FINDINGS OF THE INDEPENDENT REVIEW

ON THE MANAGEMENT OF THE CASE OF

ERIEYUNE INWEH

DURING THE PERIOD JULY 1991 TO 30 OCTOBER 1992

December 1992

CONTENTS

1. BACKGROUND

On 30 October 1992 at approximately 9.20 am a member of the care staff, Catherine Sullivan (Katy) at the M.I.N.D. mental aftercare hostel at 3, Palmer Crescent, Kingston upon Thames, was killed on duty. A resident, Erieyune Inweh (Erhi) has been charged with her murder. Erhi was also a psychiatric patient known to both the Health Services and to the Social Services in Kingston since July 1991. The three agencies decided to commission an independent case review to look into the management of Erhi's care and treatment during this period, to be carried out by Dr Gordon Langley, a psychiatrist, and Rick Willis, a former director of social services and a psychiatric social worker.

2. TERMS OF REFERENCE

To undertake an independent review of the management of the case of Erhi Inweh, from the time of her first admission to hospital, July 1991, to her arrest on a charge of the murder of Catherine Sullivan, on 30 October 1992.

The review to include an analysis of case records and interviews with key staff involved in working with Miss Inweh, and to consider and report on the following:

(i) The initial assessment and subsequent reviews undertaken;
(ii) The decisions reached in the case.
(iii) The care plans/treatment offered.
(iv) The appropriateness of the placement at Palmer Crescent.
(v) The nature and level of support given by all agencies concerned.

3. METHODOLOGY OF REVIEW

Interviews were carried out with a range of staff from the three agencies as listed in the Annex to the report. They include the relevant social worker; her supervisor; the community psychiatric nurse; nursing staff; the consultant responsible for Erhi's treatment; residential staff from Palmer's Crescent, and the officer in charge of the Springboard Industrial Unit. Social work files; nursing and medical notes; and the hostel records as well as other relevant reports and forms have been reviewed. Full cooperation and access to all relevant documents has been available to the review team. The clinical file was examined with the full consent of Erhi and this was obtained through Ms D Bevan, a probation officer at Holloway Prison. Unfortunately entries in some files have not always been signed. (SEE RECOMMENDATION No 13)

4. THE LANDSCAPE

To understand fully the events covered by this case review it is necessary to have some knowledge of a number of related issues. (See Appendices).

A. Mental health services - national policy
B. Mental health services in Kingston;
C. Homicide and violence in the mental illness services;
D. Detention in hospital, control and civil liberty issues.

5. LAND MARKS IN THE CARE AND TREATMENT OF ERHI INWEH

4 July 1991 - Admission to Kenley Ward, Kingston Hospital as an informal patient. She had been found lying in the street in a catatonic state.

5 July 1991 - Section 5(2) of the 1983 Mental Health Act applied to hold Erhi in hospital because she was refusing food and threatening to run away.

8 July 1991 - Detained under Section 2 under the 1983 Mental Health Act for her health and safety as a result of her disturbed behaviour, continued refusal of food and drink and a risk that she might try and leave the hospital.

15 July 1991 - Erhi was transferred to A2 Ward of Longrove Hospital because of her paranoid delusions that someone was trying to kill her, and because of a physical attack on another patient.

31 July 1991 - Detained under Section 3 of the 1983 Mental Health Act at Longrove Hospital for her health and safety and the protection of others in order to allow her time to make a full recovery.

14 August 1991 - Erhi was transferred back to Kenley Ward as it was felt that her behaviour had stabilised and her delusions had subsided.

26 September 1991 - Section 3 of the Mental Health Act 1983 lifted.

9 October 1991 - Erhi was discharged from hospital to 3, Palmer Crescent, a short-term aftercare hostel managed by M.I.N.D.

13 August 1992 - Because of her behaviour Erhi was detained by the police in Hyde Park under Section 136 of the Mental Health Act 1983, which led to admission to Westminster Hospital where she was detained under Section 2 of the Mental Health Act 1983 for her health, safety and the protection of others, and then transferred to the Gordon and St Mary's Abbott hospitals. Arrangements were made for her early return to Kenley Ward at Kingston Hospital.

10 September 1992- Section 2 of the Mental Health Act 1983 lapsed.

15 September 1992 - Erhi discharged from hospital.

18 September 1992 - Erhi returned to Palmer Crescent following a good response to treatment.

30 October 1992 - Fatal attack on Catherine Sullivan.

6. EVENTS PRIOR TO JULY 1991

Erhi was born in Britain of Nigerian parents on 17 July 1970. Her parents separated when she was four and she was sent to live in Nigeria at the age of five. She attended junior school there up to the age of eleven and then boarding school until sixteen when she achieved good results in her GCE/O level examinations. Erhi returned to England, took A levels and entered further education. In her own words moving back to England was difficult because of cultural differences, although she had not been happy at boarding school and was always reluctant to return after holidays with her

grandmother. There were friends and extended family in Nigeria that she was sad to leave at the time.

Erhi attended Kingston Polytechnic from September 1989 to November 1990, when, due to her inability to concentrate and her lateness and absences from college, she dropped out of her degree course. In July 1991 she commenced a secretarial course with the Employment Training Scheme at the King Charles Centre. However her increased ill health resulted in this place being withdrawn although the trainers were willing to accept her back if her mental health improved.

Whilst attending the Polytechnic Erhi lived in a hostel in central London, as she was unable to find accommodation in Kingston. However, in November 1990 she did find a room above a 24 hour taxi service, which was small and poorly furnished, with a constant flow of people below which caused her irritation.

7. FIRST ADMISSION TO KENLEY WARD

At the time of her admission in July 1991 Erhi was described as catatonic after being found lying in the road. There was evidence of personal neglect and at admission she was doubly incontinent. Erhi responded well to physical care although her delusions lead to a diagnosis of schizophrenia, and a change of behaviour to a decision to detain her under Section 5(2) and then Section 2 of the Mental Health Act 1983, under the care of Dr Obaiaya, who has been a locum in post since January 1991.

Since her return to England Erhi has maintained contact with her father, less with her mother, and with her two brothers. However, for two/three years she had been distancing herself from her family in an apparent attempt to foster her independence. Nevertheless, the family continued to take an interest throughout her period of hospitalisation.

Opinion

Based on her condition prior to admission to hospital in July 1991, and her clinical presentation on Kenley Ward, we are of the opinion that the diagnosis of schizophrenia, the treatment offered during the first few days, including the decisions to invoke Sections 5(2) and 2 were correct.

8. THE INCIDENT OF THE 14 JULY 1991

After examining the medical and nursing notes, and interviewing nursing staff, it is clear that a serious incident occurred on 14 July in Kenley Ward and that Erhi became increasingly agitated and disturbed first asking for a knife to attack a particular patient. Erhi claimed that either she had to kill "Sally", or Sally would kill her and that Sally was the anti-Christ calling the Devil "to come and lay on top of Erhi for sexual purposes". It was reported to us that later Erhi took a weapon variously described as a knife or scissors, but was restrained by staff. Ehri then tried to attack Sally. It required prompt action by four nurses to restrain her. The incident was controlled by removal to a side room, medication, and a transfer to a locked ward in the intensive care unit, A2 at Longrove Hospital..

Opinion

We are concerned that although a serious incident occurred on the ward, several observers have reported and recorded different versions of what actually happened, and this includes both written reports and evidence given verbally during the review.

Recommendation

That when a serious incident occurs individual professional reports should be collated and agreed as a definitive account of events and made available to all professionals concerned.

9. PERIOD IN LONGROVE HOSPITAL

Once in Longrove Hospital Erhi's behaviour quickly became compliant but clinical interviews showed that her delusions persisted in severe form for 2/3 days and there is a note that they were "beginning to die down" by the 8 August 1991. She was finally returned to Kenley Ward on the 14 August 1991.

On the 31 July 1991 Erhi was detained under Section 3 of the Mental Health Act 1983 for her health and safety and the protection of others. As a consequence of her period in Longrove hospital the case was allocated to a social worker, Sandra MacPhail, who now came into contact with Erhi for the first time.

Opinion

We are of the view that it was difficult for a new social worker to gauge the severity of one incident of which she had no first hand knowledge, without a full briefing and an agreed account of the events. This does not appear to have happened.

Recommendation

Any record of violence or potential violence including medical and nursing or social work notes as mentioned in the recommendation above should follow a patient on transfer and be made available to all staff newly concerned with that patient's care.

10. PROGRESS AND ULTIMATE DISCHARGE FROM KENLEY WARD - SEPTEMBER 1991

Erhi appeared to respond well to treatment and her delusions faded. She was more cheerful and keen to resume life in the community. At the pre-discharge care plan meeting held on 9 September 1991, but not attended by Sandra MacPhail, the social worker, who was on holiday, it was agreed that it would not be in Erhi's interests to return to her accommodation prior to hospital admission. As a consequence her discharge was delayed to monitor her improved mental health for a longer period and for referral to the Accommodation Panel for a decision regarding a hostel placement. Erhi was willing to attend the day hospital and continue medication plus psychiatric and social worker contact after her discharge from hospital as part of the discharge process. A series of documents and reports were completed: application to Palmer Crescent; the Section 117 form and two social history reports; these are now considered individually.

Application Form for Palmer Crescent

The information required to complete the form is basic. Nevertheless, it includes the question "has he/she been involved in "life threatening behaviour". In the case of Erhi this question was answered in the negative as the social worker's understanding was that it referred to self-directed life threatening behaviour.

Opinion

The information requested by the form is minimal and the question about "life threatening behaviour" is ambiguous. However, the social worker's interpretation could be regarded as a little naive.

Recommendation

That the contents of the application form for Palmer Crescent be reviewed by M.I.N.D. and the question relating to "life threatening behaviour" be re-drafted to clarify its meaning, and, if answered in the affirmative, to include an accurate account of the behaviour.

Section 117 Form

This form was completed by Doctor Obaiaya on the 26 September 1991 as part of the procedures under Section 117 of the Mental Health Act 1983. Within the brief information given on the form there is no mention of violence although the prognosis given is reported as guarded. The distribution of the form failed to include Social Services. There is no agreed policy as yet for Section 117 between the Health Authority and Social Services. (See Section 19 of the report.)

Opinion

We believe the form should have included reference to the events of the 14 July. The existing form is too simplistic and ought to require reference to any incidents of harm or potential violence, and a date for the first joint review.

Social History

14 August and 11 September (Addendum).

The first report stated that Erhi while in Kenley Ward had asked for a knife to kill a fellow patient, but the second made no mention of violence. Otherwise, they give a full and informative picture of Erhi: background, illness and progress.

Opinion

The social histories give useful background information about Erhi before her admission and her progress. They were prepared by the social worker in the knowledge that she would not be present at the pre-discharge meeting or Accommodation Panel. The first report mentions that Erhi asked for a knife to attack another patient. However they do not give a full picture of the event of the 14 July 1991. We do not believe there was any attempt to conceal information, but that this became diluted through poor inter-disciplinary communication and the absence of the social worker.

It is our view that neither at the pre-discharge planning meeting nor the Accommodation Panel held later in the month was there a full and informed discussion of the events leading to Erhi's transfer from Kenley Ward to A2 at Longrove Hospital on 14 July 1991. However, bearing in mind that it was Erhi's first admission to a psychiatric hospital, her first acute psychotic episode, and that she responded well to treatment, even with the knowledge of the attempted violence towards Sally, there is a high probability that it would not have changed the decision that she should be discharged to Palmer Crescent. Since Palmer Crescent normally excludes people with a known potential for violence, there should have been a discussion and debate at the Accommodation Panel about the suitability of the placement and any likely risks. The surveillance and monitoring of her condition and the importance of ensuring that medication was taken may have received a higher profile if this had been the case.

Recommendation

That any incidents of violence or potential violence should be fully discussed at pre-discharge meetings and at the Accommodation Panel if hostel or residential care within the community is being considered.

11. MULTI-DISCIPLINARY WORKING IN THE PERIOD JULY-OCTOBER 1991

The reports described above were written in order to communicate a multi-disciplinary care plan formulated while Erhi was resident in Kenley Ward. The broader plan and the integration of its components is now considered.

Opinion

In our view the medical treatment and cover offered in the care plan were appropriate. Nursing care was properly given, and on discharge, was taken up by staff at the Day Hospital. Erhi's social and financial circumstances were properly assessed and incorporated into aftercare arrangements. The only weakness we detect is the dilution of information concerning the significant episode of violence that occured on 14 July.

Recommendation

We again emphasise the importance of having accurate and agreed accounts of violence or potential violence available to staff of all disciplines.

While we accept there is a reluctance to apply pejorative labels to patients we recommend that where serious violence has occurred, full reports should be made available to all those who need to know.

12. PALMER CRESCENT - THE PERIOD OCTOBER 1991 - AUGUST 1992

Philosophy of Care

The overall aim of the hostel is to provide quality short-stay accommodation, with individual support, care and rehabilitation to persons experiencing or recovering from mental health problems. The principles and objectives underpinning the overall aim are set out in the Appendix E.

Opinion

We are impressed by the operational policy statement for Palmer Crescent which sets out clearly the aims, principles and objectives of the unit as well as the job descriptions for staff, health and safety responsibilities, the rights of residents, and the procedures for admission. We noted however that there is no policy for the management of violence, although the day book contains information about a number of incidents involving residents other than Erhi, where harm, or potential violence was a factor.

Recommendation

That Kingston M.I.N.D. draws up a policy in respect of violence at work and offers training to its staff in prevention, early recognition and management of violence.

Erhi's Progress at Palmer Crescent

During the early period upto Christmas 1991, Erhi appeared to settle well into Palmer Crescent and was popular with residents and staff. However there was a feeling that nobody came close to her; she often spent time on her own. Every morning she would leave the hostel soon after 6.00 am to attend church at St Joseph's, Roehampton, and this continued throughout her time at the hostel although she again avoided involvement. She attended the day hospital two days a week and began to engage in voluntary activity. At this time her medication was managed for her but she was never keen on taking her tablets. Indeed, over the Christmas period 1991, she stopped her medication which caused concern, even though her condition did not deteriorate; this non compliance was not reported to medical staff.

After Christmas 1991 the general view was that Erhi continued to make good progress; she began to attend the Springboard Industrial Unit one day a week and to undertake voluntary work in the borough.

Social work contact was maintained during this time, but perhaps on a less regular basis than in the period prior to Christmas; the frequency being approximately monthly. The pattern of Palmer Crescent, attendance at Springboard and voluntary work seemed settled and no problems were presented.

During this period Erhi became quite friendly with Catherine Sullivan (Katy) who was then working as a volunteer at Palmer Crescent. They were approximately the same age, intelligence and appeared to get on well. The two women went for walks and Erhi became known to the wider Sullivan family through short visits to her brother's flat or parent's home.

Sometime during early Summer, Katy was offered a vacant post of care assistant at Palmer Crescent. With a psychology degree and considerable experience as a volunteer she was regarded as well equipped to take on this role. However it is known that Erhi was very unhappy when Katy told her of the change from volunteer to member of staff, and reacted strongly, but not in any way that was clearly psychotic. Erhi's attitude became known in the hostel and was mentioned at the regular Monday weekly meetings of staff, but we could find no evidence that it had been picked up and talked through with Erhi by any one other than Katy. Erhi's change of attitude occurred at a time when she had been unsuccessful in finding work or a place on a training course and perhaps some jealousy and resentment may have developed.

Examination of the running record at Palmer Crescent suggests that during July 1992 there were some change in Erhi's behaviour. She became less available and the write-ups in the record are briefer. There was reduced interaction with staff and other residents, and she went out a lot. By then she had taken control of her own medication and it was discovered subsequently that she stopped taking this about the same time. There is no evidence in the file to suggest that these changes and build-up were identified at Palmer Crescent or that any discussion took place with the social worker or medical staff.

13. THE INCIDENT OF 13 AUGUST 1992 AND CARE IN LONDON HOSPITALS

On the morning of the 13th Erhi rushed out of Palmer Crescent screaming, and was witnessed by another resident. Later in the day she was detained by the police under Section 136 of the Mental Health Act 1983 in Hyde Park. She was lying on the grass "swimming", shouting abuse, and spitting at people. Because of her aggressive behaviour it was necessary for her to be restrained and handcuffed and she was removed to Westminster Hospital where she was detained under Section 2 of the 1983 Mental Health Act. At this time she threatened to kill the doctor dealing with her assessment and was very deluded requiring restraint. As in July 1991 she expressed delusions about the anti-Christ and a fear of being attacked herself. She was subsequently transferred to the Gordon Hospital and then to St Mary Abbott's before being transferred back to Kenley Ward at Kingston Hospital.

14. SECOND ADMISSION TO KENLEY WARD

During her period in central London, doctors in charge of Erhi's case were in direct contact with the officer in charge at Palmer Crescent and in a two way exchange of information Mr Morgan was informed of Erhi's threats to kill.

As previously, in Kenley Ward under the care of Dr Obaiaya, Erhi responded well to medication and appeared to calm down and settle, while her delusions gradually faded. Contact was maintained with Palmer Crescent and Katy is known to have visited her in hospital, and Erhi to have visited Palmer Crescent.

By then it had come to notice that Erhi had stopped taking her medication some 2/3 weeks before the Hyde Park episode. Erhi was reluctant to take the Stelazine and in consequence was started on, with her consent, a depot anti-psychotic preparation Depixol 50 mgm. monthly; oral Stelazine was maintained at this stage. Progress was such that she was regraded from Section 2 to Informal Status on the 10 September but remained on the ward until her visit to Euro Disneyland on the 15 September. On the 14 September she recalled that before this admission she had experienced a strong sense of someone wanting to kill her.

She was discharged on the 15 September and immediately went to Euro Disneyland for four days with staff and clients from the Springboard Industrial Unit sharing a bedroom with the future daughter-in-law of the officer in charge.

15. SECOND DISCHARGE FROM KENLEY WARD

a) Communication on Discharge

A full discharge summary was sent to Doctor Myers, Erhi's GP, from Doctor Obaiaya on 16 September 1992 the day after her discharge. This specifically states that during her admission during 1991 to Kenley Ward at Kingston Hospital Erhi became

aggressive and attacked a patient with a knife, spending some time in a secure ward at Longrove Hospital (A2). This letter also gave full details of the August 1992 incident when Erhi was detained under Section 136 in Hyde Park and later Section 2 of the 1983 Mental Health Act.

With regard to treatment and progress, the letter indicated that Stelazine and Procyclidine were recommenced, and that Erhi had felt well and denied any paranoid feelings. It confirmed that she had stopped her medication prior to August 1992 because she thought it wasn't doing her any good. It is reported however, during the course of her hospitalisation she became suspicious of staff and reluctant to take her medication. She agreed to start depot injections and as her mental state had improved, she was taken off Section 2 of the Mental Health Act 1983. At the time of discharge Erhi was able to talk about the episode in August 1992 which had made her feel that somebody was going to kill her with some degree of insight. A copy of the discharge letter was sent to Giselle Wilton, the community psychiatric nurse, who would be responsible for giving the depot injections. No copy of the discharge letter, or of its contents, was provided to the social worker, and communication appears to have been informal and by word of mouth.

Opinion

We find it surprising that at this time, ~~there~~ a full case review did not take place involving: medical & nursing staff; the social worker, the c.p.n. who was about to take responsibility for giving Depixol injections after discharge, and the officer in charge of Palmer Crescent Nevertheless, we understand that as far as Palmer Crescent staff were concerned Erhi was not seen as a new patient but as an old friend returning home.

By this time there had been two incidents of violence or potential violence, where the patient had expressed dangerous delusions about people wanting to kill her, and a desire to kill others. As we have already identified, social work staff and residential staff at Palmer Crescent had incomplete knowledge of the violence involved in the first incident of July 1991, and therefore perhaps did not approach the second incident in August 1992 with the urgency that they might have done had information about the earlier incident been available to them.

Opinion

We believe that on the second discharge from Kenley Ward there should have been a detailed examination of Erhi's behaviour and aftercare plan, with a conscious decision being made (1) as to whether she should return to Palmer Crescent and (2) whether or not the monitoring and support systems were sufficient to ensure that she took her medication. Because of her swift recovery and previous trouble free time at Palmer Crescent it is probable that a decision would still have been made for her to return to the hostel, but if the full history of both incidents had been considered there would have been more debate concerning any risks associated with this action.

Recommendation

In all cases where violence, or potential violence has been a factor, a full consideration before discharge should take place on any history of previous incidents, and this should be available to all the professionals and agencies involved.

b) Professional Practice Issues

A c.p.n., Giselle Wilton was allocated to the case in September 1992, when depot medication was prescribed. Contact between her and Erhi was limited; there had been no contact prior to discharge. No communication took place between the social worker and the c.p.n. up to the 30 October 1992.

Opinion

We would have expected regular contact between the c.p.n. and Erhi to have started prior to discharge, although we believe the fact that this did not occur was influenced by the restricted role for c.p.n.'s described by Mrs Wilton (to administer the Depixol injections) and the attitude of Erhi. An opportunity should have been given for the relationship between Erhi and the c.p.n. to develop before discharge.

The c.p.n. made contact with Erhi after discharge from Kenley Ward, but Erhi was reticent and it was difficult to come new to the case to form a relationship with her. One dose of Depixol was given; the next was due on the day the c.p.n. was to represent Erhi at an Accommodation Panel on 28 October. Following discussion with the officer in charge of Palmer Crescent a new date early in November was negotiated with Erhi but the events of 30 October 1992 intervened.

Opinion

We are surprised that the c.p.n. and the social worker in this case did not feel it necessary to talk to each other between discharge and the 30 October. We understand some c.p.n.'s feel isolated working in the community and would welcome the opportunity to join community mental health teams.

Opinion

We do not consider a delay of 2/3 days in the giving of a monthly depot injection would have significantly contributed to any change in Erhi's condition. But the Stelazine was being concurrently reduced and transitional stages in changing from one medication to another can lead to diminished control of psychosis.

Recommendation

The work of c.p.n.'s should be more integrated within the day to day work of multi-disciplinary community mental health teams.

Out-Patient Medical Surveillance after Discharge

Erhi was seen by Doctor Obaiaya in out-patients on 30 September and 22 October. On the second occasion Stelazine was reduced to 5 mg daily from twice daily. The reduction in the dosage of Stelazine was not communicated to the c.p.n.

Recommendations

(i) That changes in medication should be reported to c.p.n.'s and social workers covering a case.

(ii) We recommend that in all cases covered by aftercare arrangements a regular, perhaps three monthly community care summary should be prepared by the lead officer responsible for aftercare in the community and communicated to social worker; c.p.n.; the consultant; general practitioner and to the officer in charge of any residential and day unit.

16. PERIOD SEPTEMBER - OCTOBER 1992 - PALMER CRESCENT

During this time Erhi appeared to make good progress. She enjoyed the visit to Euro-Disney and after that resumed her previous pattern of attending church early in the morning; engaging in voluntary work; it was intended to increase her attendance at Springboard from one day per week to two or three. She continued to take responsibility for her own reduced oral medication. A Depixol injection was given at the end of September and a further one was due at the end of October. Due to attendance at the Accommodation Panel by the c.p.n. this was cancelled and re-arranged. During this time Erhi pressed to leave Palmer Crescent and to move into independent accommodation. The social worker negotiated on her behalf and two days before the incident on 30 October 1992 she was accepted by the Accommodation Panel for a move, and was aware of this decision. The application by the social worker to the Accommodation Panel gives a brief history of Erhi's psychiatric background, but makes no mention of the two short but severe psychotic incidents where violence or potential violence was a factor. The recommendation that Erhi be considered for independent accommodation did however reflect the view of all the professionals involved and the staff at Palmer Crescent.

17. THE INCIDENT OF 30 OCTOBER 1992

Nobody that we have interviewed during the course of this Case Review has been able to indicate that there were any signs in the preceding days to forewarn of what would occur on the morning of 30 October 1992. The running record for Erhi signed by Katy for the previous evening, 29th, suggests no problems, and there are no incidents recorded in the Day Book for the hostel. We know that at 9.10 am Katy spoke on the phone and that all appeared to be normal, but by 9.20 Erhi had made a fatal attack upon her using a carving knife from the kitchen of the hostel.

Such information as we have received about events on that day lead us to believe that the assault was part of an acute psychotic episode and was conducted under the influence of paranoid delusions.

Erhi was charged with murder and removed to Holloway Prison. A decision will be made in due course as to whether there is a full trial or whether she is deemed unfit to plead.

18. MANAGEMENT ARRANGEMENTS AT PALMER CRESCENT

Having previously outlined the philosopy of care and policies underpinning Palmer Crescent, and reviewed the events in the case, we now make some observations on the management arrangements at the hostel.

Staffing at Palmer Crescent

None of the staff at Palmer Crescent hold a full professional social work qualification, but we were impressed by the commitment, knowledge and experience of those staff we interviewed. In particular we would wish to pay tribute to Phil Morgan, the Officer in Charge, who on 30 October 1992 acted with some bravery and risk to himself in dragging Erhi off Katy and containing her until the police arrived. Mr Morgan has a considerable number of years experience in the residential field not all of it in mental health, but he clearly gives more than his 37½ hours per week in terms of personal commitment to both staff and residents. It is apparent that everybody relies very heavily upon him and when emergencies occur he is often called from his adjoining residence even when he is off duty. As the Officer in Charge, he has to deal with staff supervision, administrative matters and attend meetings, as well as undertake normal shifts and sleep-in duties. In addition, there is a deputy who works 30 hours per week and three part-time project workers.

Opinion

We do wonder whether there is not a case for increasing the hours of the deputy, or creating some additional care hours to relieve the pressure on Phil Morgan.

Palmer Crescent is not a unit where staff expect to have to deal with violent clients, but as recent events and other incidents in the day book show, there is always the possibility of situations developing either through the actions of residents or visitors.

Procedures

(i) It is accepted practice at Palmer Crescent for a range of domestic kitchen implements, including "sharps", to be kept available in the kitchen for use by residents. This is seen as part of a normalisation programme that encourages personal responsibility.

(ii) An up to date written running record is maintained by the hostel staff on all residents, including Erhi. Progress case reviews and the discussions at regular weekly staff meetings were all carefully recorded.

Opinion

(i) One member of staff on duty on their own will always be at potential risk in such circumstances.

(ii) The hours served and the responsibilities undertaken by the officer in charge are heavy.

Recommendation

(i) That M.I.N.D. reviews staffing and security at the hostel and takes advice regarding the options available eg. alarm systems to give greater protection to staff working on their own.

(ii) That the use and availability of potentially dangerous kitchen and other implements in the hostel is reviewed.

(iii) That the hours and duties of the officer in charge be reviewed.

Opinion

Whilst psychiatric and social work support was available on individual cases to the hostel, as well as management supervision from the Project Coordinator, regular psychiatric support to the unit as a whole might be beneficial in developing the full potential of the hostel and its staff.

Recommendation

That M.I.N.D. consider the possibility of arranging for regular psychiatric support to Palmer Crescent which we feel would be beneficial.

19. AFTER CARE AND SECTION 117 OF THE MENTAL HEALTH ACT 1983

Section 117, Mental Health Act 1983 provides that when a patient has been detained under certain Sections, in this case Section 3, it shall be the duty of the District Health Authority, and the local Social Services Authority, to provide, in cooperation with relevant voluntary agencies, after care services until such times as the District Health Authority and the local Social Services Authority are satisfied that the person concerned is no longer in need of such services. In this section "the local social services authority" means the local social services authority for the area in which the person is resident or to which he is sent on discharge by the hospital in which he was detained.

The provisions of the Act are supplemented in the Code of Practice published by the Department of Health and the Welsh Office (Chapter 26 - 1990) and professional advice is also offered by the Royal College of Psychiatrists (1991).

In this case Section 3 was invoked on 31 July 1991 and lifted on 26 September 1991; S117 applied from the latter date onwards. No formal decision was taken to end after care and the provisions of the section still apply.

Local policy and practices for the application of S117 are under discussion in Kingston and Esher, but are not yet agreed or implemented by the relevant authorities. Nevertheless, "Section 117 Forms" are filled in on a patient's discharge from a relevant section, but the distribution can be flawed.

In this case the Form was completed by the Consultant Psychiatrist. The Form itself is brief, and in it the Consultant conveys information about the diagnosis, treatment, and the fact that there were no longer any obvious psychotic symptoms, the name of the key worker (Mrs McPhail) and a comment that the prognosis is "guarded". There is no indication of the violence that had contributed to detention under Section 3. Follow up at the Day Hospital is noted.

In this case, after the patient's discharge from both hospital and Section 3, she remained under the care of the joint authorities. There is ample evidence that after care was delivered, but there is no formal record of any joint reviews in respect of action under Section 117 and no joint decision to terminate after care (and indeed no indication for such termination).

Opinion

Although in practice much after care was given, and the principles outlined in the above publications broadly adhered to, after care was not formally co-ordinated and regularly reviewed under S117 procedures.

Recommendations

1. Policy and practices under Section 117 should be agreed and implemented without delay.

2. The content and layout of "Form 117" should be revised and provision made for additionally recording (i) specific comments about violence or other problems such as non-compliance with medication, (ii) date(s) on which formal reviews will be undertaken, (iii) termination of care under S117, together with the reasons for such decision.

3. The distribution of the "form ~~Section~~ 117" should be agreed and clearly marked on it. Responsibility for distribution should be clearly delegated.

4. A service register of all patients subject to after care should be instituted with particular attention the matters raised in paragraphs 29-46 of the Royal College of Psychiatrists publication (1991). "Good medical practice in the aftercare of potentially violent or vulnerable patients discharged from in-patient psychiatric treatment."

20. THE CONTROL OF MEDICATION

Medication is not the only facet of treatment, but is an important and often crucial aspect of maintaining well being.

During in-patient care medication was given both formally and informally and although oral Stelazine was disliked it was, as far as can be ascertained, taken.

When a patient is no longer liable to be detained under the Mental Health Act, as when for example they are informally resident at Palmer Crescent Hostel, there are no powers to enforce medication. It is the policy of staff at Palmer Crescent to encourage personal responsibility in their clients, including the management of medication, which includes obtaining and presenting prescriptions, and regular self administration of the prescribed dose.

In this case, during the early days at Palmer Crescent, staff administered medication, as much to counteract forgetfulness as anything else. Some dislike of medication was again noted at this stage, an attitude confirmed by an episode over Christmas 1991 when, at the time of sudden departure for home, medication was left behind. The period of leave, 8-9 days, was longer than was anticipated but no attempt was made by staff to ensure compliance during the absence. No clinical deterioration was noted on return, and as medication was then restarted without difficulty, the episode was not reported to the prescribing doctor. There followed other episodes when delay in presenting prescriptions to the pharmacist made compliance suspect. During one (February 1992) it is recorded that medication was continued and during another (March 1992) there was a break of 2 days.

On 29 May 1992 it was agreed between the client and the officer in charge of Palmer Crescent, on the client's initiative, that self medication be commenced. By then the client had settled in and was liked and respected as a reliable worker. In accepting the client's request the officer in charge felt that his position with regard to medication was neutral and that compliance was a matter between patient and doctor. He saw the move to self medication as an appropriate move towards personal responsibility. He neither discussed the move with, nor reported it to, the prescribing doctor.

After a relapse in August 1992 it was discovered that, in late July and early August, the client had not been taking her medication. As she was controlling administration herself, her non-compliance was not detected. But even if medication had been supervised throughout, imperfect compliance might still have gone undetected.

Because of non-compliance, and following the August 1992 relapse, treatment with Stelazine was supplemented, with consent, with a monthly injection of a depot anti-psychotic drug, Depixol 50 mgms monthly, on 24 August 1992. This was given again after discharge on 30 September and would have been due for the third time on 28 October. On the latter date the client's community psychiatric nurse (c.p.n.), who would have given the injection, was representing her client at the Accommodation Panel, and could not administer the medication at the appointed time. The c.p.n. tried to negotiate a time later in the same day, but this was not acceptable to the client and a meeting was agreed for 2 November, by which time events had intervened.

After discharge from Kenley Ward on 15 September 1992 the client was seen twice as an out-patient by her Consultant Psychiatrist, who noted her to be well and free from psychotic symptoms. On the second occasion he reduced the dose of oral Stelazine from 5 mgms twice daily to 5 mgms daily, in keeping with his policy to slowly change the emphasis from oral to depot medication. A change in strategy over medication always carries a small risk of loss of control over symptoms. A delay of 4 days in giving a monthly depot injection is probably not, in itself, very significant, but in this case was combined with a reduction in the prescribed dose of Stelazine. Once back in Palmer Crescent Ehri returned to being responsible for her own oral medication. Although there is no evidence that she was not taking this, a degree of uncertainty over her compliance at this time must exist.

Opinion

At all times the medication prescribed between July 1991 and the index offence was appropriate to the circumstances.

Effective control of medication was exercised in hospital.

While understanding the wish of hostel staff to empower patients we are concerned that (i) some clear noncompliance with medication was not reported to the prescribing doctor and that (ii) the decision to promote self medication was taken without consultation with, or notification to, the prescribing doctor.

The transitional nature of medication at the time of the offence may have been of some significance.

Recommendations

1. That a policy for reporting non-compliance with medication be agreed between on the one hand, professional and voluntary staff working in the community, and, on the other, the prescribing doctors.

2. That changes from supervised to non-supervised self medication be, wherever possible, negotiated with the prescribing doctor, and if this is not possible, be notified to him/her as soon as possible.

3. Transitional phases between oral and depot medication should be monitored with particular care, and all the staff concerned made aware when the changes are taking place.

21. RACIAL AWARENESS

It is well known that differences in race and culture can distort psychiatric practice and judgements. In this case both the patient and her Consultant Psychiatrist were of the same ethnic origin and well understood each other. In addition, offers were made by both the social worker and Palmer Crescent staff to help Erhi make contact with services specialising in ethnic minority matters, but she declined these suggestions. When well, Miss Inweh, formed good, if rather superficial, relationships with staff and was well liked at both Kenley Ward and in the community, including the staff at Palmer Crescent. She disliked sharing her inner feelings with anyone, but did so more readily with those with the least authority over her. This attitude, as far as we can see, related to her illness and personality. We have seen no problems arising in this case from issues surrounding race or culture.

22. MEETING WITH THE SULLIVAN FAMILY

A meeting was held with the father and two brothers of Katy Sullivan. Their distress at the events which had occurred was understandable. They impressed upon us that they wanted more than anything else for the truth to be established, and for any lessons, if any, to be learnt to prevent similar tragedies in the future. They indicated to us that it was important for them to feel that the review had been carried out thoroughly and that they had the opportunity in due course to see the conclusion and discuss these with the managers of the agencies involved.

A second meeting took place with the family including Mrs Sullivan on this occasion to brief them on the main findings of the review.

23. CONTACT WITH THE INWEH FAMILY

We offered to see the father of Erhi if he so wished and we understand that he is distressed by the events; the offer has not been taken up.

24. CONTACT WITH GENERAL PRACTITIONER

Doctor Meyers, the general practitioner for Erhi, has been contacted to see whether he wished to contribute any information to the review, but none has been forthcoming.

25. SUMMARY & CONCLUSIONS

During the course of the Case Review we became aware of the distress and trauma being experienced by all the care staff who had contact with Erhi, and by the residents at Palmer Crescent, as well as two families affected by the tragedy. We wish to say that we are impressed by the dedication and commitment of the staff we met and the desire of the Sullivan family and the agencies involved to learn any lessons which might prevent similar incidents in the future. The arrangements made to offer support to relatives and staff after the 30 October are to be commended.

Katy was a well respected colleague and friend, a much loved daughter and sister. Having gained a psychology degree and experience with her involvement in community work there was a bright future for her in the field of social care. We also learnt that Erhi was a loved daughter and sister who, but for her mental health problems, had been poised to gain a degree and make a contribution to society. She was popular with staff and residents at Palmer Crescent and the day unit she attended.

The treatment offered to Erhi on her admission to Kenley Ward in July 1991 was appropriate, and proper procedures were followed in detaining her under Section 5(2) and Section 2 of the Mental Health Act 1983. Her transfer to Longrove Hospital on 14 July 1991 was right in the circumstances following an attack on another patient and it was appropriate for her to be detained at that time under Section 3 of the 1983 Mental Health Act.

Discharge arrangements in September 1991 fell down in some respects because of communication difficulties noted in the text between medical and social work staff. The social worker allocated to the case after the Section 3 became involved at Longrove Hospital and had incomplete knowledge of the violence associated with the transfer to that hospital on 14 July 1991, but she was aware that Erhi had requested a knife to attack another patient because this is mentioned in her social history prepared on 14 August 1991 which was considered by the Accommodation Panel with a brief addendum report in September. The social worker was unable to attend the pre-discharge meeting on 9 September 1991 so again an opportunity was missed for gaps in the knowledge about the incident of the 14 July 1991 to be filled. The social worker did not receive a copy of the Section 117 discharge form and we have been unable to discover a copy of the discharge letter which would have gone to the general practitioner at that time. The consequence was that the Accommodation Panel and staff at Palmer Crescent had incomplete knowledge of Erhi's illness during her time in hospital, and the violence associated with the 14 July 1991. These communication difficulties raise organisational and procedural issues which should be addressed.

Formal lines of communication are very necessary, particularly in passing information about hazards and the delegation of responsibility, but they must always be supplemented by good informal working relationships. Both formal and informal lines of communication can be weakened at times of change and although the working relationships that we have observed are good, both Health and Local Authority services in Kingston are in a considerable state of flux: the move to community care, the closure of Longrove Hospital, the reliance on Horton Hospital for disturbed clients, the as yet lack of integration of the c.p.n. services into multi-disciplinary community mental health teams, the many recent changes in the cover provided by consultant psychiatrists for Kenley Ward, and the undecided and unimplemented state of policy over S117 are all examples. While some of these factors have a direct bearing on this

case (eg. S117), others are more remote, but in aggregate, may have indirectly contributed.

The question has been asked as to whether Palmer Crescent was the right placement for Erhi. Given that July 1991 was the first episode of an acute psychosis in a young person it was right that from a medical point of view she should have been treated actively and given every chance of social reintegration into the community. Notwithstanding the violent episode of July 1991 she subsequently became a well liked resident at Palmer Crescent who contributed to the tasks of daily living. Her behaviour in Palmer Crescent prior to August 1992 gave no reason for the propriety of her placement to be questioned.

The period from October 1991 to August 1992 was in many respects uneventful. Erhi appeared to fit in well with the Palmer Crescent regime, although it was suggested that nobody ever penetrated her inner thoughts. It was known that she was reluctant about taking her medication and that during Christmas she ceased oral medication completely for a few days without any serious effects. The social worker continued to maintain contact initially dealing with practical issues relating to accommodation; the clearing of debts and social security matters, but there was a plan to move towards giving Erhi greater independence and work training in the hope that she would become fully independent in due course.

The relapse during August 1992 was preceded by a short period where Erhi appeared to be avoiding contact with people and was due to her ceasing to take her medication for which she had assumed personal responsibility earlier in the summer.

Detention under the 1983 Mental Health Act in London and return to Kenley Ward was appropriate in the circumstances as was the medical decision with Erhi's consent to commence depot injections given monthly to ensure that medication was taken.

Erhi appeared to make a rapid recovery to the extent that she was able to leave hospital on 15 September 1992 and immediately accompany other clients and staff from the Springboard Industrial Unit to Euro Disneyland for a short holiday.

A full discharge letter was sent by Doctor Obaiaya to the general practitioner on 16 September 1992 with a copy to the community psychiatric nurse, Mrs Wilton. Erhi returned to Palmer Crescent and the staff at the hostel had a full knowledge of the events which took place in August 1992 because of direct contact between the officer in charge, and the doctors treating Erhi in London.

After the second episode in August 1992 it would have been reasonable to conduct a full review before reintegrating Erhi into Palmer Crescent. If at the time of this review the full scale of the violence on the first occasion in July 1991 had been known, the staff might have taken a different view, but knowing that they had already established a positive relationship with her over a long period, and liked her as a person, and in view of her general compliance, it is probable that they would have still been happy for her to return. Even though they might have been more vigilant with full knowledge, Erhi's relapse into psychosis on 30 October 1992 was so precipitous that an incident might not have been prevented; it was both sudden and unexpected with no obvious signs beforehand.

We are surprised that with the introduction of a community psychiatric nurse to the case in September of this year that no contact took place between her and the social worker prior to the incident on 30 October 1992. This raises questions about the

strength of inter-disciplinary working and the need to ensure that community psychiatric nurses are fully integrated into the work of the wider community mental health team.

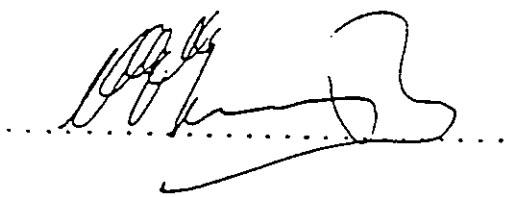
Although the second depot injection for Erhi was due on 28 October 1992, but was cancelled because the c.p.n. had to attend the Accommodation Panel, it is unlikely that this was a major factor in the subsequent incident on the 30th October. However it is known that changes in medication do sometimes take time to establish themselves and the combination of depot injection and reduced Stelazine taken orally had only been in operation for a month.

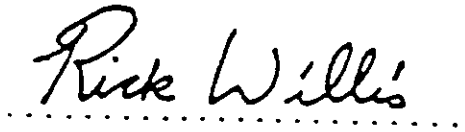
We are impressed by Palmer Crescent as a hostel and feel that it fulfils a useful role in the provision of mental health services in Kingston. We have made a number of recommendations which we hope M.I.N.D. will consider including the possibility of regular psychiatric support to the unit.

We believe that as required by good practice the principle of the least restrictive alternative was adhered to in the application of Part II of the 1983 Act in this case and that the restrictions imposed under the Act were lifted on clinical grounds in both 1991 and 1992 as soon as could be reasonably expected. There is no evidence that they were lifted too soon.

When assisting a patient to greater autonomy and fullness of life it is necessary to take some risks. Providing that they are calculated risks, consciously taken, we find such a policy acceptable. Notwithstanding our recommendations about the surveillance of medication, we consider that the decision taken by the officer in charge not to report problems was taken in good faith in the light of the situation as known to him at that time.

We believe the care and treatment offered to Erhi during the period July 1991 to October 1992 was appropriate and based on sound assessments. Although many things should have been done differently, there is no clear evidence that the professional decisions made in this case at the time were wrong, or that events of 30 October 1992 could have been predicted or avoided.





DR GORDON LANGLEY
(PSYCHIATRIST)
M.B., F.R.C.P.,
F.R.C. Psych., D.P.M.

RICK WILLIS BA (Hons)
D.S.A., Dip Swk. (Mental Health)
MEMBER OF THE ASSOCIATION
OF DIRECTORS OF SOCIAL SERVICES

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