NOT A REAL PATIENT?

Report of the Independent Inquiry into the care and treatment of

David Edward Roberts

A report commissioned by
Wiltshire Health Authority

Gordon Halliday chairman
Omar Daniels
Jane Mackay
Gordon Read

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PREFACE

We were commissioned in April 1999 by Wiltshire Health Authority to undertake this Inquiry and now present our report. The report is based upon written and verbal evidence given to us by those most closely involved with David Roberts and upon a careful study of all the medical, police and social records which were made available to us. We have also reviewed the relevant policy documents and practice guidelines. Members of the Inquiry Team met with David Roberts on two occasions, and also met with a member of his foster family, his step family and a representative from the family of Mr Joseph Osmond, deceased. We have visited Bourne Ward at the Old Manor Hospital, Salisbury, where David Roberts was detained for ten days in March 1997 under section 35 of the Mental Health Act.

Early in our Inquiry, we were told that when officers of the Salisbury Health Care NHS Trust came to consider what form of review should be undertaken of the violent incidents which are the subject of our Inquiry, the initial view was that there was no need to set up a formal serious incident inquiry. The ten-day contact during March 1997, while David Roberts was detained at the Old Manor Hospital, and the very brief period of detention under Section 136 of the Mental Health Act, and on suspicion of causing Actual Bodily Harm on 1st August 1997, suggested, in the words of one of the Trust's witnesses, that he was ***"not a real patient"***, in that on neither occasion was he treated for a psychiatric disorder. Instead, an Internal Mental Health Directorate Enquiry was set up, to which a Trust Non-Executive Director was later appointed Chairman. Later still, on the advice of the Wiltshire Health Authority, an Independent Inquiry was set up under the terms of Department of Health Circular HSG(94)27. The suggestion that David Roberts was not a real patient is, we feel, sufficiently central to our Inquiry to justify the title which we have given our report. It is now apparent, with the benefit of fuller psychiatric assessment and with the incalculable gift of hindsight, that Mr Roberts suffers from a mental disorder within the meaning of the Mental Health Act 1983, and in all probability did so at the time of the homicide.

While our terms of reference are specific, there is a small number of additional matters on which we have felt it important to comment. One such relates to problems

experienced by young people leaving Local Authority care. A second relates to ethnicity and cultural factors and their relevance in the care and treatment of Mr Roberts. These factors include his early life experiences through to adolescence and the development of young adult self-concepts which are of undoubted relevance as these years were all spent in Salisbury, a predominantly white city. We also considered the role of ethnic and cultural factors in the presentation of Mr Roberts' illness, and how these factors may have operated in his assessment at the Old Manor Hospital in March 1997, and during the Section 136 assessment on 1st August 1997. Throughout the Inquiry Team's examination of these issues, the themes of alienation and isolation have a particular resonance to David Roberts' story.

There is one further comment we wish to make by way of preface to our report. Independent Inquiries of this kind are invariably expensive. It has also been argued that the publicity they attract undermines public confidence in Mental Health Services, as well as undermining the morale of the staff who, day upon day, use their skill in offering care and treatment to very damaged and vulnerable patients. However the circumstances of Mr Osmond's death, and of Mr Compton's serious injuries, demand a full understanding and a commitment to try to ensure that lessons are learned from such tragic incidents. We believe that our report should enable this to happen, and we hope that the fullest consideration will be given to our findings, comments, and recommendations.

Finally, we wish to thank all those who have assisted us in our Inquiry. Throughout our work, we have consistently been helped by each of the agencies and individual witnesses who have been involved, and by the courtesy afforded to us. We understand the anxiety an Inquiry of this kind raises, and we are grateful for the full co-operation we have received throughout our work.

CHAPTER 1. INTRODUCTION.

1.1. Summary of the Incidents

1.1.1. On Wednesday 2nd December 1998, at Winchester Crown Court, David Edward Roberts pleaded guilty to the manslaughter of Joseph Osmond, guilty also to inflicting grievous bodily harm with intent on David Compton, and guilty to a further charge of aggravated burglary. He was made subject to detention under Sections 37/41 of the Mental Health Act, and was returned to Broadmoor Hospital, where he had been undergoing a psychiatric assessment under Section 48 of the Mental Health Act since 25th May previously.

1.1.2. At the time of the offences in August 1997, Mr Roberts was a lodger in Mr Osmond's house and had been so, intermittently, for some months. Earlier in the same year he had been charged with grievous bodily harm against Mr Osmond, but the charge was discontinued by the Crown Prosecution Service at his court appearance on 19 March 1997.

1.1.3. In the course of these several events, however, concern had been expressed by a number of people about Mr Roberts' mental health, and he had two brief but separate contacts with mental health services in the Salisbury area during 1997. On the first of these occasions he was referred to a consultant psychiatrist having been remanded to Winchester prison in late February. The consultant subsequently made arrangements through the Court for Mr Roberts' admission to Bourne Ward, Old Manor Hospital, Salisbury, for a period of assessment under Section 35 of the Mental Health Act. However Mr Roberts' stay on the ward was brief and disruptive, no adequate assessment was undertaken, and he was returned to Salisbury Magistrates' Court for court disposal after a period of ten days. On the second occasion, on 1st August 1997, he was detained by the police on suspicion of causing Actual Bodily Harm and under Section 136 of the Mental Health Act following violent and disruptive behaviour in a public place. However he was released, on bail, later the same day after being seen separately by a duty Police Surgeon and by a duty Approved Social Worker from the Emergency Duty Team, neither of whom considered him eligible for detention under the Mental Health Act.

1.1.4. Two days after his release on bail, i.e. the 4th August Mr Roberts attacked and killed his landlord Joseph Osmond in his home. Mr Osmond was in bed when the attack occurred, and suffered multiple stab wounds to his chest, face and hands. Mr Roberts then left the premises in a taxi, which had been waiting for him outside the house. The following day, in a quite separate incident in another place, Mr Roberts attacked David Compton, inflicting grievous bodily harm with stab wounds to the neck and chest. He was arrested later the same day.

1.2. The Climate of Change

1.2.1. Another key background factor within mental health services in Wiltshire in 1997, and indeed elsewhere in the country, was the climate of change being experienced. Within Salisbury Health Care NHS Trust, a significant shift was taking place towards strengthening community-based services, with the establishment of Community Mental Health Teams and the redevelopment of the Old Manor Hospital site. The strategy was being undertaken with the agreement of all the principal purchasers (Wiltshire Health Authority, Southampton and South West Hampshire Health Authority, and the two County Councils) and integrated with primary care services in each area. At the same time there was significant capital investment in acute services, and considerable discussion about their required nature, extent, and location, in particular those offering Low Security. These discussions continue. Bourne Ward, meanwhile, continues to offer intensive care in conditions of Low Security, both in-house for acute wards at Old Manor Hospital, and for other acute units within the ambit of the two main purchasing agencies. There is little disagreement that, in spite of a commitment to ensuring adequacy of nursing staff and efforts to improve the fabric, the overall environment of Bourne Ward does not lend itself to providing this service. Uncertainty remains about where such services should, in the future, be provided in the north of the area.

1.2.2. It was against this background of change, both locally and in the wider national context, that this tragedy occurred. At first glance, it might seem that some clinical practice fell below normally acceptable standards, but judgements of that kind are too simplistic unless they are seen in the context of clinical staffing levels which, by general agreement, also fell below acceptable standards. This was in the context of a clinical

environment which did little to assist the therapeutic process. In such circumstances, and at times of acute clinical pressure, it is not surprising that expedient decisions are made for the general good, sometimes to the detriment of the individual.

CHAPTER 2. A BRIEF CHRONOLOGICAL HISTORY

2.1. Personal Attributes

2.1.1. From the time of his foster placement in 1978 until his teenage years there, David Roberts had been a well liked youngster of above average scholastic abilities who excelled in gymnastics, swimming and sport – in particular, rugby. This gave promise of a career in Physical Education with the possibility, also, of some distinction in the rugby world. Many of those attributes remain. When the Inquiry Team met and interviewed him, his qualities of friendliness and humour coupled with a characteristic reserve and vulnerability were apparent. It is those characteristics which led many people to persevere in offering him assistance, including accommodation, through the troubled years of his adolescence and early adulthood during the period 1991 to 1997. Social Workers, Solicitor, Police Officers, Probation Officers and one of his foster sisters all expressed deep shock and concern at the death of Mr Osmond and the injuries suffered by Mr Compton; yet all remembered David Roberts' engaging qualities as a youngster as well as his sporting promise. All, in one way or another, reflected on the sadness he had experienced and the vulnerability which he communicated but seemed unable to let those in contact with him assist with. It is the view of members of the Inquiry Team that, in spite of the tragedies to which he has contributed and which resulted in Mr Osmond's death and Mr Compton's very serious injuries, there remains potential in this otherwise likeable young man.

2.2. Early Years.

2.2.1. Something of what went wrong with his capacity to cope in adult life can be found in his earlier history. Born on 6 March 1973, David Roberts was three weeks early and weighed five pounds. His mother was then a student psychiatric nurse, not long in England from her native Trinidad. It was reported that his father, also from Trinidad, was a psychiatric nurse in the same hospital. David Roberts' mother was ill prepared for parenthood and unsupported at his birth. Because she had to work, she initially fostered him with a friend, later placing him voluntarily into the care of Nottingham Social Services Department (SSD). She kept in touch over his first eighteen months until she moved away to Salisbury in September 1974.

2.2.2. As a foster child in Nottingham David Roberts presented a number of health concerns: infection of the upper respiratory tract at seven months; blistering to the legs in early 1975; and, just after his second birthday, referral to a paediatrician because he was below average weight and height and there was suspicion of an enlarged liver and spleen (not later substantiated). At one stage he spent two nights as an in patient for growth hormone studies. His health and development was kept under review in Nottingham until he was returned to his mother's care in April 1977 when his medical oversight transferred to the Odstock Hospital, Salisbury.

2.2.3. His natural mother had resumed contact with him in 1975 following her marriage and, in December 1975, Nottingham SSD liaised with Wiltshire SSD when she and her husband actively sought his return to her care. He was settled with a foster mother at the time and some consideration was given by Nottingham SSD to taking parental rights or even applying for a place of safety order to ensure his well being. However, it was resolved that, given assistance from Wiltshire SSD, he should join mother, stepfather and their child, Joseph. Social Services encouraged and assisted familiarisation visits to him in Nottingham and on 22nd April 1977 he travelled with his foster mother and a social worker to be transferred to his mother's care. At this stage David Roberts thought of his foster mother as his real mother. He was just four years old.

2.2.4. David Roberts' arrival, which was unsettling and disturbing for him, turned out to be traumatic for all concerned. He commenced school immediately but at home was quiet and withdrawn in contrast to the boisterousness of his half brother. He began to wet the bed, and soiling and smearing occurred. While she was anxious to care for him, his mother found herself unable to cope with his behavioural problems. The family was not well off and additional strain arose because of the difficulty in replacing damaged bedding. The social worker at the time describes her as a not uncaring mother trying to balance her duty to husband and new child with that to David Roberts. Both her ex-husband and social workers describe her as a competent and caring mother to her other children (daughters were born in 1979 and 1982 respectively) who are described as having grown up as charming children.

2.2.5. The Social Services Department continued to support the family and the prescription of Impramine relaxed David Roberts so that the soiling ceased. In November 1977 the child guidance clinic recorded a dramatic increase in his growth. He was settled at school in spite of some earlier, possibly racist, harassment but the parents continued to find him difficult and he remained withdrawn. A case conference in the December recognised the mother's difficulties and increased its support. She was also confident enough to seek assistance when she found coping difficult. However, on 29th September 1978, when aged 5 years old, David Roberts was received into care.

2.2.6. After his reception into care he was placed with white foster parents who, in addition to children of their own then reaching the stage of leaving home, also had four teenage foster children all of whom had been with the family from infancy. Placed initially on a short-term basis, David Roberts was well received and, after some six months when attempts to find permanent foster care had once more disturbed him, the family suggested that he remain with them. He settled in very quickly and was obviously well liked. Thus he grew up in a large but caring foster family in which he was the only black child. There is no doubt that he had a very stable eleven year period which was in marked contrast to the turbulent year spent with his mother and step-father. Experiencing an emotional warmth that enabled him to form attachments, he became especially close to his foster mother and also to older foster siblings. This was reflected in the reports of his social workers and schools and the fact that visits to doctors and child guidance clinic ceased. He was not seen by the medical profession again until 1985, and then for the first of a run of relatively minor rugby injuries.

2.2.7. Contact was also maintained between him and his natural mother, half brother and half sisters (his mother being divorced from his step-father in 1984 when he was aged 11). Christmas and birthday presents were exchanged and there was the occasional joint picnic between the foster family and the natural family.

2.2.8. Throughout this period David Roberts developed into an outwardly friendly but nonetheless reserved young man. One of his foster sisters reports him as very *'within'* and only saw him cry on three occasions over ten years, an observation also

reinforced by the medical records (24th November 1977, aged four and a half), i.e. *"Dramatic increase in weight. Impressed by air of unhappiness"* and, presumably from his mother's report, *"Never cries with tears, little reaction to physical punishment"*. The doctor also writes, *"Think he needs psychiatric help"*. His foster sister also expressed the view that if he could only have been able to express himself and make sense of what had happened to him as an infant he might have had fewer problems as an adolescent. What appears to have happened is that he was able to get by superficially because of his friendly nature, anxiety to please and his significant athletic talents.

2.2.9. He was a keen swimmer and gymnast and played cricket, football and rugby for his school. Indeed as a result of his talent for rugby he became a very skilled and valued player at a local level. This would certainly have gained him acceptance from the point of view of his peers as well as the wider community. Both he and his social workers described him as having had quite a wide social network and a number of friends at the local rugby club. He was a Scout until he was fifteen and attended camps away from home. He also went on family holidays as well as British and overseas tours with the Salisbury Mini Rugby Club where he had been something of a mascot from the age of eight or nine.

2.2.10. The level of Mr Roberts' racial awareness at this period is difficult to assess although there were isolated incidents of racial abuse which, in every case, greatly distressed him. His white foster sister, to whom he was close, was very supportive of him on these occasions and invariably came to his defence. She recalled these incidents clearly at her meeting with the Inquiry team.

2.3. Adolescent years

2.3.1. It was in May 1988 when he was a little over 15 years old that the first reports of difficulties in the foster home occurred although there had been isolated events earlier deriving from under age drinking at the Rugby Club. A period of considerable turmoil and upheaval ensued, characterised by his attempts to gain some form of autonomy. Arguments about coming in times came to a head in the October when he

stayed out all night when he was thought to be staying with a friend. A period of rebelliousness followed and all attempts to find compromises failed.

2.3.2. Early in 1989, having resisted any formal arrangements for contact with his natural mother, David Roberts asked the social worker to set up a meeting with her. He wanted to know about his father and received information on that score as well as some interest from his mother in helping him make contact via his paternal grandmother in Trinidad.

2.3.3. However, with regard to the specific question of his ethnicity and his awareness of that dimension at that period in his life, Mr Roberts was not very clear. Indeed his thinking was rather concrete when specifically questioned about it. Adolescence is traditionally a time when people who are adopted or in foster settings begin to explore issues such as self-concept and this invariably leads on to questions about their biological or natural parents. It is not clear how much Mr Roberts specifically thought about this aspect of his life as it seems to have been, to him, one relating to rejection in a global rather than a specific sense. He did not describe any racial connotation to the rejection, but appears to have retreated further into drug and alcohol misuse. As his circle of friends began to shrink he would certainly have begun to feel more isolated. This would have begun the process of alienation in which the social isolation was compounded by his use of alcohol and other substances, a phase that paralleled his social and emotional decline.

2.3.4. By the middle of 1989 the foster placement had broken down. He had already begun to experiment with alcohol and illicit drugs and on occasion became threatening in confrontations that were experienced as extremely frightening by his carers. Additional tension arose from failure in examinations at school where earlier expectations had been that if he worked hard he would do well. The eventual move from placement in a home that he had largely enjoyed for the eleven years turned out to be traumatic for him. He was very close to his foster mother, and the foster sister, to whom he was also close, spoke movingly of his anguish. Mr Roberts also described, with some feeling, the hurt he experienced when he had to leave. He felt very misunderstood and rejected. He did, however, remain in contact with his foster parents for a considerable period of time and continued to visit.

2.3.5. In August 1989, aged 16 and a few months, David Roberts moved into Sydney House, a hostel for young people. He is reported as keeping very much to himself there and problems again arose over time keeping and undesirable acquaintances. There were also money problems that may have been the outcome of drug debts and a gambling habit he was later observed as having developed. Towards the end of that month he absconded and stayed the night with a friend. On his return on 22nd January 1990 there was the first sign of a disturbed quality of behaviour which might have given some cause for concern about his mental health. He is reported as *"Behaving strangely, became very agitated and confused, screaming and shouting and eventually left"*. The question in the notes was *"Drugs?"*

COMMENT

A thread of vulnerability runs through David Roberts' chronological history right up to the present time. The painful early life experiences were redeemed by the eleven-year period of stability in the foster family with the development of a close attachment to his foster mother and to at least one of his foster siblings. This stability was disturbed by adolescent turmoil and was eventually disrupted and unravelled by David Roberts' experimentation with illicit drugs and alcohol. The question not raised in any of the attempts to deal with the disturbed as well as delinquent behaviour he manifested, is whether substance abuse might have had a mind altering effect requiring earlier attention to his mental state.

2.3.6. He appears to have settled down after this disturbance in January 1990 and continued with his retake course for GCSEs at Salisbury College that resulted in four passes. He went to Spain with the Rugby Club in the April and to Cornwall with a girlfriend at Easter. He even had a promising interview for the Physical Education Course at Loughborough College in June. However, from June till Christmas he was living hand to mouth with friends and the parents of friends. All seem to have been prepared to assist him on the basis of their previous knowledge and contact with him as a likeable and promising young rugby player, even though one described him as *"completely lacking in motivation"*. He was also living rough as well as, from time to time, at his natural mother's home. Efforts to find him supported lodgings failed, as did attempts to encourage him to sign on at the Youth Training Scheme and thus qualify for Income Support. He did not in the event go to Loughborough College.

2.4. Leaving Care

2.4.1. In January 1991 the wife of one of his foster brothers discovered him sleeping rough and contacted Social Services. It was eventually agreed that she and her husband, already foster parents themselves, should be approved to take him in as part of the Supported Landladies' scheme with effect from 23rd March 1991. He stayed with them until his arrest for burglary offences associated with illegal drug use some fifteen months later, in June 1992. He was reasonably settled during this time and had various short term jobs in a sports shop, a factory and with a hairdresser.

2.4.2. Formally he "left the care" of the Local Authority on 6th March 1991, his eighteenth birthday, although the Social Services Department continued to have a responsibility towards him until his twenty first birthday. This was something David Roberts was aware of. He knew the person he could go to for assistance, hence his visits to the Social Services Department in July 1993.

COMMENT.

For many young people who have spent their formative years in the care of a local authority, the transition to adulthood can require a longer period of support, particularly when a history of alcohol or illicit drug use or illness suggests a high degree of vulnerability. Social Services managers were very open with the Inquiry Team on these issues, and thought that informal contacts were very helpful to young people who had left care. We heard of such contacts being maintained by social workers, possibly at their own expense. We believe that such ongoing support should ideally be maintained for a longer transitional period for those who need or could benefit from it.

The arrangements for 18-24 year-olds in relation to employment and Housing Benefit offer an example of an administrative 'transition', and we believe that a similar period would be appropriate in relation to young people who have formerly been in care. This could include formal transfer of supervision/support to adult services where appropriate, and ongoing contact at birthdays and at Christmas where it is thought to be appropriate, even in circumstances where formal supervision is undertaken by another worker (e.g. probation or mental health services).

2.5. Involvement in Criminal Offences.

2.5.1. Details of David Roberts' involvement with offending behaviour are most easily traced through court documents and Probation records and reports. On 17th August 1992, when he was a little over nineteen, he was sentenced as a first offender to a total of two years Youth Custody. This was for five cases of burglary and theft from a dwelling with fourteen cases taken into consideration (three of theft, three of attempted burglary, and eight of burglary). The Probation Report at that time was prepared by Mrs Sybil Woodward who had access to witness depositions and the social work records and also saw his foster sister-in-law/landlady. The report offered the court a sensitive and not uncritical account of Mr Roberts' background in relation to the offences, and indicated his involvement with a disc jockey who had engaged him in selling drugs and then left him responsible for the debt to the suppliers who threatened him. The burglaries were said to have been a response to this. Mrs Woodward expressed the view that Mr Roberts was genuinely sorry for his involvement, the impact on victims, particularly one woman he pushed when she disturbed him, as well as the impact on co-defendants whom he had involved.

2.5.2. She reflected on the teenage turbulence and heavy drinking, ironically established through his otherwise self-affirming connection with the rugby club, as leading to his general destabilisation and his being easily influenced to the extent that he was soon out of his depth. She also emphasised his remorse. Recognising the sentencing climate for burglary, even for those with no previous offences, she argued that custody might well be damaging for him and that a Probation regime might be appropriate. In the event Mr Roberts was sentenced to a total of two years Youth Custody, the judge remarking: *"You have been given credit for your co-operation and previous good character. If you were over twenty one I would send you down for a very long time"*.

2.5.3. Mr Roberts is reported as being very shaken and angered by the sentence as, indeed, was his foster-sister-in law/landlady who thought that he had been scapegoated, not least on account of his colour. His Probation Through-Care officer was also attentive to his potential anger and concerned lest this was suppressed in activities like demonstrating sporting prowess. Mr Roberts did indeed become captain

of the Youth Custody Centre's rugby team and also immersed himself in study for which he obtained a CITB in Carpentry, an NVQ in Community Sports Leadership and RSAs in Maths and Computing. He was recommended for parole and, although there was one cloud on the horizon in respect of possession of a small quantity of cannabis, he was released to reside again with his foster siblings on 22nd April 1993 – just after his twentieth birthday.

2.5.4. His return commenced well but concerns soon arose about his associates, the presence at the house of threatening people and the possibility that Mr Roberts was using drugs. Confrontations over behaviour led to some terrifying responses by him, and – further evidence of a disturbance put down to anger – harassment and threats by him towards the foster sister-in-law/landlady when he was asked to leave in the July. This was followed by a precarious existence with visits to Social Services for financial help. When his Probation Officer – however sympathetic to his despairing state – found him agitated and anxious and then *"verbally abusive and I felt in danger of being physically attacked if I were to challenge his behaviour or thinking"*, his Parole was revoked. His appeal against this action was refused but the Parole Board ordered his immediate release and, to everyone's surprise, he was accepted back at his foster siblings' home. However, the situation deteriorated very quickly and the Probation Officer met with them, Mr Roberts and two social workers to plan his move to independent accommodation. He moved out on 12th December 1993 when aged twenty and a half.

2.5.5. A period of relative calm followed when he moved to live in a public house in Tisbury as an odd job person. He was also near to a girl friend at that time. In April of 1994 he was back in Salisbury in digs but his situation was deteriorating and he was thought to be under the influence of drugs, being agitated and ill at ease when interviewed by his Probation Officer and alternately jovial and tense and suspicious. In June he was evicted and on 22nd July 1994 appeared in court for shoplifting and begging.

COMMENT

He is reported as behaving very disruptively in the court on that occasion; even so, mental illness appears not to have been suspected, and he was fined and

bound over for six months to keep the peace. It is surprising that the court, faced with this kind of behaviour, did not think to enquire about him further. Had it done so it would have discovered that he was already on Youth Custody licence and causing the Probation Service some concern.

2.5.6. His Youth Custody licence and formal supervision ended on 31st August 1994. On 2nd November he was in court for two cases of shoplifting when he was made subject to twelve months' conditional discharge with a total of £30 compensation. It was just after this, on 16th November 1994, that he is recorded as having sought Social Services' assistance for the last time having been evicted from lodgings in Harnham Road. Shortly afterwards it appears he learned from acquaintances that Mr Osmond, who knew him from rugby club days, had a spare room at 25 Harnham Road and he moved in. That was his address when, on 6th February 1995, he was again in court and remanded on bail for Probation reports for a string of offences from the previous 12th August onwards: common assault (two cases); criminal damage (19th September 1994); shoplifting from Millets Stores (1st November 1994) and the conditional discharge offences from 2nd November (see above). The bind over offence from 22nd July 1994 was not recorded in the prosecution package. In respect of the above, an assistant probation officer's report identified that, on 12th August 1994, Mr Roberts had undertaken a day's work at Wilton Race Course and had been discharged peremptorily with a day's pay and required to leave. It appears he resisted this on grounds of unfairness and a struggle ensued with security guards when he was found to have a knife in his possession. While being detained he alleged that he was subject to racist abuse and, in his anger, behaved threateningly towards a secretary who was trying to defuse the situation. A second charge of common assault occurred three weeks later when he was arrested for head-butting a Macdonald's security officer when asked to leave the restaurant.

2.5.7. The Probation Service realised that Mr Roberts was once more behaving in a manner likely to lead to a further custodial sentence. He was however, persuaded to agree to a recommendation for Community Service and also attendance at an Anger Management Programme. The magistrates accepted these recommendations and on 27th February made a twelve-month probation order with a requirement that he attend

the programme, and an order for him to undertake sixty hours Community Service, plus Compensation totalling £52.99p.

2.5.8. On further assessment he was identified as isolated and lonely, something borne out by his foster sister, social work staff and solicitor who encountered him around the town. When undertaking the Community Service he seemed to function well, working with a club for the elderly and undertaking wheelchair shopping and escort duties. He was reported as mixing well with other helpers and the beneficiaries. As to the Anger Management aspect of the probation order he commenced the first session in April and completed the last at the end of June. He missed three sessions but made up for these in individual meetings when he was taken through the programme material. His involvement in the group varied. Sometimes he was engaged, at others times he manifested a lack of attention. Feedback from the group leaders to his supervisor indicated that he participated when he was the centre of attention, otherwise he could be insidiously disruptive. This might be seen to reinforce other observations that he responded to individual attention. Social workers had earlier reflected that while in the foster home he was good with small children but disliked other children of his own age being there.

2.5.9. While the Anger Management Programme was in process other aspects of his life were less satisfactory. Mr Osmond complained to the Probation Officer that Mr Roberts stayed in bed and did not claim his Housing Benefit, borrowing instead from him. In mid June Mr Osmond evicted him. At that stage, while living from hand to mouth again, he was threatening and intimidatory to his foster sister-in-law/former landlady and towards her children as well as to Mr Osmond. Probation staff advised them to take this seriously and report his behaviour to the police. At the end of June he revealed that he had been bailed for shoplifting. A month later Mr Osmond again offered him accommodation and financial help, indicating to the Probation Officer that he *"misses him"*. Mr Roberts returned to Mr Osmond and the next event, amongst some obvious turbulence at the Osmond premises, is a court appearance on 5th December1995 for theft from Mr Osmond. On 26th January 1996 David Roberts was conditionally discharged and on 26th February 1996 the Probation Order formally ended. There was one more voluntary visit to the Probation Office for assistance on 7th March 1996 (his 23rd birthday). This was the last contact until he

was before the court for being drunk in a public place and assaulting a police constable on 17th September 1996 (also for breach of the conditional discharge on 26th January 1996). He pleaded not guilty but when the charges were proved he was remanded on bail for a further Probation report.

2.5.10. He failed to keep appointments for the report and was remanded again on 10th October 1996, with a hearing date of 4th December 1996. The Probation Officer assigned to the report set out Mr Roberts' explanation for the offences i.e. that his actions were accidental and misinterpreted. He had also confided that he was capable of outbursts of temper when he thought he was being *"wound up"*. He was difficult in the interview, taking exception to the fact that reference had been made by a previous Probation Officer to the nature of the relationship with his landlord and the fact that anger was still a problem area for him. He tried to snatch the record and was asked to leave the office. As he did so he was verbally abusive to a previous supervisor and kicked at an office door. At the court hearing on 4th December1996 he was remanded in custody to enable the report to be completed. This was undertaken by Mrs Woodward.

2.5.11. In addition to the offences for which he was remanded, another charge had been laid, that of assault on Mr Osmond. Mrs Woodward's report is illuminating in that she had known him over a four-year period. She wrote that she suspected drug use – although Mr Roberts denied this – as well as problems with alcohol abuse and anger – something else he denied saying that others were to blame and not him. She commented that: *"During my interview with him,* [in HMP Winchester], *Mr Roberts was generally polite and co-operative though at the end of the interview I advised him that I believed it was due to my efforts as much as his that he kept his temper"*. She had other perceptive things to say about him, i.e. that he *"appears to be disappointed that he has not realised his earlier potential, particularly in sport. He is anxious to be liked and I consider that this can prevent him from acknowledging the nature of his problems"*; and *"So far, Mr Roberts has avoided violent acts resulting in serious injury to others. I am concerned, however, that violence is becoming a feature of his behaviour and that he generally denies responsibility for this. In my view there is a substantial risk of further offences involving violence"*. Nevertheless, she

recommended that the court again consider Community Service as a disposal, which it did on 30th December 1996 with orders totalling 120 hours.

2.5.12. At the same time as imposing the Community Service Orders the court remanded Mr Roberts on bail until 3rd January 1997 for the alleged assault on Mr Osmond. It is not clear where he was living at this time but he did not keep his appointment for Community Service the day after the court hearing and also failed to report to the police twice daily as part of his bail conditions. On 3rd January 1997 he failed to appear in court and a warrant was issued for his arrest. This was not executed until 10th February 1997 when he was remanded in custody until 18th February 1997. Meantime Mrs Woodward, who was transferring to a prison probation post wrote to her Senior Probation Officer on 9th January 1997 to say: *"next time a PSR* [Pre Sentence Report] *is asked for it may be wise for there to be a psychiatric assessment as well, in view of the different things that keep coming to light"*. She had picked up court gossip that Mr Roberts was behaving in a bizarre manner in the town and had been seen with his face whitened. His foster sister who sometimes avoided speaking to him when he was behaving oddly made similar observations. One of his former social workers was also aware that he had been observed around the town talking *"gibberish"*.

COMMENT

It was not clear to the Inquiry Team that the concerns which kept *"coming to light"* were ever communicated directly to those undertaking the psychiatric assessment on the Mr Roberts. While Mrs Woodward's Pre-Sentence Report was available there was no other referral information amongst the medical records submitted to the Inquiry by the Old Manor Hospital and the Medical Department of HM Prison, Winchester. We consider that all agencies associated with referrals for psychiatric reports should ensure that the fullest possible information is passed to those who have to form a judgement about the mental state of someone referred for assessment (see also paragraph 3.5. below).

2.6. HM Prison Winchester

2.6.1. It was at this point that David was first seen by Mrs Maureen Shaw, a Probation Officer assigned to the Wessex Project (see chapter 7) which worked out of the prison

at Winchester to make contact with, and where possible divert, those on remand thought to be mentally ill. The Bail Information Officer working at the prison had some concerns about him and referred him to her. His solicitor had indicated there would be no chance of the bail he was bound to seek unless a hostel would take him.

2.6.2. Mrs Shaw interviewed him on 14th February 1997 and found that *"he was no where near right"*. This view was reinforced when Mr Roberts was admitted to the prison's Health Care Centre over the weekend after smearing himself with his own faeces. Mrs Shaw wrote a detailed letter to the Prison Medical Officer on 17th February 1997 outlining the assessment made on the ward: that mentally *"he is not right"* and *"in danger of self-neglect and/or poses a danger to the public"*. She also referred to restlessness and poor eye contact, wariness and a tendency to answer a question with another question. At one point he had said he had not been well since in the Youth Custody centre. She also considered his thought patterns were not coherent and that he had 'thought blocks' much of the time. She also identified that he seemed *"dominated by his wish to get out of prison but to have no notion of the sort of concerns others might have – about the offence, about public safety generally, nor about playing the game to get bail..."*

2.6.3. On 18th February 1997 Mr Roberts reappeared at court and admitted the breach of Community Service. The court would not revoke the order but adjourned matters to 11th March 1997 requesting a psychiatric report and fresh probation report. At Mrs Shaw's request Ms Jennie Bradley, a Community Psychiatric Nurse member of the Salisbury Court Diversion Scheme (see chapter 7) saw Mr Roberts at the Court on 18th February. She interviewed him in the constrained setting of the cells but found him pleasant and co-operative. The only thing she felt odd about him was that his explanation for being in the hospital wing was *"stomach problems"*. She contacted the prison where staff indicated that his behaviour had seemed *"strange, odd and bizarre"*. On the strength of that, and her feeling that Mrs Shaw's opinion deserved some consideration, she wrote to Dr Michael Humphreys, consultant to the Court Diversion Scheme, who would be undertaking the psychiatric report for the Court. As is indicated elsewhere, Dr Humphreys spoke with Mrs Shaw and read the Prison medical records before writing to the Court on 3rd March to recommend detention at

the Old Manor Hospital, Salisbury for assessment under Section 35 of the Mental Health Act 1983.

COMMENT

In line with government policy and the guidance of Home Office Circulars 66(90) and 12(95), which was followed through by the Salisbury Health Care NHS Trust, the Court Diversion Scheme set up in Salisbury appears to have worked effectively in Mr Roberts' case. This was one of the earlier schemes designed to divert people thought to be mentally ill from the Criminal Justice System. The opportunity for that was Mr Roberts' referral for psychiatric assessment following which he was admitted to hospital under section 35 of the Mental Act 1983. Probation staff spoke well of the Salisbury scheme. They commended its assistance in relation to defendants thought to present a high risk, and also indicated that there is now much more effective follow up of people known to Community Mental Health Teams as well as other agencies through the Care Programme Approach.

CHAPTER 3. SECTION 35 ASSESSMENT AT OLD MANOR HOSPITAL

3.1. Detailed record of his ten-days' stay on Bourne Ward, Old Manor Hospital.

3.1.1. On 3rd March 1997, at a hearing in his absence, David Roberts was further remanded until 25th March to Old Manor Hospital under Section 35 of the Mental Health Act, for a report as to his mental condition. A bed became available on Bourne Ward on **Monday 10th March**, and he was admitted at 11am. The nursing notes indicate *"There is a query to the presentation as David may be suffering from psychosis i.e. thought disorder with auditory hallucinations."*

3.1.2. Within an hour of his admission, however, Mr Roberts had absconded from the ward. *"David presented as a little restless, but co-operative. Despite close observation he managed to break a window and abscond at 11.50 hrs. Police have been alerted - an immediate grounds search was done".* Hospital staff went to his home address in an unsuccessful attempt to find him and out of concern for Mr Osmond's safety.

3.1.3. During the afternoon of the same day, the police visited the ward to take a description of David Roberts. Discussions took place about where he should be taken when detained, and the nursing notes are explicit.... *"I have spoken to Wiltshire Police and have informed them that if they find David they should detain him and not bring him back here (on the say of Senior Charge Nurse K Kusi-Obudum)."* Notwithstanding these arrangements, the police telephoned the ward at 23.45 hrs to say that Mr Roberts had been detained and was on his way back to the ward. He arrived within a few moments, and was handed over to ward staff at the door. The nursing notes *report "Fairly pleasant though did state he was leaving here tomorrow and would...smash his way out if necessary."* The duty doctor was called.

3.1.4. At 00.15 hrs he was seen by Dr Tilley, the duty Senior House Officer (SHO). Dr Tilley noted Mr Roberts' acknowledgement of previous illicit drugs, and that he smelled of alcohol. Dr Tilley also noted: *"Thoughts - says they have been confused*

lately, but would not elaborate further. Says his confused thoughts worry him. Did not answer questions about hallucinations. Appears preoccupied during pauses...denies any mental illness". Dr Tilley concluded *"Possible mental illness. Probable personality problem. Detain overnight...Sedation SOS".* Dr Tilley also prescribed neuroleptic medication, chlorpromazine 50-100 mg, droperidol 5-10 mg, and lorazepam 2 mg on 'as required' prescriptions.

3.1.5. The following morning he was seen by Dr Heal, who was undertaking a six-month contract as an SHO at Old Manor Hospital. Dr Heal commented that Mr Roberts seemed co-operative on the ward, that he was talkative and not agitated, that he was not hallucinating or suffering from delusions, and that he was denying any problems. He was under close observation, and Dr Heal concluded that close observation should continue... *"may well try to leave again".*

3.1.6. Such caution was well-founded. The nursing notes indicate that *"he was being observed...by two members of staff while in the garden. At approx. 11.05 hrs he was in the garden and ran and climbed the back wall. He was stopped by staff whilst attempting to climb the wooden fence in the new annex garden...10 mg droperidol and 2 mg lorazepam given with good effect."* The nursing notes also indicate that Mr Roberts' landlord/friend (presumably Joseph Osmond) had visited with some belongings. The afternoon nursing notes on **Tuesday 11th March** continued in the same theme... *"Roberts appeared to be actively looking for ways to abscond, watching staff movements closely and repeatedly asking to be moved out of the secure room...appeared to be attempting to intimidate staff with his staring and speech content...has shown no apparent signs of psychosis this PM. He remains at high risk of absconding and possible endangerment to staff and fellow patients."* He remained under close observation.

3.1.7. During the day, David Roberts' named nurse completed an initial assessment of his nursing needs. Recommended nursing care included the need for close observation always to involve two members of staff when in the garden. However the recommendation also included the requirement... *"for A/N on duty to complete symptoms monitoring chart and to note other unusual or bizarre speech or behaviour in his kardex".* No symptoms monitoring chart was completed during his ten-day stay

on the ward, although there was said to be uncertainty at the time whether this was because there were no symptoms to record, or because there was a simple failure to complete the forms, which had been newly introduced.

3.1.8. Close observation was continued on the following day, **Wednesday 12th March**. The nursing notes indicate that he was not a management problem during the day, and that there *were "No apparent signs of psychosis evident at any time".* Reports from night nursing staff, however, suggest more problematic behaviour... *"Pushing the boundaries all the time, trying to intimidate staff...no apparent evidence of a psychosis...appears to be constantly looking for a way out...has been awake all night."*

3.1.9. On **Thursday 13th March** he remained under very close observation, and remained settled for the morning and for most of the afternoon. During the day he was seen by Dr Heal who noted... *"Showing no psychotic features. Very bitter about being detained. Doesn't understand why he is here."* Late in the afternoon, however, the nursing notes record... *"a sudden outburst of pressure of speech, the content of which was bizarre and disjointed."* The notes also indicate that Mr Roberts was also seen by his solicitor at his own request, and that a friend visited during the evening with a bag of sweets and books. Notes by the night nursing staff record him discussing his experiences of taking illicit drugs, *"and explaining the buzz he gets from them".*

3.1.10. On **Friday 14th March** he continued under close observation, and *"was given time in the garden this morning very closely observed by three male members of staff".* The notes again record *"no apparent signs of psychosis".* Later the same day Mr Roberts was seen by his Responsible Medical Officer, Dr Michael Humphreys, Consultant Psychiatrist. No formal mental state assessment is recorded, but Dr Humphreys noted... *"This man is obviously a management problem and showing no sign of illness at present although the diagnosis of personality disorder is probably relevant. If he absconds again the police must be informed and if possible they should accommodate him until his return to Winchester* [prison]. *If his behaviour becomes more difficult then he may have to be returned to Winchester before his court appearance".* Meanwhile, levels of observation were relaxed slightly, with no apparent effect until 20.00 hrs when he was heard *"smashing a window in his room with a small coffee table from the lounge. One pane of glass was broken, he was taken*

to the strong room for "time out" and prn [from the Latin *pre re nata* meaning 'as the situation demands' but now accepted as 'when necessary']. *Droperidol 10 mg and lorazepam 2 mg given".* He slept all night.

3.1.11. His disruptive behaviour continued on the following day, **Saturday 15th March.** He slept late, but at 10.30am he was found to have smashed a window in bedroom 3 with a fire extinguisher... *"Time out and prn medication given for high levels of frustration and agitation"* (10 mg droperidol and 2mg lorazepam). Dr Tilley, the on-call SHO, was called to see him, and recorded... *"Several attempts to abscond...Feels low but no psychotic symptoms/thought disorder. Admits that Bourne Ward is better conditions than Winchester Prison, but feels he should be at home! Worries that may be transferred back if continues to be disruptive".* Nevertheless his disruptive behaviour continued later in the day. At 1700 hrs he went to the toilet and broke a window with his fist. Again, time out and prn (as necessary) medication was given following this incident (10 mg droperidol and 2mg lorazepam), and closer levels of observation were re-introduced. Later the same evening, however, there were further problems. At approximately 21.50 hrs he was woken by night staff when asleep in a chair and was asked to return to his room for the night. He became verbally aggressive and *"attempted to attack"* one of the night care staff. Restraint was needed to control him, and further prn medication given (10 mg droperidol) as well as 15mg Zopiclone to help him sleep. *"He continued to verbally abuse staff until medication began to work... but later slept well".*

3.1.12. Mr Roberts was on close observation for the remainder of the weekend and was occasionally verbally abusive to staff, angry and unsettled. The nursing notes continue to record that he was looking for opportunities to abscond, but no further medication was administered save paracetamol.

3.1.13. On **Monday 17th March**, he *was "reasonably settled in mood"* although it is also recorded that *"he has continued to actively look for opportunities to abscond".* He continued to be nursed with close levels of observation, and nursing numbers were increased to accommodate this. The nursing notes also indicate that David Roberts was *"discussed by Dr Humphreys who is going to try to have his court case brought forward."* There is no entry in the medical notes for that day, but a letter from Dr

Humphreys to the Clerk to Salisbury Magistrates, dated 17th March, seeks to expedite a return to the Court for disposal:

"Roberts was admitted to Bourne Ward at the Old Manor Hospital from HMP Winchester under Section 35 of the Mental Health Act on the 11th March last.

His stay in this hospital has been an eventful but unhappy experience. Between his admission and the date of my dictating this report, 17th March, he has broken four windows in the hospital ward. The first by throwing a fire extinguisher through it. He has absconded on one occasion and attempted to abscond on another occasion. He required continued presence of two nurses and when vigilance is relaxed he becomes verbally and physically aggressive.

Nevertheless throughout the entire period of our observation, which has necessarily been close, neither myself nor the experienced nursing staff in this hospital have seen any evidence of mental illness in this man. He is not psychotic, he is not depressed, he does not suffer from hallucinations or delusions. I have no recommendations to make to the Court and he is fit for any disposal the court may have in mind"

COMMENT

We cannot escape the conclusion that the prime consideration in the decision to return David Roberts to the court for disposal was the difficult management problem he presented. There is little evidence in the medical or nursing notes of any systematic assessment of his mental state. The only mental state examination recorded is that of the duty SHO, Dr Tilley, on the night of 10th/11th March. The RMO, Dr Humphreys, is recorded as seeing him only once. There are repeated references in the nursing notes to the absence of psychosis, but little detailed explanation to substantiate this. In our view, it would have been more appropriate to have explained to the Court that Mr Roberts' disruptive behaviour had prevented a full assessment being made, so that consideration could be given to a fuller assessment being undertaken in a more secure setting.

3.1.14. The following morning, **Tuesday 18th March**, confirmation was received from the Court that the case had been brought forward to **Wednesday 19th March**. Mr Roberts was under close observation for his remaining stay on Bourne Ward, but he remained settled and co-operative throughout. He left for court at 10.20hrs on Wednesday 19th March, escorted by a police officer, Mr Bamborough (CPN), and by a student nurse. He was found guilty of the remaining charges against him (the principal charge of grievous bodily harm having been withdrawn) and was sentenced to a total of 3 months imprisonment (effectively 9 days because of time served on remand). The final entry in his medical notes on Bourne Ward was by Dr Heal: *"Discharged back to Winchester Prison. No mental illness observed".*

COMMENT

There is marked contrast between the disruptive, aggressive behaviour presented by David Roberts during the first seven days of his stay on Bourne Ward (which culminated in his being prescribed neuroleptic medication (prn) on four occasions within 24 hours) and his relatively relaxed presentation over the final three days before his Court hearing on 19th March. It seems very possible that the medication itself (a total of 40mg droperidol) may have been a significant factor in this change of presentation.

3.2. The Bourne Ward Environment.

3.2.1. Bourne Ward was not designed to perform the various specialist functions it has been asked to play. It has 10 beds. It is not sufficiently secure to undertake a role of Low Security. The fabric of the unit looks tired. Its design does not lend itself to the provision of intensive care. It is certainly not designed to perform both Low Security and intensive care within the same unit. Opportunities for individual programmes of care for patients in crisis are very limited. As the experienced Senior Charge Nurse on Bourne Ward, Mr Kwame Kusi-Obudum, told us, referrals are accepted from penal institutions, from Special Hospitals, from Regional Secure Units, as well as from acute wards in the Old Manor Hospital and other acute units elsewhere. *"Sometimes the mix of clients causes a real problem, with the different levels of needs...but it is the expertise of the team that helps minimise the problems that can sometimes happen with such a diverse client group."* For many years the Mental Health Act Commission has drawn attention to the severe limitations of the structure and fabric

of the unit, given the very key role it plays. These limitations have been recognised by the Trust and by the respective purchasers, and proposals have been made, but not yet finalised, for reprovision both of Low Secure care and intensive care facilities to serve the north and the south of the Trust's area.

COMMENT

We concur that Bourne Ward is not a suitable physical environment for Low Security or for intensive care. On the basis that environment is one of the key elements in the provision of adequate psychiatric care, this places a real limitation on the quality of service able to be provided from the unit.

3.3. Access to Medium Secure Services

3.3.1. A legend has grown that access to Medium Secure resources in the Region, in particular to Ravenswood Medium Secure Unit, is rarely if ever possible from local acute units. Mr Roberts' RMO, Dr Humphreys, told us frankly that, although staff at Ravenswood are co-operative and helpful, *"the Regional Secure Unit is a bit of a Holy Grail. Getting patients in there is an event in itself."* It may have been for this reason, (though Dr Humphreys did not take recourse to it as a convenient answer), that no thought was given to recommending that Mr Roberts should receive further assessment in a more secure setting such as Ravenswood. As Dr Humphreys told us, *"we were of the view at the time that the assessment had been completed."*

COMMENT

This should not be interpreted as criticism of Ravenswood or of its staff. We are aware of the pressures on Medium Secure services across the country, and of the difficulties most have in achieving a reasonable degree of turnover of patients. On the contrary, we heard several references to the valuable outreach work being undertaken by Ravenswood staff, particularly in Winchester Prison. Nevertheless the difficulty in obtaining beds in Medium Secure Units clearly places additional burdens on acute units. This is especially the case when numbers of patients who present serious management problems have to be nursed in units where neither the fabric of the unit, nor the basic medical and nursing staff establishment, are geared to perform the task. David Roberts, for instance, required high levels of supervision, invariably involving two members of staff, for the majority of his brief stay.

3.4. Section 35 (10) Mental Health Act 1983

3.4.1. Section 35(10) of the Act states: *"If an accused person absconds from a hospital to which he has been remanded under this section...he may be arrested without warrant by any constable and shall, after being arrested, be brought as soon as practicable before the court that remanded him; and the court may thereupon terminate the remand and deal with him in any way in which it could have dealt with him if he has not been remanded under this section."* Throughout our Inquiry we were told that local Trust policy and practice provides that patients who abscond from hospital whilst remanded under Section 35, and who are subsequently detained by the police, should be returned to court. The report of the Trust's "Internal Mental Health Directorate Enquiry" recommended that "*The Magistrates Court and the Police should be advised in writing that this practice should be adhered to.*" Indeed we were told in evidence that, if the police had not returned David Roberts to Bourne ward after he had absconded, there would have been no occasion to convene an independent inquiry. However, it is our view that to arrest patients and to return them to court in these circumstances should be a conditional power, rather than mandatory, and that each case should be considered on its merits before a decision is made. In the case of Mr Roberts, the police returned him to Bourne Ward at midnight against the express instructions of senior ward staff. We do not believe that doing so offended either the spirit or the letter of the law, but it nevertheless pre-empted any opportunity for discussion as to the best clinical course of action to be taken.

3.4.2. Mr Kusi-Obudum confirmed to us in evidence that the primary purpose behind his asking the police to detain Mr Roberts when they found him, was in order that he could be seen in the police cells, for reassessment, and to decide on the proper clinical course of action, given the staffing and environmental constraints of Bourne Ward. This was to give time for a judgement to be made as to whether proper management arrangements could be put in place on the ward to enable the reassessment to continue.

COMMENT

We understand that there is no case law to establish the proper interpretation of Section 35(10) of the Act but we believe that the use of the phrase "*may arrest*"

implies a discretionary power, rather than a mandatory one. In our view, an interpretation which requires that patients must be returned to court, if they are apprehended by the police when absent from hospital without leave, is too narrow and restrictive.

RECOMMENDATION

We recommend that the joint policies between the police and the Trust on this issue be reviewed to incorporate a more flexible interpretation of Section 35(10) of the Act.

3.5. Inter-Agency Transfer of Patient Records.

3.5.1. David Roberts had been remanded in Winchester Prison from 10th February 1997 until he was transferred to the Old Manor Hospital under Section 35 of the Mental Health Act on 10th March. However the period of four weeks' remand was not without incident. Less than a week after his arrival in prison, on 16th February, wing staff were expressing *"concern re: bizarre behaviour...appears confused and not 'with us'. Covered himself in excreta in his cell..."*. He was admitted to the Prison Health Care Centre for observation on the same day, and a request was made for him to be given a formal psychiatric assessment. He was seen by Dr Humphreys five days later, on 21st February, who recommended formal assessment under Section 35 of the Mental Health Act as soon as a bed became available at Bourne Ward. A further 19 days were to elapse before the transfer could be arranged, and during that time mental state examinations were undertaken by Dr Steven Allen (a senior Registrar in general adult psychiatry) on 25th February and on 3rd March. There is no record of either of these examinations being available to staff on Bourne Ward during David Roberts' subsequent stay there, and no note that any of the Medical Records from Winchester Prison were made available to the hospital.

COMMENT

We are surprised that potentially valuable medical and nursing records do not routinely pass from one medical setting to another in circumstances that are validated by formal court orders

RECOMMENDATION

We recommend that early inter-agency discussions take place to facilitate the exchange of information and patient records.

3.6. Medical Staffing in Bourne Ward in March 1997

3.6.1. Bourne Ward at the Old Manor Hospital is a locked facility for the assessment of difficult to manage patients. At the time of Mr Roberts' admission to the ward medical staffing on the Unit was comprised of Dr Michael Humphreys, who was at the time employed as a part-time Consultant Psychiatrist, and Dr Sam Heal - Senior House Officer/General Practice trainee.

3.6.2. Dr Humphreys is a senior and experienced psychiatrist who was first appointed to a Consultant post in the National Health Service in 1977. He had been employed by the Wessex Regional Health Authority on a full time basis, and transferred to the Salisbury Health Care NHS Trust in 1994. He transferred later within the Trust to take up a post as a general psychiatrist (with a special interest in forensic psychiatry) for 5 sessions per week. Dr Humphreys first saw Mr Roberts in Winchester Prison and wrote a provisional medical report in which he recommended admission for a fuller assessment and proceeded to arrange for this to take place at the Old Manor Hospital. Mr Roberts was admitted on the 10th March 1997 and absconded shortly after admission, returning in the early morning of the 11th March 1997, when he was seen by the Medical Officer on duty. On Friday 14th March 1997 Mr Roberts was seen by Dr Humphreys who made a clinical entry at the time. The entry describes Mr Roberts' attempts to escape and Dr.Humphreys' attempts to make him understand the constraints imposed by the Section 35 under which he had been detained. Dr.Humphreys described him as *"a management problem and showing no signs of illness at present although the diagnosis of Personality Disorder was probably relevant"*

3.6.3. Dr Humphreys reported that he would almost certainly have seen Mr Roberts again on Monday 17th March 1997 when he was in the Old Manor Hospital. Neither Dr Humphreys nor his Senior House Officer made a clinical or medical entry if in fact Mr Roberts was seen. Mr Roberts was subsequently transferred from Bourne Ward on the 19th March 1997 and returned to Salisbury Magistrates Court.

3.6.4. The extent of Dr Humphreys' contact with Mr Roberts is important because his was the senior medical opinion on the latter's management. In Dr Humphreys' evidence to the Inquiry he confirmed that he was out of the hospital from probably Monday lunch time on 10th March until Friday 14th; firstly, because of the nature of his contract with the Health Authority and secondly, because of other commitments. Dr Humphreys confirmed that his own clinical assessment of Mr Roberts' stay on the ward would have been influenced by the reports of very experienced and senior nurses with whom he had worked for some time. However, he acknowledged that it was his own clinical assessment that finally determined the report he made. He conceded that in his entry in the medical notes on the 14th March there were no clinical features and no detailed record, nor indeed any reference to aspects of Mr Roberts' mental state. Mr Roberts case was clearly discussed by Dr Humphreys with the nursing staff on 17th March, however, and a decision was made to terminate the assessment at the Old Manor Hospital.

3.6.5. In the context of medical staffing Dr Humphreys' lack of availability during the first week of Mr. Roberts' stay in hospital was an important factor. In his evidence to the Inquiry Dr Humphreys stated that he was unavailable until Friday 14th March and his recorded assessment at that time was dominated by Mr Roberts' attempt to abscond from the ward and other difficulties of management which he posed. There is no medical entry for the 17th March although in the nursing records it is stated Dr Humphreys discussed the patient's care with the nursing staff. As a result of Dr Humphreys' lack of availability the medical contribution to Mr Roberts' assessment on Bourne Ward was left to Dr Sam Heal, a Senior House Officer on the ward.

3.6.6. At the time of Mr Roberts' admission, Dr Heal was a general practice trainee in a rotation which would usually include several disciplines of medicine and sometimes a six month psychiatric placement for experience in that speciality. Dr Heal had no previous psychiatric experience at the time of his placement. He was placed in a very complex and demanding clinical arena without any ongoing daily contact with a more senior medical practitioner. In addition to his responsibilities on Bourne Ward Dr Heal was also responsible for some 30 to 40 other patients in medium to long stay wards under a different consultant. By his own admission Dr Heal was thrown into a

very difficult situation in which he had neither the experience nor expertise to provide ongoing management for the patients on Bourne Ward. He was, in any event, stretched by having clinical responsibilities elsewhere. There was no formal supervision time built into his weekly time table, nor was there specific theoretical input relevant to his duties on the ward.

3.6.7. Following Mr Roberts' admission to the ward on the early morning of the 11th March he was subsequently seen by Dr Heal at 11.30 am. that day. A very brief history was taken, and an equally brief mental state examination. In his treatment plan Dr Heal indicated that the constant level of observation which Mr Roberts required at that time they should be continued because of his attempts to abscond.

3.6.8. On the 13th March Dr Heal made an entry about a further attempt which Mr Roberts had made to abscond by climbing over a garden wall adjacent to the ward and in the same entry he said that Mr Roberts had *"no psychotic features"*. It is not clear if Dr Heal was present at the meeting on the 14th March when Dr Humphreys saw Mr Roberts, although one can only presume that it took place in a multi-disciplinary format that should have included Dr Heal. There is no evidence of Dr Heal's presence on the 17th March. Dr Heal's only other entry is on the 19th March when he noted that Mr Roberts had been transferred back to Winchester Prison and added that *"no mental illness"* had been observed.

3.6.9 In his evidence to the Inquiry Dr Heal agreed that his clinical entries were very sparse and they did not include any detailed description of Mr Roberts' mental state nor any attempt at serial monitoring. Dr Heal acknowledged that these entries are rather less than he would have liked or would have been his normal practice because he was exceptionally busy at that time.

3.7. David Roberts' Assessment

3.7.1. In order to evaluate the quality and competence of the assessment, the Inquiry Team interviewed the medical and nursing staff involved and reviewed the clinical notes and the nursing process notes (described as a Kardex System on Bourne Ward). The lack of detail in the clinical notes has already been described above.

3.7.2. Mr Kwame Kusi-Obudum, a very experienced Charge Nurse who had worked with Dr Humphreys for a number of years, led the nursing staff. There was, therefore, considerable clinical experience available at senior nursing level during the course of Mr Roberts' assessment. The process of assessment, however, did not appear to follow any designated sequence of guidelines. The only standardised assessment tool was a "symptoms monitoring chart" which in the case of Mr Roberts was not completed. Mr Roberts was not screened for drugs or alcohol on admission or at any time during the course of his stay on the ward. In the case of the one documented meeting between the Responsible Medical Officer and Mr Roberts it is not clear in what context this meeting took place. Neither the nursing or medical records describe any kind of multi-disciplinary format, such as a ward round or any similar meeting, at which different professionals contributed to the discussion about the patient's assessment. The discussion on the 17th March with Dr Humphreys is referred to only in the nursing reports.

3.7.3. It is ironic that apart from the mental state assessment by Dr Tilley on admission, the only other mental state reference is contained in the nursing notes which described *"a sudden outburst of pressure of speech, the content of which was bizarre and disjointed"*. This could not be clarified or cross-referenced to any appropriate or related medical entry. The nursing entries were made by both qualified and unqualified nurses and inevitably differ in terms of the quality and precision of the entry. We were told that the nursing assistants would write the more mundane daily events and the qualified staff would write about *"mood and changes in mental health state"*. Given the varying levels of nursing input there is also a continuing repetition of the idea that the patient had *"no psychotic features"* without any attempt to document what aspects of mental state or behaviour was being referred to.

COMMENT

It was not always clear to the Inquiry who was responsible for writing the entries in the nursing records. However, the UKCC "Guidelines for records and record keeping" recommend that when record keeping is delegated to a pre-registration student or health care assistant each entry should be countersigned. We could find no evidence of this. The purpose of the record is to provide evidence of the

care planned, the decisions made, the care delivered and the sharing of information.

RECOMMENDATION

We recommend that the Trust implements standards for record keeping which are in keeping with those required by the UKCC.

3.8. Decision Making Processes

3.8.1. Decision making processes in Mr Roberts' case are not documented and, therefore, remain inaccessible. The single contribution documented by Dr Humphreys focused on Mr Roberts' attempts to abscond. There was no consistent monitoring of his mental state and no serial documentation of this. There is no correlation between when Mr Roberts was given medication and its effect on his mental state. At the meeting on the 14th March, no clinical decisions were recorded, apart from the need to transfer him back to prison if his behaviour continued to be disruptive.

3.8.2. No medical records exist of the second review which took place on the 17th March when the decision to return him to court was made.

COMMENT

The medical staffing was inadequate for such a specialised Unit. The consultant worked part time and the Senior House Officer was inexperienced and overburdened. The standard of assessment of Mr Roberts during his 10-day stay on Bourne Ward fell short of what could reasonably be expected from a Unit which carried such responsibilities.

The quality of record keeping was poor and we have already referred to the standards for nursing records earlier in the report. At no time was there an assessment of Mr Roberts' mental state by the medical team directly responsible for his care. There were no standardised tools of assessment used and no attempt to record any serial changes in his mental state. No objective tests were done for drugs and or alcohol. The decision-making processes were not accessible and we have already commented on the reasons why Mr Roberts was returned to court.

RECOMMENDATION

We recommend that the Trust implements the standards set by the College of Psychiatrists for clinical record keeping and the assessment and clinical management of risk and harm to other people.

CHAPTER 4. DAVID ROBERTS' AFTER-CARE: APRIL to AUGUST 1997

4.1. Availability of Provision

4.1.1. Mr Roberts was discharged from the Old Manor Hospital on 19th March 1997, and appeared before Salisbury Magistrates Court for disposal on that day. It seems clear from the evidence of the Wessex Project as well as the Probation Service in Salisbury that neither was prepared for Mr Roberts' early reappearance at court without a medical recommendation. By the time the hearing took place, the principal charge against him (Grievous Bodily Harm) had been discontinued because, as we understand it, the victim was unwilling for the matter to be pursued. Mr Roberts' solicitor, meanwhile, urged the court to deal with the case in the interests of justice and to avoid further delay for his client. Mr Roberts was re-sentenced for the original offences (assault on the Police, and theft), having breached the previous sentences of Community Service, and received concurrent sentences of three months, one month and one week's imprisonment; the latter for failing to surrender to bail. He was released from prison nine days later, on 27th March 1997.

4.1.2. So far as we have been able to ascertain, Mr Roberts was not in contact with any service from the time of his release from prison until his detention by the police under Section 136 of the Mental Health Act on 1st August 1997. He was not considered to be subject to the Care Programme Approach. Nor was he subject to Probation After-Care. Staff at the Wessex Project, who had initially identified Mr Roberts in Winchester prison as likely to be suffering from a mental disorder, tied up as many loose ends as possible by notifying his General Practice of the period in hospital and of his impending release from prison. An accommodation list was obtained in case his previous accommodation was no longer available to him. The Probation service in Salisbury was also alerted to the date of Mr Roberts' impending release but with the recognition that any assistance from that quarter would depend on his willingness to request it or to respond if it was offered. As it was, voluntary assistance was not an option because of resource constraints at the time. The Wessex

Project had no further contact with him after his release from prison on 27th March 1997.

COMMENT

In our view it should be possible for arrangements other than 'Voluntary' after-care to apply when someone is assessed, as David Roberts was, as being of high risk or a danger. Both the recently published "Safer Services" Report and the consultation document "Managing Dangerous People With Severe Personality Disorder" draw attention to the priority to be given to this kind of person. Home Office Probation Circular (15/1999) now provides for an "Early Warning Mechanism For The Release Or Discharge Of Potentially Dangerous Offenders". This requires the Prison Service to bring to notice prisoners being released without supervision. This mechanism should alert local agencies responsible for CPA, as well as the Probation Service. However additional resources may need to be available to agencies attempting to engage prisoners who fall outside statutory licence requirements.

4.2. The Care Programme Approach.

4.2.1. The Care Programme Approach (CPA) is intended to be applied to all patients referred to specialist mental health services. It involves a process of assessment to determine the needs of people who come into contact with services and requires such services to agree and document the level of their involvement. Each person requires an individual assessment of health and social needs so that the relevant, and probably complex, issues are clearly defined. The assessment should include, if possible, the presence and degree of severity of mental illness, an assessment of risk to self and others and any behavioural difficulties.

4.2.2. In normal circumstances, it might have been expected that Mr Roberts would become subject to CPA either through the Trust's policies, or through the systems set up under the auspices of the Wessex Project. However neither route prevailed. We discussed the reasons for this carefully with the staff of the Trust and of the Wessex Project.

4.2.3. Local CPA policies in force at the time of Mr Roberts' ten-day period in the Old Manor hospital stated, *"All people in contact with specialist mental health services are eligible for the CPA."* However, the policy then goes on to describe sets of eligibility criteria. On the face of it, these would seem to have excluded him from eligibility for the full CPA, particularly as Dr Humphreys' Section 35 assessment had concluded, *"Neither myself nor the experienced nursing staff in this hospital have seen any evidence of mental illness in this man".*

4.2.4. The local policy was that patients with serious problems who failed to qualify for the full CPA would be offered a service dependent upon available resources. Dr Humphreys confirmed in evidence that it was never a consideration that CPA should be invoked, nor have we seen any evidence that such consideration was given. Mr Kusi-Obudum told us that the CPA process would not normally have begun while a patient was still under the jurisdiction of the court (i.e. under Section 35 of the Mental Health Act) but would have done so if the court had placed him under hospital jurisdiction.

4.2.5. However, we also heard in evidence that different approaches to CPA operated in the Salisbury locality from the other two localities in Wiltshire. We were told that Salisbury operated a two-tier approach while the other two localities, Swindon and North & West Wiltshire used the 3-tier approach advocated by most CPA guidance documents at the time. It is a matter of conjecture whether Mr Roberts would have fallen within the curtilage of CPA in either of the other Wiltshire localities. It is also a matter for regret that no consideration seems to have been given to what kind of ongoing support might have been recommended to the court, once he had left hospital.

4.2.6. Dr Humphreys told us frankly that Mr Roberts' behaviour during the ten days he was a patient made the process of assessment extremely difficult, but even so, the process could have been better undertaken. Dr Humphreys also told us that, with the benefit of hindsight, it would have been a wise approach to tell the court that the assessment was incomplete. This would have alerted both the court and the prison that the possibility of mental illness could not be absolutely ruled out. It may also have alerted the Wessex Project and Probation Service to the need to try to establish some

form of ongoing support for Mr Roberts when he was released from prison. As it was there was insufficient time for the Wessex Project to establish any such support.

COMMENT

We understand that the Department of Health is shortly to propose a number of changes to the Care Programme Approach, to ensure that all mental health service users on the CPA receive care that prevents or anticipates crisis and reduces risk. We do not at this stage know whether these provisions will include patients subject to detention under Section 35 of the Mental Health Act, but in our view David Roberts' care management could have been improved significantly had he been subject to CPA.

RECOMMENDATION

We recommend that patients subject to section 35 of the Mental Health Act should not be excluded from consideration for the Care Programme Approach, and that local policies should be reviewed in light of this recommendation.

CHAPTER 5. DAVID ROBERTS' DETENTION under SECTION 136 of THE MENTAL HEALTH ACT on the 1st AUGUST 1997

5.1. Local Policy

5.1.1. Section 136 empowers a police officer to remove a person from a public place to a 'Place of Safety' if he or she considers that the person is suffering from mental disorder and is in immediate need of care or control. The person can be detained in a place of safety for up to 72 hours for examination by a doctor and interview by an approved social worker in order that suitable arrangements can be made for their treatment or care. The Code of Practice to the Mental Health Act states that good practice depends on the local Social Services, Health, and Police Authorities establishing a clear policy for use of the power.

5.1.2. Such local policy was duly agreed by Wiltshire Constabulary, Wiltshire Social Services Department, and the respective Health Trusts. It was revised in November 1997, and is reviewed annually.

5.2. Events of Friday 1st August 1997

5.2.1. At 15.10 hrs on Friday 1st August 1997 CCTV located Mr Roberts acting aggressively in Salisbury City centre. The Inquiry Team has seen a video of the CCTV record. Police were alerted and made contact with Mr Roberts at the High Street gate of the Cathedral. He ran off but was caught on the Cathedral Green where several officers were required to restrain him. The incident attracted considerable public attention. He was arrested for assault, and under section 136 of the Mental Health Act 1983, handcuffed and placed in leg restraints, and taken to Amesbury police station as a 'Place of Safety'. Under normal circumstances he would have been taken to Salisbury police station but it was being refurbished. The journey took approximately 20 minutes, and we were told by the arresting officers that Mr Roberts was very violent throughout the journey and had to be carried into the police station by four officers. He was placed in a cell, still handcuffed and in leg restraints. The

arresting officers returned to Salisbury, from where one of them, PC Barr, faxed his arrest report to Amesbury police station at 18.18 hrs.

5.2.2. Meanwhile, the police custody record indicates that Mr Roberts' violent behaviour continued, and an entry in the record at 16.15 hrs states that he was still too violent for the restraints to be removed. At 16.27 hrs contact was made with the Social Services Department Emergency Duty Team and arrangements made for an approved social worker to attend. At 17.04 hrs Mr Roberts had calmed sufficiently for the wrist and ankle restraints to be removed and, at his request, attempts were made to contact his solicitor. Contact was not made until 18.05 hrs, when arrangements were made for a solicitor to attend.

5.2.3. At 18.50 hrs confirmation was received that an approved social worker would attend at 19.45 hrs, and at 18.51 hrs the duty police surgeon was paged. At 19.05 hrs the duty police surgeon arrived to undertake a medical assessment, but his entry in the custody record simply reads, *"Prisoner not willing to talk to me - Says 'he doesn't want to talk to me'. Interview terminated"*. The police surgeon then left the police station before the approved social worker had arrived. When the approved social worker did arrive, approximately 35 minutes after the police surgeon had left, she interviewed Mr Roberts. Her entry in the custody record reads, *"Interviewed David at length - he was calm and rational - no indication of mental illness - not detainable under the 1983 Mental Health Act"*. So far as we have been able to ascertain, neither the police surgeon nor the approved social worker had seen the CCTV video or the report of the arresting officer. Mr Roberts was then interviewed by a solicitor, formally charged by the police with assault on a woman in Salisbury earlier in the day, advised of his rights relating to free legal advice, processed and, at 23.08 hrs, bailed to appear at Salisbury Magistrates Court. He was given a lift back to Salisbury by the Detective Sergeant who had processed the charge against him.

5.2.4. There was a marked contrast between the circumstances of Mr Roberts' arrival at Amesbury police station at 15.37 hrs (violent, restrained hand and foot, accompanied by four police officers) and his departure 7 and a half hours later (co-operative and *'pally'*, accompanied only by the Detective Sergeant). This encouraged

us to look carefully at the period from his arrest to his release on bail, at the way in which local policies had been implemented, and at the events in the context of the guidance contained within the Mental Health Act Code of Practice.

5.3 The Police and Criminal Evidence Act 1984.

5.3.1. The locally-agreed Section 136 policy in operation at the time states, *"Once a person arrives at the police station he/she becomes subject to the PACE Code of Practice"*, while the Mental Health Act Code of Practice (paragraph 10.9) states, *"the person removed is entitled to have another person, of his or her choice, informed of the removal and his or her whereabouts"*. It is clear to us from our enquiries that although the proper steps were taken to ensure that Mr Roberts had access to legal advice, there appears to have been a misunderstanding about his entitlement to have another person, i.e. an 'appropriate adult', present at the police station. Such a person plays a different role from that of Approved Social Worker. Ms Rees was clear that she attended in her role as Approved Social Worker, and not as the "Appropriate Adult".

5.4. Medical Assessment and Social Work Assessment.

5.4.1. The police surgeon, Dr Clark, a Salisbury General Practitioner with 20 years experience as a police surgeon, although without approval under Section 12 Mental Health Act, attended Mr Roberts in the police station. He spent only a brief time with him, and terminated the interview when Mr Roberts refused to speak to him. He established that Mr Roberts was angry but otherwise unremarkable. He told us that he had experienced many similarly angry persons in police cells during his time as a police surgeon. Moreover Dr Clark was quite clear in his evidence to us that he had been asked by the police *"to examine Mr David Edward Roberts to determine his fitness for detention.....As he was physically fit and I understood he was to be assessed further later that evening by a social worker I deemed he was physically fit to be detained at Amesbury Police Station at that time.....Because of his lack of willingness to speak to me I was unable to assess his mental state at that time with regards to any potential danger to himself or others"*.

5.4.2. Dr Clark could not recall being aware that Mr Roberts had been detained under Section 136. Nor did he speak to the approved social worker, who arrived

approximately 35 minutes later, although he told us that he would gladly have returned to the police station had he been asked to do so. Dr Clark was unequivocal that he was called to see Mr Roberts in order to establish his physical well being. Nevertheless, he was aware that an approved social worker had also been contacted. This did not apparently raise any questions for him about the precise nature of the task for which he had been called.

5.4.3. It is clear to us that there was a misunderstanding between the duty sergeant and the police surgeon about the purpose of the medical examination. The arresting officer's report (timed at 18.25 hrs and faxed to Amesbury Police Station) states clearly *"Arrest - ABH on 62 year woman + Section 136 Mental Health Act"*. The duty sergeant, in his opening entry in the custody record states, *"Detention authorised to secure and preserve evidence by interview and to allow medical examination re possibility of Sec 136 MHA"*. The duty sergeant also confirmed in evidence to us that the police surgeon had been called, *"as part of a mental health assessment"*, and not simply to consider fitness for detention.

5.4.4. Ms Rees, the approved social worker who attended Amesbury Police Station, was fully aware of her role in the Section 136 assessment process. Ms Rees indicated that in her experience it was not unusual for police surgeons to make cursory assessments of patients and to have left before the approved social worker arrived. She reported that she might not have been fully aware of the reasons why Mr Roberts had been picked up on a Section 136, nor would she have been able to obtain background information out of hours. She had been given some information but not all of the detail. She had not been aware of the sustained level of behavioural disturbance following Mr Roberts' arrest, as a result of which he had been kept in handcuffs and leg restraints for the twenty-minute journey to Amesbury police station.

5.4.5. She did not find anything in Mr Roberts' presentation to suggest that he needed a period of detention for assessment under the Mental Health Act. She considered the issue of whether Mr Roberts was intoxicated by drugs or alcohol, but found the evidence was inconclusive. With regard to the possible risk presented by Mr Roberts, Ms Rees felt that he did pose a risk to other persons but this was not as a result of presumed or possible mental illness. She told us that she believed that Mr Roberts had

committed a serious offence and would not be released from Police Custody without first being placed before the court.

5.4.6. None of the participating police officers were aware of any regular structured training on section 136 of the Mental Health Act, although there was thought to have been a day training course which a few police officers had attended. The participating social worker remembered a day conference three or four years previously, *"which was very poorly attended by the medical profession and the police, it was mainly social workers and some nursing staff..."*. So far as the social worker was aware, no other joint training had been undertaken. Police and social workers thought that additional joint training would be of great benefit.

COMMENT

Mr Roberts' arrest and detention under Section 136 of the Mental Health Act was to prove to be a crucial series of events in the light of the subsequent homicide in which he became involved. This was at the end of several years of social decline accompanied by a change in his personality. The evidence of his behaviour recorded on CCTV shows someone who is not simply pushing but going beyond boundaries. He was profoundly disturbed at the time of arrest requiring drastic measures to transfer him to Amesbury Police Station. Nevertheless, once he had settled down enough to be interviewed, these circumstances appear to have faded from the perspective.

There was apparently very little by way of communication between the various agencies at any time in the process of his detention. Dr Clark, the Police Surgeon, states that he was called to assess Mr Roberts' fitness for detention but he was nevertheless aware that an approved social worker had also been summoned. Ms Rees, the Approved Social Worker, had insufficient information to assess Mr Roberts. She did not discuss his case with Dr Clark or the arresting or detention officers. Ms Rees reports that she considered Mr Roberts to be a risk to the public but felt that he should be dealt with by the due process of the law. She understood that he would not be granted bail.

The arresting officers were concerned about the level of risk that Mr Roberts presented. At least one of them was aware of Mr Roberts' social decline and change in personality and reported that he attempted to convey his concern to Ms Rees. There was an assumption by the arresting and charging police officers that Mr Roberts would be subsequently detained under the Mental Health Act. These misplaced assumptions demonstrate a real weakness in the operation of Section 136 procedures on that night.

The relocation of the usual 'Place of Safety' from Salisbury Police Station to Amesbury Police Station was probably the reason why so few of the principal players in these events actually met in the course of the evening. Nevertheless, there seemed to us to be significant weaknesses in the operation of the protocol for Section 136. Neither the Police Surgeon nor the Approved Social Worker saw the arresting officers, their report, or the CCTV video. The Police Surgeon did not see or communicate with the Approved Social Worker.

RECOMMENDATION

We recommend that a further county-wide review of the use of Section 136 and local procedures should be undertaken, and that inter-agency joint training programmes should be provided for custody officers, approved social workers and police surgeons.

5.5. The decision to release on bail

5.5.1. We have already commented on the marked contrast between David Roberts' presentation when he was brought to Amesbury, (restrained hand and foot, violent and uncontrolled, carried into the police station by four police officers), and his demeanour when he left the station a little over seven hours later. We discussed frankly with the custody sergeant the reasons for his decision to release Mr Roberts on bail, apparently so soon after his arrest in a public place in circumstances which had caused so much public concern, particularly as there seemed to be no evidence of drink having been a factor. The custody sergeant told us, *"He came in like a lion and went out like a lamb. It is not unusual behaviour. A lot of people do come in fighting and screaming and within very short spaces of time they are different people, almost. Once they have been into the system, or into a cell, they calm down, the drink wears*

off, maybe the drugs wear off, and they are totally different - perfectly rational, perfectly normal people. It is not unusual to see. David was the same...He took the paperwork that I gave him quite rationally, and there was no reason other than that to detain him further. Nothing would be gained by keeping him in the cells." The custody sergeant elaborated further...*"we are duty bound to give him the benefit of the doubt and bail first and keep in second, if certain criteria exist, and not the other way around".*

5.5.2. The simple chronology of the brief period in custody is as follows:

15.37 hrs: carried into Amesbury police station by arresting officer and three escorts. Handcuffed hands behind back and ankles together. Shouting obscenities and struggling.

15.50 hrs: visited, lying on floor. Similarly at 16.01 hrs, and at 16.15 hrs, when the custody sergeant and one of his colleagues went to the cell to release handcuffs and found Mr Roberts still too violent to allow them to do so.

16.28 hrs: visited again, still lying on floor. Similarly at 16.43 hrs.

17.04 hrs: visited in cell. *"Is now calmer. Handcuffs removed."* At this point, Mr Roberts asked for his solicitor. It was now 87 minutes since he had been brought into the police station.

18.06 hrs: by this time, he was asleep in the cell, and was roused at 18.31 hrs.

19.05 hrs: seen by the police surgeon (not willing to talk). By this time he had been in the police station for nearly three and a half hours.

19.55 hrs: seen by the approved social worker. *"Calm and rational. No indication of mental illness - not detainable under the Mental Health Act."* At about this time David Roberts was also seen by his solicitor. It was now over four hours since his arrival at the police station.

5.5.3. For the rest of his time at the police station, he was interviewed for the index offence in the presence of his solicitor, charged, processed and formally bailed.

5.5.4. The interviewing detective sergeant told us that, in his view, David Roberts should have been kept in custody, *"to prevent him from committing further offences...I felt he could possibly assault someone again."* He made representations to the custody sergeant to this effect, but was not able to influence the decision to release Mr Roberts on bail. With the benefit of hindsight, the detective sergeant's fears were prophetic.

COMMENT

The custody sergeant told us that his decision to release Mr Roberts on bail was made in accordance with a strict interpretation of his responsibilities and all the facts, as he knew them. He had seen the CCTV video, he was in possession of the arresting officer's report, and he had spoken with the police surgeon and with the approved social worker. He had witnessed the transformation in Mr Roberts' demeanour since his arrival at the police station. In his view, the events of the evening were *"not unusual"*.

CHAPTER 6. MENTAL HEALTH CONSIDERATIONS and RISK ASSESSMENT

6.1. Mental state from March until August 1997

6.1.1. The evidence that Mr Roberts underwent a change in personality as well as a slow process of decline in social functioning was made available to the Inquiry from a number of sources.

6.1.2. The Inquiry considered aspects of Mr Roberts' personality, mental state and behaviour in the early months of 1997 and during his stay at Winchester Prison and the Old Manor Hospital. The next crucial period of observation was Mr Roberts' detention under Section 136 of the Mental Health Act, and over the weekend of the 1st and 2nd August, immediately before the fatal incident. Thereafter there were the interviews after his arrest. Mr Roberts' psychiatric state was subsequently documented in detail at Broadmoor Special Hospital. Finally, members of the Inquiry Team interviewed Mr Roberts in person on two occasions at Broadmoor Hospital.

6.1.3. In the first half of 1997 Mr Roberts' process of social decline continued. Family members became aware that he was unpredictable and were wary of approaching him because they were unsure of how they might be received. He invariably appeared to be unkempt. Members of the Wiltshire Police who knew him observed a similar process of decline and change in personality.

6.1.4. The level of social contact during this period is unclear. Mr Roberts was living in the home of Mr Osmond, the victim, but describes himself as being quite unhappy to be there and wanted a place of his own. Mr Roberts' unhappiness contributed to a tense relationship with his landlord – Mr Osmond. The discord has been well documented and was the basis for a number of aggressive incidents where Mr Roberts was alleged to have assaulted Mr Osmond.

6.1.5. After one such incident Mr Roberts was arrested and eventually remanded in custody to Winchester Prison. There his behaviour and mental state aroused sufficient concern in Dr Allen and Dr Humphreys, the psychiatrists who saw him, that a recommendation was made for him to be moved to a hospital setting for a more thorough assessment. In the event this assessment did not take place. The documentation of Mr Roberts' disruptive behaviour was a poor substitute for a detailed psychiatric evaluation.

6.1.6. Mr Roberts' mental state, until his arrest just before the homicide, can only be assumed from his progressive social and emotional decline. His unhappiness during this period has already been described. He was also using alcohol and/or other substances. On the day that he was arrested after the unprovoked assault on a woman in the city centre he was behaving in a manner which showed a lack of judgement and possible disregard for the consequences of his actions. His behaviour was erratic and this was followed by such a profound level of disturbance at the time of his arrest, that he was either mentally ill and/or under the influence of mind altering substances.

6.2. Mental State on the evening of the Homicide

6.2.1. Mr Roberts' had only a vague recollection of the events on the evening that culminated in the homicide. He was similarly vague in his recall of subsequent events and the attempted homicide that followed. He acknowledged that he had been drinking and confirmed the details of his movements that evening as they have been described by various witnesses. He remembered being at home with Mr Osmond whom he may have awakened for the purpose of acquiring money. He had no recollection of anything else apart from the fact that Mr Osmond was at one stage shouting at him. He appeared to have no memory of the actual attack that was described as being frenzied. The taxi driver recalled that Mr Roberts only appeared to be in Mr Osmond's residence for what seemed to be a few minutes.

6.2.2. The level of behavioural disturbance can again be construed in the light of the brevity and ferocity of the attack. The lack of recollection is consistent with cognition altered by alcohol and other substance use. Mr Roberts' behaviour earlier in the evening had been described as *"abnormal"* and possibly as that of someone who was *"high"*. The overall impression is that his mental state, his periodic aggression, his

unusual and at times unpredictable behaviour, all point towards a process of mental illness. This was accessible to observation from the latter half of 1996 and through to the time of the index offence.

6.2.3. After the offence Mr.Roberts was observed in prison and following his transfer to Broadmoor Hospital. While in custody he was described as being *"perplexed"* and showing 'thought disorder'. His behaviour was unpredictable with aggressive components. In the course of his treatment at Broadmoor Hospital Mr.Roberts has continued to show evidence of mental illness. He was seen to be depressed with low mood and ideas of low self-esteem. He showed evidence of thought disorder and loosening of associations. He was at times verbally and physically aggressive and was secluded on several occasions. These episodes improved with the administration of medication.

6.2.4. In summary, Mr Roberts' presentation is consistent with a progressive social, occupational and emotional decline as a result of psychiatric illness.

6.2.5. Alongside the mental state considerations is that of co-morbidity or dual diagnosis (i.e. constellation of symptoms that fit the picture of substance misuse disorder as well as symptoms of psychiatric illness). Mr Roberts began using drugs in his teens and by 1992 was an established user. There were a number of related issues such as criminal offences associated with illegal drug use in 1992 for which he served a two-year sentence of Youth Custody following conviction for burglary and theft. Thereafter there was an increase of drug related offending behaviour with escalating seriousness. Mr Roberts had, therefore, an established problem of substance misuse as well as a developing psychiatric illness.

6.3. Risk Assessment

6.3.1. The Inquiry Team considered whether there had been sufficient indication of the levels of risk that Mr Roberts presented to the community. It also considered why no process of assessment had been followed to determine this risk.

6.3.2. Homicides in the general population are associated with young adult men with a history of mental illness, half of whom have a dual diagnosis. These patients with

alcohol and drug misuse and an accompanying mental illness have complex presentations of illness. In most cases there has been one or more aggressive acts in the year before the homicide.

6.3.3. Mr Roberts' behaviour had become progressively more unpredictable accompanied by an increased level of aggression. He was convicted of assault in 1995 and this was the first in a series of offences of violence against the person. He was charged with assaulting a police officer in late 1996 and then, in February 1997, was charged with grievous bodily harm as described above. It was following this charge and his failure to fulfil bail conditions that he was remanded in Winchester prison and subsequently detained under Section 35 of the Mental Health Act 1983 at the Old Manor Hospital.

6.3.4. There were reports that Mr Roberts carried a weapon. He was in possession of one when arrested in August 1997. There was a reported threat to take a female prison officer hostage while he was on remand for the homicide offence. In any event the aggression, hostility and general behavioural disturbance appears to have diminished with administration of regular medication while Mr Roberts has been in Broadmoor Hospital. This is consistent with the explanation that the level of risk presented by Mr Roberts was a result of his mental illness.

COMMENT

An overview of David Roberts' life history carried out as part of a comprehensive assessment would have identified harbingers of future problems. He displayed many of the features identified in the risk assessment literature and in recent findings in this area. During the Inquiry, the Team was aware of some of the difficulties for David Roberts, a young man of African-Caribbean parents, in being placed with a white foster family living in a predominantly white community. This posed a crisis of self-concept for him particularly during his adolescence. Nevertheless culture and ethnicity did not feature in any assessment.

As a young man heavily into substance misuse presenting with social and emotional decline and ominous behavioural changes, the question of Mr Roberts'

capacity for anger is important. There are several instances where his anger spilled over and became quite excessive and even unpredictably so. These instances went far beyond the frequent episodes of hostility and aggression which have been described in a variety of settings in the community, while in custody and in the hospital. These more sustained instances of aggression seem to point towards a high level of risk to other persons. A number of witnesses expressed the same views about the level of risk presented by Mr Roberts.

There is now a great deal of information available from inquiry findings, cogently set out in "Safer Services" (the National Confidential Inquiry into Suicides and Homicides by people with Mental Illness) and the consultation document "Managing Dangerous People with Severe Personality Disorder". This information should assist Health Authorities, Trusts and other public agencies to develop more formalised arrangements to identify those, like David Roberts, who pose a risk to the public or themselves.

RECOMMENDATIONS

We recommend that formalised arrangements to identify those who pose a risk to the public or themselves should become a key function of the Wiltshire and Swindon County Wide Steering Group on Mentally Disordered Offenders.

We recommend that clinicians should attend to social, cultural and ethnic dimensions when assessing mental health.

CHAPTER 7. DIVERSION from the CRIMINAL JUSTICE SYSTEM

7.1. Inter-agency protocols

7.1.1. Mr Roberts might have been included in existing CPA arrangements if he had been more firmly located in policy and practice as a *"real patient"* within the protocols that existed at March 1997 (jointly agreed in May 1995). It is clear to the Inquiry Team that he should come within such protocols now that professional practice is much better developed to identify him as someone needing ongoing support and attention. There are two sets of documents that give some optimism provided the patient status is recognised.

7.1.2. One is the "Joint Health and Social Services Protocol for the Assessment and Clinical Management of Risk in People with Mental Disorder". This was prepared for the Salisbury Health Care NHS Trust by Dr Gwyn Davies in conjunction with Wiltshire and Hampshire County Councils and approved in January 1999. The Inquiry Team anticipates that this protocol will underpin all clinical assessment work and arrangements for inter-agency co-operation.

7.1.3. The other is the "Wiltshire and Swindon Inter-Agency Protocol Regarding the Sharing of Information on High Risk Users/Cases" (reviewed in October 1998). This derived from the "Mentally Disordered Offenders Review" prepared in March 1998. This review led to the establishment of the County Wide Steering Group for Mentally Disordered Offenders and its subsidiary but inter-connecting Local Implementation Groups which relate closely to NHS Trust areas. We were told that three practical initiatives derived from the establishment of these groups:

- The inter-agency protocol for sharing information itself, which provides for the passing of confidential information between the Probation, Social Services, Police, Health Authorities and Trusts and identifies named personnel within agencies

through whom contact can be established and meetings for co-ordination of action can be called, certainly within office hours;

- The Court Diversion Schemes in Salisbury and Swindon; and
- Local joint training initiatives.

COMMENT

From our findings in relation to the operation of procedures for Section 136 of the Mental Health Act 1983, it is our view that there is still potential for failure in systems for exchange of confidential information out of office hours. This applies particularly in situations where there is cause for serious concern but diagnosis is uncertain. It appears to us that the Local Implementation Groups on Mentally Disordered Offenders are now ideally placed to obtain the necessary overview of such situations as well as to provide guidance on information exchange. Previous Homicide Inquiry reports have recommended that such groups should pick up the pockets of information which emerge about isolated incidents of disturbed behaviour. Such incidents are important cumulatively and, when brought together, can be evaluated in the round and then made subject to analysis, assessment and intervention.

RECOMMENDATION

We recommend that further consideration should be given to the protocols for sharing confidential information out of hours to ensure that those needing information in an emergency have access to it, particularly the Sex Offender Register; Child Protection Register; Mental Health Supervision Register and the Probation Service Register of High Risk Offenders.

7.2. Salisbury Court Diversion Scheme

7.2.1. Ms Bradley provided the Inquiry Team with background details of the Salisbury Scheme which had been established in 1996 under the auspices of Home Office Circulars 66/90 and 12/95. Funded by the Home Office, it employed two staff linked to other CPN duties on a job-share basis for 30 hours per week. The scheme was managed by an inter-agency group in which the Health Service had a lead. Mr

Philip Bamborough, himself a CPN, was the Director of the Salisbury scheme at this time and played a key role in the Section 35 process and Mr Roberts's return to court on 19th March.1997. He was also manager of the Internal Enquiry into Mr Roberts' care and treatment. One of the recommendations in the resulting report was for the extension of Court Diversion Schemes to other courts in the area.

7.2.2. The scheme itself has similarities with the Wessex Project and has a key inter-agency role. It is also a focal point for liaison between agencies and is influential in resource mobilisation. Seen as deriving from the Butler Report (1975), the Reed Report (1991), The Report of the Independent Inquiry into the Care and Treatment of Christopher Clunis (1994) and Home Office Circulars 66/1990 and 12/1995, the Scheme draws on key recommendations from the Reed Report that patients should be cared for:

- With regard to the quality of care and proper attention to the needs of individuals;
- As far as possible in the community rather than in institutional settings;
- Under conditions of no greater security than is justified by the degree of danger they represent to themselves or others;
- In such a way as to maximise rehabilitation and their chances of sustaining an independent life;
- As near as possible to their own homes or families if they have them.

Ms Bradley also made reference to the Reed Report findings of the over-representation of black people in both the Mental Health and Criminal Justice System.

7.2.3. The role of the scheme was identified as the *"Diversion of mentally disordered offenders from the Criminal Justice System at the earliest opportunity into appropriate treatment, care and support services"*. Opportunities for diversion were seen to occur at all stages of the criminal justice process, i.e. prior to charge, prior to a court appearance (when the Crown Prosecution Service may discontinue a case), and

prior to sentence. Follow up and liaison with other agencies is also a key part of the duties of the staff of the Scheme and they have an important role in mobilising CPA arrangements.

7.3. The Wessex Project

7.3.1. The Wessex Project was described to us a multi-agency partnership between Hampshire Probation and Social Services, the Prison Service, the Wessex Regional Health Authority and the Mental Health Foundation. It began its work in 1993, initially as a three-year action research project that aimed to:

- identify prisoners with mental disorder in Winchester Prison;
- improve and increase prisoners' access to appropriate services on release, through the introduction of the Care Programme Approach into Winchester Prison;
- develop an increased awareness of the needs of mentally disordered offenders

7.3.2. The Project facilitated contact between community services and serving prisoners. Its brief was also to carry out research into the profile, needs and outcomes of those identified as experiencing mental disorder. That research by Rachel Lart was published by Bristol University's Policy Press in 1996 under the title "Crossing Boundaries."

7.3.3. At the time of its involvement with Mr Roberts the project team then consisted of a manager (from Social Services), a probation officer (Mrs Shaw), a community psychiatric nurse plus a half-time researcher from Bristol University and a half-time administrator. It did not carry cases as part of a statutory caseload, rather its aim was to ensure that the links with and between agencies in the community were made, and that care planning took place prior to discharge. We were told that over the past five years the project has developed strong contacts with local services and also with those in the adjacent areas of Dorset, Wiltshire and Surrey. In Mr Roberts' case care planning i.e. CPA did not happen because he was not seen as eligible by the mental health services in Salisbury. Mrs Shaw made strenuous efforts to link in with his GP, probation staff and housing services at the time of his release.

7.3.4. We were advised that continued joint funding is now agreed up to June 2000 with the successor health authorities in the Hampshire area, with the prospect of negotiating firmer funding thereafter. There is good Health Authority interest and support.

COMMENT

We have been impressed by the work of the Wessex Project and by the multi-disciplinary commitment to its work. The Project had not looked to the Wiltshire Health Authority for funding because there are very few Wiltshire prisoners going to HM Prison Winchester. Specific funding of an individual referral was not thought to be practicable. The Inquiry Team hopes, however, that such other projects as are initiated will receive support from their respective Health Authorities.

CHAPTER 8. STRATEGIC PLANNING and QUALITY CONTROL.

8.1. Planning structures and provision

8.1.1. As the Clinical Director for Mental Health & Learning Disabilities services for Salisbury Health Care NHS Trust told us, *"Our service has gone through a significant programme of change and development over the last five years, moving from a Hospital focused service to a decentralised service with Primary Care linked Community Mental Health Teams at its core."* Nevertheless elements of this process seem to have proceeded at a varying pace. Two joint Community Mental Health Teams have been established in Salisbury together with a team for the elderly. However, a core problem which has been on the agenda for many years now, is the reprovision of the sub-standard accommodation at the Old Manor Hospital, which has been slower to develop.

8.1.2. There may be a range of reasons why some elements are taking longer to achieve but one factor is that, until recently, there seems to have been no clear mental health lead in the Wiltshire Health Authority. We were greatly assisted by each of the three representatives who gave evidence to us, but each was reluctant to acknowledge a lead advisory planning role in mental health. We understand that this factor is in process of being attended to, by the appointment of a lead mental health adviser by the Health Authority.

COMMENT

We are firmly of the view that there are significant advantages in mental health services being provided by a single specialist Trust across a defined geographical area. We believe that Salisbury Health Care NHS Trust has given proper priority and attention to mental health services, but that a lack of clinical influence at the Health Authority has been a contributory factor in the delayed development of elements of the strategic plan.

8.2. Contracts and quality control.

8.2.1. We were advised that the Health Authority has a major contract with the Trust which covers a comprehensive range of hospital and community services. Mental health services constitute approximately 10.8% of the overall contract value. In the past the purchasing of mental health services has invariably been through a single block contract. The monitoring of contracts has never, therefore, operated at very local level. What monitoring there is was informed by higher level indicators that focus more on the developmental agenda, rather than on day-to-day operational performance. The Health Authority, we were told, has not the resources to do other than this. Performance monitoring at very local level tends to have been undertaken primarily by the Community Health Council, whose reports are considered by the Trust. Reports of visits by the Mental Health Act Commission are also given consideration, and circulated widely.

COMMENT

We are of the opinion that the lack of close and regular clinical monitoring of services at local level, particularly of the increasingly central role being asked of Bourne Ward, has led to exceptional pressures being placed upon the unit.

RECOMMENDATION

We recommend that, until such time as the provision of alternative Intensive Care resources and Low Secure services has been established, particular attention should be given to the maintenance of quality control at Bourne Ward, and to the support of its staff who are being asked to undertake a range of complex and demanding tasks.

CHAPTER 9. THE INTERNAL ENQUIRY held by THE SALISBURY HEALTH CARE NHS TRUST

9.1. The nature of the Enquiry

9.1.1. The Inquiry Team was asked to comment on the "Internal Mental Health Directorate Enquiry" in accordance with its terms of reference. The Department of Health guidance in the Health Service Circular 94/27, which sets the framework for reporting all serious incidents in the mental health services, states that in the case of violence there must be an immediate investigation to identify and rectify possible shortcomings in operational procedures. It also goes on to say, *"in cases of Homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*

9.1.2. We were told that the death of Mr Osmond and the attack on Mr Compton came to the attention of the Trust through the local press coverage. One headline read, *"Violent killing of Gentle Joe"*. A check was made with the CPA Co-ordinator who indicated that no information was held about Mr Roberts who was not in contact with mental health services at the time of the homicide. As events unfolded, however, it became apparent that he was someone who was known to staff at the Old Manor Hospital because he had been admitted for an assessment. The outcome of that assessment was his subsequent return to court without any continuing care from the Trust mental health services.

9.1.3. Given the nature of the assessment, its outcome, and the fact that Mr Roberts had been transferred back to court and was not in contact with or in receipt of services from the organisation, a view was taken, in consultation with the then Chief Executive, that it was not a serious incident in the terms of the Trust's Serious Incident Policy. Instead it was agreed to conduct an internal inquiry to see if there were any shortcomings or lessons to be learned. The decision not to conduct a serious incident inquiry was seen, in hindsight, as regrettable.

9.2. The Policy on serious incidents

9.2.1. The policy at the time of the incident in question defined a serious incident as:

- The unexpected death or serious injury of a patient;
- Failure of procedures, or their application so serious as to endanger the life of a patient, member of the public or member of staff, or to pose a serious security risk;
- Failure or misuse of equipment or plant which could have constituted a risk of injury to or have endangered the life of a patient, member of the public or member of staff.

9.2.2. The policy also set out the different procedures to be followed depending on the nature of the incident and the way any investigation should be conducted:

- Management Investigation undertaken by a designated manager;
- Clinical Review undertaken by a range of clinicians, including a clinician of the same discipline;
- Officer Inquiry which includes an appropriate professional manager and nominated consultant. This is appropriate when there a need for both clinical and managerial action to be taken in more complex clinical cases;
- "Non Executive Inquiry" undertaken by a panel of non-executives with support from a senior officer.

9.3. The internal investigation

9.3.1. The decision taken to set up an investigation working party within the Mental Health Directorate was in consultation with the Wiltshire Health Authority. It was felt appropriate to carry out what was called a "Clinical Review" with the following terms of reference:

A) Whether the Trust Policies and Procedures in place between 10th –19th March 1997, with regard to placement, assessment care and treatment, and diagnosis, were appropriate for this particular case;

B) Whether any changes, alterations and/or improvements to Trust practice are desirable for future cases of this nature which may be referred;

C) Learning outcomes to share with clinical staff.

9.3.2. The Internal Mental Health Directorate Enquiry was initially led by Mr Bamborough and Mr David Bunce, Senior Nurse Advisor for mental health services. A Trust Board Non-Executive Director, Mrs Margaret Lewis, was later appointed chairman to the working party, even though some work had already commenced. It should be noted that The Department of Health guidance contained in Health Service Circular 94/27 does not contain detailed advice as to how internal inquiries should be undertaken and therefore the chairman had no formal guidelines as to how the investigation should proceed. There was no psychiatrist on the panel although we heard that advice was given from the lead Consultant Psychiatrist in the Mental Health and Learning Disability Directorate. The working party considered the case notes and other papers as well interviewing staff from Bourne Ward who had been involved in the assessment of David Roberts. They were unable to interview Dr Humphreys the RMO for Mr Roberts.

9.3.3. The Enquiry findings were presented and an action plan formulated in October 1998.

COMMENT

It is unclear from the evidence we heard which version of the policy was in place at the time the internal investigation was set up but we have no doubt that it should have included a consultant psychiatrist as part of the team to consider clinical practice and professional judgement. We learned that the revised policy gives guidance as to the composition of any internal inquiry, its framework and any resultant report. With the introduction of the 'Clinical Governance' framework, there is now an expectation that the medical and/or nursing director will be involved in the investigation of serious clinical incidents.

The Trust amended its Serious Incident Inquiry Policy in June 1998. This now sets out individual staff responsibilities for reporting serious incidents and outlines the means whereby management should respond to them. In the revised document there is an additional criterion to include any serious incident that poses a risk to property, equipment or the proper running of the Trust. The revised policy also suggests that the resultant investigation be completed within three months. Given the competing pressures in any inquiry process we feel that

it should be completed as speedily as possible in acknowledgement that any investigation is stressful for staff and families alike.

It may also be prudent for the Trust to consider any incident that will attract media coverage. This is a criterion that is contained within the policy of other Trusts. Our experience is that family members find it extremely valuable to be included in an investigative process and to meet with an inquiry team.

RECOMMENDATION

We recommend that the Trust reviews its Serious Incident Policy and takes account of:

- **incidents which attract media coverage;**
- **the "Clinical Governance" Framework;**
- **inclusion of family members in the inquiry process;**
- **involvement of outside clinicians;**
- **a time scale which causes the least amount of stress to all involved.**

CHAPTER 10. SUMMARY, FINDINGS, COMMENTS and RECOMMENDATIONS

10.1. Remit of the Inquiry team

10.1.1. Our Terms of Reference were explicit (see Appendix 1), and follow broadly upon the advice contained within the Department of Health Guidelines issued in 1994 and 1995. We believe that we have examined all the circumstances surrounding the treatment and care of David Roberts by the mental health services. In addition we have tried to answer questions raised by local media about why David Roberts should have been allowed to return to live in the community without supervision, so soon after periods spent in prison custody, in detention under the Mental Health Act, and in police custody.

10.2. In Winchester Prison, February/March 1997.

10.2.1. While in prison, Mr Roberts was identified as someone who might be suffering from a form of mental disorder, and we speak positively about both the Salisbury Court Diversion Scheme (paragraph 2.6.3. et seq.), and about the Wessex Project (paragraph 2.6.1. et seq.). The latter aims to identify prisoners with mental disorder in Winchester Prison and to develop an increased awareness of the needs of mentally disordered offenders.

10.2.2. However when Mr Roberts was transferred by order of Salisbury Magistrates Court from HM Prison, Winchester to the Old Manor Hospital so that his mental state could be assessed, not all the relevant social and medical information was passed to the hospital. In particular, records of two recent mental health examinations were not made available, and we have seen no evidence of any other relevant records being made available. **We are surprised that potentially valuable medical and nursing records do not routinely pass from one medical setting to another, particularly in circumstances that are validated by court orders.**

We RECOMMEND that early inter-agency discussions take place to facilitate the exchange of information and patient records (paragraph 3.5.1.).

10.3. In Bourne Ward, Old Manor Hospital, 10th–19th March 1997.

10.3.1. When David Roberts was transferred to Bourne Ward, Old Manor Hospital, on 10th March 1997, he presented serious management problems. He broke out of the ward within an hour of his arrival and was absent without leave for more than 12 hours. Throughout our inquiry we were told that local Trust policy provides that patients who abscond from hospital while remanded under Section 35, and who are subsequently detained by the police, should be returned to court. In our view this interpretation is too narrow and restrictive

We RECOMMEND that the joint policies between the Police and the Trust on this issue be reviewed to incorporate flexible interpretation of Section 35 (10) of the Act (paragraph 3.4.2.).

10.3.2. David Roberts attempted to break out on one further occasion, and caused damage to the fabric of the ward (including four broken windows) during the ten days he was there. For much of this time he was under close observation, requiring the attention of two members of staff. **We believe that Bourne Ward was not a suitable physical environment for patients requiring a degree of security or intensive care. The shortcomings of the environment were a serious limitation on the quality of service able to be provided from the unit (paragraph 3.2.1.).**

10.3.3. At the same time, we were told that access to assessment units offering greater security is *"a bit of a Holy Grail"*. No attempt was made to suggest to the court that a unit offering a greater degree of security was needed in order to conduct a proper mental health assessment. **We believe that the difficulty in obtaining places in Medium Secure Units places additional burdens on acute units when the numbers of patients who present serious management problems have to be nursed in settings where neither the fabric of the unit, nor the basic medical and nursing staff establishment, are geared to perform the task (paragraph 3.3.1.).**

10.3.4. Having said this, however, the standard of assessment of Mr Roberts during his 10-day stay on Bourne Ward fell short of what could reasonably be expected from a unit which carries such responsibility. The Responsible Medical Officer was

employed on a part-time basis, and was not physically available for a significant proportion of the time when David Roberts was on the ward. His Senior House Officer was inexperienced and had a wide range of clinical commitments. While there was considerable clinical experience available at senior nursing level, no standardised assessment tool was used, and Mr Roberts was not screened for drugs or alcohol on admission. The quality of medical and nursing records was unsatisfactory. At no time was there an assessment of Mr Roberts' mental state by the medical team directly responsible for his care. The medical staff complement was inadequate for such a specialised unit.

We RECOMMEND

That the Trust implements standards for record-keeping which are in keeping with those as required by the UKCC (paragraph 3.7.3.).

That the Trust implements the standards set by the Royal College of Psychiatrists for clinical record keeping and the assessment and clinical management of risk of harm to other people (paragraph 3.8.2.).

10.3.5. Mr Roberts was discharged from the Old Manor Hospital on 19th March 1997, and appeared before Salisbury Magistrates Court on that day, without further medical recommendation. By the time the court hearing took place, the principal charge against him (Grievous Bodily Harm) had been discontinued. He was re-sentenced for previous offences and received concurrent sentences of 3 months, 1 month, and 1 week's imprisonment. Because of time already served, he was released from prison nine days later.

10.4. Back in the community, April–August 1997.

10.4.1. So far as we have been able to ascertain, Mr Roberts was not in contact with any service from the time of his release from prison on 27th March 1997 until his detention by police under Section 136 of the Mental Health Act more than four months later. He was not considered to be subject to the Care Programme Approach. Nor was he subject to Probation After-Care. **In our view, it should be possible for stronger after-care arrangements to apply when someone is assessed as being of**

high risk or a danger, as David Roberts was. Home Office Probation Circular (15/1999) now provides for an "Early Warning Mechanism for the Release or Discharge of Potentially Dangerous Offenders". This requires the Prison Service to bring to notice offenders being released without supervision. However special resources will need to be allocated while attempts to engage those prisoners who fall outside statutory licence requirements are undertaken.

We RECOMMEND that patients detained under Section 35 of the Mental Health Act should not be excluded from consideration for the Care Programme Approach, and that local policies should be reviewed in the light of this recommendation (paragraph 4.2.6.).

10.5. The events of Friday August 1st 1997.

10.5.1. It seems likely that David Roberts' mental health deteriorated in the four months following his release from prison, and that he may also have been involved in further drug and/or alcohol abuse. His behaviour in Salisbury City Centre on the afternoon of Friday August 1st, which is recorded on CCTV, was frightening and uncontrolled. He was arrested by four police officers, and taken to Amesbury police station, handcuffed and in leg restraints, under Section 136 of the Mental Health Act and on suspicion of causing Grievous Bodily Harm. The officers considered that he was suffering from a mental disorder, and that he required examination by a doctor and interview by an approved social worker. He remained in handcuffs and leg restraints for nearly two hours, until it was felt safe to release him.

10.5.2. Under normal circumstances, the police officers would have taken Mr Roberts to Salisbury Police Station, but that station was being refurbished, so the extra journey to Amesbury had to be undertaken. This change is the most likely reason why, in the course of the next few hours, none of the principal actors in the events (the arresting officers, the police surgeon, and the approved social worker) met and communicated (paragraph 5.2.1 et seq.). The police surgeon believed that he was being asked to assess Mr Roberts' fitness for detention, although he knew that an approved social worker had been called. By the time the approved social worker saw Mr Roberts he was *"calm and rational - no indication of mental illness - not detainable under the Mental Health Act"* but she had not seen the report of the arresting officers, nor

spoken to them. The arresting officers had left Amesbury Police Station and returned to Salisbury before the police surgeon or the approved Social worker arrived.

Mr Roberts' arrest and detention under Section 136 of the Mental Health Act was to prove to be a crucial series of events in the light of the homicide in which he became involved two days later. This was at the end of several years of social decline accompanied by a change in his personality. The evidence of his behaviour recorded on CCTV shows someone profoundly disturbed. He required drastic measures to transfer him to Amesbury Police Station. However once he had settled down enough to be interviewed, these circumstances appear to have faded from the perspective. There was little communication between the various agencies at any time in the process of his detention.

In our view, there were significant weaknesses in the operation of the agreed protocol for Section 136. The arresting officers believed that Mr Roberts would be detained under the Mental Health Act. The approved social worker understood that Mr Roberts would be dealt with by the due process of law, and that he would not be granted bail. These misplaced assumptions demonstrate a real weakness in the operation of Section 136 procedures on that night.

We RECOMMEND that a further county-wide review of Section 136 procedures should be undertaken, and that further inter-agency training programmes should be undertaken, particularly for custody officers, approved social workers and police surgeons (paragraph 5.4.1. et seq.).

10.6. David Roberts' release on bail

10.6.1. The custody sergeant, having seen the circumstances of David Roberts' arrival at Amesbury Police Station, and having spoken to the arresting officers, released Mr Roberts on bail. He had witnessed the transformation in Mr Roberts' demeanour since his arrival at the police station. He had spoken to the police surgeon who confirmed that he was fit for detention, and to the approved social worker who did not believe that Mr Roberts was detainable under the Mental Health Act. The custody sergeant told us that Mr Roberts *"came in like a lion and went out like a lamb"* and that this was *"not unusual behaviour"*. Mr Roberts was released on bail and given a lift back to

Salisbury nine hours after his arrival at the police station. The custody sergeant's decision to release Mr Roberts on bail was made in accordance with a strict interpretation of his responsibilities and all the facts as he knew them (paragraph 5.5.1. et seq.).

10.7. Strategic Planning, contracts, and quality control.

10.7.1. It has been generally recognised for some time that Bourne Ward at the Old Manor Hospital is not a suitable physical environment for the provision of secure detention and intensive care, yet reprovision seems still to be a long way off. At the same time, no adequate monitoring of contracts at day-to-day operational level seems to have taken place. **We are firmly of the view that there are significant advantages in mental health services being provided by a single specialist Trust across a defined geographical area. We understand that such an arrangement is shortly to take place. We are also of the opinion that the lack of close and regular clinical monitoring of services at local level has been a contributory factor in the pressures being experienced by Bourne Ward.**

We RECOMMEND that, until such time as alternative facilities have been provided, particular attention should be given to the maintenance of quality control at Bourne Ward, and to the support of its staff who are being asked to undertake a range of complex and demanding tasks (paragraph 8.2. et seq.).

10.8. Risk Assessment

10.8.1. During the Inquiry, the Team was aware of some of the difficulties for David Roberts, a young man of African-Caribbean parents, in being placed with a white foster family living in a predominantly white community. This posed a crisis of self-concept for him particularly during his adolescence. Nevertheless culture and ethnicity did not feature in any assessment.

10.8.2. Mr Roberts was a young man heavily into substance misuse presenting with social and emotional decline and ominous behavioural changes. The question of his capacity for anger is important. There are several instances where his anger spilled over and became quite excessive and even unpredictably so. An overview of Mr Roberts' life history carried out as part of a comprehensive assessment would have

identified harbingers of future problems. He displayed many of the features identified in the risk assessment literature and in recent findings in this area.

We RECOMMEND that formalised arrangements to identify those who pose a risk to the public or themselves should become a key function of the Wiltshire and Swindon County Wide Steering Group on Mentally Disordered Offenders (paragraph 6.3. et seq.)

We RECOMMEND that clinicians should attend to social, cultural and ethnic dimensions when assessing the mental health of patients (paragraph 6.3. et seq.).

10.9. Inter-agency co-operation.

10.9.1. We have been given a number of examples of good inter-agency co-operation in the area (paragraph 7.1. et seq.) but we believe that there is still a potential for failure in the system for exchange of confidential information, particularly outside normal office hours.

We RECOMMEND that further consideration should be given to the protocols for sharing confidential information, out of hours, to ensure that those needing information in an emergency have access to it, particularly to the Sex Offender Register; Child Protection Register; Mental Health Supervision Register and the Probation Service Register of High Risk Offenders (paragraph 7.1.3. et seq.).

10.10. The Internal Enquiry.

10.10.1. Department of Health Circular (94)27 contains no detailed advice as to how Internal Inquiries should be undertaken. In this case the view was taken, in consultation with the then Chief Executive, that because Mr Roberts had not been in contact with mental health services at the time of the homicide, it was not a serious incident within the terms of the Trust's Serious Incident Policy. Instead, it was agreed to conduct a Clinical Review, although without a psychiatrist as part of the Review Working Party. The Review Working Party considered the case notes and other papers, and interviewed staff from Bourne Ward who had been involved in the assessment of Mr Roberts in March 1997. However, they were unable to interview Mr Roberts' Responsible Medical Officer. Their findings were presented as the report of

an "Internal Mental Health Directorate Enquiry", and an action plan formulated, in October 1998. The Trust amended its Serious Incident Inquiry Policy in June 1998. With the exception of its recommendation 5 (which is somewhat different in emphasis to our own recommendation at paragraph 10.3.1. above) we support the findings of the Clinical Review which are set out in the Annexe below.

We RECOMMEND that the Trust further reviews its Serious Incident Policy to take account of:

- **incidents which attract major media coverage**
- **the "Clinical Governance" framework**
- **the need to include family members in the Inquiry process**
- **the involvement of outside clinicians**
- **a time-scale which causes the least amount of stress for all involved (paragraph 9.3.3. et seq.).**

ANNEXE: RECOMMENDATIONS of the INTERNAL ENQUIRY

1. Ward Nursing Staff should have the opportunity to attend 'refresher courses' on Record Keeping and Kardexing in line with UKCCN recommendations.

2. A teaching programme should be formulated to educate staff further on the subject of Personality Disorder and treatability/assessment.

3. Medical skill-mix review to be undertaken and monitored for all wards. SHOs should no longer be attached to Bourne Ward. A full-time staff grade medical appointment with continuing responsibility has to be made. Staff skill mix should be reviewed yearly.

4. Regularly review security measures each six months in the light of any untoward incidents.

5. It is recommended that the Mental Health code of practice guidance note be followed in all future cases where a Section 35 patient absconds and the client can be returned to Court forthwith.

6. It should be regarded as good practice in undertaking Section 35 assessments that a Social Work and Psychology assessment be undertaken.

7. A part-time psychology post be funded particularly to provide reports on alleged mentally disturbed offenders.

8. It would be beneficial for the Trust to extend the Court Mental Health Assessment Scheme to the other Court in its Mental Health Service territory.

9. Creation of a Clinical Nurse Specialist post with a specific remit to manage Police and Court Mental Health Assessment Schemes.

APPENDIX 1: TERMS of REFERENCE

To examine all the circumstances surrounding the treatment and care of Mr David Edward Roberts by the mental health services, in particular:

a) the quality and scope of health care, social care and risk assessment.

b) the appropriateness of treatment, care and supervision in respect of:

(i) assessed health care and social care needs;

(ii) assessed risk of potential harm to himself or others;

(iii) any previous psychiatric history including drug and alcohol abuse;

(iv) the number and nature of any previous court convictions.

c) the extent to which Mr Roberts' care corresponded to statutory obligations; national guidance (including the Care Programme Approach, HSG(90)23/LASSL(90)11); Supervision Register HSG(94)5; Discharge Guidance HSG(94)27; Home Office Circular (66)90; Home Office Circular (12)95; Mental Health Act 1983 including Sec 136 and any local operational policies for the provision and support of mental health services.

d) The extent to which his prescribed treatment and care plans were:

(i) documented;

(ii) agreed with patient;

(iii) communicated within and between relevant agencies and patients family;

(iv) carried out;

(v) complied with by patient.

To investigate the scope and nature of any other reviews into the care and treatment of Mr Roberts.

To examine the appropriateness of the training and development of those involved in the care of David Edward Roberts.

To prepare a report on and make recommendations to Wiltshire Health Authority.

APPENDIX 2: PROCEDURE ADOPTED by the INQUIRY

All witnesses of fact received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement as the basis of their evidence to the Inquiry and informed 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) that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the Inquiry;
d) 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;
e) that it is the witness who will be asked questions and who will be expected to answer;
f) that their evidence will be recorded and a copy sent to them afterwards for them to sign.

Witnesses were not required affirm but accepted they would tell the truth.

Potential criticism was put to witnesses of fact, either verbally when they first gave evidence, or in writing at a later time, and they were given an opportunity to respond.

All sittings of the Inquiry were held in private.

The draft report was made available to the Health Authority, who may have chosen to share it with Salisbury Health Care NHS Trust, Wiltshire Constabulary, Social Services and Probation Service and other agencies for any comments as to matters of fact.

The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the Inquiry's report.

Findings of fact were made on the basis of the evidence received by the Inquiry. Comments within the narrative of the report and the recommendations were based on that evidence.

APPENDIX 3: DOCUMENTATION and REFERENCES

A.3.1. Written Documentation

David Roberts' Case Notes:

Old Manor Hospital records

Broadmoor Special Hospital records

Wiltshire Probation Service records

Wiltshire Social Services records

General Practitioner records

Salisbury Health Care NHS Trust:

Internal Enquiry Report and Draft Action Plan

Dr Humphreys' response to Internal Enquiry Report

Trust Management Structure

Mental Health Directorate Structure

Joint Policy and Procedure for CPA May 1996

Operational Policy and Guidelines for the MHA 1983

Team Briefing for Clinical Risk Assessment/Management

Protocol for Assessment and Clinical Management of Risk

Accident and Incident Reporting Policy 1996/7 and 1999

Inter-Agency Protocol for Sharing Information on High Risk Patients 1998/9

Kardex and Record Keeping Refresher Training 1998/9

Salisbury Court Diversion Scheme Information Leaflet

Mental Health Induction Folder for SHOs

Serious Incident Inquiry: Policy and Procedure (pre-June 1998)

Serious Incident Policy and Procedure (June 1998)

Wiltshire Health Authority

Joint Strategy for Commissioning Comprehensive Mental Health Services August '97

General Terms and Conditions Mental Health Services

The National Visit of the Sainsbury Centre 1996

Salisbury Community Health Council:

(a) Visits to:

Ravenswood Secure Unit, 23rd January 97

Old Manor Hospital, 19th March 97

Brooks House, 17th September 97

(b) Minutes of meetings:

1997: 26th February; 9th April; 20th May; 21st July; 9th & 10th September; 17th December.

1998: 28th January; 22nd July; 6th & 13th November; 18th December.

1999: 27th January.

(c) Comments on Mental Health Strategy: 2nd December 1997

Mental Health Act Commission

Reports of Visits and Responses made: 1996/1997 and 1998

Wiltshire Constabulary

Investigation Report

Witness Statements

Custody Record

A.3.2. Publications consulted/referred to in the text

United Kingdom Central Council

Guidelines on Record Keeping

Guidelines on Professional Practice

Royal College of Psychiatrists

Assessment and clinical management of risk of harm to other people, 1996

Department of Health:

The Care Programme Approach for People with a Mental Illness referred to Special Psychiatric Services HC(90) 23

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94)27

Building Bridges – A guide to Arrangements for Interagency Working 1996
Modernising Mental Health Services 1998
" Safer Services" – National Confidential Inquiry into Suicides and Homicides 1999
Mental Health Act Code of Practice 1999

Home Office
Provision for Mentally Disordered Offenders HOC66/90
Mentally Disordered Offenders: Interagency Work HOC12/95
Managing Dangerous People with Severe Personality Disorders: Proposals for Policy Development 1999 (with Department of Health)
Early Warning Mechanism for the Release or Discharge of Potentially Dangerous Offenders (Probation Circular 15/1999)

Wessex Project
Written background material to the Project

The Zito Trust
Learning the Lessons
2nd Edition Mental Health Inquiry Reports, 1996

Mental Health Act Manual 5th Edition, Richard Jones, 1997 – Sweet and Maxwell

Oxford Textbook of Psychiatry 1996 – Oxford Medical Publications

Inquiries after Homicide, Edited by Jill Peay, 1996 – Duckworth

APPENDIX 4: LIST of WITNESSES

Dr Steven Allen, Consultant Psychiatrist
Ms Ann Atkinson, Enrolled Nurse, Old Manor Hospital
Mr Philip Bamborough, Locality Manager Salisbury Health Care NHS Trust
Mr Frank Barr, Police Constable, Wiltshire Constabulary
Mr Nick Bowes, Health Care Assistant, Old Manor Hospital
Ms Jennie Bradley, Senior Charge Nurse, Community Psychiatry, Salisbury Health Care NHS Trust
Mr Ian Brennan, Clinical Director, Mental Health & Learning Disabilities, Salisbury Health Care NHS Trust
Mr Chris Brown, Enrolled Nurse, Old Manor Hospital
Mr David Bunce, Directorate Senior Nurse, Clinical Development, Salisbury Health Care NHS Trust
Mr Paul Butler, Solicitor
Dr Kenneth Clark, General Medical Practitioner and Police Surgeon
Mrs Monica Cohen, Probation Officer, Wiltshire Probation Service
Mrs Karen Cracknell
Dr Alain Gregoire, Consultant Psychiatrist
Mr Antony Griffin, Detective Sergeant, Wiltshire Constabulary
Ms Emma Grinter, Named Nurse, Broadmoor Special Hospital
Dr Samuel Heal, General Medical Practitioner
Mrs Lyn Hiscock, Senior Social Worker, Wiltshire Social Services
Mr Ian Hodson, Ward Manager, Broadmoor Special Hospital
Dr Andrew Horne, Consultant Psychiatrist, Broadmoor Special Hospital
Dr Michael Humphreys, Consultant Psychiatrist
Mr Kwame Kusi-Obudun, Senior Charge Nurse, Old Manor Hospital
Mrs Margaret Lewis, Non Executive Director, Salisbury Health Care NHS Trust
Mr Maurice Lound, Police Sergeant, Wiltshire Constabulary
Mr John Nicholas, Chief Officer, South Wiltshire Primary Care Group
Mr William Osmond
Mr Albert Persaud, Public Health Specialist, Wiltshire Health Authority
Mr John Pook, Field Work Manager, Wiltshire Social Services
Ms Deborah Rees, Approved Social Worker, Swindon Social Services
Mr David Roberts
Mrs Maureen Shaw, Youth Justice Officer, Wessex Youth Offending Team
Mrs Anne Soutar, Former Social Worker, Wiltshire Social Services
Mr John Stoddart, Area Manager, Wiltshire Social Services
Mr Ben Veckovic, Staff Nurse, Old Manor Hospital
Mr Gerald Wainwright
Mr Barry Webb, Assistant Director Planning, Wiltshire Health Authority
Miss Ruth Webb, Planning & Development Officer (Mental Health), Wiltshire Social Services
Mrs Sybil Woodward, Probation Officer, Wiltshire Probation Service

APPENDIX 5: MEMBERS of the INQUIRY TEAM

Gordon Halliday	former Director of Social Services, Devon County Council. Member of the Mental Health Act Commission.
Omar Daniels	Consultant Psychiatrist and Honorary Senior Lecturer at Princess Alexandra Hospital and UCL Medical School. Member of the Mental Health Act Commission.
Jane Mackay	Nurse and Health Visitor, former Regional Nurse.
Gordon Read	former Chief Probation Officer, County of Devon.