CAMBRIDGESHIRE HEALTH AUTHORITY

MENTAL HEALTH INQUIRY

MRS MARIE ALAWODE

THE REPORT OF THE INQUIRY

APRIL 2000

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A. INTRODUCTION

On 5th August 1998 Mrs Kelly Wilks telephoned her mother, Mrs Marie Alawode. Kelly was visiting her in-laws in Rotherham and had last seen her mother and her young half-sister, Joanne, two days earlier at their home in St Neots. Kelly asked her mother how she was and Marie Alawode said she was not alright, she had killed Joanne, she had stabbed her with a knife. Kelly put down the telephone, then dialled 999. Within a very short time, Kelly learned that the police had been to her mother's home and had found a body and that a woman had been arrested.

The body was that of Joanne. It was her mother, Marie Alawode who was arrested upon suspicion of murder. Marie Alawode was taken to Huntingdon Police Station, where she was seen by a social worker acting as appropriate adult, Mr Edwards and a police surgeon, Dr Roberts. She was attended by her solicitor, Mr Potter. She was deemed fit to be detained and to be interviewed, but it was decided to defer an interview until the following day. Overnight, her mental state deteriorated so that, the next morning, she was much more distressed and suffering from auditory hallucinations and could not be interviewed. Later that day, she was admitted under Section 2 of the Mental Health Act 1983 to George McKenzie House, Fulbourn Hospital, Cambridge. Later that same month she was transferred to a medium secure unit at Marlborough House in Milton Keynes. On 30th September she had recovered sufficiently to undergo police interview. In October, she was transferred to the Regional Secure Unit at the Norvic Clinic, Norwich.

On 11th January 1999, at Northampton Crown Court, she pleaded guilty to a charge of manslaughter, on the grounds of diminished responsibility and the Court made an Order

under Sections 37 and 41 of the Mental Health Act 1983, by which authority she remains at the Norvic Clinic to this day.

Marie Alawode was, however already well known to Psychiatric Services, both in Huntingdon (where she lived until August 1997) and St Neots. She was a patient of Dr Richard Latcham, a Consultant Psychiatrist at Hinchingbrooke Hospital, Huntingdon and she was seen by her Community Psychiatric Nurse, Kim Masson. She was subject to the Care Programme Approach, in relation to community care and support.

In the Department of Health's Circular HSG(94)27 "Guidance on the discharge of mentally disordered people and their continuing care in the community", paragraph 35 makes clear "In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved". The responsibility for convening such an inquiry therefore fell upon Cambridge & Huntingdon Health Authority (as it then was and, since April 1999, Cambridgeshire Health Authority). Upon learning the outcome of Marie Alawode's criminal prosecution, the Health Authority took this matter forward in exemplary style through its then Assistant Director, Primary and Community Care, Mr Stephen Williams. By March 1999 a Panel of Inquiry was appointed and its Terms of Reference finalised, as confirmed in a press release. By early April, the Inquiry Chairman, John Taylor had met with Stephen Williams and, most importantly, with Diana Lloyd, appointed as Administrator to the Mental Health Inquiry. The first meeting of the Panel was held on 11th May 1999, when important aspects of the Panel's approach to this Inquiry were agreed.

Sadly, for personal reasons Mrs Helen Johnson was unable to continue as a member of the Panel but facilitated the appointment of Trevor Brown as her replacement. This could not be achieved before the Panel began to hear live evidence on 6th and 7th July 1999, but Trevor Brown was at no disadvantage once appraised of the evidence given.

The Panel continued to hear evidence over some 10 days, lastly on 22nd September 1999. Evidence was heard from some 40 witnesses, all of whom attended freely and gave their evidence in an open and helpful way.

Other witnesses were approached by letter and responded helpfully, but their attendance was not necessary.

WITNESSES AND EVIDENCE

The Chairman, John Taylor first attended an Inquiry into psychiatric homicide (in fact, attempted homicide) in September 1985 (coincidentally the case concerned a patient at Fulbourn Hospital). In May 1987 he represented the Consultant Psychiatrist involved in the Sharon Campbell Inquiry, a public inquiry into the killing of a social worker by a psychiatric outpatient. In March 1999, John Taylor was asked to Chair this Inquiry, by which time he had represented individual doctors (principally Consultant Psychiatrists, occasionally General Practitioners) at over a dozen homicide inquiries convened under HSG(94)27. It therefore followed that he had seen Inquiries conducted in many different ways. These ranged from public inquiries conducted on an adversarial basis (with all relevant parties represented) through to low key, private inquiries conducted on an inquisitorial basis. He had also

represented an interested party at the Ashworth Hospital Inquiry in 1998. It was the Chairman's considered view that the best way in which to conduct an Inquiry such as this was:-

(a) To hold it in private.

(b) To make clear that individual witnesses could be represented.

(c) To record evidence on tape and, as legal Chairman, to take notes of evidence.

(d) Not to request statements in advance of hearing a witness.

(e) For the Legal Chairman to take the lead in taking each witness through their evidence, with questions from the Panel then to follow.

(f) To encourage each witness to feel free to correspond with the Inquiry on any points not dealt with, that might occur later.

(g) To make clear to certain witnesses that there might be additional questions arising, after hearing them and evidence from other witnesses, in which case those would be put in writing to the individual who would be invited to respond in writing and/or to attend the Panel again.

This framework arose naturally out of the fact that the Inquiry Panel convened with no pre-conceived ideas about the case. It is absolutely no criticism, but the very substantial psychiatric and social services records were not compiled until shortly before the Inquiry began taking evidence.

The Chairman's opening words to each witness were intended to explain that, while this was a formal Inquiry with formal Terms of Reference, an inquisitorial approach was adopted. Each witness was told that the Panel approached the case, and their evidence in particular, with an open mind. The Panel came to the case without pre-conceptions and would not apply hindsight, but was conducting a fact-finding exercise at this stage. It followed that some of the questions might be clumsy or irrelevant, but by vigorous enquiry, the Panel would establish the facts and, in particular, the information that was available to carers at the relevant time. It was also made clear that it would be a later exercise to make analysis of what occurred, when further questions might be put to certain individuals.

It was made clear that Marie Alawode had given her full consent to all those involved, to discuss details with the appointed Panel and all were told how the evidence would be recorded. Finally, each witness was accordingly told that their duty was to give a clear factual account and to put themselves back into the position they were in at the time.

It was the Panel's impression that witnesses found it helpful to know that neither they nor the Panel would or should apply hindsight at the fact-finding stage. Hence we believe that those giving evidence were as frank and open as we have described. Against such a background, no antagonism should arise and it did not do so. It is hoped that all witnesses feel that they were given a full opportunity to give an account of their own involvement.

Both the Panel and many of the witnesses were aware that this same matter had already been subjected to intense scrutiny. In particular, reports were compiled by both the Trust, the Police and the Social Services Department, to facilitate the part 8 case review undertaken by

Cambridgeshire Area Child Protection Committee. The Panel sensed that individual witnesses knew if there had already been criticism of their individual involvement and were anxious to know if this Panel would make similar adverse findings.

The Panel was also fully aware that for some witnesses, particularly those who had personally met Joanne, the recounting of events leading up to her death and reflections upon them were painful. Many witnesses spoke graphically of their own shock and surprise on learning of what occurred. However expressed, these are the views of intelligent and experienced people who have undoubtedly given this matter a great deal of thought. The Panel respects that. It may not agree with their own, individual analysis.

In the case of the evidence received from the General Practitioners, the Inquiry considered it important to obtain its own, independent expert evidence.

Notwithstanding all of the evidence received, the Panel cannot say with total confidence what were the factors that drove Marie Alawode to kill her daughter.

A chronology has been included in this report because, in one respect, it tells the full story in that anyone who reads the chronology will know the bare bones of what occurred. For example, it will become immediately apparent that Marie Alawode and Joanne were both seen by their General Practitioner, Dr Turner at the surgery on 3rd August 1998, consulting him about routine ailments, which was two days before the killing. Then, Marie Alawode was seen by the Community Psychiatric Nurse, Kim Masson on 4th August, when she was

noted to be mentally well and remaining optimistic. That was less than 24 hours before the killing.

Looking just a little further back, on 27th July the Duty Social Worker, Carole Lawrence had written to Marie Alawode to tell her that, if she had not heard further from her by 4th August, she would close the Social Services Department file relating to Joanne. And just a little further back, on 7th July, Dr Latcham wrote to the General Practitioner to say that he "reassured her that she was not going mad, and that she did not need any tablets at the moment."

Thus, within one month of the killing, it can be demonstrated that all the principal agencies had some involvement in the case and all may have had an opportunity to intervene differently. It would, in the view of the Panel, be simplistic, unrealistic and unfair to start with the tragic death of this child and then to move, inexorably and with hindsight, backwards to known interventions and to say that something could and should have been done differently on those occasions. We have not adopted that approach.

Generally, the Panel has looked at the sequence of events prospectively and on the basis of the information that was known and available to the individuals at the time and then to determine whether what was done was in accordance with good practice.

The next stage was for the Panel to determine, if there was a lapse from good practice, whether this made any difference to the outcome. Put another way, if matters had been dealt

with in accordance with good practice, where a lapse is identified, would the outcome have been any different for Joanne?

But even if the answer to that question is "no", the final question remains, might fuller and better observation of good practice make a difference in a future case and perhaps avoid a repetition of this tragedy?

That, then, has been the general approach of the Panel of Inquiry and underpins the factual findings, conclusions and recommendations that we make.

ACKNOWLEDGEMENTS

It is the case that, in an Inquiry of this nature, established by the Health Authority, the attendance of witnesses cannot be compelled. One can only hope, in such circumstances, that a tragedy such as Joanne's killing gives rise to a professional and moral obligation upon individuals to give their account. Our hopes were fulfilled, not only by witnesses employed by Hinchingbrooke Health Care NHS Trust but by others. In this context, the Panel are particularly grateful to Cambridgeshire Social Services Department, the Police and those working at Cedar House Surgery, for their co-operation. We doubt if any witness approached the task of giving evidence to the Panel with enthusiasm but all gave their valuable time freely, and the Panel are grateful.

We would like to thank Marie Alawode's solicitors, Messrs Kirkpatricks for their assistance in arming us with much documentation arising out of the Court proceedings, which has been most helpful.

Reference has already been made to the efforts of Stephen Williams in establishing this Inquiry. The Panel were, above all, assisted by the efforts of Diana Lloyd, our Administrator. Documentation was produced and copied, lines of enquiry were pursued and, above all, witnesses came at the right time on their appointed days, to give evidence. The Panel is sure that Diana Lloyd's dealings with the witnesses not only brought them to give their evidence, but to do so in as relaxed and informed a manner as possible. Much is therefore attributable to her cool, persuasive talents. Her ability to find available dates in Panel Members' diaries, where none could be perceived was one of many examples of her impressive and efficient dedication to her task. Diana Lloyd's colleagues at Cambridgeshire Health Authority who have given so much help over records, documents and witnesses also merit the Inquiry's warmest thanks.

A special vote of thanks is due to the Chairman's secretary, Sharon Watt who has magnificently taken the lead in the unenviable task of preparing the drafts of this report and bringing this document to its final form.

The Inquiry is indebted to Professor Sir Michael Drury OBE for his advice and assistance as the Inquiry's independent General Practitioner expert.

As Chairman, I claim this opportunity to thank the Members of this Panel of Inquiry. In time-honoured fashion, we came together as total strangers, knowing nothing of each other's skills and experience. We part, having completed our task with friendship and mutual respect. Conducting an Inquiry is not always easy: the hours can be long and the highest

levels of concentration have to be sustained. From their differing backgrounds, they have brought clarity and understanding to this dreadful narrative. They brought good humour to their tasks and I have learnt much in their company. We part in the fervent hope that we do not have to meet again in circumstances such as these.

To Kelly Wilks, who has lost her half-sister and whose mother is detained for her killing, we give our thanks for her evidence at the opening of the Inquiry. Through her we have gained a valuable insight into the true personality of her mother when she was well, her abilities as a mother and how she has coped with problems, including mental illness, over many years.

We also give our thanks to Mr Ademole Alawode. Marie Alawode instigated serious allegations against him, which were found to be unsubstantiated. At the hands of Marie Alawode, Joanne has been killed and Mr Alawode has lost his only child. We acknowledge the tremendous grief he bears and we have kept his wish to know what has happened here firmly in mind in our approach to this Inquiry.

Finally, we express our thanks to Marie Alawode herself. She has facilitated this Inquiry in two ways. Firstly, she has authorised all those who have been involved in the care of herself and Joanne to speak to us freely, and they have done so. Secondly, she met with us at the Norvic Clinic, where she remains detained. At the conclusion of her evidence, we wished her well and we continue to do so.

B. TERMS OF REFERENCE OF THE INQUIRY

1 To examine all the circumstances surrounding the treatment and care of Mrs Alawode, in particular:-

1.1 the appropriateness of the care plan, treatment and supervision provided in the context of:-

a her assessed health and social care needs

b her assessed risk of potential harm to herself and others

c her previous psychiatric history

d the history of her prescribed medication and compliance with that medication

1.2 the extent to which Mrs Alawode's care corresponded to statutory obligations, particularly the Mental Health Act 1983; relevant guidance from the Department of Health (including the Care Programme Approach HC(90)23/LASSL(90)11; Supervision Registers HSG(94)5; and the discharge guidance HSG(94)27); and local operational policies;

1.3 the extent to which her care plans were:-

a effectively delivered and

b complied with by Mrs Alawode

2. To examine the circumstances regarding the relationship between the care of Mrs Alawode, her mental health status and the care and treatment give to her late daughter Joanne, and to comment on the nature of this relationship in view of Mrs Alawode's history and assessed health and social care needs, and clinical diagnosis.

3. To examine the adequacy of the arrangements for collaboration and communication between the agencies involved in the care of Mrs Alawode, her daughter Joanne or in the provision of services to them.

4. To examine the adequacy of the arrangements for communication between the agencies involved and the immediate members of the family i.e. the children and the estranged husband.

5. To prepare an independent report and make such recommendations as may be appropriate in the light of the circumstances.

C. COMPOSITION OF INQUIRY PANEL

John Taylor – Chairman	LLB(Kings College, London) 1973. Admitted as a Solicitor 1977. Joined Hempsons in 1978, specialising in medico-legal practice since that time. Has represented Doctors (Psychiatrists and General Practitioners) at other homicide inquiries and represented another Special Hospital Authority at the Ashworth Hospital Inquiry.
Dr Nicholas Longhurst	Qualified, MRCS, LRCP and MBBS at Guy's Hospital, London 1970. MRCP(UK)1972. MRCPsych 1975. Elected FRCP 1996. Elected FRCPsych 1997. Since July 1977, Consultant in General Adult Psychiatry, Fair Mile Hospital, Wallingford, Oxon.
Peter Oldridge	Registered Mental Nurse 1967. Registered General Nurse 1969 MBA 1990. Director of Nursing, Doncaster Priority Care Unit 1984 – 1991. Deputy General Manager/Nursing Director, Doncaster Priority and Community NHS Trust 1991 – 1992. Deputy Chief Executive and Nursing Director/Professional Adviser, Doncaster Health Care Trust 1992 – 1997.
Trevor Brown	Certificate of Qualification in Social Work 1971. Approved Social Worker. Post Graduate Certificate in Mental Health Studies. Diploma in Management Studies. Employed by Social Services Department, Norfolk County Council 1956 – 1999. Extensive experience as practitioner and manager in childcare and mental health services. Former Lead Manager for Norfolk on Mental Health and Chair of Mental Health Joint Planning Committee. District Manager, City of Norwich (adult, disability, mental health and provider services) 1988 – 1999. Presently Business & Development Manager, the Ashcroft Project.

D. DETAILS OF WITNESSES INTERVIEWED BY PANEL OF INQUIRY

All interviews conducted at Hinchingbrooke Hospital, Huntingdon unless otherwise indicated.

Day 1 – 6th July 1999

Kelly Marie Wilks (née Stone)	Marie Alawode's eldest child, born 23.8.78. Child of Marie Alawode's first marriage.
Dr Donald Bermingham	Qualified in Medicine at University College, Dublin in 1977. MRCPsych. Appointed Consultant Psychiatrist at Hinchingbrooke Hospital, 1987. Consultant responsible for Marie Alawode's care in November 1988 and from February 1992 until re-organisation of catchment areas in mid-1996.
Sue Amode	Twenty six years' nursing experience. RMN. Holds CPN Certificate. Appointed Community Psychiatric Nurse in Huntingdon 1987. CPN and Care Co-ordinator for Marie Alawode from referral by Dr Bermingham in February 1992 until Marie Alawode's move to St Neots in August 1997.
Anne Allen	SRN, BSc in Human Biology 1975. Qualified Health Visitor 1976. Postgraduate Diploma in Social Research, Masters degree in Education. Experience in Huntingdon as Health Visitor, Community Practice Teacher and Manager of community staff. Designated nurse for child protection for over 10 years. Child Protection and Practice Development Adviser for Hinchingbrooke Health Care NHS Trust.
Ademola Ayinla Alawode	Father of Joanne. Attended accompanied by Elder of Church of Jehovah's Witnesses and produced written statement to Inquiry.

Day 2 – 7th July 1999

Annette Newton	Clinical Manager of Mental Health Services. Clinical Psychologist and Member of St Neots Community Mental Health Team.

Tim Bryson	Formerly General Manager of Mental Health Services Hinchingbrooke Health Care NHS Trust from 1994. Registered Mental Nurse. Previously Senior Clinical Nurse at Hinchingbrooke Hospital from 1990. Now Assistant Director (Mental Health and Primary Care) Cambridgeshire Health Authority.
Kim Masson	Registered General Nurse and Registered Mental Nurse (trained at Fulbourn Hospital, Cambridge). Locum Community Psychiatric Nurse, St Neots, then nursing experience on Acer Ward, Hinchingbrooke Hospital, then full-time CPN St Neots since February 1996. Holds Diploma and Masters Degree in Mental Health. CPN and Care Co-ordinator for Marie Alawode from August 1997 to August 1998.
Dr Richard Latcham	Qualified in Medicine 1974 in Birmingham. FRCPsych. MD (following 5 years MRC research in Edinburgh). Appointed Consultant Psychiatrist Hinchingbrooke Hospital and Cambridge, September 1984. On opening of Acer Ward, clinical responsibilities only in Huntingdon. Associate University Lecturer. Consultant responsible for Marie Alawode's psychiatric care upon re-organisation in mid-1996, (first consultation 1.10.96 – last consultation 7.7.98) until patient admitted under Section 2 MHA to care of Dr J Balakrishna, 6.8.98.
Dr Caroline de Cates	MB BS, BSc, MRCP, MSc, FRCPCH. Consultant Community Paediatrician, with Hinchingbrooke Health Care NHS Trust. As Designated Doctor for Child Protection, led the Trust response to Part 8 Review into the death of Joanne Alawode.

Day 3 – 30th July 1999
Norvic Clinic, Norwich

Mrs Marie Alawode	Accompanied by Elena Duhs of Counsel (instructed by Messrs Kirkpatricks, representative in attendance) and Andrea Wright, Senior Social Worker.
Dr Ann Stanley	Consultant Forensic Psychiatrist, the Norvic Clinic, MRCPsych. Responsible Medical Officer and Consultant in charge of Marie Alawode's psychiatric care since her admission to the Norvic Clinic 12.10.98.

Day 4 – 2nd August 1999
Social Services Offices,
Marshall Road, St Neots

Malcolm Stevens	Qualified Social Worker 1984. Time out from 1987. Practised in residential care. Appointed social worker, Children and Families Team, St Neots, 2.3.98. Interviewed Mr Alawode (accompanied by Elder of Church of Jehovah's Witnesses) 2.7.98.

Cedar House Surgery
St Neots

Dr John Turner	Qualified in Medicine at Newcastle in 1968. Principal in General Practice since August 1971. In practice at Cedar House Surgery since 1988.
Dr Mathew Thomas	Qualified in Medicine in 1986 at Charing Cross Hospital. Partner at Cedar House Surgery following vocational training scheme in Bedford.
Sarah Beart	State Registered Nurse 1978. RSCN. Health Visitor Training, Ipswich – 5 years in rural practice. Five years as Practice Nurse. Bank Health Visitor, Cambridge. November 1996 appointed as Nurse Practitioner, Cedar House Surgery.

Day 5 – 3rd August 1999
Huntingdon Police Station

Det. Sgt. Angus McNeill	In December 1997, Det Con attached to Huntingdon Police Family Unit. Conducted joint interview with Rachel Deakin, Child Protection Team, Social Services Department of Marie Alawode and Joanne (9.12.97) and police interview of Mr Alawode 11.12.97.

Hinchingbrooke Hospital

Dr Martin Becker	Consultant Paediatrician, Hinchingbrooke Hospital. Qualified 1969 in Germany. Practised in UK from 1978. MRCP. Appointed Consultant at Hinchingbrooke 1985. Saw Joanne upon suspicion of sexual abuse upon referral by General Practitioner. Saw Joanne on 2.12.97 and

	8.12.97. Referral to Social Services. Routine follow-up and discharge 22.1.98.
Lesley Popple	Registered Nurse 1987. Varied experience. Health Visitor training October 1992 – October 1993. Appointed Health Visitor, Priory Fields Surgery, Huntingdon, November 1993. Referred Marie Alawode to CPN November 1994, then involved in Joanne's care and assessments until August 1996.
Francesca Stevens	Qualified Registered Nurse and Registered Mental Nurse. Qualified Health Visitor 1984. Attached to Cedar House Surgery, St Neots from April 1998. Saw Marie Alawode and Joanne 26.5.98 and discussed with Social Services.
Anne Allen	Recalled, and also accompanying Francesca Stevens.

Day 6 – 4th August 1999
Fulbourn Hospital, Cambridge

Dr Jayabala Balakrishna	MRCPsych, LLM. Appointed Consultant Psychiatrist, George McKenzie House, Fulbourn Hospital, 20th April 1998 until January 1999, now Consultant Forensic Psychiatrist, John Howard Centre (medium secure unit, City and Hackney). Consultant Psychiatrist and Responsible Medical Officer when Marie Alawode admitted to George McKenzie House under Section 2, Mental Health Act on 6.8.98 until transfer to Marlborough House (medium secure unit, Milton Keynes) 21.8.98.

Day 7 – 18th August 1999
Swallow Hotel, Huntingdon

Carol Camps	Qualified Social Worker since 1983. Approved Social Worker and BA. Appointed Social Worker to Mental Health Team, Fulbourn 1992. From May 1997 acting Practice Manager, St Neots.
Barbara Wood	Mental Health Day-care Worker employed by Cambridgeshire County Council since January 1988. NVQ Level 3 in Mental Health obtained in November 1998.

	Involved in referral of Marie Alawode by CPN for financial advice and assistance from September 1997 until December 1997.
Margaret Fosbrook	Qualified Social Worker 1972, 6 years in Child Guidance Services, then training and practice in marital work, from 1980 worked at Community Mental Health Centre, London, run by independent Social Work Agency, then to Cambridge July 1990, setting up community care. Immediate Line Manager to Barbara Wood (and accompanied Barbara Wood when she gave evidence).
Kim Masson (Recalled)	To deal with specific questions set out in letter to her from Inquiry 16.8.99.
Tim Bryson (Recalled)	(and accompanied Kim Masson when she gave evidence).
Carole Lawrence	Experience in social work from 1991, St Neots, then Huntingdon, home care organiser. Diploma in Social Work 1996. Child and Families Team from 1996. Duty Social Worker when Joanne referred May 1998 until letter to Marie Alawode proposing close file, July 1998.
Barbara Muskett	Qualified as Social Worker in 1962 and as NNEB in 1963. Working mainly with children under 5 through Social Services since 1986. Family Centre Manager. Involved December 1997 in assessment with Barbara Wood, advice re playgroup etc. Funding obtained.

Day 8 – 19th August 1999

Dr R Latcham (Recalled)	To discuss matters set out in letter from Inquiry 16.8.99.

Huntingdon Police Headquarters

Det. Insp. David Fleming	Officer in charge, Serious Crime Team. In charge of investigation into Joanne's death on 5.8.98, including police interview under caution of Marie Alawode 30.9.98.
Det. Con. Christopher Bradley	Attached to St Neots Police Station. Sixteen years experience in CID. Uniformed Constable August 1998, first police officer to arrive at Marie Alawode's home, 5.8.98.

Hinchingbrooke Hospital

Colin Peddel	Social Worker since 1976. Advanced Certificate and BA in Social Work. Senior Practitioner based at St Neots. Carole Lawrence discussed contact from Marie Alawode with him, 12.5.98.

Day 9 – 20th August 1999

Jacqueline Day	BA Psychology 1983. Qualified Social Worker. Masters Degree in Applied Social Studies. Social Worker since 1989. Appointed Team Manager, St Neots Children and Families Team 1.4.98. Line Manager supervising Carole Lawrence and Colin Peddel.
Peter Wilson	Child Care Audit Manager, Cambridgeshire SSD (and accompanied Jacqueline Day when she gave evidence to Inquiry).
Mathew Bentley	Diploma in Social Work 1993, Approved Social Worker 1997. ASW who made recommendation under Section 2, Mental Health Act for Marie Alawode's admission to George McKenzie House, Fulbourn Hospital, 6.8.98.
Joyce MacDonald	MA in Social Administration and Sociology, MSc Sociology and Social Policy, Certificate of Qualification in Social Work 1982, Diploma in Social Work 1983. Worked in social work since 1983 with training in Scotland. March 1992 appointed Practice Manager, St Neots. 1.4.98 Huntingdon Child and Families Team Manager. Supervisory role in all child care work and review of duty social worker referrals.

Day 10
Arundel House Hotel,
Cambridge

Rachel Deakin	MA in Social Work, University of Leicester, 1987. Range of jobs in childcare, mental health, Approved Social Worker and management. Appointed Social Worker, St Neots Team 30.11.95. Conducted Child Protection Investigation with Det. Con. McNeill December 1997.
John Edwards	Worked as Social Worker from 1971, Residential Child Care experience. Trained as Probation Officer. Trained as Approved Social Worker under Mental Health Act, last 4 years specialist mental health role as Social Worker in St Ives Community Mental Health Team. Attended Marie Alawode as appropriate adult.

Headquarters, Cambridgeshire
Social Services Dept.
Cambridge

Liz Railton	Director of Social Services, Cambridge County Council. Career in social work since 1974 with Masters Degree in Applied Social Studies. Twenty three years with Hertfordshire County Council. Appointed Director in February 1998.

E. CHRONOLOGY

DATE:	EVENT:
16/04/53	Marie Hoppie is born.
1964	Marie Hoppie comes to England with her mother and siblings
1965	Marie Hoppie is seen in the Chest Clinic and a diagnosis of a ventricular septal defect is noted
01/04/71	GP – dizzy headaches – Diazepam 2mg tds.
25/03/76	GP – Tenuate dospan
1977	Marries David Stone.
16/01/78	GP – feels depressed.
03/03/78	GP – headaches. Blood pressure normal – fed up with accommodation.
23/08/78	Kelly Stone is born.
Dec 1978	GP – a bit depressed weight increasing.
29/08/81	Gareth Stone is born.
08/10/81	GP – normal post natal examination. Husband has left her.
17/06/82	GP – mother died. Diazepam 2mg bd 20 tablets.
14/09/82	GP – depression – weight 20 stone, divorce nearly through.
23.1.83	Domiciliary visit by Dr. Willoughby, consultant physician Lister Hospital, Stevenage. She describes that her mother died from Hodgkin's disease. Two month history of shooting pains in neck, back of head and down left upper limb. Head now feels as if it were going to burst. Recent history of blurring of vision. Admitted to Lister Hospital, anticipating transfer.
26/01/83	Transferred to the care of Dr. J.H. J. Durston, consultant neurologist, The Royal Free Hospital, London. Three month history of blurring of vision, occipital headache, pain in left shoulder radiating to left hand associated tingling. Weight gain 10 stone in six years. History of heart murmur investigated at Harefield Hospital.
08/02/83	Discharge from Royal Free Hospital. Diagnosis – benign intracranial hypertension. Discharged home on Dexamethasone (steroid) 4 mg qds, Distalgesic and Temazepam 10mg nocte.

01/03/83	Dr Durston – Out-Patient clinic – the dexamethasone has given her a steroid psychosis. Dexamethasone decreased. Chlorpromazine 25mg tds.
15/03/83	Dr Durston – Out-Patient clinic. Steroid psychosis subsided, withdraw Chlorpromazine, wean off dexamethasone over one month.
03/05/83	Dr Durston Out-Patient clinic. Off all medication. Feels depressed but brain speeded up. No frank psychotic features.
14/06/83	Dr Durston Out-Patient clinic. No medication. Benign intracranial hypertension and steroid psychosis result.
12/04/83	GP – tense, nerves +. Ativan 1mg bd.
24/04/83	GP – off steroids. Tranxene (benzodiazepine) 15 mg nocte.
24/12/83	GP – acute confusional state. Chlorpromazine 50 mg tds. Admitted to Weller Wing, Bedford Hospital under care of Dr G Kanakaratnam, consultant psychiatrist. Psychiatric admission. Diagnosis – acute psychosis. 1 month history of neglecting house and children. 1 week history extremely religious and erratic behaviour, paranoid towards brothers, giggling, singing, elated mood. Angry towards brother, irrational, communicating with God. Hears God's voice. Muttering and singing to herself. Argumentative, quarrelsome, bizarre unstructured ideas.
26/12/83	Extremely paranoid and religious, not co-operating with medication, refusing food, wanting to leave, very argumentative and quarrelsome, sitting with eyes shut and muttering to herself and singing. Bizarre unstructured ideas. Detention under s.2 of the Mental Health Act 1983. Droperidol 15mg qid for one week – improves remarkably. Hallucinations gone. Remains in hospital to allow her to move into a new house. Becomes anxious. History of being under control of God re her actions and not eating. Noted "I am sent into hospital by Jehovah to demonstrate that demons exist and God controls the demons".
24/01/84	Discharged from Weller Wing. Oxazepam 10 mg bd, to be tailed off gradually. Diagnosis to GP – Acute psychotic episode.
19/03/84	GP – low. Pre-menstrual tension. Pyridoxine 100 mg 1od.
21/03/84	Referral to Dr. Clover, Royal London Homeopathic Hospital. Feelings of depression. Not being reviewed by local psychiatrists. Starting to get a bit of difficulty coping with the children and with day to day problems. Difficulty in sleeping and a little bit of depression.
27/04/84	GP – depressed voices ++ doing irrational things. Diagnosis schizophrenia, Droperidol 15mg offered.

02/05/84	GP – 7.30pm, brother consults GP to report patient's irrational behaviour.
03/05/84	GP – patient accused of beating children. Still hearing voices, not taking Droperidol. Fentazin offered, domiciliary visit arranged.
04/05/84	Dr Kanakaratnam – domiciliary visit. Few weeks' history of becoming psychotic, now increasingly so. Auditory hallucinations in which God instructs her to go around the block and stand in the street in her dressing gown as a test of her compliance when the time comes for the world to end. Daughter kept away from school and ? neglect of children. Rude and verbally aggressive, symptom of her psychotic state and certainly not her true self. No insight, refuses informal admission and treatment with depot injections. Admitted to Weller Wing under s.2, MHA. On admission, believes family want rid of her because questioned her holiday plans, e.g. where did the money come from. Angry and swearing. (completely out of character) denies hallucinations. Paranoid and querulous. Droperidol 15 mg qid. Children taken to foster parents.
21/05/84	In-patient. Recognising that ill, accusing brother and staff of trying to harm her.
22/05/84	In-patient. Subdued, depressed, worrying about future.
30/05/84	In-patient. Early return from leave because insecure, panicky. Settles back on ward.
12/06/84	Discharged from Weller wing. Piportil 25mg four weekly (longer acting injection of low dose antipsychotic). Frisium 10mg if necessary, for anxiety. Community psychiatric nurse to follow up. Patient seeking referral to Royal Homeopathic hospital. Diagnosis to GP – Acute psychotic episode.
09/11/84	Psychiatric registrar, Weller Wing, Out-Patient clinic. CPN follow-up and depot medication confirmed. 3-4 week history of feeling unwell and low. Good insight. Not particularly depressed. Dothiepin 75mg nocte for three to six months. No further appointment.
29/11/84	Dr Clover Royal London Homeopathic Hospital informs GP that it is inappropriate to offer patient an appointment.
Dec 84	GP – Dothiepin 75 mg x 30 tablets.
17/01/86	GP. Depressed and lonely. Chat.
03/09/87	Dr Kanakaratnam review of depot medication at request of Community Psychiatric Nurse. Feels lonely during day. Some support from Jehovah's Witnesses. Extremely worried about considerable weight gain, now 21 stone. Discusses stopping Piportil, fair risk of relapse without medication explained, decides to remain on medication. Piportil 25 mg IM x five weekly, possible

	extension to six weekly in near future.
08/12/87	New GP. Patient has moved to 8 Trent Street, Huntingdon. On Piportil.
06/10/88	GP – Dr K. Lund. Referral to Dr D. Bermingham, consultant psychiatrist, Hinchingbrooke Hospital, Huntingdon. "I would be grateful for your advice about this 35 year old West Indian lady who has been with this practice for about a year. She had an acute psychotic episode back in 1984 when she was admitted under s. 2 of the Mental Health Act. She appeared at this time to have had auditory hallucinations receiving instructions from God. The episode seems to have been precipitated by the death of her mother and a divorce from her husband. She seems to have been well since 1984 and is on Piportil 25mg every five weeks. She came to see me today to see whether she could be considered for being a foster mother. I found her today a very well and likeable lady. I thought it was probably not such a good idea but as she is not known to the Community Psychiatric Service here, I wondered whether you could perhaps offer an opinion, firstly as to whether she might even be accepted and if this would be a sensible move. She has two children living with her at the moment but she is otherwise on her own".
10/11/88	Dr Bermingham sees patient at GP's surgery. Notes and letter to GP: "As you say, she had one acute psychotic episode in 1984 in relation to her mother dying and going through a divorce. I think it is also important at that time that she was on high dosage of steroids and was being investigated for what was eventually diagnosed as benign intracranial hypertension. The absence of previous psychiatric history and the absence of a family psychiatric history, and her continued good mental health, all indicate that this was a one-off episode. Despite that, Mrs Stone is very keen to continue to take depot medication as she does not want to risk a relapse..... She is a devout Jehovah's Witness and has coped very well with being a single parent. Her low times are when she gets lonely, and she sees fostering as helping to fill her life and also would help financially. Her mental state today was entirely normal and I feel the risk of a further episode of mental illness is very small indeed in this lady, and I would not perceive fostering a major stress for her".
01/03/89	GP letter to Social Services Department re suitability for fostering: *"SHE HAD ONE ACUTE PSYCHOTIC EPISODE IN 1984 IN RELATION TO HER MOTHER DYING AND GOING THROUGH A*

	DIVORCE. SHE WAS ALSO AT THIS TIME ON HIGH DOSES OF STEROIDS AND WAS BEING INVESTIGATED FOR WHAT EVENTUALLY TURNED OUT TO BE A BENIGN INTRACRANIAL HYPERTENSION. THERE IS AN ABSENCE OF PREVIOUS PSYCHIATRIC HISTORY AND THE ABSENCE OF A FAMILY PSYCHIATRIC HISTORY AND SHE HAS CONTINUED SINCE THEN TO BE IN GOOD MENTAL HEALTH, WHICH ALL INDICATE THAT THIS WAS A ONE OFF EPISODE".
02/04/90	GP – six weekly. Weight 22 stone. Planning to go to Nigeria.
21/05/90	GP. ? Piportil again.
09/05/91	GP ? 10 ampoules. Patient now married to Mr Ademole Alawode.
22/11/91.	GP. Last menstrual period October 91
27/11/91	GP letter to consultant obstetrician, Mr Brooks, Hinchingbrooke Hospital. Referral to booking clinic "She has a psychiatric history having been very ill requiring hospital admission after the death of her mother"
13/01/92	Referred by Mr Brooks to Dr C Borland, consultant physician, Hinchingbrooke Hospital because of history of cardiac murmur and finding of precordial systolic murmur. "The situation is further complicated by the fact that she is a Jehovah's Witness and would not countenance any interference with this pregnancy, or indeed any procedure that required an active blood transfusion".
Undated	Letter from GP to Dr Bermingham marked "soon". "I would be grateful for your opinion on managing this 37 year old lady who you saw back in 1988. I am concerned that she may again become psychotically ill as she was eight years ago. She is at the moment pregnant. This was a surprise pregnancy and her depo-medication has been stopped. At the moment she is quite depressed, crying a lot, lethargic and at fourteen weeks has had a lot of vomiting which has not made her feel well. At home she has a lot of money worries, is trying to get maintenance from her previous husband for her children, with difficulty and her welder husband has just had a small operation for his piles and is presently unemployed. She was initially pleased with the pregnancy but now just wishes it would all go away. Can I use any depo-injections while she is pregnant?"

17/01/92	GP. Very depressed. Maintenance difficulties with first husband.
20/01/92	GP. Prothiaden 75 mg x30.
14/02/92	Dr Bermingham – Out-Patient clinic. Letter to GP: "I do, indeed, remember seeing her in November 1988. She tells me that she married last May and that her husband was very keen to have a baby and so she went off her depo-injections six months ago and has been pregnant now for approximately 4½ months. There have been no return of psychotic symptoms but she has been feeling depressed for at least three months. Having said that she has up and down times, for instance she recently enjoyed an evening out very much but felt low when she got home. She gets tearful easily and has occasionally had suicidal ideas, but no suicidal intent. She has been bothered by nausea and vomiting during her first trimester. She finds her sleep is broken at night and that she is tired during the day. She is normally a sociable lady but now worries about everything. In particular she has considerable financial worries due to her husband's employment. He is a welder by trade. She tells me that she has recently seen Pat Gail from Social Services about this. I don't think this lady is having a recurrence of her psychotic illness and I certainly wouldn't advise going back on any form of depot medication. I would suggest prescribing Prothiaden 75mg at night and trying to keep it at this low dose in view of her pregnancy and also the fact that she has a cardiac murmur. I am going to refer her to our Community Psychiatric Nurse, Sue Amode, and also would want to see her when she comes in to have the baby but would be happy to see her sooner should anybody wish."
13/3/92	Sue Amode, CPN – initial assessment interview. "Impression. She not so depressed now, will contact me when she requires further help, but I will see her again April. Plan. Liaise with Pat Gail (Social Worker).
13/07/92	Mr Brooks advises against induction of labour and arranges for community mid-wife to visit and check blood pressure and urine every three days.
20/07/92	Patient admitted to obstetric department, Hinchingbrooke Hospital for assessment prior to induction. Patient arrives in an agitated state. The midwife in charge reports that there had been some domestic confrontation. Patient writes Will in hospital records, transferring care of her children away from her husband. On admission, no foetal heart can be heard.

21/07/92	Prostaglandin induced delivery of stillborn daughter, Deborah. Post-mortem no morphological abnormality. No stigmata of post-maturity. Long umbilical cord. Upon complaint against Mr Brooks, post natal care transferred to Mr Forbes.
23/07/92	Discharge from maternity unit with Bromocriptine, Prothiaden and Depo-provera injection.
26/08/92	Home visit by Sue Amode. Discovered to have moved to new address, 32 Sallowbush Road. Visit to new address and meets daughter, Kelly and given information of stillbirth. CPN discusses with Dr. Bermingham who had not heard of stillbirth. Plan – to revisit and assess mental state.
02/09/92	CPN home visit, meets husband, Kelly, Gareth and patient.
03/09/92	CPN discusses with Tim Bryson, senior clinical nurse re complaint.
23/09/92	GP. Scan. Not pregnant.
06/10/92	Discussed at Huntingdon Patch. CPN decision to discharge. Dr Bermingham informed.
30/12/92	Dr Bermingham. Out-Patient clinic, letter to GP. "Marie had wanted to see me as she is finding it difficult to cope since the stillbirth in July. At times she fears she is going mad, but what she in fact is describing is a severe and painful – but normal – grief reaction. She got so upset a few weeks ago that she actually gave herself an injection of 25mg Piportil from an old supply that she had and she was very keen today for me to continue this. As there is no evidence of any psychotic illness, I would be very reluctant for her to have depot medication. I tried to give her some counselling today and I think it is going to take some time for herself and her new husband to come to terms with the sad loss. I know she is still very angry and is talking about suing the hospital. I think it would help if she had a small supply of Melleril 25mg tablets to take prn. I would suggest that the dosage be 25-50 mg up to a maximum of bd.prn. I think this is also more appropriate than injections in view of the fact that they are trying for another child, although Marie isn't so keen as her husband on this matter. I told Marie that I often advise mothers who have had a stillbirth to wait about two years before having another child and she said that she agreed and would try and persuade her husband. I am going to arrange to see her again, really because I think she will need some

	support and she feels that she wants this to come through a medical source and so I will send her an appointment for February."
24/02/93	Dr Bermingham. Out-Patient clinic. Patient does not attend. No further appointment given.
25/3/93	GP. Piportil continued.
02/09/93	GP. Raised prolactin. Advice to stop Piportil.
19/02/94	GP. Very depressed. Prothiaden 50mg nocte.
07/03/94	GP. Prothiaden 25mg x 60.
13/06/94	GP. Patient reports last menstrual period 1.5.94, expected date of delivery 3/2/95. Patient requests referral to Rosie Maternity Hospital, Cambridge.
14/06/94	GP referral to Mr Hackett, consultant obstetrician: "She is 41, a Jehovah's Witness, very over weight with a past history of psychosis and depression".
29/06/94	Mr Hackett ante-natal clinic. Nine weeks gestation.
17/08/94	Dr A Green, Lecturer and Senior Registrar in Clinical Genetics reports to Mr Hackett.
29/10/94	GP Dr Sharma – Home visit. Obstetric problems – admits to hospital for observation.
28/11/94	Lesley Popple, Health Visitor sees patient at home "very anxious, paranoid and grieving. Refer to CPN".
15/12/94	Sue Amode – home visit, tearful and depressed. Letter to Dr Bermingham for domicilliary visit.
16/12/94	Dr Bermingham and CPN – joint home visit. Dr Bermingham reports to GP: "Following discussions, Sue and I visited Mrs Alawode and her husband on 16th December. Sue had seen her the previous day when she had been very tearful and anxious. She was having a better day today and was in good spirits. I reassured her, as I have in the past, that in my opinion she does not have any mental illness and that her psychotic episode in 1984 was secondary to steroids. She has obviously had a very stressful year, with the horrific murder of her brother three months ago in London during an armed robbery and also, of course, the concern of her being pregnant again at the age of 41, following a stillbirth two years ago. She is on no psychotropic medication at the moment and I think she will benefit from having Sue to talk to and hopefully we will be able to avoid medication. I told her that I would be happy to see her at

	any time... she will certainly need review by Sue and possibly myself in the post-natal period, but I would be happy to see her anytime".
20/01/95	Joanne Alawode is born.
23/01/95	Patient and Joanne discharged home. Following birth of baby, undated entry by CPN. Quite well "we decided that she will get in touch if further appt required".
07/05/95	GP. Mental illness over weekend. Melleril and referral to Dr Bermingham.
10/05/95	Dr Bermingham and CPN – domiciliary visit. CPN records: "Auditory hallucinations. Saying she hears the voice of Jehovah. Two week history increasingly bizarre, not sleeping, won't let husband touch baby. Past four days increasingly bizarre saying she hears voice of Jehovah who is going to destroy the world. Telling children not to speak and locking them in the car. Yesterday very agitated. Assaulting husband, threw herself against window, smashed fish tank. Seen by CPN in bed, eyes closed, smiling. Q what's happening? A "ask Jehovah, he's standing beside you". Voice telling her the world will be destroyed today." Dr Bermingham reports in letter to GP: "Following our conversation I called to see the above on 10th May and had a chance to obtain a history from her husband and brother. They tell me that Marie was well for the first two months following the birth of her baby at the end of January, but over the last month or so, had begun to act strangely and to become irritable and in the last two weeks had been frankly psychotic with auditory hallucinations, hearing the voice of Jehovah telling her that the world was going to end and the voice of demons interfering with her. Over the last few days she has not been sleeping, would not let her husband touch the baby, had been locking the children in the car and yesterday was throwing herself against a glass door and the window and also picked up a stool and smashed the fish tank. When I saw her today she was in bed smiling with her eyes closed. When I asked her what was wrong she said "why not ask Jehovah, he is standing there beside you". She also said that he had chased away the demons who had been keeping her awake for the last two weeks.

	My impression is of an acute puerperal affective psychosis and I have arranged for her admission to Acer Ward and we will of course keep you informed of progress". Admitted to Acer Ward, Hinchingborough Hospital Acute affective psychosis post-partum. Deluded, grandiose thought insertion. Informal admission. Verbally aggressive when approached by staff "If you touch me I'll kill you". Distressed and tearful. Refuses medication throwing it at staff. History on admission as per Dr Bermingham. Also history of murder of brother, never seems to have got over his death, being odd and pre-occupied since and has been concerned that she "may go over the edge". Psychiatric history "1984. Acute psychotic episode at time mother dying of Ca. Pregnant and going through divorce as husband had left her. Also on steroids during Ix of headaches. Diagnosis benign intracranial hypertension. Maintained on depot (Piportil) medication until [1988 deleted] 1991. Thought content "believes the world is going to end today, believes that Jehovah has been talking directly to her asking her to prophecy as Ezekiel did in the Old Testament. Wouldn't come out of shower because Jehovah told her that the towel was too small. Possession – believes she has been taken over by Jehovah for his "purposes"."
16/05/95	SHO review. Thoughts been put into her head from outside. Strong delusional ideas. She is prophetess direct from Jehovah to warn about end of world. Auditory hallucinations – several voices – one belonging to Jehovah, occur inside her head, give instructions, occasionally hold "internal conversations".
22/05/95	Mr Hackett's registrar, gynaecology department. Adamant that she does not want any more pregnancies. On waiting list for sterilisation.
31/05/95	Dr Bermingham – ward round. Discharged. For early Out-Patient follow up, Sue Amode – care co-ordinator. Chlorpromazine 100 mg tds 200 mg nocte, Procyclidine 5mg bd for side effects. On CPA.
08/06/95	CPN – Home visit. Patient well but too drowsy on Chlorpromazine

	and taking it on an ad hoc basis. CPN discusses aftercare nursing plan: "regular home visits for support plus monitoring her mental state (this needs to be regularly done, Marie can go ill↓very quickly)".
20/06/95	Out-Patient clinic. Drowsy, no voices, reduce chlorpromazine to 50mg in the morning, 100 mg at night.
06/07/95	HV. Confirms regular CPN contact. On anti-depressants. Feels well mentally but having numerous physical problems.
26/07/95	CPN home visit. Tearful, worried about negative thoughts e.g. "I might kill someone with knife" – some flashbacks to thoughts prior to admission. Encouraged to talk about her fears. ?Not taking medication regularly ?Needs depot. Dr Willett, Dr Bermingham's SHO, Out-Patient clinic review. "She still has some negative thoughts but is able to push these away and chooses to take her chlorpromazine when they become more worrying or when she becomes irritable. She is, however, not taking anything regularly... Marie felt that she would like to return to depot medication and I was fully in agreement with this. After discussion with Dr Bermingham we gave her a test dose of Modecate today, 27.7.95 and I will be asking Sue Amode to give her a full dose next week and then each four weeks. She remained very well on depot medication for seven or eight years after her previous psychotic episode and I hope that she will continue to do well on this occasion. I have given her an appointment to see my successor in three months time".
10/08/95	HV notes "up and down" moods. CPN attendance confirmed.
21/08/95	CPN home visit. Change of medication noted.
29/08/95	CPN home visit. Patient on holiday. Discussion with Mr Alawode about effect of patient's illness on their relationship.
02/10/95	CPN Out-Patient appointment. Attendance for injection. Good humour. Concern about marital problems – husband given two weeks to move out. Elders from Jehovah's Witnesses are helping and giving support.
05/11/95 and 16/10/95	CPA planned and discussed.
31/10/95	CPA form completed. This was done by a student nurse under the direction of CPN. Psychiatric history given as:

	"1984 "acute psychotic" episode. At the time mother was dying of carcinoma. She was pregnant and going through a divorce with her husband who had left her. She was on steroids at the time for investigation of headaches which was diagnosed as benign intracranial hypertension. Following this she was maintained on a depot until 1991 – which she stopped in order to become pregnant. She had no previous psychiatric history and she remained well for seven years on Piportil depot injections. 1992 experienced a stillbirth. 1994 her brother was shot and murdered during a post office raid. She was five months pregnant at the time. Her family reported that she was very odd and pre-occupied since the tragedy and was referred by the Health Visitor who felt she was tearful and depressed during her pregnancy – she was fearful of another stillbirth. Jan 1995 – her daughter Joanne was born. 2 wks after the delivery she started to exhibit some bizarre behaviour. She would not allow her husband to touch the baby and she told them not to speak as she was being persecuted by demons. Also she was showering 10-15 times a day and was demanding to be waited on hand and foot by her family. Acer – 10 May 1995 – 31 May 1995 (discharged from Acer). She was put on Thioridazine 100mg qds plus prn. She remained deluded and grandiose. She agreed to stay in hospital with the belief that some day she and her family would inherit the hospital. Medication was changed to Chlorpromazine 200 mg qds. Mood settled but varied. Switched depending on topic. Discussed. Speech was normal in volume, answered questions appropriate. Her mood became euthymic but variable. When ill, smashed a large fish tank and threw herself against the window. She maintains she never expressed any serious thoughts of suicide or self harm. <u>Outline trigger factors or early warning signs from history that may indicate deterioration in mental health and action to be taken by patient, carers and staff;</u> Usually aware when her mental state begins to deteriorate. Early warning signs include irritability, panic attacks, the feeling of not being able to cope and feeling very tearful. When this happens she contacts her CPN – Sue Amode".
28/11/95	CPN home visit. Patient moved to 12 Byron Close. Appears rather low, Modecate given. Working on marital difficulties with Jehovah's Witness Elders.
28/12/95	CPN – patient forgets to attend for her Modecate injection, arranged by stand-in Community Nurse.

03/01/96	Dr C. Walsh, Senior Registrar – Out-Patient clinic – reports to GP: "Although this was my first meeting with her, I understand that she is reasonably well at present. She denied any major affective symptoms although has brief periods when she feels somewhat weepy. She also complained of feeling exceedingly tired. This may, in part, be related to looking after a one year old baby but may also be a side effect of her depot medication. On examination, Mrs Alawode presents as an extremely pleasant reactive woman whose mood appeared euthymic. Mrs Alawode was concerned about how long she may have to remain on her depot. I had advised that she continue with this for the present until such time as I have had the chance to review her case in greater detail. I plan to review her in one month's time."
29/01/96	CPN home visit. Complaining of weight gain but "I'd rather be fat and be well". To discuss medication with Dr Walsh.
14/02/96	Dr Walsh. Out-Patient review. Report to GP:- "She remains extremely well. Her main problem is further weight gain. As you are aware, Mrs Alawode has been very keen to discontinue her medication as she feels that this is adding to her weight problems. Reading through her case notes, it is clear that her first episode was possibly related to taking steroids. Her second episode occurred during the post-natal period at a time of great stress and shortly after the murder of her brother. She has had one period of approximately a year off medication and during that time remained well. For this reason I feel it would be reasonable to have a trial off medication although I did explain to her that this would carry a possible risk of relapse. What I have suggested is that her next depot be halved to Modecate 12.5mg (due at the end of February) and that this then be discontinued if, at the end of the month, she continues well. If we proceed with this plan, she has agreed to regular reviews with Sue Amode and myself in order to detect any signs of relapse."
26/02/96	CPN home visit. Patient anxious as to whether she might have a breakdown following medication being discontinued. Quite frightened.
27/02/96	CPN discusses with Dr Walsh. Suggestion that Haldol might be used instead.

15/03/96	CPN diary records home visit.
25/03/96	CPN home visit following CPN discussion with Dr Bermingham following CPA review. Dr Bermingham prescribes Haldol 50 mg.
04/04/96	CPN. Test dose satisfactory. Depot Haldol 100mg given.
24/04/96	Dr Walsh Out-Patient clinic – patient does not attend. Report to GP notes, she has recently been switched to Haldol Depot. CPN diary records home visit.
03/05/96	CPN home visit. Haldol 100mg given IM. Very tired and depressed at times. Some communication problems with husband. Missed two appointments with Dr. Walsh.
19/05/96	Admitted to Addenbrookes Hospital for sterilisation, routine post-operative recovery and discharged home two days later.
03/06/96	CPN diary records home visit.
01/07/96	CPN diary records home visit. CPN letter to Dr C. Gregory, senior registrar in psychiatry – excessive tiredness after Haldol, and other side effects. Sometimes resents her daughter, Joanne for being around and she can't do as much as she used to. Husband trying to support but sometimes says hurtful words. Dr Gregory to advise if patient would be better off with Piportil.
27/07/96	CPN on annual leave. Depot medication due and given by colleague.
29/07/96	GP – attendance complaining tired all the time and wanting Piportil.
31/07/96	CPN. Piportil discussed, Haloperidol 50mg for time being "until Piportil can be arranged". Very tired, low, no energy.
16/08/96	Dr Gregory, Out-Patient clinic Report to GP: "She continues to complain of feeling low. I reduced her Haldol last time to 50mg and this has helped her feel less lethargic but her mild depressive symptoms continue. I have given her a prescription of Prozac 20mg daily to begin today to see if this helps, and have altered her prescription so that in a month's time she receives 25mg monthly to see if we can get her feeling a little less lethargic and active."
27/08/96	CPN diary records home visit.
05/09/96	CPN home visit. Feeling depressed. Restless. Speaks to husband re illness i.e. depression – he is trying his best to understand.
25/09/96	Dr Gregory Out-Patient clinic. Report to GP: "Since converting to Piportil 25mg and starting on Prozac 20mg, she has felt an improvement in her mental state, being more positive and

	less sleepy with more energy and enthusiasm. Objectively she seemed a lot more reactive in her mood and smiled several times during the interview, the first time I had seen her do this. I suggest that she remains on the Piportil as above, that she increases her Prozac to 40mg and that she is reviewed in six weeks' time."
01/10/96	CPA – form completed. Dr R. Latcham, new consultant psychiatrist. Patient's weight 22 stone. CPN gives diagnosis as puerperal psychosis.
03/10/96	CPN. Preparing for daughter's wedding and planning reception. Planning holidays in America. Mood slightly better.
30/10/96	CPN home visit. Feeling tired, trapped. Prozac 40mg daily, Piportil 25mg monthly.
06/11/96	Dr S. Dowse, senior registrar to Dr. Latcham. Out-Patient clinic. Report to GP: "Unfortunately she still seems to have depressive symptoms with decreased energy, appetite and poor motivation. She feels things have improved slightly on the Prozac but she is not back to her normal self. In view of this as a first line I feel that she should increase her Prozac up to 60mg per day, but I will review her again in a month's time and if there is no further improvement we will look to changing her antidepressant. She continues on her depot as previously." CPN – Mental state – quite low at times. Anergic. Some marital difficulties. Counselling by Elders.
27/11/96	CPN off sick. Depot medication given by colleague.
31/12/96	CPN home visit. Happy and pleased after USA holiday without husband. Unhappy remarriage – husband runs her down, maltreats her. Piportil given.
15/01/97	Dr Dowse Out-Patient clinic. Report to GP: "I was pleased to note that she was far brighter than previously. She has in fact started a part time job and had been on holiday and had looked better than I had ever seen her. I have advised her to continue on her current medication of Prozac 60mg per day, and Piportil 25mg and I will review her again in three months' time."
28/01/97	CPN. Quite stable. Piportil given.
26/02/97	CPN home visit. Feeling well. Nursing assistant job two nights a week. Mental state stable. More motivated. Piportil given. Some family tension evident.

18/03/97	CPA – CPN reports quite reasonable at present.
21/03/97	CPA review – patient requests her copy to be in file.
23/04/97	Dr Dowse Out-Patient clinic. Report to GP: "I am pleased to note that she is continuing to keep very well on her present medication of Prozac 60mg and Piportil 25mg per month. I will review her again in four months' time."
21/05/97	CPN home visit . Patient enjoyed holiday with husband and Joanne. Mentally very cheerful. Piportil given.
18/06/97	CPN home visit. Patient fed up with husband "putting her down" and not managing bills properly. Appears to calm down. Working part time. Medication given.
20/06/97	CPN. Urgent appointment at patient's request. Husband belittled her for six years, she wants to end marriage, mental state feels hurt, not depressed. Prozac reduced from 60mg to 40mg, to be reviewed.
26/06/97	CPN discussion with Dr Dowse to update her. CPN later bleeped to speak to patient feeling stressed "thoughts not stopping in her head".
27/06/97	CPN. Urgent appointment. Message for GP: "Sue Amode phoned this morning just to let you know the situation regarding this patient who is coming to see you next Wednesday. She bleeped Sue last night, in a very depressed state re marital problems. Sue has suggested that she take some time off work and get away from home a bit so she will probably ask you for a sick note. Dr Latcham suggested she could be prescribed Melleril but Sue didn't feel at the moment, that this is necessary." Patient seen by CPN after CPN discusses with Dr Latcham who suggests Thioridazine if necessary. Patient worried and tense re her stressors. At end of session, patient calmer.
15/07/97	CPN. Patient visited Park House for depot medication. CPA discussed and need to transfer because of new GP, following patient's move to St. Neots.
24/07/97	GP. New address – 37 Cambridge Street, St. Neots. First attendance with new GP practice, Cedar House Surgery. New

	Patient medical. "Active problems. 19.1.1967 ventricular septal defect: moderately large. 01.01.1983 benign intracranial hypertension. 01.03.1983 drug psychosis NOS; steroid induced. 01.12.1983 acute schizophrenic episode; admitted." Repeat prescriptions of Prozac and Piportil noted.
04.08.97	GP locum. Medication noted. Medical Certificate.
13.08.97	Dr Swinscoe notes history of "psychosis" and treatment under care of Dr Bermingham. Patient not suicidal, to ask psychiatric team to write to GP.
14/08/97	CPN. Depot medication given. Change of CPN discussed. Patient finding it difficult to cope. Sue Amode to discuss with Kim Masson, new CPN.
15/08/97	CPN. Sue Amode discusses with Kim Masson. Dr Dowse is to review current medication.
19/08/97	Dr Dowse, Out-Patient clinic, report to new GP, Dr Swinscoe, Cedar House Surgery, St. Neots: "I understand from Sue Amode, CPN, that you have recently taken over the care of this lady. She has been known to our services for several years and I thought it would be useful for us to fill you in with information while you get to know her. She has a history dating back to 1984, when she had an acute psychotic episode and this was felt to have been precipitated by her mother's death and also her high dosage of steroids that she was on at the time for a benign intracranial pressure. Following this breakdown she was maintained and seemed to keep very well on Piportil and intermittently antidepressants. Her diagnosis was schizo-affective disorder. She had little contact until being seen by Dr Bermingham who assessed her when she was on medication and felt she was well. She decided that when she remarried that she wished a child and stopped her depot medication and remained well, despite having a stillbirth, although did need some antidepressants to help her during this difficult time. She fell pregnant again quite quickly and unfortunately developed psychotic illness postnatally. It was very severe and required hospital admission for ten days and at that point she was having auditory hallucinations and was very

	irritable and felt the day of judgement was due. On closer questioning at this time, it appears not only had she had the pressure of the recent birth of her child, but her brother had been shot dead when she was five months pregnant and she had perhaps been in retrospect a little bit odd and pre-occupied since that time. Following her admission she again seemed to settle very well on depot medication of Modecate. She was tried on other depots, I think largely due to the side effects she was suffering from, was eventually started on Piportil 25mg monthly which certainly seemed to help her energy levels. At the same time it was felt that she was possibly slightly depressed and she was started on Prozac. This was slowly increased to 60mg at the end of last year. Since this point I have seen her several times in the clinic and have seen a slow but steady progress. From her own history it appears her relationship with her husband has not been very good and I think as her depression resolved she improved her own self esteem and actually looked at the marriage in a different light and this precipitated the break up of the marriage. She also more recently had enough energy to go out and get a job, which again has had the added benefit of helping her self esteem. Therefore, in summary I feel this lady does have a schizo-affective disorder. It seems to be very well maintained on medication, but unfortunately deteriorates at times of quite extreme stress, i.e. taking steroids, the birth of her child and the death of her family members. At present she is under considerable stress, having separated from her husband and moved to a new area. She is finding it difficult to juggle all her commitments at once and I think will need a lot of support over the next few months. I know Sue Amode is seeing her regularly and will obviously be looking to give her as much support as possible. I also will be reviewing her in Out-Patients. I feel her medication should remain stable at present, but this will continue to be reviewed at Out-Patients."
27/08/97	Dr Dowse Out-Patient clinic. Report to GP: "I was pleased to know that she has actually coped reasonably well despite all her upheavals. I do feel though on discussion with her that we should try and make sure she is not too stressed at this time and she feels that going back to work would still be quite difficult. I understand you have signed her off until the middle of September and I think she will at least need another month and possibly two months off after that. She is a very good judge of her own illness and is quite keen to work but I think feels she has too much on her plate at present.

	I hope this is all right with you but I have told her to come and discuss it with you when she comes to see you. In the meantime her medication remains stable and her care has been passed over to Kim Masson, CPN, in St. Neots. Future follow up will be arranged with Dr Latcham."
02/09/97	CPN. Review CPA, Huntingdon patch. Discharged from Sue Amode's caseload. New care co-ordinator Grant Marsh, CPN St. Neots. Review in six months. CPA form notes medication and need for regular monitoring and "continues to be supported by daughter, son and friends from Jehovah's Witness".
10/09/97	Dr R Latcham, consultant psychiatrist – Out-Patient clinic. Report to GP: "I saw the above today for the first time. I did not have the notes so the history that I got from her was all I had to go on. It seemed that at one stage she had what sounds like benign intracranial hypertension and was treated with high dosage of steroids and promptly went mad. Since then she has had three other hospital admissions to psychiatric hospitals, but on the first admission at Bedford General, Weller Wing, she was treated with the depot Piportil which she has taken ever since. Now she is taking that once a month and I think Kim Masson is due to give it to her on 13th September at her home. She is also taking 60mg of Prozac and was fairly recently on Acer Ward. She was last ill when she stopped her Piportil but also had just had her second child, who is now 2 ½ . Fairly recently her brother was murdered. She relied on her brother to a considerable extent for support. When I saw her today she was grossly overweight, something of which she was aware and thinks it is due to Piportil. Otherwise she seemed very cheerful and entirely normal and I think that really I ought probably to reduce her medication slowly and see how she gets on. I intend to see her next time at Shortsands Day Centre with Kim Masson".
11.9.97	CPN. First meeting with Kim Masson, obtains brief history. Observes seems very well at present. Money worries, CPN to

	discuss with Barbara Wood, Cambridgeshire Social Services Department. SSD. File opened upon referral by CPN. General concern re adult with Mental Health problems. History given and recorded as: "Puerperal psychosis and had admission to Acer Ward – on CPA 3 and previously seen by Sue Amode (CPN) in Huntingdon team. Marie has separated from her husband and moved out of family home in Huntingdon. (Details of financial circumstances and medication). Due to move, separation and feels she needs to look after herself and anxious she will become ill again."
12/09/97	CPN. Medication discussed with Dr Latcham, to reduce Prozac from 60mg to 40mg, depot medication to be reviewed. SSD. CPN referral discussed between Barbara Wood and Carol Camps, to be passed to duty Social Worker.
23/09/97	SSD. Home visit by Barbara Wood to assess finances and benefit situation. Appointment made for patient to see Citizens Advice Bureau and information passed re activities and playgroup, family centre drop-ins and messy play.
29/09/97	GP. Referral to Mr Al-Kurdi, consultant gynaecologist for advice re menorrhagia.
07/10/97	GP. Home visit by deputising service doctor following request at 3.50am for advice re sore throat.
08/10/97	CPN Home visit (entry dated 9.10.97). Stressors noted, particularly financial problems. Note of visit by Barbara Wood, patient more distressed and upset, mood fluctuating, sometimes tearful and low. SSD assistance noted. SSD. Home visit by Barbara Wood. Detailed notes of stressors and assistance given. Advises to discuss mood changes with CPN and Dr Latcham. Appointment to be arranged to go to CAB. Joanne present, observed to be whingy and attention seeking. Patient smacks Joanne on the bottom, not with a lot of force, Joanne settles, later starts to cry and shout, patient becomes tearful and distressed – help with Joanne offered. Matter discussed with CPN and Carol Camps, Practice Manager, to be referred to Children and Families Team, referral discussed with Joyce McDonald.
09/10/97	Referral by Barbara Wood to Children and Families Team to arrange joint visit. Patient and CPN informed of referral.
14/10/97	Dr Latcham Out-Patient clinic. Report to GP:

	"I saw the above with Kim Masson. I have seen her once before and I think wrote to you then. On the first occasion I didn't have the benefit of the notes but I took quite a good history from her which has proved to be correct now I have seen the notes. I cannot see any indication for continuing the Piportil. Mrs Alawode had an episode of steroid - induced psychosis and then two episodes of puerperal psychosis and although all of these were severe she has no history of psychosis other than this. Currently she has absolutely no symptoms of any kind of psychosis and so I have asked Kim to halve the Piportil next time, roughly in the middle of November and then to stop it. Mrs Alawode asked me about the Prozac of which she takes 40mg every day and I have said that we will think about that once the Piportil has stopped. At the moment she is living on her own at St. Neots and is finding that she is more like her old self being away from her husband. Her daughter has just had a baby and everything seems to be going reasonably well. She complains of some emotional liability but I think this is hardly surprising given all the dreadful things that have happened to her in recent years. I will continue to follow her up at Shortsands with Kim Masson". SSD. Concern to arrange for Dr. Latcham to write a letter on behalf of patient, patient does not wish this.
04/11/97	SSD. Joint visit by Barbara Wood and Barbara Muskett, Childrens Centre Manager. Joanne on holiday with father in U.S.A. Patient advised and discussion re Joanne starting playgroup.
18/11/97	Dr Latcham Out-Patient clinic Report to GP: "Marie seems very well on the reduced Piportil which I have now stopped altogether. She remains on Prozac 40mg daily. I am going to see her again in January, but Kim Masson will continue to see her in the meantime." CPN. Depot now discontinued as patient seems to be well. SSD. Home visit by Barbara Wood, copy budget taken and passed to Barbara Muskett.

01/12/97	GP. Patient brings Joanne to be seen by Dr Thomas. Concern raised that Joanne sexually abused during weekend visit to father. Telephone referral to Dr Becker, Consultant Paediatrician, Hinchingbrooke Hospital.
02/12/97	Dr Becker, Department of Paediatrics. Report to GP: "Thank you for your phone call and letter. I saw Mrs Alawode, Joanne and also Joanne's older sister Kelly Wilks on 2.12.97. Mrs Alawode has separated from her husband. They are not formally divorced. Her husband lives on his own working as a window cleaner and there is the arrangement that Joanne will stay with him from Thursday until Sunday evening, more recently from Friday until Sunday evening. Mrs Alawode has observed that when Joanne returns from staying with her father, Joanne often appears rather more difficult in her behaviour (she appears to be quite a handful anyway) and has complained of soreness in her ano-genital area. Mrs Alawode seems to know that Joanne sleeps in the same bed with her father when she stays there and when she returns she wants to sleep in Mrs Alawode's bed. As you say when Mrs Alawode asked Joanne directly whether her dad touched Joanne in this area she agreed, but on the other hand, she also agreed when mother asked her whether she herself is touching her there. Joanne's father tends to give her a bath sometimes twice a day and she wonders whether he might just use too much soap and wash her too vigorously leading to some discomfort. Mrs Alawode's older daughter, from a different marriage, Kelly Wilks, explained that she and her mother were also concerned that her father had arranged a trip to the U.S.A. without involving Mrs Alawode in the planning. She just knew shortly before the trip that this was going to happen. Mrs Alawode's history is a long list of traumatic experiences. She had a still born full term infant five years ago, mother's brother was shot when working as a security guard and she has had several nervous breakdowns and I understand is on permanent medication. I understand that a Social Worker, Barbara Woods is also involved. On examination I found a healthy looking girl who was quite

	normally reluctant to be examined. Her genital and vulval area looked unremarkable in particular the posterior fourchette was intact. There is no evidence of hymenal damage or bruising. Her anus, examined in lateral position with gentle traction of her buttocks, did not show anal reflex dilatation, nor anal scars or engorged veins. I explained to Mrs Alawode that although there are no typical signs consistent with sexual abuse that this possibility cannot be excluded and she will have to keep a high degree of vigilance. We agreed that I would review Joanne in January and that I would see her at any time beforehand if there is a particular concern. I also explained mother's right to call Social Services or the Police herself if she is acutely concerned about the safety of her child".
08/12/97	GP. Dr Turner records possible further sexual assault and refers again to Dr Becker or casualty. Dr Becker, Department of Paediatrics. Report to GP: "Mrs Alawode contacted the ward (8.12.97) and I saw Joanne on the ward. At this time Joanne was in great discomfort as she felt unable to pass urine. Her mother told me that she had come home from the weekend stay with her father on Sunday night, again complaining of soreness in the genital area and that she had not been able to pass urine normally, just producing little spurts. We had to sedate Joanne with Pethidine and catheterise her bladder to give her some relief. On subsequent examination it was noted that there was redness in the vaginal area, however no bruising, no tears or other evidence of damage. I applied anti-inflammatory cream and we observed Joanne on the ward and reassured ourselves that she was able to pass urine without difficulty later on that day. Because of the similar pattern of Joanne's symptoms after her weekend stay with father, the Child Protection Team was informed with Mrs Alawode's agreement. Children of Joanne's age occasionally complain of soreness in the vaginal area which can be either due to infection, other skin diseases, or mechanical or chemical irritation. There is no evidence

	of skin disease and there was no discharge suggesting infection. It is thus conceivable that the irritation in the genital area Joanne seems to experience regularly, could be the result of mechanical irritation i.e. rubbing." SSD. Referral by Dr Becker. Categorised "child in need" and concerns noted: "Pattern of soreness reported to GP after weekend visit to father – child in hospital with soreness in genital area, could not pass urine, is catheterised, following visit to father. Dr Becker has concerns re Joanne having been seen on several occasions by GP Dr Thomas when Marie Alawode (mother of child) has taken her with genital soreness following visits to father. No abnormality reported on these occasions. Today Joanne was sore and could not pass water and was screaming with pain – GP admitted her to hospital. Catheterised. Will be coming home to mother's address later this afternoon. Also, concerns that when she is with father he works as window cleaner and leaves Joanne with other carers? Mother is frightened of Mr Alawode's reaction to the fact that Joanne is hospitalised, feels he may be violent. Is known to B. Wood, Mental Health day-worker. Dr Becker thinks soreness could be caused by rubbing?"
9/12/97	CPN. Telephone call to patient. Prozac reduced to 20mg daily because feeling dizzy. Concern re possible sexual abuse of Joanne noted, with involvement of hospital and SSD. Patient feeling a bad mother and finding whole issue unbelievable. SSD. Referral taken up by Rachel Deakin, Child Protection Social Worker, to plan joint visit with Police. One attempt to contact GP surgery, answerphone only until 2pm. Joint home visit by Rachel Deakin, CPT, and Det. Con. Angus McNeill, Huntingdon CID.
11/12/97	Police. Det.Con. McNeill conducts interview of Mr Alawode, accompanied by Jehovah's Witness Elder. Allegations denied. To be filed as inconclusive. Det.Con. McNeill updates Rachel Deakin

	and Mrs Alawode advised about interview and action if further complaint. SSD. Rachel Deakin speaks with patient's solicitor. Dr Becker's report received by Police, to be copied to Rachel Deakin.
22/12/97	Police. Det. Con McNeill's recommendation, no further Police action, agreed by Supervisor.
5/1/98	GP. Deputising service doctor visits 7.00pm. Joanne complaining of sore vagina all day. History of suspected child abuse. Cream applied, Joanne not crying. To see own GP next day.
7/1/98	SSD – Joanne began sponsored attendance at Priory Park Playgroup.
9/1/98	CPN home visit. No psychotic symptoms. Financial problems continue. Concerns re possible sexual abuse of Joanne, is seeing Social Services. Employment obtained. Dr Latcham to be asked to help with housing.
21/1/98	Dr Becker, Department of Paediatrics follow-up appointment, report to GP: "Problem: transient vulvitis, concern about sexual abuse. Mrs Alawode tells me that since I last met her daughter at the beginning of December there had only been one very brief episode when she complained of discomfort in the vulval area. She still stays with her father from Friday to Sunday. She has started nursery school twice weekly. Mrs Alawode feels that Joanne is overall a much happier girl now and asked me to re-examine her. I am pleased to say that I could not note any abnormalities in her genital area. I have not given her a routine follow-up appointment but please let me know if I can be of further help."
23/1/98	CPN home visit. Marie stressed, financial worries, coping. CPA review. Medication – now off all medication and feels better for it, finds professional visit helpful and reassuring to "keep an eye on me", to continue at least four weekly. Mr Al-Kurdi, report to GP, Vabra aspirates removed 16/12/97 showed no significant abnormality, no further appointment for follow-up.
13/2/98	CPA form received at Cedar House Surgery, annotated "file" by Dr Turner.
2/3/98	CPN home visit. Appears well, stressed, financial worries.
18/3/98	SSD. Rachel Deakin prepares report on SSD/Police investigation upon Dr Becker's referral upon suspicion of child sexual abuse. Inconclusive interviews. Reference(para 3.4) to "support re financial problems in view of her mental health problems" and proposed action (in December 1997) recited. Report annotated by Joyce McDonald, Practice Manager.

	"Initial enquiries concluded. No grounds to proceed to S.47 investigation. Advice given. Family Centre were/are involved. Play group fees being paid. NFA to Team".
23/4/98	CPN home visit. Daughter seen, patient working full time, doing well.
29/4/98	HV – home visit by Fran Stevens HV, to initiate contact, no reply.
11/5/98	CPN home visit. Appropriate in behaviour and content of speech, enjoying work. Care plan reviewed.
12/5/98	SSD. Patient seen by Carole Lawrence, duty Social Worker re general concerns for Joanne. Categorised as "child in need." Reports: "Mrs Alawode has concerns re Joanne's genital area sore/red following contact visits with Mr Alawode. Mr & Mrs Alawode are Jehovah's Witnesses and separated (no grounds for divorce in their religion, eg adultery)." Mrs Alawode informed of previous CP inquiry Dec 97 by Rachel Deakin SW/Police Fam. Unit. Not conferenced. Joanne has continued to experience redness and soreness in genital area, always following contact weekend with her father although Joanne always pleased to go to see father and not making any allegations of inappropriate touching by father. DSW asked whether Mrs Alawode was taking Joanne to GP now; she preferred to take her next Monday following next contact visit. She will contact us following this re outcome. Also Mrs Alawode wanted advice re sale of marital home saying Mr Alawode had offered 9K as settlement rather than go to court. DSW advised legal advice should be sought. Mrs Alawode thinks Mr Alawode may take Joanne to Africa, where he has a home, without telling her. Again advised the solicitor re res order etc. Solicitor is Sally Hammond, Leeds Day. Advised would pass concerns re Joanne to CP worker as to whether/how to progress her enquiries. Discussed with Colin Peddel –agreed not CP but CIN at present."
13/5/98	SSD. Case to remain open to duty, approved by Jackie Day, Team Manager.
26/5/98	GP. Joanne brought by mother, seen by Dr Turner re concerns re sexual abuse from father. On examination nothing abnormal detected. Advised.

	SSD. Telephone call from Fran Stevens, Health Visitor, Cedar House to Carole Lawrence, DSW. Patient's fears of Joanne being abused and concerned that when contact visit to father, Joanne is left with friends. Advised patient has not mentioned this in previous visit to DSW. HV – seen at surgery by Fran Stevens, HV, notes:- "Has tried to call, phone engaged. She employed as domestic, Joanne attends Priory Park Playgroup two mornings a week. Lives alone with Joanne – suspicions of abuse following access visits to father every weekend. Says she complains of "sore bottom", v uncomfortable, no other behaviour problems although sometimes is reluctant to go on visits. Has spoken to S/S solicitor and child seen by Paediatrician. No proof so far. Advised to keep record of J's behaviour and any complaints following visit to father. Will contact S/S Carole Lawrence. Mother took Joanne to see Dr Thomas today – NAD. Joanne appears well, friendly 3½ year old, open, played with toys happily. Spoke to Carole Lawrence – no hard evidence, encouraged to contact 2½ year dev check satis, seen with father needed review of speech in 6 months ? kept."
27/5/98	SSD. Telephone call from GP Dr Turner, confirming findings on examination not conclusive. Dr Turner understands from patient that Social Services requested the examination specifically. DSW advises of current situation and that SSD has little evidence to proceed with. Discusses possibility of Munchausen's – Dr Turner does not know Mrs Alawode well enough to say.
1/6/98	CPN. Patch team meeting, review, CPA reduced to Level 1. HV – Fran Stevens telephone call to Anne Allen (child protection/practice development advisor) re above to discuss, suggests more information from referring GP to Dr Becker and to re-contact S/S for clearer information plus work with mother to nurture self-esteem. Speaks to Dr Thomas who referred Joanne to Dr Becker – says will refer again if necessary and Dr Turner who has contacted S/S with no evidence.
5/6/98	GP. Seen by Sarah Beart, nurse practitioner, Cedar House – 10 day history of giddiness and irritability. Advised.

8/6/98	SSD. Jackie Day agrees no further action, but to check previous medical assessment of mother on file should any future reports come in (schizo-affective disorder).
9/6/98	CPN. Telephone call from patient. Stressed, financial problems. Tearful at work, needing time off. Son has left Jehovah's Witnesses – patient upset. Concerns re possible sexual abuse of Joanne. CPN to contact GP and SSD. CPN speaks to Carole Lawrence re possible abuse, Carole Lawrence to discuss this with her manager.
12/6/98	GP. Seen by Dr Solanki at surgery. Recent history of feeling stressed. Problems discussed. Advised. Medical certificate.
23/6/98	SSD. Patient reports to Carole Lawrence, DSW, records: "Again concerns following contact visit with father that Joanne's private parts are sore and Joanne cries about it. GP has found no evidence of abuse or physical ailment although has prescribed an anti-pruritic cream." Discusses what to do – DSW suggests could talk to Mr Alawode about suspending contact (overnight) visits to see if symptoms persist – if they do then possibly showing not connected with father's care. Mrs Alawode fears he will "take" Joanne out of country to live with him in Nigeria. DSW suggests discuss residence order with solicitor. Agreed could ask Elder of local Jehovah's Witness congregation to sit in on discussions with Mr Alawode if Mrs Alawode fears he will bully or misrepresent her motives re contact arrangements.
24/6/98	SSD. Jackie Day agrees information to be passed to current case worker, Barbara Muskett.
1/7/98	CPN home visit – patient not at home.
2/7/98	SSD. Visit by Mr Alawode to SSD, accompanied by Jehovah's Witness minister. Mr Alawode seen by Malcolm Stevens because of Carole Lawrence's unavailability. Mr Alawode raising complaint about advice allegedly given by SSD to wife and her solicitors. Medication (cream) given by Mr Alawode to Joanne explained. Advice given to Mr Alawode.
3/7/98	CPN telephone call from patient, stressed, tearful and not coping, wants to see Dr Latcham. CPN home visit. Stressors discussed, including SSD advice re Joanne's visits to father. Patient to see SSD again to review the situation – Carole Lawrence. Sleep, appetite and concentration discussed. Does feel more tearful, confidence waivers at difficult times, husband telling people in Jehovah's Witness congregation that patient is off her head and mad. No signs of psychosis. Not

	clinically depressed. Appearance good. Appropriate eye contact. Content of speech and affect ✓, no suicidal thoughts. CPN makes appointment for patient to see Dr Latcham.
7/7/98	Dr Latcham – out-patient clinic, letter to GP: "The above has had a difficult time with her ex-husband recently. He has been round with a friend of his, and there are all sorts of difficulties with their old house. I reassured her that she was not going mad, and that she didn't need any tablets at the moment, and offered her any help that she wanted in the future." SSD. Letter from Carole Lawrence to Mrs Alawode's solicitor to inform of Mr Alawode's visit on 2/7/98 to discuss current difficulties regarding contact with Joanne. "Mrs Alawode has visited this office on several occasions since 12/5/98 and has been seen by me as duty officer; there is not an allocated social worker nor is there likely to be as it is not being dealt with as a child protection issue. I have given Mrs Alawode general advice in dealing with what she has suspected to be sexual abuse. This issue has been investigated previously and found to be unsubstantiated at that time. Since Mrs Alawode had, at my suggestion, taken Joanne to her GP following a reoccurrence of genital soreness and the GP could find no evidence of abuse I then suggested that she may consider stopping overnight contact with Mr Alawode for a time. This was to see whether Joanne continues to complain/show evidence of soreness during the period contact did not take place, which may then indicate that the contact was not directly related to the problem. At no time did I suggest that Mrs Alawode had to take this action and indeed encouraged her to discuss the matter with yourself. I believe Mr Alawode thinks that the Social Services Department have an active involvement in this issue and that we may be taking matters further. This is not the case at the present time. As you are aware Social Services do not become involved in custody matters but refer clients to legal advice. Our duty system is pleased to offer advice and support to both Mr & Mrs Alawode should they request this in the future."
15/7/98	CPN. Telephone call from patient. Very low, very tearful and unable to cope. She says her thoughts "aren't right", but can not be specific when asked what she is thinking. Sleep worse. Financial problems. CPN to discuss with Dr Latcham for letter re housing.

16/7/98	CPN. Discussion with Dr Latcham. Advises start Prozac. CPN speaks to patient (telephone) better, glad she is going on Prozac.
21/7/98	CPN. Telephone call from patient – physical symptoms, in bed, concerned for Joanne. Feeling down and panicky. CPN home visit, her mental state fine although tearful. Finances/housing getting her down. Physical symptoms discussed.
22/7/98	CPN. Telephone call from patient's daughter, patient no better. CPN home visit. Physical symptoms discussed. Reports discussion with GP on telephone, diagnosis gastro-enteritis, to give fluids and Dioralyte. Adult children worried and patient worried she is getting ill (mentally) – feels low but because she feels so ill physically. Patient to go to her son's overnight with Joanne.
23/7/98	CPN home visit at patient's son's home. Feels better. Physical symptoms improved. Brighter in mood. Going to a Jehovah's Witness convention over the weekend if she feels up to it.
28/7/98	SSD. Letter from Carole Lawrence, DSW to Mrs Alawode:- "You had made several visits to this office to speak with the duty social worker regarding your concerns for Joanne in relation to her contact visits with Mr Alawode. In order to clarify the situation as to whether there was any indication of abuse, it was suggested that you stop overnight contact for a period of time and you were advised to discuss this with your solicitor. As we had not heard from you recently I trust the matter has now been resolved. If I do not hear from you by 4/8/98 I shall close the papers. If in the future you have further concerns, please contact the Duty Social Worker, one is available between 8.45am – 5.25pm each week day (4.25pm Fridays)."
3/8/98	GP. Mrs Alawode attends with Joanne at Cedar House surgery and both are seen by Dr Turner. In respect of Mrs Alawode, Dr Turner records a complaint of chest infection, sore throat and green phlegm and prescribes Amoxycillin 500mg tds (21). In respect of Joanne, mother reports chesty cough. On examination, impetigo under nostril. Prescribes Fucidin cream 30G and Erythroped 250 qds
4/8/98	CPN. Home visit – 11.30am. "Marie has a chest infection – now on antibiotics. Mentally well. Finances poor state still, however Marie remains optimistic."

5/8/98	Death of Joanne Alawode. Marie Alawode arrested by Huntingdon Police on suspicion of murder. SSD – John Edwards, senior practitioner social worker/approved social worker attends Huntingdon Police Station to act as appropriate adult. Dr Roberts, Police Surgeon, and Mr David Potter, Solicitor also attend. Dr Roberts and Mr Edwards conclude that patient fit to be detained and interviewed. Patient increasingly distressed, some dis-inhibition. Agreed to be questioned next day.
6/8/98	10.15am. Seen by Mr Edwards – more agitated, rocking herself, mental state deteriorated, troubled by auditory hallucinations – acutely ill and unfit to interview. Application for admission to hospital under Section 2 Mental Health Act 1983 by Matthew Bentley, Approved Social Worker. Medical recommendations under Section 2 by Dr Sarah Cullum of Hinchingbrooke Hospital and Dr Neil Hunt of Fulbourn Hospital, Cambridge. Patient admitted to George Mackenzie House under care of Dr J Balakrishna, 9pm.
21/8/98	Transferred to Marlborough House sub-regional secure unit, Milton Keynes under care of Dr A P W Shubsachs, Consultant Forensic Psychiatrist.
27/08/98	Marie Alawode detained under Section 3, 5.3 Mental Health Act 1983, upon assessment at Marlborough House by Matthew Bentley, ASW.
30/9/98	Police interview under caution of Marie Alawode (with Mr Potter and Mr Edwards).
12/10/98	Marie Alawode transferred to Norvic Clinic, Norwich (regional secure unit), under care of Dr A K Stanley, Consultant Forensic Psychiatrist.
11/1/99	Northampton Crown Court – Marie Alawode pleads guilty to manslaughter on the grounds of diminished responsibility. Court Order under Section 37/41 of the Mental Health Act, to be detained at the Norvic Clinic.

F. CONSIDERATION OF EVIDENCE

1.1 PSYCHIATRIC AND MEDICAL CARE

COMMENTS ON MEDICAL RECORDS:

6.10.88 GP referral to Dr Bermingham.

The GP's letter is reasonably accurate concerning the 1984 psychosis. It mentioned Marie Alawode's marital problems and her mother's death. In the context of psychosis, it did not mention the possible involvement of steroids.

10.11.88 Initial assessment by Dr Bermingham.

Dr Bermingham advised the Inquiry that he takes about 45 minutes to see patients at the General Practitioner's surgery. This is not a lot of time to see a new patient and review the notes. But it is a reflection of the well-above average catchment area that Dr Bermingham had to deal with at that time. He still has to cover a much larger catchment area than is recommended by the Royal College of Psychiatrists. It is not easy to find all the necessary paperwork in old style general practitioner notes and Dr Bermingham did not obtain the full history of Marie Alawode's three episodes of psychosis in 1983 to 1984.

Dr Bermingham's interview and submissions to the Inquiry advised that he did not believe that the error was caused by workload. His opinion based on the history that he obtained was reasonable at that time and left it open for the General Practitioner to re-refer if necessary, which is standard practice.

It is very difficult for Dr Bermingham to know what he would have advised, if the full history of the three psychotic episodes over an 18 month period had been known. Only the first brief outpatient episode was related to steroids.

She had been off steroids approximately 8 months when she had her next acute psychotic episode requiring admission, followed by another admission five months later.

At the time of this consultation, Dr Bermingham was one of two full time psychiatrists responsible for a catchment area of 150,000 people. That was the position until early 1997, when a part time Consultant was appointed, but the catchment area population has now increased to about 160,000. That equates currently to 64,000 per Consultant. In fact, Dr Latcham has a current consultant

catchment of 68,009, Dr Bermingham 57,945. Patients fall into 3 geographical areas, covered by three patch teams:

1. St Ives/Ramsey.
2. Huntingdon.
3. St Neots.

In 1988, each Consultant was responsible for one patch, and the two Consultants shared responsibility for the Huntingdon patch. Seeing Marie Alawode at the GP's surgery was a fixed, Consultant only clinic conducted by Dr Bermingham. At this clinic, Dr Bermingham would only see new patients, two or three at each clinic.

It is the Panel's view that it is the Consultant Psychiatrist, seeing a new patient, who is best placed to ensure that a patient's psychiatric history is fully known, both to himself and to those who may come after. The Consultant Psychiatrist does not work in isolation, and both Consultant Psychiatrists have stated (in the context of an apparent high workload) that they have excellent team support. It follows that others were available to be instructed to obtain records from any known previous hospital and, indeed, to ensure that a proper summary of relevant information was prepared, upon receipt of those records. This would not add unduly to the Consultant's burden but might add considerably to his knowledge.

Instead, Dr Bermingham's omission sets in train an ever-diminishing understanding of the true sequence of events.

14.2.92 Marie Alawode was referred to Dr Bermingham because of depression. His letter to the General Practitioner confirms his careful analysis of Marie Alawode's mental state at that time. He confirms that there are no psychotic symptoms and that she should not go back on Depot anti-psychotic medication because of her pregnancy, and that the antidepressant Prothiaden should be kept at the lower end of the therapeutic range, in view of her pregnancy. He refers to the Community Psychiatric Nurse, Sue Amode for monitoring. This consultation and plan were examples of good practice.

21.7.92 Stillbirth. Although Dr Bermingham wanted to see her when she was admitted to have her baby, that was not arranged and by 6.10.92 she is discharged from the CPN's caseload.

30.12.92 Dr Bermingham's outpatient review is summarised in his letter to the General Practitioner. The letter indicates that he looked for evidence of psychotic illness and that he advised that it was not necessary, on the evidence so far, that she needed Depot medication but that a small amount of anti-psychotic medication might ease her distress. He gave standard advice based on his experience that mothers are best advised to wait two years before having another child after a stillbirth.

He arranged to review matters with Marie Alawode but she did not attend his follow-up clinic. He wrote to the General Practitioner and advised that he would be happy to see her again on re-referral. This is standard practice.

16.12.94 In the preceding 3 weeks, both the Health Visitor and the CPN were concerned about Marie Alawode's mental state, referring to her as "paranoid" and "depressed". At the domiciliary visit, Dr Bermingham found Marie Alawode to be having a better day. He noted that she had had no psychotic episode since 1984 and that she had coped with a very stressful year in which her brother had been murdered three months previously. She was pregnant at the age of 41, having had a stillbirth two years previously.

He commented that she was on no psychotropic medication and that the CPN would support her and try to avoid medication, as is good practice in pregnancy. He was available to be consulted again should the need arise, and the CPN would continue to monitor. That contact was another example of good practice. In the immediate postnatal period there is only one undated entry by the CPN, and it is left that Marie Alawode will ask the CPN to visit if she wishes. This was a reasonable plan with the history that was available, i.e. one previous psychosis associated with steroids. If there had been a more accurate history, closer monitoring would have been indicated in best practice.

7.5.95 The General Practitioner becomes aware of the alteration in Marie Alawode's mental state and offers anti-psychotic medication and refers her to Dr Bermingham.

10.5.95 Dr Bermingham and the CPN perform a domiciliary visit and find Marie Alawode to be acutely psychotic. He obtained a detailed history that, over the previous month or so, she had begun to act strangely, becoming irritable and had two weeks of frankly psychotic symptoms with auditory hallucinations. He recorded that she had been locking the children in the car and had smashed the fish tank. He gave other details of the psychosis, which is good practice. He made a preliminary diagnosis of an acute puerperal affective psychosis and arranged her admission to Acer Ward, Hinchingbrooke Hospital.

The inpatient notes give good details of her symptoms.

Previous psychiatric records were not obtained, which is below average practice upon a new psychiatric admission. It would have revealed the missing parts of the history that may have altered the diagnosis.

Some of the symptoms on this admission were not mood congruent and are more typically seen in schizophrenia, e.g. thoughts being inserted. This is consistent with affective psychosis and acute transient psychoses.

31.5.95 Discharge from Acer Ward.

The psychosis settled rapidly with appropriate treatment and she was discharged on oral medication, with the plan for the CPN to visit to monitor her mental state, aware that Marie Alawode could deteriorate rapidly.

26.7.95 The CPN notes her fears and negative thoughts, e.g. "I might kill someone with a knife". It was noted that she was having some difficulty with sedation on the oral medication. The outpatient review by the SHO noted that she would take Chlorpromazine intermittently, if she was feeling irritable with unpleasant thoughts. Dr Bermingham advised Modecate which was started with a test dose of 12.5mg on 27.12.95, to be followed with a dose of 25mg a week later, and monthly after that. It was noted that she had remained well on Depot medication for seven or eight years after her previous psychotic episode and it was hoped she would do well on this occasion. She was given a three month follow-up appointment in outpatients.

3.1.96 Marie Alawode has not been entirely reliable about attending for Depot injections but, within barely five months, is asking how long she should remain on Depot medication and the Senior Registrar, Dr Walsh is indicating that she will review the matter.

14.2.96 Dr Walsh's letter reflects the lack of accuracy in the Hinchingbrooke Hospital notes.

Dr Walsh advises that the Depot medication can be discontinued, on the basis that Marie Alawode's first psychotic episode was related to steroids and her second episode occurred during the postnatal period at a time of great stress and shortly after the murder of her brother. It was noted that she had one period of approximately one year off medication and during that time had remained well. Dr Walsh carefully explained that, for this reason, a trial off medication was in order, but there was a risk of relapse. She therefore suggesting halving the Modecate dose, and then discontinuation. She noted that Marie Alawode agreed to regular reviews with the CPN and Dr Walsh in outpatients, to detect any signs of relapse.

25.3.96 As it turned out, Marie Alawode felt too nervous about the chance of relapse. Haldol was prescribed, as it has a reputation for causing less weight gain.

16.8.96 Dr Gregory in outpatients advises that, despite reduced Haldol, Marie Alawode continues to feel low. The antidepressant Prozac is initiated and the Haldol dosage further reduced. This treatment plan was appropriate to the symptoms.

25.9.96 Dr Gregory's outpatient clinic consultation highlights the switch to Piportil 25mg and maintaining Prozac 20mg has been associated with an improvement in Marie Alawode's mental state. Dr Gregory suggests an increase in Prozac.

1.10.96 The CPA form notes Dr Latcham as Marie Alawode's new Consultant Psychiatrist. The patient's weight is 22 stone and the diagnosis is puerperal psychosis. This usefully reflects the multi-disciplinary team's view of Marie Alawode's problems.

19.8.97 Dr Dowse's thoroughgoing review, in her letter to the new General Practitioner of 19.8.97 is commendable, albeit responding to the GP's specific request for information. Such a review should be undertaken whenever a patient moves to a new General Practitioner's list. General Practitioners have little time to trawl through a new patient's records when eventually they are received. A succinct summary must be of considerable assistance to the General Practitioner who has to pick up overall responsibility for a new patient's care. The inaccuracy in the history given runs the risk of lowering the General Practitioner's threshold of concern and that of any other professionals new to the patient. There is no reference to the specific stresses mentioned in the October 1995 CPA, but this review refers to more major stresses and certainly warns the General Practitioner that the patient is currently under strain.

Dr Dowse changes the diagnosis to that of schizo-affective disorder. This summary and opinion reflect good practice.

10.9.97 Consultation with Dr Latcham.

Dr Latcham informed the Inquiry that he does not write out entries in the outpatient files. He relies upon his letters to the General Practitioner as a summary of his findings. At this consultation he obtained a detailed history without the benefits of the notes. The history he obtained suggested that steroids had played a large part in her first psychotic episode. He accurately notes that she had had more admissions to psychiatric hospitals than the Hinchingbrooke notes recorded.

He notes that she was last ill when she stopped her Piportil, but that she had also had her second child who was now aged 2½. He also notes that her brother had been murdered and that he had been very important to her.

He found her to have a normal mental state but was concerned over her weight gain, possibly due to Piportil.

He indicates it would probably be better to wean her off the Piportil slowly and to monitor her mental state.

12.9.97 The CPN's entry indicates that she had been discussing Marie Alawode's case with Dr Latcham, and that the antidepressant should start to be reduced, and the Depot medication reviewed. This indicates good liaison between Dr Latcham and the CPN and as an example of good practice.

14.10.97 Dr Latcham writes an outpatient clinic report to the General Practitioner. Dr Latcham indicates that he has reviewed the records but the first paragraph of his letter to the GP suggests that he could not find a copy of his earlier letter. He indicates his understanding that Marie Alawode had had an episode of steroid-induced psychosis and then two episodes of puerperal psychosis which had been severe, but otherwise she had been well. Based on that understanding of the history, his plan to discontinue Piportil is reasonable. He does note that she is living on her own but that is having a positive effect, being away from her husband. He notes her emotional lability but feels that this is appropriate, considering her recent life events. He ensures that the General Practitioner knows that follow-up will continue.

18.11.97 Dr Latcham advises the General Practitioner that Marie Alawode seems very well on reduced Piportil, and he advises discontinuation. He notes that she remains on Prozac 40mg a day. He advises that they will be continuing follow-up by himself and the CPN.

It can be said that best practice would advise that some form of risk assessment should have taken place at this time. With the history available to Dr Latcham, he could have rightly believed that relapse was unlikely, but a full discussion with Marie Alawode about warning signs of her psychosis might have been a useful benchmark. One cannot tell from his notes whether he discussed the risks that might occur if she should relapse, living alone with a three year old child.

It would have been best practice for him to have indicated to the General Practitioner why Marie Alawode did not have a schizo-affective disorder, as advised by Dr Dowse in her outpatient summary. This would not only have helped involve the General Practitioner in the management of his patient, but would also have made a clear statement for the psychiatric file, so that other professionals would have an understanding of the current opinion and advice. It would also ideally point out signs and symptoms to look out for, with regard to early relapse, however unlikely that might be.

9.12.97 The CPN learns of Marie Alawode's concern over possible problems for Joanne on visits to her father. There is advice to reduce Prozac because of dizziness. The records do not indicate whether Dr Latcham was involved in that decision.

23.1.98 Dr Latcham telephoned the Housing Department but did not see Marie Alawode in January, as planned. The CPN had visited on 9.1.98 and found no psychotic symptoms and it is presumed that this would have been shared with Dr Latcham, because of the evidence of previous communication between them, but it is not documented.

26.5.98 The General Practitioner, Dr Turner has stated to the Inquiry that he knew of the Consultant Paediatrician, Dr Becker's reports but he did not know about Marie Alawode's psychiatric history at this time and he did not know about any investigation by the Police and Social Services. There had been no notification to the practice about these things. He would expect Social Services would ask the General Practitioner for a report at some stage, in a child protection context and he would also expect to receive a report about Social Services' conclusions. Dr Turner has expressed his surprise that the Health Visitors attached to the practice did not know already about Joanne's referral to Dr Becker, but the GPs should have informed the Health Visitors in January. In any event, the Health Visitor took it upon herself to contact Social Services and Dr Turner then spoke with Social Services the following day, when Carole Lawrence mentioned Marie Alawode's psychiatric history, which was the first indication given to Dr Turner of such problems. Clearly, Dr Turner had little if any proper information about the background here and appeared quite unaware that, whether or not Joanne was being sexually abused, the allegations were being raised by a mother in whom stress could have a serious adverse effect. He seems to have been working in a passive and detached, not a proactive manner.

12.6.98 Dr Solanki was not interviewed by the Inquiry so it is not known what was the extent of his knowledge of the patient's psychiatric history or what is meant by "problems discussed. Advised." Rightly or wrongly, this doctor did not consider that any further assessment, medication or referral were required.

7.7.98 Dr Latcham reviews Marie Alawode in the outpatient clinic for the first time in eight months, at the request of the CPN. Marie Alawode had expressed fears to the CPN that she was going mad. The CPN had found no evidence of psychosis and Dr Latcham found no obvious signs of psychosis during his interview with her. He advises the Inquiry that he did not ask intrusive questions, as he believed there was no indication for this. The Inquiry considers it advisable to document enquiries about psychotic symptoms in a patient with a history of psychotic episodes, when the patient has raised fears that she is going mad. This general point applies equally to both a Consultant Psychiatrist and a CPN.

Due to the brevity of his letter to the General Practitioner, there are no indicators as to how far he explored Marie Alawode's mental state but, coupled with the CPN's notes and assessment of 3.7.98, there would be sufficient information to see no evidence for psychosis overtly emerging, and therefore no need for medication.

This episode highlights Marie Alawode's ability to contact the CPN and request advice from her psychiatrist when she is in difficulties, which would again encourage Dr Latcham to pursue a "wait and see" approach which he felt was in the patient's best interests, in view of her history of obesity and the danger of side-effects from anti-psychotic medication. Thus, leaving psychiatric support to the CPN, looking for signs of depression and psychosis, with an offer of review in the future if she wanted it, was a good standard of practice.

16.7.98 The CPN discusses with Dr Latcham Marie Alawode's reports of being low and tearful and unable to cope. Marie Alawode was advising her thoughts were not right but could not be specific. Dr Latcham advised antidepressant medication, Prozac. This information is learned from the CPN notes. Dr Latcham did not write to the General Practitioner confirming this advice. Best practice would suggest that a letter be sent to the General Practitioner, to re-start the Prozac.

3.8.98 Marie Alawode could give the Inquiry no account at all of taking Joanne and herself to see the General Practitioner, Dr Turner on this day. She has no recollection of it. Dr Turner's records and evidence suggest that this is a wholly normal consultation, when both mother and daughter consult him about and are treated for minor ailments. He appears still to be unaware of Marie Alawode's psychiatric history.

Among the drugs taken from Marie Alawode's home on 5.8.98 was a bottle containing 15 Amoxycillin tablets, out of 21 dispensed to Marie Alawode on 3.8.98. The indications are that she took these antibiotics as prescribed, six in two days.

The Police Surgeon's immediate post homicide interview, and the Approved Social Worker, Mr Edwards' interviews indicated that Marie Alawode gave a history of hallucinations for several weeks before the tragedy. On admission to Fulbourn Hospital, the Senior House Officer's admission notes on 7.8.98, under perception, say:-

> *"Described having been hearing voices in her head for a few days. Said she heard a voice that was not her own, would not elaborate."*

On 7.8.98, whilst talking to a Staff Nurse, it is reported that Marie Alawode talked to the Primary Nurse stating that she had been hearing voices, these beginning two days prior to the death of Joanne.

In his independent psychiatric report of 24th November 1998, Dr Shubsachs (Consultant Forensic Psychiatrist at Marlborough House to which Mrs Alawode was admitted on 21.8.98) records the patient's account as follows:-

"She said she thought things had begun to pick up without medication but was not sure because her General Practitioner had given her an anti-depressant. In the week or so before the offence she had had gastro-enteritis and had felt really ill. She felt she was on the point of dying. She had called the CPN, Kim Masson, on several occasions. She had told Kim that she felt she was getting ill and was going mad. She claimed Kim had told her that while she was physically ill, she was mentally well and should not think that she was going mad every time she was feeling physically ill.

At that time she had felt drained. She was crying a lot. She thought she was not thinking logically. She telephoned several friends trying to get some comfort. She said she could not remember much else about that period but the next thing she knew she had gone "high". She was hearing voices which she believed were those of angels..... she said the voices were like a thought in her head present all the time. In her evidence to the Inquiry, Marie Alawode

implied that she had not been asked the right questions before Joanne's death. It is accepted that this history may be coloured by hindsight.

A patient's time appreciation in psychosis is notoriously unreliable and the concept of delusional memory is a possibility. Immediately after the tragedy, hindsight started to operate so that, even in her psychotic state, Marie Alawode may have been struggling to really remember what had been happening, and to try and make sense of it.

Marie Alawode does indicate that there are certain things that she did not talk about because she was not asked directly. She was consistent in her view that the way she was questioned regularly about the presence or absence of psychotic symptoms while she has been in the Norvic Clinic seems different to that she previously experienced prior to the killing. For this reason (and others) we have closely questioned the relevant witnesses. But it is not common practice in general psychiatry closely to question patients about psychiatric symptoms when they are overtly well.

At interview, Marie Alawode has no recall of the events a few days before 5.8.98, for example seeing the General Practitioner on 3.8.98, or seeing the Community Psychiatric Nurse on 4.8.98.

1.2 GENERAL OBSERVATIONS

From December 1997, Marie Alawode has been more than usually psychologically stressed by the uncertainties over her daughter Joanne's difficulties on access visits to her father. Inefficient liaison between social services and the health services therefore denied the CPN a broader picture of the stress from which Marie Alawode was suffering which may have reduced the concern of the CPN and in turn of the Consultant. Prozac was initiated to treat her symptoms of depressive disorder. All antidepressants can promote manic mood changes, which might be thought to be more likely with a history of affective puerperal psychosis or schizoaffective disorder. Both these diagnoses have been put forward in the Hinchingbrooke notes. When she had been on antidepressants before, she had anti-psychotic medication which could protect against a manic swing. But in February 1992 she was off anti psychotic medication, pregnant and depressed and required a low dose of the anti-depressant, Prothiaden 75mg at night. She received a prescription for 30 tablets which was not repeated, so it is difficult to know how much she took. She had Prothiaden 50mg at night in February 1994 and there is a repeat prescription in March 1994, again suggesting that she took a low dose anti-depressant for short periods of time whilst off anti psychotics, without any evidence of mania.

The diagnoses in the Hinchingbrooke notes are puerperal affective psychosis (Dr Bermingham) which is revised by the senior registrar, Dr Dowse to schizoaffective disorder and vulnerability to psychosocial stress.

Dr Latcham indicated in his letters that he viewed her as suffering from puerperal psychosis and in his oral and written evidence to the Inquiry he advised that the diagnosis was far from clear, because of the mixture of affective and non-affective psychotic symptoms.

If the Bedford history had been known, would the Hinchingbrooke consultants have come to different conclusions about the diagnosis? Dr Bermingham has advised that he is not sure and Dr Latcham is of the opinion that it is still very difficult to be sure of the diagnosis, before the onset of the psychosis that led to the Inquiry.

The diagnosis is not easy because it is an unusual pattern of illness. The psychoses are characterised by very rapid onset and last less than a month. This would fit a brief recurrent psychosis with schizophrenic and affective symptoms. It could also fit schizoaffective disorder using ICD10 criteria. With the further information about the Bedford history, Dr Latcham consulted with colleagues and found a paper that had been written about brief psychosis in people of Afro/Caribbean descent.

It is possible that the psychotic illnesses in 1983 and 1984 were due to the sensitisation of her brain by the benign intracranial hypertension and treatment with steroids.

There is no definitive advice about the management of such psychosis.

Some psychiatrists would maintain anti-psychotic medication, especially if the patient requested it, but her weight gain was a worry. She had been 20 stone before she started anti-psychotic medication and this had increased to 22 stone, associated with anti-psychotic medication. The is also a risk of tardive dyskinesia by virtue of her sex and, it could be argued, by virtue of her history of benign intracranial hypertension.

Dr Latcham's approach was of a reasonable standard with the history that he obtained and, even if he had the full previous history, his management may have been the same. Monitoring by the community psychiatric nurse, with evidence of Marie Alawode's ability to contact her if she was feeling depressed or anxious, would seem a reasonable management plan.

The CPA form looks for trigger factors and highlighted anxiety with irritability, but there is no documentation of whether Marie Alawode could recognise the onset of psychotic symptoms and be able to tell her community psychiatric nurse about them.

In an established psychotic illness, anxiety and depression caused by meaningful life events often bring about a worsening of symptoms. When somebody is in remission the impact of life events is less predictable. Many psychiatrists would accept that a life event that has a particularly distressing meaning to a patient is more likely to destabilise them if they are off medication. It is not uncommon for psychotic episodes to emerge out of the blue, if the person suffers from a recurrent psychotic disorder and is off treatment e.g. bipolar disorder. There is always a problem of false attribution of previous stress to the onset of psychosis. Marie Alawode had certainly experienced marked stress and strain in her life, when she had been off anti-psychotic medication and not relapsed e.g. around the time of her stillbirth.

Overnight onset of overt psychotic behaviour has not been described in Marie Alawode before.

Marie Alawode became physically ill at the end of July/beginning of August 1998 and she was treated by her General Practitioner with the antibiotic Amoxycillin. Amoxycillin has been described as relating to two psychoses in all the literature. The physical ill health may have contributed to added stress on the nervous system, making her more vulnerable to a mood swing. It is possible that the Prozac may have contributed to the mood swing, but it is not known how much (if any) she took before the illness; she had been exposed to lower doses of anti-depressants before, without suffering psychotic relapse.

With hindsight she reports having hallucinatory experiences a week or two before the tragedy, but it has to be recognised that memory can be distorted by psychotic disorder.

The failure to obtain past psychiatric records, especially on her admission to Hinchingbrooke is below best practice. If the consultants concerned had been aware of the true history, it may have modified their understanding of how to best manage Marie Alawode's psychotic disorder. If it had been diagnosed as schizoaffective disorder, then it might have been decided to maintain anti-psychotic medication for longer, until at least Joanne was older and less vulnerable if her mother relapsed. If it was felt that she was suffering from recurrent brief psychotic episodes, then the management becomes more uncertain and the consultant is left with trying to balance the risks of side effects with the benefits of treatment.

There is a lack of documentation about the risks of relapse, and the need for early detection in a patient with a three year old child. This is below best practice. It leaves the professionals exposed to the criticism that they did not think carefully enough about the impact of the onset of psychosis, however unlikely.

Best practice would suggest that Marie Alawode, the CPN and the consultant should have been involved in a risk assessment, where a thorough discussion of the nature of the onset of her psychosis was worked out. It is possible that she may have been helped to detect early psychotic symptoms and report them. The GP could have also been better informed by this process.

She was subject to the care plan approach and there was regular CPA assessment.

The CPA contains a very good action plan. It is an active tool to ensure that the patient is assessed, cared for and treated as determined at the CPA meeting. It is not to be written and then not fully considered; it is an active piece of information for ongoing reference until the next CPA review. All professionals should relate care back to the CPA, particularly when there are changes in treatment.

Dr Latcham told the Inquiry that he does not think that he is overworked but he also stated that the average catchment for which he and his consultant colleagues is each responsible is about 64,000. On average, there is one general adult psychiatrist per 37,000 population in the country at the moment, but with very wide variations and the Shire Counties especially on average have about one consultant per 45,000. Against this background, the Inquiry is concerned that Dr Latcham does not really have sufficient time to reflect upon cases that are presenting unusually.

There may have been an excessive reliance by Dr Latcham upon the Community Psychiatric Nurse. The Inquiry has to ask, did the CPN, Kim Masson fail to ask the right questions? When interviewed by the Inquiry, Marie Alawode stated that there are some things that she would not volunteer except in answer to direct questioning, for example psychotic ideations. However, this comment is in the setting of hindsight and in the records Marie Alawode has certainly volunteered that she has had troubled thoughts, even if she has not always been able to explain them.

The Inquiry formed the view that the General Practitioners seemed to be very detached from the psychiatric care of Marie Alawode, and similarly detached in relation to the child abuse suspicions. A case conference by the Child and Families Team about the child abuse worries should have been held and could have been a very useful initiative, not least in underlining the psychosocial stress to which Marie Alawode was exposed.

It is a major concern that professionals may not get to know patients effectively enough, whilst there is such little time for face to face contact. Residual psychotic symptoms can be present without interfering with day to day activities and may not be freely admitted.

Considering the well above average catchment area and inevitably high caseload, there has been much good practice in the management of Marie Alawode. Even with a more complete history, the strategy to monitor and respond promptly to Marie Alawode's concerns was a reasonable one.

2. COMMUNITY CARE AND THE CPA

REVIEW OF RECORDS

2.1 CPA RECORDS

31.10.95 This is the first CPA Record prior to discharge from in patient care. The record was completed by a student nurse, under the supervision of the care co-ordinator, Sue Amode. The patient's diagnosis is shown as puerperal affective psychosis. The records are comprehensive and take an holistic overview to the patient's problems, care and treatment. It is stated that Marie Alawode had insight into the fact that she had experienced psychotic episodes and that she now appears bright and cheerful, although she does complain of feeling low a lot of the time. In respect of early warning signs, it is stated that Marie Alawode is usually aware when her mental state begins to deteriorate; the signs include irritability, panic attacks and not being able to cope. There is a statement that baby Joanne looks well looked after. Marie Alawode is discharged on Modecate Depot injections and a review date of six months for the CPA is shown. The CPN intervention is to visit monthly and to monitor Marie Alawode's mental health.

There is no summary sheet available. Overall, it is a good record, although the Inquiry is left with the view that it is largely a single professional rather than a multi-professional review. It is also not clear from the records, what input Marie Alawode had into her assessment and plan of care. It is worthy of note that, according to the nursing notes, Sue Amode had not seen Marie Alawode since 11. 10. 95, although there is a record in the notes of a telephone conversation on 16.10 95. The Inquiry was told by the CPN that there were further visits to those recorded in the nursing notes. While this may be so, the Inquiry would expect all visits to be appropriately recorded in the patient's notes. It is accepted that the practice in 1995/96 may well have since been improved, and that the CPN was clearly committed to the care of her patients.

At this first full CPA, Sue Amode supervised the student nurse who diligently recorded the history (which is now known to be inaccurate) from the records. For example, it is now suggested that she began to exhibit bizarre behaviour two weeks after Joanne's birth, which is incorrect but would tend to substantiate the puerperal psychosis diagnosis. It is at the foot of page two of the 12 pages of the CPA form that the "trigger factors" are set out. These are accurate and prophetic. It says that Marie Alawode knew when she was becoming ill, implying that if she complained of that, she should be taken very seriously. It suggests that she can be relied on to contact her CPN if she gets early warning signs, but the experience in the four months after Joanne's

birth and before her last acute illness should have informed those reviewing the case that the patient could not be relied on to ask for a visit from the CPN, and that the CPN should undertake pro-active monitoring.

?.3.96 This CPA summary is undated although the information it contains does appear to be for this period. The documentation is completed by Sue Amode and she states that Marie Alawode's mental health is stable at the present time, although she is slightly worried about the plan to reduce the Depot medication. It is recorded that she needs to be monitored and reviewed, although no CPA review date is shown. Copies of this summary are ticked to have gone to the patient, care co-ordinator, GP and patch team co-ordinator.

This is a useful summary but it is undated. All the summary forms are said to have been copied to the GPs but it is known that they were not all in the GP's notes. The nursing notes would indicate that the review took place on 25.3.96 and that Marie Alawode was visited at home by the CPN later the same day- A change of medication to Haldol was communicated, and Marie Alawode was said to be pleased. There is no nursing note record of the patient being seen by Sue Amode since 26.2.96. This would again indicate that the patient was not fully involved with the CPA process.

1.10.96 The CPA summary is completed by Sue Amode, the diagnosis again being recorded as puerperal psychosis. Marie Alawode is said to be low in mood, however recently being more energetic and positive, coping better with herself and family needs. The CPN intervention is to monitor mental state and to encourage Marie's strengths i.e., that she is coping with her family needs. Since the last CPA review the medication was changed from Modecate and Haldol to Piportil Depot injections monthly, with Prozac. Mention is made of the Jehovah's Witnesses and the support she receives from them and her family. A copy of the summary is ticked as being sent to the patient (for file), care co-ordinator, GP and patch team co-ordinator. The next CPN review is shown to be in six months time.

Medication had changed since the last review. It would have been helpful for the CPA assessment to have given the rationale behind this decision. If the patient's copy of the review was filed, did Marie Alawode ever have sight of it, and why did she not have a personal copy? This also applies to the remaining reviews. The last recorded home visit by the CPN was on 5.9.96 which again is a long gap between the home assessment and the review.

18.4.97 The CPA summary is completed by Sue Amode. Marie Alawode's mental health state is said to be quite reasonable at present and she is now managing to work part time as a nursing assistant in an old people's home. The CPN intervention plan states that Marie Alawode needs to be regularly monitored and reviewed with home visits and outpatient appointments. She remains compliant with regard to her Depot injections and continues to receive Piportil

and Prozac. Copies of the CPA summary are ticked as being sent to the patient (in file), care co-ordinator, GP and patch team co-ordinator. The date of the next CPN review is shown to be 2.9.97.

There is a statement in the nursing record of 21.3.97. which alludes to the CPA review on 18.3.97, saying Marie Alawode wanted her copy kept in the file. The review record is clearly dated 18 April '97. This is the first mention of the patient not wanting to keep her personal record of the review and no reason is given. It would have been good practice to record why Marie Alawode did not want a personal copy of what in effect, should have been a joint agreement on her support and care.

02.09.97 A new CPN, Grant Marsh with the St Neots team, completed this CPA summary. He states that Marie Alawode has been feeling low due to the recent separation from her husband and work pressures. Marie Alawode also has a new home address. The CPN intervention plan states that Marie Alawode needs to be regularly monitored and offered support by regular home visits and outpatient appointments. Medication is to be reviewed although Marie Alawode is still reported to be receiving Piportil and Prozac. It is noted that Kim Masson, her future CPN will give Marie Alawode her next depot injection. Copies of the CPA summary plan are ticked to have been sent to patient (in file), care co-ordinator, GP and patch team co-ordinator. The date of the next review is said to be in 6 months time.

Marie Alawode was last seen by Sue Amode on 14.8.97 when the change over of CPN was discussed. This is a positive example of involving the patient and explaining why a change in her key worker was necessary.

23.01.98 A full CPA Assessment and summary were completed by Kim Masson. This is a good record that again takes an overview of the patient's needs and the CPN's intervention. Marie Alawode is said to be mentally well and has coped with a lot of stress recently. The CPN intervention plan is to visit every three to four weeks and offer support, advice and practical help. The CPN records that Marie Alawode is now off all medication and feels better for it. The assessment also states that Marie Alawode knows her body well and knows her early warning signs - Jehovah talks to her directly - exaggerated beliefs. Copies of the CPA summary are ticked to have been sent to patient care co-ordinator, GP and patch team co-ordinator. The date of the next CPA review is to be 1.6.98.

This is another mention of Marie Alawode having warning signs, this time with exaggerated beliefs. This is a written assessment with considerable thought behind it, but not covering all the issues. It would have been helpful to include more specific information on the team's views and particularly Dr Latcham's views on the withdrawal of medication and Marie Alawode's concerns and thoughts on this matter. Also Kelly Wilks could have been more

effectively involved in the decision-making process. A shortcoming is the lack of comment or noted consideration in respect of Joanne, as it is known that the CPN and Consultant Psychiatrist were aware of sexual abuse investigations being undertaken by the Police and Social Services. The care of the child and the Social Services' involvement do not appear to have been an issue discussed, although representatives from Social Services were at the CPA review meeting. The CPN could have involved the Health Visitor, as should the GP and Social Services. There is poor communication between the agencies and a failure to take the opportunity, at the CPA review meeting, to consider the full picture. One must also be conscious of the view of the Health Visitor, Fran Stevens, (expressed to the Inquiry) that she might have been able to give Marie Alawode additional support and help. One will, however, never know if this could have been instrumental in detecting the danger that Marie Alawode eventually posed to Joanne and in saving her life. The Health Visitors were rightly concerned by the poor communication from the GPs and Social Services.

21.5.98 CPA summary is completed by Kim Masson. Marie Alawode is said to feel stressed at times but mentally she has remained very well with no psychosis but her confidence remains low. It is recorded that Marie Alawode has had financial problems since moving to St Neots but has had help from the CAB. The CPN intervention plan states that Marie Alawode finds it reassuring in seeing a mental health professional as she has lost a lot of confidence over the years. It is noted it is six months since Marie Alawode stopped all medication and that she remains well. Marie Alawode was reviewed to level one of the Care Programme Approach. There is no indication of the exact nature of future intervention or visits or the need for further review and assessment. Copies of the CPA summary are ticked to have been sent to the patient, care co-ordinator, GP and patch care co-ordinator.

There is a view that Marie Alawode was maintaining good mental health whilst off medication, but is this correct? Given the other problems that she had with money, her physical health and family, including the possible sexual abuse issue, it is questionable whether full regard was taken of the 'overview' and in particular her past mental health history, when reducing the level of CPA, although the Inquiry accepts that Marie Alawode often presented in a confident and good-humoured manner. According to the nursing notes Kim Masson last saw Marie Alawode on 11.5.98. This is again a significant time lapse from the said review date of 1.6.98. We know that, by 9.6.98, Marie Alawode was 'crying' for help, feeling stressed and again worrying about Joanne possibly being sexually abused. It may have been possible for these concerns to have been picked up earlier if she had been seen closer to the CPA review date.

GENERAL COMMENTS

As events turned out, the change in the level of CPA probably had no detrimental effect on her care or CPN visits, indeed she seems to have been visited more frequently. However, it is questionable if CPA assessments were truly Multi- Professional, also more could have been done to effectively involve others, including GP's, Health Visitors and Social Services, as clearly there is a significant lack of input.

The CPA should be reviewed when circumstances make this necessary, not only as a routine.

Full consideration seems not to have been given to a number of major life stressing events and their relationship, or possible effect on Marie Alawode's mental health. In this respect Multi Professional risk assessment was not apparent from the records and even if the Worthing risk assessment tool had been used (now introduced by Hinchingbrooke), it is hardly likely to have identified Marie Alawode as anything other than low risk. There is no convincing evidence of planned and effective involvement and agreement of the patient in her plan of care, which should have included, where possible, the patient's attendance at CPA reviews. This could have been compounded by the Care Co-ordinator, in this case the CPN, not seeing the patient for some considerable time prior to the completion of the review documentation and CPA review meetings. However, the Inquiry has heard from the CPN that she did not always record her visits in the nursing notes. This should not have been the case. The Inquiry acknowledges the pressure under which CPNs can work and accepts that further support to that recorded in the notes was probably given to Marie Alawode.

Family involvement is also significantly absent, and in particular Kelly Wilks' views should have been given more weight, given her insight into her mother's psychotic episodes, physical health, financial and family problems. Crucially how Marie Alawode's mental heath may have detrimentally impacted on Joanne and her safety does not appear to have been fully reviewed in the CPA process, nor were the sexual abuse issues adequately recorded as being considered in the CPA review.

The subsequent nursing notes do not always relate to the CPA plan of care, however on the whole they do demonstrate a significant record of CPN involvement and a clear commitment to develop a good relationship with the patient. It is noted that the Consultant Psychiatrist did not make notes relating to Marie Alawode's community care, especially in relation to the CPA. Likewise there is little evidence of the Social Services, GP's or indeed other members of the Primary Care Team's active involvement in the CPA action plan. This would have been particularly helpful in the development of the full picture. GPs and Social Services had valuable information and the Health Visitor who could (and given Marie Alawode's worries) should have had a direct supporting and monitoring role, was excluded from the process.

POLICY AND DOCUMENTATION ISSUES

A commitment to good communication and to professional, patient and family involvement are crucial to the Care Programme Approach. Unfortunately these were sometimes lacking in the care of Marie Alawode. CPA documentation needs to do the job it is designed for and of course be user friendly. It is not clear that all those concerned with the CPA in Huntingdon are committed to the current lengthy "forms". The Inquiry is not sure that those who should receive review documentation get it, and what the process is to ensure its timely distribution. The latest Hinchingbrooke policy states "the philosophy underpinning the CPA is that care is planned in partnership with people who use the service and their carers" and that "patients and their carers should be involved in their care plan and can ask for a review themselves". The 1994 policy was not as specific as this, although it does clearly make the point about patient involvement in the development of their care. From the evidence received, it is not clear what information patients and carers receive about the CPA and their rights. Some Mental Health Services ensure the patients' understanding and agreement of their programme of care, by asking them to sign the review and assessment documentation, which is also signed by the Care Co-ordinator and other appropriate members of the Community Mental Health Team. The Inquiry considers that this is good practice, as it ensures the active involvement of the patient and provides an opportunity to test understanding from both the professionals and patients perspective.

Both the Hinchingbrooke CPA policies (1994 and 1998) state the need for joint working with Social Services. Indeed this was one of the main thrusts behind the jointly released Health Dept and Social Service circulars HC(90)23 and LASSL(90)11. The policy issued by Hinchingbrooke Health Care NHS Trust generally meets the requirements of government circulars and directives including HSG(94)5. The two tiers or levels of care are typical of many other policies.

Further thought could be given to defining the factors that determine the level of CPA, and what support the patient can expect.

As previously stated the CPA policy is issued by Hinchingbrooke Health Care NHS Trust and to this extent it is not a jointly signed policy between the Trust and Social Services. The Inquiry has been told however, that the policy is available in Social Service offices, although the Inquiry did hear evidence from non-mental health social workers that they were not familiar with CPA issues. There is a joint protocol on CPA care management that has been adopted by three local Trusts, the Health Authority and Cambridgeshire Social Services. From the information received, this protocol was first introduced on 23.10.97 with subsequent amendments, the most recent being 6.8.98. The protocol quite rightly places emphasis on joint agency planning and working, individual risk assessment and joint training. The protocol states "clients will be fully involved in their assessment and in developing and delivering their care plan."

A number of NHS Trusts and Social Service Departments also have joint CPA and Supervision Register Policies, which the Inquiry recognises to be good practice, as it clearly commits both agencies to the policy rather than an overall protocol which can lend itself to different interpretations and emphasis.

2.2 NURSING RECORDS

The first nursing records available refer to Marie Alawode's admission to Ward 3 of Bedford General Hospital and relate to her admissions in 1983/84. It is documented on her first admission that she was stripping off in church, exhibiting bizarre behaviour and expressing religious delusions, stating "you are the devil". On her second admission she is described as being paranoid against her family and being restless and agitated. It is noted that her children were taken into care by social services.

The next available in-patient mental health nursing notes are from her admission to Acer Ward at Hinchingbrooke Hospital on 10.9.95. She is noted to be verbally aggressive when approached by staff and is stated to have said "if you touch me I will kill you", "don't come near me", "God will sort you all out, you're all bad". There is a competent admission assessment completed by the ward nurse, stating "Delusional thoughts feels that the world will end today, talking to Jehovah over the past week". It is also identified that she had been drinking Southern Comfort in the period prior to admission. There is a fairly well developed care plan with clearly identified problems and action to be taken.

It is noteworthy that her later CPN, Kim Masson, was working as a nurse on Acer Ward at this time and recalls this admission.

Again there is comment about religious delusional thoughts for a week prior to acute admission. Marie Alawode had also been drinking prior to the death of Joanne.

CPN Nursing Notes (Hinchingbrooke)

13.03.92 Initial assessment interview carried out by Sue Amode. This follows a referral from Dr Bermingham the previous month. A family history is taken and Marie Alawode is said to be feeling a lot better and is reported to have stated " the Prothiaden has helped me". It is left that Marie Alawode will contact the CPN if she needs further help. It is noted that her baby is due in June and that the CPN would see her again in April.

There is no nursing action plan recorded and no further record of contact in April, the next recorded contact being 2.9.92. However, there is a visit on 26.8.92 when Marie Alawode was not at home.

26.8.92 Sue Amode visits Marie Alawode to find she has moved house. She visits the new address and was met by her daughter and is informed that Marie

Alawode's pregnancy had resulted in a stillbirth. It is noted that Sue Amode discusses this issue with Dr Bermingham and it appears that he was unaware that her baby was stillborn. Dr Bermingham had intended to see her when she was admitted to the Maternity Unit, but did not do so.

There is an obvious breakdown in communication between health professionals resulting in relevant information not being shared that could have had a significant bearing on Marie Alawode's condition. There is no explanation in the records as to why Marie Alawode was not visited between March and August. The Inquiry has learned that the CPN was off sick during this period, and it was the responsibility of her manager to ensure cover in her absence.

2.9.92 Re-assessment following stillbirth: no apparent signs of psychosis. Marie Alawode is concerned about her pregnancy and delivery, and angry towards the medical staff.

3.9.92 Sue Amode discusses Marie Alawode's concerns with her manager, Tim Bryson.

6.10.92 Marie Alawode is discussed at the Huntingdon Patch meeting, and discharged by her CPN. Dr Bermingham is informed.

No recorded assessment or reasons for discharge are given.

13.12.94 Marie Alawode is re-referred by Lesley Popple, the Health Visitor, the patient noted to be tearful and depressed and again pregnant, worried about having another stillbirth.

Sue Amode acted quickly in arranging a home visit with Dr Bermingham.

16.12.94 Home visit carried out with Dr Bermingham, Marie Alawode is said to be calmer. The identified nursing action plan is to visit until the birth of the baby and Marie Alawode is to get in touch sooner if required.

13.1.95 An unsuccessful home visit is recorded, followed by an undated entry stating that since the above visit, the CPN has visited Marie Alawode following the birth of a baby daughter, and notes her to be coping well.

The CPN visits seem somewhat unplanned and do not appear to offer the support previously identified as being offered.

19.5.95 Marie Alawode is said to be more insightful and recognises she has been ill. (She appears to have been seen by the CPN on Acer Ward during the admission arranged by Dr Bermingham following a domiciliary visit on 10.5.95, upon a diagnosis of puerperal affective psychosis).

It is good practice to see a patient on the ward before discharge.

8.6.95 Upon a follow up home visit after discharge from Acer Ward, Marie Alawode is said to be feeling tired. The nursing plan is for home visits to offer support and to attend the post natal support group.

The CPN, Sue Amode emphasises that regular home visits for support and monitoring of Mrs Alawode's mental state need to be regularly carried out, as Marie can go downhill very quickly. The word "ill" is added as an afterthought. This is, however, a very accurate and important entry which should serve as a reminder to the CPN and any others who might come after her. This is a model and relevant note for future reference in the care of Marie Alawode.

26.7.95 The comment "I might kill someone with knife" is recorded verbatim by Sue Amode. Even with hindsight, it is difficult to attribute too much to such a comment, occurring as it does some three years before the killing. However, she threatened to kill nursing staff when admitted to Acer Ward and now, two months later, makes this comment. There is no evidence that this was specifically explored with the patient, how it was explored and what she may have said. It is worthy of note that Marie Alawode was sufficiently concerned by her own mental state to request depot medication, which was begun the very next day. She is said to be having flashbacks to her thoughts prior to admission.

Although Sue Amode states that she will discuss the patient with the doctor, there is no record as to the outcome of this conversation or what was conveyed to Marie Alawode.

1.8.95 It is noted that the patient is on Modecate and that baby Joanne appears well.

29.8.95 The CPN calls to give a Depot injection, to discover Marie Alawode is on holiday.

2.10.95 Marie Alawode attends the Outpatient Clinic and Modecate is given. It is stated that the Elders from the Jehovah's Witnesses are helping Marie and her husband and are giving their support.

5.10.95 There is reference to the CPA and for Sue Amode to be Care Co-ordinator.

16.10.95 Sue Amode telephones Marie Alawode regarding a questionnaire and Marie feels that some of the questions were nosy.

Presumably the questionnaire relates to the CPA assessment but this is not clear.

28.11.95 Marie Alawode appears rather low and has moved to a new address.

29.1.96 Marie Alawode still feels depressed, and her relationship with her husband is said to be improving. She is complaining of weight gain attributed to her medication, but she would rather be fat and be well.

27.2.96 Medication is reviewed and Marie Alawode is anxious as to whether she might have a breakdown.

12.3.96 The patient is not in.

25.3.96 The case is discussed with Dr Bermingham following CPA review, and he prescribes Haldol. Marie Alawode is said to be pleased with this change of medication.

4.4.96 Marie Alawode is again worried about weight gain.

3.5.96 Marie Alawode complains of being very tired and feeling depressed at times, and having communication problems with her husband. It is noted that Marie Alawode has missed two appointments with the doctor.

3.6.96 Marie Alawode is still complaining of feeling sleepy on her present medication. There is a letter to Dr Gregory, who suggests that Piportil may be re-introduced. The CPN records in the letter that "She also spoke re her young daughter Joanne approx. 2 yrs, that she sometimes resents her daughter for being around and that she can't do as much as she used to."

This is an informative letter, not mentioned in the internal inquiry. It is unclear how seriously the thoughts about her daughter were taken.

31.7.96 A different CPN sees Marie Alawode and has a discussion over her feeling sleepy and the effects of Haldol.

5.9.96 Marie Alawode is feeling depressed, but managing to look after Joanne; her husband feels he is doing his best. She is taking Prozac.

This is a good example of the CPN exploring the family dynamics in relation to the care of her patient.

3.10.96 Marie Alawode's mood is slightly better, she is preparing for her daughter's wedding and a visit to America.

30.10.96 On Piportil, Marie Alawode reports that she does not have enough energy, and is feeling tired and trapped.

There is a well thought out assessment and intervention plan by the CPN.

?.1.96 Marie Alawode is planning the trip to the USA, and is still low at times.

31.12.96 Marie Alawode has returned from the USA, she reports an unhappy marriage, her husband calls her a 'fat cow'. She feels that it is affecting her mental state.

28.1.97 Marie Alawode seems happier, she now has a part time job.

25.2.97 The patient is not in.

26.2.97 Marie Alawode is feeling well and stable. A note is made re family tension with her husband present.

21.3.97 A note on the Care Programme Review asks for the form to be kept on file.

It may be that Marie Alawode did not want the form on file because she did not want her husband to see it. No reason was given or apparently sought.

21.5.97 Marie Alawode returns from a family holiday in Turkey and is cheerful.

There is a two months' gap in the records; it may be that some contacts were not recorded.

18.6.97 Upon re-assessment, financial and marital difficulties are discussed and Marie Alawode asks the CPN for a Prozac prescription.

20.6.97 Upon an urgent appointment, Marie Alawode says that she has had enough of her husband, can't stand the abuse, and thinks that she may end up in hospital again. The action plan is for support visits and counselling, CAB and legal advice, to be discussed with Dr Dowse on 26.6.97.

Positive action is taken by the CPN at a time of crisis, and Dr Dowse is seen.

27.6.97 An urgent visit is made following a request from Marie Alawode the previous day, when she was feeling stressed, with possible thoughts of suicide. The plan of action is talked through. Problems revolving around the marriage and financial difficulties are discussed.

This is again a good example of a thoughtful and helpful response by the CPN.

15.7.97 The CPN is told that Marie Alawode has left her husband, for a new address in St Neots.

14.8.97 A change of CPN is planned, Marie Alawode is informed, having moved to St Neots. She is finding it difficult to cope.

This is sound planning for hand-over, with appropriate patient involvement.

Although Kelly Wilks has said to the Inquiry that it would have been better if there had not been a change of CPN, this was inevitable due to Marie Alawode's move from Huntingdon to St Neots and we consider that the arrangements for the handover of care were properly undertaken, with a CPA review shortly afterwards. Kelly Wilks also spoke of her observation of the good interaction between her mother and the new CPN, Kim Masson.

2.9.97 Sue Amode transfers responsibility for Marie Alawode's care to Grant Marsh.

11.9.97 Marie Alawode gives the CPN a brief history of her daughter Joanne. She seems more settled but continues to have money worries and is referred to Barbara Wood, Social Services Department for help.

This is an example of the CPN considering the welfare of Joanne.

12.9.97 Depot injection is given.

9.10.97 Marie Alawode explains how stressful she is finding life at present. She has seen Barbara Wood and tells Kim Masson, CPN that her mood fluctuates and that she is sometimes bubbly and sometimes tearful.

There is no explanation in the nursing notes as to why depot injections are discontinued, but it is known that she had been seen in the Out-patient Clinic at Shortsands Day Centre on 14.10.97, when the decision was taken to halve her Piportil. There is uncertainty about how well she was, given the comments in Kim Mason's nursing notes of 9.10.97?

Marie Alawode is demonstrating a number of trigger factors. The new involvement of Social Services could fall into that category but does not appear to be explored with her.

18.11.97 Marie Alawode is seen by Dr Latcham and Kim Masson. Depot injections have been discontinued. The plan is to continue visits, to monitor her mental state and offer support.

9.12.97 Kim Masson telephones Marie Alawode, who has cut down her Prozac as she is feeling dizzy. Reference is made to Joanne complaining of a sore bottom and there is a query of sexual abuse by her ex-husband following Joanne staying with him. It is noted that Kim Masson will see Marie Alawode on Thursday.

The next nursing note is 8.1.98 with no reference to the Thursday meeting having taken place. It is of concern that there is a gap of a month in the patient being seen by the CPN, given the seriousness of her concerns and her obvious high levels of stress. There is no mention of Health Visitors or Social Services being contacted.

9.1.98 It is noted that Marie Alawode appears well and seems relaxed and appropriately chatty. She still has financial problems. It is noted that Joanne is still complaining of her bottom hurting, following a visit to her father. It is recorded that Marie Alawode has contacted her GP and is seeing Social Services. Kim Masson is helpful in supporting her application for a Council tenancy.

This is the first home visit and direct assessment of the patient since discontinuing depot medication. The CPN records "no psychotic symptoms" but she does not record, nor could she tell the Inquiry, how she reached this conclusion. It is noted that stressors continue. Dr Latcham had stated his intention to see Marie Alawode in January, but no step is taken to arrange that.

There is no note of the CPN making direct contact with Social Services, the Health visitor or the GP regarding the child abuse concerns.

23.1.98 There is a note of CPA being completed. Marie Alawode is still feeling stressed and has financial worries.

23.1.98 A CPA review, there is no real indication what other professionals were involved in drawing up this review, other than the CPN. Monitoring the patient is to continue "at least four weekly".

2.3.98 Marie Alawode appears well, although she remains stressed. She has now got small jobs as a cleaner and dinner lady. The Council is unwilling to help with a tenancy at present.

This is the first recorded CPN home visit in over five weeks. Despite obvious stressors, the CPN notes that Marie Alawode "appears well".

23.4.98 There is an unsuccessful home visit although her daughter is in. It is noted that Kim Masson will see Marie Alawode the next week.

This home visit is seven weeks after the last. The patient is not present but her absence is explained by employment. The CPN relies upon the daughter's assessment that her mother is "doing well". The Inquiry has been told that Marie Alawode was at times reluctant to make appointments for visits by the CPN.

There is no note of her being seen the following week as intended.

11.5.98 Marie Alawode appears well and chatty, and her behaviour is said to be appropriate. She is said to be enjoying the work and is now near the top of the Council waiting list. It is noted that her care plan has been reviewed.

This is the first recorded time Marie Alawode is seen by the CPN in about ten weeks. The CPN does not record what areas she explored with the patient in determining "appropriate in behaviour and content of speech".

21.5.98 A CPA summary is completed by the CPN.

1.6.98 It is noted that the Patch Team meeting for the CPA review has taken place and that Marie Alawode is now on Level 1 of the CPA.

There is no record of what continuing intervention and support Marie Alawode was expecting from the mental health services following the revision of the level of CPA support.

5.6.98 Marie Alawode was seen by the Nurse Practitioner at Cedar House Surgery who dealt with complaints of giddiness and irritability and who rightly made it clear that, if matters did not improve, the patient should be seen by the GP.

9.6.98 It is noted that Kim Masson has received a telephone call from Marie Alawode, that she is still feeling stressed and tearful at times. The CPN undertakes to contact the GP and Social Services regarding concerns over money and Joanne. It is noted that Joanne is still complaining of a sore bottom following visits to her father. Marie Alawode is also upset about her son leaving the Jehovah's Witnesses.

Again there is no mention of contact with the health visitor or reviewing and re-assessing Marie Alawode in relation to the CPA.

The CPN has contact with Marie Alawode, but apparently only by telephone. There is a clear account of stressors and their effect. This is the first contact with the CPN in four weeks, but there is no home visit recorded.

1.7.98 Unsuccessful visit. Marie Alawode is not at home when the CPN visits.

3.7.98 Marie Alawode telephones Kim Masson because she is feeling stressed, tearful and not coping. A number of stressors are identified - her ex-husband has been bringing his friend around despite her asking him not to. It is noted that Social Services have suggested to Marie Alawode that she stops Joanne visiting him for 1 month to see if she stops complaining about her bottom hurting. Sleep difficulties are noted, she is feeling more tearful, with problems of self-confidence because she says her husband tells people in the brotherhood (Jehovah's Witnesses) that she is off her head and mad. The CPN notes no sign of psychosis.

This is a CPN home visit in response to a telephone call – it is not clear when otherwise a home visit would have been made. It is the first recorded home visit in seven weeks. Significantly, the CPN makes a full entry of areas discussed with Marie Alawode, except that she does not record (and could not tell the Inquiry) precisely what questions she would have asked in order to determine that there were no signs of psychosis and that content of speech and affect were satisfactory. In particular, there was no recorded indication that the CPN asked Marie Alawode directly, if she was hearing voices, although the CPN has stated to the Inquiry that she did ask direct questions about auditory hallucinations.

While there is a record of a re-assessment undertaken by Kim Masson, again there is no mention of the CPN contacting other health professionals regarding the concerns about Joanne. This would have been an opportunity to again review Marie Alawode in relation to the care programme approach. It is arranged for her to see Dr Latcham.

15.7.98 Marie Alawode contacts the CPN by telephone, saying that her thoughts are not right, but she could not be specific. She reports problems with sleep and money, and thinks she may have to get an order to keep her husband away.

Twelve days after seeing Marie Alawode so ill that an appointment was arranged with Dr Latcham, and eight days after being seen by Dr Latcham, the CPN appears to deal by telephone with the patient, who seems to be exhibiting exactly the same symptoms as before. The CPN does not record, and could not explain to the Inquiry, how she endeavoured to explore what the patient was thinking. The CPN offers to discuss matters with Dr Latcham. She has indicated her belief that she also visited, but there is no record.

Given that there is previous evidence of thought disturbance and religious delusions, prior to a more florid psychotic presentation becoming evident, this may have been a sign that was missed. There is concern as to how adequately one could assess a patient from comments made over the telephone.

16.7.98 As promised, the CPN does discuss matters with Dr Latcham and it is his advice that Marie Alawode should recommence Prozac. The CPN does not see Marie Alawode but tells her on the telephone of Dr Latcham's decision to recommence Prozac and the patient is glad. However, as Dr Turner has made clear to the Inquiry, the prescription for Prozac issued and signed on 16.7.98 was in fact never collected and it remains in the GP's possession, being found in the repeat prescription file uncollected, after Joanne's death.

It is worthy of note that, among drugs taken from Marie Alawode's home at the time of Joanne's killing was a carton of Prozac containing 26 capsules (out of 30) dispensed to her on 24.11.97. That is presumed to have been a repeat prescription following Dr Latcham's out patient advice and before the Prozac had been discontinued.

21.7.98 Marie Alawode telephones Kim Masson, to report that she feels hot and cold and is shivering. She is expressing concern about Joanne. A home visit is made, she is in bed, her mental state is said to be fine, although she is tearful. Finance and housing worries are getting her down. The patient's tearfulness and low mood are largely attributed to her physical symptoms at the time.

22.7.98 In a telephone call, Marie Alawode's daughter states that her mother is still in bed, feeling achy and sick. A GP on the telephone made a diagnosis of gastro-enteritis, and prescribed fluids ++. It is noted that the children and Marie

Alawode are worried that she is becoming mentally ill. Marie Alawode feels low. She and Joanne are staying at the son's home overnight, and the CPN will visit the next day.

Notwithstanding her physical symptoms, both Marie Alawode and her adult children express their worry that she is becoming mentally ill. Kelly Wilks' evidence left the Inquiry in no doubt that she knew well the signs of her mother becoming mentally ill and would report them clearly. These were significant reports.

Particularly in view of what occurred in May 1995, more should have been made of Marie Alawode and her family's concerns about her mental state. It is uncertain how Kim Masson assessed Marie Alawode at this time.

23.7.98 Upon a visit to the son's home, Marie Alawode is sitting in a chair and eating again, is said to feel brighter in mood, and is going to a Jehovah's Witness convention over the weekend if she feels up to it.

This is a follow-up home visit by the CPN. She does not record, and could not explain to the Inquiry, how specifically she concludes that Marie Alawode was "brighter in mood" but, given the level of concern the previous day, this may not have been an in-depth assessment. It appears that the CPN concentrates mostly upon the fact that Marie Alawode's physical symptoms have improved.

4.8.98 There is no record how Marie Alawode's mental state was assessed on this occasion.

This is a CPN home visit 12 days after Marie Alawode was last seen. It it noted that Marie Alawode has a chest infection and is on antibiotics, she is said to be mentally well. Her finances are still in a poor state, however she remains optimistic. The Inquiry is not certain what prompted this visit by the CPN. It is not recorded in the nursing notes, nor could the CPN remember or inform the Inquiry, what specific issues were covered to assess the patient's mental health. However the Inquiry has latterly been informed that she would ask the patient direct questions about auditory hallucinations or other psychotic symptoms (what have been described as intrusive questions).

The Inquiry is of the view that a detailed mental health assessment was probably not undertaken during this visit. The absence of a recorded mental health assessment on this occasion hinders the Inquiry and the CPN in determining what was asked. Marie Alawode has indicated to the Inquiry her belief (which itself may be influenced hindsight) that noone was really asking her how she felt or what was going on in her mind. It is also questionable, how much information about her feelings and thoughts Marie Alawode would voluntarily share with her healthcare professionals. The Inquiry recognises

that the depth or thoroughness of a mental health assessment will often depend on the circumstances. However, it should be remembered that, at the time of this visit, Marie Alawode was very much alone with Joanne.

GENERAL IMPRESSION OF CPN INVOLVEMENT

The CPN notes offer examples of good practice with well thought out assessments and nursing intervention being recorded. Both Sue Amode and Kim Masson seem to have developed a good rapport with Marie Alawode who presented as a likeable, good-humoured woman. There are, however, other examples of the patient not being visited when previously intended, and of poorly recorded assessments.

The Inquiry has heard from both CPNs that they did not always record visits in the nursing notes. Kim Masson makes the point that she often 'dropped by' on the off chance, as it was difficult to make appointments with the patient, partly because she would be at work. On occasions she says that she left notes for the patient. Unfortunately there is no record of these visits, as they were not included in the nursing records, nor was there a course of action to address the difficulties she was encountering in making contact with Marie Alawode.

It would have been helpful and reassuring if the nursing entries had more frequently specifically addressed the patient's problems, nursing intervention and action plan, as identified in the Care Programme Approach documentation. A number of decisions relating to Marie Alawode's care did not have their rationale recorded, nor the patient's and others' involvement in the process. It is often difficult to determine how Mental Health Assessments were made without adequate recording of the issues covered.

It is possible that the CPN and others missed warning signs, particularly in relation to the development of religious thoughts and delusions, prior to a marked psychotic episode. However, this has to be balanced with how the patient presented, and it is known that she was not always as open about her thoughts as those involved in her care may have believed.

The Inquiry is of the opinion that both CPNs formed a good professional working relationship with the patient and this is well demonstrated. This is a view supported by he family members and indeed by Marie Alawode herself. Both nurses impressed the Panel with their clinical knowledge and caring approach.

The Inquiry is impressed by a number of aspects of the nursing care, although by its very nature, it is inevitable that an Inquiry places emphasis on areas of concern where it is identified that things could and should have been done differently.

HEALTH VISITOR ISSUES

Health visitors were aware of Marie Alawode's mental health problems and had liaised with the mental health services on a number of occasions. On 28.11.94 Lesley Popple notes that the patient is very anxious, paranoid and grieving, and refers her to the CPN. There is also a record of Lesley Popple liaising with Acer Ward when Marie was an in-patient (30.5.95).

There was regular HV contact with Marie Alawode and Joanne throughout 1995. After an 18-month check carried out on 19.7.96, the situation becomes somewhat confused in relation to Joanne's records transfer. On 31.7.97, Joanne was taken by her father for her 2½ year check, to his general practice.

There continues to be confusion as to the whereabouts of the notes and the time that appears to lapse before transfer. There are three recorded failed attempts to visit Marie Alawode and Joanne between 1.4.98 and 28.4.98 and it is not known if these visits were planned. On 26.5.98 Marie Alawode and Joanne are eventually seen at the GP surgery in the health visitor's office. This is the first time that the health visitor becomes aware of the sexual abuse allegations. The health visitor takes appropriate action, contacting the social worker and speaking to the GP. On 1.6.98 there is further discussion with the GP and Anne Allen.

There appears to be poor communication within the Primary Health Care Team. It is unacceptable that the Health Visitor was not made aware of the possible sexual abuse issues. It is also of concern that there is confusion over the transfer of the child's health records and that the Health Visitor made a number of failed visits, perhaps because no appointment had been made.

2.3 COMMUNITY PSYCHIATRIC NURSE STAFFING ISSUES

Evidence was heard from Community Psychiatric Nurses about their way of working and the arrangements for patient referrals within the Community Mental Health Teams. We were told that the average active case load for a CPN, attached to the Huntingdon Mental Health Team, was approximately forty five, during 1997 and 1998. Without a full understanding of the complexity of these cases and the work entailed, it is difficult to draw firm conclusions, however this level of caseload does appear to be excessive. Therefore, this to some extent must limit the nurse's active assessment and support of her patients. It is also good clinical and professional advice to limit to a safe and manageable level the number of patients for which an individual CPN has responsibility. This is particularly so when acting as Care Co-ordinator for patients subject to the Care Programme Approach. The Inquiry heard that Clinical Supervision takes place on a regular basis and through this and sound clinical management any professional concerns should be effectively addressed. While recent figures suggest that Kim Masson's catchment has increased, it was noted that two initiatives are said to have been introduced in 1999 to reduce the workload of Community Mental Health Workers, firstly the change to the Huntingdon CMHT boundaries and secondly the establishment of an Intensive Support Team. The Inquiry is unable to say that, if Marie Alawode's CPN had had a lighter caseload, the care and support Marie Alawode received would have been significantly different. However, the planned changes to the Community Health Team workload since January of 1999 are welcome.

2.4 HEALTH VISITOR STAFFING ISSUES.

The Inquiry heard the concerns of Health Visitors in respect of the de-investment programme, and was told that the agreed establishment for the Trust reduced from 22.5 WTE in December 1997 to 15.88 WTE by March 1998. The Inquiry was told that this led to disenchantment and professional concerns about the adequacy of the service provided. Following the loss of Health Visitor establishment at Cedar House Surgery in St Neots, the practice purchased additional Health Visiting from March 1998. There were difficulties in arranging to see Joanne in April 1998, however she was eventually seen in the latter part of May 1998. It is known that it was in May 1998 that the Health Visitor found out about Marie Alawode's concerns regarding the possible sexual abuse of Joanne, first voiced in December 1997. It is not clear if staff changes or 'shortage' of Health Visiting input at Cedar House was a contributory factor to the fact that the Health Visitors were not informed of the concerns in December 1997. For whatever reason, the fact is that the Health Visitors were excluded from the active support to the family. The view has been expressed that an additional professional, visiting Marie Alawode's home and involved in the CPA assessments and review, may have raised concerns about the safety of Joanne. The Inquiry does not know if this is true, but the opportunity was not afforded during a significant period of time.

3. CAMBRIDGESHIRE SOCIAL SERVICES DEPARTMENT

3.1 THE RECORDS

The duties carried out by Cambridgeshire Social Services Department (Cambs SSD) for Marie Alawode were in relation to their responsibilities under The National Health Service and Community Care Act 1990, Section 47 - Assessment of needs for community care service: (1) "where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority:-

(a) shall carry out an assessment of his/her needs for those services, and

(b) having regard to the results of that assessment. shall then decide whether his/her needs call for the provision by them of any such services.

1 The first referral of this case to Cambs SSD was on 11.9.97. It was made by Kim Masson, Community Psychiatric Nurse and Care Co-ordinator who was the named Care Programme Approach worker for Marie Alawode. She was employed by Hinchingbrooke Health Care NHS Trust and was a member of The Community Mental Health Team.

2 The referral to Cambs SSD was clear and precise – it described Marie Alawode's psychiatric problems and outlined her financial difficulties, with which Kim Masson was asking the Cambs SSD to assist with.

3 The information given by Kim Masson included details of Marie Alawode's medication and confirmed that she was under the care of Dr. Richard Latcham, Consultant Psychiatrist and was also subject to the CPA.

4 The referral was categorised as Adult Mental Health using the Social Services coding as indicated on referral form SOC 301. It was made directly by Kim Masson to Barbara Wood, Mental Health Day Care Worker, employed by Cambs SSD and a member of the Community Mental Health Team (CMHT) (and therefore a colleague of Kim Masson as part of the inter-disciplinary make up of the CMHT). Although unqualified, Barbara Wood was an experienced worker in Mental Health and worked closely with CPN's and Dr Latcham. She was supervised on a day to day basis by Margaret Fosbrook, a Mental Health Social Worker employed by Cambs SSD, who was also a member of the CMHT.

5 The Cambs SSD file on Marie Alawode confirms that the case was allocated to Barbara Wood, that she began work on the referral on 22.9.97. and did an initial visit to Marie Alawode on 23.9.97, to assess and record her financial circumstances. The record of this visit also shows that Marie Alawode expressed worry over her daughter Kelly, who was expecting a child in four week's time. She also told Barbara Wood that she was on depot medication and Prozac, which had recently been reduced from 60 mgs to 40 mgs per day. Also on 23.9.97, Barbara Wood obtained information and discussed possible services and activities for Marie Alawode and Joanne, with Barbara Muskett, the Family Centre Manager for the St Neots Area and a member of the Children and Families Section of Cambs SSD. Barbara Wood also made an appointment for Marie Alawode to visit the Citizens Advice Bureau on 30.9.97, for advice on her financial difficulties.

6 Barbara Wood next visited Marie Alawode on 8.10.97. and Joanne was also present. The detailed record of this visit by Barbara Wood highlights the stress Marie Alawode was feeling at that time - she mentioned her concern over her son Gareth, who had just returned home after a few days in hospital after being 'beaten up' in Huntingdon. She also talked about her mood changes and gave Barbara Wood permission to share this information with Kim Masson and Dr. Latcham (Marie Alawode was seeing Dr Latcham the next day). Marie Alawode also explained the problems she experienced with her estranged husband and the financial elements of this, as well as his wish to have more access to Joanne which she, Marie Alawode did not want him to have. During this visit, Marie Alawode was tearful and distressed and was struggling to cope with Joanne, who was 'whingy' and demanding her mother's attention. At one point Marie Alawode smacked Joanne's bottom 'not with a lot of force' after which she settled. A further detailed review of Marie Alawode's finances was also carried out. The detailed recording by Barbara Wood gives good insight into the range of stressors present with Marie Alawode at this time:- (a) Her concerns over her son Gareth (b) Her own mood changes (c) Her concerns over her financial negotiations with her estranged husband and his wish to see more of Joanne (d) Her wider financial difficulties and debts.

7 The summarised outcome of this visit by Barbara Wood was for her:

to contact CAB re debt and financial benefits;

to find telephone numbers of local playgroups;

to find out times of activities at Children's Centre.

Further recorded contacts on file on the 8th, 9th, 13th, 14th, and 22nd October, 1997 confirm positive actions and information to other Agencies by Barbara Wood.

8 On 4.11.97 Barbara Wood and Barbara Muskett visited the Alawode household to assess Joanne for playgroup attendance - Joanne was not there as she was in the United States of America with her father. Subject to confirmation of Marie Alawode's financial circumstances, it was agreed that Cambs SSD via Barbara Muskett would

fund Joanne at playgroup for two days per week. Further contacts by Barbara Wood with CAB during early November saw the completion of the work she had been asked to do and she made arrangements to close the case following supervision with Margaret Fosbrook on 18.12.97, having earlier (9.10.97) referred it to the Children and Families Team to assess Joanne's needs. The appropriate closure notifications were undertaken by Barbara Wood.

9 The referral accepted by the Children and Families Team on 9.10.97 was to shift the focus to Joanne by the time of Barbara Muskett's visit with Barbara Wood on 4.11.97. The closure of Marie Alawode's case as an active client meant that nobody from Cambs SSD was visiting her; Barbara Muskett's role as the allocated worker for Joanne was administrative only in approving playgroup funding, although her name continued on file as the active caseworker throughout.

From this point, all subsequent interventions were undertaken by staff of cambs ssd children and families team in accordance with duties upon the local authority under the children act, 1989.

10 Following the cessation of work by Barbara Wood of the Mental Health Team and the acceptance of Joanne's case by the Children and Families team, the next event notified to Cambs SSD was a referral by Dr. Becker, Consultant Paediatrician at Hinchingbrooke Hospital 8.12.97.

11 Prior to looking at Dr Becker's referral it is necessary to review his involvement with Joanne. Dr Mathew Thomas, General Practitioner at Cedar House Surgery, St. Neots, saw Joanne with her mother on 2.12.97. He was concerned over the information supplied by Marie Alawode that "she (Joanne) has complained on returning from her father's custody that her vagina and anus are sore" and also that Marie Alawode was "a little bit worried that some sort of abuse was occurring whilst she (Joanne) was in the care of her husband" and that "her mother says that when she asks if anyone has touched Joanne's vagina and bottom, Joanne mentions her father."

12 Dr Becker saw Joanne in his out patient clinic as an urgent referral on 2.12.97, with her mother and sister Kelly present. Dr Becker's report of that examination dated 10. 12.97 was thorough and within the context of this review of Cambs SSD activities, his relevant remarks were "I explained to Mrs Alawode that although there are no typical signs consistent with sexual abuse that this possibility cannot be excluded and she will have to keep a high degree of vigilance" and then "I also explained mother's right to call Social Services or the Police herself if she is acutely concerned about the safety of her child". Dr Becker again saw Joanne with her mother as an emergency referral on 8.12.97, the day after Joanne had returned from a weekend with her father. Dr Becker's report of his examination is incorporated in his report of 10.12.97. referred to earlier and the following is extracted "At this Joanne was in great discomfort as she felt unable to pass urine. Her mother told me that she had come from the weekend stay with her father on the Sunday night again complaining of soreness in the genital area and that she had not been able to pass urine normally, just producing little spurts. We had to sedate Joanne with Pethidine and catheterise her bladder to give her some relief.

On subsequent examination it was noticed that there was redness in the vaginal area, however no bruising, no tears or other evidence of damage" – "Because of the similar pattern of Joanne's symptoms after her weekend stay with her father, The Child Protection Team were informed with Mrs Alawode's agreement."

13 Dr Becker's referral to Cambs SSD on 8.12.97 was clear and well recorded. Further information was added when the duty Child Care Social Worker spoke to him later in the afternoon. Liaison with the police occurred appropriately and a joint investigation was agreed.

14 The "Arrangements for Dealing with Child Protection in Cambridgeshire" at that time were dated January, 1994, and had been produced by The Cambridgeshire Child Protection Committee, the co-ordinating group for professional agencies established at the request of the Secretary for State for Health in 1974.

The following extracts from the procedures contained in this publication were applicable to this investigation:-

(a) Para 1.4. 1. (part) Section 47(1) of The Children Act, 1989, gives the Local Authority the duty to investigate where they "have reasonable cause to suspect that a child who lives, or is found in their area is suffering, or likely to suffer, significant harm"

(b) Para 2. 1. describes four recognised categories of Child Abuse : NEGLECT - PHYSICAL INJURY - SEXUAL ABUSE and EMOTIONAL ABUSE - each of these categories carries brief descriptive guidance notes.

(c) Para 6. 1. Investigation is the responsibility of Social Services or the NSPCC and the Police.

(d) Para 6.2. (part) "Whenever the case is referred alleging likelihood of significant harm, it must be investigated under Section 47 of the Children Act, 1989."

(e) Para 7.2. (part) "Child Protection Conferences are an essential feature of inter-agency co-operation and the need for a conference should always be identified at an early stage. An initial conference must be held for every child who has been abused, is suspected of having been abused or is likely to be abused under one or more of the four categories of abuse defined in 2.1."

(f) Para 16.1.3 (part) "As stated in the introduction to this booklet, it is essential that when any agency becomes concerned that a child may be at risk that they share their information with other agencies."

Para 16.1.4 goes on to say "all messages and contacts with other persons involved must be recorded accurately giving time, dates, information received and action taken."

(g) Para 33.4. (part) "During the process of investigation the social worker will consult agencies who may have information about the child and family".

(h) Para 35.2.1. "Where there is a suspicion that a child has been sexually abused the social worker must consult their line manager. The Child Protection Co-ordinator will also be consulted. Early liaison with the police will take place to determine when an investigation will take place. There may also be a need for a Strategy Meeting." (See 14.4).

(i) Paras 14.4., 1,2 and 3 describe Strategy Meetings – "the purpose of a strategy meeting is to discuss how best to plan the immediate management of the investigation and to co-ordinate the gathering of necessary information. It is not a substitute for a Child Protection Conference" – "Strategy meetings need to take place rapidly, often the same day. Although a meeting is desirable, contact or discussion on the telephone must take place" – "The following should be involved in the strategy discussion:-

The Social Worker and Practice Manager if possible.

Police Officer.

Appropriate Medical Practitioner.

The professional who initially received the allegation.

The professional making the referral if appropriate."

15 Following the referral from Dr. Becker, appropriate consultation took place between the police and Social Services and the joint investigation was undertaken by Det Con Angus McNeill and Rachel Deakin, Senior Social Work Practitioner. The investigation has to be seen as being under Section 47 of The Children Act, 1989. Marie Alawode and Joanne were seen at their home on 9.12.97 by Rachel Deakin and Angus McNeill. Mr Alawode, accompanied by a Jehovah's Witness Elder was interviewed at Huntingdon Police station by Angus McNeill on 11.12.97. Following these interviews it was decided that no further action was necessary - there is no record of any communication external to their own agencies by the investigating officers, other than an unsuccessful attempt by Rachel Deakin to speak to the GP at Cedar Road Surgery, St. Neots on the 9.12.97 which did not get through, as the telephone answering service was on until 2 p.m. There is no record that this was followed up. Dr Becker, when interviewed stated that he had not received any acknowledgement to his referral from the investigating officers.

16 The Cambs SSD file at this time did not contain adequate assessment of the initial interviews which might have been useful if future referrals occurred. Rachel Deakin's summary of this investigation did not appear on file until 18.3.98.

17 Marie Alawode telephoned Cambs SSD on 22.12.97 for advice whether Joanne should be allowed to stay with her father - she was advised by the Duty Social Worker following consultation with the Team Manager, that it was her decision.

18 It is worthy of note that, as well as the absence of external communication by the investigating officers, the detailed report by Dr Becker sent to the referring GP, Dr. Thomas (which indicated that Dr Becker had referred the case to the Child Protection Team) did not trigger any communication between him and the Child Protection Team.

19 Playgroup fees were paid by Cambs SSD for Joanne for one session per week from 7.1.98. to 3.4.98 (12 sessions). No review of her progress or records relating to attendance exist. At the end of the agreed period, a review of need should have taken place, but did not. It is understood that attendance continued with Marie Alawode paying the fees. It is important to reiterate that Joanne's case remained open at this stage (January 1998), but no active care plan or work was under way. It remained open as an administrative process whilst playgroup fees were being met. This could have led future staff involved to assume that care activity was in place. At the same time it is confirmed that Marie Alawode's case was closed and any future access to Cambs SSD support would be via a new referral to the Duty Social Worker (Child Care Team if it related to Joanne, Adult Mental Health Team if it related to Marie Alawode's needs).

20 Marie Alawode next contacted Cambs SSD on 12.5.98. She expressed the same concerns to the Child Care Duty Social Worker, Carole Lawrence that she had expressed to Dr Thomas, Dr Becker, Rachel Deakin and Angus McNeill in December, 1997, namely that Joanne continued to experience redness and soreness in the genital area following visits to her father. Other problems between Marie Alawode and her husband were also discussed. It was left that Marie Alawode would take Joanne to her GP after her next visit to her father on the following Monday. Carole Lawrence discussed the referral with Colin Peddel, Senior Child Care Practitioner and it was decided that it was not a Child Protection matter but a Child in Need matter. No external communication with other agencies took place at this stage, although both Carole Lawrence and Colin Peddel were aware of the previous Child Protection investigation. No examination of the file was undertaken and there appeared to be no knowledge of Marie Alawode's psychiatric history and the current CPA involving Kim Masson and Dr Latcham, although this information was available on the Cambs SSD file.

Carole Lawrence followed this up by trying to telephone Marie Alawode on 19.5.98 to see if she had taken Joanne for examination by the GP but the number on file was incorrect. Carole Lawrence therefore wrote to Marie Alawode on the same day asking her if this had happened; there is no evidence of a reply from Marie Alawode.

21 On 26.5.98. Fran Stevens, Health Visitor at Cedar Road Surgery telephoned Carole Lawrence advising that Marie Alawode had seen her and Dr Turner, GP at Cedar Road Surgery, that day, expressing fears of Joanne being abused. On 27.5.98, Dr Turner, telephoned Carole Lawrence as well to discuss the matter and advised her that his examination was "not conclusive". Carole Lawrence asked Dr Turner about the possibility of "Munchausen's" (i.e. Munchausen's Syndrome by proxy) but Dr Turner said he did not know Marie Alawode well enough to say. The Cambs SSD decision to take no further action on this episode was confirmed by Jackie Day, Team Manager, who noted on file: "check previous medical assessment of mother on file should any future referrals come in (schizo-affective disorder)" - this note was dated 8.6.98.

22 Marie Alawode again visited Cambs SSD on 23.6.98 and saw Carole Lawrence. Her concerns expressed were as before - that following contact with her father, Joanne's private parts were sore and she cried about it. Marie Alawode also talked about other problems with her husband and received appropriate advice. No advice on the possibility of Sexual Abuse was given, except suspending overnight visits to her father. No internal consultation or referral to Health professionals occurred.

23 On 24.6.98. a note on a contact sheet from Jackie Day, Team Manager addressed to Barbara Muskett asks "Barbara have you noted any changes in Joanne recently?" The reason for this request is unclear; Barbara Muskett had no role in monitoring Joanne's care and the playgroup fees responsibility had ceased early in April, 1998. This had obviously not been picked up due to the absence of a review, which led to Marie Alawode paying for Joanne's attendance.

24 On 2.7.98. Mr Alawode visited Cambs SSD with an Elder from the Jehovah's Witnesses' Church. He saw the Duty Social Worker, Malcolm Stevens (acting in the absence of Carole Lawrence) and expressed concern over the advice being given by Cambs SSD to his wife relating to his contact with his daughter. Malcolm Stevens gave advice to Mr Alawode which was confirmed in a letter to his solicitor from Carole Lawrence on 7.7.98.

25 On 27.7.98 Carole Lawrence wrote to Marie Alawode referring to her previous visits about her concerns for Joanne. The letter pointed out that the case would be closed on 4.8.98 if nothing further was heard from her. This is the last recorded action by Cambs SSD.

3.2 COMMENTARY ON THE RECORDS (SET OUT IN PARAGRAPHS 1 – 25 ABOVE)

Paragraphs 1 - 9.

The interventions carried out by Barbara Wood, the Mental Health Day Care Worker, following the referral by Kim Masson (CPN) on 11.9.97 were prompt and efficient and the required action requested by the referral was completed. Good and appropriate communication between Barbara Wood and Kim Masson was noted and Barbara Wood received regular supervision from Margaret Fosbrook, the Mental Health Social Worker within the CMHT.

However, at the point of the case transfer between the Mental Health Team and Child Care Social Work Team, internal structural and practice issues can be observed. The focus of Cambs SSD attention switched to the child, Joanne, and Marie Alawode's case was closed. The need for Joanne to be assessed for appropriate service was acknowledged. The records of Barbara Wood demonstrate the stress and psychiatric elements in Marie Alawode's life which were an integral part of this. It was assumed that the CPA approach would look after Marie Alawode's needs. The case of Joanne was only open on a notional basis to cover the administrative fact of Cambs SSD paying her playgroup fees. The separation of the assessment of need between mother and child, under the separate arrangements of the NHS and Community Care Act, 1990 and The Children Act, 1989, must be reviewed. In all situations where Cambs SSD (and others) are working with either a Child in Need or at Risk, or a vulnerable adult is subject to concern or risk assessment such as the CPA, a lead agency must be identified. That agency must ensure that all other members of the family or persons within the immediate environment are part of the risk assessment. A mechanism for communication and review must be established between agencies and within the Cambs SSD, where there is a separation of practice and management between Child Care and Adult Care Social Work teams.

The evidence from the files and from the Inquiry's interviews with staff suggests that Social Workers, Senior Practitioners and Team Managers in the Child Care Section had little or no knowledge of the CPA and its operational procedures. This is an immediate training issue requiring attention. Conversely, Social Workers in the CMHT and other Adult Care sectors must have an appropriate level of Child Protection Training.

Paragraphs 10 – 18

The referral of possible Child Sexual Abuse of Joanne was made clearly by Dr Becker.

The initial duty of the Child Protection Team was to respond to the referral under Section 47(1) of The Children Act, 1989.

This investigation was significantly flawed – Marie Alawode and Joanne were interviewed by Angus McNeill and Rachel Deakin and Mr Alawode by Angus McNeill and a "NFA" decision was taken. Crucially:

(a) Contrary to Child Abuse Procedures, an initial case conference was not considered or held;

(b) Contrary to Child Abuse Procedures, no communication was made to share the concerns disclosed in Dr Becker's referral with other agencies. No contact was made with known professionals working with Marie Alawode at the time (Kim Masson and Dr Latcham). There was no noting of the psychiatric history of Marie Alawode already on Joanne's file;

(c) Contrary to Child Abuse Procedures, no strategy meeting was convened;

(d) Dr Becker received no reply to his referral made to the Cambs SSD following the investigation - this is poor practice;

(e) There was no clear assessment on file of the initial investigation until18.3.98, some three months later;

(f) When Dr Becker sent his report of 10.12.97 to Dr Thomas, he stated he had referred the matter to the Child Protection Team - Dr Thomas took no communicative action with them.

The whole area of Joanne Alawode receiving a service is disappointing in practice standard terms. She was never seen by Social Services staff, except when interviewed by Rachel Deakin and Angus McNeill on 9.12.97. She was not present during her own assessment of need (she was in the USA) but should have been, as part of a comprehensive assessment of her needs related to that of her mother's. She was never reviewed nor was any record of her progress maintained.

Paragraphs 20 – 25

The self referrals made by Marie Alawode to Cambs SSD on 12.5.98 and 23.6.98. (when she again expressed concern to Carole Lawrence that Joanne might be being abused) should have been treated with more vigilance toward the possibility of Sexual Abuse.

On 12.5.98, Carole Lawrence did consult with Colin Peddel. This took no account of Marie Alawode's psychiatric history, nor was it noted that on file was information that Marie Alawode was under the CPA and still being seen by Kim Masson and Dr Latcham.

On 23.6.98, Carole Lawrence gave advice but did not consult elsewhere. Minimum practice standards demand that Marie Alawode's concerns should, at the very least, have been discussed by the Social Worker with the GP, Health Visitor or possibly with Dr Becker, as well as with those already working with her e.g. Kim Masson and Dr. Latcham. Cambs SSD staff did not appear to make any connection with the fact that Joanne was attending a playgroup at their own instigation, and that this would have been a good opportunity to observe and monitor her.

It is well recognised in Cambridgeshire's Child Protection Procedures dated 1994 (and those revised and published in April 1998) that a Child Protection Assessment is a process of compiling and evaluating all available and relevant information regarding a child and its family circumstances, to determine the needs of the child and assist in planning and decision-making. Child Protection Investigations are necessarily multi-agency and multi-disciplinary processes. No single agency can adequately assess the needs of a child at risk, based solely upon their own knowledge and skills.

The formal CP investigation in December 1997 and the assessments following Marie Alawode's referrals of 12.5.98 and 23.6.98 failed to meet, on both procedural and practice grounds, the standards and requirements set out in Cambridgeshire's Child Protection Procedures.

There is clearly a strong indication of a lack of Management rigour in ensuring that good practice and adherence to procedures occurred in each CP intervention and assessment. This must be set against the enormous pressure staff and Managers were under, due to departmental restructuring early in 1998, and to changes in personnel.

3.3 OTHER RELATED MATTERS

The practice of having a full time Duty Child Care Worker (as in the case of Carole Lawrence) should be reviewed. Given the pressure on duty workers, often working single-handed, space must be made available to ensure thinking and consultation time and to seek information from existing files and other agencies when needed. Supervision should not be allowed to drift, as happened with Carole Lawrence. It is difficult to fault her Team Manager at this time, Jackie Day who, as well as just having taken up her new post, was carrying out highly pressurised case work due to staffing shortages. It clearly demonstrates the impossible position staff are placed in, when having to take on additional Child Protection work due to resource shortfalls.

Comments on the "Individual Case Report for Social Services on the case of Joanne Alawode" and "The Cambridgeshire Area Child Committee Report (Part 8 Review)"

The Individual Case Report (ICR) provides a detailed review of all Cambs SSD activity. It does, however, contain one serious flaw which is carried into the ACPC Part 8 review. The ICR for Social Services in Para.9.1. comments and accepts that Child Protection Procedures were followed and determined an outcome that Joanne was a Child in Need, not a child at Risk needing to proceed to a Section 47 investigation. The police stated

they were proceeding under Section 47 and the referral from Dr Becker required it to be a Section 47 process.

The Part 8 review at Para.10.2.1 believes it should have been. Therefore the comment in the ICR for Social Services at Para.9.1. that "the team acted in accordance with Child Protection Procedures" cannot be accepted.

Further notes

A feeling remains that all Cambs SSD interventions were rapid and that a need existed to resolve things quickly – which is the antithesis of Child Protection work and its requirement, methodically to obtain and assess all available information.

Ideally, the out of hours referral to the GP deputising service on 5.1.98 by Marie Alawode (expressing concern that her daughter was being sexually abused) ought to have been referred to the CP team.

The chronology of the CPN's involvement with Marie Alawode indicates that Marie Alawode told her CPN on 9.6.98 that Joanne was complaining of vaginal soreness after seeing her father. Kim Masson telephoned Cambs SSD the same day and it was noted in the duty book, but no action followed.

The Inquiry had some difficulty in following the chronology and detail of Cambs SSD's files due to the separation of referral: contact: incident and summary/review solutions.

Particular concern is expressed at the lack of information on file concerning the Child Protection Investigation in December 1997, and it is noted with concern that no detailed information appeared on file relating to this Investigation until 18.3.98.

The Inquiry suggests that both the Health Authority and Cambs SSD should explore the use of Information Technology in relation to case recording, where clients and patients are subject to the involvement of each agency under the Care Programme Approach or Child Protection Procedures. This should enable access to information by each other's staff, subject to strict protocols concerning confidentiality and any requirements within the Data Protection Act.

3.4 THE CONTEXT OF EARLIER ISSUES AND INQUIRIES

The comments and recommendations of this Inquiry which have a specific resonance for Cambs SSD (and others) are very much shaped by its keen awareness of the high level of scrutiny and audit which Cambs SSD has undergone, and which continues, following the death of a child on its Child Protection Register. That led to Cambridgeshire County Council commissioning the Bridge Child Care Development Service in August 1996, to

undertake a Professional Audit of its Social Services Department's activity in relation to the child who died.

Following this, in April 1997, acting upon a request from the Parliamentary Under-Secretary in the Department of Health, the Social Services Inspectorate published the report of its inspection into Child Protection Services in Cambs SSD.

In November 1998 the Social Services Inspectorate undertook a further inspection of Child Protection Services in Cambridgeshire, to evaluate to what extent its recommendations, made in April 1997, had been implemented and whether Cambs SSD now had an effective Child Protection Service in place.

In November 1999, the Social Services Inspectorate undertook a follow-up inspection, to judge that state of progress made on its recommendations the previous November, and it is noted that a further inspection will take place in July 2000.

The Inquiry has scrutinised each of these reports and, from its experience of interviewing Social Workers, Senior Practitioners, Managers and the Director of Social Services, fully acknowledges and concurs with how much progress has been made in practice standards, management, supervision and training. The Inquiry also particularly comments on the high standard, style and clarity of "the Inter-Agency Child Protection Procedures" which were issued in April, 1998.

Notwithstanding the above contextual comments, the Inquiry is bound to make recommendations relating to its findings contained in this report, acknowledging that some may well already have been implemented or are on their way to that status.

Generally, the Inquiry recognises that the agencies involved will be working towards the implementation of the National Service Framework for Mental Health and further guidance on improving the CPA.

G. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

1. Homicide by the mentally ill is a rare event.

2. There was nothing predictable about the death of Joanne.

3. Marie Alawode's relapse into overt psychotic behaviour probably occurred very shortly before Joanne's death, perhaps overnight.

4. Marie Alawode's risk of psychotic relapse off medication was assessed as low, based in part upon the partial history obtained.

5. The full history of previous psychotic episodes and Marie Alawode's circumstances, living alone and with her worries about Joanne, made relapse more of a possibility.

6. The care plan was in place to monitor Marie Alawode when she was off medication, in the belief that emerging symptoms would be reported. This was reasonable practice upon the assessment based upon the partial history.

   The full history may have led to more vigilance about the onset of relapse, but would not have indicated a need for continuing medication. The CPN kept in close contact.

7. Hindsight can give a false perspective. The more detailed the contemporaneous notes, the less hindsight will obscure events. There is a lack of documentation about the risks of discontinuing Depot medication and the effect that a relapse, however unlikely, might have had, considering the social circumstances.

8. Social Services and the General Practitioners were too detached.

9. There were poor internal, inter-professional and inter-agency communications in relation to the CPA and risk assessment.

10. It is not demonstrated that the CPA was used to assess the risk to a young child, particularly in relation to child abuse concerns and a mother who had a long history of psychotic illness.

11. There was inadequate involvement of the patient and family in assessment and in the development, implementation and evaluation of the plan of care.

12. The CPA documentation did not appear to be a "live" multi-professional tool which was used in the continuous assessment and care of the patient.

13. Some Social Services staff were unaware of the CPA policy.

14. Marie Alawode and her family were not directly involved in CPA review meetings.

15. There are examples of excellent nursing practice and contemporaneous record keeping, although this was not consistent throughout the care of Marie Alawode.

16. There are a number of examples of inadequate nursing records, which do not demonstrate the assessment process or reflect upon the agreed plan of care or its implementation. Evaluation of the care plan or nursing interventions is not well demonstrated, particularly with Marie Alawode's and her family's involvement in mind.

17. Examples of ad hoc arrangements for the CPN to visit the patient, just "dropping in", do not reflect best practice.

18. A number of CPN visits to Marie Alawode were not recorded in the nursing notes.

19. There were administrative delays in the transfer of child health records, and a failure to involve the Health Visitor when child abuse concerns were raised by Marie Alawode.

20. The work carried out by the mental health day care worker, Barbara Wood, was prompt, efficient and appropriate.

21. The response to the referral by Dr Becker, Consultant Paediatrician concerning possible sexual abuse of Joanne, was disappointing and there was a failure to adhere properly to Child Protection Procedures.

22. The Child Protection Assessment was incomplete. No reference was made back, after the initial interviews with Joanne, Marie Alawode and Mr Alawode, to Dr Becker. No contact was made with other health care professionals who were involved in Marie Alawode's care and treatment under the CPA – although this information was already available on Social Services records.

23. A proper record of the initial Child Protection Assessment should have been promptly done, but this did not appear on the Social Services file until 18th March 1998, over three months after the event.

24. The further referrals made by Marie Alawode on 12.5.98 and 23.6.98 should have been treated with more vigilance, given the information on file regarding the initial child protection enquiry, and other information which confirmed that she was under the care of the Community Mental Health Team.

25. There was responsibility upon the General Practitioner, as well as the Social Worker, to ascertain the outcome of the Consultant Paediatrician's referral to the Child Protection Team.

    The Child Protection referral was responded to without clarity between the Police and Social Services staff involved. The Police viewed it as a response required by Section 47(1) of the Children Act 1989, and Social Services as a response under Section 17.

26. Social Workers, Senior Practitioners and Team Managers in the Child Care Team had insufficient knowledge of the CPA operating in their district for persons with mental health needs.

RECOMMENDATIONS

1. Medical records relating to previous hospital admissions should always be obtained. Suitably experienced staff should always be available to assist a Consultant Psychiatrist in the obtaining and analysis of earlier hospital and other records, and medical record departments should have responsibility to prompt clinicians to obtain such details.

2. There should be an agreed standard for documentation by clinicians relating to each contact with a patient. In particular, the Inquiry recommends that it is insufficient to rely solely upon clinical correspondence (for example, a letter dictated by a Consultant Psychiatrist to a referring General Practitioner at the conclusion of an outpatient clinic attendance) without benchmark details of mental health and risk assessment performed.

3. Mental health practitioners should develop the risk assessment component of CPA, to include the patient. They should also develop documentation that is readily accessible to the CMHT and General Practitioner. Such development should underline the extra risks to be considered, when children are involved.

4. There need to be more Consultant Psychiatrists and other CMHT members employed, to enable more detailed assessments and documentation to be implemented. It is recognised that Clinical Governance, the National Service Framework for Mental

Health and General Medical Council Revalidation will also drive the necessity for more realistic staffing levels.

5. General Practitioners need to be more involved in the monitoring of patients with mental illness. Practice records of the children of those suffering from mental illness should be suitably marked, to heighten awareness at times of contact.

6. Social Services need to improve effective liaison with Mental Health Services following contacts by people with mental health problems, especially those with young children. This must include the improvement of documentation.

7. Mechanisms should be established to ensure that information is freely shared between all professionals involved in the assessment, care and support of patients subject to the CPA. Specific attention should be given to inter agency communication.

8. The CPA process and documentation offer an excellent opportunity for multi-professional risk assessment and action planning, which should be further developed.

9. The patient should receive a copy of the Summary of Care and, if they choose not to do so, their reasons should be clearly recorded.

10. Further efforts should be made to involve patients and relatives in the CPA. This should include the patient being invited to the CPA review meeting, with family or advocate attendance if they so wish.

11. Consideration should be given to the practicality of a patient jointly signing with the Care Co-ordinator the plan of support and care, following the CPA review.

12. The CPA documentation should clearly demonstrate a multi-professional and multi-agency overview of the assessment and agreed action plan. The patient's and others' input and views should also be clearly recorded.

13. The CPA documentation should be used as an ongoing, multi-professional working tool in the continuing care and assessment of the patient. This provides an opportunity to further develop multi-professional record keeping.

14. Regular joint agency training should be established, to cover not only the CPA policy and its implementation, but also cultural, religious and ethnic issues that may impact on the understanding and care of the patient.

15. The CPA policy should require Social Services to consider each referral against any known information. Relevant information should be shared with the CPA Care Co-ordinator.

16. The CPA policy should be clearly identified as a joint agency document.

17. Attention should be given to ensure that nurses make contemporaneous records. All CPN visits, contacts or attempted contacts should be clearly recorded.

18. Nursing records should clearly demonstrate the assessment process, the patient's reported problems, clinical objectives, plan of nursing intervention and evaluation.

19. Further thought should be given to the planning of CPN contacts, to avoid missing the patient when they are not at home. Ad hoc arrangements should be avoided and, wherever possible, patients should have agreed appointment times.

20. CPNs and Clinical Managers should ensure that clinical supervision is effective, particularly in respect of the care of patients subject to CPA. The role of Care Co-ordinator is stressful and demanding, and consideration should be given to the provision of further support.

21. All Child Protection enquiries must be scrutinised by the Line Manager of each person involved in that investigation, contemporaneously to ensure full compliance with procedures.

22. The Area Child Protection Committee must ensure that a robust and ongoing inter-agency programme of training in all areas of child protection is available to practitioners, managers and administrators. Particular note should be taken of the need for General Practitioners to participate in such training.

23. The Social Services Department should ensure that its practitioners and managers in both its Children and Adult (Mental Health) Sections have training and operational knowledge of each other's risk management areas of work (e.g. Child Protection and CPA procedures) and should have an internal procedure for communication on matters of risk and concern.

24. The Social Services Department should establish a policy on supervision and appraisal for its staff, which contains procedures for regularity, recording content and performance evaluation.

25. All relevant agencies should give immediate consideration to creating a body, based upon the constitutional model of the Area Child Protection Committee, for the at risk mentally ill population, which establishes clear procedures and requirements in identifying risk in mental health patients. This should require the CPA to be more rigorously constructed and owned within an agreed inter- agency framework.

26. In relation to and distinct from the previous recommendation, the Inquiry recommends that each relevant agency should consider the establishment, through joint investment, of a single, overarching information system which holds and manages information currently held in differing systems, relating to Child Protection and the CPA (such a system could also extend to other at risk groups). Criteria, access and protocols should be agreed as soon as possible. The Inquiry recognises the problems contained in such a recommendation but believes that it is no longer sustainable to hold separate and often duplicated information in a variety of systems. These should now be harmonised.