Inquiry into the Treatment and Care of **Damian Witts**

Summary of the report commissioned by

Gloucestershire Health Authority

December 1997

PREFACE

We were commissioned in December 1996 by Gloucestershire Health Authority to undertake this Inquiry.

We presented our full Report to the Health Authority at its meeting 20 October 1997, having followed the Terms of Reference which were specified to us in January 1997 and the Procedure which was subsequently adopted and issued to all witnesses and their representatives.

To our knowledge, no document has been withheld from us by any party. We have closely studied and compared the case records from each agency. We have reviewed the operational policies, procedures and reports provided by the agencies.

We have been impressed by the frank and open manner in which all 22 of the material witnesses have co-operated with the Inquiry and answered our questions or requests for further information. We are particularly indebted to the witnesses from Damian Witts' family and his former girlfriend for the thoughtful and helpful way they responded to the matters raised by the Inquiry.

This summary has since been prepared at the Health Authority's request in order to publish the Inquiry's findings and recommendations more widely. We have been assured that relevant sections of the full text will be disclosed to health service employees and appropriate staff of other agencies on a 'need to know' basis and subject to the rules of confidentiality relating to their work.

Our agreement to the preparation of this summary has been given in the light of current clinical advice that a wider dissemination of the full text would be prejudicial to the health and personal interests of identifiable individuals at the present time.

Richard Lingham

RICHARD LINGHAM
DSS DipMH
Chairman

Julian Candy

JULIAN CANDY
FRCP FRCPsych DPM
Medical Member

December 1997

ACKNOWLEDGEMENTS

We offer our sincere thanks to Mrs Sallie Tiley who has performed her role as Clerk to the Inquiry with diligence and suitable objectivity, but always with good humour.

Mr John Bray of Bray and Dilks Solicitors has been most wise and helpful in his legal advice to the Inquiry and in his scrutiny of our report at draft stage.

Ms June Martin and Mr Ivan Trussler of Harry Counsell and Company provided a most thorough and efficient transcription service.

Mrs Marie Rowe of Word Up DTP has shown tireless commitment in word-processing our report and in its preparation for publication.

In particular we record our thanks to the witnesses of fact for being so forthcoming in the presentation of written and verbal evidence.

Similarly we are indebted to our expert witnesses Professor Pamela Taylor and Professor Charles Brooker for their independent perspectives on a range of complex issues.

CONTENTS

SECTION 1

INTRODUCTION

1.1. COURT PROCEEDINGS

1.1.1. At Bristol Crown Court on 18 March 1996, Damian Witts pleaded not guilty to murder but guilty to the manslaughter of his brother at Cinderford, Gloucestershire on 26 September 1995. He had been charged on 27 September 1995 with the murder of his brother and remanded to Her Majesty's Prison (HMP) Gloucester.

1.1.2. Whilst on remand at HMP Gloucester he was seen by two Consultant Forensic Psychiatrists on the staff of the Fromeside Clinic, the Regional Secure Unit (RSU) at Bristol operated by Frenchay Healthcare NHS Trust. Their reports and recommendations, which were considered by Bristol Crown Court on 18 March 1996, both concluded that Damian Witts was not then detainable under the Mental Health Act 1983.

1.1.3. The prosecution having indicated that Damian Witts' plea was not acceptable, the Judge, Mr. Justice Smedley, adjourned the case to a date to be determined for trial. On 5 June 1996 he further adjourned the case for Damian Witts to be assessed by Fromeside RSU and he then also decided to reserve the sentence to himself.

1.1.4. Mr Witts reappeared in the Central Criminal Court on 30 July 1996 for sentence. In the light of revised psychiatric recommendations, he was made subject to a hospital order under Section 37 of the Mental Health Act 1983 with a Restriction Order under Section 41 to be treated at Fromeside Clinic. He was transferred to the clinic on 27 August 1996 and has remained there since.

1.2. INTERNAL REVIEW

1.2.2. A Preliminary Review of the Care of Damian Witts was completed by Severn NHS Trust in October 1995. This action was in accordance with the requirements of HSG (94)27, which had been issued by the NHS Executive in May 1994. The Inquiry has seen the text of that Review and interviewed the Senior Manager who completed it.

1.3. EXTERNAL INDEPENDENT INQUIRY

1.3.1. Following Damian Witts' transfer to Fromeside in August 1996, Gloucestershire Health Authority, as purchaser of his treatment and care, commenced the drafting of Terms of Reference for a formal Independent Inquiry.

1.3.2. The Chairman, Medical Member and Clerk were commissioned in December 1996 and in January 1997 the Inquiry's Terms of Reference were accepted. In February 1997 a public announcement about the Inquiry was made by the Health Authority. The Inquiry Team fully examined all of the relevant medical and other personal records in February and March and received the written and verbal evidence of witnesses between April and June 1997.

1.3.3. The Inquiry Team presented their full report to Gloucestershire Health Authority on 20 October 1997. In view of the very personal and sensitive nature of the details contained in the Report about Damian Witts and his family, the Health Authority proposed and the Inquiry Team agreed that only the Summary of Findings and Recommendations from the Report should be made available publicly.

1.3.4. It should be noted however, that sections 4, 5 and 6 of this Summary reproduce in their entirety the chapters of the full report which cover the Inquiry's findings and recommendations.

SECTION 2

THE ORGANISATION AND PLANNING OF SERVICES

2.1. GLOUCESTERSHIRE HEALTH AUTHORITY

2.1.1. Gloucestershire Health Authority is the purchaser of the services provided by Severn NHS Trust which gave treatment and care to Damian Witts. In common with NHS practice nationally, the specifications for the mental health services to be provided by the Trust in the financial year 1995/96 were contained in the contract drawn up by the Health Authority in consultation with the Trust in the second half of the preceding year.

2.1.2. The importance of risk assessment had been highlighted in NHS Executive circular HSG(94)27, issued in May 1994 to all Health Authorities and Trusts. The frontsheet of the circular included an action list which specified that 'NHS professionals and provider unit managers should:

- ensure in cooperation with their personal social services counterparts that the guidance is put into immediate practice;
- establish local guidelines, agreed with purchasers, to ensure that the necessary priority is given to meeting the needs of the most seriously ill patients;
- establish audit and monitoring systems to support implementation;
- discuss any problems with purchasing authorities.'

It also required that 'NHS purchasers, including GP fundholders, should in cooperation with health service providers, social services, criminal justice agencies, voluntary organisations and other relevant groups:

- secure through contracting, not later than 1995/96, the necessary service provision to support the aims of this guidance
- set up arrangements to monitor and evaluate the implementation of the guidance.'

In addition, paragraph 40 of the circular specified to purchasers the key elements which were to be implemented through contracts.

2.1.3. Having received all the evidence of witnesses from the Trust, the Inquiry panel decided that it was essential to re-examine not only the Severn NHS Trust's operational policies but also to review the contract documents for 1995/96 to see in what manner Gloucestershire Health Authority had included the above requirements in its contract with Severn NHS Trust for that year. We have to record that the contract and the subsequent quarterly quality monitoring reports include no reference to the guidance contained in circular HSG(94)27. The only specific reference to risk relates to Supervision Registers, as distinct from risk assessment prior to discharge, which was the subject of the circular. Beyond this, the contract documents went no further than establishing a general requirement for the Trust to report on implementation of national reports and guidance.

2.1.4. This significant omission on the part of the Health Authority was discovered by the Inquiry after the evidence of operational staff had been received, but we concluded that this fact should appear at the beginning of the Inquiry's report since it illuminates a situation in which risk assessment played little part in the practice of those who cared for Damian Witts, had not been included in the training of his key workers and was not prominent in the operational procedures at the day hospital he attended up to the day of the killing.

2.1.5. It is, of course, a great mistake to assume that national guidance, even when issued in the categorical terms of circular HSG(94)27, will rapidly have an impact on treatment and care practices everywhere. We would have expected, however, that by the summer of 1995 the Health Authority and the Trust would have ensured that staff were alive to the importance of risk assessment, not only as a result of the circular but in view of a sequence of nationally published and widely reported inquiries and reviews into suicides and homicides involving mentally disordered people. In fact we found that not only had Gloucestershire waited until July 1996 to begin the formal process of establishing agreed risk procedures, but that those had yet to be implemented at the time of the Inquiry's hearings in the Spring of 1997.

2.2. SEVERN NHS TRUST

2.2.1. From June 1993 to September 1995 Damian Witts received treatment and care primarily through Coleford House Day Hospital, the base for the community mental health team covering his home locality.

2.2.2. In 1995 the Trust's Management arrangements were extensively reviewed by the Trust Chief Executive. His evidence to the Inquiry showed that at that time there was a significant tension between the concept of locality management and care group management. It had seemed to him that although the focus for provision of care was rightly placed in each locality, it lacked coordination across localities for particular aspects of service.

2.2.3. It is clear that by 1995 the Trust's management arrangements for its mental health and other services were in need of review and adjustment, but that the changes introduced from April of that year onwards did not alter operational patterns or accountability within the team at Coleford House. However, the team's acknowledged clinical leader, the consultant psychiatrist, had worked under considerable pressure since her appointment to the management post as Medical Director of the Trust, and by the Summer of 1995 the attempts by the Trust to provide support of consultant standard had only just proved successful. This coincided with a crisis in her home life due to illness of a family member to which she was bound to give time and attention. We conclude that her coordinating influence and the focus which her presence provided for work with individual patients was inevitably under strain as a result of her commitments and that it was disrupted during August and into September 1995.

2.3. MULTI DISCIPLINARY WORKING ARRANGEMENTS

2.3.1. Cooperation and information sharing between team members and from them to other agencies seems to have had no impediments. The team as described to us worked in an organic way, with shared records and a reliance on case discussions and reviews on Mondays and Wednesdays which were similar to consultant ward rounds. The consultant psychiatrist

told us that in addition each month 'we would go through the whole lot of patients attending the day hospital'. The arrangements for supervising the key worker's clinical work were not to her line manager, but to a fellow team member. Thus, if matters relating to her management of Damian Witts' care as his key worker were not brought up at the team meetings or in discussion at another time with the consultant psychiatrist, they could be talked through with her supervisor, but not as part of the team's system of accountability.

2.3.2. We have noted the absence from the written records of any account of many informal contacts and discussions about Damian Witts and his care, not least those at the Wednesday staff meetings. While we respond to the force of the aphorism 'care before paperwork' we believe that it is a responsibility of management, both general and clinical, to provide the logistic and cultural setting in which the recording of relevant information is made easy and routine. Not only does this greatly enhance patient care, it also protects staff from unjustified criticism. We understand that Trust management is currently tackling this matter, but considers that a more complete answer will depend on the introduction of an electronic patient record system.

2.3.3. The pattern of working at the Day Hospital did not include any provision for systematic full case reviews or conferences for all regular attenders. The consultant psychiatrist confirmed to us that most reviews took place in an 'ad hoc' way, often at the instigation of the key worker, and that work pressures often meant that only a few professionals were present. We consider that unless reviews are undertaken in a systematic way by the whole team important issues concerning care and diagnosis may be neglected, and the opportunity for valuable input from those not centrally involved may be missed. We believe that when determining the professional establishment, management should include provisions for such systematic case conferences. Clinical staff should not be forced by pressure of urgent work to set aside the need of their long term patients for careful multidisciplinary review. This is a quality issue, and one which we show to be directly relevant to the care of Damian Witts.

2.4. LINKS WITH PRIMARY HEALTH CARE

2.4.1. Correspondence in the Trust's notes and contained in the records of both general practitioners who had Damian Witts on their lists between his birth and 1995 showed that the Child Psychiatrist who treated Damian Witts between 1991 and 1993 and the consultant psychiatrist's written communications were methodical and comprehensive.

2.4.2. His GP from July 1993 onwards told us in his statement 'Throughout the time I had dealings with Damian the psychiatric services provided me with regular updates of their consultations with him, which were comprehensive and always advised of any changes in medication. Contact with the key workers involved has always been easy and prompt.'

2.4.3. We noted that some important letters and full discharge summaries were delayed before typing so they were not received in the GP's surgery until some weeks after they had been dictated. This we were told was due to inadequate secretarial help, which has now largely been rectified. In practice the GP told us this delay did not cause difficulty, partly because brief written summaries were sent to him at discharge.

2.5. SOCIAL SERVICES

2.5.1 The mental health multi-disciplinary team included input from Gloucestershire Social Services, but Damian Witts was not thought to require social work help between 1991 and 1995. In fact, other than for the brief period in 1990 when he was subject to an Intermediate Treatment condition as part of a Supervision Order, Damian Witts was not referred for assistance of any kind from Social Services. His only period of intensive social work assessment and support involving home visits had been between 1988 and 1991 from probation officers.

2.6. PROBATION SERVICES

2.6.1. We received evidence from the probation officers who had known Damian Witts from 1986 until 1990, and who took over from then

until his Supervision Order was completed in 1991. The first probation officer had also assessed him on remand at prison following the stabbing, and made reports to the Crown Court in 1996. The Probation Service maintained contacts with other members of his family until the mid 1990s, largely as a result of his father's and brother's offending.

2.6.2. We have reviewed all the correspondence and exchange of reports relating to Damian Witts between probation services' and health services' staff. It seems very clear that they have been used to working openly and cooperatively with each other.

2.6.3. The only apparent exception to such a pattern occurred after the killing and relates to March 1996 when Damian Witts appeared at Bristol Crown Court. The probation officer could not recall any proposal at that time for him to return to hospital as an informal patient subject to probation conditions. She later checked all the related records and could find no correspondence or other record to show that this had been discussed and agreed between the forensic psychiatrists and the Probation Service at that time, which would have been the usual procedure.

2.7. CARE PROGRAMME APPROACH

2.7.1. The Care Programme Approach (CPA) was introduced in the former Mental Health Unit in November 1991. The policy was monitored by returns to a manager who was identified as CPA Co-ordinator. We were shown the two documents, a procedure and a summary, which made up the CPA system from that date.

2.7.2. Following an audit in 1993/94 a revised policy was jointly agreed with Social Services and introduced in August 1994. The Trust's Chief Executive told us that he regarded the CPA as an integral part of the change process, particularly in the development of community services and training commenced for all staff in the autumn of 1994. The second tranche of training was provided for Coleford House staff on 13 February 1995. Key worker training did not, however, start until April 1996.

2.7.3. The initial documentation for introducing the CPA in the Trust during 1991 was minimal in scope and content in the opinion of one of our expert witnesses. Although the revisions in 1994 created a more thorough system, that witness has pointed out that it did not, as in many other Trusts, incorporate a tiered assessment which would establish a priority to each patient's needs and define the frequency of contact according to the patient's changing circumstances. We acknowledge however the Trust's contention that such tiering might run counter to the need to tailor programmes of care to the uniqueness of each individual patient.

2.8. RISK ASSESSMENT PROCEDURES

2.8.1. The NHSE circular HSG (94)27 specified that contracts placed with providers by purchasers must by 1995/96 ensure that a number of key elements were implemented. These included 'staff adequately trained in the care programme approach and in risk assessment and management.'

2.8.2. At the time of the incident in September 1995 there was no formal specific training in risk assessment. However, reference was made to this subject during CPA and Supervision Register training. In addition the Trust's course on managing aggression covers assessment of dangerousness.

2.8.3. In her verbal evidence the key worker told us that she had received no training in risk assessment, nor was it provided by the Trust so far as she was aware. In her statement the previous key worker said that to her knowledge the extent of training in this area was nil.

2.8.4. The Trust provided the Inquiry with the full details of the Gloucestershire Common Policy on Risk Assessment, which in April 1997 had reached its final draft and was now to be formally adopted by all of the agencies in the County which had contributed to its development.

2.8.5. Evidence to the Inquiry indicated that the pace of implementing Circular HSG(94)27 in Gloucestershire and of disseminating its basic

message to the Trust's staff has been very slow since it was issued in May 1994, notwithstanding the inclusion of source elements in the training given on the CPA and the Supervision Register. The fact remains that its requirements relating to risk assessment had not been made known to Damian Witts' key workers by the Summer of 1995.

2.8.6. The significance of the advice contained in that circular has also been demonstrated in a sequence of widely distributed and publicised inquiry reports since 1994.

2.8.7. It is a matter of great concern that although considerable time has elapsed since the killing which brought this Inquiry into being, the vital information contained in the jointly agreed Gloucestershire policy, together with training in the implementation of its essential procedures, has yet to be given to staff. Its guidance has so far been given to operational staff only by circulation of the draft documents for comment.

2.9. RESOURCE ISSUES

2.9.1. A number of witnesses stressed to us the pressures under which professional staff were working in 1995, and which by their account are even greater now. As an example, the consultant psychiatrist told us that an analysis in 1996 showed that her case load numbered at least 210 patients, half of whom were psychotic. As a result recording, communicating, monitoring and supervision all may suffer, and routine appointments often have to be cancelled because an emergency has arisen. Other staff often have to undertake responsibilities greater than their training or experience warrants.

2.9.2. A further consequence of such a demanding work load, coupled with difficulties in recruitment, was that staff, particularly social workers, Community Psychiatric Nurses and psychologists, were (and are) generally unable to attend and contribute to case conferences and reviews unless they were directly involved.

2.9.3. Trust management records showed a substantial increase in referrals to Coleford House in the period June to September 1995.

2.9.4. The caseload referred to by the consultant psychiatrist was clearly excessive. We share the concern of professional staff at the unremitting pressures described. Up to a certain level work pressure may enhance performance and efficiency; beyond that level they decline, and mistakes, omissions, fatigue and 'burn out' more and more impair the effectiveness of the service. Furthermore, training and personal development tend to be neglected, to the long term detriment of the service and its personnel. In this particular case input from other professional groups at properly conducted case reviews would have greatly enhanced their value, both to Damian Witts and for those attending the reviews.

2.9.5. The pressures on staff to handle new work may have influenced the time available for observations and recording Damian Witts' progress in August and September, when staff holidays also contributed to the apparent diminution of recorded contacts with him.

SECTION 3

PERSONAL HISTORY, DIAGNOSIS, TREATMENT, CARE PROGRAMMING AND RISK ASSESSMENT

3.1. PSYCHIATRIC ASSESSMENT AND TREATMENT

3.1.1. In the full report the Inquiry team have set out extensive details of Damian Witts' personal and family history, the manner in which his illness first emerged in May 1991 when he was sixteen years of age and his subsequent treatment by Psychiatric Services as an adolescent and as an adult up to September 1995.

3.1.2. Details are included of his two admissions to local psychiatric hospitals, from April to June 1993 and briefly in July 1995. From June 1993 until the time of the killing in September 1995 he attended Coleford House Day Hospital each week, with the exception of absences from the end of February to early April 1995, the reasons for which were known to the staff responsible for his care.

3.2. DIAGNOSIS

3.2.1. The Inquiry report discusses the initial diagnosis of schizophrenia in May/June 1991 and the medication and other treatments provided from then onwards. The significance of an alternative diagnosis of post traumatic stress disorder made in May 1995 is considered, together with its impact on Damian Witts and his carers' understanding of his illness from then on. His present diagnosis and progress are described in order retrospectively to review his diagnosis, treatment and care from 1991 to

1995. The opinion of the Inquiry's independent expert witness is also given.

3.2.2. The Inquiry's perception of the case has been formed by studying all the clinical notes and summaries made between June 1991 and July 1995, initially by the child psychiatrist and latterly by the consultant psychiatrist, enhanced in most cases by a discussion with their author. Consideration has also been given to similar information about his mental state and behaviour gathered by those who have examined and cared for him since the killing, and which includes our own interview with Damian Witts. In our view an appropriate diagnostic formulation is that he suffers now and suffered then from a psychotic illness which is schizophrenic or schizoaffective in type, associated with long standing drug misuse and the consequences of an emotionally distorted and physically abusive childhood, including its damaging effects on personality development. We do not consider that he suffers from progressive 'process' schizophrenia, and regard the outlook for psychosis as linked with, though not entirely determined by, the other elements in his condition. He probably has experienced both true psychotic hallucinations and 'flashbacks'. He benefits from standard doses of antipsychotic and mood stabilising medication, which enables other psychological and psychotherapeutic interventions to be of maximum benefit to him.

3.3. CARE PROGRAMMING

3.3.1. We could find little evidence that care plans were reviewed, particularly in 1995, when Damian Witts' circumstances were changing. There appears to have been no multidisciplinary review following his brief admission to hospital in July 1995, as expected by the Trust's CPA policy.

3.3.2. When CPA forms and records were completed, this was done in the manner of nurses' notes and summaries of action taken. It appears that in practice the new procedures were being adapted to fit in with existing operational systems and recording methods.

3.3.3. The plans and targets set for Damian Witts appear to have derived principally from his one-to-one discussions with his key worker as a patient attending the day hospital, and after September 1994 they convey little sense of evaluating him as a man with a severe mental disorder living in the community.

3.3.4. From January 1995 onward, following the change in the interpretation of his symptoms, the care process as recorded gives the appearance of being increasingly inward-looking and retrospective. It records concerns with the psychodynamics of his relationship at that time and as a child with his mother, rather than his failing relationship at home with his cohabitee and his withdrawal from social life. None of that reality is adequately formulated in the notes that were kept and there were no reviews of the kind expected by the Trust's CPA procedure during 1995. The consultant psychiatrist and key worker have assured us, however, that at this time he was encouraged to develop positive interests in his home, educational opportunities and voluntary work and that the focus of his care was on current and future needs.

3.4. RISK ASSESSMENT

3.4.1. The medical and nursing notes made in 1994 and 1995 contain no specific references to risk other than when Damian Witts harmed himself. The consultant psychiatrist's letter to his GP dictated on 19 July 1995 referred to the risk of self harm and the possibility of lashing out at others, although not in the context of psychotic illness. The letter described the arrangements made for Damian Witts to request admission to hospital for his own or other people's protection.

3.4.2. As we have observed in Section 2, national guidance on risk assessment issued in 1994 had not been implemented at the time of this Inquiry's hearings in 1997, neither had staff received training other than that as part of Supervision Register procedures. We have been told that the evaluation of risk was an ongoing rather than a separate element of the team's case recording process. The absence of such references in the running records of Damian Witts suggests that risk factors were not

particularly identified in the team's assessments of his condition and circumstances during 1995.

3.4.3. The Gloucestershire draft joint policy on risk assessment (see 2.8.4) includes a section under the heading 'Situations and Circumstances Known to Present Increased Risk' which says 'Note should be taken of any change in circumstances either reported or observed. These might include:

- loss of home, employment, relationship, death or threats of any of these
- change in attitudes to illness / offending behaviour and / or treatment / supervision management
- changes in settled behaviour, for example changing housing, relationships, employment
- returning to the type of environment or situation where previous harm has occurred, for example within the context of a close relationship
- not turning up for appointments or not complying with treatment / care plans
- stopping taking medication against medical advice
- substance abuse / misuse including alcohol especially where this is a factor in previous incidents of harm.'

3.4.4. We have to observe, and the key worker and consultant psychiatrist have agreed with us in the course of their verbal evidence, that almost all of those factors had applied in the circumstances of Damian Witts in July, August and September of 1995.

SECTION 4

SUMMARY OF FINDINGS

4.1. TREATMENT AND CARE: INQUIRY'S SYNOPSIS AND FINDINGS

4.1.1. The accounts of Damian Witts' childhood years and education disclose no evidence of psychological disorder, despite a family history of alcohol misuse, drug abuse and mental illness. His first deviant behaviour occurred in May 1988, at the age of 13 years and 7 months, when a psychiatric assessment concluded that his offending was reactive to family stresses, to influence by older companions and possibly to alcohol abuse. He started abusing a range of substances from an early age and abuse continued on and off until 1995.

4.1.2. As a result of persistent minor delinquency he was placed on Probation supervision and appeared to do well, but in July 1991, at the age of 17 years 9 months, he disclosed psychological symptoms which caused his Probation Officer to seek urgent referral for psychiatric assessment. A month later the consultant child and adolescent psychiatrist diagnosed that early schizophrenia was a possibility.

4.1.3. We conclude that the assessment was prompt, and that the treatment was appropriate to such a diagnosis.

4.1.4. As treatment proceeded over the next two years, that diagnosis was confirmed and a programme of medication was established, to which Damian Witts responded satisfactorily. In 1992 he left home to establish a stable cohabitation with his long-term girlfriend.

4.1.5. His condition deteriorated early in 1993, notably with symptoms of distress and depression and in April 1993 he was informally admitted to psychiatric hospital. During the month-long admission he was transferred to the care of a general psychiatrist who recorded a working diagnosis of schizophrenia with blunted affect and chronic psychotic experiences.

4.1.6. We conclude that this was consistent with the history of his illness and the records of his symptoms and behaviour at that time, but have noted that the general psychiatrist considered from then that his clinical presentation was not altogether compatible with a diagnosis of schizophrenia.

4.1.7. At the end of May 1993 he refused to return to the hospital from weekend leave and was discharged. In June 1993 he commenced attendance on three days per week at the local psychiatric day hospital where he was allotted a qualified nurse as key worker.

4.1.8. We conclude that although his hospital discharge was unplanned, the arrangements for continuing care and treatment were well organised by the consultant psychiatrist and her team. Liaison with primary health care services was also well managed throughout.

4.1.9. From then until the beginning of 1995 he attended day hospital quite regularly and he co-operated well in the treatment provided. His medication for schizophrenia was supervised by his girlfriend, apparently without problem. However, he has told us that he used illicit drugs during that period, notably at times of stress. His key worker recalls that he consistently denied taking illicit drugs and symptoms of abuse were not identified at the day hospital. No regular drug screening was undertaken, in part due to inadequacies in the Trust's screening service. He was seen regularly by the consultant psychiatrist and key worker, who routinely recorded their contacts.

4.1.10. From July to September 1994 supervision of his treatment passed to a locum consultant whilst the consultant psychiatrist was on sick leave, and after her return his regular contact was with a more junior psychiatrist.

Medical notes, treatment and medication at that time remained consistent with a primary diagnosis of schizophrenia. The consultant psychiatrist relied on the team's weekly discussions to keep her up-to-date until she resumed direct clinical supervision of Damian Witts in May 1995.

4.1.11. We conclude that although those running records reflect a good standard of clinical commitment and understanding of Damian Witts, there were no sequential treatment and care plans or reviews during that period, and the weekly discussions by the day hospital team of his progress were not recorded.

4.1.12. In January 1995 the day hospital manager, a qualified nurse, assumed key worker responsibility for Damian Witts. Early in her contact with him she felt that his symptoms could be more attributable to flashbacks or past experiences. She discussed this with the consultant and senior registrar, after which she encouraged Damian Witts to talk through his earlier abusive experiences and to write accounts of them.

4.1.13. We conclude that although this was a plausible notion with potential benefit for Damian Witts, it should have been thoroughly examined and validated. In the event we have been unable to find any associated medical notes, clinical care plan or review other than routine nursing notes. We further consider that the newly suggested diagnosis was too readily regarded as an alternative rather than as complementary to the existing diagnosis.

4.1.14. In February 1995 Damian Witts' attendance became erratic. He did not attend at all in March, when he and his girlfriend were moving back to the town where his family resided. After he resumed attendance on 7 April 1995 he told the key worker of his urge to abuse drugs. She recommenced working with him on the lines started in January, and in May the consultant psychiatrist felt that his apparent improvement justified discussing with him the possible change in diagnosis. The consultant psychiatrist wrote to Damian Witts' GP on 8 June 1995, referring to six month's work by the key worker which the letter described as psychotherapeutic intervention relating to flashback experiences.

4.1.15. We conclude that discussion in May 1995 with Damian Witts regarding the suggested change in diagnosis should have been based on a full multidisciplinary review, including a close examination of the clinical evidence and prior discussions with Damian Witts and with his girlfriend who was his primary carer. In fact their relationship was deteriorating and Damian Witts was abusing both prescribed and illicit drugs at that time. He took the information about an alternative diagnosis to mean that he was not schizophrenic and he then stopped taking his medication regularly.

4.1.16. During June 1995 both key worker and consultant psychiatrist noted some deterioration in his mental state and ability to cope. In July 1995 contingency arrangements were made for him to request a respite admission to hospital, and with support from his girlfriend he did so on 19 July 1995. He was seen by the consultant psychiatrist on 20 July, who agreed that he could leave when he wished, and he went home later that day.

4.1.17. We conclude that this was a lost opportunity to reassess his condition thoroughly, to examine his circumstances and to review treatment plans. In the event it was the last time before the stabbing that he was seen by the consultant psychiatrist, who had to take urgent compassionate leave late in August.

4.1.18. Damian Witts recommenced at the day hospital, where on 26 July 1995 an unsigned CPA review identified goals for his personal attainment but made no mention of medication compliance. On 2 August 1995 the key worker interviewed his girlfriend who expressed concerns about the relationship and in fact she left their home on 26 August 1995. After then Damian Witts was living alone, was not regularly taking his medication, was increasingly abusing illicit drugs and was re-exposed to the stresses of his family.

4.1.19. Although he attended day hospital on at least ten occasions between 22 August 1995 and 20 September 1995, there are no nursing or medical notes between these dates. The record for 20 September then gives an unfolding picture of drug abuse, self-neglect and non-compliance

with medication. On 26 September the key worker decided to draw this to the consultant psychiatrist's attention the next day.

4.1.20. We conclude that by then a full clinical review, including a home visit and social circumstances assessment and a risk assessment had been seriously overdue for several weeks. From the end of August Damian Witts had been needing support in his domestic surroundings more than in the day hospital. Above all he required help and supervision to ensure his compliance with medication, and to assess his abuse of illicit drugs, together with an assessment of the risks which might be emerging for him and for others as he became exposed to mounting pressures and stresses in his old home area.

4.1.21. In the light of the shortcomings in the planning and delivery of his treatment and care, we have had to conclude that although the killing could not have been foreseen, it might have been prevented if the available resources had been more appropriately focussed and equipped to respond to Damian Witts' changing needs and circumstances.

4.1.22. We have observed a serious lack of attention to the importance of risk assessment and risk management. The necessary lead was not provided by Gloucestershire Health Authority's contract for 1995/96 with the Severn NHS Trust and the expectations defined by national guidance in 1994 had not percolated from the Trust to its staff working in Coleford House Day Hospital by 1995.

4.1.23. We strongly urge the Gloucestershire Health Authority and the Severn NHS Trust to ensure that service contracts require training on risk assessment and risk management to be given, notably to all key workers without further delay, so that the requirements of national guidance which was issued by the National Health Service Executive more than three years ago is now properly followed.

4.2. INQUIRY'S RESPONSES TO THE REMIT SET BY GLOUCESTERHIRE HEALTH AUTHORITY

4.2.1. The Remit set for the Inquiry included three main items, the first of which was divided into three sub headings, to which we are able to respond as follows.

> Item 1 With reference to the incident that occurred on 26 September 1995, to examine the circumstances of the treatment and care of Mr D Witts by the mental health services, in particular
>
> i. the quality and scope of his health, social care and risk assessment;
>
> ii. the appropriateness of his treatment, care and supervision in respect of
>
> a) his assessed health and social care needs;
> b) his assessed risk of potential harm to himself or others;
> c) any previous psychiatric history, including drug and alcohol abuse;
> d) the number and nature of any previous court convictions.

4.2.2. The Inquiry's finding is that although the killing could not have been predicted, the treatment and care Damian Witts was receiving in August and September 1995 had the following significant shortcomings, which we list under the above headings.

i. Although health care had been closely involved and supportive it was lacking in clinical focus and it ran thin during August and September, just at the time when he was becoming alone and at his most vulnerable following the break-up of his cohabitation. No risk assessment procedures were in place which could have identified this. The nursing staff involved in his treatment and care had no specific training in risk assessment and the issue of risks did not arise spontaneously in their involvements with him.

ii. (a) Although aspects of his changing health and social care needs were addressed, they did not form part of a regularly updated plan which would review the consequences of changes in his personal circumstances. Changes in his clinical management and its emphasis depended on incompletely tested assumptions about the accuracy of his original diagnosis of schizophrenia.

(b) Staff did not sufficiently identify that his mental state in September was vulnerable due to his non-compliance with prescribed medication, and also increasingly influenced by his abuse of illicit drugs.

(c) His record of drug abuse, although it went back into his childhood, was largely uninvestigated, and facilities to screen the degree of his actual abuse were inadequate.

(d) There were no relevant court convictions after adolescence.

4.2.3. Item 1 (iii) The extent to which Mr Witts' prescribed treatment and care plans were

a) documented,
b) agreed with him,
c) communicated within and between relevant agencies and his family,
d) carried out,
e) complied with by Mr Witts.

4.2.4. The Inquiry's findings are as follows.

(a) Treatment and care plans were well documented by the child and adolescent service, but there were almost no multi-disciplinary treatment plans by the general (adult) service. However, the notes of doctors' and nurses' individual dealings with Damian Witts were generally fully completed up to August / September 1995, when a marked reduction in recording is apparent.

(b) There is evidence that Damian Witts regularly discussed matters with key workers and at intervals with doctors when he attended the day hospital. There is no suggestion that he was unaware of the purpose of his sessions with his key worker or of the changes in diagnosis in 1995, but the tentative nature of those changes may not have been understood by him or his carer.

(c) Communication within and between agencies appears to have been very satisfactory, notably correspondence with general practitioners. Communication with his girlfriend, as his carer, was open but unstructured and it ceased after 2 August 1995. It appears that communication with his mother was as much a focus as communication with the girlfriend who was his carer until her departure at the end of August 1995.

(d) Treatment and care in the day hospital was ongoing rather than planned, and reviews at the weekly meetings with the consultant psychiatrist were unrecorded. It is therefore difficult to define the extent to which reviews were carried out, but running records suggest that day hospital staff felt in touch with Damian Witts and his treatment.

(e) It is clear that Damian Witts' compliance with treatment was very variable. He discharged himself from both hospital admissions. His attendance at day hospital became inconsistent and after May 1995 he was not regular in taking his medication for schizophrenia.

4.2.5. Item 1 (ii)(e) Statutory obligations, national guidance (including the Care Programme Approach HC(90)23/ LASSL(90)11, Supervision Register HSG(94)5, and the discharge guidance HSG(94)27 and local operational policies for provision of mental health services.

4.2.6. The Inquiry's findings are as follows.

i. The Gloucestershire Health Authority expressly required the Severn NHS Trust to adhere to the national guidance on the Care Programme Approach and Supervision Register. The Authority's contract

with the Trust for 1995/96 did not specifically require the discharge guidance as set out in the National Health Service Executive circular HSG(94)27 to be fulfilled. That circular had incorporated essential national requirements in relation to risk assessment and related staff training, and had been issued to all purchasers and providers of mental health services.

ii. The Severn NHS Trust has been slow to introduce procedures which follow the first two elements of national guidance, and it is clear that some operational staff believed that existing local practices were already sufficient, or better. The Care Programme Approach which had been introduced in 1991 was revised in 1994. Staff were trained in the Autumn of 1994, but those procedures and policies were limited in their scope in that risk assessment training was not provided to all operational staff who were key workers.

iii. The elements relating to risk assessment and risk management contained in HSG(94)27, although thoroughly considered as part of a comprehensive inter-agency project in Gloucestershire from 1995 onwards, had yet to be implemented when the Inquiry received evidence from managerial and operational staff in March 1997.

4.2.7. Item 2 To examine the appropriateness of the training and development of those involved in the care of Mr Witts.

4.2.8. The Inquiry's findings are that in 1995 the staff of the day hospital involved in the care of Mr Witts, although widely experienced in mental health, had received no formal training in risk assessment and risk management. In 1997, the Trust's draft training programme on risk contains an assessment schedule for such key workers which would precisely identify someone in Damian Witts' circumstances in August and September 1995 as highly vulnerable.

4.2.9. Item 3 To prepare a report and make recommendations as appropriate to Gloucestershire Health Authority.

4.2.10. The Inquiry's Findings and recommendations are presented in full in this Summary.

SECTION 5

CONCLUDING COMMENTARY

5.1. DID THE SERVICE LET DOWN DAMIAN WITTS AND HIS BROTHER?

5.1.1. A central issue for us is one which we cannot evade and which the professionals involved have openly acknowledged. It is that Damian Witts, who has been under continuous psychiatric care for over four years, fatally stabbed his brother less than two hours after being brought home by minibus from the day hospital. Could this have been prevented?

5.1.2. The conclusion of the consultant psychiatrist and the two reporting psychiatrists was that the killing could not have been directly anticipated, and as we have said we agree with that. However, we have had to consider whether different methods or an enhanced standard of treatment and care would have created circumstances such that Damian Witts would not have acted as he did, or would not have found himself in such a situation in the first place. Any judgement about this must be tentative, and now is unavoidably reached with hindsight. Nonetheless we consider we should express a view.

5.2. STRENGTHS AND WEAKNESSES OF THE SERVICE

5.2.1. The multidisciplinary health team which provided care for Damian Witts was cohesive, responsive to perceived need and well-led. Although we detected tensions between the outlook of some individual members, these appear to have been no greater than any group of professionals might encounter, and the members of the team appear to be loyal to each other and to have the capacity to use tensions creatively. It seems that the team has been generally well supported managerially, and

the clients we encountered were and remain very appreciative of the treatment, care and support they were given.

5.2.2. Like all such teams, they work under great and at times unreasonable pressure. The consultant psychiatrist in particular had too many responsibilities during 1995, and was inevitably and unavoidably somewhat distracted from these by serious family illness during the Summer and Autumn of that year. This was a time when referral pressures had increased, and was of course the peak period for staff holidays. We formed the impression that these pressures, and perhaps also the team's familiarity with and confidence in each other, were partly responsible for the absence of systematic, regular and probing case reviews which might have avoided what we perceive as a somewhat unbalanced formulation of Damian Witts' complex problems and vulnerabilities, and which in turn led to the lack of continuity and focus in his management to which we have already referred.

5.2.3. We have observed that time was found for the team's daily briefing and debriefing and for twice weekly case discussions. Some of that time might have been more effectively used for the systematic, regular review of individual patients.

5.2.4. The absence in 1995 of clear local guidance to and training of team members in clinical risk management, in spite of national emphasis on this aspect of care, also contributed to weaknesses in care reviews. No basic check list of the kind which is to be included in the new Gloucestershire policy was available in 1995, nor do key workers appear to have been familiar with such notions in the routine appraisals of their patients.

5.3. ANTICIPATION AND PREVENTION

5.3.1. The mental health multi-disciplinary team included input from Gloucestershire Social Services, but Damian Witts was not thought to require social work help between 1991 and 1995. In fact, other than for the brief period in 1990 when he was subject to an Intermediate Treatment

condition as part of a Supervision Order, Damian Witts was not referred for assistance of any kind from Social Services. His only period of intensive social work assessment and support involving home visits had been between 1988 and 1991 from Probation Officers.

5.3.2. Even had the management of his treatment and care been ideal, it does not follow that the events of 26 September 1995 would have unfolded differently. Not every tragic event can be anticipated and, as he recognises, Damian Witts was not so ill at the time as to avoid all responsibility for his actions.

5.3.3. Others though had responsibilities to him, and we must conclude that if the team had during 1995 provided a more truly multi-disciplinary, focused and reviewed package of care then the growing danger he presented might have been recognised earlier and their actions might have prevented the tragedy. Notably he might have been assessed and given support at his home, and help to cope with his renewed exposure to the emotional stresses of his family and pressures from drug users.

5.3.4. Although we have made a number of recommendations, we do not intend to imply that if any or all of these matters had been attended to before the event it would necessarily not have occurred. In our opinion the services the Severn NHS Trust provided in 1995 compared favourably with many in the country. However, the change to more systematic methods of working, to the targeting of treatment and care and to their review, as defined in national guidance, was very slow to be developed. Our recommendations must be taken in the context of two overriding themes:

- not every tragedy can be prevented;
- every service can be improved.

SECTION 6

RECOMMENDATIONS

6.1. INQUIRY RECOMMENDATIONS

6.1.1. The Inquiry panel has attempted to compose the full text of its report in ways which will facilitate discussion and action on the part of the managers and staff of Severn NHS Trust. In particular the 'comment' items draw attention to many organisational and professional matters which need to be considered in relation to practices at present as well as in 1995.

6.1.2. The following recommendations should not, therefore, be regarded as a summary of all the matters which the panel would wish to see influenced by the Inquiry's findings. It does, however, cover the major items on which categorical recommendations should be made.

RECOMMENDATION 1 ***The National Health Service Executive should now review the extent to which its guidelines to NHS purchasers, contained in circular HSG(94)27, have been adhered to nationally. In particular the requirements laid on purchasers regarding the terms of contracting from 1995 / 96 onwards and for monitoring the implementation of the guidance should be audited in each Health Authority.***

RECOMMENDATION 2 ***Gloucestershire Health Authority should now review the terms of its contracts with providers since 1995 / 96 in order to***

a) revise its contracts for the current year, 1997 / 98, so that the guidance contained in circular HSG(94)27 is implemented immediately

b) ensure in particular that the circular's guidance relating to risk assessment is followed by Severn NHS Trust without delay;

c) draw up its specification and service agreements for 1998 / 99 in the light of a) and b).

RECOMMENDATION 3 Severn NHS Trust should ensure that its clinical policy on risk assessment is fully implemented without delay and that it meshes fully within the Gloucestershire joint policy on risk assessment.

RECOMMENDATION 4 Training in risk assessment and risk management should be provided to all existing key workers under the Care Programme Approach as a matter of urgency. Thereafter staff should not be appointed as key workers until they have completed the training.

RECOMMENDATION 5 The Care Programme Approach operated within Severn NHS Trust should be reviewed in terms of its scope and effectiveness.

RECOMMENDATION 6 Severn NHS Trust should audit the time at present committed by the staff team at Coleford House Day Hospital to daily briefing and debriefing, twice weekly discussions with the consultant and to scheduled supervision sessions for individual staff. Multidisciplinary case planning and review should be accorded appropriate priority within the time available.

RECOMMENDATION 7 Clinical staff should schedule regular systematic and as far as possible multidisciplinary reviews of all patients who attend Coleford House Day Hospital for more than two

weeks. The key worker should be responsible for recording the outcome of such reviews, which should be monitored using an audit cycle.

RECOMMENDATION 8 Written guidance should be given to all staff regarding the involvement of carers and other family members in the care and treatment of patients and so that their views are sought and recorded when Care Programme Approach plans are made and reviewed.

RECOMMENDATION 9 Social histories of long term patients should be gathered cumulatively and should include the views of carers and family members, unless the patient has made a formal declaration to the contrary.

RECOMMENDATION 10 Managers, both clinical and general, should devise and implement systems to ensure that as far as possible clinical records, in either paper or electronic form, are available when and where needed.

RECOMMENDATION 11 Discharge letters to GPs should be sent within 2 weeks and copies should then be provided to key workers.

APPENDIX A

REMIT FOR INQUIRY

GLOUCESTERSHIRE HEALTH AUTHORITY

MR D WITTS: REMIT FOR INQUIRY

1. With reference to the incident that occurred on 26 September 1995, to examine the circumstances of the treatment and care of Mr D Witts by the mental health services, in particular:

   (i) the quality and scope of his health, social care and risk assessments;

   (ii) the appropriateness of his treatment, care and supervision in respect of:

   (a) his assessed health and social care needs;
   (b) his assessed risk of potential harm to himself or others;
   (c) any previous psychiatric history, including drug and alcohol abuse;
   (d) the number and nature of any previous court convictions;
   (e) statutory obligations, national guidance (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 for the provision of Mental Health Services.

   (iii) the extent to which Mr Witts' prescribed treatment and care plans were

   (a) documented,
   (b) agreed with him,
   (c) communicated with in and between relevant agencies and his family,
   (d) carried out,
   (e) complied with by Mr Witts.

2. To examine the appropriateness of the training and development of those involved in the care of Mr Witts.

3. To prepare a report on and make recommendations as appropriate to Gloucestershire Health Authority.

APPENDIX B

PROCEDURE ADOPTED BY INQUIRY

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:
   a) of the terms of reference and the procedure adopted by the Inquiry;
   b) of the areas and matters to be covered with them;
   c) requesting them to provide written statements to form the basis of their evidence to the Inquiry;
   d) that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Inquiry;
   e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness;
   f) that is the witness who will be asked questions and who will be expected to answer;
   g) that their evidence will be recorded and a copy sent to them afterwards for them to sign.
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, whether verbally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.
4. Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances.
5. Those professional bodies or interested parties may be asked to give oral evidence about their views and recommendations.
6. Anyone else who feels they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.
7. All sittings of the Inquiry will be held in private.
8. The findings of the inquiry and any recommendations will be made public.
9. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final Report.
10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.
11. At the conclusion of the Inquiry, the Inquiry records including witness statements and copies of transcripts of oral evidence will be held securely by the Health Authority as custodian under seal.

APPENDIX C

LIST OF WITNESSES AND INTERESTED PARTIES

1. Witnesses providing oral, written and documentary evidence in person

Patient Carer, Family Members

Mr D C L A Witts
His Girlfriend
His Mother
His Sister

Severn NHS Trust

Ms M A Applegate, Key worker to December1994
Ms C Blackmore, Named Nurse
Ms P A Coetzee, Social Therapist
Mr D Coombs, Director of Nursing
Ms J Collins, Community Psychiatric Nurse
Ms M Getgood, Mental Health Services Manager
Dr G I Hodgson, Consultant Psychiatrist
Dr R B Ibbotson, Senior Clinical Medical Officer
Mr R James, Chief Executive
Ms R Kyne, Day Centre Manager - Key worker from January 1995
Dr K Williams, Specialist Registrar in Psychiatry
Dr F Zaw, Consultant Child and Adolescent Psychiatrist

Frenchay NHS Trust (Fromeside Clinic)

Dr A R Lillywhite, Consultant Forensic Psychiatrist from September 1996
Dr R W K Reeves, Consultant Forensic Psychiatrist to September 1996
Dr J E Smith, Consultant Forensic Psychiatrist

General Practitioner

Dr E Portman
Probation Service
Mr T R Nixon, Senior Probation Officer
Mrs G Peyton, Senior Probation Officer

Expert Witnesses

Professor Charles Brooker, Professor of Mental Health Nursing, University of Sheffield
Professor Pamela Taylor, Professor of Special Hospital Psychiatry, Institute of Psychiatry, London University

2. Interested Parties providing written and documentary evidence

Gloucestershire Health Authority
Gloucestershire Royal NHS Trust
Gloucestershire Social Services
Gloucestershire Education Department
Forest of Dean Housing Department
Wyedean Housing Association
Gloucestershire Police
The Prison Service