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

House and from there into a community house with gradually reducing support. In the event of deterioration, he would transfer to TRU's stage 1 or stage 2 programmes at Lyme House which offer *"a greater degree of structure and support and could tolerate more aggressive behaviour."*

2.6 Care in TRU, 27th August 1996 to 23rd December 1996

2.6.1 The Transitional Rehabilitation Unit now provides a range of community living settings and associated vocational and day activities, together with outreach programmes, for people with an acquired brain injury. It has developed primarily on the initiative of Dr Jackson, who had worked for some years in a Special Hospital setting. The first such unit, at Ashton Cross in Ashton-in-Makerfield, opened in 1992, and subsequently a second unit, at Lyme House in Haydock followed in 1996. Both units are registered under the Registered Homes Act 1984 by St Helens Metropolitan Borough Social Services Department. The concept of Transitional Rehabilitation originated in the United States. It is implemented at TRU via the use of a supervisory team of case organisers, who are therapists from various professional disciplines who devise and monitor rehabilitation programmes. The implementation of programmes is carried out by "coaches", who are largely without previous clinical experience. The coaches are required to undertake a 12-week induction and training programme, followed by an examination, prior to working with clients on their own.

2.6.2 TRU training manuals describe a number of key elements in its service: these include the use of highly structured individualised behaviour programmes based upon a hierarchically organised system of colour-coded planners, the use of personal rehabilitation coaches to work with clients under the direction of a transdisciplinary team, and the provision of a holistic and progressive approach to brain injury rehabilitation. Clients enter the planner system at a level appropriate to their needs and abilities, and a system of daily and weekly individual plans and reviews are established, directly involving the client.

2.6.3 Lee Powell was admitted to Ashton Cross on 27th August 1996, to a small unit with 4 bedrooms, a lounge, and a kitchen. Dr Jackson told the Panel that the transfer was carefully prepared and the transfer of records properly undertaken, but that there were limitations with regard to *"the actual neurological evidence with respect to his brain injury, which I do not think we ever really got hold of"*. Dr Jackson told us that Dr Finnegan had discussed the incident of 14th July with him (see paragraph 2.5.25 above). Dr Finnegan's view was that the incident had been provoked by the uncertainty and consequent anxiety experienced by Lee Powell as the date for transfer to TRU approached. It was recognised that one of the danger areas was of sudden aggressive responses to anxiety-provoking situations. Indicators of relapse were recorded by Scott Clinic as *"Outbursts of anger unameliorated by behaviour treatment and or counselling. Threats to harm people. Displays of violence and aggression to inanimate objects. Assaults on people. Self harm due to build up of frustration and*

anxiety. Re-establishment of tension within Lee's family of origin should he become involved with them again. Wish to return to conditions of greater security and safety."

2.6.4 Comment:

Lee Powell had been a resident at the Scott Clinic for more than 5 years when the transfer took place. The placement had followed an initial assessment by Dr Rose in January 1995, (which first suggested an approach to TRU), and a further assessment by Dr Jackson himself in March 1996. Several meetings had taken place leading up to the transfer date. A Section 117 pre-discharge meeting was held on 23rd July. Meetings had taken place with each of the purchasers (South Cheshire Health and Cheshire Social Services Department) and joint funding responsibilities agreed, and a further meeting on 23rd July formally recorded the aftercare programme. The placement was to be on the basis of 12 weeks' trial leave, and emergency action was agreed should difficulties arise. The question of the possibility of placement on the Supervision Register or of Supervised Discharge was deferred until the next Review Meeting. Staff at the Scott Clinic (notably Dr Finnegan, who would continue as RMO, and Mr Heywood, who would become the keyworker,) would maintain a close ongoing contact with Lee Powell. There seems to have been an unanimous hope that, after such an extended stay in the Scott Clinic and after such long preparation, a suitable placement had finally been found for Lee Powell.

2.6.5 Lee Powell settled well at Ashton Cross. A regular programme of Daily Planners and Target Sheets was undertaken, together with Daily Reviews and self-assessments. A Primary Coach was allocated to him, while Dr Jackson was his Case Organiser. Lee Powell was placed immediately on the second stage Planner level, and achieved all his behavioural targets easily. He was engaged both in the joinery workshop and the garage at TRU. It is recorded that he was proactive in seeking assistance and was fully involved in negotiating his work placements and rehabilitation programme. He indicated a wish to learn to drive.

2.6.6 Although a number of minor outbursts of frustration were recorded, they had been short-lived and reasonably well-controlled. Lee Powell himself sought out staff to discuss his problems and there was every indication that he was investing a great deal in making a success of his placement. He was engaging positively in group work, which incorporated the development of anger management techniques, and was generally very positive regarding his placement and future. He was adamant that he wished to have no contact with his family, and that his new address should not be made known to them.

2.6.7 The first monthly review at TRU was held on 9th October 1996 (six weeks after placement, as planned), and the second review meeting took place on 13th November, five weeks later. No further formal review meeting is recorded before the homicide on 23rd December, and no further meeting had been arranged by that time. We understand that the minutes of the October Review were taken by Dr Jackson (although not

circulated until after the homicide, and which contained a number of errors) and minutes of the November Review were taken by Ms Pippa Cross, a Clinical Psychologist at TRU (and not circulated until after the homicide) and by Dr Finnegan. Mr Heywood's role as keyworker, while confirmed at each of the Review meetings, was confined largely to maintaining regular contact with Lee Powell. Mr Heywood was unavoidably absent from the November Review, but both November Review notes stress the importance of copies of Review notes being made available to him. The date for the next Review was deferred until Mr Heywood's availability could be confirmed, but a date had still not been fixed six weeks later. Responsibility for arranging meetings, and for the taking and circulation of minutes had been given to Dr Jackson, on the basis that the meetings could be arranged to coincide with TRU Review meetings. However no firm grip seems to have been taken when Dr Jackson's responsibilities failed to be undertaken.

2.6.8 Comment:

Management of the Review process is very much at variance with advice contained in successive Department of Health Circulars and Guidance Notes, and with the recommendations of many previous Homicide Inquiries. Responsibilities normally associated with the keyworker were delegated, and failed to be undertaken. It was not clear who was managerially accountable. Knowledge about the Care Programme Approach within TRU seems at best to have been superficial.

These limitations had, however, already been recognised within the Scott Clinic. Following an internal audit in 1995, a revised procedure modification rationale was published in October 1996, and a new set of documentation introduced in December 1996. A further revision took place during 1998, in which risk management protocols and the responsibilities of both inpatient keyworker and community keyworker were very much more clearly set out.

However we remain concerned that, for whatever reason, the culture of the Care Programme Approach generally has taken a considerable time to inculcate clinical teams across the country, particularly 'outposted' teams, and that there remains no definitive practice guide for keyworkers. This concern was echoed in evidence by the Assistant Director of Social Services for St Helens Metropolitan Borough Council, Mr Wakefield, (Mr Heywood's supervising officer). We understand, however, that in 1996 the NHS Executive commissioned the Care Programme Approach Association to produce a handbook for CPA keyworkers, and that the handbook is now in final draft.

We support the recommendations of the Trust's Internal Inquiry (see Appendix A) relating to the effective implementation of the Care Programme Approach.

2.6.9 Lee Powell's initial progress was maintained through October and early November 1996. It was reported that he was using anger management techniques consistently without prompting, that his social interaction with staff and other clients had been exemplary (although there had been minor problems with one other client), that he was using systems and routines successfully and that he was achieving goals in advance of schedule. Occasionally, Lee Powell's written 'options' for anger management and control of incidents became bizarre... *"Maybe kill somebody because I'm selfish"*...but they seem to have been written in a flippant style, and the Panel is uncertain whether or not to attach any significance to them. A move up to the next planning level had opened up the possibility of residence in the community if current progress was maintained. More significantly, the decision had been taken not to seek to renew Lee Powell's detention under Section 37 of the Mental Health Act, which would expire on 15th November, and the implications of this had been carefully discussed with him by Dr Finnegan. The importance of running future CPA Reviews and Section 117 Aftercare meetings in parallel was stressed. Mr Heywood's position as keyworker was confirmed, at least until it was clear that it was appropriate for a change to be made. It was agreed that Lee Powell's name should be placed on the Supervision Register (though not with any great expectation from the Scott Clinic that this would provide any additional safeguards or additional service). It was agreed that he should not be made subject to Supervised Discharge, on the basis that it would *"not assist Lee Powell in obtaining services and would, in any event, alienate him rather than ensure his co-operation"*.

2.6.10 **Comment:**

The decision not to invoke Supervised Discharge was not unanimous. Mr G Meyer, an Approved Social Worker with Cheshire Social Services Department, who acted as Care Manager for Lee Powell, told the Panel that he and his colleagues believed that safeguards were required after Lee Powell's detention under Section 37 of the Mental Health Act was allowed to lapse. He felt that Supervised Discharge would assist in this by building in formal requirements to the care plan, including conditions relating to change of residence.

However the views of the clinical team prevailed, and reflect the very limited take-up of Supervised Discharge since the guidance was issued by the Department of Health in February 1996 (HSG(96)11). It could be argued that, had Supervised Discharge been invoked, Lee Powell's move from Ashton Cross to an ILU at Lyme House would have been the subject of a further review before the move took place, but his perceived general level of progress was such that the proposed move would in all probability not have been challenged by any of the Agencies involved.

2.6.11 The notes of the November Review, which were not circulated until after the homicide, make clear that Dr Jackson was cautious about Lee Powell's remarkable rate of progress in the eleven weeks since his admission to Ashton Cross, and commented that *"when things get more hectic things may not go so well"*. Dr Jackson expressed the

view that *"the rate of progress may slow down"*, and, prophetically, that *"Christmas might be a difficult time for Lee"*. Mr D Birkett, a primary coach at TRU, also commented *"we need to be wary that once Lee's restrictions are removed then certain potential for adverse reaction to situations he dislikes or disagrees with is a definite possibility"*.

2.6.12 Comment:

With the benefit of hindsight, Dr Jackson's caution was well-judged, but little action seems to have been taken to acknowledge it. Dr Finnegan was also wary of the possibility of Lee Powell moving back into the community without adequate ongoing support. He had been resident at Ashton Cross for less than three months.

2.6.13 Mr Heywood continued to visit Ashton Cross regularly, but by the end of October was already discussing the possibility of the keyworker role being transferred to the primary coach in TRU, Mr Grady, particularly as Lee Powell was expressing the wish gradually to dispense with regular or frequent interviews and visits. It was also felt that the role of Cheshire Social Services Department needed clarification if TRU were to take on the keyworking role.

2.6.14 Early in November, Lee Powell's father learned that he had been moved on from Scott Clinic, and wrote to Dr Finnegan expressing his surprise and unease at not being told previously. He had made contact with Dr Finnegan because a small life insurance policy had matured in Lee Powell's favour, and required administration. Dr Finnegan replied to Mr Powell explaining what had happened and why.

2.6.15 On 12th November Lee Powell's status of detention under the Mental Health Act was allowed to lapse. On 18th November he was informed in writing that his name had been placed on the Supervision Register, and that he had been discharged from Scott Clinic. He was nevertheless to receive ongoing support from Dr Finnegan and from Mr Heywood.

2.6.16 On 7th December, Lee Powell signed his agreement to TRU terms and conditions of residency, which included references to no alcohol and to restricted access to the bedrooms of other residents.

2.6.17 Comment:

So far as the Panel has been able to establish, this is the first occasion when a formal contract of residence had been signed by Lee Powell. He had been in residence for more than fourteen weeks. It is important for the protection of both client and organisation that clear agreements are made and formalised at the earliest possible stage.

2.6.18 Lee Powell continued to make good progress in self-assessment and anger management. The only major problem is recorded on 18th December, when Lee Powell's self-assessment (*"brilliant"*) was considered wholly unrealistic by the coach Mr Birkett, who recorded several *"problem areas"*, including Lee Powell's attitude and his petulant behaviour to everyone..

2.6.19 On the following day, 19th December, Lee Powell was moved to one of the 4 ILU's at Lyme House. This move towards greater independence had been planned to take place sometime in the new year (1997) if his level of general progress had been maintained. It was accelerated because Ashton Cross was to close for the Christmas period. All the other residents would be away, most of them at home, which would have left Lee Powell as the only remaining resident. In the light of his continuing progress, it was agreed within TRU, and with Lee Powell himself, that the best available option was for him to move to an ILU for a trial period over Christmas. His keyworker Mr Heywood learned of the move by chance on the day it occurred when he visited Ashton Cross, but none of the other partners in the placement, including South Cheshire Health and Cheshire Social Services Department, knew of the move until after the homicide.

2.6.20 Comment:

The decision to move Lee Powell to an ILU at Lyme House was unilateral, but there is little to indicate that this decision would have been opposed by the other agencies involved, despite the earlier expressions of caution. It seems likely that his progress at Ashton Cross had been such that the move would have been agreed by all the partners in care. But the lack of consultation is indicative of an inherent weakness in care planning, which in all probability was due to the lack of clarity about the role of the keyworker, and by a lack of understanding within TRU about the basic principles of the Care Programme Approach. For the keyworker to have learned about such a critical change in the care plan by chance is a serious failure of communication. Nor do any of the daily planners give warning of an impending move, suggesting that planning and preparation for the move was relatively late.

2.6.21 Three of the four ILU's at Lyme House were occupied over the Christmas period. The units were situated two on each corner of the main building. The unit next to Lee Powell's was unoccupied. Paul Masters occupied one of the remaining two units. Some of the staff from Ashton Cross, including Lee Powell's primary coach Mr Grady, transferred their duty to Lyme House to give additional support. Lee Powell moved from Ashton Cross during the morning of Thursday 19th December, and during the afternoon went out for a walk and bought himself a radio cassette recorder. He was disappointed to find that the recorder didn't work, but dealt with his frustration sensibly. His end-of-day self-assessment was 'good', the only blot being the faulty radio. The assessment was countersigned by one of the coaches, Mr Lockwood, and the daily review was completed by a separate coach, Mr Bailey.

2.6.22 On Friday 20th December Lee Powell completed his daily planner, spending most of the day settling into his new unit, but he also took time to join Haydock Library, and rang to find out about his attendance at the mechanics centre. He completed his end-of-day self-assessment (*"an experience I've been looking forward to – it's a good and worthwhile one"*) which was countersigned by one of the coaches. However no daily review took place, the first such omission since Lee Powell moved to TRU.

2.6.23 A similar pattern was followed on the following day, Saturday 21st December. (*"Had another good day – getting on in my ILU – thought I'd have had problems by now (the night is young)"*) with all targets achieved. Again, however, no daily review was undertaken by a coach.

2.6.24 There are no records at all for Sunday 22nd December, neither daily planner, or self-assessment, or daily review.

2.6.25 The only record for Monday 23rd December is an (unsigned) daily review by one of the coaches for the afternoon period. However it records *"Followed planner unsupervised. Mechanics unsupervised. Client reported no problems to point of contact coach. Dinner unsupervised. Watched TV and relaxed."* There were no indications of the tragic events which were to follow so shortly afterwards.

2.6.26 Comment:

Given the importance attached to the very structured approach to daily living at all units at TRU, it is very surprising that the routine of daily planning, self-assessment, and review should have collapsed so soon after Lee Powell's arrival at Lyme House. Dr Jackson had warned at the November review that Lee Powell's progress would probably be slow, and that Christmas would probably be a difficult time, so the sudden absence of a structured routine at such a critical time is not easy to comprehend. Dr Jackson was unable to offer any explanation when asked by the Panel.

CHAPTER 3 Paul Masters

3.1 A background note

3.1.1 The Panel 's terms of reference relate to the examination of Paul Masters' care at TRU. Nevertheless it has seemed appropriate to give a brief background description of his earlier years.

3.1.2 The main documentary evidence available to us concerning Paul Masters previous and contemporary history were the files made available by TRU. These contain a number of psychological reports, probation reports, and internal TRU records.

3.2 Early years and school history

3.2.1 Information on Paul Masters' early years is sparse and based on his own accounts given to various professionals after his head injury. The documentary evidence at our disposal is somewhat contradictory in its detail and timing. This is not unexpected, given that it is based on interviews with Paul Masters after his head injury when his memory for dates and detail might be expected to be unreliable. From the various reports we learned that he was born in Chester and brought up in Broughton. He had a normal birth and early development. His parents divorced when he was 3, and he had no further contact with his natural father. He attended Broughton Junior School, Queensferry Junior School and Deeside High School. He left school at 16 with no formal exam qualifications. He apparently required extra tuition in English and Mathematics. He is also described as truanting from school. It appears that when he was 15 he got into trouble with the law for stealing eight bicycles. He received a fine and a two year Probation Order for this offence.

3.3 Early life after school

3.3.1 On leaving school in 1985, Paul Masters attended a YTS training scheme in woodwork. This was followed by a period of unemployment and then in April 1989 to June 1991 he attended another employment training scheme as a storeman in a warehouse. It was over this period that he had his first sexual experiences.

3.3.2 As sexuality and sexual experiences play an important part in Paul Masters' life, and ultimately and tragically in his death, we have considered this aspect in some detail. According to the report by Dr E Ghadiali, Consultant Neuropsychologist, he had girlfriends at school and his sexual interests were in females until he had homosexual experiences with an older man in 1989. It appears that this man was a dominant and

corrupting influence. It also appears that around the same time he had sexual relations with a female partner, which he reported as being more satisfying.

3.3.3 Paul Masters also began a sexual relationship with a younger man who he introduced to his older partner. He later claimed that he was unaware of the age of this man and regarded him as a willing partner, but he was in fact a minor. He appeared in Court in May 1995, charged with offences of buggery and indecent assault on a minor. The charges themselves appear to relate to the making of a pornographic video, at the initiative of the older man. There are indications that the cognitive deficits arising from the head injury may have been a significant factor in the commission of these offences, along with impaired social judgement arising from frontal lobe brain injury.

3.4 The effects of head injury

3.4.1 Paul Masters received his injury from an assault in 1992. A report by Ms S Hope-Borland, a Consultant Clinical Psychologist from the North Wales Forensic Psychiatric Service, describes him as remembering events before the assault quite vividly. He was in his bedroom, heard someone throwing stones at his window, and saw four men running away. He got dressed quickly, chased them and managed to grab one of the men's T-shirt. The next thing he remembers is waking up in hospital.

3.4.2 Paul Masters was seen for a neuropsychological examination on 21st March 1995 by Dr. Ghadiali. This examination involved an interview and extensive psychometric testing. Dr. Ghadiali noted that he had been unconscious for 16 days following an assault and injury in 1992, and commented that this is indicative of a *"very severe head injury"*. [The Panel has sought the hospital case notes relating to this accident to corroborate the information given to Dr Ghadiali but has been advised that they are no longer available]. Dr Ghadiali also commented that *"It would not be uncommon to find a significant psychological change caused by permanent brain damage in a head injury of this severity"*.

3.4.3 The test results obtained bear this out. Paul Masters is reported as having suffered some acquired intellectual impairments and also some degree of memory impairment, which overall was not considered severe *"and should not cause any major difficulties in his everyday life"*. No impairment of language function was found.

3.4.4 There was clear evidence of impairment of frontal lobe functioning on the Wisconsin Card Sort test, which Dr. Ghadiali describes as *"very abnormal result, and strongly indicative of specific impairments to frontal lobe executive functions of planning, problem-solving, and concept formation"*.

3.4.5 Dr. Ghadiali reports that he was within normal limits on a standard screening scale for anxiety and depression.

3.4.6 **Comment:**

While the test results indicate a significant degree of intellectual impairment, it has been difficult for the Panel to understand how this was reflected in Paul Masters' everyday behaviour at the time. On the face of it, there is a contradiction between his ability to live in the community and apparently to work on the one hand and the significant level of difficulties and impairments he later showed at TRU on the other. This contradiction is perhaps resolved to some extent by the observation that he lived with his mother up to the time he lived in the Bail Hostel. She may have provided a high level of supervision and support to him after his head injury.

3.4.7 The Court imposed a Probation Order of 3 years duration on Paul Masters in August 1995. The condition of the Order allowed the Probation Service to seek alternative placements that would address his specific and specialised needs.

3.4.8 Prior to sentence, Paul Masters was assessed by Ms Hope-Borland at the request of the staff at the Plas y Wern Approved Probation Hostel. The assessment was sought because of behavioural difficulties at the Probation Hostel and was arranged by the defence solicitors. He was seen on 3rd August. The problems he was seen to be experiencing at that time were considered to be a result of a combination of factors: anxiety about his forthcoming sentencing, worries about his mother's health, and difficulties within the hostel arising from impulsiveness and disinhibition caused by brain injury. The recommendation was to refer Paul Masters to a specialised neurorehabilitation centre where he could be given treatment to address some of difficulties arising from frontal lobe dysfunction. Investigation of his sexuality was also recommended.

3.5 Referral to TRU

3.5.1 An approach was made to TRU by the Probation Service to assess Paul Masters' suitability for rehabilitation, and he was seen there for assessment by Dr. Jackson on 16th October 1995. It is noted in Dr. Jackson's report that Paul Masters' mother had died three weeks prior to this assessment.

3.5.2 The records indicate that Dr Jackson's initial assessment report was based on an interview with Paul Masters and a review of previous assessments undertaken by Dr. Ghadiali and Ms Hope-Borland. Paul Masters was also accompanied by his Probation Officer, Mr E. Evans. There is no record of a further assessment of independent living skills being carried out at this stage. Paul Masters is described by Dr Jackson as disorganised and impulsive over spending money, and disinhibited sexually. *"His basic self care is good but he requires help in organising and structuring his life, because at times he lacks motivation and other times he appears highly impulsive."* He is reported to have become very intolerant and that minor frustrations *"lead to him exploding."* Dr Jackson gives no details in this report about the nature of these

'explosions'. Paul Masters was reported to be *"very concrete and literal"* as a consequence of his frontal lobe injury. He was said to be *"... socially gauche and blunt, prone to misinterpretation and has considerable problems in both appreciating social nuances and moral issues"*. Dr Jackson considered his memory function to be impaired to a degree that did affect his everyday life function, in contrast to Dr Ghadiali's report.

3.5.3 Paul Masters is reported to be over-reactive to trivial events, echoing the report by Ms Hope-Borland. For the first time he is explicitly described as having mood swings *"with periods where he has little control over his emotions with resulting temper problems and swings from depression to elation and excitement"*. Dr Jackson comments that *"It is clear that his ability to self-monitor and modulate his moods is impaired."*

3.5.4 It is stated in Dr Jackson's report that *"Paul Masters has not worked since the assault"* though this is in contradiction with other reports which state that he worked on a scheme to assist people with disabilities after his injury. We have been unable to determine if Mr Masters worked in a voluntary or paid capacity on this scheme.

3.5.5 Dr Jackson's overall conclusions in this report were as follows:

"Mr Masters suffered a diffuse brain injury with pronounced frontal lobe injury affecting his cognitive abilities, abstract thinking, self-control, judgement, planning and organisation. He is therefore more suggestible and easily influenced and more at the mercy of personal whims and immediate gratification. The impact of this brain injury on his life has been severe, but his impairments are subtle and difficult to see in casual conversation. At a cognitive level, he is experiencing reduced speed and efficiency of thinking, impaired memory for new information, impaired attention and attentional control and impairment of judgement and decision-making. He has suffered considerable personality change with marked mood swings and apathy and impulsivity. In my opinion this is largely due to his brain injury although it is undoubtedly further compounded by subsequent psychological factors, leading to general deterioration in mood, motivation and behaviour."

3.5.6 The aims of the care plan were clearly set out at the end of Dr Jackson's report:

1. *Developing community re-entry skills*
2. *Developing adaptive coping behaviours to ameliorate cognitive deficits – including these effects are always for memory, planning, organisation self evaluation and goal directed behaviour.*
3. *Psychological counselling with respect to sexual morality/appropriateness and mood.*
4. *Temper control training.*
5. *Improving attention and concentration.*

The means by which these were to be achieved were set out in the appendix to the report.

3.6 Admission to TRU

3.6.1 Clwyd Health Authority accepted financial responsibility for funding a 12-week placement. Paul Masters commenced his rehabilitation at TRU on 4th March 1996. He was initially resident at the Ashton Cross site, and was placed on the second lowest of the 6 planner levels in the TRU system and the one on which new residents are typically placed. Clients are required to use a daily and weekly planner to set their activities and targets and are able to earn 50p per target at this level to a maximum of £4 per day. Prompts from coaches to achieve targets are expected at this level and the client cannot move to the next level until coach prompting for individual targets is minimal. Ms L Harrison was Paul Masters's primary coach initially.

3.6.2 The initial monthly client report for March 1996 gives a picture of someone who is helpful towards others "*He will carry bags for people or out shopping he will help someone to read a price on food or help to get food off the shelf*" and who likes to talk about himself to coaches or other staff. He appears to be having some difficulty accepting TRU routines and procedures "*Thinks attention training exercises are stupid and doesn't see the point in them..... Needs prompts to use weekly planner and notebook. Tends to reschedule without telling coach working with him and tries to make other arrangements without coach knowing*". It is noted that he needed prompting to change his clothes, that he tended to be impulsive while shopping and that his cooking tended to be a bit hasty and disorganised. It appears that Paul Masters was at this stage quite resistant to prompting, guidance, and instruction. "*If a coach is talking to him he will not give eye contact and most of the time will walk off mid conversation*"; "*When confronted with a situation, Paul Masters will withdraw himself from the situation. When behaviour is inappropriate Paul will not take prompts immediately.*"

3.6.3 Five monthly rehabilitation aims were specified in this report: to help him become more socially interactive with other clients; to help him to use systems more effectively; to help him become more socially aware; to get him to stick to allocated meal times; and to provide backup for the primary coach by an 'authoritarian' figure "*to provide boundaries for Paul's abusive behaviour.*"

3.6.4 Comment:

There is little indication in the documentation of what this abusive behaviour is at this point of Paul Masters' stay at TRU.

3.7 Progress at TRU

3.7.1 We have been unable to obtain sight of the daily and weekly planner sheets which will have been the basis of Paul Masters' programme at TRU. Consequently we are reliant solely on the monthly reports for information on his progress, together with retrospective information from witnesses, and from reports written after the homicide.

3.7.2 **Comment:**

The Panel has seen no formal record of Paul Masters' agreement to undergo the programme in the documentation at our disposal, though we understand it is normal practice for all TRU clients to receive a formal contract and a Bill of Rights. Such records are an important source of reference and protection for both client and organisations, and we are surprised that no documentation of this nature could be made available to us by TRU.

3.7.3 The difficulties that Paul Masters had initially in engaging in the TRU programme and structure are reported to have continued throughout his stay. He never managed to move up to the next planner level because of his difficulties in accepting the basic rationale for the system and his continuing need for prompting and support. Some activities he clearly enjoyed, such as gardening and computers, where the reports on his participation and progress are positive in almost all the available monthly reports. There are positive reports on his progress in his personal self-care, his abilities to shop and to prepare meals. However, he is reported to have been quite resistant to using his planner as intended. There are numerous references throughout the reports to his failure to refer to his daily planner without prompting, and his failure to take it with him during the day. It seems that throughout, he was unwilling to refer to his weekly planner while completing his daily planner, despite this being the intention and requirement of the system.

3.7.4 Comment:

It seems that the major difficulty that the TRU staff had with Paul Masters was with his general attitude and social behaviour rather than with any specific activity. Mention has already been made of the March report's rehabilitation aims of *"providing boundaries for Paul's abusive behaviour"* though the nature of this behaviour was not clearly specified in that report.

3.7.5 Later reports give more specific examples: in May, it is recorded that:

"If talking to Paul he will interrupt half way through the conversation. Will speak inappropriately and in a loud voice. Has been found spitting round site quite a few times. When pointed out Paul doesn't see there is any wrong in it".
and
"Paul has spoken aggressively to three members of staff. These coaches have felt very confronted by Paul's behaviour due to him shouting and clenching his fist.

This is due to Paul being confronted. When he is confronted he normally walks away. In these situations he kept coming back."

3.7.6 It was also noted in the same report that *"Paul is very impulsive which we are trying to work on"* and that he had been given a specific target of not walking away when a coach was speaking to him.

3.7.7 Despite attempts through targeting behaviours and work in therapy sessions to reduce Paul Masters' level of impulsiveness and aggressive inclinations towards staff, it appears that his behaviour did not improve. He was transferred from the Ashton Cross unit to Lyme House on the 10th of June, as the June monthly report records:

"On 10th June, Paul was transferred from the Ashton Cross to the Lyme House unit due to continued behaviour incidents, including verbal and physical aggression towards coaches. The move was made to provide Paul with greater structure and supervision within which to increase his behavioural stability and display of positive social behaviours."

3.8 Transfer to Lyme House

3.8.1 Paul Masters' primary coach now changed from Ms Harrison to Mr J Martin III. According to the report by Mr Martin written after Paul Masters' death, (in January 1997), there had been an escalation of verbally abusive and threatening behaviours towards particular staff members, and the move was precipitated by an incident where Paul Masters threw a brick at a staff member.

3.8.2 Lyme House is generally occupied by those clients with greater cognitive impairments, behaviour difficulties, or other high levels of care needs. The June monthly report, the first of his stay at Lyme House records:

"At times since his move to Lyme House, Paul has become both verbally and physically aggressive. These episodes have occurred approximately 2-3 times each week, lasting from between 5 minutes up to 45 minutes. Most often, the incidents have resulted from limitations placed on his behaviour, such as not being able to leave site when he wants, or not being allowed to carry sterling. On one occasion, he became upset because a restricting bar had been placed on his window to prevent it opening fully. The bar was placed because Paul had climbed out of the window on one occasion and gone to a male peer's independent living unit after bedtime. The window was subsequently locked, but Paul broke the lock. When he discovered the bar, Paul became argumentative and verbally abusive with a coach and kicked the window. He was restrained for approximately 5 minutes to ensure his safety. Afterwards, he remained abusive and attempted to walk off-site. When he was prevented by a coach, he became physically aggressive towards the coach and was restrained for 10 minutes until he had regained his composure. It should also be

noted that Paul has had no significant behavioural incidents for the last eight days of the month."

3.8.3 Comment:

These are the first records of his requiring restraint and they would appear to represent something of an escalation of his aggressive behaviour and the need for greater degrees of control. These issues will be discussed in detail later in the report.

3.8.4 In the following (July) report, two further incidents requiring restraint are noted, along with other lesser periods of agitation which occur on average 4-6 times per week.

3.8.5 On the positive side, it was noted that he continued to work well in his vocational activities, that his participation in daily living skills, decision-making and communication skills sessions was 'active and relevant', and that his use of the cashbook was improving. His social interactions were improving in some respects; he was using fewer swear words and his interactions with others were said to have been appropriate *"a majority of the time"*, though he still tended to interrupt coaches when they were doing other things.

3.8.6 The August report cites two further incidents towards coaches which again ultimately required restraint. Additionally, he had been requested to leave structured activities 8-9 times during the month because of verbally abusive behaviour. It was also noted that *"lesser degrees of redirection for negative remarks or cursing occur almost daily"*.

3.8.7 This month also saw the first recorded incident of Paul Masters being involved in an aggressive incident with another client which occurred on 30th August. Information about the nature of this incident is limited. The notification to the Registration Authority at St Helens simply states that Paul Masters was involved in an altercation with another client and received a cut under his eye and a swollen left cheekbone. He was taken to Wigan Infirmary where he was examined, the cut sutured, and he was discharged and advised to rest for 24 hours. Mr Martin's January 1997 report states that this incident was caused by Paul Masters making an insulting remark to another client. It also noted that Paul Masters *"took no responsibility for provoking the assault"*, and this lack of perceptiveness about the consequences of his behaviour is a recurrent theme throughout the reports.

3.8.8 Another new development during this month was an incident of stealing money from another client's room. At first Paul Masters denied he had done this, but subsequently admitted it. He hid some of the money in the Ashton Cross unit and some he buried in the flower beds at Lyme house. He could give no explanation as to why he took the money or why he hid it as he did.

3.8.9 The final full report available to us is that for September. This reports a 1½ - 2 week period at the middle of the month *"where he exhibited less confrontation, cursing, and*

agitation and had no significant behaviour incidents". It was suggested that the improvement was motivated by a desire for a personal shopping outing and an attempt to demonstrate his readiness to return to Ashton Cross. However, following the shopping outing *"Paul's behaviour gradually returned to previous levels"*. There were, however, no incidents of physical aggression and no occasions resulting in restraint.

3.8.10 At some point in September a new behaviour programme was introduced - this is referred to in the September monthly report and in Mr Martin's January 1997 report. The new programme used a points system whereby Paul Masters could earn points for positive behaviours (like replying politely to comments from coaches) and losing points for negative behaviours (like swearing). It would appear that this brought about a temporary improvement in Paul Masters' behaviour, as this extract from Mr Martin's report shows:

"Improvement continued to be noted during late September and into October as a more stringent behaviour programme was started. During this time, fewer and shorter outbursts were noted, less general use of inappropriate language was observed, and Paul appeared more willing to listen to feedback and suggestions from staff members. For the first time, he also began expressing pride in his achievements with the programme. In vocational placements, particularly gardening, he was receiving positive evaluations from his supervisors."

3.8.11 The improvement was only temporary, however, according to Mr Martin's subsequent observations:

"By the end of October, however, Paul appeared to lose interest in the behaviour programme and was beginning to express a growing frustration with his progress. During this time there was an increase in behaviour problems and a decrease in his participation in rehabilitation activities. There was also an incident where Paul self-injured himself, cutting his arm superficially with an unknown object. Faced with the possibility of losing the gains in behaviour achieved, the decision was made to provide Paul a trial in an Independent Living Unit with a more "reality based" treatment programme".

3.8.12 Comment:

This is the first recorded incident of deliberate self-harm and suggests a further deterioration.

3.8.13 Documentary evidence from here onwards is very sparse. There is a sheet headed 'October big review notes' which appears to be the conclusions of a substantial review of Paul Masters' case. In it, the decision is recorded to move him to an ILU for a trial period. The conditions of this are stated as: *"Cash management, no aggressive behaviour or outbursts, no going off-site unless with a coach, no visitors in his ILU, twice daily reviews - morning and evening"*. It was also suggested (by Dr Jackson) that

Paul Masters be taken out of the planner system, taken off targets, and paid daily on a per activity basis. There is a single set of (undated) target sheets for each day of the week which appear to have been designed to implement the new programme. It is unclear if they were ever used.

3.8.14 Comment:

The Panel found it difficult to understand the rationale for this move - normally clients would only move to an ILU at the end of a period of rehabilitation, having reached a high planner level, in preparation for a transfer to community living. In Paul Masters' case, however, he was on a low planner level, had shown a number of ongoing behavioural difficulties and impairments and was clearly incapable of full independent living at this point. The concerns of the staff were perhaps reflected in the final comment of these notes: *"The repercussions on other clients have to be considered. "Be bad and get moved to an ILU!!!!!!""(sic).*

In view of the ultimate outcome of the move, it is of course possible to say with the wisdom of hindsight that the decision was a critical one, and this is no doubt something that will have been in the minds of TRU staff as much if not more than it has been in the mind of the Inquiry Panel. However, the important issue is whether the decision as it was made at the time was soundly based and whether appropriate measures and precautions were put in place to ensure the safety of both Paul Masters and the staff. Here, as so often, it is difficult to come to a firm judgement with the documentation available. It was clearly at odds with the perceived policy and procedure in TRU, but at the same time so far as it is possible to tell the decision seems to have been quite carefully considered, and could be viewed as a constructive and creative solution to the particular problems Paul Masters was presenting at the time.

Some of Paul Masters' behaviour following his transfer to the ILU was clearly against the rules of the unit - visits to other ILU's, unauthorised exits from the ILU, breaking the window lock, and particularly bringing alcohol to the unit as on the night in question. It was difficult to police Paul Masters' behaviour both because of the location of the unit and because of his particular personality and propensity for rule-breaking. However, the Panel learned that at the time of the incident there were at least three clients in Lyme House with a forensic or criminal history - Paul Masters, Lee Powell, and a third client from Ashworth Special Hospital. It is not clear if any systematic consideration was given to potential problems arising from interactions between these and other clients. The Panel recognises that the subsequent reconstruction of Lyme House and the removal of Independent Living Units from the site removes the possibility of the exact circumstances of the incident repeating themselves. Nonetheless it is clearly important for the future that risk assessment procedures, which include the evaluation of risk arising from interactions between clients, are put in place.

3.8.15 There is very little information on Paul Masters' functioning in the ILU. Mr Martin's January 1997 report mentions that he had improved relations with staff members and had formed a friendly and supportive relationship with the client in the adjacent ILU. He had become interested in improving the management of his finances and he was making successful unsupervised outings to the local town. Mr Martin describes him as being more positive and hopeful as the end of 1996 approached.

3.8.16 Comment:

The Inquiry's Terms of Reference require it to examine the extent to which Paul Masters' care plan was effectively drawn up, delivered, complied with and reviewed. The difficulty in evaluating this properly is that much documentation is missing or non-existent. The daily planners and evaluation sheets which were available for Lee Powell were not made available in Paul Masters' case, nor was there a full set of monthly reviews. In addition, we have seen no documentation which records incidents of aggression towards staff in the form of either an incident book or review log. Additionally, the Inquiry is also charged with examining the history of Paul Masters' medication and his compliance therewith, but the records to hand are very limited and give no information about the medication actually taken at any point.

The Panel found no reason to suppose that Paul Masters' treatment at TRU was not caring and committed. This view is supported by the good impression created by each of the staff who gave evidence. It is also based on such documentation that is available. Throughout Paul Masters' stay it is clear that he presented quite difficult problems of management through being prone to aggressive insulting behaviour, and being frequently uncooperative. The reports of meetings show that the organisation accommodated itself to this, refrained from institutional marginalisation or retaliation, and continued to work with him. However, the absence of documentation dealing specifically with critical incidents of aggression or where restraint was required is a serious omission, rendering the Panel incapable of evaluating the seriousness of any given incident or the appropriateness of the measures taken in that incident.

CHAPTER 4 The events of 23rd/24th December 1996

4.1 Sequence of events

4.1.1 Information about the events described below has been gathered from Lee Powell himself, from staff on duty at the time of the incident, from others who became involved as the events unfolded, and from information obtained from the Crown Prosecution Service.

4.1.2 Lee Powell told the Panel that, having spent the afternoon of 23rd December in Knowsley with one of the coaches, he returned to Lyme house at approximately 4.30pm. Shortly afterwards, he said he met Paul Masters on the way back to his ILU, and Paul Masters suggested that they meet later. Lee Powell refused, having been advised by Dr Jackson to avoid Paul Masters, without, he said, being told why. There is no evidence that Dr Jackson communicated this advice to any other member of staff. Lee Powell then completed his paperwork, and later spent an hour with his supervisor, obtained medication for his migraine from one of the coaches (Mr J Martin), went around the building securing the external doors before returning the keys to the night staff and returning to his ILU before 10pm.

4.1.3 The working day at Lyme House normally closes at 10.00pm. On the night in question there were 2 staff on duty, Mrs J Dobbin and Mr D Harley, but neither was expected to be on waking night duty throughout the night. The Panel received evidence that all the clients had gone to their rooms before 11pm, and the two staff were preparing for bed. An electronic buzzer then sounded in the main Lyme House unit, warning the night staff that the front door of one of the two pairs of ILU's where Paul Masters lived had opened. Shortly afterwards there was a similar electronic warning that the front door of Lee Powell's ILU had opened (the other ILU of that pair being vacant). Mr Harley told the Panel that he assumed that Paul Masters had gone to Lee Powell's room, although of course there could have been other explanations for the two separate electronic buzzers. However he did not investigate the buzzers, because he told us that he was unsure about staff responsibilities towards the ILU's. He pointed out that the ILU's were not required to be registered. His colleague on night duty, Mrs Dobbin, was also uncertain about staff responsibilities towards the ILU's *("as far as I can recall, there weren't any set policies")* but said that her usual practice was to *"go and see just to make sure that everything looked in place and looked all right, but no further than that, really"*. In the event, Mrs Dobbin was bathing in preparation for bed, so neither electronic warning was investigated.

4.1.4 Comment:

The evidence given to the Panel suggests a surprisingly 'laissez-faire' attitude towards the electronic warnings, if the absence of policy was as described to the

Panel . However the mere presence of the devices would suggest that night staff were intended to take notice of them when they were activated, particularly as it was policy not to allow patients to enter other units after 10.30pm. In the event, each of the two staff on duty told the Panel that they were uncertain as to their duties and responsibilities towards residents of the Independent Living Units on the night in question. Dr Jackson told the Panel that he believed that the duties are set down in TRU training manuals, and that he was surprised that the staff had not responded to the electronic warnings. We have been unable to locate the reference in the TRU training manuals. This indicates a failure in the training given to night staff.

Clearly, if the electronic warnings had been thoroughly investigated at the time they had been activated, Paul Masters' presence in Lee Powell's living unit should have been discovered, and subsequent events prevented.

4.1.5 Lee Powell told the Panel that Paul Masters knocked on his door sometime after 10.30pm. He tried to persuade him to go away, but failed and let him in. They both drank some lager, Lee Powell drinking about two and a half cans of special brew, according to his evidence to the police. They watched a video. Lee Powell asked Paul Masters to leave at about midnight. Paul Masters asked to go to the toilet before leaving, and when he returned he made a homosexual advance. Lee Powell said that he pushed him away, but Paul Masters made a second approach and so he hit him. He then hit him several more times, beat his head against the wall, and then tried to strangle him. He took the laces out of his boots and tied them round Paul Masters' neck. He said that he had lost control, and watched him die. He also said that he jumped all over Paul Masters' body. By the end, the head was soft and the face was unrecognisable. He stripped the body to remove its dignity. He showered and changed, and later moved the body outside and tried to hide it in a culvert. However the drain was not deep enough and the body stuck out. After he moved the body he said that he went to Paul Masters' ILU and found literature which he found objectionable. This upset him further and he set fire to the flat. The cause of death was later given as ligature strangulation and blunt force head injury. 33 separate injuries were identified by the Home Office pathologist.

4.1.6 Mrs Dobbin, meanwhile, was woken from her sleep by what she thought was the sound of the electronic buzzer indicating the opening of one of the ILU doors. She put on shoes and a jumper and went outside to investigate. She saw nothing unusual or untoward, it was a frosty night, so she returned to the unit and went to bed.

4.1.7 Lee Powell told the Panel that he did not know, until reading later reports, that Paul Masters had received an earlier brain injury which affected the control of his impulses. His reactions might have been different, had he known. Lee Powell also recognised that alcohol had heightened his response to Paul Masters' approach. He also said that his response was influenced by his own previous experiences of sexual abuse, both in the Scott Clinic and previously, as a child. He had not set out to kill Paul Masters. The

incident was an uncontrolled response to what he perceived to be another such abusive assault.

4.1.8 Comment:

The question must inevitably arise as to whether an assault of this violent and fatal nature could reasonably have been foreseen, without the benefit of hindsight. Several witnesses told the Panel in evidence that they were not surprised to hear of such an assault, but others said with equal conviction that they did not believe that the homicide could have been foreseen. Such comments emphasise the uncertainty of relying on informal personal judgement, and underline the need for systematic review and recording of episodes of violent and dangerous behaviour. It is generally accepted that past behaviour is by far the best predictor of future behaviour, and it is the view of the Panel that a comprehensive record of potentially serious violent behaviour by Lee Powell, starting with the assault on a member of staff at Glen Parva Youth Custody Centre in 1988, continuing with assaults on members of his family in 1992, with assaultative behaviour and threats while in hospital, and culminating in the serious events in the Scott Clinic on 14th July 1996 would have offered a better predictor. Much of the relevant information is contained in Dr Finnegan's formal assessment dated 13th November 1996, but the process of recorded risk assessment was inadequate, and in the Panel's view the risk assessment form itself requires review.

Risk assessment is discussed more fully below in Chapter 5.

4.1.9 The two members of the night duty staff were awoken by the activation of the fire alarms at about 3.30am. Mr Harley told the Panel that the fire display indicated that one of the ILU's was on fire, so he ran outside to try to see which unit was on fire. He went first to Lee Powell's unit and discovered the body of Paul Masters, naked and half-hidden in the culvert, close to the entrance. He returned to the main unit and alerted Mrs Dobbin. Other residents of Lyme House had now been awakened by the fire alarm and were beginning to congregate. The staff were not able to silence the alarm. The lights went out. Some of the residents were becoming distressed. Mrs Dobbin phoned the emergency services, and then concentrated on keeping other clients from panicking and from wandering outside. The staff evacuated the clients from the building in the darkness, and tried to account for them all. Two clients, including a client sleeping in the ILU next to the one on fire, had to be woken and taken outside to join the others. Lee Powell could not be accounted for. One client had become very distressed because he had learned that there was a dead body, and the staff were trying to keep other residents from seeing the body. The Fire Service arrived and took over, while Mrs Dobbin went back into the main building to try to contact one of the on-call clinicians. The night staff had difficulty in contacting any senior clinical staff. Eventually they were able to make contact with Mr W Kenyon, the Financial Director of TRU, who quickly arrived. By this time the police and ambulance services had also arrived. Mr Kenyon arranged for all the residents to be taken to Ashton Cross in available cars, and given food.

4.1.10 Comment:

The work of Mr Harley, Mrs Dobbin, and Mr Kenyon in the management of this crisis deserves the highest praise.

4.1.11 Lee Powell, meanwhile, had left the site. At 5.12am he made a 999 call from a telephone box, and gave his location to the police. He was still at the telephone box when the Police arrived. He was arrested and taken to the Police Station.

CHAPTER 5 Consideration of key issues

5.0 Introduction

5.0.1 The Report thus far has been primarily a narrative record of the progress of each of the two men through the critical path of their care. The narrative has raised a number of issues which the Panel believes are of sufficient importance to warrant further more detailed discussion. These issues are set out in this Chapter.

5.1 Acquired brain injury – assessment and treatment.

5.1.1 When The Panel of Inquiry began its deliberations and investigations, it appeared that both men involved in the incident in question had a clear and unambiguous primary problem of brain injury. The incident took place at a brain injury rehabilitation unit specialising in the treatment of individuals with acquired traumatic brain injury.

5.1.2 As the Inquiry progressed, however, and the Panel was able to review the volumes of evidence relating to the care and treatment of Lee Powell over the years, it became clear that a primary assessment of organic personality disorder was less straightforward than had originally appeared. In the case of Paul Masters, there was less to complicate the picture of brain injury.

5.1.3 The Panel of Inquiry did feel it was appropriate to consider the decision-making processes as they were recorded in the contemporary casenotes with a view to evaluating the care and treatment received by Lee Powell as required by the Terms of Reference. The following will focus on the decision-making processes that eventually led to the adoption of brain damage (in the form of a diagnosis of organic personality disorder) as the primary diagnosis and ask whether there were further investigations or considerations that might have been desirable to secure this diagnosis. In the second section we consider what further investigations or considerations might have been desirable to explore the main competing diagnosis of mental illness. From this we derive some recommendations as to appropriate future practice.

How and why did brain damage come to be considered as a possible explanation of Lee Powell's problems and behaviour?

5.1.4 Clinical consideration of the possibility of brain damage as a major factor in Lee Powell's presentation did not arise until a relatively late point in his 'career' as someone with psychiatric and behavioural difficulties. Contemporary case notes of his admission to hospital following his road traffic accident aged 8 give no indication that

he might have suffered brain damage as a consequence of this accident. Any period of unconsciousness appears to have been very short, no confusion or disorientation is recorded, and physical recovery appears to have been rapid and satisfactory. Problems at school and at home began to develop some time after this accident resulting in his referral to the Child Guidance Service (CGS) but there is no mention of the accident as a possible causative factor in these problems in any of the CGS notes or reports. It appears that the accident did not figure strongly in his parents' minds as a cause of Lee Powell's problems at the time he first attended the CGS at the age of 11. If they had volunteered it as a relevant fact it would be surprising if it was not recorded somewhere in the notes. There is no such record.

5.1.5 There is some indication that Lee Powell had some degree of abnormal cognitive function at this age. When tested on the Wechsler Intelligence Scale for Children – Revised (WISC-R: a standard test of intelligence) there was a substantial discrepancy between his verbal and his non-verbal abilities. He obtained a Verbal Intelligence Quotient (IQ) of 111 and a Performance IQ of only 90, a significant difference. His full-scale IQ (a weighted average of Verbal and Performance IQ scores) was 101, very near the average IQ level of 100. There were also specific weaknesses apparent in certain subtests: Similarities, which measures abstract verbal thought; Picture Completion, which evaluates visual search and problem-solving, and Coding, which is a measure of psychomotor speed. The assessing Educational Psychologist, Mr D Baldwin noted these features but he did not suggest any explanation for them.

5.1.6 Comment:

It is possible that these results reflect an underlying impairment of brain function, but in the absence of further contemporaneous assessment or investigation other explanations in terms of motivation or development cannot be ruled out.

5.1.7 At no point in Lee Powell's further contact with the Child Guidance service or in his subsequent contact with the Prison Medical Service and the Psychiatric service at the West Cheshire Hospital did any consultant consider organic brain damage as a possible explanation of his condition. Dr Shapero's report of 1989 mentions the occurrence of the accident but does not ascribe any significance to it. *"It is alleged that his attitude and behaviour began to deteriorate following this* [accident], *although I understand he did not sustain any head injury in the accident"*

5.1.8 The first substantial consideration of the possibility of brain damage appears to have been in 1991 by Dr Finnegan at the Scott Clinic . In a report of a clinical meeting he writes: *"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."* Although at the time this was considered to be the main diagnosis and Dr Finnegan expressed doubts about its treatability, he expressed the intention to seek a second opinion of a Special Hospital consultant. However, the question of organic brain damage had also come up in the meeting because the notes ended *"In the meantime he needs a full psychological assessment, including*

personality profiles and tests for organic brain damage. There are some reasons to think that the pathology he displayed may have originated in the head injury he suffered when he was eight." No account of what those reasons might have been was given at this point.

Psychological investigation (1)

5.1.9 The first part of the psychological investigation was carried out by Ms D Fisher, a Senior Clinical Psychologist. She saw Lee Powell on 23rd September 1991 and reported him *"cheerful and friendly and fully co-operative"*. No formal psychological report appears to have been written at this time. Clinical meeting notes of 24th September 1991 report that *"...Dawn Fisher has done some preliminary psychological tests on Lee and these are at the very least suggestive of brain damage. She intends to perform further tests, and eventually to use the computer-based more definitive tests either here or just possibly at Rodney Street."* The clinical meeting notes of 1st October 1991 add the comment *"Dawn Fisher's preliminary WAIS* [Wechsler Adult Intelligence Scale – a standard test of intellectual function for adults] *shows a marked verbal performance discrepancy although this does not quite reach statistical levels. There is considerable variation among subtests and justification for pursuing the computerised tests of brain damage."* The computerised tests were carried out the following week. Again the available documentation does not carry any formal report of the tests or the results but the clinical meeting notes of 8th October 1991 record *"Following the introduction of the structured programme last week Lee's behaviour has been very much better than it was previously. We cannot be sure that this is the reason but it seems likely. It would fit quite well with the evidence that has come out of Dawn Fisher's use of the Bexley Maudsley Brain Damage Assessment Test on the computer at Rodney Street. This showed very marked frontal lobe damage and some mild parietal lobe damage. This would be consistent with the impulse control problems and his clear difficulty in suitably planning his behaviour. He had marked perseveration of his thinking. The only likely cause of this that we can identify is the head injury when he was eight. Further investigations are necessary. Dawn Fisher, who is leaving, is arranging for Julie Hird to complete some further tests of brain damage. A complete global assessment is now necessary, preferably by next week. He would benefit from structural investigation of his brain and Teresa Slade will negotiate with Tony Lock at the Royal for a P.E.T.*[Positron Emission Tomography scan – a sophisticated neuroradiological method for directly investigating brain function] *or if not that an M.R.I.* [Magnetic Resonance Imaging – a powerful neuroradiological method for imaging brain structure]. *Dawn Fisher will speak to Lee this afternoon to explain her findings and Dave Heywood will be meeting his family in the very near future to discuss it with them. It is likely, despite the awful prognosis, that they will be pleased to discover that there is a specific cause and that it is not their fault."*

5.1.10 Comment:

The practice of inferring brain damage directly from neuropsychological test results, while widespread, is unreliable. There are many factors other than brain

damage that may lead to poor performance on neuropsychological tests and test results need to be interpreted in the light of motivation, concurrent mental and physical state, the patient's history and everyday behaviour and the results of other investigations. Ideally a neuropsychological evaluation should be carried out or at least supervised by an appropriately qualified clinical neuropsychologist though in practical reality this may be hard to achieve because of the shortage of such staff. Where such an arrangement is not possible, neuropsychological test results of themselves can at best only be indicative of the possibility of brain damage and need to be followed up with other investigations. Dr Finnegan's considerations as quoted above and his subsequent actions show that he understands this. The casenotes record that he speaks to Lee Powell on the same day as the clinical meeting: *"Pleased to be told he has brain damage because 'it can't be my fault' ...I told him of its probable cause, future investigations and possible outcome."* **A meeting was held between Mr and Mrs Powell and Dr Finnegan and Mr Heywood on 16th October 1991 where Dr Finnegan told the parents that "...** *Lee suffers from significant frontal lobe damage, almost certainly resulting from the road traffic accident when he was 8 years of age but perhaps also exacerbated by a rather less serious accident when he was 16."* **The report of the meeting also records that** *"Mrs Powell in particular appeared extremely angry that* (it had) *taken so long for Lee's problem to be diagnosed. Dr Finnegan attempted to explain that brain damage would not necessarily have been the most obvious explanation at the time. Mr and Mrs Powell have considered taking legal action against various people who were involved at the assessment stage prior to Lee going to Brookfarm School."*

Further investigations

5.1.11 Dr Finnegan recognised that further investigations were needed. A MR scan was carried out. No formal report of this by a neuroradiologist is available and the Panel of Inquiry understands that none was ever made. The scan was carried out on a Sunday, apparently more in a research than a clinical context. However, a verbal report of the scan results is recorded in the clinical meeting notes of 5th November 1991. There appears to be definite evidence of a lesion: *"On the AX Scan 2 cm above the [basal] ganglia his MRI scan shows pathological lesion, predominantly on the left side in the white matter, half way between the basal ganglia/temporal lobe and the frontal lobe. The total volume is about the size of a 2p piece. There are also lesions above. Their nature is not clear. It might be gliosis following a head injury but it could be vasculitis or even multiple sclerosis. The functional significance is not entirely clear but it may represent a disconnection of the frontal lobe from the temporal lobe. She advised looking for soft neurological signs, which we have done and found none. ... I think we should invite a neurologist to see him and it may well be worthwhile doing an evoked potentials."*

5.1.12 Comment:

This was perceived as confirmatory evidence of brain pathology which accords with the psychometric findings and with Lee Powell's presentation in terms of

poor impulse control, etc. However there was no formal request for, or any formal report by a neuroradiologist.

Psychological investigation (2)

5.1.13 In the same (5th November 1991) clinical notes, Dr Finnegan records his decision that Lee Powell should stay in the Scott Clinic *"Lee's behaviour has been such that there is not really a justification for him going to Special Hospital or to St Andrew's. After discussion with the clinical team it was felt that he would be most appropriately dealt with at the Scott Clinic"*. He also records a decision to seek further expert neuropsychological opinion. *"We will also need to seek advice from either Howard Jackson or from Eric Gadielle* [sic] *as to whether or not they are aware of any specific behavioural programmes that would be worthwhile. We will need to focus our attention on programmes designed to moderate impulse control and anger control and relaxation."*

5.1.14 Dr Jackson was contacted by Dr Slade and saw Lee Powell on 31st January 1992. Dr Jackson administered a number of further tests and considered the results previously obtained by the Scott Clinic staff. His report of 27th February 1992 is quite guarded in its conclusions *"The above* (test) *results are unclear with respect to neuropsychological dysfunction. Although there* (is) *evidence for reduced speed of processing and attentional problems, such problems may arise because of emotional problems, psychosis, or even test anxiety. They may also be attributed to his mild/moderate head injury at the age of 16."*

5.1.15 Dr Jackson had discussed the significance of the two road traffic accidents. He concluded that in view of Lee Powell's apparently clear memory for the accident when he was 8 that it was unlikely to have resulted in significant neurological sequelae. However, he did consider the second accident to have been more serious: *"His second accident at the age of 16 seems to be much more significant. He reported that he was unconscious for about 30 minutes and can't remember anything about the accident. His first memories after the accident were being in the hospital with his father at his bedside. Coma duration of 30 minutes with PTA* [Post Traumatic Amnesia] *of several hours would indicate a significant head injury with the strong possibility of intransigent brain dysfunction. In such cases the frontal and temporal regions of the brain are most vulnerable to head injury."*

5.1.16 Dr Jackson also reports Lee Powell as saying that he had blackouts or fainting fits following the accident which had continued with the last episode being a month previously. Lee Powell was also *"adamant regarding the presence of his auditory and olfactory hallucinations."* However, Dr Jackson comments *"I would agree that these seem atypical and incongruent with other reports."* In his later discussion he suggests a neuropsychological explanation for these symptoms: *"With respect to his 'psychotic symptoms', it is well known that there is a relationship between left hemisphere dysfunction and hallucinatory and delusional experiences ... There may be some fragments of truth to these symptoms of hallucinations, although there does appear to have been some secondary gain in their reporting"*

5.1.17 Dr Jackson felt that Lee Powell's case was more than a straightforward case of brain injury: *"Overall, my impression is that Mr Powell's problems are complex, with long-standing psychological problems, the possibility of a post-traumatic stress reaction at the age of eight following a road traffic accident, overlaid with a mild/moderate head injury at the age of 16. 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."* This made it difficult to suggest any standard approach to management: *"Considering the equivocal nature of his neuropsychological profile, it is difficult to make any firm recommendation regarding rehabilitation or management. Clearly a well organised and structured environment would reduce the demands on his limited attention and therefore provide a less stressful environment."* Dr Jackson suggested training in the use of external memory aids in therapy sessions, with sessions of *"specific limited content and aim"*. He also recommended further assessment of memory function with the Wechsler Memory Scale - Revised and a procedure called 'Attention Process Training' to help with attentional problems. His final comment is of interest given Lee Powell's repeated complaints of hearing voices: *"Such attentional limitations may contribute significantly to his poor social functioning, his unreliability in self-reporting and stress in stimulating and distracting environments. There may be some possible relationship between his attentional deficits and his 'hallucinatory experiences'"*

5.1.18 Comment:

Dr Jackson's report is equivocal with regard to the presence of neuropsychological impairment and properly refrains from unsupported claims regarding the presence and localisation of brain damage. He states quite definitely that the accident aged 8 is unlikely to have caused brain damage and such damage as there is will have accrued from the injury aged 16. This contrasts with the previous thinking of Dr Finnegan and the clinical team.

5.1.19 Later interviews with Lee Powell's parents by Mr D Heywood and Dr M Rose give a rather different picture of the potential severity of the accident at age 8. In Mr Heywood's social work report of 2nd April 1992 we find this account: *"Mrs Powell thinks Lee was probably unconscious for a period of 20-30 minutes. He was in hospital for 3-4 days. She cannot recall whether he complained of headaches. Obviously the accident was extremely traumatic not only for Lee but for his family"*. Dr Rose's report of an assessment carried out in January 1995 for a Mental Health Review Tribunal cites in the section 'Information from Parents': *"At the age of eight (when his sister was six months old) Lee was knocked down by a car. His mother saw him within two minutes when he was on the ground covered by a blanket and she feared he was dead. She remembers that there was a cut on the left side of his head and there were facial injuries. He was at least dazed for six to eight hours but they were not immediately aware of any major problems"*.

5.1.20 Comment:

These two accounts of this accident elicited from Lee Powell's mother suggest the possibility that the early accident did cause a greater period of impaired consciousness than the contemporary hospital records suggest with a correspondingly greater likelihood that brain damage occurred. However, these accounts were elicited respectively 14 and 17 years after the accident following the establishment of brain injury as the primary problem. These factors make it difficult to recall events with reliable accuracy. There is a clear conflict between the length of stay in hospital documented in the contemporary casenotes and Mrs Powell's later recollection. While Mrs Powell's report may have suggested that a significant injury occurred, the normal clinical principle is to regard contemporaneous notes as the more accurate record and the Panel of Inquiry found no reason for this principle not to apply here.

5.1.21 A discussion of Dr Jackson's report was held at the clinical meeting of 4th March 1992. *"We have received the report from Dr H Jackson. A very thorough assessment. He is of the view that the influence of neurological injury on Lee's presentation is perhaps less than we had at first thought. He has recommended a further test of memory which we will ask the Psychology Department to complete."* There is no subsequent record of this having been completed.

5.1.22 From this point onwards the diagnosis of organic personality disorder is considered to be established and does not change throughout the remainder of Lee Powell's stay at the Scott Clinic. Submissions to Mental Health Review Tribunals (MHRT) held in 1993, 1994 and 1995 all cite Organic Personality Syndrome as the diagnosis. An Audit case conference report of 13th March 1992 identifies a number of points about Lee Powell's case for further consideration. Those points relevant to establishment of brain injury as the primary problem include: obtaining further information on the second head injury; chasing up the report of the MR scan; and *"If he does have an organic personality syndrome, about which there is reason to doubt, why has no neurological referral been made and why has he not had anticonvulsants?"* An additional note of the meeting says *"There was considerable debate about the diagnosis and whether or not making a diagnosis of organic personality syndrome had any significance with regard to management techniques that are necessary."*

5.1.23 A case conference held on 13th November 1992 *"raised the question as to whether there was any ethical justification for an argument that there was an increasing sense that Lee was untreatable, his behaviour put him more in the category of Psychopathic Disorder than Mental Illness..."* This discussion was carried out in the context of a consideration of regrading Lee Powell as an Informal patient, a course which was rejected by the conference. A further discussion of the diagnosis is recorded in the Peer Group Review meeting of 5th November 1993: *"The question was raised as to whether or not, given the nature of Lee's problems, the diagnosis should be reviewed and consideration given to reclassifying him as suffering from psychopathic disorder. Again it was unanimously felt that this would not be appropriate, that there was*

substantial evidence to support the argument that Lee had suffered significant brain injury at some stage in his earlier life, and that given the stability of his siblings there was little evidence to support an argument that nurturing was the major source of his difficulties. Consequently organic personality syndrome was felt to be an appropriate diagnosis and thus he should remain classified as suffering from mental illness."

5.1.24 The diagnosis was also supported by Dr Rose in his 1995 report for the MHRT: *"I believe that Lee Powell suffers from an organic personality disorder (ICD 10 classification 107.0) and that this may be considered a mental illness. Therefore I am in complete agreement with Dr Finnegan."*

5.1.25 Dr Jackson's initial assessment for TRU in his letter of 25th April 1996 also accepts this diagnosis: *"I have read both your reports and that of Dr Martin Rose. I am in agreement with those reports and the conclusions that Lee suffered a severe head injury resulting in higher level cognitive impairments and a personality disorder involving impulsivity, poor reflective thinking, aggressive outbursts, emotional lability and suicidal ideation."* He appears to reverse his previous position in his 1992 report on the relative severity of the two brain injuries: *"This report will consider his appropriate admission to TRU for community re-entry rehabilitation and specialised brain injury rehabilitation in the light of his residual problems following a severe head injury from a road traffic accident when he was aged eight. In addition, Lee suffered a mild/moderate head injury aged 16 which may have added to his neuropsychological problems.* In oral evidence to the Panel, however, Dr Jackson considered that he had been mistaken in this second report, and restated his earlier position that it was likely that the injury at 16 had been the more significant one. Regardless of which head injury had been the more severe, however, it appears now to be firmly established in the minds of Dr Finnegan and Dr Jackson that the diagnosis of brain injury (*qua* organic personality disorder) is the primary one.

5.1.26 Comment:

As we have seen, a diagnosis involving brain injury emerged relatively late in Lee Powell's involvement with psychiatric and other services. There was no consideration of the possibility during Lee Powell's contact with the Child Guidance Service through his teens. Dr Shapero considers the accident aged 8 in his report, and decided that it did not involve a significant head [and consequently brain] injury. Brain injury is not considered as a explanatory hypothesis by either Dr Boyd or Dr Halstead during the period that Lee Powell was being treated in the Psychiatric service at the West Cheshire Hospital, although the occurrence of the injury is noted. Dr Brabbins, in her extensive admission history when Lee Powell was transferred to the Scott Clinic, refers to a 5 minute loss of consciousness, but adds *"No head injury according to old notes"*, a reference suggesting she is referring to the original Countess of Chester A&E notes.

Once the brain injury hypothesis had emerged, it was pursued with some vigour and energy, with both psychological assessment and the MR scan investigations

put into place quickly, with a further neuropsychological assessment from an external expert, Dr Jackson, arranged as soon as possible. At first sight, the evidence for Lee Powell having a brain injury was perceived as strong with both the psychological investigations and MR scan results giving indications of organic brain damage. However, the arrival of Dr Jackson's report casts some doubt over the importance of brain damage in Lee Powell's presentation, and his assessment of which head injury was the significant one directly contradicts that of Dr Finnegan and the clinical team. In addition, no formal report of the MR scan results arrived, despite some attempts by the team to pursue this. Nor does there appear to have been any formal report or interpretation of the neuropsychological test results by the Scott Clinic psychologists. Perhaps most seriously, despite the expressed intention to seek a neurological opinion on more than one occasion, this was never followed up. The consequence of all these shortcomings is that that the hypothesis that Lee Powell had suffered an acquired brain injury remained just that - a hypothesis - although with the passage of time it becomes accepted as an established and incontrovertible disorder such that four years later Lee Powell is accepted for admission to TRU by Dr Jackson on the basis that he has suffered a severe head injury.

When the Panel of Inquiry reviewed all the available documentary evidence for Lee Powell's diagnosis of acquired brain injury, there were a significant number of unresolved contradictions and deficiencies in that evidence. These are:

There is no formal report of the MR scan from a consultant neuroradiologist. This is essential if the reported abnormalities are to be correctly attributed. It was the opinion of the independent neurologist consulted by the Inquiry that the abnormalities as reported verbally were unlikely to be the product of traumatic brain injury, though in the absence of the original films this could only be a tentative judgement.

There was no referral to a neurologist. This was desirable to help secure the diagnosis. It may also have been indicated by the suggestion in the verbal MR scan report that the appearances were consistent with Multiple Sclerosis or vasculitis.

The neuropsychological assessment was somewhat piecemeal and incomplete: an initial assessment was carried out by one Clinical Psychologist within the Scott Clinic, extended a little by a second, and reviewed and extended by Dr Jackson who recommended a further assessment which was not carried out. Given that Lee Powell was to spend a further four years in the Scott Clinic, it would have been desirable for a full reassessment to have been carried out at some later point to provide a check on the validity of the initial assessment and to investigate what changes, if any, had occurred over time. As this assessment was carried out during a period of psychiatric instability which may itself have affected cognitive function, substantially different results might have been obtained once he became more stable.

The contradiction between the opinions of Dr Jackson and of Dr Finnegan and the clinical team about which head injury may have caused brain damage was never resolved. A review of the admission notes at the time of Lee Powell's two accidents could have been helpful both to resolve the contradiction and to reconsider the severity of the accidents and their likely consequences.

Lee Powell's case was a difficult and puzzling one and the initial decision to investigate the possible contribution of organic brain damage was undoubtedly a step forward. However, we believe that too strong a hypothesis and consequently diagnosis was built upon the available evidence, and this evidence was never reviewed satisfactorily, nor was sufficient scepticism exercised about the diagnosis reached.

We RECOMMEND that, with patients where brain injury is suspected, the history is carefully checked, contradictions and differences of view are reconciled as far as possible, and a full neurological examination should be performed. The neuropsychological examination should be carried out, or at least supervised by an experienced neuropsychologist to ensure that appropriate assessments are made, and that the conclusions drawn can be supported by the data.

We RECOMMEND that admission procedures include a full documented medical history to incorporate the history of any brain injury and its treatment, psychiatric history, and forensic history, together with any other relevant factors such as drug and alcohol abuse, criminal convictions, history of assaults etc. Completion of such standard information on all new patients should ensure that diagnostic issues are clarified, missing information is sought, and potentially significant risk factors are brought to the fore.

5.2 Psychiatric considerations: treatment and management

Introduction

5.2.1 Lee Powell's presentation to psychiatric services was complex and invoked diagnostic doubt. Initially he presented with certain depressive features and was considered vulnerable to depression. His aggressive behaviour was thought indicative of a personality disorder and consideration was given to detaining him under the Mental Health Act under the category of psychopathic disorder. Eventually, he revealed a variety of abnormal mental experiences, and these together with his seemingly fixed preoccupations led to repeated psychiatric admissions where he was treated as though he was suffering from a form of schizophrenia. Diagnostic doubt remained. It proved very difficult for the psychiatric teams to recruit Lee Powell's co-operation with the assessment process and with all the necessary treatment. After escalating violence he was admitted to a regional secure unit, the Scott Clinic. Here the previous treatment was discontinued and any diagnostic doubt became narrowed by excluding mental illness; impairments in his intellectual functioning were thought to be related to his

earlier head injuries and he acquired the diagnosis of organic personality disorder. His clinical team at the Scott Clinic were not persuaded by the significance of the abnormal mental experiences which Lee Powell at first repeatedly declared to them. Lee Powell's former treatment was withheld, against his requests, but in time he stopped declaring his abnormal mental experiences and schizophrenia was not further considered. Many psychiatrists and clinicians were involved in his care and there was no substantial diagnostic or therapeutic discordance.

5.2.2. The Panel of Inquiry did not venture into re-diagnosis. Diagnosis is properly a clinical judgement best made by the examining clinicians.

Early indication of possible psychiatric problems

5.2.3 Lee Powell was first referred to the child guidance clinic in Ellesmere Port at the age of ten, by a health visitor and the Head-teacher at Sutton Green Primary School. For the past year he had been underachieving due to poor concentration and application. He had begun to show social difficulties, was no longer applying himself to his school work and in class was seen staring out of the window. His family was concerned by his developing interest in funeral paraphernalia. His stealing from home and his aggressive temper were also new developments. Thr Educational Psychologist wrote in his report, *"Lee presents as an intelligent boy who is certainly not fulfilling his potential in school. In addition to his poor work habits in the classroom, he is experiencing increasing difficulties as regards his relationship with other children. He has become more and more of an isolate and a target for ridicule."* He did not see a psychiatrist at this stage.

5.2.4 After a further three years, in March 1984, when he was 13, he was referred to the Child and Adolescent Psychiatrist, Dr Katwala, at the Child Guidance Clinic at Ellesmere Port. The letter of referral from the Headmaster, Mr W Smith, included "... *doubts were raised as to his continued attention seeking, in that he has, on three occasions in the last year or so, attempted a mock suicide with twine and plastic bags. On none of these occasions had there been any particular stimulus, either at home or at school".*

5.2.5 The assessment tended to focus on family dynamics. The family failed to attend their follow-up appointment three months later.

5.2.6 Around December 1986, at the age of 16, Lee Powell was re-referred to Dr Katwala by the Youth Training Scheme supervisor. Lee Powell was having difficulties at work and *"his parents know that Lee tends to isolate himself and that he does not like to mix."* Dr Katwala concluded in his letter to the GP that he did not see any particular psychiatric problems or depression, and again referred to issues involving the family dynamics.

5.2.7 The Inquiry Panel was able to speak to Lee Powell's father who commented that his son would spend hours drawing pictures relating to funeral paraphernalia and then

screw his drawings up. Yet, he was very upset if anyone moved or touched his drawings. His preoccupation in his interests and increasing isolation were gradually progressive rather than sudden developments.

5.2.8 Matters became more traumatic when Lee Powell was around the age of 17. The family suddenly heard banging which was either Lee Powell banging his head or kicking while he was in his room. He told his parents that he was hearing voices telling him to do evil things. He complained that the voices would not stop. He said he could not take it anymore and was crying. He seemed depressed and distressed.

5.2.9 It was around this period that Lee Powell began to show serious aggression to his family. Indeed, his father reported that when his son attacked his mother, by attempting to strangle her, he seemed to be in a trance and was saying unpleasant things as he was holding her around the neck.

Contact with adult psychiatric services

5.2.10 Following his arrest after offences of robbery and attempted robbery, committed on 28th April 1988, he was seen on two occasions by Dr Sarkar, a Consultant Psychiatrist, for the preparation of a psychiatric court report. Dr Sarkar considered Lee Powell to be of below average intelligence, and to be likely to suffer from depressive episodes when under pressure.

5.2.11 In prison, Lee Powell was referred to the therapeutic community in the prison hospital, and apparently initially settled in well. But from a report by the Senior Medical Officer, Dr Timmins, there was increasing concern as Lee Powell became agitated and despondent about his situation and problems in life. Three days later the assault on the hospital officer occurred. He suddenly attacked an officer with a weapon made from a sock filled with batteries. Dr Timmins found no evidence of a psychotic mental disorder.

5.2.12 Dr J Shapero, Consultant Forensic Psychiatrist, prepared a psychiatric report, dated 6th June 1989, on Lee Powell for the purposes of his court appearance in relation to the charge of assault against the prison officer. Dr Shapero could not find any evidence that Lee Powell was suffering from signs or symptoms of major mental illness. Lee Powell was unable to explain why he attacked the officer to Dr Shapero nor could he recall doing so.

5.2.13 Dr Shapero concluded that Lee Powell was detainable under the Mental Health Act under the category of Psychopathic Disorder and referred him to the Personality Disorder Treatment Service at Park Lane Special Hospital, now Ashworth Hospital, in Liverpool. It was clear that he regarded Lee Powell as a dangerous young man.

5.2.14 Dr I Strickland, Consultant Forensic Psychiatrist, at Park Lane Special Hospital, saw Lee Powell and prepared a report dated 11th October 1989. In this assessment there is the first reference to Lee Powell's claims of being sexually abused. Lee Powell was

again unable to explain his motivation for the robberies nor the assault on the prison officer. Dr Strickland supported the diagnosis of Dr Shapero, namely psychopathic disorder, but did not conclude that Lee Powell was sufficiently dangerous to be offered a bed in a special hospital.

5.2.15 Dr N Hogan, a Medical Officer at Glen Parva, referred Lee Powell to Dr C Boyd, Consultant Forensic Psychiatrist at the Scott Clinic, for follow-up when Lee Powell returned to the community. The referral letter of the 20th October 1989 revealed that he had been treated in prison with regular antipsychotic medication, Chlorpromazine 200mgs daily in divided doses, which helped relieve his distress and reduced the risks of his spontaneous outburst of arousal and verbal aggression.

Outpatient care

5.2.16 Lee Powell was seen by Dr Boyd on 1st November 1989 and on some four further occasions. Initially, Dr Boyd suspected that Lee Powell might be suffering from temporal lobe epilepsy and advised the discontinuation of the antipsychotic medication. In February 1990, Lee Powell revealed his voices for the first time to medical staff.

5.2.17 Dr Boyd restarted the antipsychotic medication, beginning with Trifluperazine 15mgs daily. On the next appointment, within two weeks, there were signs of improvement. However, the treatment response was incomplete and Lee Powell reported on further visits that he was still troubled by these voices. Dr Boyd recommended doubling the antipsychotic medication. Prior to his next appointment, Lee Powell began his career as a psychiatric in-patient.

Progress as a psychiatric in-patient

5.2.18 Lee Powell was first admitted as an emergency on 10th March 1990 to the psychiatric unit of the West Cheshire Hospital under Dr N Halstead, Consultant Psychiatrist. There were to be five short emergency admissions over the ensuing year, before more sustained in-patient care began in April 1991. In all, from the case-notes, he had seven periods of in-patient care and a spell of psychiatric day care.

5.2.19 Dr Halstead, recorded Lee Powell as, *"a loner, has difficulty relating to people. Says he's heard voices since he was eleven years old. Often for days on end and then they go away or reduce to a mumbling. Squeaky voices; sometimes second person. Telling him what to do and sometimes third person saying things about him. Gets paranoid feelings when in crowds."* Lee Powell continued to reveal his abnormal mental experiences and was considered to have schizophrenia. He was treated with oral and long acting intramuscular antipsychotic medication. Depressive symptoms were also noted, for which antidepressant medication was prescribed. On 17th June 1991 he was transferred to the Eastway Rehabilitation Ward under the care of Dr Avery, Consultant Psychiatrist in Rehabilitation (a specialist in managing patients with enduring mental illness). However, the patient was insufficiently settled to stay. The medical notes indicate accruing therapeutic exasperation at the lack of sustained progress and Lee

Powell's continuing irresponsible behaviour. Nonetheless, to the time of his arrest and discharge from the hospital, he continued to report his abnormal mental experiences and other symptoms to the nursing staff. From the nursing notes there was no suggestion that the staff perceived his troubles as other than genuine. There was no suspicion or evidence of illicit drug use.

5.2.20 During this period, Lee Powell was treated with antipsychotic drugs. Oral prescriptions included Chlorpromazine, Trifluperazine and Sulpiride; the long-acting injections were administered in the form of Pipothiazine or Flupenthixol. The antidepressant medications used were Clomipramine and Lofepramine.

5.2.21 Comment:

The evidence before the Inquiry relating to this stage of Lee Powell's treatment did not indicate that his response to medication, be it antidepressant or antipsychotic drugs, was atypical or inconsistent. Furthermore, throughout his psychiatric care he was treated with only relatively modest doses of psychotropic medication. It seems he was responsive in the short term to those changes and increases implemented.

During his care there were difficulties in gaining Lee Powell's reliable openness; in sustaining his interest in staying in hospital; in maintaining the aim of progressive rehabilitation to live independently from his family; and in helping him achieve insight so that he could co-operate with the necessary monitoring of his treatment and risk management.

Lee Powell did not consider himself mentally ill and was persistently eager to leave hospital. Therefore, it is difficult to identify any obviously manipulative behaviour to assume he was feigning his symptoms.

Assessment leading to the admission to the Scott Clinic

5.2.22 Dr Finnegan first saw Lee Powell in HMP Walton on the 25th July 1991. This appears to have been a lengthy assessment and Dr Finnegan wrote over five pages of detailed notes.

5.2.23 Dr Finnegan prefaced his assessment with an understanding of the case gained from his discussions with Dr Halstead. Dr Finnegan wrote that there was an increasing view that Lee Powell's voices were not genuine and his basic problems were due to personality disorder. Nonetheless, Dr Finnegan proceeded carefully to explore Lee Powell's mental state for himself. He wrote, "*says he has heard voices since 16. Initially TV talking specifically to him over and above the broadcast. Can't recall its content except 'unpleasant'. Told nobody initially because they would think he was 'mad'. ...committed robbery aged 17. Asian food suppliers and Nat West Bank. Threw money away. Not sure why he did it. TV causing distress at time. Auditory hallucinations in third person had also started. Men and women criticising him. Also*

second person (voices). The room would fill up with people that weren't really there. ...Glen Parva 18 months sentence did 13 months ...voices continued." Dr Finnegan noted Lee Powell told him the symptoms improved with medication but then returned, leading to a psychiatric admission. Dr Finnegan wrote, "*command hallucinations - telling him to kill his mother and father, to kill himself 'look it doesn't matter, its OK, she won't be upset, kill her'; didn't want to do any of this."* Dr Finnegan was also able to elicit an account of why Lee Powell attacked his sister and attempted to do the same to his brother, "*(at this point → very tearful, head in hands, remorseful) He was trying not to listen to them. One day sister's ball hit his window. He remonstrated, she continued, suddenly found his hands around her neck. Says stopped himself. Frightened by what he could do. Admitted to ward voluntarily for three days. Self discharged because he hated the ward. Six weeks later attacked brother - went to his room with an axe and said would kill him. Voices were telling him to kill him. Voices said 'don't ask just do it'. Didn't actually make an assault and returned downstairs. Went out and called the police because convinced had killed him."* Furthermore, Dr Finnegan was also able to gain an understanding of Lee Powell's attack on his mother, "*two weeks later: very hallucinated. Frightening voices. Argued with mother. Swore at her. She told him to leave the house. He replied, 'I'm going to have to strangle you' and he did so. Pulled off by brother. Thinks might have killed her if not stopped."*

5.2.24 Dr Finnegan also discovered that Lee Powell found Chlorpromazine helpful, although the voices still continued to a degree. He learned that Lee Powell's voices urged him to leave hospital, which led to the attempted robbery of a post office with a toy gun. The voices persisted: "*Continuously distressed by voices telling him he is worthless, his parents don't love him, that he should be dead."* Lee Powell also indicated that he derived benefit from the anti-depressants and did not know why they were stopped. Dr Finnegan explored the offence that led to Lee Powell's remand into custody, "*Put fire extinguisher through window because frustrated because couldn't kill self, distraught with voices. Says finally instructed to by voices. Says not done for any effect. Didn't make him feel better"* Lee Powell also indicated to Dr Finnegan that he disliked being in prison. He perceived that a female officer was abusive to him, and that he felt like killing her but had had no physical contact.

5.2.25 Dr Finnegan described a full mental state examination, including, "*sullen never smiles... Affect* (emotional responsiveness) - *morose, flattened. Tearful at times... occasional paranoid feelings. Describes, oddly, thought insertion... Perceptual disturbances - describes constant distressing second and third person auditory hallucinations, male and female, clear consciousness. Outside head. At present in background, saying how pathetic I am - talking amongst themselves. Visual hallucinations - e.g. officers entered his cell and started knitting... last night - but he insists there is no one there. No olfactory hallucinations. Occasional episodes of strange tastes - petrol, varnish".*

5.2.26 Dr Finnegan reviewed Lee Powell again on the 6th August 1991 when he covered the background history but, from the notes, it does not appear that he performed a further

mental state examination. Dr Finnegan recommended Lee Powell's admission to the Scott Clinic under Section 35 of the Mental Health Act.

5.2.27 He concluded in his report to the defence solicitors,

"In my view it is extremely important to clarify, if at all possible, whether or not Lee Powell has a serious mental illness which clouds his judgement or whether, in fact, his behaviour is more wilful and his descriptions of symptoms relatively spurious. I do not think such a distinction can be made unless he is admitted to a ward with security where he can be taken off his medication and his violence, should it occur, be adequately contained."

5.2.28 Dr Finnegan also made clear his thinking in a further letter to the solicitors on 9th August 1991.

"...his aggression is not clearly explicable in terms of the psychotic symptoms he claims to experience. Nonetheless, he is a very peculiar person with an odd mode of speech, morbid fascination with death and immature and impulsive behaviour. He persistently claims second and third person auditory hallucinations and thought insertion. These are features of a psychotic illness, but doubt has been cast over whether or not Lee Powell has used their description to justify his impulsive outburst of violence. Unfortunately, because he is on large doses of anti-psychotic medication it is not possible for me to make a clear statement at this stage about what I think." Dr Finnegan prefaced his assessment with an understanding of the case gained from his discussions with Dr Halstead. Dr Finnegan wrote that there was an increasing view that Lee Powell's voices were not genuine and his basic problems were due to personality disorder. Nonetheless, Dr Finnegan proceeded carefully to explore Lee Powell's mental state for himself. He noted Lee Powell told him the symptoms improved with medication but then returned, leading to a psychiatric admission. Dr Finnegan was also able to elicit an account of why Lee Powell attacked his sister and attempted to do the same to his brother. Furthermore, Dr Finnegan was also able to gain an understanding of Lee Powell's attack on his mother, *"two weeks later: very hallucinated. Frightening voices. Argued with mother. Swore at her. She told him to leave the house. He replied, 'I'm going to have to strangle you' and he did so. Pulled off by brother. Thinks might have killed her if not stopped."*

The assessment period at the Scott Clinic From 22nd August 1991 to 13th November 1991

5.2.29 Lee Powell was admitted on the 22nd August 1991 under the care of Dr Finnegan.

5.2.30 On admission, a Senior Registrar noted that Lee Powell's main complaint was hearing voices but that these had reduced to just 'mumbling' with the following regime of medication, administered in prison: Trifluperazine 15mg thrice daily, Pipothiazine 50mg intramuscularly every four weeks (both drugs are anti-psychotics) Procyclidine 5mg twice daily (anti-Parkinsonian to reduce the side effects of the previous drugs) and

Amitriptyline 25mg twice daily (an anti-depressant). As Dr Finnegan planned, all regular psychotropic medication was discontinued on admission. By the next day Lee Powell had begun to report that his voices were worsening and repeatedly continued to plead for the reinstatement of his anti-psychotic medication. Nonetheless, the trial without such treatment continued. Lee Powell's increasing frustration and anger at not having this treatment is duly recorded in the case notes.

5.2.31 By the 14th September 1991, although he was still complaining of his voices, he seemed to be better accepting the cessation of his former treatment.

5.2.32 Dr Finnegan recorded Lee Powell's accruing unhappiness with the withdrawal of anti-psychotic medication, and that he did not accept his problems are just *"thoughts"*. *"Lee asked to speak to me to request medication. He told me about 'kicking off' this afternoon and throwing a chair, barricading himself and threatening with some delight. He says that Largactil makes him feel calmer and suggests his increasing irritability is because depot is wearing off* (Lee Powell was referring to the long term anti-psychotic medication he previously received and this would be wearing off about now). *This may be true."*

5.2.33 Dr Finnegan's psychiatric Registrar during this period did not write in the case-notes but did compile a full admission report, which is undated. The doctor wrote, *"He says he heard voices talking both to him and about him. The voices were telling him to smash the funeral parlour up and to embalm his boss alive, voices talking about him said he was fat and ugly and that he was going to be killed when walking down a dark alley at night."* On the 15th October 1991 a clinical meeting entry indicated the 'as required' Diazepam was also discontinued, and a more general sedative sleeping tablet substituted, namely Chloral Hydrate.

5.2.34 Another nursing entry on the night of the 24th October indicated that Lee Powell still pursued his former complaints, *"More of the 'old' Lee was present - saying he was hallucinating - voices were telling him constantly to do certain things in fact they have been present all the time, though he did not sound particularly convincing. He also said that he was schizophrenic and <u>not</u> brain damaged. He also wished to be re-written up for medication, Diazepam or Chlorpromazine - and the Welldorm* (chloral hydrate) *has no effect."*

Social work assessment

5.2.35 Mr Heywood prepared a Social Work report dated 2nd April 1992 based on interviewing both parents, and information from the Brook Farm School, the local social worker and the probation officer. Mr Heywood obtained the history that Lee Powell had a precocious early development. There were no problems of sibling rivalry. Lee Powell's early temper tantrums and aggression to other children, were attributed to the difficulty he was having in adjusting to the transfer of his care to his natural parents from his paternal grandmother. Indeed, Mr Heywood described learning that there were no problems with Lee Powell's behaviour academically or

socially, indeed he was an able pupil, until the time of the first road traffic accident. Yet, Mr Heywood did not elicit from the Powells any immediate impact upon Lee's behaviour of the accident,

"Mr & Mrs Powell cannot remember any major changes in Lee immediately after the accident. He remained at the same school and continued to be friendly with the same group of children with whom he appears to have got on quite well. There were no adverse reports from the school either about Lee's scholastic performance or his behaviour. However, approximately eighteen months later the family moved to a house half a mile away and, because it was the other side of a major road, he had to change schools. Shortly after moving Mr & Mrs Powell were called into Lee's new school to see the headmaster. Lee was described as being clever but inattentive. The headmaster told Mr & Mrs Powell that he constantly stared out of the window and had difficulty concentrating on his lessons. Consequently, his work deteriorated. At about the same time Lee apparently began to isolate himself both at school and at home...".

5.2.36 Mr Heywood appeared to apprehend the alarming escalation of Lee Powell's propensity towards violence, *"Lee's behaviour has become increasingly more aggressive over the years... There appears to have been almost a frenzied intensity about the most recent series of violent incidents in March 1991."*
His final conclusion addressed the unfavourable indicators for further progress.

5.2.37 Comment:

There was a pattern of gradual but progressive behavioural deterioration. Lee Powell changed from a sociable child to a withdrawn teenager: from being a bright early student he became a distracted and withdrawn poor pupil. He developed a bizarre preoccupation with funerals in his teens. There was the later emergence of strange delinquency (e.g. committing a robbery and then discarding the money). There was escalating violence. This was all consistent with a mental illness process.

There were some 34 discrete case-note entries by nurses and doctors during this assessment period recording symptoms associated with mental illness. During this period Lee Powell's behaviour remained turbulent. The notes report at least eight incidents of aggression to others and seven of self-harm.

The treatment plan not to administer antipsychotic medication was adhered to, although Lee Powell reported the return of symptoms and repeatedly asked for medication to be restarted. There is a contrast between the provisions in the Mental Health Act to protect a patient's interest where clinicians wish to administer medication and the absence of any such protection where clinicians refuse a patient's request for medication.

Particularly with regard to diagnostic issues that decide on different treatment pathways, we RECOMMEND that all due clinical evidence be sought, including

carefully checking past records. Equivocal tests should be repeated, as necessary. Further expert guidance should be gained if the pathology is considered to go beyond the responsible medical speciality.

Remaining care at the Scott Clinic

5.2.38 Lee Powell continued to present with behaviours possibly indicative of mental illness. On 2nd December 1991 he complained to the senior registrar that he was preoccupied by the sexual abuse he said he had sustained from his uncle.

5.2.39 An audit case conference was held and the only written record appears to be a summary prepared by Dr Finnegan dated 13th March 1992. This appears to have involved reconsideration of diagnosis, although apparently not towards mental illness such as schizophrenia. Yet, one of Dr Finnegan's points included, *"If he does have an organic personality syndrome, about which there is reason to have doubt, why has no neurological referral been made and why has he not had an anti-convulsant."*

5.2.40 Furthermore, for example, on 21st April 1992, the notes from a clinical meeting report that Lee Powell was still *"hearing voices urging him to harm himself"*.

5.2.41 Dr Finnegan arranged a case review on 12th May 1992, *"to which all interested parties and the clinical team are invited because the case is losing direction and interventions have not been successful"*. The issues were raised again in the review meeting and this was summarised in a report by the senior registrar, dated 15th May 1992. Again, consideration of wider diagnostic issues concluded: *"Eliminated the possibility of serious mental illness."* A new management plan included stopping anger management programmes, continuing structured day activities and introducing Carbamazepine for a six-week trial. (Carbamazepine is an anticonvulsant drug and is sometimes used to stabilise mood). Carbamazepine was started on 2nd June 1992 and the dose was steadily increased to the maximum tolerated, which went, for a period, beyond the normal therapeutic blood levels. By 25th August 1992 it was concluded at a clinical meeting to discontinue Carbamazepine, *"It was unanimously agreed that this had been of no benefit at all and it had certainly not affected his thinking or behaviour in any way as far as we could judge."*

5.2.42 During this period Lee Powell made allegations of staff mis-treatment, including violence. Internal inquiries failed to substantiate his allegations. Lee Powell remained angry about a particular nurse. Indeed on 5th July 1992, Lee Powell's alarming plans for revenge were noted by another nurse. At the subsequent clinical meeting Dr Finnegan noted, prophetically, *"There seems little doubt that one must be concerned for the safety of others if Lee should lose control in circumstances where intervention is not possible."*

5.2.43 On 20th October 1992 Lee Powell requested that his occasional prescription of Chlorpromazine be discontinued and this was granted. It is not clear from the case-notes or the copies of the prescription cards exactly when this was started or how often

he received it. The dose was relatively small at 50-100mgs up to eight hourly and under the instruction that it should only be given in 'emergencies'.

5.2.44 In Dr Finnegan's report to the Mental Health Review Tribunal, which is dated 25th November 1992, there was some discussion about the diagnosis. The report contained the comment, which was repeated in subsequent Tribunal reports, *"We entertained great scepticism about the diagnosis of schizophrenia and became satisfied that Lee did not have any form of process psychotic illness."*

5.2.45 Lee Powell's turbulent progress continued. There was an attempt at community placement, as outlined in Chapter 2. This proved unsuccessful and the Peer Group Review was held on 5th November 1993. Dr Finnegan's senior registrar presented a historical review but a copy of the latter's summary was not available to the Inquiry. From the summary of the meeting by Dr Finnegan it does not suggest that the symptoms and signs of schizophrenia, observed earlier, were revisited. The process of differential diagnosis seems to have been only extended to considering the classification under psychopathic personality disorder; this option was discounted. In oral evidence, Dr Finnegan explained, *"There wasn't any debate about the diagnosis because we did not think there was anything to debate."*

5.2.46 Lee Powell alleged that he was sexually abused for a second time, involving another patient. He complained of feeling angry and having thoughts to kill. Again prophetically, his concern was noted, on 2nd August 1994, *"he went on to say that he did not intend to kill him but felt that he might in an outburst of anger"*.

5.2.47 A nursing note of 3rd November 1994, after yet another one of Lee Powell's acts of tying ligatures around his neck, revealed *"Lee spoke about the benefits he gets from this behaviour as it eases the problematic thoughts which make him feel so angry."* This was not further explored by the nurse, but the next day by the junior doctor: *"Lee describes how the hypoxia* (lack of oxygen) *induced by the ligature eases his troublesome thoughts but that when they are lessened he is left with a light-headed, peaceful feeling."* Inquiry into the nature of the troublesome thoughts was not recorded in the clinical notes. From the subsequent clinical meeting there was reference to Lee Powell smashing his sink because of 're-awakening' thoughts about the abuse, provoked from the content of a meeting with his solicitor. Incidents of self-harm and aggression continued to mar progress, without a significantly greater understanding of his actions.

5.2.48 A significant event occurred on 14th February 1996. A nursing assistant made an entry in the case-notes which Lee Powell subsequently perceived as unduly prejudicial. He became verbally abusive and had to be restrained. Two days after the incident, the nursing notes indicated that he was still expressing anger towards the care assistant, *"stating the he could have 'hit her'"*. In oral evidence, the care assistant described to the inquiry that since the incident, she had felt intimidated by him. Previously, she had enjoyed a good relationship with him and had helped him in therapeutic activities. It was not possible to ascertain from all the evidence before the Inquiry why Lee Powell harboured such hostility towards this care assistant, when she had merely recorded

what he had said he had drunk. His subsequent objection to the actual quantity recorded seemed to be irrational. The entry by the care assistant did not alter his subsequent care or prejudice his opportunity for freedom. Yet, it appears that he continued to bear resentment to this care assistant. The incident, some five months later, when he launched two attacks at this care assistant, seemingly with homicidal intent, has been described in Chapter 2 (paragraph 2.4.21). His resentment to the care assistant even continued during his remaining stay at the Scott Clinic. Moreover, Lee Powell had apparently told a fellow patient that he intended to kill this care assistant. It was known that he knew where she lived.

5.2.49 A day after the attempted assaults, he was reviewed by Dr Finnegan. The mental state examination states: *"Lee is tense in relation to his forthcoming move and accepts that he expressed his tension in the events of yesterday. We discussed possible options for future negotiations at TRU regarding the regime."* Apart from references to Lee Powell being mildly agitated about the recent incidents, there was no further apparent exploration of his mental state.

5.2.50 Comment:

The animosity towards this care assistant was understood by the staff as a reflection of his emotional distress in planning to leave the Scott Clinic. The staff concerned in the incident on 14th July confirmed that the nature and extent of the behaviour was not usual for patients placed on the pre-discharge ward, awaiting discharge into the community. In retrospect, the extraordinary irrationality in attaching such significance to the minor matter five months before, his apparent persistent resentment to the care assistant, whom he had previously worked well with, and the intensity of his violent eruption without any significant precipitant might together suggest a worrying degree of mental instability. At the time,the Consultant and the other members of the clinical team continued to see this as evidence of some form of emotional turbulence, not unexpected, at a time of potentially stressful change. If Lee Powell's reactions were the consequences of his disability from an organic personality syndrome, then it should be anticipated that his responses to future stresses might be the same.

Psychiatric care at TRU

5.2.51 Dr Finnegan kept what can be described as 'a watching brief' on Lee Powell's progress. No other psychiatrists were involved. Lee Powell was not prescribed any psychotropic medication.

Psychiatric considerations regarding the care of Paul Masters

5.2.52 The Panel of Inquiry has seen no evidence that Paul Masters was seen by a psychiatrist. It is known however that a number of different specialists were involved in consideration of his placement at TRU.

5.2.53 From one of the psychology reports, written by Dr Jackson, there is an indication of problematic mood swings. In his assessment report Dr Jackson notes, *"Mr Masters suffers from rapid mood swings and periods where he has little control over his emotions with resulting temper tantrums and swings from depression to elation and excitement."* It was also noted that he was being treated with Dothiepin (an antidepressant), although the report indicates its use as a sedative.

5.2.54 It seems that Paul Masters continued on Dothiepin 75mgs daily initially at TRU; this was discontinued some three weeks after his admission. It is not known why this decision was taken. There was no formal review of his mental state for consequent signs of deterioration. A psychiatrist was not involved.

5.2.55 Comment:

Had Paul Masters had an underlying mood disorder, then it is possible that the behavioural deterioration observed during his time at TRU may have been related, at least in part, to the cessation of antidepressant medication.

We RECOMMEND that whenever costly placements are being considered, appropriate medical or other specialist opinion be sought. This may help to clarify the relevance of any underlying medical disorder, and ensure a wider view of a patient's treatment needs.

5.3 The Care Programme Approach and risk assessment

5.3.1 The Scott Clinic protocols for the care programme approach (CPA) had been in place since June 1994, and notes of Care Planning meetings and CPA routine assessments had been in place since January 1995, often incorporating Section 117 after-care requirements. Lee Powell's after-care programme was carefully drawn up on 23rd July 1996 alongside the Section 117 pre-discharge meeting on the same date. However one notable omission was a copy of the risk assessment form, which was not completed by Dr Finnegan until 13th November 1996, and sent to TRU very shortly afterwards.

5.3.2 Mr Heywood told us that he was inexperienced in the responsibilities of keyworker, having only acted in this capacity on two or three previous occasions. By agreement, he took no part in calling subsequent CPA reviews, and he was unable to attend the second of the two reviews which took place between August and December 1996. By arrangement, he did not take the notes of these meetings, each of which were long delayed in their circulation. The minutes of the meeting on 9th October were not received by the participants until 8th January 1997, and contained basic errors, including the wrong date and errors in the attendance list. Dr Finnegan took separate minutes of the meeting of 13th November because of his concern that the important details and decisions were recorded prior to the decision about the renewal of Section 37 which was due two days later. Mr Heywood was not told, and learned only by chance on the day of the move, of Lee Powell's transfer from Ashton Cross to Lyme

House, despite maintaining regular contact with Lee Powell throughout his placement at TRU.

5.3.3 **Comment:**

These matters were not raised by either party during the regular monthly supervision sessions between Mr Heywood and his immediate supervisor, Mr J Wakefield, who told us that he had never heard of Lee Powell before the homicide. Mr Wakefield spoke strongly about the need for authoritative guidance, ideally from the Department of Health, about the role of the keyworker within the Care Programme Approach, and we would endorse this. Mr Wakefield told us that the role of a supervising officer is to provide support, assistance, guidance and advice to the person being supervised, although he acknowledged that the regular monthly meetings with Mr Heywood, which took place in Mr Wakefield's office, generally focused on managerial rather than clinical issues. Given Mr Heywood's limited experience as a keyworker, and the complex problems presented by Lee Powell over a long period, his absence from their joint agenda is not easy to understand, and in the view of the panel it is a matter of some importance that the nature of the supervisory relationship is clarified as a matter of urgency.

5.3.4 **We also discussed the merits and demerits of "outposted" staff in specialist settings. We have been told that the Social Services Inspectorate conducted a national review of social work staff in medium secure units in 1994, and that Scott Clinic was included in that review. Clearly the benefits which accrue to having social workers (and psychologists) based within the unit are balanced to an extent by their separation from the mainstream of social work practice and training. Mr Heywood, despite his long experience within Scott Clinic, had only very limited practical experience of the central role of the keyworker within the Care Programme Approach. It is important that the management and supervision of outposted staff is comprehensive and dynamic, if the clinical and management problems posed by cases with the complexity of Lee Powell are to be properly addressed.**

We RECOMMEND that an authoritative guide to the role and responsibilities of keyworkers is commissioned by the Department of Health as a matter of urgency. It is now nearly eight years since Circular HC(90)23 was published, which required Health Authorities to implement the Care Programme Approach. We believe that the slow development of a CPA culture across the country generally may be traced to a lack of appropriate guidance for keyworkers.

Risk assessment and management

5.3.5 The only formal risk assessment document completed while Lee Powell was at the Scott Clinic was made well into his trial leave at TRU, on 13th November 1996. Dr Finnegan completed a risk assessment form. Missing from the information given is

any of Lee Powell's threats to kill others, the threat to set fire to the house of a member of staff, and the attempt at hostage taking. Neither the last serious incident, namely the two potentially homicidal attacks on 14th July 1996 nor a subsequent threat about this member of staff, occurring in the period prior to his trial leave, were cited. His attempted and actual assaults on fellow patients are omitted from the information given. There is also no mention of the occasions when physical restraint was needed to prevent serious harm. However the risk assessment form does indicate that Lee Powell acts aggressively to staff and property, *"in relation to episodes of frustration"*. There is no specific guidance given that Lee Powell is prone to harbour resentment when he misperceives the actions of others in an unduly prejudicial manner. Similarly, omitted is the history of him accusing others, including fellow patients, of serious sexual assaults and subsequently becoming angry and aggressive to them. Yet, Lee Powell himself described having thoughts of killing the last fellow patient he alleged of perpetrating a sexual act against him and although he did not intend to kill him he felt that he might do so in an outburst of anger. Lee Powell's long-standing history of accusing others of sexual crimes against him and harbouring hostilities as a consequence, would have implications for his community rehabilitation. It would have been expected that eventually he would have opportunities for further sexual relations and his past indicates that he was at risk of misperceiving such events. The risk assessment form does give some guidance but does not allude to these specific risks: *"when finally placed in the community it is important that adequate support mechanisms are available which would facilitate him seeking help and enable him to avoid rumination. ... He needs an opportunity for confidential outlet of emotional concern and this is available."*

5.3.6 Comment:

Despite the limitations in the information conveyed on the risk assessment form, we have been advised that a large quantity of additional information was passed to TRU, which included discussions about Lee Powell's violent characteristics. However, given our expressed concerns elsewhere in this report about TRU's poor administration, the separation of case files between the individual units and the administrative headquarters, and other management deficiencies, it would not be surprising if the information became dispersed. Dr Jackson gave oral evidence to the Inquiry that on the information given to him about the incident on 14th July he did not consider it a major incident, and that Scott Clinic were still wanting to proceed with the referral. The importance of a single, focused, comprehensive record of risk assessment, in which the gravity of risk is clearly spelled out, cannot be over-emphasised.

Furthermore, it became clear to the Inquiry that the carers at TRU who gave oral evidence were unfamiliar with risk assessment and management.

We RECOMMEND that each of the factors to which we have drawn attention, namely the importance of a review of serious incidents in patient care, and the training of keyworkers and other key staff involved with the Care Programme

Approach is given careful attention in the audits proposed by the St Helens & Knowsley Hospitals Trust.

5.3.7 A central practice of the Speciality of Forensic Psychiatry is risk assessment and management. As yet, there are no definitive guidelines in this challenging area. However, the essential principles of risk management would be carefully and systematically indoctrinated within the higher psychiatric training given to doctors before they are appointed as consultant forensic psychiatrists within the NHS. As a guide to assist all psychiatrists, the Royal College of Psychiatrists published A Special Working Party Report on Clinical Assessment and Management of Risk (1996).

5.3.8 The Report highlights the basic principles. These are as follows. Risk can not be eliminated entirely but can be rigorously assessed and managed. Risks vary over time and circumstances, and therefore should be frequently reviewed. Risks can be against specific individuals or be more general. Interaction between the clinician and the patient is crucial, as a good rapport enhances assessment - risk may be increased if doctor-patient relationships are poor. Information should be gathered from as many relevant sources as possible. Risk assessment can rarely be adequately done by one person alone and best involves the clinical team and where necessary a supervisor. It is important to share the outcome of the risk assessment and the management with as many others as appropriate. Risk to others is often associated with the risks of self-harm. It must be appreciated that therapeutic interventions can increase as well as decrease risk.

5.3.9 The psychiatric assessment of risk should include very careful history taking, appreciation of environmental circumstances and proximity to potential victims, and the patient's mental state. Historical factors commonly associated with the risk include, primarily, a history of violence, self-harm or otherwise endangering others (it remains a generally accepted principle that the best predictor of future behaviour is past behaviour); other relevant factors are lack of social stability, poor compliance or disengagement from care, substance misuse especially of dis-inhibiting substances or a social background where violence is acceptable. There must be an identification of any factors that precipitated a change in a patient's mental condition or behaviour prior to previous violence or relapse of their illness. There should also be an inquiry into any recent stresses that may impact into these factors. Environmental concerns relate to the potential accessibility to possible victims, particularly those who can be identified as potential victims through the risk assessment process. Abnormal factors in the patient's mental condition which should give rise to concern include beliefs of persecution by others, hearing voices commanding them to act dangerously, and the patient perceiving that they are controlled or influenced directly by external forces. Any specific threats that the patient may have made should be noted. The patient may be more vulnerable to act adversely if their emotional state is that of irritability, anger, hostility or suspiciousness.

5.3.10 The risk formulation should address the extent and severity of the risk, whether it is immediate or distant, factors likely to exacerbate the risk and any management guidance.

5.3.11 The report sets two principles of clinical risk management: *"A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring the risk is reduced and managed effectively."* And *"The management plan should change the balance between risk and safety, following the principle of negotiating safety."* How risk is managed will depend on what pathway of care is offered to the patient. General principles should include the careful recording of the assessment and management plan, consideration of any special patient characteristics, the involvement of other appropriate agencies and the dissemination of relevant information and guidance.

5.3.12 The report also gives specific recommendations regarding the transfer of clinical responsibility: *"If responsibility for implementation of the management plan is passed on to another clinician or service, it must be handed over effectively and accepted explicitly. Information passed on under such circumstances must be comprehensive and include all the information known to the informant likely to be relevant to the assessment and management plan, i.e. covering the points above as a minimum.*

5.3.13 *Direct discussion will probably need to supplement correspondence. More than one discussion may be needed to ensure adequate hand-over."*

5.3.14 The Health Service Guidelines, "Guidance on the discharge of mentally disordered people and their continuing care in the community," HSG (94)27, specifies responsibilities: *"Those taking individual decisions about discharge have a fundamental duty to consider both the safety of the patient and the protection of other people. No patient should be discharged from hospital unless and until those taking the decision are satisfied that he or she can live safely in the community, and that proper treatment, supervision, support and care are available."*

5.3.15 Comment:

In retrospect, and set against these standards, risk assessment practice in the case of Lee Powell fell below what was required, with particular regard to its formal recording, and in the delayed completion of the risk assessment form in use at that time.

We RECOMMEND that the management of the Scott Clinic should ensure that they have a comprehensive risk management strategy, with clear protocols, and provide relevant training in risk assessment and management.

We also RECOMMEND that, if TRU are to continue to take patients who are a potential risk to others and to themselves, their service managers should ensure

that the culture of risk assessment is developed, with appropriate protocols and training.

We RECOMMEND that a programme of risk assessment continues to be undertaken in the case of Lee Powell.

5.4 Working in partnership

Partnership in seeking suitable facilities for difficult to place patients

5.4.1 *"All agencies should recognise that particular efforts need to be made to inform, involve and meet the specific needs of certain people and groups. For example.....People who suffer from a physical or sensory disability in addition to mental illness may require particular support or facilities to help them access information and care." (Building Bridges. Department of Health. 1995)*

5.4.2 There have been significant changes in care services in recent years and in the needs of the people who use them. The needs of Lee Powell and of Paul Masters illustrate the point. Each was believed to have suffered from an acquired brain injury, and in addition Lee Powell had spent more than 5 years in a medium secure unit as a detained patient under the Mental Health Act. It is not therefore surprising that each of them posed particular problems with regard to their long-term placement and care, and we have looked carefully at the attempts to find a suitable placement for Lee Powell during his stay at the Scott Clinic, and at the degree of inter-agency involvement in this task.

5.4.3 During the initial period of remand in the the autumn of 1991, Lee Powell's behaviour at the Scott Clinic was sufficiently impulsive and violent for Dr Finnegan to seek the advice and assistance of Ashworth hospital, with the possibility of St Andrews hospital as an alternative placement also being mentioned in the clinical notes. (A previous referral to Ashworth in 1989, while at Glen Parva, had been unsuccessful because he was not considered to fulfil the dangerousness criteria). However a marked improvement in his behaviour in the weeks leading up to the court appearance caused a review of plans and Dr Finnegan's recommendation to the Court was for a Section 37 treatment order, to remain at Scott Clinic with a view to rehabilitation in the Chester area, away from his family.

5.4.4 During the next five years, consideration was given to a number of different placements in the community. However, as Mr Heywood told us, *"the process was very inconsistent because Lee's behaviour changed over time"*. Dr Finnegan told us...*"It is a difficult process. It is often rather a haphazard process because there are a great lacunae of knowledge. Our social workers tended to make a big effort to acquire a database of places.....there was a folder full of brochures from various private companies, together with knowledge of local health authority and local social services resources, to try to find somewhere that might meet their needs."*

5.4.5 The picture presented to the Panel during this period is therefore one of a rather uncoordinated process, led by the keyworker at Scott Clinic, varying at one extreme from referral to Special Hospital and on the other to discharge of the Section 37 order and a return to the community to allow any legal process to take its course. In between, a range of suggested community placements seemed to have no very consistent theme. Meetings with purchasers took place on 27th January 1994, on 16th April 1996, and on 9th July 1996. The recommendation for placement at TRU had emerged from a Mental Health Review Tribunal in 1995, from the Consultant in Neuropsychiatric Rehabilitation at St Andrews Hospital.

5.4.6 Medium secure units were never intended to provide longer-term care for patients who offer major management problems. From their inception, it was intended that regional secure units would provide medium secure care for up to two years. It has only been appreciated since that there is a significant need for patients requiring longer term care under this level of security. It is not uncommon in any medium secure service to find a proportion of patients have been there well over two years and they may not have any imminent discharge plans.

5.4.7 As yet, there is no national programme of implementation for the provision of long-term medium secure care. We were advised that new services within the NHS may be somewhat slow to evolve because of the long planning procedures required, the complicated funding arrangements and the many options that have to be considered before implementation. In contrast, the independent sector is able to develop services more swiftly and without the same restrictions on financing or planning. As a consequence, provision for long-term medium secure care is largely provided in the independent sector. Across England and Wales there is no universal agreement as to the extent of the need nor how it should be met. Each national health region will be assessing its own needs and determining the best means of providing such services.

5.4.8 The Panel of Inquiry were advised by the Regional Co-ordinator for Mental Health Services, Ms Carole Jobbins, that across the three medium secure units in the North West Region, the Scott Clinic is not burdened by the problem of patients requiring long-term care, as are the other two medium secure units. The case of Lee Powell therefore seems to be unusual in both the type of care he was deemed to require and the length of his care in the Scott Clinic.

5.4.9 It is likely that where medium secure services are well integrated with the general psychiatric services they serve, there can be more dynamic flow of patients. This may help minimise the delays in transferring patients to less secure care. Similarly, it may place less burden on medium secure services for admissions, as mentally disordered offenders can be better tolerated and accommodated within general services, with the knowledge that they can be promptly supported by specialist regional services as necessary. These factors may be relevant with regard to the Scott Clinic not having a waiting list or a general problem with patients requiring long-term care.

5.4.10 The provision of more specialist medium secure services may be difficult to achieve even on a regional basis. The Panel of Inquiry was informed that nationally there is only one medium secure facility for those with brain injury, and this is based at St Andrews Hospital in Northampton. This hospital enjoys a charitable trust status. Other independent medium secure services that may occasionally admit patients with such specialist needs, are run on a profit making basis. The need for such services in any region is likely to be much less than for mainstream medium secure services. It may only be that such services can be provided within the NHS on a supra-regional basis.

5.4.11 The Panel of Inquiry heard of the plans to establish a long-term medium secure provision in the Salford area. However, all its thirty beds are to be purchased, at least initially, by the High Security Psychiatric Services Commissioning Board to provide for those patients currently in high security, largely at Ashworth Hospital, who are judged to need long-term medium secure provision. This would not cater for such problematic cases as Lee Powell.

5.4.12 Witnesses stressed to the Panel of Inquiry the benefits of establishing a comprehensive national network of resources. More formal links could be developed across specialist resources.

5.4.13 Comment:

The Panel of Inquiry would support maintaining an up to date directory of such resources, nationally, to assist those searching for very specialist levels of care, and RECOMMEND that consideration is given to establishing and maintaining such a register on a national basis.

There may also be merit in each of the medium secure services in the region interacting in a manner more dynamically supportive of one another. Occasionally, there may be advantage in the exchange of problematic patients. At the very least, the staff involved may benefit from a respite from the particular clinical burden. Similarly, such patients may be assisted by a fresh clinical approach. This opportunity could be more fully developed, although we recognise the practical and clinical difficulties which might ensue. Furthermore, existing catchment area boundaries may not facilitate such patient placements.

5.4.14 However there is evidence that these problems of placement for patients with special needs were being recognised. A working group of the high dependency network was established under the auspices of the North West Regional Health Authority to look specifically at the co-ordination of response to the needs of people with personality disorder, and a discussion paper was published in January 1996, with a protocol for referrals to specialist services outside contracts. The following year, in February 1997, NHSE North West focused more directly on acquired brain injury with a paper on specialist rehabilitation services for clients within this category. *"At the present time, a comprehensive range of services to meet the needs of those with physical, cognitive,*

and/or emotional problems as a result of acquired brain injury is not available across the whole of the North West." The paper recognised that specialist services of this nature cannot be provided by every Trust, and that purchasers need ideally to work together on a consortium basis both to identify the need for rehabilitation services for this group, (and, presumably, for other such groups).

5.4.15 Within South Cheshire Health, a "Complex Case Policy" was set out in 1998, relating to patients whose proposed costed care package exceeds £30,000 per annum. A Complex Case Panel would consider all cases in this category, with packages of care costing more than £30,000 requiring Health Authority approval. The decision-making process, in other words, was becoming established, although the methods of validation of a proposed placement and of review of the placement probably still required sophistication. It is worth recording that no process of this nature existed in July 1996, although meetings took place between the proposed purchasers to try to identify suitable placements and to reach agreement about the apportionment of the costs of placement of these expensive packages of care, and Section 117 pre-discharge meetings were taking place in accordance with the Care Programme Approach.

5.4.16 Two meetings were held between the prospective purchasers to discuss the funding of the placement of Lee Powell at TRU (on 16th April and 9th July 1996). Agreement was reached that Social Services would contribute towards the cost of a placement which they had initially considered to be exclusively a health responsibility.

5.4.17 **Comment:**

By general agreement, decisions about placement of patients with complex needs before 1996 were haphazard. Knowledge of and information about specialist care resources was diffuse and uncoordinated. Progress has clearly been made, but the notion of a regional consortium of purchasers has not yet, we understand, found a champion. The Panel recognises the many major pressures on Health Authorities at the current time, but the notion of purchasers working together on a consortium basis to take service development forward has, in our view, great merit.

Partnership in purchasers' assessment of the suitability of a proposed placement

5.4.18 The Panel has looked carefully at the arrangements for purchasers' validation of proposed placements. The circumstances of Lee Powell's trial placement at Alpass Nursing Home in 1994, for instance (see paragraph 2.4.24 above), illustrate the dangers of an over-intrusive and unilateral stance by the purchasers in the face of the provider's recommendation. Neither party has exclusive rights in this matter. The need for the very closest collaboration is self-evident if the purchase of the most suitable service is to be achieved.

5.4.19 Furthermore, as Dr Klein, Consultant in Public Health Medicine for South Cheshire Health Authority, made very clear to us, it is unlikely that purchasers, Health or Social Services, will have sufficient expertise to be able to make accurate assessments about the suitability of placements. Recourse has to be made to the detailed knowledge and understanding of current specialist providers, or, in these specific circumstances, of the registration authority as well.

5.4.20 Comment:

Despite the care with which preparations for Lee Powell's placement at TRU were made, misconceptions apparently remained. His ward manager, for instance, told us that she thought that TRU was a nursing home, providing greater security, in terms of staffing levels and expertise, than Ward 4. The main social services purchasing representative at the funding meeting on 9th July is quoted in the minutes of that meeting as believing that *"he needs an environment which has a degree of security"*. Yet at the final pre-discharge Section 117 meeting on 23rd July it was recorded that *"final decisions concerning placement (at Ashton Cross or Lyme House) will be made between Lee and the staff at TRU."* We have been left with a clear impression that TRU in the person of Dr Jackson had not picked up the whole story of Lee Powell's potential dangerousness, while Dr Finnegan and his staff (and the main purchasers) may have had a slightly over-optimistic view of TRU's capacity to cope with some of Lee Powell's most impulsive and violent behaviour. We do not suggest that either TRU or Scott Clinic in any way deliberately misled the other. Both, however, were investing a lot in the success of the placement, and conflicting commercial and care considerations will always produce tensions.

We were told that Mr S Cullen visited TRU on behalf of South Cheshire Health Authority, the main purchasers. Cheshire Social Services Department, the secondary purchasers, had completed a needs assessment on Lee Powell but had not visited TRU. The registration authority, St Helens Borough Council, were not represented at the Section 117 meetings, but Lee Powell's keyworker, Mr Heywood, had spoken to registration officers and obtained a favourable general view of the facilities. However we remain uncertain why Lee Powell, in the light of his long history of impulsive and violent behaviour during his five years at the Scott Clinic, should have been admitted to Ashton Cross in the first instance rather than to Lyme House (which had higher degrees of supervision). We have already commented (see paragraph 2.5.24) on the need for clarity in contracts.

5.5 The Supervision Register and Supervised Discharge

5.5.1 **Supervision Registers** were first announced by the Secretary of State for Health in August 1993, with the purpose of identifying "people who no longer require treatment as in-patients, but nevertheless are at significant risk of committing serious violence, or suicide, or self-neglect, as a result of severe and enduring mental illness, should their

condition deteriorate." Health Authorities were required to have in place by 1st April 1994 contracts which ensured that all provider units providing mental health care set up registers which identified and provided information on such patients. Registers themselves were to be established by 1st October 1994.

5.5.2 DOH Guidelines indicated that consideration for inclusion on the Supervision Register should take place as part of the discussion of the care programme before patients leave hospital, and at care programme reviews following discharge. The decision as to whether a patient is included on the register rests with the consultant psychiatrist responsible for the patient's care.

5.5.3 In the event, consideration about Lee Powell's inclusion on the Supervision Register was not given until the review meeting at TRU on 13th November 1996, eleven weeks after the start of his trial leave from the Scott Clinic. The decision was taken to include Lee Powell on the register, despite the expressed concern of Lee Powell himself, and despite the reservations of the clinical team. Dr Finnegan's record of the meeting states *"We have no expectations that placing Lee on the Supervision Register would make any difference to the management of risk or assist him in obtaining service either in greater quantity or of better quality than are available to him. However, in view of Lee's long history, which has involved violence, and the fact that he is coming off a Section 37 from a Regional Secure Unit after five years, it was agreed that he would be placed on the Supervision Register and that his place on the register would be reviewed on a three-monthly basis."*

5.5.4 Comment:

Dr Finnegan's view of the practical value of the Register probably reflects a widely-held view by medical and other clinical staff. Nevertheless the decision, in the view of the Panel, was a correct one in the light of Circular HSG(94)5, albeit the decision was made after Lee Powell's discharge from hospital.

5.5.5 Lee Powell was formally notified by letter by Dr Finnegan on 18th November that his name had been entered on the register. His registration, however, could have had no bearing on the fatal events of 23rd/24th December 1996.

5.5.6 **Supervised Discharge** was introduced as part of the provisions of the Mental Health (Patients in the Community) Act 1995, and the regulations made under it, which introduced new arrangements for after-care under supervision with effect from 1st April 1996. Supervised Discharge is intended to apply to the limited number of patients who, after being detained in hospital for treatment under the Mental Health Act 1983, need formal supervision in the community to ensure that they receive suitable after-care. Its purpose is to help ensure that the patient receives the after-care services provided under Section 117 of the Mental Health Act. Detailed guidance was contained in HSG(96)11, which was issued as a supplement to the Mental Health Act Code of Practice. The guidance states:

"Before a patient is discharged from hospital, a risk assessment should be carried out, a care plan established based on a systematic assessment of need and a key worker identified to monitor the patient's progress and the delivery of care in the community..... Patients who are placed under supervised discharge will have been assessed as presenting substantial risk of serious harm to themselves or other people, or of being seriously exploited, if they do not receive suitable after-care"

5.5.7 Health Authorities were asked to ensure that their contracts for mental health services, and specifically for the provision of services under Section 117 of the Mental Health Act 1983, included the necessary arrangements for implementing Supervised Discharge.

5.5.8 In the event, it was decided at the first TRU monthly review meeting on 9th October 1996 that Lee Powell should not be subject to Supervised Discharge. The decision is recorded not in the belated notes of that review meeting, but in the notes of Dr Finnegan's clinical meeting a week later. *"George Meyer raised the issue of the Supervised Discharge Order but neither I nor Dave Heywood felt that this would assist Lee in obtaining services and would, in any event, alienate him rather than ensure his co-operation so we did not advocate it."*

5.5.9 Comment:

One of the conditions of Supervised Discharge is that *"Supervision is likely to help ensure that the patient receives after-care services".* Dr Finnegan and the clinical team clearly felt that this would not be the case, although the care manager, Mr Meyer, told the Panel that he felt that supervised discharge would have offered some safeguards (eg conditions of residence) after the Section 37 order had been allowed to lapse.

5.6 Scope of the Registered Homes Act 1984

5.6.1 Correspondence relating to the possibility of TRU's registration under the Registered Homes Act 1984 commenced in 1990, and initially involved both St Helens Metropolitan Borough Council and St Helens & Knowsley Health Authority. The Health Authority was involved in case TRU wished to register as a nursing home. Subsequently it became clear that registration was to be as a registered care home, although the categorisation for a home for adults recovering from the effects of brain injury was a matter for some discussion: *"There has been some debate about the categorisation of the unit as the definitions used by the Registered Homes Act 1984 do not allow for flexibility of residents' needs and dependencies. The term 'mental disorder' and 'mental handicap' are not appropriate for this client group. The only other possibility is 'physical disablement' which would reflect the physical damage previously inflicted on the brain of the persons to be cared for and treated at the TRU...."*

5.6.2 In the event, TRU Ashton Cross was registered for 4 residents on 19th August 1992, and for a total of 9 residents on 14th September 1992, with the category of physical disablement.

5.6.3 Inspections by the St Helen's Social Services Inspection Unit continued on a regular basis thereafter, the main concerns relating to the administration and management of records, and the delayed response to correspondence from the Inspection Unit. There was, however, additional concern expressed by the Inspection Unit when it was discovered that one of the residents was a Schedule 1 offender, having been convicted of offences against a minor. The Inspection Unit was not notified of this by the placing agency, or by TRU.

5.6.4 Four years later, in August 1996, following an application for registration of a further TRU unit at Lyme House, Haydock, an officer of the Inspection Unit visited to find a total of 13 people already in residence, four of them in 'Independent Living Units', five of them in an eight-bedded unit, and four more in a six-bedded unit. Paul Masters was one of the residents in the eight-bedded unit. An application for registration was quickly prepared for consideration *"for adults with post-acute brain injury"*. A decision was made that the four Independent Living Units did not require to be registered under the Act. These Units, although contained within the confines of the Establishment, had separate and independent entrances. The definition *"physical disablement"* was again used, and Lyme House was formally registered on 22nd August 1996, for a total of 14 places. Regular visits of inspection commenced. One such visit, on 29th/30th October 1996, commented *"the current arrangements for staff when sleeping –in need to be reviewed"*.

5.6.5 Paul Masters and Lee Powell were each resident in an ILU on 23rd December 1996. Paul Masters was murdered in Lee Powell's Unit. Paul Masters had broken house rules on the night in question, firstly by visiting Lee Powell's Unit after 10.30pm, and also by drinking alcohol on the premises. Lee Powell had also broken house rules by drinking alcohol on the premises. The two night staff on duty told the Panel that they were unsure of their responsibilities towards residents of the ILU's, and took little or no action to investigate warning bleepers from the Units. One made the point that he knew that these Units did not require to be registered under the Registered Homes Act.

5.6.6 Comment:

The Panel raised two questions with the St Helens Metropolitan Borough Council Inspection Unit:

(i) whether TRU should have been registered as a Mental Nursing Home under Section 22 of the Registered Homes Act; and (ii) why the 4 ILU's did not require to be registered.

It is clear that the Inspection Unit also felt the need to review the first of these questions after the St Helens & Knowsley Hospitals NHS Trust's Internal Inquiry

had reported. On 20th October 1997, the Director of Social Services wrote to Dr Jackson and Mr Kenyon at TRU...."*It is timely to reconsider the registration category of TRU as it is clear that on occasions, the admission criteria has been extended to embrace clients with mental health problems, although we accept that the individuals concerned have also suffered brain injury.*" Pending the outcome of further discussions, it was agreed that TRU would admit no more clients who were subject to the Care Programme Approach. The Panel has been told that to date no application has been made by TRU for a change of category of registration.

In correspondence with the Panel, the Manager of the Inspection Unit, Mr G Brown, described the rationale behind each of the authority's decisions. With regard to the registration of the ILU's, Mr Brown commented *"When we visited the premises we found that accommodation at two extreme wings of the property did not form part of the establishment which was to be the Residential Home. They were independent living units which people were renting."* The authority also took the view that there was no "board" element in the arrangements with regard to the ILU's, so that an essential part of the requirement for registration ("residential accomodation with both board and personal care for persons in need of personal care") was absent. The Panel considers these views to be debatable, particularly in view of Decision No 146 of Registered Homes Tribunal decisions. The Panel received no evidence that Lee Powell or Paul Masters were independently renting their accommodation. They were each transferred into ILU's with no change in the previous financial arrangements.

On the question of possible registration as a Mental Nursing Home, Mr Brown commented..."*following discussions with the Health Authority, neighbouring authorities and the SSI, we came to the view that the correct category for the Home should be physical disablement rather than mental disorder.*" We are advised that this view has been reviewed and confirmed subsequent to the homicide.

It is also clear that, since the Registered Homes Act came into force 16 years ago, the policy of Care in the Community has resulted in significant changes in the numbers and the needs of vulnerable people living in the community, and in an increasingly diverse range of services being provided. Following the closure of many acute facilities, there are more people with challenging conditions (eg substance addiction, alcohol, acquired brain injury, etc) now requiring placement. The private health sector plays an increasingly full part in the provision of services for people with special needs, and much of this new provision does not sit easily within the terms of the Registered Homes Act. As the Registration and Inspection Manager of South Cheshire Health, Mr P Lynch told the Panel, *"The legislation has served its purpose, but now needs a radical overhaul as it is outdated and does not support regulators in protecting extremely vulnerable people nor in ensuring the highest possible standards of care, services and facilities.....Regulations are required which explicitly define the minimum standards required to achieve and maintain patient care."*

This view seems to be shared by the present Government. In December 1998 a White Paper was issued entitled *"Modernising Social services"* which, starting from the premise that *"the present regulatory arrangements are incomplete and patchy"*, proposes the establishment of eight regional Commissions for Care Standards to regulate a wider range of care services, working to new national standards. The Panel considers it vital, in the light of the evidence they have heard, that such standards are sufficiently flexible to meet the needs of vulnerable clients who may have complex care requirements which cut across traditional client categories, and that standards are fitted to meet the needs of clients, rather than clients having to be fitted into categories which may be too narrow to describe their full needs, and which offer them inadequate protection.

Detailed operational proposals need to be made in support of the broad principles contained within the White Paper, but the Panel endorses the main thrust of the White Paper, and the recommendation in the White Paper that *"regulation is a priority area for authorities in the period before the new system is established"*.

5.6.7 We have been advised by the Registration Authority that, when TRU admitted residents who were outside the criteria upon which their registration was based, it was done without any form of consultation, discussion, or notification to the Authority. We have also been advised by the Registration Authority that TRU are now providing the Authority with information with regard to proposed admissions, to enable the Authority to take a view as to whether it would be appropriate to admit.

5.6.8 **Nevertheless, taking account of current patient mix, we RECOMMEND a joint review by St Helens Metropolitan Borough Social Services Department and St Helens & Knowsley Health Authority of the registration of the Transitional Rehabilitation Unit to ensure that the current registration offers sufficient protection for its residents and staff.**

5.7 The Transitional Rehabilitation Unit

5.7.1 The Panel had great difficulty in assimilating the strengths and weaknesses of TRU. On the one hand, there is pioneering work with a client group whose special needs are not adequately met. Lee Powell was making good progress before the fateful night in December 1996. It was the view of the registration authority that, despite many failings in management and administration, the general standards of care adequately met the registration requirements.

5.7.2 On the other hand there were very real limitations, not only in general management and administration which are described in the Report.

5.7.3 It is our view that TRU accepted clients whose needs stretched the organisation's care resources to the limit. Both the Panel and the registration authority had the greatest

difficulty in gaining information about the number and the needs of residents at TRU, and despite repeated requests, and repeated promises, we have still not been given details from the register of residents at Lyme House on the night of Paul Masters' death. Furthermore there were operational decisions (for instance the circumstances of Paul Masters' move into an Independent Living Unit at Lyme House) which even the staff found difficult to comprehend.

5.7.4 It is our view that TRU potentially has a positive and important role to play in the care of clients with acquired brain injury. Nevertheless we have the impression that the Directors regarded the requirements of registration as a bureaucratic imposition, while the registration authority spent an inordinate time trying to ensure that TRU met the basic legal requirements of registration. The relative inflexibility of the current registration requirements do not assist this conflict. While current arrangements for registration remain, and for so long as the Registered Homes Act 1984 remains in force, it is difficult to see how progress may be made without the fullest understanding and co-operation on both sides. Nevertheless our close examination of the circumstances of the death of Paul Masters lead us to the view that, for so long as TRU continues to admit patients with complex needs, particularly those with a background of mental ill-health, so will additional safeguards be required for the proper protection of all the residents.

We therefore RECOMMEND that the guiding principles contained within the Mental Health Act Code of Practice, and particularly Chapter 15 ("Medical Treatment") and Chapter 18 ("Patients presenting particular management problems") should govern the care of TRU residents, and that TRU policies should reflect this. It is particularly important that careful records are maintained of the application of medical treatment, and in the use of restraint with individual patients.

5.8 The Peer Group Review

5.8.1 The Panel of Inquiry heard that the Peer Group Review process came out of an earlier inquiry at the Scott Clinic, in the 1980's. A Peer Group Review can be called by any discipline. It is thought to be helpful when there may otherwise be an un-resolvable difference in the clinical team; although we had oral evidence from Dr Finnegan that the meetings had not yet been used for such a purpose. The meetings are called when a patient requires longer than two years admission to the Scott Clinic, or after a failed community placement, or in regard to the admission of a patient with psychopathic personality disorder. The Inquiry was not presented with any written protocol for these meetings. Dr Finnegan advised us that the meetings were likely to be chaired by the patient's consultant. The latter or their senior registrar usually takes the minutes. With regard to Lee Powell's only Peer Group Review meeting, it is not possible to identify all who were present. Normally advice from beyond the caring clinical team would come from additional staff from the Scott Clinic representing each discipline. The junior doctor on the clinical team would be expected to present relevant case details.

5.8.2 Dr Finnegan stressed in his oral evidence to the Panel that the meeting deliberately avoids an academic emphasis and aims to make discussion 'free-flowing'. *"Healthcare assistants will be accorded as much right to speak and to express a view about the case as the consultant"*.

5.8.3 Comment:

The Peer Group Review process as practised at the Scott Clinic is commendable. It might be further enhanced if the peer group was extended to professionals beyond the working environment of the Scott Clinic. It must be appreciated that regional secure units are relatively circumscribed institutions. Many of the staff may have been working in the service for a long time and may have also been trained within the same service. Therefore, the process of peer review would put a heavy emotional burden on staff potentially perceived as criticising their close colleagues and possible former mentors. An independent view is also more easily achieved from colleagues who have not been involved in the case and thus they may be able to take a different perspective. Particularly in a case as complex and challenging as Lee Powells', there is the risk that when clinicians are at close quarters it may be difficult to discern salient information from the myriad of problems, or as it were, 'to see the wood for the trees'.

There would appear to be merit in perhaps maintaining two forms of Peer Group Review. One an informal meeting to allow all involved, together with relevant colleagues not directly involved, to brainstorm the issues and encourage the expression of all concerns. The second type of review could then be more formal, ensuring a robust and vigorous debate in a systematic manner regarding assessment, diagnosis and management. There would appear to be little to be lost if teaching and training were included within the meetings.

The Panel of Inquiry were told that there was no system in place for regularly participating in academic case conferences within the University Department of Psychiatry. If not, then this would deny the clinical team a robust and independent review of the case history, mental state examinations, investigations, progress, differential diagnosis, and clinical management.

5.9 Record keeping

Scott Clinic

5.9.1 Patient records at Scott Clinic are now typed, thereby making clinical notes exceptionally clear and uncomplicated to read. The notes contain medical, nursing, social work and other records in chronological order, together with weekly nursing reviews and notes of clinical meetings. Quality of the notes is generally of a high order.

5.9.2 Comment:

We commend the standard of clinical notes. Records of separate meetings are more varied in quality, many being unsigned and one being undated. Consistency also varied in the title of the meeting being held, although this improved during 1995 and 1996 as the implementation of the care programme approach policy became better established. The range of quality in the completion of records of meetings probably reflects the skills of the authors, who were invariably junior doctors.

TRU

5.9.3 Records from TRU were deficient in a number of ways, and the provision of records to the Panel was unsatisfactory. Many promised documents were not made available despite repeated requests. It is the Panel's understanding that master files for all TRU clients were maintained at TRU headquarters, accessible to staff at Ashton Cross or at Lyme House only on request. Files maintained at the units contained the daily and weekly review sheets.

5.9.4 The daily and weekly planners relating to both Lee Powell and Paul Masters were each deficient in the days leading up to the homicide. We received evidence that, when the police requested information from the file of Lee Powell after the homicide, the folder was empty. This implies that his daily and weekly records had not followed him from Ashton Cross to Lyme House when he moved there on 19th December.

5.9.5 Comment:

The Panel has reluctantly come to the view that the standards of record-keeping, correspondence, and general administration at TRU leave much to be desired. The view is endorsed by the records of correspondence with the registration authority, St Helens Borough Council, whereby the authority on more than one occasion threatened strictures if TRU failed to respond to the requirements of registration.

We RECOMMEND that TRU Directors give a higher priority to managerial issues. The Panel is of the view that the quality of the service offered by TRU would be greatly enhanced by the appointment of a senior administrator to support the care services, which are generally held in higher regard.

5.10 The Court Hearings

5.10.1 We record here simply that Lee Powell pleaded guilty to the murder of Paul Masters. The summary of events presented to the court was not disputed. The Court relied on the report of one Consultant Psychiatrist, Dr C Boyd. Leading Counsel for the defence

confirmed that his client had chosen not to invite consideration either of the question of diminished responsibility nor to the question of possible provocation.

5.10.2 Lee Powell was subsequently sentenced to life imprisonment for murder and seven years concurrent imprisonment for the offence of arson, by being reckless as to endangering life.

5.10.3 When the Panel of Inquiry interviewed Lee Power in October and November 1998, he expressed a strong preference for being dealt with under the criminal justice system rather than being considered for any form of psychiatric care. Indeed he may remain reluctant to submit candidly to psychiatric assessments or monitoring.

5.11 Other considerations

Aspects of Lee Powell's reported attitudes and attributes

5.11.1 The Panel wishes to record the many positive references to Lee Powell's character, personality and temperament that were made in evidence, even by those with least cause to do so. People liked him. When he was well, and able to manage his impetuous behaviour, he could be charming with an engaging sense of humour, articulate, and able to express regret for his actions. Members of the Panel saw this for themselves when they visited Lee Powell on two occasions.

5.11.2 In the light of this, there are three aspects of Lee Powell's social history as set out in this report which require some additional consideration, to give a more balanced record. The Panel felt that, rather than make repeated references to these aspects throughout the text, it would be better to make one specific reference to each in this way. Each is discussed below:

His allegations of sexual abuse

5.11.3 There are repeated references throughout his records of his claims of having been sexually abused. They refer to alleged abuse relating to an uncle four years his senior (there is some uncertainty about the date to which these allegations refer, but most frequently they are alleged to have taken place during his early childhood), and to at least two alleged assaults by fellow patients while at Scott Clinic. So far as was possible, the alleged assaults at Scott Clinic were thoroughly investigated, with police involvement, but no evidence whatsoever was found to support the allegations. With regard to the allegations against the uncle, they are vigorously denied by Lee Powell's family, and no corroborative evidence was found.

5.11.4 Clearly, however, these alleged assaults weigh heavily with Lee Powell himself, in that he repeatedly maintained that much of his more impulsive and unrestrained behaviour was brought on by his memories and thoughts of the assaults. Psychological attempts

to explore and resolve these problems were not successful. It should be remembered that the homicide on 23rd December was, from Lee Powell's account (and there is no other), provoked by an alleged approach of a homosexual nature.

5.11.5 In these circumstances, the Panel has taken a neutral stance towards the alleged sexual abuse, simply reporting it when its significance in Lee Powell's history seemed to warrant.

His sexual orientation

5.11.6 Lee Powell has maintained consistently since his teens that he is homosexual. At one stage he claimed to be HIV positive but this proved not to be so when he was tested. Again, nothing would turn on a detailed discussion of his professed sexual orientation in this report, although it should be noted in the context of the alleged sexual abuse discussed in the previous paragraph.

Relationships with his family

5.11.7 It should be remembered that, in the course of the history of his illness, Lee Powell made serious assaults upon his mother, and upon his younger sister, and a threatened assault with an axe upon his brother. His father told us that his family is bewildered by such behaviour. It should also be noted that Lee Powell asked specifically, both after his placement at TRU and after he was sentenced, that his family should not be informed of his whereabouts.

5.11.8 Understandably, his family remains fearful of further such assaultative behaviour, but the Panel have been impressed by his father's continuing support and his wish to remain supportive to his son, and by the continuing concern of other members of his family, as reported by his father.

CHAPTER 6 Conclusions and recommendations

6.1 An overview

6.1.1 This report, unlike many such others, does not reveal any long catalogue of error or any deliberate dereliction of duty. On the contrary, the Scott Clinic, the Transitional Rehabilitation Unit, the Social Services Departments and the key individuals within each of these organisations generally played their parts conscientiously and with commitment. The Panel has been impressed by the willingness and the openness of individual witnesses to examine their role in this story. For many witnesses, the giving of evidence was a matter of considerable stress, as the Panel searched for accuracy.

6.1.2 Nevertheless, no detailed examination of this kind, within the comprehensive terms of reference set for us, would find a faultless scenario. There are a number of critical points in Lee Powell's story where a different decision, or a different set of circumstances, might have altered events. The summary of conclusions which follows highlights those aspects of practice which we believe could have been improved, or which we believe require further attention, either locally or nationally. This is not to say that any direct causative link should be drawn between these failings and the fact of the homicide. In the last resort, both Lee Powell and Paul Masters broke the rules of residence in the Transitional Rehabilitation Unit, and the night staff failed to intervene because of their uncertainty as to their responsibilities.

Specific conclusions and recommendations

6.2 Acquired brain injury

6.2.1 Brain injury, particularly when severe, almost invariably brings multiple problems in its train for the injured person, for their family, and for professional care-givers. From cognitive impairments through emotional and behavioural difficulties, relationship problems and loss of social role, all parties have a great deal to contend with: self-centredness, lack of awareness, memory and concentration problems, increased irritability, and impaired planning and initiative may follow brain injury. It is therefore a difficult and often complex client group with whom to work.

6.2.2 With regard to Lee Powell's brain injury, we believe that the Scott Clinic was mistaken not to establish the relevance of brain injury more securely. The Clinic team and the Responsible Medical Officer are to be commended for considering and for investigating the possibility in the first place, but once started, the investigation needed to be more rigorous and extensive.

6.2.3 We RECOMMEND that, with patients where brain injury is suspected, the history is carefully checked, contradictions and differences of view are reconciled as far as possible, and a full neurological examination should be performed. The neuropsychological examination should be carried out, or at least supervised, by an experienced neuropsychologist to ensure that appropriate assessments are made, and that the conclusions that are drawn can be supported by the data.

6.2.4 We also believe that Residential Homes and Nursing Homes have a responsibility to satisfy themselves that prospective clients with brain injury are within their capacity to manage and to treat. Specialist providers of rehabilitation services for clients with brain injury should seek to ensure that this is the primary source of impairment and behavioural difficulty. If such clients have additional mental health or other potentially difficult problems, it is essential that suitable expertise is recruited to advise and assist with these problems.

6.2.5 We RECOMMEND that admission procedures include a full documented medical history to incorporate the history of any brain injury and its treatment, psychiatric history, and forensic history, together with any other relevant factors such as drug and alcohol abuse, criminal convictions, history of assaults, etc. Completion of such standard information on all new patients should ensure that diagnostic issues are clarified, missing information is sought, and potentially significant risk factors are brought to the fore.

6.3 Psychiatric considerations

6.3.1 In the case of Lee Powell, there was an apparent lack of clinical evidence to substantiate significant brain injury. Yet the exclusive adoption of the diagnosis of Organic Personality Syndrome limited other treatment opportunities.

6.3.2 Particularly with regard to diagnostic issues that decide on different treatment pathways, we RECOMMEND that all due clinical evidence be sought, including carefully checking past records. Equivocal tests should be repeated, as necessary. Further expert guidance should be gained if the pathology is considered to go beyond the responsible medical speciality.

6.3.5 Consideration of Paul Masters' placement at TRU did not involve a medical assessment. The potential for other psychiatric or medical disorder should be given due consideration, not least because such conditions may have implications for the appropriateness of the placement.

6.3.6 We RECOMMEND that when costly health placements are being considered, appropriate medical or other specialist opinion be sought. This may help to clarify the relevance of any underlying medical disorder, and ensure a wider view of a patient's treatment needs.

6.3.7 Despite their best clinical endeavours, Dr Finnegan's team at Scott Clinic made only limited progress in advancing the care and stability of Lee Powell. In clinical situations where sufficient progress is not made over a prolonged period, there may be merit in facilitating a fresh approach by another clinical team, though we acknowledge that this may be difficult to achieve.

6.3.8 We RECOMMEND that where clinical teams feel that with a particular case they are becoming therapeutically exhausted, even after pursuing external advice, they should seek an alternative placement for the patient. It may be sufficient to transfer the patient to the care of another Consultant and clinical team within the unit, or to another secure unit within the region. To make this reciprocally advantageous to the services, it can involve an appropriate exchange of similarly challenging cases. If placement beyond the service is required, then there is little to be lost and much to be gained by an active consideration of all opportunities. A process of options appraisal should occur in deciding the most appropriate care.

6.4 Risk assessment

6.4.1 In all the clinical settings investigated by the Inquiry, there was a lack of formal risk assessment and management.

6.4.2 We RECOMMEND that the management of Scott Clinic should ensure that they have a comprehensive risk management strategy, with clear protocols, and relevant training in risk assessment and management.

6.4.3 We also RECOMMEND that if TRU are to continue to take patients who are a potential risk to others and to themselves, their service managers should ensure that the culture of risk assessment and management is developed, with appropriate protocols and training.

6.4.4 We RECOMMEND that a programme of risk management continues to be undertaken in the case of Lee Powell.

6.5 The Care Programme Approach

6.5.1 The Inquiry had the benefit of seeing the recommendations of the St Helens & Knowsley Hospitals Trust Internal Inquiry into possible shortcomings in operational procedures, and of meeting the chair of the Inquiry, Mrs J E Bowden. The remit of the Inquiry made particular reference to the Care Programme Approach and made thirteen recommendations, which are set out in Appendix A.

6.5.2 We endorse each of these recommendations.

6.5.3 We have been concerned particularly on three counts: firstly that the incident at the Scott Clinic on 14th July 1996 (described at paragraph 2.4.21 above) did not result in a major review of Lee Powell's mental state and of his management plans; secondly that by his own admission the appointed keyworker was inexperienced in the role, and that his supervisor was unaware of this; and thirdly that the process of risk assessment seems to have fallen below the standards set out in DOH Guidelines HSG(94)27.

6.5.4 We RECOMMEND that each of these factors (ie the review of serious incidents, the training of keyworkers and other key staff involved with CPA, and risk assessment) is given careful attention in the Trust's proposed audits of CPA. We are particularly aware of the vulnerability of outposted workers who operate away from the mainstream of social work, whose needs for appropriate training may be doubly acute.

6.5.5 We were also impressed by the repeated assertion from witnesses that there is no authoritative published guidance on the roles and responsibilities of keyworkers in the CPA. We have already drawn attention in paragraph 2.6.8 to the draft guide for keyworkers produced by the Care Programme Approach Association.

6.5.6 We therefore RECOMMEND that this draft guide, or a guide of similar quality, is published as a matter of urgency. It is now nearly eight years since circular HC(90)23 was published, which required Health Authorities to implement the Care Programme Approach. We believe that the slow development of a CPA culture may be directly attributable to a lack of appropriate guidance for keyworkers.

6.6 The Transitional Rehabilitation Unit

6.6.1 The Transitional Rehabilitation Unit does not fall comfortably within any of the categories contained within the Registered Homes Act 1984. We have been made aware of a number of residents with a psychiatric history, including a former patient from a Special Hospital. We were also told of other residents who are entitled to Section 117 after-care under the Mental Health act 1983.

6.6.2 On the basis of this knowledge, and taking account of current patient mix, we RECOMMEND a joint review by St Helens Metropolitan Borough Social Services Department and St Helens & Knowsley Health Authority of the registration of the Transitional Rehabilitation Unit under the Registered Homes Act 1984 to ensure that the current registration offers sufficient protection for its residents and staff.

6.6.3 We have also been made aware of other practices in TRU which in our view demand a greater degree of protection for its residents. We were told in evidence that some of the staff at TRU are trained in control and restraint techniques, and that Paul Masters was repeatedly restrained during his eight-month residence at TRU. We also learned that he had been prescribed anti-depressant medication.

6.6.4 **We RECOMMEND that the guiding principles contained within the Mental Health Act Code of Practice, particularly Chapter 15 ("Medical Treatment") and Chapter 18 ("Patients presenting particular management problems") should govern the care of TRU residents, and that TRU policies should reflect this. It is particularly important that careful records are maintained of the application of medical treatment, and in the use of restraint with individual patients.**

6.6.5 We also wish to bring to the attention of the Directors of TRU, and of the registration authority, the following matters:

(i) the failures in patient records held at unit level.
(ii) the drawbacks of storing main patient files at the administrative centre, making access unnecessarily difficult for unit staff.
(iii) the perceived absence of a clear statement of the duties and responsibilities for night staff.
(iv) the inadequate preparation of contracts, both with main purchasers and with individual residents.
(v) failures in matters of general correspondence.

6.6.6 **We RECOMMEND that TRU Directors give a higher priority to managerial issues.**

6.7 Complex placements – tailoring care

6.7.1 The problems of identifying suitable placements for clients with complex needs are well rehearsed in this report. We have been encouraged by the progress made in the North West Region and within South Cheshire Health Authority to address this problem. We endorse the concept of a consortium of purchasers, and hope that an authority within the region will take the lead in developing the concept. The sharing of knowledge about resources, and access to reliable information in this respect is seen to be invaluable. We hope that these processes may be further refined.

6.7.2 We have also been made aware of the problems of purchasers' validation of suggested placements, and the reliance of purchasers on providers' close knowledge of patient needs and requirements. We support the notion of buying-in expert advice for the purposes of validation, in the belief that any additional costs would be recouped by more reliable placements. Simple agreements across agencies for mutual support in validation is seen as likely to be productive.

6.7.3 The problem across regional boundaries is more problematic. It became clear to the Panel that knowledge of specialist health care resources, provided nationally, is difficult to obtain.

6.7.4 **We therefore RECOMMEND that consideration is given to establishing and maintaining an up-to-date directory of specialist health care resources on a national basis.**

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May 1999