REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF LEE POWELL AND PAUL MASTERS

A Report Commissioned by
South Cheshire Health Authority

May 1999

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Gordon Halliday, Chairman.
Eric Mendelson, Consultant Forensic Psychiatrist.
Richard Warburg, Consultant Neuropsychologist.

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Preface

We were commissioned in September 1998 by South Cheshire Health Authority to undertake this Inquiry, and now present our report.

The report is based upon written and verbal evidence given to us by those most closely involved in the care of Lee Powell and Paul Masters, and upon a careful study of all the relevant records pertaining to both patients which were made available to us. We have also reviewed all the relevant policy documents and practice guidelines which were made available to us. We have interviewed Lee Powell on two occasions, and have met with representatives from his family and from the family of Paul Masters. We have also visited the Scott Clinic, two units of the Transitional Rehabilitation Unit, and another relevant specialist care setting.

Throughout our work, we have consistently been helped by the full assistance of the Agencies and the individuals involved in the Inquiry, and by the courtesy afforded to us. We understand the anxiety which an Inquiry of this nature raises, and we are grateful for the full cooperation we have received throughout.

Gordon Halliday
Chairman

Eric Mendelson
Consultant Forensic Psychiatrist

Richard Warburg
Consultant Neuropsychologist

CHAPTER 1 Introduction

1.1 Summary of the incident

1.1.1 On Friday, 18th July 1997, Lee George Powell pleaded guilty to and was convicted of the murder of Paul Frederick Masters on a date between 22nd December 1996 and 25th December 1996. He was sentenced to life imprisonment. At the same time he pleaded guilty to and was convicted of a charge of arson being reckless as to whether life was endangered, and was sentenced to 7 years imprisonment, to run concurrently.

1.1.2 At the time of the offence, Lee Powell and Paul Masters were each resident at Lyme House, a part of the Transitional Rehabilitation Unit (TRU), which is a registered care home for the physically disabled in Haydock. Each man was believed to suffer from the effects of an earlier traumatic brain injury. In addition, Lee Powell had previously been detained under Section 37 of the Mental Health Act (a Hospital Order imposed by a Court), following an offence of criminal damage committed some 5 years earlier. For most of this time he had been a patient in the Scott Clinic, which is a Regional Secure Unit situated in St Helens.

1.1.3 At the time of the killing, Lee Powell was aged 26 years and Paul Masters was aged 27 years.

1.1.4 The circumstances of the killing are understood to have been as follows: sometime after 10.30 pm, Paul Masters left the front door of his Independent Living Unit (ILU) within Lyme House, walked about 50 yards around the outside of the building, and knocked on the front door of the ILU occupied by Lee Powell. He took with him several cans of strong lager. He persuaded Lee Powell to admit him, although he was initially reluctant to do so. The Lyme House rules at that time did not permit the consumption of alcohol on the premises, nor did they permit residents to visit other units of accommodation on the site after 10.30 pm.

1.1.5 Some time later, after midnight, it is understood that Paul Masters made an approach of a sexual nature to Lee Powell, which provoked a physical assault of a frenzied and violent nature, from which Paul Masters suffered fatal injuries. Lee Powell removed the clothes from the body, and tried to hide the body in a culvert in the grounds of Lyme House. He also set fire to Paul Masters' living unit.

1.1.6 On the night in question, there were 4 ILU's attached to Lyme House. Three of them were occupied. Two members of staff were on sleeping night duty at Lyme House, covering the whole of the unit which included 14 beds within the main unit and the 4 ILU's. Whenever the front door of an ILU opened, a bleeper sounded in the area where the night duty staff were stationed. The bleeper on Paul Masters' door was activated soon after 10.30 pm, but the staff did not investigate the occurrence. Nor did

they investigate when the bleeper on Lee Powell's door sounded a few minutes later. The bleeper for Lee Powell's front door sounded again at 2.45 am, and a female member of the night staff went to investigate, but found nothing untoward.

1.1.7 The fire in Paul Masters' unit led to the Fire Brigade being alerted, whose attendance led to the discovery of Paul Masters' body. Lee Powell meanwhile had left the site, but at 5.12am he made a 999 call, and was put through to the Police. He was still in the telephone kiosk when the Police arrived. He was arrested and taken to the Police Station.

1.2 Internal inquiries into the incident

1.2.1 In accordance with Guidelines set down by the Department of Health (HSG(94)27, issued on 10th May 1994), the Chief Executive of St Helens & Knowsley Hospitals Trust set up an immediate internal investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach. The internal Panel of Inquiry subsequently made a number of recommendations, which are set out at Appendix A.

1.2.2 The Directors of TRU also held an internal inquiry into the incident, and subsequently wrote to the Personal Services Manager of St Helens Social Services Department indicating a number of operational changes to be introduced. These included the introduction of waking night staff, improved communication systems, and a review of the purpose, location, security and support systems for the Independent Living Units.

1.3 The Independent Inquiry

1.3.1 The Independent Inquiry was set up by South Cheshire Health Authority, also in accordance with the Department of Health Guidelines . Membership of the Panel of Inquiry is set out at Appendix B, terms of reference are set out at Appendix C, and agreed operational procedures are set out at Appendix D. In the event, the Panel decided not to ask witnesses to affirm the truth of their evidence. The Panel was consistently reassured by the very full co-operation of witnesses to assist with the purpose of the Inquiry, and by their willingness freely to examine their part in the care of Lee Powell and of Paul Masters.

1.3.2 The report is based upon written and verbal evidence given by those most closely involved in the care of Lee Powell and Paul Masters. All the relevant and available records pertaining to both patients were reviewed. All relevant policy documents and practice guidelines made available to the Panel were also reviewed. In addition, a public invitation was given at the start of the Inquiry for any other contributions to be made pertaining to the Panel's terms of reference.

1.4 Acknowledgements

1.4.1 The Panel of Inquiry owes a debt of gratitude to Mr Steven Preece, a partner of Hill Dickinson, solicitors, for his thoroughness and efficient management as Clerk to the Inquiry, and for the unfailing perceptiveness of his legal advice to the Panel.

1.4.2 The Panel members wish also to express their thanks

To the administrative and clerical staff of South Cheshire Health Authority, in particular to Mrs Angela Roberts, for their consistent support in the course of the Inquiry.

To Dr Richard Grunewald, Consultant Neurologist at the Royal Hallamshire Hospital in Sheffield, for giving his expert opinion in matters relating to brain injury.

To members of the family of both Lee Powell and Paul Masters, for their full assistance in providing information to the Panel of Inquiry.

CHAPTER 2 Lee Powell

2.1 A background note

2.1.1 We are indebted to Lee Powell himself, and to his father, for their assistance and co-operation in providing background information both for this Chapter and for other parts of this report.

2.2 Early years

2.2.1 Lee Powell and his parents speak positively of his early years. His paternal grandparents played a full part in his care following his birth while his parents, both in employment, strove to establish their first home. Soon after Lee Powell's second birthday, he returned to live with his parents in their first family home. However he remained very close to his paternal grandmother. A brother was born when he was three years old, and a sister when he was eight years old. Lee Powell was described as a bright young lad, who made good progress at school. Shortly after the birth of his sister, he was involved in a road traffic accident, being knocked down by a motor car as he crossed the road not far from his home.

2.2.2 Hospital records are inconclusive as to the severity of the injury. The Accident Unit report from the then Chester Royal Infirmary indicates that Lee Powell had been unconscious following the accident, but the subsequent clinical notes state "*wasn't KOD, can remember being hit*". However the notes indicate a "*large sutured laceration over L eye, and other multiple cuts and grazes*". The following day he was discharged... "*general condition very good. Go home. District nurse to remove sutures in ten days*". Clearly the medical staff did not expect any significant consequences from this injury.

2.2.3 Comment:

The clinical notes in themselves do not suggest evidence of any brain injury associated with this accident. The Panel asked the independent opinion of Dr Richard Grunewald, Consultant Neurologist at the Royal Hallamshire Hospital in Sheffield, who reviewed the relevant notes and commented:

"Taking into account the evidence available, I concluded that the initial head injury at the age of eight was extremely unlikely either to cause any significant behavioural disturbance in the short or long term, or to be responsible for the lesion reported to be present on the MRI scan in 1991. Mr Lee Powell was not unconscious after the accident, and the prospect of a significant head injury at that time seemed remote.

Even if he had accrued a head injury, it is hard to imagine how such a mild injury would have produced such a focal abnormality on the MRI scan, or a long term behavioural change such as was observed."

2.2.4 Although there seems to have been no immediate reaction to the accident, it was one of a number of potentially unsettling life experiences for Lee Powell at about this time. His maternal grandfather had died shortly before the accident, and shortly after the accident the family moved to a larger house, which also entailed a change of school for him. His paternal grandmother died when he was 10 years old, and this bereavement was particularly distressing for him. His father told us that he had also been to some extent subject to bullying at primary school, but this seems to have got worse after the change of school. At about this time, he was also required to wear spectacles, which he disliked intensely.

2.2.5 There followed a gradual deterioration in his behaviour at home, and he began to do less well at school. The headmistress suggested that he should see a child psychologist, and he was seen shortly before his 11th birthday. The Educational Psychologist's report expressed concern that he would be at risk in a large comprehensive school, and recommended that both his educational and his emotional needs would be *"better met in a smaller environment"*, and that he would *"much benefit from a residential placement"*. He subsequently became a weekly boarder at Brook Farm Residential Special School in Tarporley. He was to stay there for the next five years. Lee Powell told us that he felt that he could have managed well with help in normal Secondary school, but with his school records generally no longer available, there is little evidence of his progress during these years and there is no evidence of any review of the placement having taken place. However he continued to be seen intermittently at the Ellesmere Port Child Guidance Clinic, and there are brief references in these records to Lee Powell's *"morbid preoccupation with death"* and to *"three occasions in the last year or so (1984), attempted a mock suicide with twine and plastic bags."*

2.2.6 Following the end of his schooling, Lee Powell entered a Youth Training Scheme with a firm of Funeral Directors, pursuing a growing interest in funerals which seems to have started by the time he was eleven. This interest was to become an increasing preoccupation as he grew older.

2.2.7 Shortly after the commencement of the course, however, in September 1986 when at age 16, he suffered another road accident which resulted in overnight admission to hospital. On this occasion he fell off his moped, but the clinical notes indicated *"no head injury apparent, no dent in helmet"*. The notes record *"complain of frontal headache – has headaches quite regularly"*. They also record *"short-term amnesia"*.

2.2.8 Comment:

Dr Grunewald comments on this second accident *"The second head injury at the age of 16 years is more difficult to interpret. It would appear that the degree of*

amnesia might have been out of proportion to the severity of the head injury Mr Powell had experienced. He did not seem to have accrued significant injuries to his body and there is no documented period of unconsciousness following the accident at the age of 16.

Despite this, he had a period of amnesia for short-term memory, which lasted about half a day. It is possible, although I think it is unlikely, that this head injury was severe enough to cause the structural abnormality on his MRI scan in 1991".

2.2.9 He lost his YTS position with the firm of Funeral Directors following a disagreement with the owner, and although he obtained a second such position, this also did not last. Apart from two other short-term jobs he remained unemployed thereafter.

2.2.10 In April 1988 he committed his first offences, those of robbery from a grocer's shop and attempted robbery from a bank, on each occasion using his father's (unloaded) pellet gun. After the successful robbery, he took the sum of money he had gained and threw it into a canal without even counting it. The offences came out of the blue, and Lee Powell was unable to offer any explanation for them. He was sentenced to 18 months Youth Custody, and he spent the latter part of his sentence, a period of approximately ten months, receiving psychiatric care at Glen Parva Youth Custody Centre after he threatened to harm himself. During his time at Glen Parva, he committed a serious assault on a Prison Officer with a sock containing batteries, which resulted in a further sentence of 6 months imprisonment, to run concurrently. Following this episode, he was referred for consideration for admission to Ashworth Special Hospital, but was not considered suitable.

2.3 Early contact with mental health services

2.3.1 After his release from Youth Custody in 1989, Lee Powell returned to live with his parents, and received follow-up care from the Mersey Regional Forensic Psychiatry Service under the care of Dr C Boyd, Consultant Forensic Psychiatrist. Antipsychotic medication was prescribed.

2.3.2 In March 1990, aged 19, he was admitted to what was then the West Cheshire Hospital. He had been referred by his GP, who said he was complaining of hearing voices. He was discharged home approximately a fortnight later and referred to Day Hospital, but over the next year was admitted on a further 5 occasions, with repeated reference to auditory hallucinations of an increasingly intrusive nature, often with violent overtones.

2.3.3 A further admission to hospital occurred in late September 1990 ("*exacerbation Schizophrenic illness*"). He was again complaining of hearing voices, but discharged himself against medical advice eight days later.

2.3.4 He was again admitted early in January 1991 ("*Auditory hallucinations. Suicidal ideation. Violent outburst*"). He again discharged himself after a week.

2.3.5 A further admission to hospital occurred on 20th March 1991, following an incident at home in which he reportedly threatened his brother with an axe. He was still complaining of auditory hallucinations.

2.3.6 The next admission to hospital, on 3rd April 1991, followed serious assaults on his young sister and on his mother. Consideration began to be given to the possibility of placement away from his family, possibly in self-contained accommodation or in a hostel. He attended Eastway Rehabilitation Unit, but worrying and impulsive behaviour continued and early in July, while he was understood to be visiting his home, he stole a toy gun from a newsagent and attempted to hold up a Post Office. He was arrested, taken to Chester Police Station, and returned to hospital, without charge.

2.3.7 A further violent incident occurred, this time in hospital, late in July. Lee Powell threw a fire extinguisher through a ward window, narrowly missing other patients below, and the Consultant Psychiatrist, Dr N Halstead, decided that it was no longer possible to manage him on an open psychiatric ward, "*especially as he does not have a treatable mental illness*". He was therefore discharged from hospital on 22nd July 1991 and charged by Chester police with criminal damage.

2.3.8 Lee Powell was remanded in custody to Walton Prison. After an initial assessment by Dr D Finnegan, Consultant Forensic Psychiatrist, on 22nd August 1991 he was further remanded under Section 35 of the Mental Health Act (remand to hospital by a Court for assessment) and admitted to the Scott Clinic.

2.4 Care in the Scott Clinic, 22nd August 1991 to 3rd October 1993

2.4.1 The Scott Clinic is a purpose-built Regional Secure Unit providing facilities for 42 patients. There are 4 wards, whose functions are defined as:

Ward 1	-	Asessment/Special Care Ward	-	6 beds
Wards 2 & 3	-	Admission/Rehabilitation	-	12 beds each
Ward 4	-	Self-Care/Pre-discharge	-	12 beds

The catchment area serves the population of Merseyside (2.4 million).

2.4.2 Lee Powell was initially admitted to Ward 1. Dr Finnegan was his Responsible Medical Officer, and remained so throughout his stay at the Clinic. The earliest notes at the Clinic make reference to Lee Powell's continuing talk of being "*under the influence of voices*". His complaints persisted after a decision was made to observe him for a period without medication, a decision which he resented. Ten days later he was transferred to Ward 3, still complaining of hearing voices and asking for medication.

Two days later he attacked a nurse on the ward. He was transferred back to Ward 1, where his unsettled behaviour continued.

2.4.3 The clinical notes at this time said *"The evidence is accumulating , both that Lee does not have a mental illness and that he has very severe personality difficulties"*. Lee Powell was also talking of his homosexual orientation and claiming that he was HIV positive (tests later found him to be HIV negative). Episodes of self-harm were recorded, as were episodes of aggressive and threatening behaviour. By 17th September, a month after his admission to the clinic, the recorded diagnosis was stated more definitely.... *"He has a gross personality disorder which in its extent and in terms of the behaviour he has shown would under the terms of the Mental Health Act be classified as Psychopathic Disorder..... I have considerable doubt as to whether Lee Powell's disordered personality is treatable, but in fairness to him and to society I think it would be appropriate to seek a second opinion from a Special Hospital consultant"*. The notes also indicated plans for a full psychological assessment, including personality profiles and tests for organic brain damage.

2.4.4 Psychological testing indicated the possibility of frontal lobe brain damage, as did a subsequent MRI scan. Following a general improvement in Lee Powell's behaviour, referral to a Special Hospital or to St Andrew's Hospital (a hospital which contained a secure unit for brain injury rehabilitation) was not considered appropriate. The recommendation to the court for the adjourned hearing on 13th November 1991 was that, as Lee Powell was suffering from mental illness within the meaning of the Mental Health Act 1983 ("*Organic Personality Syndrome*") an order under Section 37 of the Mental Health Act should be made. Lee Powell returned to Ward 1 at the Scott Clinic, and a few days later was transferred to Ward 2.

2.4.5 Initial progress seems to have been satisfactory, although a number of outbursts of anger are recorded involving damage to property. A programme of anger management was planned, together with counselling sessions, and the advice of Dr Howard Jackson, Principal Clinical Psychologist at Ashworth Hospital, was sought. Dr Jackson's report recorded that *"Mr Powell was adamant regarding the presence of his auditory and olfactory hallucinations"* and that *"the evidence for frontal lobe syndrome is equivocal"*. The report continued *"In my opinion, Mr Powell's behaviour and personality problems cannot be ascribed entirely to neuropsychological factors since they predate the only significant head injury at the age of 16"*. The report made a number of tentative suggestions about rehabilitation and management programmes.

2.4.6 At a Clinical meeting held on 4th March 1992, there was considerable debate about the diagnosis of organic personality syndrome *("about which there is reason to have doubt")* and the need for further neuropsychological testing. Nevertheless the decision was taken to continue with the present programme, without medication, pending further review in three months' time. *"Riding two horses is likely to confuse which therapeutic interventions are being successful"*.

2.4.7 Lee Powell's progress on the ward remained variable, with intermittent episodes of violence against property and threatening behaviour. There were also occasional incidents of superficial self-harm, and he told staff that he was hearing voices telling him to harm himself. At a clinical meeting on 5th May 1992, his detention under Section 37 of the Mental Health Act was renewed. *"Given the considerable violence and impaired control when angry, and the failure, so far, to effect significant changes in Lee's mental state and attitudes, the team was unanimous that he continues to represent a risk to others, particularly his family, and requires further detention in hospital for his organic personality syndrome."*

2.4.8 Lee Powell's behaviour remained very unsettled over the next few days. His parents visited him on 9th May, but in the course of the visit he struck his mother across the face. He then became remorseful and depressed and several episodes of self-harm occurred, and he said that he felt suicidal. Close observation was maintained by the nursing staff. A serious assault on a member of the nursing staff on 16th May resulted in a brief period of seclusion, and close observations were maintained. Lee Powell subsequently alleged that he had been punched by the nurse in question, and that he had sustained injuries while being restrained. The allegations were investigated by the police, and his complaint investigated by a nurse from outside the Unit. However the complaint could not be substantiated and no further action was taken by the police.

2.4.9 There were further unsettled periods in July 1992, involving a dispute with another patient on the ward, and also in connection with bringing substances from the old Rainhill Hospital Pathology Laboratory onto the ward. As a result, *"It was felt that the level of disturbance that Lee shows, his failure to respond to all the interventions we have tried, and the very obvious risk which he poses both to staff and patients, and also to his family, is to be construed as grave and immediate and on that basis I will refer him to Special Hospital"*. The proposal was discussed with Lee Powell by Dr Finnegan. On 14th July he was transferred back to Ward 1, as a precautionary measure.

2.4.10 The referral to Ashworth Special Hospital was sent on 24th July 1992. The case was referred to Dr Cocker in view of Lee Powell's history of brain damage, and the interview took place on 6th October. By 20th October, however, the clinical notes indicate that *"It seems fairly clear that Ashworth are not going to take Lee"*. (Formal confirmation of this decision was not sent until 27th May the following year. *"Whilst accepting that Lee is potentially still dangerous in an inappropriate environment .....because he does not fit the treatability criterion, transfer to a Special Hospital at this stage is not appropriate").*

2.4.11 Comment:

By any standards the long delay by Ashworth Hospital in responding to a referral of a patient thought to present a grave and immediate danger, is most unsatisfactory.

2.4.12 On 13th November 1992, a Case Conference was held to try to reach a long-term strategic view, particularly in view of what was seen as Lee Powell's increasing dependency on the Clinic. Detailed discussion took place concerning Ashworth Hospital's comments on his treatability, and to the possibility of Lee reverting to informal status and allowing the law to take its course if there should be further problems. This suggestion was unanimously rejected. Possible placement at St Andrews Hospital was again discussed. The notes of the meeting indicate that *"the circumstances were inducing a sense of helplessness in the team (and Lee)"*. However the strong majority view was that the Clinic should continue its work with Lee Powell, with the introduction of a simple behavioural programme as part of a structured day in order to try to prepare him for a long-term placement.

2.4.13 Comment:

The commitment of the Clinic staff can only be applauded in the face of the delayed advice from Ashworth Hospital. However there is no evidence that the planned neurological investigations were in fact followed up, and the notes do not indicate that a review of the diagnosis took place at this stage, despite the lack of progress.

2.4.14 However, following the intervention of the Clinical Psychologist, Mr A Hossack, and the introduction of the behavioural programme, progress seemed to be made. The Clinic Social Work Team Manager, Mr D Heywood, contacted Cheshire Social Services Department for preliminary discussions regarding a community placement, with the planned involvement of the Chester Health Authority. On 24th November, Lee Powell moved from Ward 1 to Ward 3. On 3rd December, Mr Heywood made informal contact with Harewood Park residential care home. The possibility of a referral to Longview House, a hostel, was also considered.

2.4.15 Mr Heywood and a representative from Cheshire Social Services Department, Mr M Dodd, visited Harewood Park early in February 1993. The home were concerned about the differences in the degree of security on Ward 3 to that which they were themselves able to provide in a relatively unstructured setting. However it was seen as *"potentially a very good placement for Lee although it is likely to take a few months to prepare him for the move."*

2.4.16 A Mental Health Review Tribunal considered Lee Powell's continued detention on 15th February 1993, but decided that he should not be discharged. Dr Finnegan's report included the following opinion:

a. *"Lee Powell's case presents major difficulties of management....in the light of the seriousness and protracted nature of his assaultative behaviour in the context of his other manifest psychological difficulties all of the team caring for him at the Scott Clinic consider him to represent a danger to the public, particularly to his family, and to himself.*

b. *Because of the strong evidence initially in favour of organic brain damage a diagnosis of organic personality syndrome was made. Subsequently the psychological support for this has been found to be less convincing. Nevertheless the investigations point towards this and we did not feel that it was appropriate to recommend his reclassification. The management problems remain very similar, however.*

c. *In my view Lee Powell continues to suffer from an organic personality syndrome, which is a mental illness, and remains liable to detention under Section 37 of the Mental Health Act 1983."*

2.4.17 Meanwhile the situation was further complicated by the placement of Lee Powell's sister's name on the Child Protection Register following the assault by Lee Powell in 1991. There was concern about the possibility of further danger to her if he were to be allowed to visit his home while on parole from the Clinic.

2.4.18 Early in March 1993, Lee Powell was accepted for placement on Ward 4 in order to try to prepare him for any subsequent move to a less structured environment. Careful preparation was made for the change of wards. The move took place on 8th March. However a series of incidents with other patients on the ward caused difficulties, and he was moved to Ward 3 on 24th March, continuing with the same planned programme. He returned to Ward 4 on 30th March.

2.4.19 Comment:

This continued to be an unsettled period for Lee Powell. He changed wards on 5 occasions between November 1992 and April 1993.

2.4.20 Careful preparations were also made for an introduction to Harewood Park. His keyworker and the Social Work team Manager visited the Home on 23rd March, and arrangements were made for staff from the Home to visit Lee Powell and to meet Clinic staff. A Section 117 discharge meeting (planning for aftercare) was also proposed.

2.4.21 Further problems on Ward 4 arose early in April, however. An incident in which he threatened to stab another patient with a knife led to him being transferred back to Ward 3, and in view of his difficulties with other patients on Ward 4 it was decided that he should remain on Ward 3. However these incidents raised doubts about his ability to manage in independent accommodation, and staff from Harewood Park were reluctant to consider Lee Powell in the light of the recent difficulties.

2.4.22 Comment:

The episode with the knife understandably halted progress towards placement at Harewood Park, but it does not seem to have altered the planning for placement in another community setting.

2.4.23 Following the problems which had arisen with the planned placement at Harewood Park, plans were made to investigate an alternative placement at Alpass Nursing Home, in Aigburth, Liverpool. The placement would require validation by Cheshire Social Services Department and by the Chester Health Authority. A meeting with the Manager of Alpass Nursing Home took place on 12th May, which Lee Powell attended. A visit to the Nursing Home took place 6 days later, which seemed to be very successful. A further visit took place on 25th May. However Lee Powell's enthusiasm quickly waned, and he began to show anxiety about the proposed move. A further accompanied visit took place on 4th June, after which he agreed to the proposal for a period of 6 weeks' trial leave at the Nursing Home.

2.4.24 Problems then arose with Cheshire Social Services Department's validation of Alpass Nursing home. They were expressing misgivings about the lack of day care within the Home, and instead proposed another option, Mount Pleasant Nursing Home in Knutsford, which was said to offer a wider variety of therapeutic options. Not surprisingly, there was some frustration within the Scott Clinic at this belated change of plan.

2.4.25 Comment:

In view of the careful preparations which had been taking place for the planned move to Alpass, the late intervention of Cheshire Social Services Department does not compliment the levels of co-operation between the two agencies at that time.

2.4.26 Further incidents over the next few days continued to undermine hopes for progress. On 4th July Lee Powell smashed the windscreen of a security guard's van in the grounds of the old hospital, and was interviewed by the police. Three days later he was found on the ward with a ligature tied tightly around his neck. His breathing was restricted and he was becoming cyanosed. Assistance was needed to cut the tie loose.

2.4.27 On 8th July, Mr Heywood visited Mount Pleasant Nursing Home. He found that it had only been open since 1st April, and had yet to admit the first resident. The home was said to have been set up to cope with residents who present challenging behaviour. The home seemed to be interested in the possibility of taking Lee Powell, and a Section 117 aftercare meeting was provisionally set up for 28th July. Staff from the home visited Scott Clinic on 9th July, and Lee Powell made an escorted visit to the home on 15th July. He was later offered a place at the home in writing, but pointedly expressed the view that he hoped that Social Services would not change their minds again. The placement still had formally to be validated by the Social Services Department.

2.4.28 A month later the proposed placement had still not been validated, and Lee Powell's frustration was becoming evident on the Ward. On 2nd September news finally came that Mount Pleasant Nursing Home was in the process of changing its designation from mentally ill presenting with challenging behaviour to that of the elderly mentally ill, and was therefore no longer a suitable placement. In these circumstances Cheshire

Social Services agreed that Alpass Nursing Home seemed to be the best option for Lee Powell if he was not to stay at Scott Clinic.

2.4.29 Comment:

This further delayed change of plan indicates the vital importance of close co-operation between Purchasers and Providers in the planning of complex community placements.

2.4.30 The proposed placement at Alpass Nursing Home was quickly resurrected, with Lee Powell's approval, and a Section 117 aftercare meeting was arranged to take place on 14th September. Six weeks' trial leave at the Nursing Home was scheduled to start on the same day. It was agreed that he would remain subject to Section 37 of the Mental Health Act until the expiry of his trial leave. He was placed at Alpass Nursing Home on 14th September.

2.4.31 A visit to the Nursing Home three days later by CPN Team Leader Mr Bayliss from Scott Clinic showed him settling in well. However an outburst the following day over a relatively trivial matter saw him returning to the Clinic for the night, before he was persuaded to return to the Nursing Home. Another issue then arose from another quarter when the Nursing Homes Registration Unit of Liverpool Health Authority insisted that Alpass should be registered for admitting residents who are liable to be detained under the Mental Health Act.

2.4.32 Within a few days Lee Powell's own difficulties at Alpass began to cause problems. On 3rd October he smashed two windows at Alpass, cutting his hand and needing to be treated in a hospital Accident and Emergency Department. The Manager at Alpass was not prepared to have him back because of the fear he aroused in other residents, and he returned to Scott Clinic.

2.4.33 Comment:

This unsuccessful episode in the effort to reintegrate Lee Powell into community life must have been very dispiriting for everyone concerned. It was now more than two years since his admission to Scott Clinic, and little overt progress had been made. The degree of difficulty in identifying a suitable placement for Lee Powell was becoming increasingly apparent. In these circumstances Dr Finnegan decided to convene a Peer Group Review to consider the position.

2.5 Care in the Scott Clinic, 3rd October 1993 to 26th August 1996

2.5.1 The Peer Group Review on 5th November was attended by representatives of all disciplines and from all clinical teams at the Scott Clinic. The possibility of allowing Lee Powell's detention under Section 37 of the Mental Health Act to expire (it was due for renewal on 12th November) was discussed and rejected as inappropriate and ill-

advised. His diagnosis was reviewed, and the possibility of re-classification to Psychopathic Disorder was considered but unanimously rejected. Organic Personality Syndrome was confirmed as the appropriate diagnosis. The recommendation of the Peer Group Review is worth recording in full:

"...that Lee should remain in the Scott clinic, currently on Ward Four, that Special Hospital referral is inappropriate at present and that much of the success currently being enjoyed represents the style of management to which Lee is subjected together with his relative happiness at being in the Scott Clinic. There will be major long-term placement difficulties and a long term strategic view needs to be taken during the course of which a focus should be established on improving Lee's limited control over his impulsivity and his sensitivity to slights. The Review Group considered it important to recognise that Lee was one of the rare individuals coming through the system who require for humanitarian, clinical and safety reasons a longer term view to be taken of their stay in the Scott Clinic than is generally the case. There is no other immediately identifiable facility available at present. His case should be reviewed in one year."

2.5.2 Comment:

The Panel of Inquiry has been impressed with the concept of the Peer Group Review in the discussion of cases of particular complexity. The recommendations bear witness not only to the apparent paucity of alternative facilities for patients with special needs, but also to the commitment of the staff at the Scott Clinic to try to see the task through.

2.5.3 On 13th November 1993, Lee Powell's detention under Section 37 of the Mental Health Act was renewed. A meeting was also arranged for the new year with Purchasers from Health and Social Services to explore future options. Lee Powell settled back into life at the Clinic, although there were increased incidences of self-harm involving the use of ligatures, which were considered by staff to be generally attention-seeking.

2.5.4 The joint meeting with Purchasers took place on 27th January 1994. Discussions about future options for Lee Powell were largely inconclusive at this stage, although the possibility of gradual introduction to a local Residential Care Home, Park Road, was canvassed. There was general agreement, however, that any such move would need careful preparation with the probability of a long lead-in time.

2.5.5 Over the next few weeks, incidents of self-harm continued, involving ligatures and occasional minor laceration. A pattern developed whereby Lee Powell would tie ligatures tightly around his neck, and then call nursing staff for help.

2.5.6 On 17th March Lee Powell was taken to see Park Road, and the visit seemed to go well. A further visit a week later was equally positive, and further visits were arranged. By mid-April the possibility of overnight stays were being raised by Lee Powell but the need for careful planning, involving the support of Purchasers and Section 117 pre-

discharge meetings was emphasised. On 10th May Lee Powell moved back to Ward 4, and was encouraged to continue to visit Park Road. However, he was reluctant to begin a series of introductory visits, building up his expectations, if the placement were to fail to materialise for any reason.

2.5.7 Occasional setbacks on Ward 4 occurred. One outburst followed an alleged sexual assault by another patient, and Lee Powell subsequently made a formal complaint to the police, who came to interview him. Unsettled behaviour continued, including an unprovoked attack on an elderly fellow patient on 24th June and further incidents of self-harm. He transferred back to Ward 3 on 25th June.

2.5.8 The situation was reviewed at a clinical meeting on 28th June, at which doubts about future strategy were expressed. *"It is obvious from what has gone on over the last three years that Lee does not have a condition that is treatable or that is even amenable to treatment.....Lee continues to represent a significant risk to others.....the fact of the matter is there is little formal evidence of brain damage and the nature of the problems that he shows have no characteristics of mental illness as it is conventionally interpreted and very much more in the nature of psychopathic disorder."* The decision was taken to move Lee Powell back to Ward 1, and to convene a further Peer Group Review as soon as possible. It was agreed that a move to Park Road was no longer an option at this time.

2.5.9 A behavioural programme was started, involving lack of privileges when the programme was not complied with, and corresponding rewards for compliance. Late in July he made a further allegation of sexual assault against another patient, which was again referred to the police. Further incidents of self-harm of the usual pattern were recorded, but some progress is also recorded. During the month Lee Powell achieved stage 6 on his behavioural programme before *"there were a number of outbursts reducing him to stage 3"*. At a clinical meeting on 6th September, there was a discussion about the possible reintroduction of medication, but *"On balance it was felt the disadvantages outweighed the dubious possible advantages"*. There is no record of any further Peer Group Review taking place.

2.5.10 Comment:

Although the behavioural intervention here is described throughout the Scott Clinic notes as a 'programme', it is in reality more of a behavioural contract. The following commitments were required of Lee Powell as a condition of reinstatement of parole:

1. **No violent incidents against furniture or objects;**
2. **No verbal threats;**
3. **No visiting the old Rainhill Hospital site;**
4. **No bringing objects back to the clinic which could be used for self harm.**

All these required behaviours are described in negative terms and the consequences of compliance may be somewhat distant from the desired behaviour. This contrasts with the normal definition of a behavioural programme where desired behaviours are specified in positive terms (e.g. "Lee will always express his wishes and feelings verbally") and the consequences of appropriate (or inappropriate) behaviour have a clear and specific relationship to the production of the behaviour.

2.5.11 Lee Powell was transferred to Ward 2 on 14th September. Initially his behaviour was sufficiently worrying, with serious threats being made against members of staff on the ward, for a meeting to be convened. The decision was made for him to remain on the ward, but for parole to cease temporarily. A further behavioural programme was commenced, and the clinical team agreed that (with the Section 37 due for renewal) continued detention in hospital was appropriate.

2.5.12 On 11th October 1994 a Mental Health Review Tribunal confirmed his detention. There followed several very disruptive days on the ward, involving threatening and aggressive behaviour towards staff and other patients. During November the Senior Clinical Psychologist, Mr Hossack, prepared a review of incidents in which Lee Powell had been involved since his arrival at the Clinic, a total of 119 incidents. Of the 119 incidents, 8% related to acts of aggression on others, 29% to violence against property, 60% to forms of self-injury, and 3% wherein he was himself the target of violence. Mr Hossack proposed continuing with the behavioural programme. Further unsettled behaviour continued, including an assault on the Social Work Team Manager Mr Heywood and further assaults on property. There were also serious threats against members of staff. A Care Planning Meeting was arranged early in 1995 to review the current and future management plans.

2.5.13 The Care Planning Meeting took place on 17th January 1995. It was decided to continue with the current behavioural programme, with the management plan to focus on interventions aimed at improving Lee Powell's self control. It was also decided that medication trials would not be introduced at this stage, but would be reconsidered for the management of Lee Powell's anger outbursts if anger management programmes were not helpful.

2.5.14 A further Mental Health Review Tribunal was held on 1st February 1995. The Tribunal decided that Lee Powell's detention under Section 37 should continue, but the decision was accompanied by written comments which endorsed the report of an independent assessor, Dr M Rose, a Consultant in Neuropsychiatric Rehabilitation based at St Andrew's Hospital, Northampton. The suggestions from Dr Rose involved an approach to the Transitional Rehabilitation Unit (TRU) for advice or even transfer to that establishment, and failing this a possible transfer to St Andrew's Hospital. These suggestions initially failed to find favour with the clinical team, who expressed doubts as to whether TRU would be able to handle the sort of violence that Lee Powell had shown. Nevertheless it was agreed that Dr Howard Jackson, now Clinical Director of TRU, should make his own assessment of Lee Powell. In the event, the assessment

was delayed because TRU was *"developing an additional facility to manage clients with slightly greater behavioural problems"* (Lyme House) and it was thought that Lee Powell would be appropriate for that unit. The new unit was thought likely to be available in July/August 1995. A separate Routine Assessment under the Care Programme Approach took place on 4th April.

2.5.15 Gradual progress was made with the behavioural programme and with anger management, although Lee Powell occasionally expressed frustration at the apparent lack of progress with long-term plans. By early May 1995 the possibility of a return to Ward 4 was being discussed., but there were regular setbacks, including further assaults on property.

2.5.16 A further Care Planning Meeting took place on 11th July, following a period of relatively sustained progress. A number of agreements were made with Lee Powell, including attendance at a Horticulture Group and National Vocational Qualification, together with weekly attendance at the Drop In Centre in Rodney Street, Liverpool. Progress continued for some weeks.

2.5.17 By October, however, his attendances had fallen off and there was increasing frustration within the clinical team at what was seen as a progress ceiling. Further violent incidents were recorded. Furthermore, the proposed opening of the Lyme House unit had been delayed.

2.5.18 On 24th October Lee Powell moved to Ward 4, on a temporary basis, primarily as a result of difficulties with another patient on Ward 2. However he remained stable there and stayed by agreement. A further Routine Assessment under the Care Programme Approach on 7th November decided to resume discussions with Purchasers about placement at TRU. Over the coming weeks Lee Powell's anxieties over any move to TRU needed constant reassurance.

2.5.19 During February 1996 there were further incidents of aggressive behaviour over relatively trivial incidents, with Lee Powell being extremely intimidating to staff on occasions, followed by apology and contrition. These were ascribed to his apprehension about a possible move to TRU.

2.5.20 On 6th March 1996 Lee Powell and his keyworker, Nurse C Edwards, went to TRU for an interview with Dr Jackson and a tour of the unit. Lee Powell was impressed with the unit and anxious to give it a trial. The keyworker's report indicated that Dr Jackson felt that Lee Powell was an ideal candidate for TRU, and that he would recommend that he be transferred there initially on 12 weeks' trial leave.

2.5.21 A Routine Assessment under the Care Programme Approach held on 11th March confirmed the intention to pursue the possibility of placement at TRU with the Purchasing Agencies. A meeting was held on 16th April (unfortunately in the absence both of Dr Jackson and a representative from Cheshire Social Services, who had been invited but failed to attend) at which it was made clear that details of the proposed

package of care would be required by each of the Purchasing Agencies. A Needs Assessment under the NHS & Community Care Act would be undertaken by Social Services in order to decide the extent of any funding from that source.

2.5.22 Dr Jackson wrote formally to Dr Finnegan on 25th April 1996, recommending that Lee Powell be admitted to TRU on a trial leave basis for an initial period of six months. The letter contained a list of rehabilitation targets and proposed methods for achieving them. Despite the wait for the opening of Lyme House, it was proposed that Lee Powell should be admitted in the first instance to the less restrictive Stage 3 of TRU's community re-entry programme, at Ashton Cross, with a fall-back to Lyme House if his behaviour should deteriorate.

2.5.23 The Needs Assessment was sent to Lee Powell for his agreement early in June, but he expressed his frustration at the slow pace of progress. A further meeting was arranged with Purchasers for 9th July to discuss funding arrangements, in particular the apportionment of the weekly charge of £1330, but the proposed placement had the strong backing of the clinical team. At the meeting on 9th July, joint agreement was reached on the apportionment of funding, and to fund Lee Powell's placement for a maximum of 12 months. The agreement was confirmed in writing by South Cheshire Health Authority on 12th July 1996

2.5.24 **Comment:**

The Panel of Inquiry has seen no formal service contract between the Purchasers and TRU. It is also uncertain which of the purchasers conducted a formal assessment of the suitability of TRU, in particular of the Ashton Cross unit, for Lee Powell. When a potentially costly referral is made, particularly when security issues are involved, it is desirable that a full evaluation of the costs and benefits is carried out prior to placement with a clear contract between both parties of their respective responsibilities.

2.5.25 A further incident occurred on the night of 14th July when Lee Powell presented a violent and intimidating threat against the two female members of night staff on duty on Ward 4. He was asked to turn his radio down following a complaint from another resident, but responded with threats and aggression of sufficient seriousness for the duty staff nurse to activate the disturbance alarm. Two assaults on a female Health Care Assistant were only prevented by the skilled intervention of the duty staff nurse, by two male staff who were passing the ward entrance and heard the commotion, and then by the intervention of staff from other wards who responded to the alarm call. The Health Care Assistant was extremely distressed and frightened. Lee Powell was restrained until he was calm, and he then became contrite and apologetic. Discussion took place about whether he should be removed from the ward, but the consensus view was that he was anxious about his impending move to TRU, (the term 'gate fever' was used by several witnesses), that the outburst might be a device to delay the move, and that to remove him from the ward might be the response he was seeking. He was taken to a local public house by the senior male nurse on duty, to give him the

opportunity to disclose his anxieties. On return to the unit he remained apologetic and retired to his room, but two days later he was recorded (via another patient) as still making threats against the Health Care Assistant.

2.5.26 Comment:

The Panel of Inquiry looked carefully at this incident, and interviewed the staff most directly involved. We are of the view that the incident was both serious and dangerous. The notes of the clinical meeting which took place two days later are muted in their description of the event, and we understand that none of the staff involved in the incident attended that meeting, and that Dr Finnegan himself was unable to do so. There seems to have been little attempt to gather information about the incident from the staff involved, although an incident report form was completed by staff nurse J Dunn, who had been the senior nurse on duty on the ward. Consideration was given to moving the Health Care Assistant off the ward until after Lee Powell's move to TRU *"due to threats made against her."* The incident was not mentioned at all at the Section 117 Pre-Discharge meeting which took place seven days later, on 23rd July. Whatever the cause of the outburst, and 'gate fever' seems unlikely per se to have been the sole cause, its manifestation was acute, and required skilled professional intervention to contain.

After such an incident, especially in a forensic psychiatric service, we would have expected that there would be a major review of a patient's mental state. We would also have expected there to be a careful consideration of the implications for future management plans.

2.5.27 The Section 117 Pre-Discharge meeting on 23rd July confirmed the plans for the proposed move to TRU. The possibility of Supervised Discharge or of a Guardianship Order was deferred for consideration at the next meeting. The Section 37 Order was to remain for at least 12 weeks, and Lee Powell would be on leave, under Section 17 of the Mental Health Act, after his placement at TRU. A review would take place six weeks after placement, on 9th October, at TRU. Mr D Heywood, Social Work Team Manager at the Scott Clinic was named as the keyworker. Lee Powell himself expressed the wish that his parents should not be involved in his future care. There had been no contact between him and his parents for some time. Lee Powell went to visit TRU and met his primary coach, Mr N Grady. He moved from the Scott Clinic to Ashton Cross on 27th August 1996.

2.5.28 Comment:

Earlier proposals that Lee Powell would initially be transferred to the new, more secure facility at Lyme House (stages 1 and 2) had now changed. Dr Jackson considered that the Ashton Cross site (stage 3) would be more appropriate *"since this will permit him to continue to engage fully in personal care, provides maximum contact with work and social activities".* If Lee Powell made good progress, he would in due course transfer to one of TRU's Independent Living Units at Lyme