REPORT OF THE INQUIRY PANEL SET UP BY NOTTINGHAM HEALTH AUTHORITY TO INVESTIGATE THE SERIOUS UNTOWARD INCIDENT AT THE TUDOR REST HOME, WEST BRIDGFORD, ON THE NIGHT OF 3RD/4TH AUGUST 1993.

Nottingham Health Authority
Forest House
Berkeley Avenue
Nottingham
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November 1993

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1. TERMS OF REFERENCE

1.1 The Terms of Reference of the Panel were:

to establish the facts and examine the actions of those concerned with the events, leading to the arrest of a resident, which took place at Tudor Rest Home, 72 Henry Road, West Bridgford, Nottingham from 1st to 4th August 1993;

to consider the management and treatment of the five residents of the residential home who were under the care and supervision of the Nottingham Healthcare Unit;

to make such recommendations to the District Health Authority as may be considered necessary in the light of the findings.

2. MEMBERSHIP OF THE PANEL

2.1 The members of the panel were:

Chairman	Mrs. P. Turnbull, Non-executive Member, Nottingham Health Authority
	Dr. O.A. Oyebode, Consultant Psychiatrist, Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham
	Mr J Archer, Director of Nursing Services, Tameside General Hospital Ashton-under-Lyne

2.2 The panel was assisted by the following people:

Miss D Hallatt, Oxley & Coward, Solicitors
Mrs H J Filby, Administration Manager
Mrs J Willins, Committee Clerk
Mrs J Grant, Service Head (Health and Disability), Nottinghamshire Social Services, attending the hearings as an observer

3. PROCEDURE ADOPTED BY THE PANEL

3.1 The Panel met initially for three days, on 15th, 16th and 17th September 1993. A follow up meeting took place on 14th October 1993.

3.2 Prior to the hearings, background information on the Nottingham Mental Health Services in the community and on registration requirements for residential homes was obtained from the Chief Executive, Nottingham Healthcare Unit and the Nottinghamshire Social Services Inspection of Registered Homes Unit respectively. Certain witnesses also submitted reports prior to giving evidence to the Panel.

3.3 On 7th September, Mrs Turnbull and Dr Oyebode visited Tudor Rest Home (TRH).

3.4 Those people who had been closely involved in the care and treatment of DU during his period at Mapperley Hospital and subsequent discharge to community accommodation, together with consultant medical staff responsible for the care of the other residents of TRH, were invited to give evidence to the Panel. The Panel also considered the medical records of DU and other residents at TRH.

3.5 The Panel's investigations have been necessarily constrained in certain respects, eg. lack of access to TRH's records, due to the restrictions imposed by the criminal investigation and proceedings. Any factual inaccuracies or omissions should be resolved at the conclusion of the criminal process. The resident whose actions gave rise to the investigations, is referred to throughout as DU.

3.6 The Panel has throughout been careful to adhere to its fact finding role. It saw its task as being to ascertain the facts, reach conclusions and make recommendations to Nottingham Health Authority who would then have the responsibility for taking appropriate action.

4. BACKGROUND TO THE ENQUIRY

4.1 DU first came under the care of Nottingham Mental Health Services in March 1990. Details of his contact with the Service are set out in Appendix 1.

4.2 He was discharged to his own flat in Nottingham on 1st September 1992 and after experiencing difficulties in independent living, moved into TRH on 30th April 1993.

4.3 He received regular visits from his Care Manager, Mr Derek Hamlin, CPN, and the placement at TRH appeared to go well until the end of July 1993 when DU's behaviour changed noticeably.

4.4 On 28th July, additional psychotropic medication was requested and obtained by the owner of TRH from the general practitioner. DU's behaviour continued to cause concern and on Sunday, 1st August, the owner/person in charge tried to contact the general practitioner.

4.5 On 2nd August the sector team base at Stonebridge Centre, Carlton, was contacted and during that day, domiciliary visits to TRH were made by a CPN and a Senior Registrar in Psychiatry. The clinical judgment was that compulsory admission to Mapperley Hospital was not appropriate. On the basis of this assessment and changes in medication, DU remained at TRH. During the day of 3rd August, no problems in DU's behaviour were noted but in the late evening he attacked two residents, Mr. V and Mr. M with a knife, fatally wounding Mr. V. DU was taken into police custody and charged.

5. EVIDENCE AND CONCLUSIONS

History and Description of Mental Health Services in Nottingham

5.1 Nottingham Healthcare Unit operates on the basis of seven clinical directorates, four being exclusively for mental health (Addiction and Forensic; Child and Adolescent, General Psychiatry and Psychotherapy; Rehabilitation and Community Care), one for physical and mental illness of older people, and the other two for non-mental health. Each directorate is headed by a Clinical Director who reports to the Chief Executive and has a Directorate Manager and appropriate supporting sub-structure.

5.2 The specialist Rehabilitation service was established in the late 1970s, and following expansion into Rehabilitation and Community Care Service (RCCS) has addressed the needs of those people who were formerly long-stay patients in Saxondale and Mapperley psychiatric hospitals.

5.3 The development of RCCS coincided with the formation, from 1982, of six sector teams with a brief to provide a more locally based service that was able to respond more appropriately to community needs. The sector teams comprise psychiatric medical staff, community psychiatric nurses, social workers and other professional staff.

5.4 Within the Nottingham Community Mental Health Sector Teams, Care Managers, who may be a community psychiatric nurse, occupational therapist or social worker within a sector team, are appointed for each community resident suffering from long term serious mental illness. Care Managers have primary responsibility for co-ordinating all the medical and social care input. In addition every long-term psychiatric inpatient and outpatient has a key worker who provides the bulk of the therapy. For inpatients the key worker is a nurse. For community residents the key worker may also be the Care Manager. The key worker focuses on the key area of therapy and is responsible for his/her own input but not for co-ordinating the work of others. The role of the Care Manager in the Sector Teams corresponds to that of the key worker as defined in the Care Programme Approach (HC(90)23).

5.5 Care managers are individually responsible for the quality of assessment and care planning and its subsequent documentation. Each individual discipline has a separate standardised method of assessment and care planning. As a result there is no standardised method of multidisciplinary assessment, common documentation nor guidelines to ensure a comprehensive assessment is undertaken.

5.6 The staff interviewed were not aware of any established standards or quality assurance programmes to provide audit and evaluation specifically of the Care Programme Approach.

5.7 The Nottingham Mental Health Service is one of the original six national Demonstration Centres for the Rehabilitation of People with Continuing Mental Health Difficulties and is linked with a research project being undertaken by 'Research and Development for Psychiatry' (RPD) that is attempting to monitor the effectiveness of Care Management.

5.8 The Care Programme Approach is co-existing with a Social Services led Care Management system which is also utilised by the Rehabilitation services.

5.9 The Nottingham community mental health service was developed well in advance of the national requirements for the Care Programme Approach introduced in April 1991 with Health Circular HC(90)23. The implementation of the Care Programme Approach in Nottingham was reviewed by Trent Regional Health Authority in March 1993.

5.10 The key elements of the Care Programme Approach as outlined in HC(90)23 are:

- **systematic arrangements** for assessing and reviewing the health care and social needs of patients/clients who are, or could be, treated in the community.

- a **named key-worker** who is responsible for co-ordinating the package of care, communicating with others involved in the client's care, ensuring that the best course of action is taken in the client's interests and ensuring that the agreed package of care is followed through;

- **effective systems** for ensuring that services are provided as agreed and that contact with patients/clients is appropriately maintained.

5.11 The key worker's assessment should be comprehensive and standardised. There should be monitoring and evaluation of assessments. The roles and responsibilities of key workers should be written down.

5.12 There is a variety of accommodation in Nottingham which has evolved to cater for mentally ill people in the community. The accommodation ranges from hostels specifically for the mentally ill with various combinations of multidisciplinary supervision, through individual flats and bedsits to residence in a care home with domestic services provided plus support from visiting key workers. Much of the accommodation is provided within the private sector.

5.13 Conclusions

The relationship between the Care Programme Approach and the Care Management system and the two services (Sector Community Mental Health Teams and Rehabilitation and Community Care service), is complex with an organisational weakness in terms of clarity of purpose.

5.14 Work is presently being undertaken to review and revise existing Care Programme arrangements in relation to Care Management systems.

Care and treatment of DU prior to placement at Tudor Rest Home

5.15 DU (date of birth 13th January 1965) was born in London. His father is a Nigerian who returned to Nigeria in 1984. His mother, who was Irish, died possibly by suicide in 1980. He has a full-sister and also a half-brother who both live in Nigeria. He is single and unemployed.

5.16 DU received psychiatric care in several London hospitals including King's College, St Giles', Peckham, Bexley Heath, Lane Hill Secure Unit, Surrey and Camphill Hospitals. He also required psychiatric care whilst serving a sentence in Pentonville Prison.

5.17 He has a history of criminal convictions and at least three custodial sentences

served at Pentonville, Parkhurst and Grendon Underwood Prisons.

5.18 DU has a history of seven admissions into Mapperley Hospital, Nottingham in the period March 1990 to September 1992 (Appendix 1). From 20th January 1992 his consultant was Dr. B. Ferguson. The clinical diagnosis was bipolar affective disorder - manic episode on each occasion. This diagnosis was complicated by a persistent history of solvent abuse. There was also evidence supporting the additional diagnosis of personality disorder. DU's psychiatric disorder was episodic in nature and characterised by such features as elated mood, irritability, motor restlessness, pressure of speech, flight of ideas, delusions of persecution and grandeur, and an aggressive and hostile attitude towards others. The aggressive and hostile outbursts were often associated with acute solvent intoxication.

5.19 DU was involved in several untoward incidents during the period of treatment at Mapperley Hospital (see Appendix I). His last admission was arranged following criminal charges for aggravated burglary and causing actual bodily harm. He remained in hospital for a total of eight months. He received a combination of neuroleptic medication administered as a depot preparation and lithium carbonate administered in tablet form.

5.20 DU was discharged into the community to live independently in his own flat on 1st September 1992. Prior to discharge, a multi-disciplinary meeting took place on 16th July 1992. An experienced CPN, Mr Derek Hamlin, was appointed as DU's Care Manager, with a named male CPN substitute, Mr. A. Peel, identified to cover any absence of the Care Manager. Information was recorded regarding the client's potential aggression and initial plans were devised to ensure the workers' safety.

5.21 Following discharge, DU was seen regularly on at least a fortnightly basis by his CPN, usually at his flat, and was also followed up by Dr Ferguson, who reviewed the clinical progress in his outpatient clinic held at DU's general practitioner's surgery. DU did not, however, attend every outpatient appointment.

5.22 There is evidence of good medical support to the care manager from the psychiatrist and continued medical monitoring, with updates of treatment changes forwarded to the general practitioner.

5.23 The monitoring and administration of prescribed medication was well documented.

5.24 DU's condition appeared stable until March/April 1993 when it was noted that he was no longer taking the lithium carbonate as prescribed. This prescription was then withdrawn. When he was assessed jointly by Dr Ferguson and Mr Hamlin on 22nd March 1993 it was decided that as he was not coping very well in his own flat, a more supportive residential placement was indicated. This judgement was based upon the fact that DU reported that some of his acquaintances were taking undue advantage of his generosity and that he felt exploited by them. He had also taken an overdose of chlorpromazine, a neuroleptic agent, and had spent a few days in Manchester in response to the pressures which he felt were on him.

5.25 A summary social assessment was available to the Panel. Mr. Hamlin indicated he recorded sufficiently high scores on DU's assessment to warrant care in a nursing home. However a recommendation for admission into a registered psychiatric hostel was made because this type of placement was considered to be more appropriate to DU's social skills and relative independence, than a nursing home. There is no evidence in the Care Manager's records of a comprehensive assessment

from a nursing and social perspective. DU inspected three homes, Corporation Oaks Residential Home, Alexandra House and TRH, each of which had vacancies, and he decided to accept to enter TRH. He moved into TRH on 30th April 1993.

Conclusions

5.26 DU had demonstrated repeatedly since March 1990 the potential for exhibiting unpredictable, aggressive and hostile behaviour. It was also recognised by the clinical team that DU continued to abuse solvents and that his behaviour was particularly disruptive when he was in a state of acute intoxication. In the month before his discharge he needed to be administered extra medication on at least three occasions because of rapid deterioration of his mental state. This underlined the lack of a sustained improvement in his condition. In addition, DU himself indicated that although he wished to return to live in his own flat, he was not sure that he would be able to cope on his own.

5.27 The arrangements for DU's discharge and aftercare were good. There is evidence of significant discussion and consideration of the care plan in the case of DU. A series of trial leaves were organised before his final discharge. Following his discharge, he was seen regularly by Mr. Hamlin his Care Manager and also by Dr Ferguson.

5.28 The effectiveness of the aftercare arrangements was demonstrated by the ability of the clinical team to respond promptly to the breakdown of DU's placement in his own flat. Once it became clear that the placement in his flat had broken down, an assessment of his social needs was conducted. He was also given the opportunity to visit two examples of community accommodation and his preference was taken into account in the decision to place him in TRH.

5.29 The accuracy of his social assessment as demonstrated by the completed "Summary of Need" form is in doubt. For example, his social behaviour was rated "M" which suggested that his behaviour was likely to cause a disturbance to others but was unlikely to be physically threatening. This judgement was erroneous given his past history. The Panel understands that the form was completed upon the basis of his most recent behaviour rather than upon a longitudinal appraisal of his history.

Care and Treatment of David Usoro at Tudor Rest Home

Tudor Rest Home Background

5.30 TRH is an established residential care home, registered by the Local Authority in a residential, suburban area. It is situated in West Bridgford which is in the Rushcliffe mental health sector. The original registration was extended in 1991 to include the mentally ill. This extended registration was based on the training and experience of the owner who, with her husband, manages TRH.

5.31 The aim of the owner was to provide a comfortable home with a friendly, understanding and supportive atmosphere. All those who came in contact with TRH referred positively to the nursing qualities of the owner, the domestic management of the home, and the friendly, supportive and individual care extended to each of the residents.

5.32 The Registration Authority does not require staff to have psychiatric nurse training. With the exception of the owner who had twenty years experience in psychiatric

nursing, all other staff at TRH were unqualified.

5.33 There were five staff at TRH: the owner, her husband and three care assistants (two women and one man). There was always a minimum of two on duty.

5.34 The physical standards of the accommodation at TRH met the requirements for registration at the time, although accommodation with a high proportion of shared bedrooms would not now be approved by the Registration Authority. Personal accommodation consisted of shared rooms for six of the complement of seven residents, i.e. three rooms with two beds each, and one single room occupied by the one female resident. Flexible screening provided individual privacy in the shared rooms. All new residents knew of the shared room arrangements when they came to TRH.

5.35 The residents were three elderly people (two men and one woman) and two young men in their twenties. There was no evidence from any source of incompatibility between the older and younger people during the three months of DU's residence, or indeed between individuals in either age group. DU shared a room with Mr. V. the fatally injured resident.

Events leading up to the incident

5.36 DU moved to TRH on 30th April 1993. He shared a room at the home with Mr. V and appeared to settle well. He was visited at least fortnightly by Mr. Hamlin.

5.37 Mr. Hamlin gave some background information to the owner regarding DU's psychiatric history and past aggressive outbursts, however the full implications appear not to have been understood by the care staff; the staff variously commented they were aware DU was suffering from "depression" and had received a jail sentence for attacking someone. The owner was advised to contact the Stonebridge Centre if Mr. Hamlin was unavailable and also that Mapperley Hospital could be contacted if 'out of hours' advice and support was necessary.

5.38 He was last seen as an outpatient on 22nd April 1993 (follow-up appointment made for 24th August 1993) and his consultant had notified his general practitioner at St. Ann's Health Centre of his currrent status and medication. This letter was sent on 6th May.

5.39 Two days earlier, on 4th May, DU had joined a new general practice at West Bridgford. This was not the nearest general practice to TRH. However it was the owner's preferred choice. He was accompanied by the home owner and seen by Dr. Rahman for a minor medical condition. At that stage, DU's previous general practice records had not been transferred, however he gave a reasonably detailed account of his family and personal history.

5.40 The previous general practice records were received by the West Bridgford practice on 27th May 1993 and DU visited and was seen by Dr. Shankar for a minor condition on 4th June 1993.

5.41 Mr. Hamlin continued to make regular visits to support DU at TRH and also to administer his fortnightly depot injections. He discussed with DU future plans for training opportunities and in particular a mechanics training course.

5.42 Mr. Hamlin began a period of annual leave on 16th July 1993. Appropriate

arrangements were made for the named substitute CPN, Mr. A. Peel, to take over the care of DU.

5.43 On 28th July, the owner noted a change in DU's behaviour. He was not sleeping well, his previous daily visits to the Catholic church had ceased abruptly, he had laughing and crying episodes, admitted he was thinking a lot about his mother and father and was having sexual fantasies. The owner also found he was making several visits to the kitchen during the night to make cups of coffee. As a result, she telephoned the West Bridgford general practice requesting a sedative for DU. She spoke with a locum, Dr. Chibb, and he agreed to prescribe 20mg of temazepam at night.

5.44 DU was noted by the care staff to be restless, anxious and "high". A Care Assistant reported to the owner that DU had threatened to stab another member of staff. She took the precaution of hiding the kitchen knives.

5.45 On 30th July, Mr. Peel visited DU at TRH to administer the regular depot injection. The visit lasted approximately twenty five minutes and Mr. Peel noted DU appeared quite well and settled, with no sign of solvent abuse. DU stated he was happy at TRH. Mr. Peel was not made aware of DU's change in behaviour over the previous two days, the contact with the general practitioner, the additional medication which had been prescribed or the threat to stab someone.

5.46 On 31st July, DU spent almost the whole day in bed, but was awake during the night, listening to loud music. The following morning, Sunday 1st August, DU was seen by the owner walking on Trent Bridge. On his return she questioned DU with difficulty and was sufficiently concerned that she tried to contact the general practitioner between 9 and 10 am. The surgery's deputising service was not available. DU made a further threat to stab someone. This was reported by a Care Assistant to the owner and noted in TRH's Day Book. DU was subdued for most of the day and spent the afternoon in bed.

5.47 On Monday, 2nd August, DU apologised to the owner for having refused to talk to her the previous day. She continued to be concerned and telephoned the Stonebridge Centre, requesting an increase in his dosage of chlorpromazine. Mr. S. Hewitt, CPN, took the call and rang back once he had reviewed DU's records. Mr. Hewitt also discussed the request with Dr. Naik, Senior Registrar in Psychiatry, who offered a domiciliary visit later that day if necessary.

5.48 Mr. Hewitt visited TRH at approximately 10.30 and interviewed DU in the owner's presence. He found him to be excitable, over-familiar, over friendly and with presssure of speech. Mr. Hewitt telephoned Dr. Naik from TRH and arranged for a visit that afternoon and in the interim Dr. Naik gave a verbal order for a further 50mg chlorpromazine immediately, and 100mg after lunch.

5.49 At approximately 3.30pm, Dr. Naik and Mr. Hewitt made the domiciliary visit accompanied by a student nurse. Dr. Naik had reviewed DU's records prior to the visit. Dr. Naik concluded he was in a hypomanic state. Dr. Naik and Mr. Hewitt did not recall DU expressing any persecutory ideas. He was not aggressive and overall Dr. Naik did not consider he was a threat to himself or others, or detainable under the Mental Health Act 1983. DU would not agree to a voluntary admission to Mapperley Hospital and the owner indicated her willingness for him to remain at TRH. There was no evidence of drug or solvent abuse. Dr. Naik revised the medication to include lithium and increased the dosage of chlorpromazine. He

took blood samples and requested further blood tests be done a week later on 9th August.

5.50 Later that afternoon Mr. Hewitt collected the medication and returned to TRH. DU accepted his medication.

5.51 Dr. Naik and Mr. Hewitt appear not to have examined TRH's Day Book and were not aware of the involvement of the general practitioner the previous week, the extent of staff's concerns and in particular the threats to stab someone.

5.52 DU slept well on Monday night, and on Tuesday, 3rd August, had a reasonably good day. He was not agitated although he continued to play loud music in his bedroom. This prompted the owner's husband to give him some personal earphones.

5.53 The blood test results were within normal levels. Dr. Naik wrote a letter to the general practitioner, Dr. Shankar, confirming the domiciliary visit and changes to the medication.

5.54 At 2pm on 3rd August, the owner went off duty and her husband came on duty. At approximately 2.30 p.m, Mr. Hewitt telephoned TRH to check on DU's condition. He was told DU had settled, and had slept well the previous night. Mr. Hewitt arranged that Mr. Peel would visit the following morning.

5.55 At 7.30 pm the owner's husband went off duty. The owner came back on duty at 8 pm. There was nothing of particular note in DU's mood or behaviour. At approximately 11.40 pm the owner returned home briefly to collect her asthma inhaler. Meanwhile the Care Assistant agreed to DU making a cup of coffee in the kitchen.

5.56 The Care Assistant unlocked the kitchen and returned to his room to get dressed. There was no-one else in the kitchen at that stage. A few minutes later the Care Assistant thought he heard an argument and found DU had attacked Mr. V and Mr. M. The Care Assistant did not attempt to tackle DU but telephoned the police. He also telephoned the owner at her home but she had already left. The police and the owner arrived at TRH a few minutes later and DU was apprehended at the rear of TRH and taken into police custody.

Conclusions

Tudor Rest Home

5.57 The range of available accommodation to meet DU's needs in the community was limited. Much of this type of accommodation is provided within the private sector and the availability at any given time is not within the direct control of the community psychiatric service.

5.58 TRH offered a good standard of care overall to residents.

5.59 Staffing levels and staff training were the responsibility of the owner.

5.60 The shared accommodation and age mix of residents at TRH may have heightened the risk of violence by DU.

5.61 The caring approach adopted by the owner and staff at TRH worked well until challenged by the complex mental illness of DU.

5.62 TRH staff had a limited knowledge and understanding of DU's long and complex mental history. Whilst all staff interviewed had noted a marked change in DU's behaviour, the unqualified staff were not sufficiently experienced to provide the degree of supervision required. This combination of limited knowledge of DU's history, and staff inexperience led to an underestimation of his changed treatment needs, and certain significant events were not reported to those who could have better interpreted and acted upon them.

Support by the Mental Health Service

5.63 Mr. Hamlin established a good relationship and regular contact with DU and TRH and contacted the probation officer.

5.64 Cover arrangements were carefully put in place during Mr. Hamlin's annual leave with a named substitute CPN.

5.65 There was an immediate response to urgent requests for assistance, both from a CPN and an experienced psychiatrist. Whilst the CPN knew of DU's background, neither he nor the pyschiatrist had had any prior active involvement.

5.66 There is evidence of regular letters from the Consultant Psychiatrist to the former general practitioner. A follow up outpatient appointment had been arranged.

5.67 Mr. Hamlin did not make contact with DU's new general practice.

General Practitioner Aspects

5.68 The general practitioner will often be the first point of contact for individuals, or residential care owners in an emergency, at weekends or out of hours.

5.69 The general practitioner's role in Community Care is not clearly defined in all cases. Consultant psychiatrists' expectations of general practitioners' contribution to care programmes varied. The general practitioner's role and responsibilities in DU's care programme were not clearly defined.

5.70 The general practice records were transferred from the St. Ann's general practice to the West Bridgford practice in just over three weeks. In the intervening period the general practitioner only had the information provided by DU himself.

5.71 Full information regarding DU's previous mental illness, medication and social circumstances was then available in the general practice records for use by the general practitioner.

5.72 The temazepam medication prescribed by the locum general practitioner was inappropriate. This suggests the general practitioner had inadequate information or had failed to review thoroughly the medical records prior to prescribing.

5.73 The locum general practitioner agreed to prescribe psychotropic medication without seeing DU following only telephone contact with the owner.

5.74 The general practice emergency deputising service was not operational on Sunday,

and was covering during Dr. Ferguson's leave. He did, however, review DU's previous history and records prior to amending his medication and making the domiciliary visit.

5.86 Dr. Naik made no contemporaneous record in the case notes of the domiciliary visit on 2nd August, however, he did write a letter the following day to the general practitioner.

Other residents in Tudor Rest Home

Mr. V

5.87 Mr. V was a 59 year old who had a long psychiatric history. The clinical diagnosis was paranoid schizophrenia. He had received psychiatric care at Saxondale Hospital and King's Mill Hospital in the past.

5.88 He was referred to Dr Baruah on 2nd July 1992 by Dr Rao, his general practitioner. The case was allocated to a community psychiatric nurse as soon as the referral was received, and he was seen on 21st July 1992. He was referred to the social group held at the Rushcliffe Community Team Base and to the Open Door Day Centre, both of which he attended regularly.

5.89 The community psychiatric nurse who acted as his care manager saw him regularly and communicated satisfactorily with all other agencies involved in his care.

5.90 Mr. V was seen by Dr Baruah on 4th September 1992. He defaulted from two subsequent appointments but was reviewed again on 21st May 1993 by Dr Baruah's Senior House Officer. The changes made to his medication were carefully considered and implemented. The general practitioner was duly informed of the changes.

5.91 The placement at Tudor House was judged to be satisfactory up to the time of his death. There was no evidence of any difficulties with regard to his relationship with other residents at Tudor Home. He appeared settled and happy there.

Mr. O

5.92 Mr. O is a 64 year old man. He has a long psychiatric history dating back to 1958. The initial clinical diagnosis was schizophrenia complicated by alcohol abuse. This diagnosis has been revised to bipolar affective disorder, presenting in manic episode in 1990 and depressive episode in 1992. His condition is currently well-controlled on a combination of lithium carbonate and thioridazine, a neuroleptic agent.

5.93 He moved into TRH in September 1992. The reason for the move is unclear, however, he seemed to settle into the routine of the Home without any major difficulties.

5.94 He was followed-up regularly for the 12 month period January 1992 to January 1993 by community psychiatric nurses. His clinical progress was reviewed regularly by Dr Baruah's medical team and he continues to be seen on a regular basis.

5.95 The placement at TRH was deemed a success, especially because Mr. O's abuse of

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5.95 The placement at TRH was deemed a success, especially because Mr. O's abuse of

alcohol ceased to be a problem once he had settled into TRH.

Mr. M

5.96 Mr. M is a 30 year old man. He has a psychiatric history dating back to August 1987. Since then he has had six admissions into hospital. The clinical diagnosis is paranoid schizophrenia. His psychiatric condition is currently well controlled on a combination of chlorpromazine and trifluoperazine. Both drugs are neuroleptic agents.

5.97 Mr. M moved into TRH in February 1992. In February 1993 he was re-admitted into hospital for a brief period following an incident when he assaulted a careworker. He was discharged back to TRH on 17/2/93. Following this discharge a case conference was held on 22/4/93 to discuss his case. This conference was attended by all interested parties including medical and nursing members of the clinical team involved in his care. The manager of TRH was also present. The immediate and long term plans were discussed and decided upon. The recommendations included arrangements for Mr. M to attend Open Door weekly and for alternative accommodation to be inquired into on his behalf.

5.98 Mr. M is currently seen and reviewed regularly by nursing and medical staff. He attends Open Door on a weekly basis and is also a member of Uhuru, an Afro-Caribbean support project.

5.99 Mr. M's placement at TRH appears to be appropriate and satisfactory at present. He appears to have a good relationship with the owner of TRH. His compliance with medication has improved since his placement there.

Mrs. A

5.100 Mrs. A is a 67 year old woman who has a psychiatric history dating back to 1962. She has had several psychiatric hospital admissions, the most recent being in September 1987 when she was under the care of Dr Turner. The clinical diagnosis is bipolar affective disorder.

5.101 Mrs. A was followed-up by Dr Holden's team regularly between February 1988 and April 1989 when she was discharged from follow-up. The general practitioner was informed of this decision.

5.102 Mrs. A was referred to Dr Waite's team in September 1991 whilst she was an inpatient on a surgical ward at the Queen's Medical Centre for complaints relating to peripheral vascular disease. She was seen initially by Dr Turner's Senior House Officer whilst she was in hospital and later by Dr Waite's Senior Registrar at home. The opinion was that she was in a depressive episode of a bipolar affective disorder. Dr Waite's Senior Registrar expressed the view, in his letter, that she needed to be followed-up and took responsibility to do this. However, she was lost to follow-up. Mrs. A has multiple problems including bipolar affective disorder, diabetes mellitus and peripheral vascular disease. She was prescribed a course of dothiepin, an antidepressant medication, when she was seen in 1991. This prescription has not been monitored by any psychiatrist since then. There is no evidence of continuing aftercare in her case. The lack of need for such aftercare in her case has not been unequivocally established.

Conclusions

5.103 Although there was a wide range of ages in the residents of TRH, the evidence suggests that the other residents were appropriately placed and were responding to the personal care and attention provided.

5.104 There are problems in arranging attendance at outpatient clinics for Mrs. A. These problems are created by her multiple handicaps. She remains on psychotropic medication which was prescribed in 1991 and which has not been formally reviewed since then.

6. RECOMMENDATIONS

Care Programme Approach

6.1 The Care Programme Approach should be implemented consistently throughout the service to an agreed timescale in line with Department of Health guidelines. The recommendations made by Trent Regional Health Authority following their monitoring visit of 16th March 1993 should be adopted.

6.2 An agreed method of multidisciplinary assessment together with clear guidelines and standardised documentation should be introduced.

6.3 A training programme should be constructed and implemented to support these arrangements and to introduce consistency of approach.

6.4 A quality assurance strategy to monitor and audit the value of the new arrangements against agreed outcomes, should be established. Full advantage should be taken from the investment made by Dr Ferguson to develop a computerised information system.

TRH

6.5 The matching of an individual to proposed accommodation needs to be prepared more systematically. Whilst taking account of an individual's preference, accommodation should be carefully assessed in terms of the individual's needs as well as the "care culture" of the establishment, overall competence and experience of staff and staffing levels, the existing mix of residents and appropriateness of the physical accommodation.

6.6 The Summary of Need form should be completed taking into account the long-term history of the individual and not only the most recent observations.

6.7 Staff in community residential accommodation catering for mentally ill people should receive relevant and appropriate information, advice and training in working with mentally ill people.

General Practitioners

6.8 At the time of discharge from hospital or at change of residence, the community psychiatric service should notify the relevant general practitioner as soon as he/she is known.

6.9 This notification should include early contact with the general practitioner by the

community psychiatric service with regard to diagnosis, treatment programme, and the support to be provided by the community psychiatric service.

6.10 General practitioners should familiarise themselves with the patient's previous mental, as well as medical, history.

6.11 The general practitioner must be clear where he/she fits into the community care plan, whether he will be simply a point of contact in an emergency, whom he should contact at the community psychiatric service, or whether the patient's mental illness will be completely managed by community psychiatric staff.

6.12 If the general practitioner does provide an initial emergency service or makes any substantial change to the treatment programme including medication, he must report such actions to the key worker at the earliest opportunity.

6.13 General practitioners should not prescribe psychotropic medication by telephone without first reviewing the patient.

6.14 A general practice has round the clock responsibility to the practice patients. This responsibility includes provision when the practice doctors are off duty. When all members of a practice are off duty, it is the doctors' responsibility to ensure that an efficient deputising service is available and functioning.

Communications

6.15 Clear guidelines should be produced concerning basic information which should be available to home owners/carers.

6.16 There should be prompt information available to general practitioners concerning any significant change in patient circumstances. New general practitioners who are awaiting transfer of medical records should receive basic information about the patient from the Care Manager as soon as ever practicable.

6.17 Arrangements should be made for communication of key information between all relevant parties involved in the care programme. The Care Manager, or another designated person, should be responsible for receiving and disseminating information to the various parties.

6.18 The Care Manager should be aware of the format of record keeping in the home/hostel and have access to records by prior arrangement with the owner/carer. The Care Manager should agree with the owner/carer how relevant information will be passed on, either orally or by reference to the home's records.

6.19 In the Care Manager's preliminary review of accommodation (s)he should seek to ascertain information on the background, age and mix of residents in a home.

6.20 The home owner should receive clear guidelines on who to contact and how to obtain advice and support at all times and particularly out of hours.

Other patients

6.21 Mrs. A's psychiatric state should be reviewed shortly and follow-up plans which reflect her needs should be implemented and communicated to her general practitioner.

7. COMMENT

7.1 The Panel extends its deepest sympathy to the relatives and friends of Mr. V and its continuing support to Mr. M. Support systems and care provision were in place for DU and he appeared to be responding. However, the Panel believes that there was room for significant improvement by all the parties involved in DU's care in their communications with each other. More prompt and more comprehensive information concerning DU should have been exchanged especially during the period covered by his time at TRH.

7.2 The Panel would like to thank all those who attended the Panel hearings and/or provided information which enabled the Panel to reach its conclusions and make recommendations.

Appendix 1

SUMMARY OF ADMISSIONS OF DU TO MAPPERLEY HOSPITAL AND UNTOWARD INCIDENTS

13/3/90 Admitted to Lady Middleton ward under Section 136 Mental Health Act 1983 under Dr. Gill: Self-inflicted lacerations of left arm and spraying blood on passers-by.

15/3/90 Admitted to Lady Middleton under Section 2: Broke door of hostel. Discharged 20th April 1993.

23/4/90 Broke into house and threw TV through window.

23/5/90 Admitted to Lady Middleton ward under Section 3

27/6/90 Admitted to Lady Middleton ward under Section 3

29/6/90 Smashed three windows, wrecked pool table and threatened staff with broken glass.

5/7/90 Assessed by Dr Shapero, consultant forensic psychiatrist for suitability for the Towers medium secure unit. The transfer was not effected because he settled shortly after the assessment. Discharged 29/8/90.

14/9/90 Admitted to Lady Middleton as informal patient under Dr. Gill. Discharged 25/9/90.

12/4/91 Smashed car window in the city and also smashed hospital building windows. He was reported as saying "I smash things so I can be arrested and have a nice comfy bed for the night".

19/4/91 Admitted to Lady Middleton ward as an informal patient. Discharged 30th May 1991.

21/11/91 Admitted to Lady Middleton ward under Section 2: Self-inflicted wrist injury.

4/12/91 Glue sniffing, abusive and threw pot of glue at staff.

5/12/91 Continuing aggressive behaviour and threatening towards staff.

10/12/91 Discharged from Lady Middleton ward.

20/12/91 Admitted to Lady Middleton ward under Section 35: Charged with offence of aggravated burglary and causing actual bodily harm.

21/12/91 Assessed by Dr Harris, consultant forensic psychiatrist who thought that his behaviour was unpredictable.

20/1/92 Transferred from Lincoln Prison to Lister ward under Section 36 as patient of Dr. Ferguson.

14/2/92 Kicked another patient.

19/2/92 Threatened to hit another patient.

10/7/92 He was assaulted by another patient and the assault was reported as being unprovoked and DU did not retaliate.

15/7/92 Involved in fight with another patient.

1/9/92 Discharged back into community.

Appendix 3

SCHEDULE OF DOCUMENTATION CONSIDERED

Transcripts of Interviews of

1.	Dr B. Ferguson, consultant psychiatrist	15.9.93 + 14.10.02
2.	Dr P. Naik, senior registrar psychiatry	15.9.93 + 16.9.93
3.	Mr A Peel, community psychiatric nurse	15.9.93
4.	Dr Rahman, general practitioner	15.9.93
5.	Dr R Baruah, consultant psychiatrist	15.9.93
6.	Mrs Chengebroyen, owner T.R.H.	15.9.93
7.	Mr Chengebroyen, co-owner of T.R.H.	15.9.93
8.	Ms A Summerson, care assistant,T.R.H.	15.9.93
9.	Mr S Williamson, charge nurse, Mapperley Hosp.	15.9.93
10.	Mr D Hamlin, community psychiatric nurse	16.9.93
11.	Ms C Turton, care assistant, T.R.H.	16.9.93
12.	Mr D Hendry, care assistant, T.R.H.	16.9.93
13.	Mr S Hewitt, community psychiatric nurse	16.9.93
14.	Mr J. Smith, Notts CC S.S. inspectorate	17.9.93
15.	Dr Waite, consultant psychiatrist	17.9.93
16.	Dr G. Harrison, consultant psychiatrist	14.10.93
17.	Mr. G.J. Smith, chief executive, Nottingham Healthcare Unit	14.10.93

Reports submitted by:

18. Graham Smith, chief executive, Nottingham Healthcare Unit, 4.8.93, 5.8.93, 29.9.93.
19. Steve Hewitt, community psychiatric nurse, 4.8.93.
20. Rose Hobbs, clinical nurse manager, 5.8.93.
21. Dr P Naik - reports of interviews of David Usoro at police station 4.8.93, 5.8.93 + 6.8.93. - typed + manuscript entries in case notes.
22. Mrs R A Cutler, senior purchasing manager Nottingham Health Authority 14.9.93
23. Dr R Baruah, consultant psychiatrist, 7.9.93
24. Press Release, Notts Constabulary, 4.8.93
25. Transcript of Statement of A.Smith, 4.8.93
26. Press Cutting "Man Charged with Hostel Murder", 5.8.93
27. Press Release, Nottingham H.A., 11.9.93
28. East Nottingham & Carlton Mental Health Team - Guide8 (Yellow)
29. Drug Custody & Administration Code of Practice, July 1988
30. Nottm Drug Custody & Administration Code of Practice, 2nd edition, 1988
31. East & Carlton Mental health Team, Stonebridge Centre Duty System, December 1988.
32. Community Psychiatric Nursing Service Operational Policy, February 1991.
33. Letter Mr B Wickett, Directorate Manager to G Smith, 10.9.93.
34. Mental Health Act Commission Visit Report, 7/8.4.93.
35. Regional Monitoring Visit, Second Round, Report 17.3.93 (visit 16.3.93),
36. Letter D Repper, Quality Adviser, Healthcare Unit, responding to Regional Monitoring Visit Report, 5.4.93.
37. Confidential Draft Report of Notts Mental Health Services - Care Management Review Group - Sept.1993.
38. Department of Health Circular HC(90)23 - The Care Programme Approach
39. The Care Programme Approach: Tameside General Hospital

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37. Confidential Draft Report of Notts Mental Health Services - Care Management Review Group - Sept.1993.
38. Department of Health Circular HC(90)23 - The Care Programme Approach
39. The Care Programme Approach: Tameside General Hospital

40. DU's medical records, Mapperley Hospital. 27.6.90 - 4.8.93.
41. Community/Day Patient Card, 27.6.90 - 4.8.93
42. Care Plan Review, 27.6.90 - 4.8.93
43. Medical Records, Bexley Hospital,
44. DU - "Summary of Need" completed by D.Hamlin, CPN, to establish eligibility for Social Services support (includes "Needs Definitions and Coding Guidelines").
45. DU "Community Care Financial Authorisation".
46. Letter Sonia Oliver to D Hamlin re Probation Order, 7.6.93.
47. Manuscript note of telephone message re events at T.R.H. 4.8.93.
48. Family First Limited, Furniture Service, application form, 20.8.92.
49. Sample copy of T.R.H's Care Plan Records. (not a copy of DU's).
50. Medical Records of other residents of T.R.H.

Glossary

CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
RCCS	Rehabilitation and Community Care Service
TRH	Tudor Rest Home