Unit (HPU), arrangements were made for her to see a CPN (CPN 1) from the Tamworth Road Resource Centre the next day and an outpatient appointment was planned with SHO 3, Cons 4’s SHO. SHO 3 also planned to refer X to the local psychology service. X stated that she had plans to move to a privately rented flat from 29 November 2002. She was given the telephone number for the local MIND counselling service, a sick(ness) certificate and information on the Active Lifestyles Programme which is a community health initiative facilitated by Croydon Council. The discharge plan was sent to her GP.

Comment

There was a good initial assessment and plan, which included requesting and receiving information from locum consultant psychiatrist Cons 5 based at the psychiatric department in Medway Maritime Hospital. Following admission however the following problems/omissions occurred:

- a. A full risk assessment was never completed (see chapter 15 for further comment).*
- b. X was never assessed for enhanced CPA (see chapter 15 for further comment).*
- c. CPN 1 did not meet with X prior to discharge. Cons 4 said that CPN 1’s involvement was solely to comply with the trust policy on providing a ‘seven day follow-up on discharge’ and had no link to X’s CPA status.*

- d. *It is unclear how and when a referral was to be made to the psychology department. It is surprising that no such referral was made during X's inpatient stay and explicitly mentioned only in the letter from SHO 3 to X, written on 4 December 2002 and typed on 13 December 2002. As X had by then been re-admitted and no inpatient files are available, we do not know whether X was referred to psychology during her second admission. We suspect that the only referral received by psychology was from the GP on 21 November 2002. We consider such a referral should have been made by the inpatient team soon after her admission or at least on the point of discharge. The team at Bethlem Royal Hospital knew that she had been seeing GT 1 and that this had been considered an important part of her treatment to date. It should have been assumed that it would be equally important in the future and it would have been reassuring to X to know that she had been referred even if there was a long waiting list, especially in view of her anxiety about being discharged from the ward.*
- e. *A discharge plan was sent to the GP, but there is no record of a complete discharge summary being sent. This is perhaps not relevant in this case, as it would probably have taken several weeks for the SHO to produce this and by then X had already been re-admitted to Bethlem Royal Hospital.*
- f. *Cons 4 was not present at the last two ward rounds on 5 and 12 November 2002 as she was on leave. We do not know what influence, if any, she exerted over the discharge planning or whether SG 1 was making independent decisions without consultant supervision. This is not an uncommon situation, but is less than desirable. As Cons 4 was on leave at this time, there would have been a covering consultant with whom SG 1 could have discussed patients. However, in general, we feel that Cons 4's approach to this admission was sensible, consistent and well communicated to the other professionals involved. In her own words:*

“... with emotionally unstable personality disorders - and they will be at long-term risk of harming themselves, and they frequently do that when they are in any crisis. Sometimes inpatient admissions may be useful when there is a crisis just to give them time to settle down and plans can be made to discharge them...”

Inpatient admissions (for somebody like X) are from my point of view limited (in value).”

Period between admissions:

14/11/02	X was seen by CPN 1.
18/11/02	X missed an appointment with CPN 1.
19/11/02	CPN 1 phoned to discover the reason for her having missed the appointment. X said she had forgotten. CPN 1 informed her of an outpatient appointment with SHO 3 on 4 December 2002 at the Tamworth Road Resource Centre.
21/11/02	GP records show that she was seen and given 28 x venlafaxine 75mg tablets. The GP also referred her to the psychology services at Lennard Lodge on the same day.
01/12/02	X went to Worthing Hospital Accident and Emergency Department on the night of the 1 and 2 December 2002, having taken an overdose of 28 x zopiclone 7.5mg tablets (this is described in more detail in paragraph 10.5 below).

It is possible that she took other medication at the same time, e.g. paracetamol, but it is not known if she was tested for this possibility in the Accident and Emergency department. She left the department, but it is not known if she did this against medical advice or not.

- 02/12/02 X was further discussed in a multi-disciplinary team meeting and SHO 3 then planned to phone her.
- 03/12/02 The GP referral to the psychology services was passed on to the psychotherapy service by the head of psychology.
- 04/12/02 SHO 3 wrote to X at an address in Croydon (it is not known whether this was a friend's home or a privately rented flat) stating he was aware that she would not attend on 4 December 2002 and asking her to contact the Tamworth Rd Resource Centre to arrange another appointment. He also mentioned that they would then be able to discuss referral for psychotherapy. This letter was typed on 13 December 2002, by which time X had been re-admitted.

There was also telephone contact between SG 2, a staff grade psychiatrist in Worthing Hospital and SHO 3 on this date regarding X's treatment on 1 and 2 December 2002. However, written information regarding this assessment was only faxed to SHO 3 from SG 2 on 10 December 2002 i.e. after she had been re-admitted. X mentioned to SG 2 that a fellow patient on Gresham 2 during her first admission, had committed suicide on the day after X was discharged, *i.e.* 14 November 2002.

X possibly took a further overdose of paracetamol and zopiclone, before presenting to the Accident and Emergency Department at Mayday Hospital on 4 December 2002. However, this entry is more likely to suggest that X only took one overdose, on 1 December 2002 (Worthing) and then re-presented to Mayday Hospital on 4 December 2002.

Comment

Despite the lack of clarity over X's CPA status, after her discharge both SHO 3 and CPN 1 performed their roles effectively, pursuing non-attendances by contacting X on her mobile telephone and liaising well with the CMHT about future plans. SHO 3 appeared to do everything he could to act on the information he received from Worthing and once he and CPN 1 realised that X had been re-admitted, he liaised well with Gresham 1 nursing staff.

Her assessment and care in the Worthing Hospital Accident and Emergency department.

10.3 X went to Worthing Hospital Accident and Emergency Department on the night of the 1 December 2002, having taken an overdose of 28 x zopiclone 7.5mg tablets. Police took her to the Accident and Emergency Department where she was then seen by both an Accident and Emergency Department doctor and a psychiatrist. Both doctors took histories. She then left the department, but it is not known if she did this against medical advice.

Comment

Treatment for an overdose of zopiclone is mainly "conservative", i.e. observations for at least four hours after ingestion because of the likely sedation plus monitoring of heart rhythm in patients showing central nervous system features e.g. ataxia, irritability, confusion. On the basis of the clinical description of X, the treatment she received at Worthing Hospital for this overdose was appropriate; she was not over-sedated, had none of the more worrying central nervous system features and she had taken the tablets four hours earlier.

On the assumption that we received all records relating to this episode of treatment, it notes that they do not refer to any physical examination. Records of X's temperature, pulse, blood pressure and respiratory rate do not appear on

the assessment sheets. The records include no evidence that her blood was screened for paracetamol, a standard test to be undertaken in an Accident and Emergency Department for a patient with her history.

SG 2 (staff grade psychiatrist on call) recorded plan was to “contact CMHT Croydon to organise urgent local reassessment”. He telephoned SHO 3 two days later. In the event, by the time SG 2 had contacted SHO 3, X had again been to the Mayday Hospital Accident and Emergency Department.

SG 2’s outline of his assessment in the records did not include a formal risk assessment. He recorded that she: “denies active suicidality but obviously at risk of further self harm”, but did not state how that risk should be managed in the time before the Croydon CMHT could reassess her. It is not apparent why SG 2 judged that the risks X posed to her own health and safety did not merit consideration of the use of the MHA.

Second admission 4 December 2002 to 31 December 2002

4/12/02 X presented to the Mayday Hospital Accident and Emergency Department. It would appear that she initially registered under her ex-boyfriend’s details and was therefore not traced on the hospital computer system when the CMHT attempted to locate her. She was again seen by the liaison service and given Parvolex.

6/12/02 (Fri) Liaison 2 contacted CPN 1 at 4.45pm to request notes as X had been admitted. CPN 1 arranged for someone from the CMHT to contact Mayday Hospital on 9 December 2002.

X absconded. She was later located by the police and was being transported by them from a bar in Kennington to Gresham 2 at Bethlem Royal Hospital, when she tried to

escape from the van while it was moving and was taken under section 136 to the Lambeth Hospital instead.

7/12/02

She was assessed on arrival at 12.30am by the duty doctor and stayed on Leo Ward informally overnight. A full risk assessment was completed by a member of staff (it is not clear if this was a doctor or nurse, but he/she appears to have been the SHO on Leo Ward).

X was then assessed under the MHA and detained under section 2 on 7 December 2002.

X was transferred to Gresham 1 Ward later the same day. At this point it was known that S a fellow patient with whom X had formed a close relationship during her previous admission on Gresham 2, had committed suicide by jumping from a high building in Croydon. This was thought to have been a significant factor leading X to return to hospital and also a reason for not re-admitting her to the same ward at Bethlem Royal Hospital.

- 10.4 The South London and Maudsley NHS Foundation Trust were fully co-operative in making X's health records available to us but unfortunately the medical and nursing notes relating to X's second admission could not be located. The only available records from this time are a discharge summary by SHO 3 dated 20 January 2003, nursing observation records covering the period from admission to 15 December 2002 and MHA records. From these, the following information can be extracted:

7/12/02-10/12/02 X was placed on "*maximum 1:1*" nursing observations which presumably means she was to be kept within arm's reach at all times.

- 11/12/02-12/12/02 Nursing observations were reduced to “close 1:1” which presumably means she was to be kept in sight at all times.
- 13/12/02-15/12/02 Nursing observations were further reduced to every 15 minutes. The records also reveal that promethazine and lorazepam were being used occasionally on a PRN basis up to this time and that X was granted escorted “home” leave on 15 December 2002 for up to six hours.
- 17/12/02 There was a significant event when X left the ward and self-harmed. She took 80 diphenhydramine 50mg tablets and drank alcohol before going to the top floor of the multi-storey car park in Croydon, where her friend had killed herself. She was seen on CCTV and the police returned her to the ward later the same day.
- 20/12/02 X appealed against her detention under section 2 and was given a Mental Health Review Tribunal date of 30 December 2002.
- 23/12/02 Cons 4 discharged X from detention under section 2 and then allowed her leave over Christmas to stay with her mother.
- 31/12/02 X did not return as planned and was discharged in her absence after telling staff that she was staying with her sister in Nottingham. Follow-up was scheduled to take place with “her CMHT”. It is not clear if this refers to the Tamworth Road or Purley Resource Centre and it is not known what arrangements were made to facilitate this. She was also asked to continue to take venlafaxine XL 75mg per day.

Comment

It is difficult to comment on the period between 7 December 2002 and 23 December 2002 as no medical or nursing notes are available. We cannot explain why the nursing observation records and discharge summary were located and yet all other records for this admission remain missing. However, we make the following comments:

- a. X's initial assessment at Lambeth Hospital was of a good standard and led to her being appropriately detained under the MHA.*
- b. Liaison between Lambeth Hospital and the Bethlem Royal Hospital was efficient and led to the appropriate transfer of X's care to Bethlem Royal Hospital on 07 December 2002. Sensitivity was shown regarding the ward X was admitted to in view of her friend's suicide soon after X's discharge in November.*
- c. No discharge plan or discharge summary was sent to the GP for this admission.*
- d. The problem of lack of clarity regarding X's CPA status in relation to her October admission continued. Given that she was discharged from section 2 less than a month before her re-admission in December, we consider this alone should have resulted in her being placed on enhanced CPA.*
- e. It is not known whether the appointment for X to see locum consultant Cons 8 at the Purley Resource Centre on 23 January 2003 was made at the time of her discharge or whether it was made in response to GP 3's (GP) letter of 8 January 2003 requesting "a fairly urgent appointment". We suspect it was the latter, as previous appointments had been with the Tamworth Road Resource Centre. Thus, no-one from the inpatient team or CMHT appears to have tried to make contact with X to arrange follow-up in the community after her discharge.*

Period after second admission:

- 23/12/02 Psychotherapist 1, from the psychology service at Lennard Lodge wrote to the consultant at the Purley Resource Centre acknowledging receipt of the GP referral (21 November 2002) and asked if a psychology assessment was still needed if X was in contact with the CMHT.
- 6/1/03 Cons 8 wrote to Psychotherapist 1 asking for the assessment from the psychology service to go ahead.
- X also contacted her GP in Purley on this date and was given a sick certificate. She reported that she had been *“sorting out follow-up with Tamworth Road”*.
- 8/1/03 X’s GP wrote a referral to the Purley Road Resource Centre requesting a *“fairly urgent”* appointment. The psychotherapy service placed X on the waiting list the same day.
- 13/1/03 X was sent notice of an outpatient appointment with Cons 8 on 23 January 2003.
- 14/1/03 Another GP in the same practice in Purley recorded that X *“feels she needs admission”* and that she had been given the crisis line number. The GP planned to refer X to the *“Liaison Team”* at Mayday Hospital.
- 15/1/03 CPN 1 received a telephone call from a member of the Mayday Hospital liaison team at 12.30pm. X had contacted the service complaining of feeling down and depressed. An appointment with CPN 1 was arranged for 17 January 2003 and X was reminded of her appointment

with Cons 8 at Purley Resource Centre on 23 January 2003.

X later went to the Medway Maritime Hospital Accident and Emergency Department and was admitted informally. She remained there until her death.

- 17/1/03 X did not attend her appointment with CPN 1, who informed Purley Resource Centre and confirmed the appointment on 23 January 2003 with Cons 8.
- 20/1/03 SHO 3 wrote to Cons 8 before the scheduled outpatient appointment on the 23 January 2003 suggesting that he had recent contact with X, but details of this are unclear.
- 23/1/03 Cons 8 phoned X and learned that she was an inpatient at Medway Maritime Hospital.
- 21/2/03 The psychotherapy service wrote to X (the address used is not known) telling her that she had been placed on their waiting list and that she would be sent a pre-assessment questionnaire before her first assessment appointment. There is no copy of this letter in the clinical file.

Comment

CPN 1 does not seem to have been asked to make contact with X until a colleague from the Mayday Hospital liaison team contacted her on 15 January 2003. She then acted promptly by making an appointment for 17 January 2003 and reminding X of her appointment with Cons 8 on 23 January 2003 (the liaison team took responsibility for telling X, presumably by mobile telephone, as X had called them earlier in the day). CPN 1 also acted appropriately by informing the rest of the CMHT when X did not attend the appointment on 17 January 2003.

SHO 3 acted responsibly by writing an urgent letter to Cons 8 ahead of her planned appointment with X on 23 January 2003. This suggests that he was still considered the care co-ordinator until X had been accepted by the Purley Resource Centre and was trying to ensure that the transfer of her care to that team went ahead. We believe that the fact he seemed to be surprised by the appointment with Cons 8 and needed to write urgently to her adds further weight to our presumption that X's appointment had been arranged by the GP rather than the inpatient team or the Tamworth Road Resource Centre.

Cons 8 acted appropriately when X failed to attend the appointment on 23 January 2003. She telephoned X and discovered that she was an inpatient at Medway Maritime Hospital, recording this in her notes and on the electronic system used by the South London and Maudsley NHS Trust. As a result of this, she appropriately informed the GP that she was discharging X.

The psychology department seemed slow to offer X a first appointment. Despite Cons 8's confirmation that the GP's referral was still appropriate in January 2003, a letter from Psychotherapist 1 inviting X to complete a pre-assessment questionnaire was not sent to X until 1 July 2003. This was also wrongly sent to R's address, which suggests that there had either been no communication between the CMHTs (whether that be Tamworth Road Resource Centre or Purley Resource Centre) and the psychology department following X's discharge or that the database for X had not been updated to change her address or contact details. This is despite the letter from GP3, dated 8 January 2003, recording a temporary change of address and advising that the best way to communicate with X was by mobile telephone (number supplied), which Cons 8 clearly had received.

Cons 8 could, therefore, have passed the contact information to Psychotherapist 1 after she received the letter from GP3. The letter from Psychotherapist 1 dated 1 July 2003 was copied to Cons 8 and to the GP, so there was an opportunity for Psychotherapist 1 to be informed that the letter had been wrongly addressed (no one at the Bethlem Royal Hospital or the GP practice appears to have known at this stage that X was dead). Neither party did so, perhaps assuming X was still in the Medway (or other) area or had recovered and did not wish to be seen.

Psychotherapist 1 then wrote to Cons 8 and the GP on 7 August 2003 closing X's case, as she had received no response. This was appropriate as it also gave Cons 8 and the GP an opportunity to re-refer X if they thought it necessary.

We do not know what the waiting list for outpatient psychology services was like at this time, but over seven months seems an excessive delay; the GPs who gave evidence also expressed this view. Psychotherapy was important for X, as CPN 1 said;

“the only therapy she wanted was psychotherapy...her view was nothing else could help her”.

11. X's inpatient care and treatment in Shelley Ward from 15 January to 30 March 2003

Introduction

11.1 We have considered X's psychiatric care and treatment during 2003 in two parts. This chapter deals with the period from her admission until 30 March 2003. A chronology of her care and treatment during this period is contained in annex 5. On 31 March 2003 the details of the arrangement that she made with Y which led to her murder were made. Chapter 12 details the events from 31 March 2003 to her death.

The purpose and duration of her admission

11.2 We asked some of the professionals involved in the care and treatment of X why they thought she had been admitted. Nurse 7 and X's primary nurse considered it to be a:

“short-term crisis admission to gather information, refer her to the community and back to GT 1”.

11.3 Similarly, Nurse 8 considered that the purpose of the admission was *“to assess her mental state and to maintain her safety”* Nurse 4 said he thought the purpose of her admission was to facilitate her:

“re-engagement with mental health services...her admission was maybe necessitated out of the risk that she was presenting at the time, that she was possibly not containable in the community”.

11.4 The assessment of the risk that X presented to herself varied during the course of her admission. CPN 2 assessed her on 13 February 2003, four weeks after her admission, and wrote: *“I really don't think you can discharge this lady”*. When GT 1 saw her on 6 March 2003 he said:

“she was still being brought downstairs, escorted, it did not seem as though there was any quantifiable movement. She had been sectioned in the previous year, here she was some months ahead and there is a discharge date set, and I thought how will this happen that quickly, given the situational issues.”

- 11.5 Cons 6, locum consultant psychiatrist, told us that his treatment strategy would have been to make the admission short and move her on quickly. He did not believe that there was any delay in her discharge. Nurse 8 had a different view:

“I personally don’t feel that she needed to have that length of admission, and it was just an issue that the community team felt unable to fully meet her needs at the moment...I did feel that the longer she was with us the less constructive it became for her.”

- 11.6 Ward manager 1 recognised that X needed some sort of plan *“so she’ll know where she is and where she’s going”*.

Turnover of medical staff

- 11.7 X was admitted to Shelley Ward under Cons 6’s care, but he was on leave from 6 February 2003 until 10 March 2003 and did not see her again until the ward round of 12 March 2003. In his absence two other locum consultants oversaw her care (Cons 9 and Cons 10). When Cons 6 returned, X immediately objected to seeing him. Cons 6 recorded:

“X expressed her dissatisfaction about me being her consultant. She said she does not believe that I listen to her. She believes I see her as a little girl who takes overdoses. She does not feel I am giving her the best care.”

- 11.8 Cons 6 arranged for her care to be transferred to consultant psychiatrist Cons 7’s team. Cons 7 was on sick leave and her position was being covered by Cons 2, in a locum capacity.

11.9 Furthermore, SHO 5, the original SHO to Cons 6, moved to a new post at the end of January and was replaced by SHO 6. After X objected to Cons 6 on 12 March 2003, he asked a staff grade doctor, SG 4, to see her on a temporary basis. According to Cons 6, Cons 7's team was not able to assume her care until 24 March 2003 and so he described his role as being consultant "on paper" from 13 March 2003 to 23 March 2003.

"They (SG 4 and SHO 6) did not discuss her with me and I made no clinical decisions regarding her care. In keeping with X's request.

11.10 When Cons 7's team took over X's care, two other junior doctors became involved, namely S and SG 3 (staff grade). X was seen during her 12-week admission by three SHOs and two staff grade doctors, while four locum consultant psychiatrists were in charge of her care.

Comment

There appears to have been general agreement about the purpose of X's admission. There was less agreement about the duration of her admission.

At the time of her admission, nursing staff believed X would be an inpatient for a brief period. Planning "X's discharge to minimise dependence" was discussed by Cons 10, SHO 6 and Nurse 2 (acting charge nurse) on 21 February 2003. As time progressed, however, it does not seem that this plan was sustained.

By mid-March Ward manager 1 was "extremely worried at the time that we weren't going anywhere with X". He and Nurse 7 both wrote similar letters to Cons 2 on 21 March 2003 asking for:

"an urgent review of her management plan because X is clearly not complying with her treatment".

Nurse 7 did not agree with the approach that Cons 6 and Ward manager 1 had towards X's management:

“Cons 6 was very much on the lines that she was personality disorder and that she shouldn't have medication, and didn't really have an empathic approach to her because she was labelled as personality [disorder] by him. Whereas with Cons 10 it was much more on the fact that she had other issues than personality disorder: she had depression and there were obviously other underlying issues. He was much more on the fact that perhaps she should have antidepressants to help her, and also community support, where Cons 6 didn't feel that was necessarily necessary. They had two different management styles.”

Nurse 7 felt manipulated in writing her version of the 21 March 2003 letter. She told us that she wrote the letter because Ward manager 1 wanted X off the ward. She did not feel X was being helped. GT 1 was also advocating against early discharge. A divergence of opinion in relation to X's management therefore existed. We are not critical of this disagreement; in other circumstances it might have focused thinking about her case. However, in the absence of strong medical leadership, this disagreement was not to X's advantage.

We consider the approach of Cons 6 and Ward manager 1 in trying to limit the time that X spent as an inpatient was the most effective strategy. Cons 6 handed over her care on 12 March 2003 because he and X did not have a good therapeutic relationship, this led to the transfer of her care to Cons 2 in March.

Nursing staff apparently felt unable to influence X's medical management until the letters were written to Cons 2 on 21 March 2003. We heard no evidence that these letters were acted on and the letters were written by nurses with differing views about her management. Ward manager 1, should perhaps have challenged the position earlier, but he was fairly new in post and his view was that “it's the consultant who has the last say in the management of her care”.

In summary, we consider it likely that X was disadvantaged by a number of factors:

a. Those in charge of her care during this period occupied locum positions:

“The problems that when you have locums...they often won’t make a decision because they know they’re only there for two or three weeks, so they’ll delay decision-making for the next person and then the next person.”

This is not to criticise locums but to reflect the reality of employing senior medical staff in short-term positions.

b. There was rapid turnover of both senior and junior medical staff which resulted in doctors with different approaches to X’s management and treatment caring for her and prevented a consistent approach to her treatment plan. We could see no evidence of anything but a reactive and short-term approach to her care other than her referral to GT 1.

c. X’s primary nurse and the Ward Manager disagreed about the most effective strategy for her care.

We contrast the situation in 2003 with X’s two admissions to the Bethlem Royal Hospital where Cons 4 was responsible for her medical treatment and care throughout both admissions and appeared to have a clear view about the management of her condition. She regarded the purpose of the admission as to manage a crisis, and then to set boundaries so the patient did not become dependent on services. She accepted that she kept the pressure on X by setting out a clear time scale for her discharge.

Cons 6 was the only consultant in charge of X’s care at Medway Maritime Hospital from whom we were able to hear evidence. He could remember little about her. He only vaguely remembered that she did not want to see him. We offer no criticism of Cons 6 in this respect; many witnesses could not remember her.

The clinical notes record that Cons 6 saw her on 17 January 2003, 24 January 2003, 29 January 2003 and 12 March 2003. He was on leave from 6 February 2003 until 10 March 2003. He described his responsibility for X from 13 March to 23 March 2003 as being “on paper”. That was not satisfactory as he would have still been regarded by everyone else as the responsible consultant until her care was taken over by another consultant.

The lack of consistency in X’s medical care was made worse by the failure of any of the doctors responsible for her care to obtain any information from the Bethlem Royal Hospital. These notes would have told Cons 6 what medication X received i.e. venlafaxine 75mg per day, as well as the treating team’s views on her admission and what plans were made for her after discharge.

After evidence was taken from Cons 6, he was sent a copy of the discharge summary prepared by SHO 3 SHO at the Bethlem Royal Hospital. Cons 6 had been unaware of this document before giving evidence. Cons 6 subsequently wrote (2 January 2007) that he concluded that, even if SHO 3’s discharge summary had been available to him, it would not have changed his management of X.

Despite this assertion, we consider it would have been likely to focus the minds of staff on keeping her admission brief and her medication regime simple. We agree with Nurse 8 who said the information from the Bethlem Royal Hospital:

“would’ve given the whole team a much clearer picture of who X was, and the reason why she was on Shelley Ward”.

Information from X’s GP could also have helped with her medical management and treatment. She said on admission she was not registered, but she later said she was registered with GP2 in Rainham. Notes in the clinical file relating to her previous outpatient contacts with the psychiatric services in Medway also clearly showed that she had been registered with this surgery, but no attempt was made to contact GP2. If this had been done, or if the Bethlem Royal Hospital had been contacted, it is likely to have emerged that X was in fact registered with a GP surgery in Purley. Those notes would have contained information about the

antidepressants (including dosage) X had taken and the fact that she had been referred to the local psychology department, as well as the local CMHT. Even though GP2 was not contacted, a letter from SG 4 to the GP surgery in Purley, dated 18 September 2002, detailing X's care up to that date was filed in the clinical notes at Medway Maritime Hospital. This should have told medical staff that X was still likely to be registered with a GP in Purley, but Cons 6 seemed unaware of this.

We consider it was Cons 6's responsibility as doctor in charge of X's treatment to obtain, or arrange to have obtained, both her medical records from the Bethlem Royal Hospital and the notes, or a summary of those notes, from her GP.

Treatment planning

11.11 In the main, entries in X's treatment plans are to medication, "*diversional activities*", behavioural contracts and to "leave".

Accommodation

11.12 Given the stated importance of X being discharged to suitable accommodation, the paucity of references to accommodation issues in her treatment plans is surprising. These are the references:

Date	Doctor in charge of treatment	Reference to accommodation issues
24/1/03	Cons 6	Need to see accommodation officers.
5/3/03	Cons 10	Discharge CPA2/52, helpful for housing. X to liaise with Nurse 10 for support and information she might be needed re housing.
27/3/03	Cons 2	To liaise with Nurse 10 regarding accommodation.

Comment

A (X's sister) thought her need for help with accommodation was a red herring, because she felt that X would ultimately have managed to arrange something for herself. She thought that the "difficulties" may have been a ploy used by X to prolong her stay in hospital because she felt safe there. Even if this were the case, we would have expected there to have been more discussion about this issue and how staff could help X resolve any accommodation difficulties.

Medication

11.13 It is evident from the incomplete prescription charts that the plan was to establish her on an antidepressant and increase the dose depending on the clinical response and her ability to tolerate any side effects. With this in mind, she was started on citalopram, (proprietary name Cipramil), 20mg per day immediately after admission. The citalopram was stopped on 7 February 2003

and changed to venlafaxine (proprietary name Efexor) because X apparently said that it was not helping her. Venlafaxine was started at 75mg per day but increased to 150mg per day from 14 February 2003 and increased further to 225mg per day on 26 February 2003. She stopped taking it on 20 March 2003, saying that it was not helping her and the dosage was reduced to 75mg twice per day after a ward round on 24 March 2003. This dosage was continued until 31 March 2003, when it was increased again to 75mg in the morning and 150mg at night.

- 11.14 Carbamazepine was first prescribed on 12 February 2003 in a dosage of 100mg twice a day, then increased to 100mg three times a day from 28 February 2003 and to 200mg three times a day from 3 April 2003. This was being used as a mood stabiliser.
- 11.15 The use of flupentixol decanoate (proprietary name Depixol) by intramuscular injection was first suggested by SG 3 during a ward round on 24 March 2003 and a test dose of 20mg i.m. was given on 27 March 2003. This medication, in higher dosages, is an antipsychotic, but in this case it appears it was used to control X's anxiety/agitation. If X tolerated the injection, it was intended to continue this at weekly intervals beginning on 06 April 2003, but X's reluctance meant that it was not administered again. During the ward round with Cons 2 on 31 March 2003, X apparently reported she felt the injection was working.
- 11.16 X also received several medications on a PRN basis throughout her admission. These included promazine, clonazepam and lorazepam, which were used to control her anxiety/agitation during the day and zopiclone to help her sleep at night.

Comment

It is not known why citalopram was chosen over other antidepressants, but X had mentioned she had previously taken venlafaxine and may have also suggested it

was not effective or that she did not like it for some reason. X had taken citalopram before in dosages up to 60mg per day. This had been initially prescribed by Cons 1 in outpatients in August 2000 and was continued by different GPs. It had been stopped by her GP in September 2002 after X complained that it wasn't helping. Cons 6 told us he was aware of X's previous experience of citalopram because he had read the hospital notes, but he would not have been aware that it was stopped by her GP.

Antidepressants take some time to achieve any therapeutic benefit and it is generally advised that they should be prescribed for six-eight weeks before any decision is made about their effectiveness. This is flexible advice and if the patient is complaining of side effects, or simply refuses to take them, they can be changed to another medication at any time. However, on 7 February 2003 X seemed to be saying that she did not feel that citalopram was working. Given this, the more appropriate action by Cons 9 (locum consultant) at the time would have been to explain to X that it was not surprising she felt no better and that she should give the citalopram more time or perhaps accept an increase in dosage.

There was no logic in changing X to venlafaxine after only a three-week trial of citalopram. Any agitation could have been treated with the short-term use of a benzodiazepine (and she did receive PRN lorazepam and clonazepam) until there had been time to assess whether citalopram had begun to lift her mood. However, once venlafaxine had been started, it was reasonable to increase the dosage from 75mg to 150mg after only one week as this was perhaps more likely to be effective, given X's degree of depressive symptoms. This is subjective and Cons 4 seems to have felt that 75mg was appropriate while X was in Bethlem Royal Hospital. There was no reason to increase the dose further until the six-eight week point, but in X's case it was increased after only two weeks. If there had been some evidence of improvement in X's mood, but less than might be expected, then an increase in dose might have been justified, but only when the six-eight week point was reached.

We consider it illogical to have started a mood stabiliser before the effect of the antidepressant on its own had been evaluated for the full six-eight week period, or even longer if it had been felt appropriate to increase the dosage of antidepressant. Adding another drug in these circumstances makes it difficult to decide which treatment, if any, is more effective. It also increases the chances of drug interactions and therefore side effects, which has a negative impact on compliance.

It is not surprising that both the carbamazepine and the venlafaxine were gradually increased over weeks, usually during ward rounds. It was probably the only thing the doctors felt able to do to show to X and the nursing staff that they were trying as hard as they could to help improve the way she was feeling and acting. However, it does not mean that this was a logical or good clinical plan and it would probably have been better to have resisted making so many changes and simply waited. If more attention had been placed on helping X to solve her accommodation problem and organising psychological follow-up, her medication could have been adjusted over a longer time in the community.

It was reasonable to use benzodiazepines and promazine, on a PRN basis, to control her anxiety levels and thus hopefully control her behaviour on the ward. This is normal practice and would have been a short-term measure until her mood lifted. It was also reasonable to consider the use of flupentixol decanoate to see if it would help control her agitation and thus reduce her need for the benzodiazepines/promazine. There was not a clear plan of action regarding this, but it was implied that, if the depot injection helped, the other medication would have been reduced or stopped.

In relation to X's response to flupentixol decanoate, the manufacturers Lundbeck suggest that the maximum effect from an injection is achieved in five-seven days. It is possible that X was feeling sedated and thus slightly calmer as a consequence of the pharmacological effects, even at this early stage, and comparatively low dosage (flupentixol decanoate is mainly used for psychotic patients and the

maximum dosage is 400mg per week but, given that X was not psychotic, much lower dosages might be expected to cause sedation or a reduction in anxiety). However, some of this response may have also been due to the placebo effect. Injections are always more powerful in this regard when compared to oral medication.

Nursing care

11.17 Nurse 5 wrote an initial nursing care plan on 16 January 2003. It said the “desired outcome” following admission was “in 14 days time X will achieve a stable mental status and avoid suicidal thoughts”. The nursing actions to be taken were as follows.

- a. *“X to be nursed on appropriate level of observations to ensure her safety.*
- b. *P/N, A/N (primary and associate nurse) to hold 1:1 time with X in order to develop a therapeutic relationship and enable her to ventilate feelings/thoughts.*
- c. *Nursing staff to observe and record X’s mood, behaviour, level of interaction, dietary intake, sleep pattern.*
- d. *Trained staff to give X prescribed medication, observing for any side-effects.*
- e. *Nursing staff to engage X in diversional activities to keep her occupied.*
- f. *X to complete BDI (Beck’s Depressive Inventory) forms at least twice weekly to assess levels of depression.”*

11.18 Nurse 9 amended this plan on 9 March 2003 after a CPA meeting on 5 March 2003. Desired outcomes were:

- a. *“X will continue to maintain stability in her mental health, which will be evidenced by absence of self-harming behaviour whilst an inpatient on Shelley Ward.*
- b. *X will demonstrate less level of anxiety and identify positive coping strategies to manage this.*

- c. *X will demonstrate/verbalise reduction in negative self image and self-worth.”*

11.19 The actions to be taken were:

- a. *“Allocated nurse per shift to continue to monitor X’s mood and behaviour, level of anxiety, interaction and socialization, dietary intake, thinking pattern - to include suicidal thoughts/negative self-image.*
- b. *PN/AN to hold 1:1 time with X to enable her to ventilate thoughts, feelings and concerns in a more safe and supportive environment.*
- c. *Allocated nurse per shift to encourage X to attend Occupational Therapy activities/programme whilst on Shelley Ward. This will include relaxation group, healthy lifestyles, anxiety management and social group.*
- d. *X will continue to use identified coping strategies in dealing with her anxiety and negative self-image.*
- e. *X will continue to engage with GT 1 for psychotherapy on a regular basis or as planned.*
- f. *X will be encouraged to have unescorted leaves/ day leaves in view of her forthcoming possible discharge on 19/03/03.”*

11.20 These actions largely accord with the CPA plan completed on 5 March 2003.

11.21 Ward manager 1 and Nurse 7 wrote to Cons 2 on 21 March 2003 asking for *“an urgent review of her management plan because X is clearly not complying with her treatment”*.

Occupational therapy

11.22 X was assessed by an Occupational Therapist on 28 January 2003 and the following treatment plan was made:

“Aims and objectives:

- a. *To manage anxiety*
For X to attend anxiety management weekly
For X to attend relaxation session weekly
- b. *To increase knowledge of healthy lifestyle*
For X to attend HL [Healthy Living] group on weekly basis
- c. *To maintain social interaction during admission*
For X to attend social group weekly.”

11.23 A timetable for these activities was given to X although it would seem that X rarely attended these scheduled activities.

Comment

Nursing and Occupational Therapy plans were in the main adequate and aimed at occupying X's time while she was on the ward as well as giving her strategies to manage her anxiety and opportunities to discuss her problems.

Too little emphasis seems to have been placed on discussing accommodation plans. The widely held assumption was that one nursing assistant, Nurse 10, was the “accommodation expert” and all accommodation issues were to be channelled through her. In reality, however, Nurse 10 was poorly equipped to deal with this (and this is no criticism of her); she could spend only two days a week in this role and covered two wards, Shelley and Brooke. She could help patients apply for council accommodation, or give them a list of private landlords and she could accompany patients to view properties if they wanted. However, she had little time to discuss options in detail. Nurse 10 acknowledged that CMHT care co-ordinators had much more influence on the type of council accommodation offered as they were more able to give details of the person's medical condition. The care co-ordinator, however, never assumed this role with X. If she had done so, or if her accommodation needs had been more fully explored on the ward, staff might have discovered that X wanted to make her own accommodation arrangements, possibly with friends or family.

The specific objective in the care plan dated 9 March 2003 stating “X will be encouraged to have unescorted leaves/day leaves in view of her forthcoming

possible discharge on 19/03/03”, *was never amended, even though her observation level was changed on 12 March 2003 to “level 4 with escort” and despite the discharge CPA being cancelled. There was thus an inconsistency in plans for X which should have been addressed.*

The control of “leave”

11.24 As an informal patient, X could not be prevented from leaving the ward whenever she wanted to. However, it is normal practice to negotiate leave arrangements and come to a mutually acceptable arrangement. This is based on an assessment of the patient’s risk to themselves or to other people if the patient leaves the ward and whether the person’s time could more usefully be spent engaged in some kind of organised therapeutic activity in the hospital.

11.25 In X’s case, the decision whether to allow her time off the ward was largely based on the assessment of risk of self-harm or suicide. This risk was assessed to fluctuate over time and she was sometimes allowed off the ward on her own, although at other times she was required to have a nurse or a “*responsible adult*” e.g. a relative or trusted friend with her.

11.26 Such changes in her leave arrangements were recorded in the nursing notes and on a specific “*Observation Level*” form. Decisions to change the level of observation were often made solely by nursing staff, based on X’s recent behaviour, but were sometimes discussed with a junior doctor. They were then later discussed at ward rounds, where a multi-disciplinary decision would be reached.

Comment

During this period of her admission, appropriate decisions regarding her leave were made, although X occasionally disregarded them and left the ward unescorted when she had been advised not to. This reflected the more general

problem related to her management during this admission, i.e. that it was unfocused and poorly structured.

12. Medway Maritime Hospital - X's in-patient care and treatment from 31 March to 4 April 2003

Introduction

12.1 Y and X met by chance on Shelley Ward in March 2003. X had been an informal patient since 15 January 2003. Y was admitted to Shelley Ward on 27 March 2003 and discharged himself on 30 March 2003. This chapter focuses on the chain of events leading up to the murder and, in particular, considers the response of health professionals to the management of the risk that Y presented to X.

Transfer of X's care from Cons 6 to Cons 2

12.2 We analyse elsewhere the medical management of X's case from the date of her admission to Medway Maritime Hospital until 30 March 2003. Cons 6 transferred her care to Cons 2 on 20 March 2003. At that time Cons 2 was a locum consultant psychiatrist working at Medway Maritime Hospital. Cons 2 did not have a formal meeting with Cons 6. She remembered Cons 6 telling her that X was uncooperative and non-compliant:

"She would not follow the ward routine and she was a difficult patient to deal with."

The ward round on 31 March 2003

12.3 Cons 2 saw X once before she was killed, at the ward round on 31 March 2003. Cons 2 said in her interview that she thought that X was *"quite okay, more or less cheerful"*. Cons 2 then said that X told her:

"..she was having a contract with (a) patient to give her (a) heroin injection and she was supposed to give him some money".

12.4 Cons 2's memory of events was confused. The minutes of the ward round clearly state that *"Nurse staff suspect that patient Y was involved in*

promising her heroin". The minutes do not record any discussion about informing the police. Cons 2 gave a statement to the police on 11 April 2003 in which she did not mention alerting them to what had happened. The issue was also not discussed at the post-incident reviews (see chapter 17). Y's identity was suspected at the 31 March 2003 ward round and even if Cons 2, as she maintained, was uncertain as to his identity further inquiries could have been initiated and steps could have been taken to notify the police when his identity was confirmed the next day.

The medical records

- 12.5 The clinical notes for 30 March 2003 (recording Cons 2's ward round) contain the following information about the "arrangement" between X and Y:

"Says has an idea from one of ex-inmates of Shelley Ward regarding injecting IV drugs to die easily if she pays £1000. To be reviewed at ward round today and Cons 2 alerted regarding drug abuse plans."

"S/N suspect that patient Y was involved in promising her heroin for £1000. Still ambivalent about getting heroin, feels her mother will be sad. My head keeps going from one thing to another. Denies current suicidal plans (I'm not going to do it)."

Nursing input

- 12.6 The two nurses Nurse 7 and Nurse 8 were central to X's care in late March/early April 2003. Nurse 7 was allocated as X's primary nurse following her admission to Shelley Ward in January 2003. She was working as an E grade or staff nurse. She was a newly qualified nurse when she started work on Shelley Ward in April 2002; this was her first post-qualification job. Nurse 8 was working on Shelley Ward at the time as an agency RMN. She was employed through a private agency. She was an experienced psychiatric nurse and at the time was also working as an E grade or staff nurse. Nurse 4 and Nurse 2 were the senior nurses on the ward.

The nursing notes

12.7 On 31 March 2003 Nurse 7 made the following entry in the nursing notes:

“X approached Nurse 7 and requested 1-1 time. X became very distressed as she explained that she had spoken to an ex-patient about street drugs and their overdose risk. X had arranged for this ex-patient to purchase £80 of heroin for £1000. X was planning to meet the ex-patient in town and not return today. X was shocked and distressed that she had made such a plan as normally she is too afraid to act on her thoughts. X explained that she is fed up of feeling like this and wanted to get her life back. X talked about her depending on others and how they let her down ruining her life. X identified a need to rebuild her life independently for herself but was finding it hard to take the first steps. Identified accommodation as a possible beginning. Due to X’s plan she has agreed to stay on the ward today. To approach staff for support during times of intrusive thoughts X has also placed her bank card in her locker to avoid temptation of access to cash. X declined to inform staff the name of the ex-patient but confirmed that it was a male.”

Comment

The only reference in the nursing notes to the arrangement between X and Y is the entry quoted in full above. Nurse 8 told us (and she told the police when interviewed) about notes that she had made of her conversation with Nurse 7 on 1 April 2003 when Y’s identity was confirmed.

“I told Nurse 7 and made notes of my conversation with X on X’s nursing notes.”

Nurse 8 said that because she was writing third party information (about Y) in the nursing notes she wrote a separate record entitled “information regarding a third party”. This record has been lost.

Details from the police inquiry

12.8 During the police inquiry after X's murder, a number of health professionals gave statements to the police about the incident. These are extracts from their statements:

WITNESS	DATE OF STATEMENT	SUMMARY OF CONTENTS
SHO 4	11/4/03	Describes meeting X on 31 March 2003. X told him that she had a conversation with an unidentified male patient who had <i>“suggested using heroin as a painless way to die by injecting herself, but that he would do it for £1000”</i> .
Nurse 4	7/4/03	Describes medication X was receiving and identifies her as being <i>“mildly agitated”</i> on 4 April 2003. He does not refer to the arrangement between X and Y.
Nurse 8	9/4/03	Describes seeing Y and X talking together on 28 March 2003. Describes a conversation with Nurse 7 on 31 March 2003 where Nurse 7 told her that X had told her that <i>“she had made a deal with somebody to get heroin for her to overdose with”</i> . Describes talking to X on 1 April 2003 about the incident and X identifies Y as the person she made the deal with. X then describes in detail the “arrangement” including the fact that Y had agreed to take her life for payment of money.
Nurse 7	5/4/03 and	Describes meeting with X on 31 March 2003 where

	8/4/03	she tells her about a “pact” she made with an ex-patient who she does not identify. “The £1000 was to get the heroin and he was to help her inject the heroin as she had never done drugs before and didn’t know what to do.” She describes a conversation with Nurse 8 on 1 April 2003 when Nurse 8 tells her that X had identified Y as being responsible for the “arrangement”. ‘This confirmed to me my suspicions as to who it could be as Y had been a patient on the ward recently.’
Cons 2	11/4/03	Describes the ward round on 31 March 2003 (the only meeting she had with X) “I had been told by other medical staff that X had previously made a pact and enquired into how to use heroin to commit suicide. I asked her about this and she admitted that she had discussed this with another patient, but she realised it was a silly thing to do or talk about and that she was extremely sorry for her behaviour and ashamed.” She “learnt through staff” that the person that X had made the pact with was Y.

The response to the “arrangement” between Y and X

- 12.9 Once the details of the arrangement between Y and X were known, the following steps were taken by the professionals involved to share the information.
- a. Nurse 7 told “the nurse in charge of the ward” (Nurse 4 could not recall any conversation) and Ward manager 1.
 - b. Cons 2 was given information by SHO 4.

c. Nurse 8 told Nurse 7 that X had identified Y as the person she made the pact with.

12.10 Nurse 7 thought she spoke to Nurse 2. Nurse 2 said she knew about the matter, as it was raised during handover and discussed in the ward review, but she did not recall Nurse 7 discussing it directly with her. She suggested it may have been discussed with the person in charge of the night shift, as Nurse 7 was working a long day. We have been unable to trace this person. Nurse 12 who was working on the night shift on 1 April 2003 could not remember any discussion at handover. Ward manager 1 could not recall any conversation that he had with Nurse 7. According to Nurse 7, Ward manager 1 “downplayed” the information.

“He didn’t believe she’d act upon it, that it wasn’t necessarily true, and just agreed with the things I’d put in place and that there was no further action to take.”

Comment

There was discussion among professionals as the information about the “arrangement” unfolded; nobody recognised its significance. The fact that the key witnesses had so little recall when they were answering our questions about the incident demonstrates how unimportant they regarded the information at the time. Ward manager 1 barely remembered his conversation with Nurse 7 about the “arrangement”. We accept Nurse 7’s evidence that she shared the information with Ward manager 1 and take the view that she acted properly by seeking the advice of Ward manager 1 and cannot be criticised for his response.

By the beginning of April the risk X presented to herself had been played down. For example, she was regarded as having a history of self-harming behaviour which had never resulted in serious harm. When she had considered harm, for example, on 19 March 2003, she told Nurse 9 that she still had distressing thoughts of running away and jumping from a multi-storey car park in Bromley South, she had not acted on these thoughts.

Despite this, we do not accept that professionals were justified in minimising the information that X provided. A more considered approach would have been to recognise that, although X certainly did have a history of self-harm, she had previously engaged in behaviour that was (at least potentially) treatable. When she had taken overdoses she had usually ensured that she raised the alarm, either by calling an ambulance or by going directly to an Accident and Emergency Department. Alternatively, she had contacted family or friends who called the emergency services.

It should also have been recognised that the “arrangement” with Y was completely different from any previous behaviour, but the potential lethality of X taking £80 of heroin by intravenous injection when she had no history of opiate use or abuse does not seem to have been recognised.

Protective measures

12.11 Once details of the arrangement were known, certain protective measures were put in place. Nurse 7 recorded:

“Due to X’s plan she has agreed to stay on the ward today. To approach staff for support during times of intrusive thoughts. X has also placed her bank card in her locker to avoid temptation of access to cash.”

12.12 These plans were not mentioned in the 31 March 2003 ward round and no formal assessment of risk using a CPA4 was made.

12.13 Nurse 7 also gave evidence that other safeguards were put in place ‘keeping an eye on her phone calls, increasing her observations.’

Comment

The immediate step to protect X by seeking her agreement to staying on the ward was sensible. Monitoring her phone calls solely related to the use of the patients’

phone on the ward. There was little value, as professionals accepted when they gave evidence, in monitoring these calls and they did not consider that they could monitor her frequent mobile telephone usage.

There was, however, a fundamental inconsistency underlying these responses. Taking these steps, however ineffective, constituted an acknowledgment that risk existed. The risk was then never properly evaluated. Cons 2 had been told by Cons 6 that X was “difficult”. She had also been alerted to problems about her behaviour by the letters from Ward manager 1 and Nurse 7. Y was admitted to hospital under Cons 2’s care on 27 March 2003. She knew by the next day that (in her words) Y was “extremely manipulative”, a “chronic drug addict with a long history of violence and drug addiction”. Cons 2 failed to process any of this information in assessing the risk to X; rather she preferred to rely on X’s self report.

Y and the commission of a criminal offence

12.14 An aspect of the inquiry has focused on whether the health professionals involved in the care and treatment of X could (and should) have told the police about the information they had been given concerning the agreement that X made with Y to supply her with heroin. It is clear from the evidence referred to above that details of the agreement, including the identity of Y, were known to health professionals by 1 April 2003.

12.15 The case officer in the prosecution of Y for the murder of X was Pol 1. He was familiar with the police inquiry and the prosecution. We asked for his views on what might have happened if the police had been told about the ‘agreement’ between X and Y on or about 1 April 2003. We found his views convincing and attach to this report (annex 4) an excerpt from the transcript of his evidence.

12.16 We sought the views of Pol 2 who was the area crime manager for Kent Police and senior officer in charge of the police inquiry in 2003. He wrote as follows:

“As the Area Crime Manager and SIO of the inquiry, I confirm that if we had received information in advance that Y had agreed to supply unlawful drugs to cause the death of X then a risk assessment would be made of the parties concerned. Following that process, which would be timely, I believe that with the history of Y, he would have then been arrested and the matter investigated fully.

Obviously this is a hypothetical question as you indicate in the transcript provided. I believe that in the event of this becoming reality in the future, an assessment would be made on the individual circumstances and action taken to preserve life and investigate fully where appropriate.”

Comment

We conclude that steps would probably have been taken to protect X, if health professionals had alerted the police. The failure to do so is explicable only in the context of the minimising of X’s risk to herself. This led the senior health professionals involved, Ward manager 1 and Cons 2, to fail to consider either contacting the police direct or discussing the matter further with manager/colleagues. In the case of Ward manager 1 this would have been Man 1, in Cons 2’s case it would have been the clinical director Clin dir 1.

We asked Cons 2 why she did not take steps to enquire further after Y’s identity was discussed at the 31 March 2003 ward round. She was not able to offer a credible explanation beyond saying that she was not notified when his identity was confirmed on 1 April 2003.

We accept that the question posed to Pol 1 and Pol 2 was hypothetical. We however consider that if there had been communication between the police and health professionals about the ‘arrangement’ then it is likely that the police would have acted upon the information, particularly because they knew about Y and his criminal background.

We consider that Ward manager 1 and Cons 2 were wrong not to judge that the arrangement between X and Y merited serious consideration. We single them out for criticism while acknowledging they were not alone in failing to recognise the problem. Ward manager 1 had a responsibility to guide Nurse 7, who was in her first post as a qualified nurse. He also had several years of experience in the local substance misuse team before taking up his post on Shelley Ward. Cons 2 was in charge of X's treatment and care and she had a responsibility to supervise junior staff.

We also have concerns about what is best described as the "corporate response" to this issue. Man 3, who conducted the Serious Untoward Incident inquiry as well as those who attended his inquiry never considered this area as relevant.

3 April 2003 risk assessment

12.17 On 3 April 2003 Nurse 9 and SHO 4 completed a risk assessment form, a CPA4. This is discussed in chapter 14. They emphasise on the form the history of self-harm and mention X's concerns about her imminent discharge, but there was thought to be "*no current risk of suicide*". In fact, no current risk factors were identified in any category. The only mention of the "arrangement" with Y was included under the heading of "*Risk of self-neglect/exploitation/abuse by others*". A history of self-neglect and vulnerability to exploitation or abuse was highlighted, followed by this entry in the "*comments*" box:

"Has history of self-neglect. Sexually abused by step-father. On 31/03/03 X had arranged for an ex-patient to purchase £80 of heroin for £1000."

12.18 The summary of the risk assessment was:

"X has history of overdoses from the past but currently denies any suicidal thoughts, has been maintaining her safety on the ward and whilst off the ward on escorted leave. When left on her own off the ward, able to come back to the ward and maintain safety evidenced by absence of self-harming/suicidal acts/behaviour. X's main concern is about her

forthcoming discharge set on 17th of April - worried about relapse and the package of care she'll receive from the community.”

12.19 The immediate action to manage risk was:

“No current risk of suicide at the moment. Level of observation reviewed to level 4 negotiating time off the ward. MDT and X agreed for a contract stipulating taking responsibility for her actions whilst off the ward. Level of observation to be reviewed accordingly, i.e. any risks identified, X’s mental health presentation.”

12.20 The whole assessment was discussed with SG 3 during a ward review on 3 April 2003, the day the risk assessment was completed. A reduction in her observation level was recorded on the appropriate form.

12.21 During the ward round on 31 March 2003, her leave was considered and it was decided to maintain the nursing observations at *“level 4 with escort”*. However, only three days later and with no apparent reference to Cons 2, the level was changed to *“level 4 negotiating time off the ward”*.

12.22 On 4 April 2003, X left the ward at 11.40am to go swimming and shopping unescorted. She planned to return at 4pm. She later telephoned the ward to say that the plan had changed as her parents had invited her to lunch in Faversham, but she still agreed to return by 4pm. She came back as planned but left the ward again soon afterwards, saying she was going to the League of Friends shop in the main hospital. She did not return. Nursing staff later reported her missing to the police, the duty doctor and the senior nurse on call. They also tried to contact X’s mother, but succeeded only the following morning. She had not spoken to X since their lunch-time meeting on 4 April 2003.

Comment

Before 31 March 2003, the use of the MHA was barely considered in X's case during the time she was on Shelley Ward. If the use of the MHA had been considered once the details of the "arrangement" were known then protective measures could have been put in place. These measures could have included restricting X's mobile telephone use. As it was, by this time, the risk that she presented to herself was either played down or not understood, and so this was never considered. Cons 2 told the inquiry that the use of the MHA may have been discussed at the 31 March 2003 ward round; there is no reference to this discussion in the minutes of that ward round and we consider it unlikely that such a discussion took place.

The risk assessment by Nurse 9 and SHO 4 and the decisions taken during the ward review on 3 April 2003, in particular the reduction in the observation level to allow X unescorted time off the ward, demonstrate that the risk of X acting on the arrangement she had made with Y was not appreciated. The changes to the observation level were made without reference to Cons 2 who was in charge of X's care and treatment. Cons 2 expected that any such assessments should have been countersigned by the consultant in charge of the patient's treatment.

13. A comparison between the care and treatment that X received in 2002 and 2003

Introduction

13.1 X's stay as an inpatient on Shelley Ward based on the site of the Medway Maritime Hospital closely followed her two compulsory admissions to Bethlem Royal Hospital. We have therefore compared her care and treatment in these two hospitals.

Inpatient care

13.2 We consider that the most significant difference between the care X received in Bethlem Royal Hospital compared with Shelley Ward was that there was only one consultant and one SHO involved during both admissions to Bethlem Royal Hospital. Also, despite the shortcomings in following the CPA processes, the inpatient team appeared clear that it was not a good idea for X to be an inpatient for long. The plan was to try to support her in the community, first using the CPN and outpatient appointments with the SHO and then referring her to psychology services, while continuing her on an antidepressant.

13.3 Shelley Ward staff also had to deal with a new threat to X's safety caused by the pact with Y. They failed to see how this threat significantly differed from past suicide threats in that it gave no chance for X to change her mind and seek help as she had normally done in the past. Because of this, they failed to consider informing the police or using the MHA to protect her.

Comment

X progressed rapidly to discharge when treated at the Bethlem Royal Hospital. This partly reflected the way that the Gresham Wards functioned and partly Cons 4's way of managing patients like X. The imperative to plan "X's discharge to minimise dependence" identified by Cons 10, SHO 6 and Nurse 2 on 21 February 2003 was never achieved at Shelley Ward.

Discharge plans

- 13.4 The discharge plan developed at the Bethlem Royal Hospital was appropriate, but the absence of a formalised risk assessment, lack of clearly identified care co-ordinator and lack of appreciation of where she would live and the probable impact that living in a B&B would have on her mental state, meant that the management of the risk of self-harm she presented was inevitably made more difficult.
- 13.5 Bethlem Royal Hospital staff were perhaps luckier than their Shelley Ward counterparts as, in November 2002 and in early January 2003, X probably felt she could still more readily turn to her family (mother, grandmother and sister) and friends for support. She also had more accommodation options open to her rather than going into a B&B organised through the local authority. Even though she was suspended from her job, she was still being paid by the police and perhaps still had some hope of returning to work and therefore eventually being able to afford to rent privately. Even so, she took a significant overdose in between her admissions to Bethlem Royal Hospital and could have caused herself physical harm by the time she reported to the Mayday Hospital Accident and Emergency Department on 4 December 2002.
- 13.6 By the time X was facing discharge from Shelley Ward her father had been released from prison and he and her mother were planning to move away from the area. Her parents had apparently offered X the opportunity of living with them when she left hospital and her stepfather told us that she had already chosen her bedroom in their new house. According to her sister she had not 'ruled out' living with her parents although she had also said to others that she was finding somewhere else to live. If she had decided to live with her parents, even on a temporary basis, it would undoubtedly have had an impact on her mental state. She also knew that her employment with the police was under review and was likely to be ended as she was still "*on probation*". Thus, her community-based options were more limited; she was likely to have felt isolated and scared for her future and so was much more at

risk of self-harm. Staff on Shelley Ward do not seem to have recognised this and it was not reflected in their plans to discharge her.

Comment

The CPA process in both hospitals fell short of local guidance. Comments about her admissions to Bethlem Royal Hospital are to be found above. In Shelley Ward, although X was assessed as eligible for enhanced CPA, the co-ordination between inpatient team and the CMHT was poor and the CMHT apparently chose not to involve themselves as they thought that would be likely to hasten X's discharge, which they did not feel she was ready for. If they had become engaged at an early stage, it might have been possible for them to provide help and support for X with her accommodation and X might have been able to build a relationship with CPN 3, her care co-ordinator, thus reducing her anxieties about discharge.

If there had been contact between psychiatric staff on Shelley Ward and staff at Bethlem Royal Hospital on 15 January 2003 or soon after, X might have been transferred there. She had only recently been discharged, was still registered with a GP in the area and had two imminent appointments there, one with CPN 1 on 17 January 2003 and the other with Cons 8 on 23 January 2003. There was also still an active referral to the psychology department. X would probably have objected to being transferred. Notwithstanding her likely opposition to a move, contact with staff at the Bethlem Royal Hospital should have been speedily initiated by the assessing team at Medway Maritime Hospital. If she had not been transferred, the admissions to Bethlem Royal Hospital and the plans for community follow-up would have been known to the psychiatric staff at Medway Maritime Hospital. Despite Cons 6's assertion that receiving the discharge summary from Bethlem Royal Hospital would not have affected X's care, we consider it would have been likely to focus staff minds on keeping her admission brief and her medication regime simple.

The use of the MHA

13.7 In relation to both admissions to the Bethlem Royal Hospital, X was detained under section 2 of the MHA. The two medical recommendations completed before her October 2002 admission refer to her not being able to make an *“informed judgement”* about admission and her ‘verbal consent’ not being reliable. The two medical recommendations completed before her December 2002 admission record that she was *“at high risk to self and refusing informal admission”* and *“will only give conditional consent to hospitalisation”*.

13.8 The circumstances of her admission to Shelley Ward were different insofar as X was recorded as *“wanting help”* and clearly agreed to her admission. On 24 January 2003 at a ward round with Cons 6 the nursing notes record that she:

“sat quietly and sullen was asked if she felt she needs to be in hospital, which she agreed she did.”

13.9 From this time on X was generally compliant with her informal treatment, but the boundaries between compliance and resistance were sometimes blurred. For example, on 10 February 2003 it is recorded that she asked SHO 6 *“to go out unescorted”* and he *“refused”* her request. The legal regime for treating her was recorded by SHO 6, the context being her apparent disquiet about taking medication:

“Unhappy to see Cons 6, agreed to take medication, requested for SOAD [Second Opinion Appointed Doctor] will request SG 4, explained to her S/E [side effects] if she does not wish to comply ‘medication not helping me’.

“Advised to continue, since she is informal we have to respect her wishes. She is not sectionable and does have reasonable understanding and capacity.”

13.10 Her case was reviewed on 3 April 2003. The clinical record notes that “she is not compliant with treatment”. This never triggered a re-assessment of her circumstances; rather her observation level was reduced.

Comment

We do not consider there was any real need for an assessment under the MHA until the disclosure of the arrangement with Y. If X had been “pushing boundaries” i.e. not adhering to jointly agreed care plans such as negotiating time off the ward, not bringing alcohol/tablets onto the ward or attending Occupational Therapy using sessions with her primary nurse, this could have been discussed with her. It could have been suggested that she would be discharged if she was not able to change her behaviour. If this led to an increase in disturbed behaviour, the team would then have had to consider the MHA. Alternatively, depending on the assessment of risk at the time, she could have been discharged with an offer of an outpatient appointment, an appointment with her care co-ordinator and a re-referral to GT 1. This was Cons 4’s plan when she was discharged from the Bethlem Royal Hospital. If sections 5(2) or 2 of the MHA had been used, they could have been used for a short time until a particular behavioural crisis (threats of or actual self-harm) had been reduced.

The urgent review of her management plan requested respectively by Nurse 7 and Ward manager 1 on 21 March 2003 should have led to further discussion with the team and with X along the lines above.

We believe that the only time sections 5(2), 5(4) or section 2 of the MHA should have been considered was when the pact was disclosed in April, because of the marked increase in risk to her safety it involved. This would have enabled more robust protective measures to have been introduced e.g. restriction of leave and the temporary confiscation of her mobile telephone. This would have required a focused re-evaluation of risk. Such an assessment took place on 3 April 2003, but it was so inaccurate it was of no help in indicating whether a full MHA assessment was needed.

14. X - risk assessment and management

Introduction

14.1 Mental health risk assessment forms, CPA4s, were, and remain, part of the standard paperwork used by the trust. These forms are completed by health and social care professionals when working with patients eligible for the CPA both in the community and in inpatient settings. In X's case we read four such forms.

14.2 Nurse 4 spoke about the purpose of completing the forms:

“It is to acknowledge and record and evaluate risk and identify the plan of care, nursing and clinical care, around risk. It should be done on admission, it should be done after any significant event, and it should be done on discharge, but likewise it should be done as care progresses because there is a time when people’s risk is going to change, and although that may be reflected through daily reports from nurses or doctors and through level of observations, and obviously discharge, it should be reflected through the risk assessment as well, which was the purpose of the document.”

The forms

14.3 We reproduce below the relevant sections from the four forms with a brief description of the context of each form being completed:

15/1/03 Nurse 7

Completed on X's admission to Medway Maritime Hospital.

Past	Present	1.Risk of suicide or self harm:	Date and author
			15/1/03 Author: Nurse 7
<input type="checkbox"/>	<input type="checkbox"/>	Minor self-harm or suicide gestures without significant risk to life or health	
<input type="checkbox"/>	X	Suicide threats	
<input type="checkbox"/>	<input type="checkbox"/>	Client has indicated that she/he may be seriously contemplating/planning suicide	
X	<input type="checkbox"/>	Self-harm or attempted suicide	
		<u>Comments</u> History of 7 or 8 previous attempted overdoses. Has thoughts of taking an overdose but is frightened in case of been put on a Sec 3 MHA 83.	
Past	Present	3. Risk of self-neglect/exploitation/abuse by others:	
X	X	Self-neglect	
<input type="checkbox"/>	<input type="checkbox"/>	Inability to recognise hazards	
<input type="checkbox"/>	<input type="checkbox"/>	Has difficulties with activities of daily living	
X	<input type="checkbox"/>	Is vulnerable to exploitation or abuse (financial/sexual/physical etc)	
		<u>Comments</u> Reports to self neglect when feeling bad. Previously sexually abused by adopted father.	

13/2/03 CPN 2

Completed during her assessment of X for CPA eligibility.

Past	Present	1. Risk of suicide or self harm:	Date and author
X X X X	X X X X	Minor self-harm or suicide gestures without significant risk to life or health Suicide threats Client has indicated that she/he may be seriously contemplating/planning suicide Self-harm or attempted suicide <u>Comments</u> Can see no future for herself. Feels alone and isolated. Homeless.	13/2/03 Author: CPN 2
Past	Present	3. Risk of self-neglect/exploitation/abuse by others:	
[] [] [] X	[] [] [] []	Self-neglect Inability to recognise hazards Has difficulties with activities of daily living Is vulnerable to exploitation or abuse (financial/sexual/physical etc) <u>Comments</u> Past relationships have been physically abusive sexually abused by father 6-13 yrs old	

15/2/03 Nurse 4

The completion of the form coincided with an entry he made in the nursing notes about reviewing X's observation levels after she had left the ward without permission the previous day.

Past	Present	1. Risk of suicide or self harm:	Date and author
<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	<p>Minor self-harm or suicide gestures without significant risk to life or health</p> <p>Suicide threats</p> <p>Client has indicated that she/he may be seriously contemplating/planning suicide</p> <p>Self-harm or attempted suicide</p> <p><u>Comments</u> Hx (history of) 7/8 overdoses. Currently - acknowledge suicidal ideation coupled with low self-esteem and subj statement of worthlessness. Left ward on 14/2 - admitted thoughts of jumping in front of train.</p>	<p>15/2/03 (H9) Author: Nurse 4</p>
Past	Present	3. Risk of self-neglect/exploitation/abuse by others:	
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Self-neglect</p> <p>Inability to recognise hazards</p> <p>Has difficulties with activities of daily living</p> <p>Is vulnerable to exploitation or abuse (financial/sexual/physical etc)</p> <p><u>Comments</u> Hx of self-neglect. Sexual abused by adopted father - vulnerable</p>	

3/4/03 Nurse 9 and SHO 4

This form was completed just before, or at, the ward review. SHO 4 thought that this form might have been completed just before the ward round. Nurse 9 thought it might have been completed at the review.

Past	Present	1. Risk of suicide or self harm:	Date and author
			3/4/03
<input type="checkbox"/>	<input type="checkbox"/>	Minor self-harm or suicide gestures without significant risk to life or health	Author(s): Nurse 9 / SHO 4
X	<input type="checkbox"/>	Suicide threats	
<input type="checkbox"/>	<input type="checkbox"/>	Client has indicated that she/he may be seriously contemplating/planning suicide	
X	<input type="checkbox"/>	Self-harm or attempted suicide	
		<u>Comments</u> Has history of overdoses from the past. Currently denied any suicidal ideation and has been maintaining safety on the ward, however has continued to verbalize concerns around physical well-being (gained 2 stones), job and forthcoming discharge (17.04.03)	
Past	Present	3. Risk of self-neglect/exploitation/abuse by others:	
X	<input type="checkbox"/>	Self-neglect	
<input type="checkbox"/>	<input type="checkbox"/>	Inability to recognise hazards	
<input type="checkbox"/>	<input type="checkbox"/>	Has difficulties with activities of daily living	
X	<input type="checkbox"/>	Is vulnerable to exploitation or abuse (financial/sexual/physical etc)	
		<u>Comments</u> Has history of self-neglect. Sexually abused	

		by adopted father. On 31/03/03 X had arranged for an expatient to purchase £80 of heroin for £1000.	
--	--	---	--

Comment

The way the forms were completed illustrates the variable ways in which X's risk was interpreted during her inpatient treatment. All but the last risk assessment were reasonable reflections of the situation at the time the forms were completed.

The assessment on 3 April 2003 failed to highlight any current risk to X's safety, when only three days earlier she had openly discussed the plan she had made with Y to allow him to inject her with a lethal amount of heroin. The information concerning the pact was recorded as a comment under the heading "self-neglect/exploitation/abuse by others", which was an error and served to minimise its importance.

In addition, no mention was made of other comments X had made since Nurse 4 's assessment of risk on 15 February 2003, which suggested she was still at risk of self-harm:

- | | |
|---------|---|
| 23/2/03 | In a one-to-one session between X and Nurse 7, X still expressed suicidal thoughts but "something" stopped her acting on them. |
| 11/3/03 | X left the ward and a fellow patient subsequently handed a packet of paracetamol, that he had taken from her, to nursing staff. |

- 12/3/03 X's observation level was increased to "level 4 with escort" by nursing staff following the incident with paracetamol the previous day. X later said:
- "whatever they do I'm still going to take an OD when I'm out there anyway".*
- 19/3/03 X was seen by Nurse 9. X said she still had distressing thoughts of running away and jumping from a multi-storey car park in Bromley South. She expressed thoughts of hopelessness regarding her future and became tearful.
- 23/3/03 X was tearful at times throughout the day and ran off the ward during the late evening. She was returned by nursing staff, but said that she needed to go for a walk as she felt like her *"insides were about to explode"*.
- 24/3/03 X said she did not feel the medication was working, she still had suicidal thoughts and was still upset by the break-up with her boyfriend, her work problems and her family disharmony. She also said she was homeless.

The above information was recorded in the clinical file and should have been used when Nurse 9 and SHO 4 were completing the risk assessment form.

The form completed on 3 April 2003 appears to reflect the readiness with which the assessors accepted self report. In this context we note the conversation Cons 2 told the police she had with X:

"At the meeting on 31st March X was feeling a little depressed and low. Also she stated that although she had discussed using heroin she had no intentions in her mind at that time to do such a thing and had no suicidal feelings at that time."

We accept that the risk assessments forms are of limited use; in general they record “risk” only at a moment in time. In this case however, the inaccurate information on the form was apparently used and replicated in rationalising the change in X’s “leave” status:

“Has maintained her safety on the ward. No self-harming behaviour expressed and observed, although has continued to verbalize concerns around physical health, job and forthcoming discharge.”

At the Clinical and Practice Review of the Care and Treatment of X, Cons 2 “stated that she had insisted on joint risk assessments prior to decisions about leave periods”. We take this to mean that she wanted both medical and nursing staff to be involved in the assessment of risk and this is what happened on 2 April 2003. However, errors were made in the completion of this assessment form which resulted in the safeguards available to X being reduced. We consider the responsibility for these errors lies with the assessors and, more importantly, those tasked with their management and supervision.

15. X - the application of the CPA

Introduction

- 15.1 The delivery of all mental health services is framed in the CPA set out in circular HC(90)23/LASSL(90)11 and in the Welsh Office Mental Illness Strategy (WHC(95)40) national guidance. Building Bridges, published in 1995, states that the CPA is the cornerstone of the government's mental health policy and provides detailed guidance about the operation of the CPA. Some requirements of the CPA were modified in 1999. These modifications are contained in a booklet entitled "Effective Care Co-ordination in Mental Health Services - Modernising the CPA".
- 15.2 The CPA applies to people under the care of the secondary mental health service (health and social care), regardless of setting. This chapter considers care planning for X. It looks at the period when X was cared for by South London and Maudsley NHS Trust (SLaM) in 2002 (part one) and when she was cared for by West Kent NHS and Social Care Trust in 2003 (part two).

Part one - SLaM

Admission 1 (19 October 2002 to 13 November 2002)

- 15.3 If the criteria contained in the SLaM CPA policy current at the time are applied to X's case, it is not clear whether she was regarded as eligible for enhanced CPA. The policy lists the criteria for enhanced CPA and emphasises 'severe and persistent major mental illness'. Personality disorder is not mentioned. Social dysfunction, major housing difficulties, serious suicidal risk or self-harm are mentioned and could therefore have made X eligible, especially given the statement in the policy that the criteria represent "*a minimum standard*" and "*in certain circumstances a clinician may choose to include service users who do not meet these criteria*".
- 15.4 The policy clearly states that "*all service users admitted to hospital should be assessed for enhanced CPA*" but this did not appear to have taken place or

at least, it was not recorded as having taken place. There are records of ward rounds and “*multi-disciplinary care plans*” apparently written by nursing staff. A multi-disciplinary care plan records a meeting on 5 December 2002. The form refers to a meeting on 5 October 2002, but we think it likely that this date was incorrectly recorded. It states that X was not on ‘CPA Register Group 1’. Witnesses from SLaM did not appear to know what this meant and suggested that out-of-date paper work had been completed.

- 15.5 Her discharge plan does not refer to her CPA status. There is no CPA documentation to suggest that a care co-ordinator was appointed, although SW 2 is described as “*care manager*”. We learned that SW 2 was a social worker in the Central Croydon CMHT, based at the Tamworth Road Resource Centre.
- 15.6 A full risk assessment was never carried out. A brief risk screen was completed on 19 October 2002 on admission to the Bethlem Royal Hospital. The assessing doctor ticked a box marked “yes” in answer to the question ‘in your professional judgement, is a full assessment of risk indicated?’ The remaining documentation which allows for a more comprehensive risk assessment is blank.
- 15.7 It is not known whether X knew what her care plan in the community was and which professionals (other than the CPN) she was meant to see after her discharge. It is also not known what plans were in place should X fail to attend community appointments and whether X was ever referred to the psychology service by anyone other than her GP. CPN 1 mentions such a referral, but she was told by someone at the Purley Resource Centre (Croydon South CMHT) that the referral had not been accepted. There is no record of what, if anything, the CMHT were planning to do about that.

Comment

CPA arrangements remained unclear throughout and there was an incomplete assessment of need and risk. A care co-ordinator was not identified, but we

assume it was implicitly accepted that X was on standard level care and that SHO 3 was assumed to be the care co-ordinator. We doubt X was aware of this. With reference to the CPA policy current at the time both in relation to standard and enhanced CPA, X does not seem to fit any of the criteria for standard CPA. She did, however, meet the criteria for inclusion on enhanced CPA:

- a. She was unable to manage her own her mental health problems at that time.*
- b. She had a poor informal support network.*
- c. She posed considerable danger to herself.*
- d. She was unlikely to maintain consistent contact with services. This perhaps only became more evident following her discharge, but in view of her diagnosis and the information received from Medway, staff should have been aware that there was a risk of poor compliance for both medication and attending appointments.*

We believe that all these factors plus the fact that she may have needed help with accommodation should have tipped the balance in favour of enhanced CPA. In correspondence with us Cons 4 considered that she may on balance have decided not to place X on enhanced CPA. Clin dir 2, the Clinical Director of Croydon integrated adult mental health services, asserted that our conclusion “reflected a poor understanding of clinical practice” in cases of this nature. We consider that their views reflect a belief, common at that time among psychiatrists in England and Wales, that people with personality disorder should not be assessed as eligible for enhanced CPA. The document, “Personality Disorder: No Longer a Diagnosis of Exclusion” published in 2003 and referred to in more detail in chapter 16, sought to address this issue. When X’s CPA level was assessed the next month at Medway Maritime Hospital there was no dispute that she should be placed on enhanced CPA.

Despite the lack of clarity concerning X’s CPA status, after her discharge both SHO 3 and CPN 1 performed their roles well, following up when X failed to keep appointments by contacting X on her mobile telephone and liaising well with the CMHT about plans.

Admission 2 (7 December 2002 to 31 December 2002)

15.8 X's CPA status during this admission was not clear. It was also not clear whether she had a nominated care co-ordinator, what community care plan had been organised for her, what plans were in place if she failed to attend community appointments and whether anyone in either the Purley Resource Centre or Tamworth Road CMHTs was aware of the GP's referral of X to the psychology service prior to Psychotherapist 1's letter to the Purley Resource Centre dated 23 December 2002. It would seem that an assumption had been made that X was on standard level CPA and that SHO 3 (SHO to Cons 4) was responsible for co-ordinating her community follow-up.

Comment

It has been difficult to comment on the period between 7 December 2002 and 23 December 2002 as no notes or other written records were made available to us. However, the same problem with X's CPA status that occurred in relation to her first admission appears to have re-occurred. When discussing her CPA status Cons 4 considered that X would not have been eligible for enhanced CPA on her first admission; there would have been a discussion after her second admission about placing her on enhanced CPA. This discussion did not take place because "she did not return to the ward and when we contacted her she said she was in Nottingham".

SHO 3 again seems to have assumed the role of care co-ordinator and acted responsibly by writing an urgent letter to Cons 8 before her planned appointment with X on 23 January 2003. Cons 8 then seems to have assumed the role of care co-ordinator and took an appropriate decision to discharge X once she discovered that X had been admitted to Medway Maritime Hospital, informing the GP of this decision.

Part two - West Kent NHS and Social Care Trust

Chronology

15/1/03	X's admission to Shelley Ward based on the site of the Medway Maritime Hospital.
19/1/03	Fax referral from Shelley Ward to CMHT intake team.
31/1/03	Letter from CPN 2 to X offering her an appointment.
13/2/03	Assessment by CPN 2.
17/2/03	CPN 2 writes to Cons 6 highlighting her concerns about X and confirming her eligibility for enhanced CPA.
12/3/03	Shelley Ward notified that CPN 3 would come up to the ward and see X <i>"anytime this week"</i> .
26/3/03	CPN 3 meets with X on the ward.
27/3/03	CPN 3 attends a mini review on Shelley Ward and plans a CPA review on 7 April 2003.

The assessment of X

- 15.9 We have considered the process of risk assessment, an integral part of the CPA process, in chapter 14.
- 15.10 X was assessed by CPN 2 who was part of the intake team attached to the CMHT at Gillingham at the time of the assessment. The function of the intake team was *"to do all the new assessments and any short term work"*. CPN 2 explained that the response time to the referral was based on urgency and X's case was classed as being non-urgent. She completed CPA forms one, two and four.

- 15.11 Following her normal practice, after the assessment on 13 February 2003 she wrote to the referrer summarising her concerns. CPN 2 explained that Shelley Ward wanted to discharge X while her view, based on her experience, was that X was “*actively suicidal*”. She was quite clear that X was eligible for enhanced CPA on the basis of her multiple needs. She then passed on the case for allocation.
- 15.12 CPN 3 could not remember when, and how, the case was allocated to her; she thought it may simply have reflected her ability to take an extra case at that particular time. The nursing notes record that on 12 March 2003 there was a message received from Nurse 11 (she is recorded as being an acting E grade on Shelley Ward, but did not attend the ward round that day) that:
- “CPN 3 will come up to the ward and see X anytime this week: X has been accepted for enhanced CPA.”*
- 15.13 CPN 3 could not remember anything about this message. She thought it might have been left by a team member who attended a ward round.
- 15.14 There is no mention of CPN 3’s appointment as care co-ordinator in the record of the ward round on 12 March 2003. The only relevant reference in the record of the ward round on 5 March 2003 is “*discharge CPA 2 weeks. Helpful for housing*”. Both those ward rounds were attended by CPN 4, a CPN from the Gillingham CMHT.
- 15.15 In the event, CPN 3 saw X on 26 March 2003. She regarded this as an introductory meeting. She saw her only once. When she attended what she described as a “*mini-review*” at the hospital on 27 March 2003 she did not stay to see X. She told us she saw her function as care co-ordinator starting when X was discharged. She was uncertain about who had care co-ordinator responsibility while the client was an inpatient, but felt it was the primary nurse. X’s primary nurse was quite clear that she was not the care co-

ordinator. CPN 3 reflected that the role of the care co-ordinator had changed since 2003.

15.16 In the context of planning for X's discharge, we note that on 27 March 2003 a discharge planning meeting was arranged for Monday 7 April 2003. This date was not organised by CPN 3, she was simply asked whether she was available. GT 1 was asked to attend the Monday meeting late on Friday 4 April 2003. He recorded 'this is not adequate notice.'

15.17 The CPA policy states that the CPA care plan should be "*prepared/reviewed and distributed prior to discharge*". At the ward round on 3 April 2003 a discharge date for X was set for 17 April 2003. Her body was found at 1.30pm hours on 5 April 2003.

Comment

Compared to their counterparts who worked for SLaM, the staff working for West Kent NHS and Social Care Trust had no uncertainty about X's CPA eligibility. CPN 2's assessment of X was detailed and insightful. Unfortunately, a number of problems occurred in relation to the application of the CPA policy to X:

- a. Her assessment, the subsequent identification of a care co-ordinator and the meeting between X and the care co-ordinator did not take place within the time limits set down in the CPA policy that was current at the time.***

"Identification of the care co-ordinator and contact with the primary/named nurse and client should take place within two weeks of admission."

If the policy had been followed, X would have been allocated a care co-ordinator by 29 January 2003 rather than first meeting her care co-ordinator on 26 March 2003, a delay of some eight weeks. Given that X was identified as an enhanced CPA patient by 13 February

2003 she arguably could not have been discharged until a care co-ordinator had been appointed. In any event, planning for discharge which should have taken place in her case as soon as she was admitted was significantly delayed. We consider that this delay and uncertainty added to the anxiety she felt about her proposed discharge. This anxiety was compounded by the different approaches to her care and treatment evidenced by the confusion about her discharge date. (See Annex 5 where on 11 March 2003 X was wrongly informed by Ward manager 1, that she would be discharged on 17 March 2003.)

- b. When CPN 3 was appointed as CPA care co-ordinator, her view of her role was restricted to becoming involved after X had been discharged. This followed much of the thinking at the time:*

“The idea of early discharge planning wasn’t talked about in 2003; it was an unknown concept.”

Man 2 reflected that in 2003 there was no recognition that the care co-ordinator had a “key responsibility” in managing what he described as “through care” for a patient eligible for CPA while that patient was still an inpatient. Nurse 4 said current practice was that care co-ordinators should engage as soon as possible with an inpatient. Man 1 said:

“If you’re trying to manage the beds effectively you need to start planning for discharge the minute somebody is admitted.”

- c. The list of “tasks of the care co-ordinator” in the CPA policy states that a specific task of the care co-ordinator was to “prepare and implement a CPA care plan”. The fact that X was perceived to be safe in the inpatient environment appeared to have delayed both*

the involvement of a care co-ordinator and the development of a care plan.

Accommodation and the involvement of Nurse 10

- 15.18 In 2003 Nurse 10 was working on Shelley and Brooke Wards as a nursing assistant. She said one of her managers asked her to perform the *“role of accommodation officer at that time”*. Man 1, who was responsible for appointing Nurse 10 to help with accommodation, was clear that her brief was to work with patients on standard level CPA as the care co-ordinator would expect to take on that role with the enhanced CPA patients. Nurse 10 regarded her function as just being a *“liaison officer”* with Medway Council housing department. She regarded the care co-ordinator, in her words, as having more “clout” with the council and therefore more power to influence their decisions in relation to accommodation.
- 15.19 Other professionals had different views of her role. Despite concluding that X should be on enhanced CPA, on 17 February 2003 CPN 2 asked *“the Accommodation Officer”* to help pursue supported accommodation. CPN 3 noted on 27 March 2003 at the mini-review that *“issues around housing need to be addressed”* and she regarded Nurse 10 as looking into X’s housing needs and that there was no need at that point *“to be stepping in”*. Both Ward manager 1 and Nurse 7 wrote letters to Cons 2 referring to Nurse 10 *“working tirelessly to try and secure her accommodation”*.

Comment

We consider the confusion surrounding the role of Nurse 10 demonstrated two significant organisational problems. The first was the poor communication between community and inpatient staff; X was on enhanced CPA and therefore Nurse 10 should have had little or no function in her case according to our interpretation of the CPA policy. The second problem was the perception of the role of the care co-ordinator. Both CPN 2 and CPN 3 considered that it was for Nurse 10 to help with finding accommodation while Nurse 10 and her manager considered it was the role of the care co-ordinator to do so. Cons 6 regarded the ward staff as responsible for finding her accommodation.

We found no evidence of a discussion earlier in X's admission about her particular accommodation needs.

"I think a multidisciplinary discussion would take place around what sort of housing X would have benefited from: would it have been conducive to X's mental health to go to a B&B somewhere run by the homeless persons' unit, or would she have perhaps benefited more from supported accommodation or could she have been assisted in finding private accommodation."

Given that a care co-ordinator was not appointed until the end of March 2003 and the care co-ordinator did not regard it as part of her role to facilitate such a discussion, the absence of a focused multi-disciplinary discussion was hardly surprising.

16. The management and treatment of persons with personality disorders

Introduction

16.1 We asked at the outset of the inquiry: When X was a psychiatric inpatient, what would have been regarded as good and effective care and treatment for her, given her diagnosis of personality disorder? In this chapter much of the information about the management of patients with this diagnosis is based on two papers published in 2003. Many of the comments about X's care and treatment, sometimes critical, are based on the information and analysis in this chapter.

Diagnosis

16.2 Personality disorders emerge in the course of an individual's development as a result of both constitutional factors and social experience. They comprise deeply engrained and enduring behaviour patterns, manifesting in inflexible responses to a broad range of personal and social situations and represent significant deviations from the way the average person in a given culture perceives, thinks, feels and relates to others. They are frequently associated with subjective distress and problems in social functioning and performance.

16.3 Emotionally unstable personality disorder (borderline type) is defined as one in which there is a marked tendency to act impulsively without consideration of the consequences. There is also marked instability of mood or emotion. The individual's self-image, aims and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

- 16.4 Borderline personality disorder is more commonly diagnosed in women and is often (but not always) associated with a previous history of childhood emotional, physical or sexual abuse.

The National Institute for Mental Health in England (NIMHE) report

- 16.5 The guidance within the NIMHE report aimed to build on standards four and five in the national service framework and set out specific guidance on the development of services for people with personality disorder. It brought this often neglected and isolated area of mental health into focus for the first time.
- 16.6 Many, if not most, adult mental health services in England have become psychosis services, dealing with those who are suffering from severe and enduring mental illness. Personality disorders are common, and are also disabling conditions. Many of those who suffer distress as a result of their conditions, or who place a burden on others, are managed by primary care. Only those who suffer the most significant distress or difficulty are referred to secondary services, but provision is patchy even for this group. Some may be admitted to an acute inpatient unit at times of crisis, but many are unable to access secondary mental health services. People suffering from these conditions often describe themselves as *“the patients psychiatrists dislike”*. They are made to feel blamed for their condition, and are met with prejudice and an unhelpful approach from professional staff.
- 16.7 In 2002 a questionnaire was sent to all mental health trusts in England. Of those that replied, only 17% of trusts said they provided a dedicated personality disorder service, 40% provided some level of service and 28% provided no service. This last finding indicates there are trusts that do not see personality disorder as part of their core business. In fact, because many people with personality disorder are unable to access mental health services, the burden of care and support generally falls on social services, housing, voluntary agencies, as well as the probation and prison services.

- 16.8 The authors of the NIMHE report reviewed the available evidence on treatment and concluded that, in general, a combination of psychological treatments reinforced by drug therapy at critical times is the consensus view. They suggest that scepticism is unfounded and there is real cause for optimism that therapeutic interventions can work for people with personality disorder.
- 16.9 They state that the “*key principles*” for effective therapy are that it should:
- a. be well structured
 - b. devote effort to achieving adherence
 - c. have a clear focus
 - d. be theoretically coherent to both patient and therapist
 - e. be relatively long term
 - f. be well integrated with other services available to the patient
 - g. involve a clear treatment alliance between therapist and patient
- 16.10 Treatment will usually be delivered on an outpatient basis and the role of acute inpatient units will be largely confined to managing crises, including escalation in risk to self or others.
- 16.11 Psychological treatments shown to be effective include:
- a. Dynamic psychotherapy
 - b. Cognitive Analytical Therapy
 - c. Cognitive Therapy aka Cognitive Behaviour Therapy (CBT)
 - d. Dialectic Behaviour Therapy (DBT)
 - e. Therapeutic Community Treatments
- 16.12 Drug (medication) treatments shown to be effective include:
- a. Antipsychotics - These have shown variable results in controlled trials. Reduction in hostility and impulsivity are claimed but not always reliably achieved. The use of “atypical” antipsychotics may offer advantages but results are preliminary.

- b. Antidepressant drugs - Both tricyclic antidepressants and selective serotonin reuptake inhibitors have been recommended in the treatment of borderline personality disorder. Improvement in borderline patients may be linked to depressive symptoms rather than personality pathology. Impulsiveness is particularly improved and selective serotonin reuptake inhibitors may offer advantages in this respect.
- c. Mood stabilizers - Lithium, Carbamazepine and Sodium Valproate have all been used to treat symptoms of mood disorder in those with personality disorder. There is weak support for the notion that borderline and some other personality disorders may be helped by mood stabilisers.

Comment

The National Institute for Mental Health in England report was published in January 2003, just at the time X was admitted to Shelley Ward, so it is unlikely it would have had much, if any, direct impact on her care. However, most of the “key principles” listed above were well known by that time and clinicians involved in her care should have been aware of them. We therefore applied the key principles identified in the report to the care and management of X, both while she was at Shelley Ward and at the Bethlem Royal Hospital.

X’s admission to Shelley Ward was undoubtedly thought to be clinically indicated in order to manage a crisis, which included an escalation in the risk to her safety. However her care after admission was poorly structured, with little focus. This was not aided by the large number of medical staff involved in her inpatient care in Medway Maritime Hospital. Her treatment could not be said to have been “theoretically coherent” to either X or the treating team and there was no clear “treatment alliance” between X and the team. Her main long-term treatment was likely to have been provided by GT 1 or one of his colleagues in the psychology department, but at the time her discharge was being planned, GT 1 was warning that she was not ready to participate in psychotherapy and that, from his previous experience of her, she was not yet ready for discharge.

X's discharge was being planned when she had many unresolved problems in her life. These included:

- a. lack of accommodation*
- b. a possibility that she was going to lose her job with the police*
- c. she had not come to terms with her relationship breakdown with her boyfriend, her mother was suffering from breast cancer and was said to have an alcohol problem*
- d. her father had just been released from prison after serving a sentence for child sexual abuse and her parents were planning to move away*

Furthermore, a new consultant team had only taken over her care in the previous two weeks and were still making changes to her medication, none of which would have reached optimum therapeutic effectiveness by the time her discharge CPA meeting was scheduled to take place on 7 April 2003. There appeared to be no real integration of the various professionals she was likely to see in the community (CMHT and GT 1) with the inpatient team, which made her future care plan uncertain and vague.

X had told GT 1 in March 2003 that "things were different this time". She had complained of "feeling tired and not being able to get going", which was unlike her response to problems he had discussed with her in the past. GT 1 felt that she was demonstrating a "different way of thinking that was a little defeatist" and that "she had given up". He also felt that progress towards discharge should have been made in "an agreed, set out, stage managed way and that this could have happened over a couple of months". This contrasted with the inpatient team's plan to discharge X by mid April.

In these circumstances, while the treating team believed they were "keeping her safe", by providing her with inpatient care, the unstructured and uncoordinated nature of that care, the ongoing "threat" of discharge to an uncertain future and an uncertain community care plan were unlikely to have led to a reduction in X's impulsivity or a reduction in her thoughts, threats and/or acts of self-harm.

In comparison, both of X's admissions to the Bethlem Royal Hospital were better structured and had a clearer focus. This was undoubtedly linked to the fact that Cons 4 was the only consultant in charge of her care and had clear ideas of how someone with X's diagnosis should be managed. However, despite Cons 4's clarity of thinking, it is doubtful that X fully understood what the longer-term approach to her care would involve. We highlight concerns about the lack of clarity about her CPA status and her referral to the psychology department elsewhere (chapter 10, paragraph 10.3 and chapter 15, paragraphs 15.8 and 15.9). Thus, at the time of X's second discharge from hospital, the key principles of ensuring that the treatment approach was "theoretically coherent to both the patient and the therapist" and "a clear treatment alliance between the therapist and the patient" existed had not been achieved. However, there was a plan to refer X to the psychology department in the future and monitor her progress in outpatients at least in the short to medium term. If X had engaged in that process rather than seeking help from Medway Maritime Hospital, her longer-term treatment from SLaM might have fulfilled both these aims.

17. The response of West Kent NHS and Social Care Trust following the homicide

Introduction

17.1 This chapter considers two separate, but linked, areas. Part one deals with the trust's immediate response to the homicide. Part two deals with the conduct of the two post incident reviews into the homicide.

Part one - the response to the homicide

The account of Nurse 7, X's primary nurse

17.2 Nurse 7 recounted her recollection of events. On the afternoon of Saturday 5 April 2003, the police telephoned Shelley Ward to say a woman's body had been found. As X had been reported missing, the police thought it likely to be her body and asked if she had any tattoos, which Nurse 7 confirmed. The police requested that a member of staff come to identify the body. Nurse 4 was on duty and agreed to go. Nurse 7 agreed to accompany him and, in the event, police chose her for the formal identification, as she knew X better. The staff returned to the ward after identifying the body and giving statements to police.

17.3 The staff contacted the on-call manager, Man 4, who came in to the ward. Ward manager 1 was also telephoned, he rang back and the on-call manager requested that he too came in, which he did. Nurse 7 described a debriefing by the manager at this time and then having to tell the patients of X's death. At this point police said they thought X had committed suicide, but later that evening they returned to seize her property because "they realised it wasn't plain suicide".

17.4 Nurse 7 also said that later that evening she and her colleague, Nurse 9, had to tell X's parents she had been found dead. Police had apparently not told them and they came to the ward, having heard of the discovery of a body.

The staff were initially unaware that X's parents had not been told and had no option but to inform them.

The account of Man 4, the on call manager

- 17.5 During the week in question (from Monday 31 March 2003 to Sunday 7 April 2003), the on-call manager was Man 4, whose normal role was to manage the Older People's Services in Medway and Swale. In this 'on-call' capacity he covered the services for Dartford, Medway and Swale.
- 17.6 Man 4 described the on-call role as usually being managerial, rather than clinical. In terms of a sequence of events, as to who would contact, him, and at what stage of an incident, he said this varied, depending on individual circumstances, who was around etc. Usually, however, he would expect the bleep-holder (a senior nurse) to have been called first.
- 17.7 In the event, he said he was called by Nurse 4, both when Shelley Ward had been told, by police, of the discovery of a body and then once the identification of X had taken place. He came to the ward, ascertained the sequence of events, checked the notes and then spent time checking on the wellbeing of staff. After these initial stages, he said that he went through the Serious Untoward Incident process with the staff. He discussed with them what might occur, such as the trust management "*pulling the notes back*" from the ward and asking the staff to make statements. He described his role that afternoon/evening as "*a mixture of fact-finding, supporting the staff and gearing them up for the next steps*". He subsequently telephoned the director on call, Dir 1, and told him of his actions.
- 17.8 In terms of offering specific support/debriefing to the members of staff who had identified the body, he said he did not do a formal debriefing, but talked with both Nurse 7 and Nurse 4 to ensure that they were all right. He also indicated that he believed "*somebody from the night staff came in an hour earlier*".

- 17.9 Man 4 made it clear that he was unaware, at this stage, that X's death had been anything other than suicide. He became aware of the significance of the involvement of the other patient only when he was briefing the managers of the service, Man 1 and her manager, Man 2, on the following Monday 7 April 2003.
- 17.10 He said he was now more familiar with policies and procedures for handling serious incidents as they are "*much more tangible*". At the time, however, as on-call manager he was not issued with, for instance, a policy and procedure manual and felt that one acted more by general instinct or common sense, rather than by following a set procedure. Hence, he made his own notes, as an aide-memoire to pass on to the appropriate manager on the Monday morning, but he did not retain them.

The account of Ward manager 1

- 17.11 He recalled being telephoned, but was unsure of the time of day. He remembered coming to the ward and meeting a manager and the staff involved, but not their identities. He did, however, undertake a debriefing with staff:

"to let them air their feelings and frustrations ... whatever it was that wanted to come out."

The record made by Nurse 4 , the nurse in charge of the afternoon shift on 4 April 2003

- 17.12 Nurse 4 recorded in X's file that he had accompanied the police to the ward after Nurse 7's positive identification of X and they had conducted a brief search of X's bed space. He had given police information regarding her regular medication and copies of her recent nursing notes. He further recorded that the manager on call, the RMO and SHO on call, the team SHO and the ward manager had all been "*made aware*". The ward manager, senior manager and the SHOs attended the ward and the senior manager "*has contacted directorate level manager*".

The policy “*Communication in the Event of a Serious Untoward Incident*”

17.13 This policy was issued by the trust in February 2003. According to its front sheet, it had been approved by the Chief Executive, agreed by the Director of Social Care and issued by the Director of Performance and was apparently issued to all staff, but no specific date was stated as to when, or the manner in which this may have occurred.

17.14 The policy defines a serious untoward incident as an:

“event resulting in significant (physical or psychological) harm, suffered by a service user or a member of staff and/or significant adverse publicity for the Trust, its partners and the NHS in general. The Kent and Medway HA describes a serious untoward incident as ‘something out of the ordinary or unexpected, which is likely to be damaging to the NHS and attract media, ministerial or public attention’”.

17.15 In relation to “*responsibilities*”, the policy says:

“Directors are responsible for ensuring that all staff are aware of the reporting procedures described in this policy, including ‘out of hours’ arrangements and for implementing this policy.”

17.16 Out-of-hours Serious Untoward Incidents were to be reported to the line manager, who in turn was to contact the director on call. The director responsible for the service where the serious untoward incident took place:

E will inform the patient(s), the relatives of the patient(s) and the patient(s) GP. If relevant, he/she will inform the police”.

17.17 The policy requires the person to whom the Serious Untoward Incident is reported to make an immediate written record. Issues to cover include names and contact details of the person who reported the incident, dates and times

of the report and incident, including its location, circumstances and outcome.

17.18 The lead director was required to secure the patient's notes as well as all relevant files, with photocopies made to replace the originals to ensure that clinicians can provide continuity of care to patients if necessary.

17.19 In the event of a major incident, further amplification of the above procedures was provided. There was no further definition of what constituted a major incident.

Comment

The policy "Communication in the Event of a Serious Untoward Incident" had been formulated, and apparently issued, about two months before the incident. We did not know how far it had been circulated, and by what method, by this date. Certainly, witnesses seemed unaware of its existence and it may be unfair, therefore, to criticise potential non-compliance in the light of this. Nonetheless, we are surprised that more formalised procedures and expectations of the on-call manager were not in place before the new policy was issued, for instance in relation to writing a formal handover report to the responsible service managers and maintaining a communication 'log' to assist the next manager on call.

The on-call manager appeared to act promptly and appropriately in attending the ward and offering support and guidance to the staff, particularly those who had identified the body. Versions differed as to the acceptability of the response of the ward manager, but he seemed unclear as to what needed to be done after the incident, especially by the police. Some of this confusion may have arisen as staff still believed this to have been a suicide, rather than, as it later emerged, a murder.

We are surprised that the connection between X's death and the known pact with Y did not appear to have been identified and discussed at the time. This may have been due to the shock, and the fact that staff did not wish to believe that

the pact had been carried through. It may be that the risk to X was simply never acknowledged and understood.

We were concerned at the lack of communication which led to the parents of X being informed by two staff nurses of the death of their daughter some hours after she had been found. We do not know where the breakdown occurred, but would have thought, as staff did, that the police would already have told X's parents. This shock when the parents came to the ward further added to the stress on Nurse 7. Responsibility for telling relatives of a bereavement lay, according to the policy, with the director of the service. This does not appear to have been considered at the time.

The experience of each individual when they have to deal with a distressing incident is unique. Nurse 7 did not feel she had adequate support, either at the time of the incident or in its aftermath; no one raised this. In such circumstances there are various options to provide for staff support needs. It is good practice to enable affected staff to be fully debriefed in the company of each other, but this would necessarily involve bringing in more staff to cover the shift, to enable sufficient time to be allocated to the task. A staff member could, on occasions, be offered the option of going home, if they can be sure of receiving appropriate support there.

Part two - post-incident reviews

17.20 In 2003 Man 3 was clinical governance manager for the trust. Part of his responsibility was to investigate serious untoward incidents. He conducted two reviews:

1. Clinical and Practice Review of Care and Treatment of X (Enhanced CPA) Shelley Ward, Medway Hospital (6 June 2003) - the X review
2. Clinical and Practice Review Related to the incident involving Y and X Shelley Ward (19 June 2003) - the Y review

17.21 His methodology was his own development of the Root Cause Analysis approach using the CPA as a framework. He considered that the purpose of the reviews was twofold: to allow those involved in the incident to reflect on the experience and to allow the Mental Health directorate ‘to have a handle’ on the key issues that they needed to address. A number of staff involved in the care of both patients attended the reviews; Cons 2 attended both reviews.

17.22 Man 3’s recommendations arising from both reviews, his analysis of the response to the recommendations prepared at our request in December 2006, and our comments are listed at the end of this chapter

The X review

17.23 Under the heading “Inpatient Care Risk Management”, Man 3 identified a number of factors including the following:

- a. Identified risks and management of these risks were not routinely discussed at ward rounds.
- b. There was no formal handover between Cons 6 and Cons 2 when she took over X’s care in March 2003

17.24 He also noted that:

“Cons 2 expressed concerns that there was no care plan in place. Upon taking RMO responsibility Cons 2 stated that she had insisted on joint risk assessments [which presumably means they should have been jointly conducted by a doctor and a nurse] prior to decisions about leave periods.”

17.25 He then went on to list “Issues of Concern” which include the following (edited here):

- a. Inconsistencies in the management of the risk posed by X in particular where incidents of risk had not been followed by a review of her risk management plan.

- b. The failure by the Gillingham CMHC (sic) to connect with X (sic) at an early stage was also not helpful.
- c. Following her assessment in January 2003 the absence of a single care plan that staff could follow.
- d. Delay in the CMHT staff assessing X and appointing a care co-ordinator

The Y review

17.26 Under the heading 'Care and Treatment' Man 3 noted the absence of medical documentation relating to Y's treatment:

Cons 2 had attended the ward on 28.3.03 to review Y. However, the nursing staff advised her that Y was settling and requested that she postpone seeing him. Cons 2 went along with this. She stated that she was unhappy with the range and type of medication that had been prescribed by SHO 1 following his assessment but decided to wait until the ward round the following Monday to review the medication.

17.27 He listed 'issues' including the following (slightly edited here):

- a. It was felt that an acute inpatient service is not a suitable environment for patients with Y's history.
- b. There are no clear guidelines for SHOs to prescribe medication for people admitted with substance abuse history.
- c. There was disagreement about the referral pathway for assessments via the probation service.
- d. Admission to inpatient services was considered the only risk management plan.

Comment

Man 3 was expected to conduct a number of complex reviews on his own. Taking into account his personal circumstances, we can only commend him. He managed to complete two focused reviews within a short time and captured a number of

key points, with which the panel agrees. Given the resources available to this inquiry, it is not surprising it has identified a number of other issues.

Two particular issues remain that Man 3 should have identified. The first is the simple failure by the inpatient staff to have accessed information about X from both the Bethlem Royal Hospital and her GPs. The second is the more complex issue around whether the inpatient staff, as part of their risk management strategy for X, should have considered notifying the police about the “arrangement” between her and Y. Man 3 did not have available to him the statements that the key staff gave to the police and so the chronology of X’s disclosure was not clearly spelt out. We note neither Man 3 nor the other senior managers who presumably considered his review identified this as a concern.

Man 3 completed two action plans which are considered in chapter 20.

18. Psychiatric services in Medway from 2002 to the present day

Introduction

18.1 The significant period of this inquiry covers the period between 2002 and April 2003, although it includes some background history on both X and Y from their early childhoods. This report concentrates on the structure of the mental health services in this period. It describes the configuration of services, problems with the services and how they have changed. Analysis is based largely on the evidence from the following staff who occupied key posts in 2003 (annex 2):

- a. Nurse 4 - acting charge nurse on Shelley Ward
- b. Man 1 - inpatient service manager for the adult mental health wards at Medway Maritime Hospital, including Shelley Ward
- c. Dir 2 - director of nursing/human resources
- d. Man 2 - area service manager covering Medway and Swale (seconded from Kent County Council)
- e. Dir 3 - director of mental health (east)
- f. Dr Clin dir 1- clinical director
- g. CPA 1 - CPA co-ordinator

Commissioning of mental health services

18.2 The authority responsible for commissioning mental health services in the Medway area up until April 2002 was the West Kent Health Authority. From 1 April 2002, responsibility passed to the newly created Medway PCT and this body retains the role to date. At the same time the new Kent and Medway SHA came into being and this was the authority responsible for commissioning this inquiry. On 1 July 2006, this body merged with Surrey and Sussex SHA to form South East Coast SHA.

Provision of mental health services

18.3 The organisation responsible for providing mental health services in Medway from April 1998 was the Thames Gateway NHS Trust. Mental health social work staff continued to work for Medway Council, which became an independent authority from Kent County Council in April 1998. In April 2002 Thames Gateway and Invicta merged and became the West Kent NHS and Social Care Trust. Social services staff were seconded to the trust in September 2002, in order to better integrate the provision of health and social care. A further amalgamation took place in July 2006, when the Kent and Medway NHS and Social Care Partnership Trust was formed from the West Kent Trust, with Medway Council and the East Kent Trust and Kent County Council.

Hospital mental health care

18.4 The relevant inpatient service provided to both X and Y was based on the Medway Maritime Hospital site. This is a large general hospital, with an Accident and Emergency Department, managed by Medway NHS Trust. In 2002 there were three acute psychiatric wards in an area of the hospital known as “A Block” - namely Brooke, Shelley and Betjeman with 24, 24 and 19 beds respectively. Each ward related to a specific catchment area and the relevant ward for both Y and X, who lived in the Gillingham/Rainham area, was Shelley Ward. Betjeman Ward closed in 2003 because of staffing difficulties, reducing the available beds from 67 to 48.

Addiction services

18.5 An outpatient addictions centre was based at Manor Road in Chatham and remains there to date. Historically, six of the 24 beds on Shelley Ward had been allocated for providing inpatient detoxification facilities for people addicted to drugs and/or alcohol. As the detoxification beds are no longer available on Shelley Ward, the emphasis is on community-based detoxification, but if inpatient care is necessary this has to be sought outside

the trust, usually at Bridge House in Dartford. In relation to detoxification beds at this time, Man 2, said:

“Even though there weren’t any detox beds on Shelley Ward, there seemed to be this myth maintained that somehow there were. Even a year ago, there was still this view around some of the doctors that we had detox beds.”

Services to mentally disordered offenders

18.6 The main specialist inpatient facility for mentally disordered offenders is the Trevor Gibbens Unit in Maidstone. This medium-secure unit is a component of the Kent Forensic Psychiatry service provided by the West Kent NHS and Social Care Trust. In July 2002 a new service was introduced in Medway, with the appointment of a social worker for mentally disordered offenders, SW 1 , who was based with the Gillingham CMHT at Kingsley House. Part of her role was to provide an advice and assessment service to the local probation service in Chatham when probation staff had concerns about the mental health of a client. The social worker developed the role to provide a monthly ‘clinic’ where she saw clients by appointment along with a probation officer.

Shortcomings in the delivery of inpatient psychiatric services in 2002-2003

The inpatient environment

18.7 Nurse 4 described Shelley Ward as:

“a chaotic environment, as were all the wards in so much as it was a time when members of the public could walk on to the ward and ask to be seen by a doctor... There was almost a continuous pressure on beds....almost daily there were more patients on the ward than beds, and so there would be a continual need for nursing staff to identify patients to be sent on leave or identified for an earlier discharge.”

18.8 Man 2 described:

“high numbers of clinical incidents, there were frequent staff assaults. There was no control over who came in and went out; there was drug dealing going on....there was no way you could tell who was a visitor and who was a patient; there wasn't any medical leadership.”

18.9 Man 1 described the environment as reactive:

“in the sense that giving proactive care was quite difficult because you had 24 acutely unwell service users all milling around on the same ward”.

Staff problems

Generally

18.10 Clin dir 1 commented upon a *“chronic shortage of staff, both nursing as well as medical staff”*. Man 2 commented on low staffing ratios with high use of agency staff. Man 1 said the ratio of staff to patients was inadequate.

Medical staff

18.11 Clin dir 1 described problems in relation to consultant and other medical cover. There are three localities in Medway - Gillingham/Rainham, Rochester/Strood and Chatham. A total of seven consultants from Medway and two from Swale were admitting to the three wards. Three of the seven Medway consultants were locums and four were in substantive posts. There was one substantive consultant for Gillingham/Rainham, but she was apparently off sick at the time.

Supervision of medical staff

18.12 Clin dir 1 considered that the supervision of junior medical staff - one hour of one-to-one supervision a week - was not always adequate Man 1 also confirmed this .

Shortcomings in the delivery of community psychiatric services in 2002-2003

18.13 The period in question was one of transition for all aspects of mental health services. The integrated trust had been in existence since April 2002, but a year later movement towards fully integrated CMHTs, working from the same premises, was not complete. Man 2 identified that CMHTs at this time “*were pretty much in an embryonic stage*”. Outpatient services were largely still hospital-based, with medical staff initially still sited in the hospital.

Admission to inpatient service

18.14 This is discussed in chapter 5. Man 1 said:

“We didn’t have a robust intake system within the community and often the wards would be the first point of entry into secondary mental health. If a service user presented for emergency assessment or to A&E out of hours the assessment would be conducted by the junior doctor on call and a ward nurse.”

18.15 In early 2003 it was still the practice for patients with urgent mental health needs to go to the Accident and Emergency Department at Medway Maritime Hospital, to await assessment by the on-call mental health trust doctor and a nurse from one of the psychiatric wards. It did not appear that, even within normal office hours, people would attend the Gillingham CMHT for assessment, unless they were already actively involved with the service. A member of the CMHT based at Kingsley House could request that a new client be seen by one of the consultants based in the psychiatric department at Medway Maritime Hospital, without recourse to the Accident and Emergency Department route. But as Man 2 commented “*there wasn’t really a robust system in place*”.

Delivery of the CPA

- 18.16 This is analysed further in chapter 15 where we identify failure to follow CPA guidelines and a restricted view of the care co-ordinator role as two particular problem areas.

Lack of adequate community facilities

- 18.17 Clin dir 1 convincingly linked the decision to admit both Y and X as being partly due to the inexperience of the assessors and partly to the adequacy of community facilities, presumably meaning both accommodation and effective community treatment alternatives. He told us that the absence of community facilities led to a perception that patients such as Y and X needed to be given “a place”.

Relationship between inpatient and community staff

- 18.18 Man 2 described the situation in relation to CMHTs at the time of the incident:

“Gillingham...were still operating from the current site, Kingsley House and from A Block, which is where acute services are based. The main split was between CMHT and medical staff, so they were working very much in the traditional separated way, almost as if they were two services....there wasn’t really a sense of team at that point...There was very little workload management within the teams...”

- 18.19 Clin dir 1 confirmed this view.

“The relationship between the consultants based in A Block at the Medway Maritime Hospital) and the teams which were very thin on the ground was not robust, and there were problems in getting community staff to attend

ward rounds... and vice versa of getting the consultants to go and attend CPA reviews.”

18.20 He also said there was a single consultant with responsibility for the inpatients.

Comment

The purpose in linking together in descriptive form some of the problems facing the West Kent NHS and Social Care Trust in 2002-2003 is to identify some of the factors that contributed to the errors and shortfalls in the delivery of care to Y and X.

Developments in the delivery of mental health services from 2003 onwards

Inpatient services

The physical environment

18.21 During the second half of 2003, tighter control of beds was initiated with the introduction of a new policy in relation to admission and discharge. A new controlled door policy was introduced to reduce the likelihood of the public coming on to the wards without authority. There had apparently previously been a lax attitude to visitors, increasing the possibility for illicit substances to be brought onto the ward. Access to Shelley Ward is now restricted but the physical environment remains the same.

Inpatient staffing

18.22 One of the essential ingredients to combat the extreme staffing problems that existed in 2002-2003 was to develop a stable population of substantive consultants and a stable population of experienced nurses. Clin dir 1 was confident that *“it is a happier scene at the moment but there is still much more to be done”*. Man 1 also said a rolling programme of recruitment for nurses has been relatively successful.

Single inpatient consultant

18.23 From October 2005 an inpatient consultant was appointed for the Medway area which, according to Man 1, has had an *“unbelievable effect on the way the unit functions”*. For example, ward rounds have now been replaced by area-based reviews which will promote better co-ordination with the CMHTs.

Assessment/admission processes

18.24 In October 2004 a crisis service was introduced for the whole of Medway, known as the Medway Assessment and Short-term Treatment Team (MASST), which provided extended hours of opening and tighter control of admissions. In January 2006 further progress was made with the split of the MASST into a separate Crisis Resolution and Home Treatment Team (CRHT) and an intake/assessment team providing 24-hour cover. Consequently, inpatient beds have been reduced to 32 and should further reduce to 24 after rebuilding in 2007.

CMHT

18.25 Clin dir 1 described the Gillingham/Rainham teams as now much more “solid”. Man 2 identified significant improvements in terms of the relationships between the CMHTs and acute services and between the MASST team and acute services. CMHT manager 1 became manager of the CMHT on 5 January 2004.

CPA

18.26 CPA 1 considered that the ‘fault line’ identified in X’s case about her stay in hospital apparently being prolonged because of the delay in accessing appropriate accommodation has now shifted. She thought this was because of the greater pressure on beds and the related need to discharge people from hospital. She was generally optimistic that the CPA was now better embedded in professional practice than in 2003.

Resource statement

18.27 Man 2 told us that between 2002 and 2007 Medway PCT investment into services at Medway had remained at best neutral but overall there were indications that there had been disinvestment as newer teams vied for investment of their own. Throughout this period the trust has maintained a PCT-based approach to resourcing rather than the trust identifying where the budget should be distributed.

18.28 Man 2 added that he thought Medway PCT's record on investing in mental health services was poor, as shown by the fact that the PCT was undertaking a whole systems review of investment to help the PCT prepare local delivery plan bids for mental health.

Comment

Those who remain in senior managerial posts within the trust gave clear and convincing evidence that many of the problem areas that impeded the delivery of care to both X and Y have been, or are being, tackled. We identify these problem areas throughout this report and suggest in our recommendations that providing evidence of change would reassure the public.

19. Conclusions

- 19.1 We saw examples of good and effective care delivered to X. The psychological services provided a service that she valued and maintained contact with when it would have been easy to close her case. Her GPs treated her with care and followed up her various contacts with psychiatric services. We also found that Y's GPs had provided a good standard of care and communicated appropriately with other services. During the time she was treated at the Bethlem Royal Hospital, she received focused care and treatment and she was appropriately followed up in the community.
- 19.2 We consider that the errors made in this case can only be understood in context. In early 2003 X was being cared for and treated by an organisation that was experiencing significant problems, some of which are reviewed in chapter 18. To summarise, they included a chronic shortage of nursing and medical staff, a sometimes unsafe inpatient environment, poor linkage between inpatient and community services and a system for care and treatment (the CPA) that was not operating effectively.
- 19.3 The consultant psychiatrist is still regarded as responsible for the course of an inpatient's care from admission to discharge. X's care and treatment lacked direction and focus because of a number of factors, in particular a high turnover of consultant staff in the main locums.
- 19.4 On a day-to-day basis X received effective nursing care. In particular, we consider that Nurse 7 went out of her way to develop a positive relationship with her. There came a point when nursing staff perceived that the medical management of her case was unstructured and uncoordinated, and when that point was reached their challenge was ineffective. The reasons for this were various, including the relative inexperience in this post of the ward manager and a general shortage of experienced nursing staff on the ward.

- 19.5 In Shelley Ward there appeared to be an absence of structure in the inpatient team which allowed decisions about X's care (for example observation and leave) to be made without reference to the psychiatrist in charge of her care. The CMHT, as the providers of psychiatric care in the community, were barely linked at this time with the providers of inpatient care. Delays in providing X with a care co-ordinator were unacceptable and contributed directly to her stay as an inpatient being unnecessarily prolonged.
- 19.6 The formalised risk assessments we analysed were adequate, except for the risk assessment completed on 3 April 2003. This failed to highlight any risk to X's safety. The assessment was fundamentally inaccurate and did not take into account recent developments in X's circumstances. It relied on self-report. The individual assessors made errors, but the responsibility for ensuring that the risk assessment was reviewed must rest with the senior nursing and medical staff. Effective supervision of junior staff did not appear to be a feature of the working environment in 2003.
- 19.7 The failure to adequately manage the risk that X presented to herself at this time was linked with the failure in risk assessment in late March and early April 2003. By the end of March, the risk that X could present to herself appeared to be largely forgotten or at least minimised. Details of the "arrangement" that X made with Y were known by nursing and medical staff by 31 March 2003. We believe that if this information had been considered properly then effective measures to protect X could have been put in place. The failure to do this must in part rest both with Cons 2 (the doctor responsible for X's care at the time) and Ward manager 1.
- 19.8 The doctor in charge of X's care from her admission until mid-March, Cons 6, demonstrated a sound grasp of up-to-date clinical guidance in relation to the principles of treating a person with personality disorder; in particular, that inpatient admission should be used sparingly, and in order to manage a crisis. Management of the crisis that precipitated X's admission was, however, largely achieved as early as late January. We originally assumed that the delay in discharging X was largely attributable to her difficulty in being able

to find suitable accommodation. The evidence that we heard, particularly from X's sister, suggested an alternative view. This was that X would probably have chosen to find accommodation without the help of professionals and that X, despite her stated ambivalence about the inpatient regime, did not want to leave hospital. This was never discussed in a multi-disciplinary setting and might have led to a more consistently assertive approach to her discharge planning.

- 19.9 The significant delays in assessing X and appointing a care co-ordinator for her then contributed to her stay in hospital being prolonged. The failure to speed up this process is partly attributable to a vacuum in medical leadership, but was also related to systemic problems at the time in relation both to the role of the care co-ordinator and the inadequate links between inpatient and community services. There was no dispute about her assessed need. We can only attribute the failure to problems with the interface with the community teams at that time. There was a particular problem with the way the care co-ordination role was perceived in 2003 insofar as there was little expectation that the care co-ordinator would be pro-active while their patient remained in hospital.
- 19.10 Even if Y's admission to inpatient psychiatric care was justified, he should have been speedily assessed by an experienced psychiatrist on admission. The failure to conduct this assessment is inexcusable. The problem was compounded by the absence of admission criteria which took into account the risk to other patients and staff of admitting to the ward a person with Y's history.
- 19.11 We consider some individuals made errors. In accordance with recognised good practice for inquiries of this nature, drafts of relevant material were sent to these individuals for comment. The report was amended accordingly. All those criticised responded appropriately and gave helpful information to us. We are clear that any individual error is explicable only in the organisational context, and this report focuses on systemic weakness.

19.12 As with many inquiries of this nature, by the time the problems are identified the services responsible have moved on. We have considered whether the organisational shortcomings have now been remedied. The following points are particularly significant:

- a. The CPA appears more robust. A care co-ordinator would today be more speedily appointed and the responsibility of that person to engage earlier with an inpatient is now recognised.
- b. The high turnover of medical staff that was such a feature of X's care has now been reduced with the appointment of more substantive consultants.
- c. A safer inpatient environment with more controlled physical access to the ward.
- d. The intake team now reviews admissions more thoroughly and the CRHT helps to reduce admissions and facilitate earlier discharges. These teams would make it less likely that patients with either Y's or X's profile would have to be admitted to hospital and it is likely that a patient with X's difficulties would now be discharged to community-based care more quickly.
- e. Tighter admission criteria make it less likely that a person such as Y would be able to manipulate the system to gain access to an inpatient environment providing care and treatment to highly vulnerable women.
- f. The appointment of a single consultant for inpatient care should lead to greater consistency in inpatient care.

19.13 X's personality and diagnosis would always have made her a challenging patient. Her history of self-harm and suicide attempts make this clear. Even if she had been protected from Y, it was always likely she would have continued to present a significant risk of harm to herself. Her death, however, occurred while she was an inpatient in a NHS hospital. If the risks surrounding the arrangement she made with Y had been properly understood steps could have been taken to prevent her murder. The police should have been told about the arrangement with Y. Examination of the treatment and

care provided to her leads therefore to the conclusion that she was not adequately protected at a critical time when she was particularly vulnerable.

- 19.14 It was her vulnerability that allowed Y to exploit her mercilessly. This report ends by quoting from the comments of the judge when sentencing Y :

“X was a young woman of 23. She was a vulnerable victim. She had suffered suicidal tendencies for some ten years, due to severe depression. She was an in patient on a psychiatric ward when she died. She was a young woman who required protection from herself. You knew perfectly well how vulnerable she was. Instead of reporting to the hospital staff the wish she expressed to you that you should help her die by a heroin overdose, you cynically took advantage of her vulnerability.

You obtained the necessary fatal dose, and then you took her to a lonely, squalid clearing, where you injected her with the heroin, and then left her to die, intending that she should die. You did this because you saw the opportunity of getting your hands on X’s money, which you intended to use to fund your heroin addiction. It was only because X reported her card lost or stolen, that your plan to take the money in her account was thwarted.

I am very aware that no minimum term can restore X to her family and her friends. The ordeal of her parents and her brother and sister, who have sat in court listening to the harrowing details of X’s death, must have been quite dreadful. I salute them for the dignified way in which they conducted themselves throughout this trial.”

20. Recommendations

Action Plans

20.1 The starting point in making recommendations is to comment on the action plans developed following the two clinical practice reviews conducted in 2004 by Man 3. The numbering system here followed that used in the original action plans:

X action plan

LS1

20.2 Single care plans including risk management plans with contributions from all disciplines involved with the patients. Such care plans must be initiated by the admitting doctor and the nursing staff. This care plan needs to be reviewed at ward rounds. Up-to-date copies of the care plan including the risk management plan must be available in the nursing notes and medical notes of each patient. When other disciplines become involved with a patient a copy of the care plan and risk management plan must also be provided to them. As in recommendations from previous reviews, these care plans must be located in the front of each patient's file for easier access to all staff.

20.3 We agree with the importance of this recommendation and identify the following areas for further discussion:

- a. 'Initiation' is not a helpful word in this context. The lack of clarity concerning the responsibility of the professional for creating the plan needs to be addressed.
- b. Agreed timescales for review of the plans are needed.
- c. Audit procedures should be in place to determine
 - i. Compliance with the above requirements
 - ii. Quality of care plans

iii. Accessibility of these plans within the patients' notes

LS2 Administration support

20.4 This was not raised as a particular issue in this investigation and we understand that the provision of administrative support to assist professionals in processing CPA documentation has been achieved.

LS3 Interface between wards and CMHT to ensure a “*seamless service*”

20.5 We were told that interface issues are now addressed by

- a. Monthly CPA interface meetings
- b. Care co-ordinators being invited to service users' initial and discharge CPA meetings
- c. Communication protocols between CMHTs and inpatient units

20.6 We consider that the need for a care co-ordinator to attend must be strengthened. We recommend that care co-ordinators are required to attend all CPA meetings. In the absence of the care co-ordinator, a CMHT representative should attend all CPAs, or exceptionally the care co-ordinator should submit a written report. In circumstances where this is not possible the CMHT manager should be notified, and reasons recorded.

20.7 We have not seen the joint working protocol between the inpatient unit and the CMHTs regarding communication and contact. We hope the document stresses the importance of alternative forms of communication which should not solely be based on ward rounds or CPA meetings. The care co-ordinator can always telephone the ward, or junior doctor, and leave a message, which should then be recorded in the patient's notes. The ward staff also have the care co-ordinator's contact number. When the care co-ordinator sees the

patient on the ward, they must record this on the patient's notes, with details of any actions/decisions taken.

Y action plan

WA1

20.8 There needs to be a protocol for the treatment and management of patients with substance misuse history in acute settings.

20.9 We have not seen such a policy and recommend that it should be developed.

WA2

20.10 An experienced member of the medical staff must review patients with a history of substance misuse admitted to inpatient settings within 24 hours or the following working day if admission occurs during weekends.

20.11 We were told that this recommendation had been implemented; that all newly admitted patients are reviewed by the inpatient consultant within 24 hours, Monday-Friday. This still means that a patient admitted on Friday evening may not be seen until Monday morning.

WA3

20.12 On admission there must be an initial management plan including a risk management plan etc. This links with LS1 above.

WA4

20.13 An explicit referral pathway for external agencies needs to be agreed. We were told about the pathway *i.e.* that the Intake Team is the first point of contact for secondary mental health services on a 24 hours/7 days a week basis. We recommend that information about the pathway is circulated to all referring agencies and that evidence is sought that they are aware of it.

WA5

20.14 The admission policy needs to make explicit that patients newly admitted to inpatient services are not allowed out without escort for 72 hours after admission. Explicit information about this policy should be made available to patients in verbally and in writing.

20.15 We have been referred to a draft admission policy apparently not yet agreed. There need to be enough staff to implement such a policy.

WA6

20.16 All patients admitted on an emergency basis must be reviewed within 24 hours of admission by an experienced medical staff. This links with Y 2 above

20.17 After considering all available evidence we agreed the following recommendations:

RECOMMENDATIONS	
Serious Untoward Incident Policy	In the event of staff being involved in a SUI, such as a homicide or suicide, we recommend the trust consider amending the policy to allow for additional staff to be called in to cover a shift/shifts to enable affected staff to be fully debriefed and, if necessary, be allowed to return home, if there is sufficient support available at home.
Transfer of patients between consultants	As a minimum, there should be a discussion between consultants, which should be recorded in the notes. A transfer summary should be produced.

<p>CPA policy</p>	<p>The statement that ‘discharge planning begins immediately’, in the 2006 draft policy, be amplified and given proper prominence.</p> <p>The tasks of the care co-ordinator, for an inpatient, be identified and described in section 3 of the same policy in the care co-ordination section. The need for early involvement with a client should be stressed, as well as the responsibility to prepare and develop a care plan.</p>
<p>Admission Policy</p>	<p>We are particularly concerned about the circumstances of Y’s admission and the failure to promptly review his treatment plan. To address this, we recommend criteria to deal with the admission of patients who pose a risk to staff and other patients should be developed. Discussion is needed within the trust to ensure that any admission criteria compliment existing criteria in all inpatient units (including psychiatric intensive care units) and also takes account of the impact this may have on community services.</p> <p>We recommend that protocols for managing patients admitted to psychiatric units, with both mental disorder and a significant substance misuse problem are developed.</p>
<p>Women-only provision</p>	<p>We identify the configuration of inpatient wards to facilitate provision of social, day, sleeping and bathing areas for women only, as relevant to the inquiry and recommends that the trust provide an update on progress according to current guidance.</p>
<p>Links with police</p>	<p>The arrangement between Y and X was never regarded as a criminal activity worthy of reporting. This suggests a need for developing a formal channel for communication and training between the police and mental health services. We are not aware</p>

	<p>of formal liaison arrangements between local police and mental health services apart from in the context of the MAPPAs and the operation of section 136 MHA. We recommend that the trust considers developing further links with the police which could allow a named police officer to develop an understanding of relevant mental health service issues and be available to discuss potential problems, at short notice, with senior health service staff.</p>
<p>Audits</p>	<p>The trust should provide evidence from existing sources that the changes in service identified in this report have resulted in improved patient care. For instance:</p> <ul style="list-style-type: none"> a. The completion and sending of handwritten discharge plans to GPs on the day of a patient's discharge, plus confirmation of receipt by the GP. b. The completion and sending of type-written discharge summaries to GPs within an agreed period of a patient's discharge (perhaps two-three weeks) plus confirmation of receipt by the GP. c. Adherence to CPA policy, e.g. timing of first CPA, timing of appointment of the care co-ordinator and timing of first meeting with the care co-ordinator. d. Risk assessment and risk management plans, e.g. timing of the first assessment and plan, which professionals are involved, which risk factors are taken into account and who supervised/approved the assessment and plan. e. Adherence to admission criteria <i>i.e.</i> review cross section of inpatients to discover whether admission criteria and policy are being followed (e.g. are the CRHT always involved). <p>Evaluation of the time limits on the allocation of a named</p>

	nurse/primary nurse upon admission (This arises from the lack of clarity surrounding the allocation of named nurse for Y.)
Psychology	If the waiting time to first appointment is more than three months we recommend that confirmation of address with referrer is undertaken prior to any appointment letter being sent.
Inpatient management skills	We recommend that basic skills including obtaining records from other inpatient units and primary health care are reinforced to all clinical staff.
Training	<p>The inquiry findings raise a number of areas where the need for training is indicated:</p> <ul style="list-style-type: none"> a. Fundamental issues around risk assessment and management, and b. The role of the care co-ordinator for patients in hospital. <p>Rather than making specific recommendations in this area, we recommend that the trust identify the mandatory training available to all levels of staff so as to review the adequacy of the training and whether it covers the problem areas identified in this inquiry.</p>

ANNEX

Annex 1 Terms of reference

SOUTH EAST COAST STRATEGIC HEALTH AUTHORITY

Independent inquiry into the care and treatment of Y and X in West Kent NHS and Social Care Trust (WKNSCT)

Commissioner:

This inquiry is commissioned by Kent and Medway Strategic Health Authority in accordance with Department of Health circular HSG 94/27 *“The Discharge of Mental Disordered Offenders and their Continuing Care in the Community”* and amendments.

Terms of Reference:

Fact Finding

1. To report on the treatment and care provided to Y and X by West Kent NHS and Social Care Trust particularly in the 12 months preceding X’s murder by Y.

Evaluation

2. To assess the suitability and appropriateness of the services provided in the light of the patients’ assessed health and social needs and previous histories.
3. To review specifically any assessments made of the likelihood of Y harming X and of X being harmed by Y.
4. To examine the extent to which those services and any decisions made corresponded with statutory obligations, relevant national guidance and local operational policies.
5. To assess the adequacy of the arrangements in place within the health and social care systems for the sharing of information about, and the provision of services to, drug users.

Recommendations

6. To comment upon the progress that West Kent NHS and Social Care Trust has made in implementing any recommendations arising from their internal inquiries. This should include seeking evidence of demonstrable change and improvement to services.
7. To make recommendations to the responsible bodies, via the Strategic Health Authority, so that as far as possible a similar event is avoided in the future.

Approach

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

It will follow established good practice in the conduct of interviews; for example, offering the opportunity for interviewees to be accompanied and given the opportunity to comment on the factual accuracy of notes.

The panel will have the support of Kent Police in conducting their work, in accordance with the Memorandum of Understanding.

Timetable

The precise timetable will be dependent on a number of factors, including the panel's own assessment of the need for information and the number of interviews necessary. The panel is asked to aim to have completed the Inquiry, or a substantial part of it, within nine months of starting its work. Monthly reports on progress should be provided to the Strategic Health Authority.

Publication

The outcome of the Inquiry will be made public. The nature and form of publication will be determined by Kent and Medway Strategic Health Authority. The decision on publication will take into account the views of the chair of the review panel, relatives and other interested parties.

Annex 2 Schedule of witnesses

Family members

A	Sister to X
C	Brother-in-law to X
E	Father to X

Kent and Medway NHS and Social Care Partnership Trust

Clin dir 1	Clinical director
Dir 2	Director of nursing and human resources
Dir 3	Director of mental health (east)
Man 2	Area service manager (Medway)
Man 1	Adult wards inpatient services manager / modern matron
Man 4	Manager older peoples services: Medway and Swale
Man 3	Clinical governance manager
Cons 6	Formerly locum consultant psychiatrist
Cons 2	Formerly locum consultant psychiatrist
SHO 4	Formerly Senior house officer
SHO 1	Formerly Senior house officer
Psychologist 1	Consultant clinical psychologist
GT 1	Gestalt therapist
CPA 1	Formerly care programme approach lead
Ward manager 1	Formerly manager Shelley Ward
Nurse 4	Formerly acting charge nurse Shelley Ward (F grade)
Nurse 2	Formerly acting charge nurse Shelley Ward (F grade)
Nurse 8	Formerly staff nurse Shelley Ward
Nurse 7	Formerly staff nurse Shelley Ward (primary nurse to X)
Nurse 10	Nursing assistant/accommodation advisor, Shelley and Brooke wards
Nurse 1	Formerly staff nurse Shelley Ward
Nurse 3	Formerly staff nurse Shelley Ward

Nurse 9 Formerly staff nurse Shelley Ward (associate nurse to X)

Nurse 12 Formerly staff nurse Shelley Ward

CPN 3 CPN: Gillingham and Rainham CMHT

CPN 2 CPN: Gillingham and Rainham CMHT

Kent Police

Pol 1 Investigating officer

National Probation Service (Kent)

Prob 1 Probation officer / practice teacher

Prob 2 Probation officer

CSO 1 Community service officer

Medway Council

SW 1 Social worker

South London and Maudsley NHS Foundation Trust

Cons 4 Consultant psychiatrist

SW 3 Social worker / Team manager Westways resource centre

Ward Manager 2 Ward manager Gresham 1 Ward

Nurse 6 Primary nurse Gresham 2 Ward

Keston House Medical Practice (Purley)

GP 5 General practitioner

GP 3 General practitioner

Annex 3 Documents considered by inquiry team

1. West Kent NHS and Social Care Trust
Trust Headquarters
35 Kings Hill Avenue
Kings Hill
West Malling
Kent ME19 4AX

Kent and Medway NHS and Social Care Partnership Trust psychiatric records (File K)

Shelley Ward duty rota (File P)

Trust internal clinical and practice review (File F)

Action plan to meet the recommendations of the clinical and practice review

Progress update on recommendations and action plans resulting from the Y and X clinical and practice reviews (File F)

2. Medway PCT
7-8 Ambley Green
Bailey Drive
Gillingham Business Park
Gillingham
Kent ME8 0NJ

Primary care records (File G)

3. National Probation Service (Kent)
27-35 New Road
Chatham
Kent ME4 4QQ

Probation records (File A)

Letter dated 28/11/06 from Probation Officer Prob 1 detailing Combination Order to which Y was subject

4. Crown Prosecution Service
Priory Gate
29 Union Street
Maidstone
Kent ME14 1PT

Prosecution evidence (File C)

Victim impact statements (File C)

5. Reports submitted by independent experts

Report prepared by Christopher J Wheeler (previously Chief Probation Officer, Wiltshire Probation Service): Y contact with Kent probation service

Report prepared by Angus Cameron (London probation area mental health advisor): Y contact with Kent probation service

6. West Kent NHS and Social Care Trust
Trust Headquarters
35 Kings Hill Avenue
Kings Hill
West Malling
Kent ME19 4AX

*Child and adolescent mental health service psychiatric records (File E)
Adult psychiatric records (1999-2002 File J) / (2003 File H)
Psychology records completed by GT 1 (File T) and Psychologist 1 (File U)
Shelley Ward duty rota (File P)
Trust internal clinical and practice review (File F)
Action plan to meet the recommendations of the clinical and practice review
Progress update on recommendations and action plans resulting from the Y and X clinical and practice reviews (File F)*

7. Medway PCT
7-8 Ambley Green
Bailey Drive
Gillingham Business Park
Gillingham
Kent ME8 0NJ

Primary care records (1979-2000 File E) / (2000-2002 File G)

8. Medway NHS Trust
Medway Maritime Hospital
Windmill Road
Gillingham
Kent ME7 5NY

Acute NHS Trust records (File C)

9. Croydon PCT
Leon House
233 High Street
Croydon CR0 9XT

Primary care records

10. South London and Maudsley NHS Foundation Trust
Bethlem Royal Hospital Monks Orchard Road
Beckenham
Kent BR3 3BX

Psychiatric records (File N)

11. Worthing and Southlands NHS Trust
Worthing Hospital
Lyndhurst Road
Worthing
West Sussex BN11 2DH

Accident and Emergency Department attendance record

12. E (stepfather of X)

Letters to panel dated 11 March 2007, 22 March 2007 and 11 April 2007

Policies and Procedures

13. West Kent NHS and Social Care Trust
Trust Headquarters
35 Kings Hill Avenue
Kings Hill
West Malling
Kent ME19 4AX

Issued by West Kent NHS and Social Care Trust unless otherwise stated (**File R / S**)

Learning and sharing the lessons learned from the inquiry of serious untoward incidents (01/04/02 policy ref. CORP.GOV.20.02)

Kent Wide Care Programme Approach Policy and Guidance Notes (September 2002)

Procedural arrangements for joint assessment for admission to mental health admission beds (Invicta Community Care NHS Trust: 27.11.02 policy ref. CLIN.002.002)

Communication in the event of a serious untoward incident (CORP.GOV.06.02 February 2003)

Undertaking a management review following an SUI (CLIN.GOV&SOC.CARE.96.01 October 2005)

Being open- supporting patients and families when things go wrong (CLIN.GOV&SOC.CARE.95.01 February 2006)

How to investigate incidents, SUI's claims and serious complaints (CORP.GOV.20.01 01/04/02)

Stress management policy (25/07/05 policy ref. HR.56.01)
Medway and Swale operational policy (May 2006)
Medway assessment and short-term team (MASTT) INTAKE operational policy (June 2006)
Kent and Medway Care Programme Approach policy and procedure (updated September 2006)
Request by the police for the disclosure of confidential information to assist in the inquiry of serious crime
Draft admissions criteria
Staff and service users code of conduct on admission wards

14. South London and Maudsley NHS Foundation Trust
Bethlem royal Hospital Monks Orchard road
Beckenham
Kent BR3 3BX

Care Programme Approach Policy (April 2000)

Miscellaneous

1. Kent Police
Police Headquarters
Sutton Road
Maidstone Kent
ME15 9BZ

Letter (dated 6 December 2006) from Pol 2

2. Mental Health Act Commission
Maid Marian House
56, Hounds Gate
Nottingham
NG1 6BG

Report of Mental Health Act Commission visit to Medway Maritime Hospital (23 July 2002)

3. Medway Council,
Civic Centre,
Strood,
Rochester,
Kent ME2 4AU

Job description Medway Council Social Worker

4. Marten Walsh Cherer
27-29 Cursitor Street
London EC4 1CT

Transcript of sentencing judges comments: Regina v E Transcript of sentencing judges comments: Regina v Y

5. Written comments submitted at interview by witness SW 1 in response to the internal trust clinical and practice review (Y)
6. Written submission (dated 26 February 2007) from Liaison 1 giving an outline of Medway Maritime Hospital Accident and Emergency Department Psychiatric Liaison service
7. Thames Gateway NHS Trust staff transfer/change form: Nurse 10

Annex 4 Excerpt from discussion with Pol 1 (2 October 2006)

Mr Harbour

- Q.** The other question I asked is in a sense a hypothetical question but I hope you can assist us. What might have happened if the police had been given the information about the suicide pact on 1 April?
- A.** The suicide pact concerned the supply of controlled drugs to X, and from what had already been told to the nursing staff I believe an offence of offering to supply controlled drugs under the Misuse of Drugs Act would already have been made out. Therefore if it had come to the police attention he would have been arrested for offering to supply controlled drugs, given that X was willing to then give the evidence to the police once it transpired. Certainly the suspicions would already have been there for that offence.
- Q.** Obviously he was a man well known to the police and his name could have been given to the police on 1 April.
- A.** Yes. He would have been well known to us and, given his previous convictions and the intelligence that was held on him, it would have been treated quite seriously and not dismissed, because from their own intelligence the police would have known he is perfectly capable of supplying drugs and known that he was a drug user himself.
- Q.** In terms of the procedure that would have been followed if the information given to the police had come direct from health staff - it would have come from the health manager - what would have been the first step? Would the police then have interviewed X?
- A.** I would have thought the first step would have been to confirm it with X, may be obtain a statement from her if it was considered she was in a fit state to make a statement.
- Q.** If she had refused to give a statement to the police but the information given by health staff was very clear, what -
- A.** It would still give somebody sufficient enough to arrest him for the offence of offering to supply. Whether that could then have been proceeded with, given X wasn't then making a statement, but if anything it would have been a warning shot across his bows.
- Q.** In other words it would not have precluded an arrest even if she had said she didn't want to make a statement.
- A.** No. Section 4 of the Misuse of Drugs Act is an arrestable offence. As long as an officer has reasonable suspicion that that offence has occurred, from my own experience over the years, given the grounds that I'd heard that she'd made the admissions to professional people, there would have been enough suspicion to arrest him.

Dr Amor

- Q.** With regard to (the pact) if the nurses had told the police about this pact or the discussion between Y and X, I understand what you're saying about the

supply of controlled drugs - or I think I do - but presumably that is just any supply, it's not linked with any intention to kill her.

A. I understand where you are going. Yes, that is an offer to supply controlled drugs. What would heighten the awareness and the seriousness of the offering to supply is that that is combined with the offer to then inject it and kill her.

Q. I suppose I am looking at it in a rather cynical way, that there must have been a lot of people in Medway towns and elsewhere who were offering to supply drugs, then and now.

A. Yes. There would have been a lot of supply of controlled drugs in that area and information coming in about people supplying controlled drugs, but in the circumstances we were given, it's a one-on-one offence that's been made out, and within the circumstances of that the offer to inject to kill her in respect of that. The offence is made out and therefore I think the police would have acted on it because of the circumstances.

Q. Do you think that's realistic?

A. I think it is realistic, given the circumstances and the police's previous knowledge of the individual knowing that he is perfectly capable of getting hold of heroin and other controlled drugs.

Ms Bolter: Can I ask something on that same subject? When you say given the circumstances, do you mean the willingness to inject her? Is that the circumstance you are referring to?

A. The offence is obviously made out as soon as you offer to supply a controlled drug, but I think what Tim was talking about was there must be lots of that going on within the policing area and are the police acting on all of that that might come in intelligence. What I am saying is that in these circumstances - and I was asked to comment in these circumstances - I think the police would have put that on a much higher priority level because the offer had been made in order to then go on and injure her, and had been made by somebody who was perfectly capable of getting hold of those drugs and would have the wherewithal to inject it and the wherewithal to obtain the supply.

Q. So if he had been arrested what would have been the likely course of action thereafter, *i.e.* how could it have been prevented realistically?

A. Kent Police area is within statutory charging for the CPS now, so any authority to charge comes from the CPS. Our normal course is to arrest, interview, obtain the evidence - in this case from the staff and X- and then put the matter to the CPS. It would have been up to them whether they felt it met the charging standard.

Q. How long would that process take?

A. It can be done within the period he's in custody, or sometimes it's done on an extended bail back to the police station when the file is put into the CPS. As I said before, it may well have been a shot across his bows regarding the fact that everyone knew what was going to happen.

Annex 5 A chronology of X's healthcare

- 14/2/95** X presented to the Accident and Emergency Department at Medway Maritime Hospital having taken an overdose of paracetamol. She was referred to Child and Family Therapy Team, Canada House Gillingham. Gillian Gott, CPN, saw X on 15 February 1995, 21 February 1995, 2 March 1995 and 13 March 1995. Her parents were seen on 17 February 1995. It is unclear what happened after March, but X was discharged for non-attendance on 24 August 1995.
- 7/3/96** X was referred to the Accident and Emergency Department by her GP after having taken an overdose of forty-seven Codydramol tablets. She was admitted to hospital, treated with Parvolex and assessed by a General practice nurse and a Senior practitioner. They referred her to the social services Child and Family Team for help with finances and accommodation, but the outcome is unclear. She was discharged on 12 March 1996.
- 24/4/96** She was discharged after not attending appointments.
- 4/12/98** X's GP prescribed Efexor (venlafaxine, an antidepressant) 75mg per day for depression.
- 15/2/99** X was referred by a locum GP to Cons 3 at Medway Maritime Hospital after complaining she was still depressed.
- 05/3/99** Her GP started Lustral (sertraline) 50mg per day (an antidepressant) instead of venlafaxine.
- 17/3/99** X was seen in outpatients by SHO 2, SHO to Cons 3. She revealed sexual abuse for the first time and was advised to continue Lustral.
- 24/3/99** GP increased Lustral to 100mg per day.
- 3/4/99** X was assessed in the Accident and Emergency Department after taking an overdose of 80 Lustral tabs, plus oral contraceptives. An

outpatient appointment was made and her antidepressant treatment changed to paroxetine (Seroxat) 20mg per day.

- 8/4/99** X was referred by SHO 2 to Psychologist 1 clinical psychologist.
- 12/4/99** X was seen by SG 5, staff grade to Cons 3. She refused an offer of admission and was referred to the Christina Rossetti Day Hospital five days per week.
- 28/4/99** She was discharged from Day Hospital as she had not attended. A letter confirming this was sent to the GP by DH2.
- 30/4/99** X's GP prescribed paroxetine 20mg after a telephone call from Cons 3's secretary.
- 25/5/99** X self referred to the Accident and Emergency Department stating that she was feeling low. She was re-referred to Day Hospital and "*restarted*" on paroxetine.
- 27/5/99** Did not attend review at Day Hospital.
- 29/6/99** She was discharged from Day Hospital due to non-attendance (DH3 acting Head Occupational Therapist).
- 5/7/99** X was seen in the outpatient clinic by Cons 3. Paroxetine was changed to Zispin (mirtazepine) 30mg per day because X complained of migrainous headaches.
- 8/7/99** X attended her first session with Psychologist 1.
- 22/7/99** X complained to her GP of 'problems' with Zispin and was changed back to paroxetine 20mg per day. There is no indication that the GP communicated this to Cons 3 but there is an undated entry suggesting that Psychologist 1 was aware of this and may have told Cons 3.
- 3/9/99** Her GP recorded starting monthly scripts for paroxetine 20mg per day.

- 13/9/99** X attended an outpatient clinic to see Cons 3. He continued paroxetine and planned to see X again in three months. She was also referred back to Day Hospital.
- 11/10/99** Her GP increased paroxetine to 30mg per day at X's request (with no suggestion that Cons 3 was informed or that he recommended this). X told him that she was still attending the Day Hospital, but this was not so. She was awaiting an appointment there on 27 October 1999.
- At some point after this date X presented to the Accident and Emergency Department, but it is unclear why. She reported she was taking her medication (paroxetine 30mg) irregularly and was referred back to Cons 1's outpatient clinic and prescribed paroxetine 20mg per day.
- 27/10/99** Assessment at Day Hospital. A plan was made to see X over the following three-four months.
- 4/11/99** X was due to be seen in Day Hospital monitoring clinic but did not attend.
- 5/11/99** She was reviewed in Day Hospital having been re-referred by Psychologist 1 to cover the period between November 1999 and January 2000. She was due to see DH1 for 1:1 sessions of supportive psychotherapy.
- 10/12/99** X had not attended Day Hospital since 1 December 1999. She was back at work (recruitment) and had difficulty attending.
- 13/12/99** Outpatient appointment with Cons 3. There is no record of her attending.
- 10/1/00** X saw her GP and told him she had stopped paroxetine three weeks before but was still attending the Day Hospital (which was not true). She was re-prescribed paroxetine 30mg per day (Cons 3 seems to have thought she was receiving 20mg per day at this time).

13/1/00 X was recorded to be not attending her Day Hospital appointments. On the same day she presented to Accident and Emergency Department wanting admission, but was instead referred to Cons 1's outpatient clinic and asked to continue paroxetine 20mg per day.

20/1/00 A letter was sent to Cons 3 from DH3 confirming X's discharge from Day Hospital.

21/1/00 X took an overdose of paroxetine and presented to Accident and Emergency Department. Cons 1 was informed and X was given an outpatient appointment for 23 February 2000.

3/2/00 Psychologist 1 met with X for their final session.

10/2/00 A letter was sent to Cons 3 from Psychologist 1 confirming that she was ending her sessions with X.

21/2/00 X took an overdose and was seen in the Accident and Emergency Department, but no details are available.

23/2/00 Did not attend outpatient appointment with Cons 1.

1/3/00 A letter was sent from Cons 1 to her GP (GP2) stating that she would not be offered further outpatient appointments but that she would be re-referred to Psychologist 1.

07/3/00 A letter was sent from Psychologist 1 to X, declining to see her again, but re-referring her to Day Hospital.

16/3/00 Psychologist 1 re-referred X to Day Hospital. X was reviewed by SG 5, who planned 1:1 sessions at Day Hospital with a nurse and to review in six weeks.

27/4/00 Reviewed by SG 5. X had attended three sessions with DH1. A plan was made to continue and to review in four weeks.

- 30/5/00** X took an overdose of paracetamol and diclofenac (an anti-inflammatory). She was admitted until 2 June 2000 and treated with Parvolex.
- 2/6/00** She was seen as an emergency following overdose as above. The assessment was discussed with Cons 1. A plan was made to discharge X to Day Hospital and continue paroxetine 20mg per day.
- 5/6/00** X saw her GP, attending with her sister who expressed her concern about X. She was prescribed paroxetine 20mg per day.
- 10/6/00** She was seen by SHO 8, SHO on call at Medway Maritime Hospital, and 'demanded admission' but this was refused. The SHO informed Cons 1. X said she had been re-started on paroxetine 30mg per day two weeks previously (this appears to be untrue).
- 12/6/00** Cons 1 made an outpatient appointment for X on 26 June 2000.
- 13/6/00** X was seen in the Accident and Emergency Department with "*suicidal intent*". No other details are available.
- 15/6/00** X's case was reviewed in Day Hospital (in her absence). It was planned to continue the same treatment and review in four weeks.
- 26/6/00** Arrived late for an outpatient appointment with Cons 1, but was given another for 30 June 2000.
- 30/6/00** Outpatient with Cons 1. Day Hospital attendance was stopped and venlafaxine 37.5mg started. X was advised to contact "*family matters*" and to think about living away from her parents.
- 13/7/00** X was discharged from Day Hospital.
- 14/7/00** She saw her GP and was prescribed venlafaxine 37.5mg per day.

- 28/7/00** X made telephone contact with Cons 1 who then wrote to her asking her to increase the venlafaxine to 75mg per day until her outpatient appointment in August.
- 9/8/00** Outpatient with Cons 1. X told him she had stopped the venlafaxine after three days as she had developed “spots”. He prescribed Cipramil (citalopram), another antidepressant, 20mg per day for a week then increased to 40mg per day. A letter was sent to her GP confirming this change.
- 5/9/00** X had telephone contact with Cons 1, who advised her to increase the Cipramil to 60mg per day. A letter was sent to her GP confirming this change.
- 15/9/00** She saw her GP and was prescribed Cipramil 60mg per day.
- 20/9/00** Outpatient with Cons 1. X told him that Cipramil was working and she was taking it regularly. He planned to pursue a referral to the psychology department and a referral back to Day Hospital was kept pending until a response had been received from psychology.
- 25/9/00** Cons 1 referred X to the psychology department at St Bart’s Hospital (New Road Rochester ME1 1DS).
- 5/10/00** Her GP prescribed both venlafaxine 37.5mg and Cipramil 60mg per day (this must have been an error by the GP).
- 8/11/00** X did not attend an outpatient appointment with Cons 11, locum consultant psychiatrist.
- 16/11/00** Her GP re-prescribed Cipramil 60mg per day.
- 21/11/00** X was seen in the Accident and Emergency Department with “*a tension headache*”. No other details are available.
- 21/12/00** She was seen by GT 1 for the first time.

1/2/01 X did not attend an outpatient appointment with Cons 1.

14/2/01 She did not attend an outpatient appointment with Cons 11.

19/2/01 A letter from Cons 11 was sent to her GP (GP2) offering one further appointment.

28/4/01 X was seen in the Accident and Emergency Department complaining of depression and advised to continue to see GT 1, stop using cocaine and to see locum consultant psychiatrist Cons 12 as an outpatient. Citalopram 60mg per day and zopiclone 7.5mg at night (night sedative) was prescribed.

16/5/01 She did not attend an outpatient appointment with Cons 12.

1/6/01 X registered with a new GP in Kennington Lane, London SE11.

16/8/01 She was prescribed citalopram 60mg per day by her GP.

5/12/01 She was late for an outpatient appointment with staff grade to Cons 12. She had stopped citalopram six weeks previously. SG 4 recommended that she started again at 20mg per day for one week then 40mg per day.

31/12/01 X saw her GP in London and told him of the sexual abuse and her previous overdoses. *“Restarted on Cipramil due to recent low episode”*. X said that she had been seeing a psychologist in Gillingham weekly for the last year (which was untrue). She was prescribed citalopram 40mg per day.

16/1/02 She did not attend an outpatient appointment with SG 4, now staff grade to Cons 5 (locum consultant).

12/3/02 She saw her GP in London and was prescribed citalopram 60mg per day.

- 15/3/02** X saw her GP in London and told him that she had a diagnosis of Obsessive Compulsive Disorder and was seeing a psychologist weekly in Gillingham and a psychiatrist every six months, with her next appointment due in April.
- 3/4/02** She did not attend an outpatient appointment with SG 4.
- 9/4/02** X told her GP in London that she was planning to go to Greece for six months and was given 2x3 months prescriptions for citalopram 60mg per day. She may have been simply as she knew there would be uncertainty over where she was going to live in the next few months.
- 15/5/02** She did not attend an outpatient appointment with SG 4 and was discharged to the care of her GP (GP2, who was not then her GP).
- 26/7/02** X registered with a GP surgery in Purley and reported to them that she was still taking citalopram 60mg per day.
- 9/9/02** Her GP changed the antidepressant to sertraline 50mg per day plus zopiclone 7.5mg at night. He diagnosed her as suffering from Obsessive Compulsive Disorder and stated that she had felt no benefit from citalopram.
- 11/9/02** X was referred by her GP (GP4) to the Purley Resource Centre (CMHT).
- 13/9/02** GT 1 wrote a letter to the GP in Purley summarising his work to date.
- 18/9/02** SG 4 wrote a letter to the GP in Purley summarising the psychiatric input to date.
- 25/9/02** A further letter by GP4 was sent to the CMHT forwarding the recent letters from Kent (above). On the same day, a letter from Purley Resource Centre (CPN 5, Professional Lead (nurses)) was sent to the GP suggesting a re-referral later, if X was no better after a longer trial on a new antidepressant, either to the CMHT or to the Lennard Road psychological therapies service.

- 10/10/02** The GP increased the dosage of sertraline to 200mg per day and re-prescribed zopiclone 7.5mg at night.
- 17/10/02** X presented to Accident and Emergency Department at Mayday Hospital, Croydon and was subsequently transferred to the Bethlem Royal Hospital on 19 October 2002 under section 2 of the MHA. Refer to chapter 9 for further details of X's two admissions, ending on 31 December 2002.
- 15/1/03** X presented to Medway Maritime Hospital Accident and Emergency Department and was assessed by SHO 7, SHO on call at 4.20pm. X told SHO 7 she was not registered with a GP, but did tell him that she had been admitted to the Bethlem Royal Hospital, giving accurate dates. She told him that she did not wish to be transferred back to Bethlem Royal Hospital because of the associations with her friend S who killed herself whilst an inpatient. SHO 7 diagnosed a moderate to severe depressive illness with no biological symptoms and possible personality disorder. There is no record of any discussion with a senior doctor.
- She was admitted to Shelley Ward where she was seen by Nurse 7 and SHO 5, who jointly completed CPA forms 2 and 4. X told them that she was currently living with her mother in Rainham, but this accommodation would not be available beyond the end of January as her mother was due to move in preparation for her step-father's impending release from prison. SHO 5 suggested a plan for "close obs" (nursing observations) due to the risk of self harm, to start Cipramil 20mg per day and to reorganise contact with GT 1 or Psychologist 1.
- 17/1/03** At a ward round with Cons 6 and SHO 5. X said that she had no thoughts of self harm and no longer felt suicidal, but had 'felt poorly' before admission. Her mood was described as euthymic (normal). She was placed on 'level 4 escorted' observations, which seems to mean that nursing staff checked her whereabouts every hour and escorted her if she wanted time off the ward.

- 19/1/03** X was referred to the Gillingham CMHT. She expressed thoughts of hopelessness, worthlessness and self-harm. She was tearful and distressed at times.
- 21/1/03** The observation level was reduced to "*level 4 negotiated*", which appears to mean she could negotiate time off the ward without an escort.
- 24/1/03** At a ward round with Cons 6 and SHO 5. X highlighted a problem with future accommodation because of the uncertainty over her employment and not knowing when she would feel well enough for discharge. Cons 6 recorded that there was "*no evidence of depressive illness*" and she was likely to have a "*personality disorder*". He planned to "*continue present management*", to "*continue Cipramil*" and suggested X "*needs to see accommodation officers*".
- 29/1/03** At a ward round with Cons 6, he recorded there was still no evidence of a depressive illness and planned for her to attend anxiety management classes and to await her assessment by the CMHT.
- 31/1/03** SHO 5 wrote a referral to GT 1 asking him to consider seeing her again. CPN 2, CPN from the Gillingham CMHT sent an appointment to X suggesting an appointment on 11 February 2002.
- 3/2/03** X told nursing staff that she did not like Cons 6 and did not wish to see him again. She later left the ward and on her return she smelt heavily of alcohol.
- 5/2/03** A CPA meeting was planned for 12 February 2002.
- 6/2/03** Cons 6 commenced annual leave.
- 7/2/03** X was seen by Cons 9 (another locum consultant, covering Cons 6's leave). X complained that Cipramil was not helping her and was prescribed venlafaxine instead (see under '**Medication**' heading, chapter 11).

She later took leave from the ward to visit a man whom she had met soon after her admission. He had also been an inpatient on Shelley Ward with *“alcohol problems”* and after he had been discharged X continued to meet with him. On this date he had not been at home when she visited and she had felt *“no one cared about her”*, so she bought paracetamol and took an overdose on her return to the ward. She later gave a different explanation to SHO 6, SHO to Cons 6. She was seen by the duty doctor, blood levels were checked and no specific treatment was required.

12/2/03 A ward round and CPA meeting with Cons 9 and SHO 6, was also attended by CPN 4, CPN from the Gillingham CMHT. Medication was changed, with carbamazepine prescribed. *“X was advised to attend OT [occupational therapy] to occupy herself during the day”*. She expressed ongoing concern about her job. The team was still awaiting a reply from GT 1 regarding the referral made on 31 January 2003.

13/2/03 X was assessed by CPN 2 from the CMHT. It is recorded that she recommended X should be eligible for enhanced CPA and that *“X is engaged with ASAP.”*
X was later seen by Nurse 10 and given forms to apply for local authority housing. X stated that she would need *“supported housing”* as she did not believe she could cope alone.

14/2/03 At a ward round with SHO 6, her medication was changed. She was allowed to go out with her grandparents. Later, she left the ward without permission, with the intention of catching a train from Gillingham to Croydon to see her ex boyfriend. She stated that she had then changed her mind, had considered self-harm, but then returned to the ward at 11.30pm.

15/2/03 GT 1 informed X that he would agree to see her on 20 February 2002.

A further Mental Health Risk Assessment (form CPA4) was completed by Nurse 4, which concluded that X was at increased risk of self-harm. Her observation level was changed to ‘level 3:15’ as a result

(which appears to mean that nursing staff checked her whereabouts every 15 minutes and she was not allowed off the ward).

- 17/2/03** X was seen by Cons 10, another locum consultant, covering Cons 6's absence. She was also seen by her union representative regarding her ongoing disciplinary problems.
- 18/2/03** X was seen by SHO 6 and by Nurse 4 . After pressure from X, her observation level was subsequently changed to 'level 4 escorted', enabling her to leave the ward for the first time since 14 February 2003.
- 19/2/03** At a ward round with Cons 10 and SHO 6 no major changes were made to her management.
- 20/2/03** X was seen by GT 1.
- 21/2/03** At a ward review with Cons 10 and SHO 6, X was discussed but not seen. It was planned to invite GT 1 to the next CPA "*to discuss planning X's discharge to minimise dependence*".
- 23/2/03** In a 1:1 session between X and Nurse 7, X still expressed suicidal thoughts but 'something' stopped her acting on them. She also spoke of her feelings about her step-father's impending release from prison on 8 March 2003. X wanted her medication reviewed and an idea of a date for her discharge. It was noted that she was still awaiting the appointment of a care co-ordinator and "*information regarding accommodation*".
- 24/2/03** X secreted her night-time medication but was challenged by nursing staff and later agreed to take it.
- 26/2/03** At a ward round with Cons 10 and SHO 6, it was reported that X was still sleeping excessively during the days. Little was changed in her management plan, except an increase in her medication and a suggestion that she try "*one zone*" relaxation exercises with her primary nurse.

- 27/2/03** X was seen by GT 1. She later wrote a letter to her step-father with a view to discussing its contents with GT 1 prior to sending it.
- 28/2/03** X again expressed concern that her step-father was due to be released from prison on Friday 7 March 2003 and that she did not wish to be discharged until after he and her mother had organised where they were going to live.
- 3/3/03** X was informed that she had been accepted for council housing, but she would need to contact them again once she knew a discharge date.
- 5/3/03** A ward round and CPA with Cons 10 and SHO 6 was also attended by CPN 4. GT 1 attended and advised that in hospital (X) tends to become dependent very quickly but can manage her affairs. X expressed concern about her work and stated:
- £I don't want to do anything, don't want to leave, live anywhere or work anywhere. Usually I can do anything but this time I am not bothered - just sit on my bed throughout the whole day."*
- The plan was to hold a discharge CPA meeting in two weeks time, with the comment that it would be "*helpful for housing*".
- Later that day X left the ward without informing staff and did not return until the next day. Nursing staff informed the police of her absence.
- 6/3/03** X returned to the ward at 12.30pm and said that she had caught a train to Croydon. She was upset at the thought of having a discharge CPA in two weeks as she did not feel ready and was no better than on admission.
- X was later seen by GT 1, who came to the ward and suggested that it might be best to delay her discharge for perhaps a month to enable her to prepare herself.

7/3/03 At a ward review with Cons 10 and SHO 6, it was planned to review her again in the ward round on 12 March 2003, to encourage her to increase her physical activity by joining a local sports centre and to continue to plan her discharge in two weeks time.

11/3/03 Cons 6 returned from annual leave. X was wrongly informed by Ward manager 1, that she would be discharged on 17 March 2003. X became angry and took some time to settle even after other nurses explained Ward manager 1 had made a mistake and a CPA date had been set for 19 March 2003. X later called her mother, who telephoned the ward to express her concern about the discharge plans. She stated her intention of attending the ward round on 12 March 2003 and the CPA on 19 March 2003 and also stated that X would not agree to see Cons 6 as she did not like him. X asked nursing staff to give her contact details for *“the locality manager, the directorate manager and ward manager”* so that she could make a complaint about her treatment.

X later left the ward and a fellow patient subsequently handed a packet of paracetamol, that he had taken from her, to nursing staff.

12/3/03 At a ward round with Cons 6, X and her mother requested a change of consultant. Cons 6 suggested that he should talk to Clin dir 1 to arrange this, but that SHO 6 remain involved in her care and that SG 4 (staff grade) should see her in the interim.

X's observation level was increased to *“level 4 with escort”* by nursing staff following the incident with paracetamol the previous day. The CPA scheduled for 19 March 2003 was also cancelled despite Cons 6's note from the ward round to *“continue present management”*. X later stated *“whatever they do I'm still going to take an overdose when I'm out there anyway”*.

The ward round was also attended by CPN 4, a CPN from the Gillingham CMHT A message from Nurse 11 that, *“CPN 3 will come up to the ward and see X anytime this week: X has been accepted for enhanced CPA”* was recorded in the nursing notes.

- 13/3/03** X was seen by GT 1 for the final time.
- 15/3/03** Several patients on the ward, including X, appeared to be under the influence of alcohol. X refused breath testing.
- 16/3/03** X refused her evening venlafaxine and carbamazepine.
- 17/3/03** CPN 3 contacted the ward to confirm that she had been allocated as X's care co-ordinator. She would "*try to find the time*" to visit the ward and introduce herself.
- X requested to see a doctor to discuss her medication and her observation level. She was seen by SHO 6, who suggested that both issues would be reviewed at the next ward round.
- 19/3/03** X was seen by Nurse 9. X stated that she still had distressing thoughts of running away and jumping from a multi-storey car park in Bromley South. She expressed thoughts of hopelessness regarding her future and became tearful.
- 20/3/03** X was seen by SHO 6. She was unhappy about her medication and felt it was not helping her. She refused to be seen by Cons 6 to discuss this, so SHO 6 suggested that SHO 4 saw her. SHO 6 recorded that, although he recommended that she continued the medication, since she was an informal patient, they would have to respect her wishes. He added "*she is not sectionable and does have reasonable understanding and capacity.*"
- Cons 6 recorded that after a discussion with Cons 10, X's care would be transferred to Cons 7's team. It appears that Cons 7 was on sick leave at this time and her position was being covered by Cons 2, acting in a locum capacity.
- X later refused her evening medication.

- 21/3/03 (Fri)** X refused her antidepressant medication and her morning dose of carbamazepine. She continued to do this over the weekend until 24 March 2003.
- Ward manager 1 and Nurse 7 both wrote (very similar) letters to Cons 2 on this day asking for:
- “an urgent review of her management plan because X is clearly not complying with her treatment”.*
- 23/3/03** X was tearful at times throughout the day and ran off the ward during the late evening. She was returned by nursing staff, but said that she needed to go for a walk as she felt like her *“insides were about to explode”*.
- 24/3/03** A ward round was held with SG 3, a staff grade doctor attached to Cons 7’s team and SHO 4, SHO to Cons 7. X explained that she did not feel the medication was working, she still had suicidal thoughts and was still upset by the break-up from her boyfriend, her work problems and her family disharmony. She also said she was homeless.
- SG 3 decreased the dosage of venlafaxine and prescribed zopiclone on a regular, rather than a PRN basis. SG 3 also prescribed a test dose of flupentixol decanoate (Depixol).
- X later became very anxious and was seen by the duty doctor, who diagnosed her to be suffering from withdrawal effects from venlafaxine (as she had suddenly stopped it several days before).
- 26/3/03** X was seen by CPN 3 for the first time. She explained she would now be the care co-ordinator. X’s main concern was said to be finding somewhere to live.
- 27/3/03** X was seen by CPN 3, SG 3 and Nurse 2 in the presence of X’s mother. CPN 3 stated that she would be the care co-ordinator. A plan was made to arrange a discharge CPA meeting on 7 April 2003. In the

mean time it was suggested that X participate in “*diversional activities*”. She was advised to remain abstinent from alcohol and to “*comply with ward management*”. X received the test dose of flupentixol decanoate later in the day and was due to commence regular weekly injections from 6 April 2003. She was to continue taking venlafaxine 75mg twice per day. It was also suggested that X liaise with Nurse 10 regarding accommodation.

30/3/03

X reported feeling much better since receiving the test dose of depot injection.