County Durham and Tees Valley NHS
Strategic Health Authority

REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PATIENT Q AND PATIENT G

A report commissioned by the former
County Durham and Darlington Health Authority

September 2003

CONTENTS

	Page
Preface	**4**
Chapter 1 – Background to the Inquiry	
-Introduction	5
-Terms of Reference for the Inquiry	6
-Obtaining Records and Documents	6
-Witnesses and Witness statements	6
-Preliminary meetings	7
-Oral Hearings	7
-Expert Report	8
-The Report	8
-Acknowledgements	9
Chapter 2 – The incident and the outcome	**10**
Chapter 3 – Background and involvement with health and social Services of Patient Q and Patient G	**11**
Chapter 4 – Issues and concerns relating to Patient Q	**12**
-care from the General Practitioners	12
-in-patient treatment at the County Hospital	15
-drinking on the ward	15
-non-enforcement of patient contract	17
-patients keeping supplies of drugs	18
-relationships between patients	18
-liaison and communication with family	21
-listening to carers	22
-provision of information	23
-focus of multi disciplinary team meetings	24
-arrangements for professional supervision	24
-training needs of staff	24
-development and monitoring of policies	25
-continuity of consultant and CPN care	25
-appropriateness of treatments	26
-risk assessment	27
-standard of record keeping	28
-review of medication	28
-use of CPA processes	29
-was the patient mentally ill	30
-interface of services	32
-response to information received	32
-handling of discharge arrangements	34
-overall culture of the ward	35

-CPN, Day Hospital and
Out-patient care for Patient Q 36
-Drug and Alcohol Services care for Patient Q 38
-Care from Social services for Patient Q 40
-need for a social worker 41
-effectiveness of referral procedures 42
-communication between specialist teams 45

Chapter 5 – Issues and concerns relating to Patient G 49

-care from the General Practitioner 49
-contact with Day Hospital 50
-care as an in-patient at the County Hospital 51

Chapter 6 – Organisation of Services 53

-organisation of health services 53
-organisation of social services 54
-joint working between health and social services 55

Chapter 7 – Key Findings and Conclusions of the Panel 58

-General Practitioner involvement 58
-care and treatment 58
-risk assessment and management 59
-systems and processes 59
-communication and inter agency working 59
-cultural and organisational issues 59
-conclusions 60

Chapter 8 – Recommendations 62

Appendices

A Terms of Reference

B Bibliography

C Specimen letters

D Extracts from the Sainsbury Report

(Patients' names have been removed from this report, following discussion with relatives.)

PREFACE

A panel consisting of the persons listed below was established by the County Durham Health Authority in 2002 to undertake an inquiry into the care and treatment of Patient Q and Patient G.

Mrs Anne Galbraith LL.B	Formerly Senior Lecturer in Law in University of Northumbria, Member of the Council on Tribunals
Mr Keith Murray	Director of Social Services, Leeds
Mr Simon Rippon	Nurse Consultant, Hull & East Riding Community Health Trust
Dr James Isherwood	Consultant Psychiatrist, York Health Services Trust

We now present our report, having had regard to the terms of reference set down for us by the Authority.

Anne Galbraith Keith Murray

Simon Rippon Dr James Isherwood

September 2003

Chapter One

Background to the Inquiry

Introduction

1.1 This inquiry was established by the former County Durham and Darlington Health Authority, in conformity with the guidance contained in the NHS Management Executive document HSG (94)27, which requires such an inquiry to be held where there has been a homicide committed by a person who has been receiving mental health services. The guidance suggests that where a violent incident occurs, in serious cases it is important to learn lessons for the future. That is the purpose of this inquiry.

1.2 The incident at the heart of this inquiry involved the death of Patient Q on or about 4 October 1999. Patient G pleaded not guilty to her murder, but guilty to manslaughter at a trial which took place in July 2000. Patient G was sentenced to five years' imprisonment.

1.3 Some delay occurred in the setting up of the independent inquiry, whilst advice was sought as to the appropriateness of holding such an inquiry. Once a decision had been taken, a panel was established, and met for the first time in April 2002.

1.4 Both Patient Q and Patient G had been receiving care from County Durham and Darlington Priority Services NHS Trust. The terms of reference of the inquiry required the panel to consider the care and services in relation to both of them.

1.5 The inquiry panel met on a number of occasions to determine its method of working, and to decide which records, documents and publications it required. Work was put in hand to obtain the necessary consents for the release of records and documents, and to establish who should be approached for written statements. Subsequently, these written statements informed the view of the panel in determining which witnesses should be invited to the oral hearings. Dates were fixed well in advance for panel meetings and the oral hearings, in order to minimise delays.

1.6 The approach to the conduct of the inquiry adopted by the panel was based on experience of earlier panels, both in County Durham and elsewhere. The panel was also mindful of the judgement in Crampton and others v Secretary of State for Health ("the Allitt case"), which set out some important principles to be borne in mind in such proceedings.

1.7 This report is the result of the combined views and opinions of all the panel members, who have participated fully in its drafting.

Terms of Reference for the Inquiry

1.8 The terms of reference established for the inquiry panel are set out in Appendix A.

Obtaining Records and Documents

1.9 Patient G was approached via the prison authorities to obtain his consent for the release of his medical records. Consent in the case of Patient Q was given by her elder daughter. As the work of the panel proceeded, it became clear that some information of value to the panel was contained in a social services file held in relation to Patient Q's younger daughter. Her consent was then sought to access specific information relating to her mother from the social services file.

1.10 The panel also identified the Trust and Social Services policies, Department of Health strategy documents, independent research documents and earlier independent inquiry reports which were regarded as essential preparation for the inquiry. These documents are listed in a bibliography at Appendix B. The panel is grateful to those who played a part in locating, gathering and compiling the necessary documentation.

Witnesses and Written Statements

1.11 Once all the records were available, and the panel had had time to peruse them, its members met to determine the list of those to be approached with a request for a written statement about their involvement with Patient Q and Patient G. In all, letters were written to more than 30 people or organisations.

1.12 The written statements received in response to this approach were very useful to the panel, although some of those approached did not respond. In one case, the recipient indicated that he did not wish to attend the oral hearings.

Preliminary meetings

1.13 The panel recognised that the inquiry would be stressful for the daughters of Patient Q, and decided that it was appropriate for the Chairman to offer to meet with them in advance of the oral hearings, to explain the terms of reference and to answer any questions they may have. This offer was accepted, and a most informative and useful meeting resulted.

1.14 It was established by the panel that there were no close relatives of Patient G who were in touch with him, thus there was no question of making a similar approach in his case.

Oral hearings

1.15 Once the panel had had the opportunity to consider the written statements, it was then possible to form a judgement about those who should be invited to attend the oral hearings. A decision was also taken about the order in which the panel wished to meet those attending, but this inevitably required some flexibility to accommodate the availability of those concerned. The letter sent to those invited to attend the oral hearings is reproduced at Appendix C.

1.16 A number of those attending were accompanied, either by a friend or family member, colleague, or a solicitor. Many of those who attended had now moved on from the role they fulfilled at the time of the incident, or had been affected by reconfigurations of service.

1.17 The panel gave consideration to whether there would be advantage in seeking to interview Patient G. A decision was taken that this matter would be further considered at the close of the oral hearings. At that point, it was felt by all panel members that sufficient was known of the views of Patient G from the earlier internal inquiry, when an interview with him had been held. It was decided not to seek to interview him again.

1.18 The panel was heartened at the cooperation from Patient Q's daughters and other relatives, friends and acquaintances, and express their appreciation for the commitment shown to assist the work of the inquiry.

1.19 All those attending the oral hearings were given an overview by the Chairman of the process being adopted, including information about the making of transcripts, the order in which the panel would put their questions, how the draft report would be prepared, what the likely timescale would be, and the opportunity which would be afforded for further comment and response at draft stage to anyone who may be the subject of criticism in the draft.

1.20 It was clear in a number of the interviews that there was further information or documentation which could be of assistance to the panel, and which was subsequently submitted. All of this additional material has been considered fully by the panel.

Expert Advice

1.21 Both of the patients involved in this inquiry were heavy users of alcohol, for which in-patient detoxification treatment was given, in addition to attempts made to support them in the community. The panel wished to take expert advice on the treatment and care offered in relation to the alcohol problems, and are grateful to Dr E Gilvarry, the Clinical Director of the Northern Regional Alcohol and Drug Unit, for her report in this case.

The Report

1.22 At the close of the oral hearings, the panel members took time to formulate their thinking about the key issues which had emerged during the hearings and from the written statements and materials gathered. They also identified further information which they wished to seek from Social Services. A working draft of the report was then prepared by the Chairman, with appropriate contributions from members of the panel, which was considered in detail at a number of meetings of the full panel. Revisions were made in the light of those drafting meetings.

1.23 The panel also agreed those sections which needed to be circulated in draft form to parties or organisations who may be subjected to criticism, to allow them a full opportunity to comment further. Once their responses were received, the panel then gave them their consideration, and further re-drafting was undertaken where appropriate.

Acknowledgements

1.24 The panel is grateful for the administrative support it has received from David Baggott and Christine Williamson of the Corporate Governance and Facilities Management Service for County Durham and Darlington, to Glyn Snowden at County Durham and Tees Valley Strategic Health Authority, and to Harphams who made the transcripts of the oral hearings.

Chapter Two

The Incident and the Outcome

2.1 Patient Q had met Patient G when they had been in-patients at the County Hospital in Durham during September 1999. Both were undergoing detoxification treatment. They continued to see each other once they had both left the hospital. There is evidence which points to the volatility of their relationship, violence between them, and to the fact that they were both continuing to consume alcohol. At the stage when he left the County Hospital, Patient G was living in hostel accommodation, from which he was evicted on 30 September 1999. He made his way to Patient Q's home, where she permitted him to stay.

2.2 According to police statements, at some stage over the course of Sunday evening, 3 October 1999 or during the early morning of Monday 4 October 1999, Patient G and Patient Q had an argument which resulted in him hitting her. Patient Q became unconscious, and her injuries were sufficiently severe to cause her to aspirate, and to choke to death.

2.3 The trial of Patient G took place at the Crown Court in Newcastle upon Tyne on 19 July 2000. Patient G pleaded guilty to manslaughter, on the basis that there was no intention to kill or to do serious harm. That plea was accepted. There were no pre-sentence reports or psychiatric reports before the court in this case, and none had been requested. Taking account of the plea of mitigation made on behalf of Patient G, the Judge sentenced him to five years imprisonment.

Chapter Three

The background and involvement with health and social services of Patient Q and Patient G

This Chapter comprises detailed information relating to the medical history of Patient Q and Patient G, and information relating to their contact with Social Services. It is not reproduced here because it contains confidential information from their medical records and confidential information regarding third parties.

Chapter Four

Issues and Concerns relating to the case of Patient Q

Introduction

4.1 The panel have approached the care of Patient Q by examining each aspect of the services separately. Throughout, the panel has been mindful that in highlighting difficulties and deficiencies which existed in 1999, it should also be borne in mind that there has been considerable change and improvement in services and systems over the last four years. In particular, the panel has noted developments since this incident in relation to integrated Community Mental Health teams and joint working with Social Services and other agencies; improved staffing levels and staff training; improved processes of risk assessment; upgraded policies and procedures; new management structures; greater emphasis on safety, dignity and privacy for patients; and environmental improvements at the County Hospital. Issues with regard to the organisation of services and effective collaboration between services are considered in Chapter Six.

Care from the General Practitioners

4.2 Patient Q was a long-standing patient of more than twenty five years of a practice in Durham. Her principal contact was with Dr Z. Her husband and children were also patients of the practice.

4.3 The panel considered a number of issues in relation to the input from the practice, and in particular from Dr Z. The members of the panel looked carefully at the prescribing patterns for Patient Q, the timeliness of actions and responses of the practice, the readiness of the doctors in the practice to make home visits, the willingness to make referrals, and the appropriateness of such referrals, the interface of the practice with other agencies caring for Patient Q, and the state of knowledge of the doctors in the practice latterly, particularly over the last six weeks of Patient Q's life.

4.4 **The panel wishes to record** that the GP notes were full and kept in good order in the case of this most complex patient. This was greatly appreciated by panel members, as it allowed a ready check to be made of the various issues its members wished to pursue.

4.5 On the question of prescribing patterns for Patient Q, the notes make clear that she was being treated by a variety of specialists, both in respect of her pancreatitis, her need for pain relief, and her dependence on alcohol. In the case of each of the specialists involved, there was good inter-communication, with letters being copied to relevant persons in a timely way. In consequence, for much of the prescribing which was occurring through the GP practice, the doctors would be responding to changes or repeat patterns which had been indicated by the relevant specialist. There is nothing in the notes to give rise to any concern that the GP practice was mindless or careless in its prescribing routines.

4.6 **The panel noted** the number of occasions on which Patient Q was admitted to hospital via Accident and Emergency, often in connection with overdoses of drugs, or suspicion of overdose. **Members of the panel accept** that there would usually be no role or involvement on the part of the GP practice on these occasions. However, on the general question of the timeliness of the responses made by the GPs, there is evidence in the notes that when a situation required follow up, these steps were taken quickly, and when referral was indicated, the practice appears to have made the necessary arrangements without delay. There is nothing in the notes to indicate any lack of timeliness with regard to interventions by the GPs.

4.7 The panel learnt from members of Patient Q's family that her home was close to the GP surgery. Her notes indicate that she did attend the surgery quite regularly, but they also indicate that doctors from the surgery made numerous home visits. Some home visits related to bouts of pain connected with Patient Q's pancreatitis, but some related to situations where the GP had been called when some crisis had erupted caused by Patient Q's use of alcohol. **The panel believes** that the doctors at the surgery responded appropriately when requested to do so in relation to home visits.

4.8 Examination of the GP notes shows that in relation to in-patient hospital episodes, where these were connected with pancreatitis or pain relief, it is possible to follow through the progress of her admission, and her discharge. The letters sent on discharge frequently involve the GP in her on-going care, usually by virtue of the drug regime being proposed where the GP would then take over prescribing for Patient Q. At earlier stages of her care under Dr I, it is also the case that there is detailed information being passed regularly from him to the GPs.

4.9 However, the panel was less impressed by the information in the GPs notes relating to later stays in the County Hospital, Day Hospital attendances there or out-patient attendances, or Patient Q's involvement with the CPN service. There are no discharge letters on the GP file relating to Patient Q's admissions in 1999. The lack of detailed information on the file is particularly marked towards the end of Patient Q's life, when the level of anxiety being felt about her and the risks she posed to herself are not apparent to the panel on the

face of the GP records, because there are so few letters from those working with her, or copies of risk assessments, or records of multi-disciplinary review meetings. **The panel regards it as a significant omission** that important information was not being communicated to the GPs.

4.10 From the information on the file, and from information gleaned in interview with the GP, Dr Z, **the panel has formed the view** that it would have been difficult for the GPs to have realised how swiftly a deterioration in Patient Q's circumstances was taking place. The questions relating to lack of discharge letters, and other lack of communication with the GPs are taken up later in this chapter. **In the view of the panel,** the failure to ensure that the GPs had all the up to date information about Patient Q meant that they were effectively out of the loop during the last six weeks of Patient Q's life.

4.11 In discussion with Dr Z, who was the GP who had had most contact with Patient Q, the panel was keen to pursue the issue of how well the dynamics of the family had been understood by the practice, and the extent to which the doctors could have known about the dynamics. **It was clear to the panel** from Dr Z's evidence that he had always found Patient Q to be a sensible person, who could well understand what she was being told. He had found both Patient Q and her husband were quite reticent, not keen to talk about family matters which he felt they would often play down. He considered that Patient Q's lack of openness about her alcohol problems, and her plausibility may have made matters more difficult for everyone involved in her care. There were occasions when he had believed what Patient Q had told him, only for it to become apparent later that he was not being told the truth. He recognised that he had treated Patient Q for many years, but nevertheless felt that he could not say that he knew her well.

4.12 Although Dr Z was the GP who had had most contact with Patient Q, it so happened that he did not see her at all after the death of her husband. Dr Z's view that Patient Q was plausible and did not always tell the truth is borne out by evidence which the panel heard from other witnesses. **The panel accepts** that this would impede any GP from forming a fully effective view of the patient and her needs. **The panel further accepts** that not every patient wishes to share family problems with the GP, and do not wish to imply any criticism of Dr Z in his understanding of the family dynamics.

4.13 **In the view of the panel**, Dr Z provided good continuity of care to Patient Q, and did as much as any doctor in general practice could do to support such a patient. He was thoughtful about her case, and **the panel recognises** that her case would be a most complex one for any family doctor to handle.

Patient Q's treatment as an in-patient at the County Hospital

4.14 Although the panel has noted that Patient Q had a lengthy stay in the County Hospital in 1994, its members have concerned themselves more with the two in-patient stays in 1999. The details of these two stays have been noted in chapter three. Several key themes emerged which were of concern to the panel, including:

? allegations of drinking on the ward,
? non-enforcement of the patient contract,
? patients keeping supplies of drugs,
? relationships between patients,
? liaison and communication with the family of the patient,
? listening to carers, especially young carers,
? provision of information for service users and carers,
? narrow focus of multi disciplinary team meetings,
? arrangements for professional supervision,
? training needs of staff,
? development and monitoring of policies and procedures
? continuity of consultant and CPN care,
? appropriateness of treatments for alcohol dependent patient
? risk assessment,
? standard of record keeping,
? review of medication,
? use of the CPA processes,
? consideration given to the question whether Patient Q was mentally ill,
? the interface of the substance misuse service with the in-patient ward,
? the response to information fed to them from DASH,
? handling of discharge arrangements,
? overall culture of the ward.

Each of these aspects will be considered in turn. Although the focus of the points made inevitably reflect aspects which did not work well, the panel recognises the difficulty for clinicians in getting the right balance between the need to intervene to protect a vulnerable individual, and respecting an individual's human right to self determination. The panel also recognises the difficulty for clinicians of managing patients who engage in risk taking behaviour and who choose to share information with staff on a selective basis.

Allegations of drinking on the ward

4.15 There is evidence in Dr I's notes during Patient Q's lengthy stay in the County Hospital in 1994 which indicate that she was finding it difficult to abstain from drinking alcohol while she was on home visits. However, more specifically, when the notes are examined for the in-patient stay during July 1999, it is clear that Patient Q was regularly drinking on the ward, especially during the latter part of her stay. Although she was admitted to the ward on 5 July, she did not sign the alcohol and drug/solvent contract until 17 July, by which time there are several episodes recorded of her being found intoxicated.

4.16 Patient Q's family shared their concern with the panel about the level of her drinking whilst she was on Harding Ward, and it is confirmed by the evidence of the Hospital Chaplain. At that time, the Trust has confirmed that there were no specific policies in place for the management of substance misusing clients. From evidence given to the panel, it is apparent that the ward staff tolerated Patient Q's behaviour although it would have generally been regarded as unacceptable, and would have given sufficient cause to review her stay on the ward. However, it was recognised that she had suffered a traumatic experience with the suicide of her husband. Ward staff who were interviewed by the panel considered that staff had gone out of their way to be supportive to Patient Q during the July admission, and to overlook her breaches of ward routines.

4.17 However, the family expressed concern that when a decision was eventually taken during this first admission to discharge Patient Q, they believe that the hospital had planned to send her home with alcohol which she had purchased during her stay. In fact, her elder daughter obtained Patient Q's permission to remove the alcohol, otherwise their mother would have gone home with a ready supply. While **the panel accepts** that there was no basis on which the hospital could have removed the alcohol from Patient Q without her consent, **it considers** that some record of these exchanges should have been made in Patient Q's notes.

4.18 During Patient Q's second admission in 1999, in August, ward staff were more alert to her previous behaviour on the ward, and more regular and random breathalysing took place, to attempt to keep Patient Q committed to her detoxification. The alcohol contract which Patient Q signed on this second admission is dated 23 August, and has a number of handwritten additions made by staff to reinforce the significance of it. It states that "Should Patient Q break contract to be discharged at Dr P's request".

4.19 It was felt by those staff who were interviewed by the panel that Patient Q seemed more committed and determined to complete detoxification during this admission, but this is somewhat at odds with the view of Patient Q's family, who believe that she was drinking regularly during this second in-patient stay. They are surprised that Patient Q was allowed leave in the afternoons to go into Durham, where they are sure that she was purchasing alcohol. They felt in something of a dilemma, as they felt a natural reluctance to report the drinking to staff, as they feared that she would have to leave the hospital, and they were anxious about how safe their mother would be at home. **The panel is concerned** that there does not appear to have been an ethos on the ward which would have encouraged a discussion between staff and relatives, to attempt to determine where matters stood, and what their common understanding of progress was.

4.20 **The panel accepts** that Patient Q was drinking on the ward, more so on her first admission. **Panel members consider** that there was a lack of guidance with regard to confiscation of drink. **The panel believes** that staff were well motivated in their levels of toleration during Patient Q's first admission, but **members of the panel consider** that the evidence of non-compliance with ward rules was so substantial that it ought to have triggered a higher level of review and discussion among the ward team than appears to have occurred. **In the view of the panel,** the clinical team should have received greater support from the ward manager than appeared to have been given in respect of this problem. **The panel is also of the view** that in granting leave during the day for patients, some check should be in place to determine where they have been, and what they are bringing back into the ward, not only for the safety of the individual patient, but also for the safety of other patients and staff on the ward. **The panel considers** that when a patient is out on leave, staff remain under a duty of care, and in accordance with good practice, they should see leave arrangements as contributing to the patient's overall treatment.

Non-enforcement of the patient contract

4.21 On the question of the non-enforcement of the patient contract, it is noted above that during the July admission, Patient Q only signed the contract on 17 July. Before that time, there is evidence in the notes, and from the comments of her daughters, that Patient Q had a good spell, and had improved quite a lot. However, on 17 July, she had been found to have gin hidden in the toilet, and was also found to have numerous types of pills, including severedol, in her handbag, her locker and in a bag of sweets. The duty doctor was called to speak to her. By the next morning she was discussing with nursing staff that she would prefer to be at home. Entries in her notes for both 19 and 20 July note that she was using the ward inappropriately, openly drinking on the ward despite numerous warnings. Eventually, for this reason and because of Patient Q's own wishes, she was discharged. It could be said on this occasion that the non-compliance with the patient contract was a reason for her discharge, but this was not explicitly stated anywhere in the notes.

4.22 During Patient Q's second admission, the nature of the patient contract was significantly firmed up. Evidence in the notes shows that on all the occasions when she was breathalysed, the results were negative. The notes frequently make mention of her showing no withdrawal symptoms. The evidence in the notes therefore points to the fact that Patient Q was not breaching her patient contract during this second in-patient stay. Patient Q's daughters, however, remain of the view that she was drinking whilst in hospital on this admission, and their view is supported by the younger daughter's foster parent, who visited on several occasions, and did report to staff that Patient Q was drinking on the ward.

4.23 **The panel has concluded,** on the balance of probability, that she did adhere to the rules more effectively during this second admission, although members of the panel accept that she was drinking whilst she was out of the hospital on weekend leave, and they cannot rule out the possibility that she was drinking on the ward. **The panel is disconcerted** to discover that there is no reference anywhere in Patient Q's notes to any inter-action with the foster carer on the issue of her reporting Patient Q's drinking, not any inter-action with family members on such an important matter. **The panel believes** that an issue of such significance should have been entered in the notes. Panel members have taken account of the fact that ward staff were attempting to be supportive to Patient Q during times of real crisis in her life, and they were aware that evidence that she was drinking on the ward would result in her being asked to leave. This may be one of a number of possibilities which could have coloured their view that it would not be sensible to make a note of reported drinking on the ward.

Patients keeping supplies of drugs

4.24 There is evidence in the notes that during Patient Q's admission in July, she had numerous drugs in her possession, including severedol, MST, amitryptiline, diazepam, co-danthrosate, bioartox and atenolol. By the time these were found, Patient Q had already been on the ward for 12 days. **The panel is concerned** that ward routines and admission procedures had failed to discover the quantity of drugs in Patient Q's possession, and would expect that systems have been considerably improved to eliminate such a possibility. The failure to discover the drugs in Patient Q's possession would be poor practice in any event, but is more concerning in the light of the known risks in Patient Q's case, where the staff do not appear to have made any link between her hoarding of pills and the risk of further suicide attempts. **The panel also considers** that this failure to discover the hoarding of drugs could also have put other patients at risk.

Relationships between patients

4.25 A matter of concern to the family of Patient Q was that she was able to form a relationship with Patient G while she was an in-patient at the County Hospital, and it appeared to them that nothing was done to prevent this happening, or to warn her of any risks he posed to her. This relationship was formed over the period from about September 3 1999. He was a patient on an adjacent ward, Rushford, and it was clear that patients from the two wards would socialise together. Some staff interviewed by the panel had known nothing of the burgeoning relationship. The primary nurse was aware of it, and did spend time with Patient Q, asking her about the nature of the relationship. She was assured by Patient Q that it was a platonic relationship, and that she enjoyed his company and was helping him with his literacy skills, as he could not read or write. Helping him gave her a purpose, and she

had skills in that area as she had worked with special needs children. The primary nurse had concerns that as Patient G was also an alcoholic, he could lead Patient Q astray, but she was not so concerned that she felt it necessary to note those concerns in the record. **The panel is concerned** that although the intervention of the nurse, in giving one to one time to Patient Q on this matter, was sound and appropriate, it was a significant event which should have been recorded, which would have allowed the nurse to set out what the nature of her concerns was. This matter raises **a more general concern of panel members** about the style of documentation, and the decision making about which matters need to be written up. This in turn causes the panel to question the leadership being given on the ward at that time.

4.26 Although Patient Q was indicating that her friendship with Patient G was platonic, her daughters already entertained suspicions that it amounted to more than this, even while Patient Q was still in hospital. A friend who visited her and met Patient G formed the same view. This view was strengthened in the minds of her daughters when a relative told them that she had seen Patient Q out in Durham with a man, kissing in public.

4.27 The panel sought information about the possible level of risk posed by Patient G to Patient Q. He was described by nurses as an amiable person. It was known on Rushford Ward that he had a known history of violence or assault against others, but further details of that were not pursued. He had a scar on his face, but was otherwise physically unremarkable. Nurses from Rushford Ward recalled that they were aware that he had been in prison, possibly for offences of grievous bodily harm, but those had occurred several years earlier, and he was not currently under a probation order at that time. His "history of violence" may have been exaggerated by Patient G himself, as he appears to have told different versions of his past history to different people. The "stories" included one that he had murdered his sister. It is apparent that some of these stories became known to Patient Q's daughters. The Chaplain indicated that she was aware that he had a reputation, that he had been an aggressive person, but made clear that he had not presented in that way when she had had dealings with him. It was surprising to members of the panel that Patient G's history had not been more proactively assessed. **In the view of the panel**, a fuller risk assessment would have allowed staff to form a risk management plan.

4.28 In overall terms, the detoxification for Patient G appeared from his notes and records to have proceeded reasonably well. Although there had been contact from the DASH hostel indicating that he had been drinking over the period of weekend leave, he was breathalysed on his return and it was negative. Staff on the ward would therefore have reason to believe that he had been significantly assisted with his alcohol problem during his stay there.

4.29 Viewed overall, therefore, there is a situation where Patient G appeared to have responded to treatment, he had behaved on the ward, his friendship or deeper relationship with Patient Q was not widely known on the ward, his past history of violence appeared to be behind him, and he was being discharged in a conventional way. Against this background, **the panel has concluded** that it would have been difficult for staff in the hospital to have acted to have stopped the friendship or relationship, given that both Patient Q and Patient G were adults, fully able to understand the implications of their actions and behaviour, albeit she was at a vulnerable stage following the death of her husband. However, **the panel is concerned** that throughout Patient Q's stay, staff owed her a duty of care. Members of the panel recognise that staff had to balance their duty of confidentiality owed to Patient G with their duty to share relevant information with Patient Q. If staff considered that it was not appropriate for them to ensure that Patient Q knew of Patient G's history, given that some staff were aware that she was mixing with him, then they ought to have made a record of this tension in the notes. The failure to inform Patient Q of his history appeared to the panel to be symptomatic of the lack of focus on risk issues, and the lack of clinical and operational leadership on this matter.

4.30 However, **the panel is of the view** that as there was information known to key members of the team caring for Patient Q, it would have been sensible to note it more explicitly in the notes, and to relay this information to the CPN who was to take over responsibility for her care. Information about a relationship with a longstanding alcoholic who had a past record of violent behaviour may have influenced later handling of Patient Q's care. **The panel notes** that the primary nurse was not present at the discharge meeting, which was particularly unfortunate, as she had made no note of her discussion with Patient Q about her relationship with Patient G.

4.31 Moreover, **the panel considers** that there should have been more structured arrangements in place on the ward for review of the success of leave arrangements, and a note of such review should be included in the clinical notes. If such a structured review had been carried out with Patient Q, following her weekend leave on 4 – 6 September, it may have been possible to encourage her to share some information about the turbulent weekend she had spent with Patient G. **The panel also notes** that there did not appear to have been any liaison or consultation with Patient Q's daughters about the prospect of their mother having weekend leave. This omission is symptomatic of the lack of involvement of staff with family carers. It is also unclear whether any support mechanism was established by ward staff to check on Patient Q's well-being over the weekend.

4.32 The panel has noted that Patient Q had lengthy consultations with the Cruse counsellor immediately prior to her discharge on 9 September. This was one of several sessions she had with Cruse. It is possible that her new friendship with Patient G was discussed at these sessions. The

panel made efforts to receive information from Cruse, but because of their policy of confidentiality, none was forthcoming.

4.33 As the national policy and thinking with regard to dignity and privacy for patients has developed, and in recognition of the number of vulnerable women who may be patients at the County Hospital, **the panel considers** that the hospital needs to consider the development of more explicit guidelines on these issues, particularly with regard to noting contact and relationships between patients, noting any steps taken, and to explore these issues and any advice given. The Trust should take account of recent policy guidelines issued by the Department of Health on women's mental health and on privacy and dignity.

Liaison and communication with the family of the patient

4.34 Patient Q's two daughters and her brother were all deeply concerned about the care of Patient Q. Her elder daughter had left home some years earlier, and was pregnant at the time of Patient Q's July admission. Her baby was born during Patient Q's second admission. Despite her pregnancy and subsequently the commitment to her young baby, Patient Q's elder daughter continued to be heavily involved with supporting her mother. Much of the day to day burden of supporting Patient Q fell on her younger daughter, who was aged 14 in 1999. This support is recognised frequently in notes and letters, and there are regular references to her maturity and ability to cope with various situations. Patient Q was also assisted from time to time by her brother. She had gone to stay with him immediately following the death of her husband, he assisted in sorting out financial and legal affairs, he made numerous phone calls to those involved in her care, and he attended meetings at the hospital.

4.35 Once Patient Q became an in-patient at the County Hospital, the daughters found it very difficult to obtain information, to understand how their mother's treatment was proceeding, or to ascertain who was the most appropriate person with whom to share their concerns about her continued drinking, or the fact that she had supplies of pills that she was secreting. They were unfamiliar with in-patient mental health facilities, and found the ward environment quite intimidating. Eventually, both daughters found the lack of information and the fact that they were not being listened to so frustrating, that the elder daughter took her stepmother with her on one visit, to attempt to be heard, and the younger daughter asked her foster mother to accompany her. However, even when accompanied in this way, they did not feel that they were listened to any more effectively. Patient Q's younger daughter felt that they treated her like a child, and that she was not taken seriously. Approaches to staff to ask for updates on their mother's treatment were met with the response that information could not be divulged, unless their mother chose to tell them herself.

4.36 Patient Q's daughters believed that they knew their mother and the patterns of her behaviour. They were also aware of how manipulative she could be, and her ability to convince staff with what she was telling them. However, at a meeting on the ward, they consider that they were made to feel they were being over-cautious, as if their point of view had no validity. The foster carer confirmed how frustrating it was for the younger daughter, that staff were not interested in what she had to say when she tried to give them information about how her mother was at home.

4.37 **Panel members were deeply impressed** by the care, support and commitment shown for their mother's well-being by her two daughters, and consider that they shouldered a great part of her care over substantial periods. They are both intelligent and articulate, and it was clear that they would have been an outstanding resource to those in the County Hospital who were caring for Patient Q, if only they had chosen to involve both of them more fully, and communicate with them more effectively. **The panel considers** that the level of liaison and communication with Patient Q's daughters fell significantly below what could have been reasonably expected, and is in consequence critical of practice in the ward at that time.

Listening to carers, especially young carers

4.38 Many of the points with regard to failure to listen to young carers are outlined in the paragraphs above. Some of the difficulty in this case may have been that the two daughters of Patient Q were not perceived by the ward staff to be carers of their mother. However, by the time of Patient Q's second admission, there is already a letter on file from Dr P to the GP, which makes clear that the younger daughter had been shouldering an unacceptable emotional burden, and it was unrealistic to expect her to go on bearing the responsibility and burden of care for her mother. Much of the information in Patient Q's records shows that the younger daughter was involved daily in a variety of ways in supporting and caring for her mother. The elder daughter was an adult carer throughout the period in question.

4.39 During both in-patient admissions, Patient Q was regularly being visited by her daughters and they were making regular inquiry about her progress. It would have been possible on numerous occasions for staff to discuss with them the level of care they had previously been giving, and to ascertain the extent to which they were expecting to be involved in on-going care on Patient Q's discharge. Such opportunities were never taken. **The panel is concerned** that no holistic view was ever formed on the ward about the status of the daughters as carers, nor about their ability to contribute information of value and benefit in planning Patient Q's care, despite the fact that both daughters had been recognised as carers by Dr M and Dr P.

4.40 Under the CPA policy in force in the Trust at that time, there would be a responsibility on the key worker to "act as a focal point for communication with patients and carers". **The panel believes** that this responsibility was not effectively discharged. **The panel expects** that this situation should have improved on the ward, as a result of obligations in the new Care Co-ordination policy, which requires that "carer contribution should be explicitly recognised throughout each element of the Care Co-ordination process". In the new policy, carers would be informed of their right to request an assessment of their own caring needs. On discharge, the new policy provides for the carer to be involved in the review of the care plan prior to discharge. Had such a process been in place when Patient Q was discharged from hospital on both occasions in 1999, this would have been of great value to her daughters. Despite the lack of such a clear policy at the time under review, **the panel considers** that any member of the team caring for Patient Q could have set up a multi-agency review meeting at any time, to which the daughters could have been invited, and to which the panel considers they could have made a valuable contribution.

Provision of information for service users and carers

4.41 Admission to an in-patient mental health facility is a bewildering experience for many patients and their relatives, who may have had no contact with such services previously. They will be unfamiliar with ward routines, with the hierarchy of personnel on the ward, and with the disciplines and expectations with regard to their own behaviour. The panel were told by Patient Q's daughters and the foster carer that it was difficult to find people to talk to on the ward, that it was unclear to whom they should speak, and they were uncertain about ward routines, for example about outings into town, and trial leave arrangements. The panel has not seen any documentation which might have been available for patients or their carers and relatives at that time, but **the panel considers** it essential to have such information available, in a readily digestible form, with key contact details on it for the patient concerned.

4.42 This requirement for information becomes more acute at the time when a patient is about to be discharged. There will be a mass of information at that point, including referral points, names of new staff to be involved with the patient, and key phone numbers and addresses in case of recurring crisis. Although the notes often detail that information was given on these matters, it seems as though it was given to Patient Q herself, who would be in no position to recall it or use it at times of crisis. It is striking that those most closely involved in Patient Q's on-going care, her two daughters, had no information about who to contact, and would have to rely on their GP when emergency situations developed. They did not know the names of any of the staff who would be involved with the on-going care of their mother. **The panel considers** that there was a deficiency in the systems operating at discharge at that time at the County Hospital, in that

effective communication of key information to all relevant persons did not occur. This is only one aspect of what are regarded by the panel as generally unsatisfactory discharge procedures. Other aspects of this will be dealt with later.

Multi disciplinary team meetings and review meetings

4.43 The panel have had some difficulty in judging the effectiveness of the multi-disciplinary team meetings and review meetings held during Patient Q's two in-patient stays, as the notes and comments about these are very often sketchy, and very few such meetings took place. There is some better detail in letters written to the GP following the meetings. One feature which **the panel found particularly disappointing** is a failure to record who was present at meetings or ward rounds. There was clearly a regular meeting between consultants at the beginning of each week, when particular patients would be discussed, but there are no notes of those meetings. While in practice the team may have been operating in a multi-disciplinary fashion, **the panel is disappointed** to find so little evidence of multi-disciplinary team working in the records, so little information about which team member is following up issues, and very little evidence of multi-agency working.

Arrangements for professional supervision

4.44 From evidence which the panel heard, it seems that supervision arrangements for staff in the Trust at that time were rather informal. There was an expectation that staff would have the opportunity to receive clinical supervision on a monthly basis. There would have been no records of supervision at that time, and it was accepted that it was a system without much rigour or discipline. New systems are now in place, monitored by the Trust Board, which should ensure greater confidence that the clinical supervision arrangements are effective. **The panel considers** that the arrangements in place for clinical supervision at the time of this incident were ineffective, and is pleased to note the introduction of a more rigorous system. **The panel would urge** the Trust Board to continue to maintain regular monitoring of the system, to ensure its continuing effectiveness.

Training needs of staff

4.45 The panel attempted to put together a framework of what existed at that time in the Trust to satisfy training needs of staff, and discovered that it could best be described as fragmented. Few mental health in-patient nurses appeared to take up training opportunities which were offered, and it was uncertain whether information about available training ever filtered through to them at the County Hospital. As staff tended to be out of the loop of training events, it appeared to produce inertia about taking up new opportunities presented. It

transpired that very little training had taken place in connection with CPA processes.

4.46 Some of the training required seemed to members of the panel to be at a most basic level, down to matters such as what needs to be talked about, what needs to be observed, what needs to be recorded, what needs to be communicated to others. **In the view of the panel,** provision of training, and the take-up of what was available, was poor at the time of the incident.

Development and monitoring of policies

4.47 The panel considered that a number of the issues being reviewed in this inquiry should have been covered by policies developed within the County Hospital. It was disconcerting to discover that at the time of the incident, such policies did not exist, for example in relation to contraband items on the ward, professional supervision of staff, leave from the ward, weekend leave, care of women on acute wards, or relationships between patients. **In the view of the panel**, staff on the ward ought to be involved in the development of appropriate policies and guidelines, and management of the ward should regularly monitor the effectiveness and compliance with the policies.

Continuity of consultant and CPN care for Patient Q

4.48 The background to the situation with regard to consultant cover in Durham was highlighted in evidence to the panel, indicating that there had been significant under resourcing of mental health services in the area for a long period. In consequence, in 1999, there was a shortage of consultants, with several posts vacant, and the need to create other new posts. Steps were already in hand to improve this situation, but the Trust had not then achieved the more stable basis which it currently enjoys in relation to consultant appointments. This was a factor, along with numerous mergers and re-organisations of the Trust, which contributed to a very low level of morale across the Trust in 1999. Morale had also been dented by previous inquiries which had taken place in relation to other patient deaths. The recruitment difficulties in respect of consultant appointments also meant that there was a lack of leadership at consultant level, which may have impacted on morale.

4.49 Patient Q had enjoyed a significant period when she was under the care of Dr I, but following his death, the same continuity of care was not achieved. At various times, Patient Q was under the care of Dr I, Dr P, Dr M, Dr IW and Dr T. Dr T was a locum consultant, who worked only in out-patients on two days each week, so his contact with Patient Q was minimal. Dr M was the RMO in regard to Patient Q's July in-patient stay, and Dr P in relation to her August stay. Both were new appointments in the Trust, and in the case of Dr P, it was his first consultant appointment.

4.50 The lack of continuity of care by consultants was exacerbated in the case of Patient Q because of the turbulence which was prevailing at that time amongst the CPNs, where a combination of holidays, maternity leave, job interviews, and leaving to take up new posts meant that a large number of people were involved in Patient Q's care. This could only work satisfactorily if systems were in place to permit excellent communication, and those systems were fully utilised. Unfortunately, the systems were not adequate to cope, and many of the key players involved in her care were operating in isolation, ignorant of important parts of the wider picture.

4.51 **The panel recognises** that some of the problems of lack of continuity of care were beyond the control of the Trust, but **the panel urges** the Trust to monitor its systems for cover, and effective handover of patients, to attempt to minimise the kind of problems created in this case. **The panel also urges** all consultants to exercise clinical leadership and to demonstrate personal and professional presence. The panel looked closely at working relationships among various professionals, as good communication and team work are vital to the successful care of patients. Some considerable stress was placed on staff at the time under review, largely due to turnover and recruitment problems amongst consultant psychiatrists and CPNs. This in its own way would lead to a situation where it would take time for everyone to build confidence to work effectively together. **The panel takes this opportunity to reinforce its concern** that patient care in this field requires committed team work, and where any conflict or potential conflict exists between members of teams, the Trust should ensure that it supports effective resolution of such matters by management.

Appropriateness of treatment for alcohol dependent patients

4.52 On the question of how Patient Q's care was planned and delivered, the panel considered that it would be helpful to seek some more specialist view from an expert in alcohol dependency. Specific questions were put to the expert, Dr E Gilvarry, Consultant Psychiatrist specialising in addictions, and Clinical Director at the Northern Regional Alcohol and Drug Service.

4.53 The questions relevant to the care of Patient Q at the County Hospital were in regard to the appropriateness of attempting to detoxify Patient Q in hospital during August/September 1999, and the appropriateness of continuing this treatment, despite the knowledge that she was continuing to drink alcohol while in hospital, and whether detention under the Mental Health Act 1983 may have been considered appropriate at any time between July and October 1999. This latter point is referred to in paragraph 4.69 of this report.

4.54 In the expert report, the view is advanced that Patient Q was dependent on alcohol in early July, therefore detoxification was appropriate. Admission at that time was not necessarily for detoxification but for assessment of mood following her overdose, and so detoxification was more of expedience. During that admission, the expert agrees that it was a difficult decision whether or not to discharge Patient Q, pointing out that many would have discharged her much earlier, and recognising that the decision to maintain her in hospital appeared to be more related to the family concerns and the risk of self-harm. When Patient Q was discharged on this occasion, the expert comments that "at the very least, she should have been on daily pick up or the medication should have been given to the family."

4.55 In the view of the expert, on occasions when Patient Q had been found to be drinking on the ward, no leave should have been given, her room should have been searched with full discussion of her behaviour and discussion with the medical team. During the July admission, the expert concedes that the consultant was faced with a difficult decision. Patient Q had a risk assessment showing past self-harm and alcohol misuse, but there was no evidence of depressive disorder. She had not adhered to any of the contract conditions noted on 17 July. The expert considers that the medication and the contract should have been reviewed, particularly the continuation of amitriptyline and observation levels.

4.56 In regard to the August admission, the expert considers that detoxification was probably not required, but considers that admission was not only for detoxification but also because of family concerns again regarding her risk of self-harm, and in an effort to motivate and further assess her. The expert comments in relation to this admission that "it was appropriate and handled well."

4.57 **The panel accepts** the points made by the expert, and recognises that overall, the expert confirms the appropriateness of the treatment regimes.

Risk assessment

4.58 There was a general acceptance by a number of staff interviewed that the risk assessment methods used in 1999 were not particularly thorough, and were generally rather basic. The clinical notes do not contain comprehensive documentation of regular risk assessment, so it is difficult after such a period of time to evaluate how thoroughly risk issues were addressed by the team caring for Patient Q. If appropriate documentation had existed, this in itself may have acted as a spur to those caring for Patient Q to add new elements as they became known. Certainly, reports from those visiting her that she was drinking on the ward, the knowledge that she had a store of many different types of pills, her burgeoning relationship with Patient G, any doubts or suspicions that she had spent her weekend leave with him, are all pieces of information which could have been of value to others

working with Patient Q, if they had been documented as part of a risk assessment.

4.59 **The panel is of the view** that risk management was virtually non-existent at the County Hospital at the time of the incident. The general view of staff interviewed is that these matters are much more thoroughly addressed now, with new documentation available, with provision for regular review which permits better comparison to be made with a patient's earlier assessment. Such an approach is to be welcomed, as the former over-reliance on forms with boxes to be ticked did not allow dynamic risk factors to be taken into account. **The panel would urge** the Trust to audit compliance with risk assessment procedures at the County Hospital on a regular basis, and ensure that this topic forms part of regular on-going training for staff at all levels.

Standard of record keeping

4.60 The panel had available all the nursing and medical records for Patient Q during her in-patient stay at the County Hospital, and after making a thorough review of the records, **the panel has formed the view** that they contain some very good examples of detailed and holistic record keeping. The panel would particularly draw attention to reviews undertaken by Drs V, S and I. However, **in the view of the panel**, much of the other record keeping during 1999 is rather limited in its scope, and it is difficult to find much formal noting of risk assessment or multi-disciplinary team activity. Given the limitations of the risk assessment documentation being used, it is disappointing to note that risk issues are notably absent in comments in the notes. The nursing notes omit some important detail, for example there is no note of the discussion with Patient Q about her developing relationship with Patient G. Nor do the notes contain much information about feedback from Patient Q's periods of leave. Care plans and the interventions planned are vague, and there is virtually no carer sensitive information, or views of carers. More detailed notes about the consideration given to using the Mental Health Act would be helpful.

Review of medication

4.61 From some of the evidence which the panel heard, there are suggestions that Patient Q was not necessarily compliant with the regime which had been established for her with regard to a number of drugs. The panel recognised that there were a number of professionals advising with regard to Patient Q's medication. A common theme which developed latterly in her care was the issue of seeking to reduce her reliance on diazepam and to wean her off amitriptyline. Dr P was particularly focussed on these issues and did make some progress.

4.62 Throughout the notes, there is evidence of good liaison among the various consultants treating Patient Q, and evidence that they kept her

GP informed with regard to her needs and his role in prescribing. Although the panel recognises that Patient Q may have been failing to take medication as prescribed, **the panel has formed the view** that there was satisfactory regular review of her medication, appropriate communication on this matter between professionals, and recognition of the impact of the combination of drugs.

4.63 The panel has been helped by comments made in the expert's report with regard to medication. On some occasions when diazepam was given, it was being used more as an anxiolytic rather than for formal detoxification. The expert considered this to be appropriate. The expert does however suggest that the continuation of amitriptyline should have been reviewed. **The panel notes** that this was done latterly, but could have been tackled at an earlier stage.

Use of CPA processes

4.64 At the time when Patient Q was a patient at the County Hospital in 1999, the panel has learnt that within the Trust, there were two different approaches to the implementation of the Care Programme Approach in the north and the south of the county, which had not at that time been fully standardised. This difference in approach had been caused because of the merger of two former Trusts. Patient Q was noted to be assessed as level 1 on the Care Programme Approach (CPA) processes. This level applied to all patients accepted by specialist mental health services. There was no requirement to register this level on to the CPA database, and no explicit requirement to complete the CPA care plan documentation.

4.65 Although not explicitly stated in any documentation in use at that time, the CPA process would not be applied to patients with a pure drug and alcohol problem. For this reason, **the panel accepts** that it was clearly not appropriate to be used in the case of Patient G, but because of Patient Q's relationship and emotional problems, the panel can understand the reasons why level 1 was considered appropriate in her case. **The panel further accepts** that when Patient Q was discharged in September 1999, she had a level of support from CPNs and from the Drug and Alcohol Service which did in practice equate more with someone graded at level 3, as it was considered that she had some immediate issues to be resolved.

4.66 Being graded as level 1 CPA at that time did appear to the panel to mean that there were likely to be weaknesses around the discharge of the patient. Had the patient been graded at level 2, this would have brought into effect the CPA discharge planning process, whereas at level 1, evidence put to the panel suggested that it was more likely that in relation to such a patient, the services would work in isolation

from each other, there was a greater danger of "silo working". At level 1, it is likely that all that would be needed at discharge would be a letter to the GP.

4.67 **The panel shared the view** that the CPA process as it was operated at that time would have little meaningful impact in Patient Q's case. Looking at the criteria applied for grading patients at that time, **the panel is uncertain** what would have triggered a reassessment of Patient Q's CPA status. It appears that only the RMO could change the level of care. If this was the case, then **the panel considers** that this is a very medically led model. Looking at the criteria in use at that time, it did appear to the panel that either level 2 or level 3 might have been appropriate for a short period for Patient Q, given the network of support that she needed from statutory and voluntary agencies and from informal carers. **The panel considers** that it would have been helpful for more detailed notes to be made whether any reassessment of her CPA status had been undertaken.

4.68 The panel has heard that the integration difficulties caused by having two CPA systems have now largely been resolved within the Trust. Members were however disturbed to learn that there is still an issue to be resolved about interface between the Drug and Alcohol service and the CPA system. **The panel would urge** the Trust to give early attention to full co-ordination of the Drug and Alcohol service into the Care Co-ordination system.

Consideration given to whether Patient Q was mentally ill

4.69 The panel were aware of the high level of concern expressed by members of Patient Q's family that powers under the Mental Health Act 1983 should have been used in order to formally detain Patient Q for assessment or treatment under the Act. The panel was also concerned to review any evidence pointing to Patient Q being mentally ill or not, in order to judge the suitability of her admissions to the County Hospital.

4.70 The panel made an extensive review of Patient Q's notes, and heard evidence from a significant number of the professionals who had been involved in her care during 1999. This question was pursued in detail. It is clear from all the evidence that Patient Q could be said to have a lifelong pattern of "behaviour", (i.e. an enduring pattern since adolescence of poor coping and self harming behaviour) which when further associated with her use of alcohol, led to a rapid decline in her general health in the last few months of her life. It is possible that a diagnosis of borderline disorder may have been appropriate at some stages. There are also some indications in her notes that Patient Q may have had a tendency to depression. Her situation was further exacerbated by the suicide of her husband. After that time, it may have been possible to consider a diagnosis of grief reaction or

adjustment reaction. It is unclear from the notes whether these diagnoses were ever considered.

4.71 Possible use of the powers under the Mental Health Act was considered by the doctor who carried out a thorough review of Patient Q in ITU in Dryburn Hospital on 5 July 1999. After commenting that there was no suicidal ideation, his notes clearly indicate that the patient "cannot be sectioned – no grounds".

4.72 It is clear on at least one occasion that there was sufficient concern for Patient Q's safety, after an overdose on 22 July, for Dr V and the CPN, CPN EB, to confer with the consultant, Dr M, to consider using section 2 of the Mental Health Act. However, it was felt that they had no grounds to employ the Act, and instead, they attempted to persuade her, unsuccessfully, to stay in hospital. **The panel is satisfied** that this was an appropriate point at which to consider the use of the Act, and is satisfied that the decision of the consultant was correct. However, this was an occasion when the consultant could have considered convening a case conference, which **the panel considers** would have been timely, given that Patient Q had been admitted to Accident and Emergency having abused alcohol, and with some uncertainty about whether she had taken an overdose of medication. **In the view of the panel,** this was an opportunity missed for a wider perspective on Patient Q's problems.

4.73 On the question whether Patient Q was suffering from depression, **the panel has concluded** that there was no clear history of depression in August and September 1999, up to the point of discharge from the County Hospital. Professionals who assessed her found that she was hopeful for the future, her reactions to what had been happening to her presented as sensible and normal, she took pleasure in happenings such as the birth of her first grandchild. Her GP had also seen her in some acute situations, and he confirmed that he had never seen her in such a condition that he would have considered using the Mental Health Act, the more so as Patient Q was usually either willing to be admitted to hospital, or arrived there through the A and E department. In the view of the expert, in answer to the question whether use of the Mental Health Act would have been appropriate between July and October, the view is clearly expressed that the Mental Health Act was not considered to be appropriate during this period.

4.74 After discharge from hospital, it is difficult to judge whether Patient Q became depressed. CPNs and workers from the Drug and Alcohol Service who saw her after her discharge in September had also considered her mental state, and did not detect any significant mental health issues that would have facilitated an admission. Although they felt considerable anxiety about the various risks to Patient Q, they also appreciated that she understood the risks too, and was well able to give informed consent. There was a firm view that use of the powers under the Mental Health Act would not have been possible. **The panel concurs in this view.**

4.75 However, it is clear that Patient Q was not conforming to the discharge plan which had been formulated. She was still on level one CPA, and this does raise in the minds of the panel the question that some kind of case conference should have been convened at this point. Ideally the family could have been included at such a meeting. A wider perspective on Patient Q's situation would have been gained by the presence of an Approved Social Worker at such a meeting, who would have brought highly relevant experience to the question whether admission under the Act should be considered. **The panel considers** that in not convening such a meeting, an opportunity was lost to professionals to appraise the disintegration which was occurring in Patient Q's life.

The interface of the substance misuse services with the in-patient ward

4.76 **The panel has formed a view** that the referral from the in-patient ward to drug and alcohol services was not particularly effectively managed. It seemed that the drug and alcohol service was being asked to encourage Patient Q to remain alcohol-free and to undertake some longer term support work with her, including monitoring her medication. In fact, given the resource constraints on that service, it was not geared up to do either of these tasks effectively. Their normal position would be to refer those in need of longer term support to the North East Counselling on Addictions service, nor would they expect to monitor medication unless the patient was on a home detoxification programme, which Patient Q was not, as she had been discharged from the County Hospital after completing detoxification.

4.77 Nursing notes seem to indicate that only short term input was expected from the drug and alcohol CPN, until a referral to NECA could be made. This was in addition to a more normal CPN referral. From the minimal amount of information passed on from the County Hospital to the drug and alcohol CPN, **the panel has had some difficulty** in evaluating whether this was a useful and sensible referral, particularly in view of the fact that the drug and alcohol CPN could not access any information held on the CPA system, and would have to rely on the other CPNs who had contact with Patient Q to access such information. Moreover, given some evidence of limited team working between the consultants and the drug and alcohol service, this was further likely to impede effective working. **The panel was however impressed** by the efforts made by Mr IY, the drug and alcohol CPN, which are amplified later.

Response of County Hospital to information provided by DASH

4.78 Patient Q left the County Hospital on 9 September 1999. Patient G had been discharged the previous day, and went back to the DASH hostel. The panel learnt that there were no regular systems in place at that time for the hospital to alert DASH with regard to any concerns they may have about a patient. **In the view of the panel**, good multi-

disciplinary team working and CPA processes would have drawn in agencies such as DASH, and the ward would have had protocols in place about communicating with such agencies.

4.79 In the view of those working at DASH, Patient G was drinking more heavily after he left the County Hospital following completion of his detoxification programme than before he went in. Moreover, his drinking habits had changed. Previously he had been a cider drinker, whereas now he was drinking spirits.

4.80 Patient Q had no connection with the DASH hostel, other than that workers there got to know her through her visits to Patient G. They would therefore be unaware of why she had been a patient at the County Hospital, or what support mechanisms existed for her in the community. They found her in Patient G's room in a bruised and frightened state on 29 September, and took her to her own home, giving her advice on security, and alerting the police.

4.81 DASH evicted Patient G on 30 September, for further drunken and abusive behaviour. They arranged a hostel place for him in Consett, to which he did not go. DASH also alerted Patient Q and the police, as well as telephoning Patient Q's former named nurse at the County Hospital. **The panel is of the view** that staff from DASH acted in a most responsive and responsible way, above and beyond what could have been expected from them. **The panel wishes to commend** the behaviour of both Mr EH and Mr AD, as showing outstanding commitment to the well being of Patient Q.

4.82 **The panel is in no doubt** that the message from DASH that Patient G was being evicted and of their concerns for Patient Q was received by the named nurse. **The panel also accepts** that she did pass on the gist of the message to the consultant psychiatrist. Although it is clear the information was received, nothing was done in consequence of receiving it. Whilst **the panel accepts** that the in-patient service had discharged both patients, and furthermore now had a full cohort of other patients to care for, **the panel considers** that at the least, it would have been appropriate for the named nurse or consultant to have undertaken to inform the CPN involved with Patient Q. This failure to do so **appears to the panel** to be a clear indication of the type of "silo working" which was taking place in the hospital and across all the statutory services involved with Patient Q.

4.83 In the wider context of patients generally, rather than in the specific case of Patient Q and Patient G, **the panel has also been disappointed** to learn how little contact was ever made with DASH in respect of patients being released back to their accommodation, and to learn how limited is the liaison and contact made by health services generally with their service.

Handling of discharge arrangements

4.84 In its review of procedures in the County Hospital, one aspect which **the panel has found to be particularly disappointing** has been the discharge arrangements from both of Patient Q's in-patient stays. A view expressed to the panel was that each consultant had his own style in relation to discharge. **The panel accepts** that the discharge of Patient Q on 20 July was unlikely to be a model of best practice, as it was clearly the case that Patient Q had continued to drink on the ward, was being unrealistic about her alcohol abuse, and was keen to be discharged. Indeed this discharge is noted to be unplanned. The In-Patient Discharge Summary has attached to it a long note from Dr V, which is undated, but which appears to be a discharge letter.

4.85 If the note is a contemporaneous note written to the GP, **the panel is of the view that** it does contain a reasonable amount of useful information. Although it notes how future management will take place, and notes the involvement of child care social services, there is nothing in the letter or the notes to indicate any liaison with Patient Q's family, either her brother or her two daughters, despite the fact that the daughters were likely to be bearing a burden of her care. The panel acknowledges that Patient Q was on CPA level 1 at that time, and all that the policy called for on discharge was a discharge letter to the GP.

4.86 However, by the time of Patient Q's second discharge, in September 1999, the panel has learnt that some tightening up of CPA procedures had occurred within the Trust, in an effort to monitor better the discharge arrangements for those on level 1 CPA. Despite these changes, **it is the view of the panel** that the discharge on September 9 was even less effectively managed. There does not appear to have been any kind of discharge letter written to the GP, and the copy of the discharge summary contained in Patient Q's medical notes simply notes that there is to be CPN follow up, and the patient can have a small supply of diazepam 5mg for occasional use.

4.87 There is no evidence that the panel can find of any liaison or consultation with Patient Q's relatives in respect of her discharge. All of the staff caring for her would be aware of their concerns for her safety and well being, as one consultant had had an earlier meeting with family members at their request, when her daughters and more particularly her brother had expressed their concerns that she would make further self harm attempts, and that she would put herself in danger through drinking excessively. Another consultant had made a domiciliary visit to Patient Q's home, and had recognised the intolerable burden which was being thrust upon Patient Q's younger daughter in particular. Nursing notes also make reference to these issues.

4.88 **The panel considers** that there was an over optimistic assessment of Patient Q's progress at the time of this discharge. Her situation was one

of growing complexity, and she had deteriorated in general terms over the last few months. She was patently in need of a lot of support after discharge, and yet the discharge information was minimal. **The panel considers** that it is a particular cause of concern that the GP had no information about her discharge, particularly in view of what a good extra resource he could have been. Moreover, **the panel is disconcerted** to discover that the minimal discharge information which does exist does not in any way reflect other issues which are contained in the clinical notes, for example efforts to secure some social work support and the input which was expected to be made by the drug and alcohol CPN. **The panel reiterates its concern** at the lack of information sent to the GP. In the event, for a variety of reasons, Patient Q chose not to be in contact with her GP after her discharge on 9 September, but if some situation had developed where the GP had been called, there would have been inadequate information to inform his decision making.

Overall culture on the ward at the County Hospital

4.89 The panel wishes to make clear that its members have not visited the County Hospital, as it is recognised that much has changed since 1999. Their impressions of the prevailing culture have been informed by discussion with staff working on the wards at that time, or with managers, or with the family of Patient Q and others who visited her on Harding Ward.

4.90 **The panel does however recognise** that a significant number of factors would influence the culture of the wards. It is recognised that both Harding and Rushford wards are large, with 28 and 25 beds respectively. The County Hospital itself is old, not originally designed for mental health care, with wards inconveniently arranged for fully effective nursing care. There was a shortage of consultants, and the resource supporting nursing staff was quite stretched. Programmes of education and training were accepted to be inadequate through lack of investment. Morale was low, not only for the reasons already listed, but also because the organisational structure had undergone a period of constant re-organisation. Uncertainty about jobs could well have been resulting in a lack of leadership. The amount of change which had been going on had probably resulted in lack of long term planning. There had been other mental health inquiries which had had an impact on confidence.

4.91 The panel is mindful of all of these factors, but nevertheless, in the view of its members, **the panel considers** that there was a reactive culture on the wards. Although its members have no doubt that staff were well motivated to support Patient Q, **the panel does not consider** that opportunities were taken to gather a more rounded view of her situation. It may be that some of the notes are quite cryptic in relation to Patient Q, as staff may not have wished to record that she was drinking on the ward in case they endangered her stay there, but in all of the notes for the July and August/September admissions, there is

very little family context or awareness of the levels of support which they had been offering to Patient Q, nor of their concerns for the future. The notes for the later admission create an impression of relative calm and constant progress which **in the view of the panel** sits rather uneasily with the very turbulent period which had occurred prior to this admission.

4.92 The discussions which the panel held with managers tends to reinforce its members views about the culture on the ward. The management approach at all levels, both clinical and operational, appears to have been lacking in drive and vision, more concerned with dealing with the day to day matters rather than taking a more strategic approach to issues such as training, ward procedures, or development of thinking on good practice, and seeking to relate the work of the wards to national agendas or the developing agenda of the Trust.

4.93 **The panel is also concerned** that during her last admission to Harding Ward, when Patient Q was causing fewer problems for ward staff, she may have become rather "invisible" to ward staff, particularly if the ethos of the ward at that time was a somewhat reactive one.

CPN, Day Hospital and Out-patient care for Patient Q

4.94 During the key period of July to October 1999, Patient Q had a number of CPNs who were involved in her care. For a period from July to 1 September, this was CPN EB. From his notes and records, and from copies of letters which he wrote, **it was clear to the panel** that he had formed a good understanding of Patient Q's case, was concerned about a continuing risk of suicide and Patient Q's own lack of realism, and he was alive to the wider family perspective. He communicated effectively with others involved in her care, and undertook unusually to call frequently on Patient Q, to deliver her medication daily, in order to minimize the risk of overdose.

4.95 CPN EB also undertook a risk assessment, and shared his concerns about Patient Q's situation with both his community mental health team and also with the consultant, Dr M and his junior. He gave consideration to the need for social work support, and he prompted consideration by the consultant of the question whether an admission under the Mental Health Act was called for. At times when he called and found Patient Q was not at home, he would call again later that day. He arranged appropriate cover in respect of Patient Q's care when he was on leave or away at interview. He informed appropriate parties when he was leaving and handing over Patient Q's case to a colleague.

4.96 **The panel considers** that the care given by CPN EB was professional, and that he had a sound and holistic grasp of the issues. In his delivery of care, he performed in conformity with good practice, having regard to what could normally be expected from the CPN service.

4.97 The question about appropriateness of attempting out-patient detoxification was put to the expert. She took account of Patient Q's refusal of in-patient treatment, the support of the CPN visiting each day with daily amounts of diazepam, the GP was organising medication for the weekend, and the family were involved, albeit suffering considerable anguish. In those circumstances, the expert considered that out-patient detoxification was appropriate to be attempted.

4.98 When CPN EB was leaving on 1 September, he handed responsibility for the case to CPN IA, who was himself due to go on holiday. In consequence, the case was dealt with in the interim period by the generic CPN. The person who mainly supported Patient Q after 1 September was CPN NK, who had also covered during some of CPN EB's leave in August, so she was familiar with Patient Q's case. She was aware of discussions which had taken place among the team, that the level of support and input being made for Patient Q was too high for an out-patient, and with that level of risk, it may have been more appropriate for her to be in hospital. However, it was clear that in terms of priority among clients, Patient Q would not have been afforded a high priority, but the team empathised with her in the plight she was in, and hoped that a short, sharp intervention would get her over this period, and allow things to settle down.

4.99 From the evidence available, **it was clear to the panel** that CPN NK had a sound grasp of all the issues, both in relation to Patient Q herself, and the wider family perspective. She responded promptly to situations which presented, for example on two occasions when Patient Q's brother telephoned her. On the first occasion, he raised with her his fear that his sister would kill herself. She promptly contacted Dr P to discuss this call, and to take his advice whether there was any prospect that the provisions of the Mental Health Act could be used. Dr P was of the view that this was not possible.

4.100 On the second occasion, CPN NK had been told by the brother that the daughters were coming to the end of their tether with their mother. She arranged to go to the house, accompanied by the social worker Ms ER, and took advice from Dr P before she arrived there.

4.101 During the time when she was working with Patient Q, it was clear to CPN NK that there was considerable risk, but that it was unlikely that Patient Q would be admitted to hospital. She was therefore concerned to attempt to put a safety net around her, to the extent that it was possible to do so without using compulsory powers. CPN NK did indicate however that Patient Q was an educated woman, who was well able to understand the risks herself.

4.102 Throughout the short period in which CPN NK was involved with Patient Q, **the panel is of the view** that her input was timely, appropriate and

professional. Her notes are informative, and she maintained good contact with others involved in Patient Q's care.

4.103 Once Patient Q was discharged from hospital on September 9, her CPN was CPN IA. The period over which he acted as her CPN is also a period when she had also been referred to Mr IY at the drug and alcohol service. CPN IA also became aware subsequently that there was some question of KR from social services being involved. His attempts to see Patient Q was largely unsuccessful. He did know her from her in-patient stay, as he was normally based on the ward at the County Hospital, but had been seconded out to the CPN service because of their severe staff shortages. He attempted to see Patient Q on 13 September, without success, but later in the day did manage to make contact with her by telephone, and arranged to see her on 16 September. In the event, Patient Q cancelled this appointment.

4.104 CPN IA told the panel that he had tried to make contact with her through ad hoc visits and telephone calls, but he did not see her before her death. **The panel accepts** that he may have made numerous attempts to see Patient Q, but believes that it would have been good practice to have communicated with the consultant, indicating the level of problem he was having. **The panel also considers** that Patient Q's absence from home was a factor which should have triggered some more proactive discussion within the team, prompted by CPN IA, to determine if it was appropriate to hold a case conference. **The panel also considers** that CPN IA could have discussed this matter with the Community Mental Health Team Manager, and could have informed Patient Q's GP about her lack of co-operation.

Drug and Alcohol Services care for Patient Q

4.105 One feature of the support proposed for Patient Q when she was discharged on 9 September from the County Hospital was that she should have input from the drug and alcohol CPN, Mr IY, who had previously supported Patient Q's husband. This suggestion was made by CPN EB, at the point where he was leaving the Trust. The primary nurse followed up this suggestion by discussing the matter with Patient Q, who was agreeable, on the grounds that she felt she may need additional support in remaining alcohol free on her discharge.

4.106 Mr IY indicated that he was willing to take the referral, and he also made suggestions about NECA for counselling and Kairos, for a period of rehabilitation. He wrote to Patient Q on 8 September, offering her an appointment for 20 September. Patient Q did not confirm whether she would attend, but that coincided with the date of a review meeting in respect of her daughter, and Mr IY was able to meet her there. In consequence, a new date of 24 September was fixed. At this stage, Mr IY's background supporting information about Patient Q was limited. He knew something of the family from earlier contact with

Patient Q's husband, but he was unaware that there had been a referral of Patient Q to the social services substance misuse team. He knew nothing about Patient Q's burgeoning relationship with Patient G.

4.107 When he attended at her home for that appointment, Patient Q was not there. He opened the unlocked door, and shouted her name, but there was no response. He sent her a further appointment for 30 September. When he attended on that date, it was difficult to undertake a full assessment as Patient Q was intoxicated. **The panel accepts** that this was the first proper opportunity which Mr IY had had to form a professional judgement about Patient Q. **The panel considers** that he wrote an appropriate note of his visit. He noted the fact that Patient Q had bruising on her face, questioned her about its origins, and gave her appropriate advice to ensure her safety. He also arranged to go again the next day, accompanied by a female colleague, as he felt anxious that Patient Q's behaviour posed a risk to a lone male worker. **The panel commends** the thoroughness of his review, and the steps he took during and after his visit.

4.108 At Mr IY's next visit, accompanied by Ms UC, he found Patient G at the house, and both he and Patient Q appeared intoxicated. Patient Q was covered only by a towel, and was at first apparently asleep. The two workers stayed until Patient Q had pulled round. They checked whether she wished to be readmitted to hospital. They checked whether she wished them to seek to have Patient G removed. They learnt that her daughter was due at tea time, and was to be staying over that night or the weekend.

4.109 Once Mr IY learnt that the daughter was coming, he was anxious for her safety, and contacted social services, asking them to alert the social worker involved with the daughter. He formed a judgement that although Patient Q was drunk, he did not observe any significant mental health concerns, and he recognised that it was unlikely that she would be admitted to the ward, even if he could persuade her to go. **The panel accepts** that Mr IY made a proper and rounded assessment of the state of affairs, given the limited information that was made available to him in respect of Patient Q's referral. **The panel considers** that he acted appropriately in alerting social services. **The panel also considers** that this was an opportunity when a wider team discussion about Patient Q's care could have been triggered, but has noted that there was an absence of systems to support Mr IY in generating such a team discussion.

4.110 Mr IY was due to see Patient Q again on Monday 4 October. He got no answer when he called at her home. It is likely that his visit coincided with the time when Patient G had left the house, realising that Patient Q was dead. **The panel considers** that his prompt return to see her, having seen her on the Thursday and Friday of the previous week, is evidence of his concern for her welfare and well-being, and was an attempt to deliver care for her beyond what could normally be

expected from a specialist worker such as Mr IY. **The panel commends** his assiduousness in seeking to support Patient Q.

4.111 **The panel further accepts** that it was unlikely that Mr IY could secure admission to hospital for Patient Q. However, it was clear to the panel that one step which he might have taken was to speak to Patient Q's consultant at the County Hospital. Instead, he had written to him, expressing his concerns about lack of progress in working with Patient Q, and seeking any guidance which the consultant could offer. **The panel accepts** that Dr P was relatively new in post at that time, but he was Patient Q's consultant, and his appointment was specifically in respect of drug and alcohol abuse.

4.112 **It appeared to the panel** that there was a reluctance to approach Dr P directly, as there appeared to be differences of view prevailing in the team about the policy of admitting or not admitting to hospital for detoxification. If it was the case that differences of view among the team directly concerned with drug and alcohol abuse were to any extent hampering the achievement of optimum care for patients, **the panel is disturbed** that this matter had not been resolved by the management of the Trust.

4.113 **The panel wishes to emphasise its view** that in situations where multi-disciplinary team work is required, it is of the essence that all professionals respect the views and experience of others in the team, and that appropriate discussion takes place to agree policies in accordance with national guidance and best practice which are acceptable to the team as a whole. **The panel regrets** that there appeared to be no arrangements in place at that time in the Trust to facilitate such discussions and developments.

4.114 In the circumstances in which Mr IY was attempting to support Patient Q, with very limited information communicated to him, and with virtually no cooperation from Patient Q herself, **the panel commends** his efforts, and particularly the care and concern he showed for Patient Q's daughter.

Care from Social services for Patient Q

4.115 A number of key themes have emerged in relation to Patient Q's care from social services which are of concern to the panel. These are:

? whether Patient Q needed a social worker in her own right,
? the effectiveness of referral procedures,
? communication between specialist social services teams,
? communication between agencies (considered in Chapter Six).

Need for a social worker in her own right

4.116 A key concern of the panel has been to try to identify whether, in accordance with guidance and referral criteria in existence in social services in 1999, Patient Q should have been allocated a social worker in her own right. This question was explored with Ms ER, who was the child protection social worker who was involved with Patient Q's daughter. She was clear in her evidence to the panel that Patient Q had a good relationship with her GP who was supportive to her, she was being visited by a CPN, she was receiving counselling from Cruse in respect of her bereavement, her brother was assisting with sorting out financial matters, and her principal needs at that time therefore related to her alcohol abuse. She did not rule out that there may have been a role at some stage for social work input, but at the stage where she had been involved with the family, up to the beginning of August 1999, she could not identify what a social worker from an adult team could have achieved for Patient Q.

4.117 It was also clear from letters on the daughter's social services file that Ms ER had made clear that Patient Q and her daughter should contact social services again if their circumstances should change. **The panel accepts** that there may have been no need for Patient Q to be allocated a social worker in her own right up to that time, **but believes that later opportunities were missed**, for example when Ms ER became aware of a further admission of Patient Q to Accident and Emergency within days of her closing her involvement, or when Patient Q was discharged from hospital in September 1999, when contact was again made with social services, at which a re-appraisal of Patient Q's need for social services support should have been made.

4.118 It was at the point of Patient Q's readmission to Accident and Emergency that Ms ER referred the case on to the Children and Families Team. **The panel recognises** the commitment shown by Ms ER in continuing to be involved in the case until the Children and Families Team could allocate the referral. For this reason, she attended a meeting on 11 August, after which her notes make clear that "Whilst there may be a need for social work input, I do not feel this needs to take place in the child protection arena". Ms ER continued to be heavily involved during August 1999, seeing Patient Q at home and in the County Hospital, as the need to make foster arrangements for her daughter were being implemented. Some picture of the chaotic nature of Patient Q's lifestyle emerges from her notes in the daughter's file, and was information available to those picking up the referral of the daughter. **The panel found** the notes made by Ms ER to be helpful and informative.

4.119 The referral to the Children and Families Team was eventually taken over by Ms RA. **In the view of the panel,** the referral appears to have been seen as exclusively relating to Patient Q's daughter. There is no evidence in the file of any consideration having been given to separate support for Patient Q, despite some of the file entries referring

to various events and incidents which appear to be evidence of Patient Q's vulnerability. The lack of a more holistic view in this case is an example of what **the panel has perceived** to be "silo working" in departments within social services.

4.120 It is also **a cause for concern to the panel** that once Patient Q's daughter was a client of social services, all the information coming to social services about Patient Q was then filed in her daughter's file, where the significance of some of it may not have been fully assessed or appreciated. One example of this is in relation to a telephone referral made by a Sister in Accident and Emergency on 4 August 1999. This generated no apparent action in relation to Patient Q herself. Indeed, the entry in the note ends rather lamely, saying that "the hospital believe social worker may be involved but I can't find one listed. Don't have address for sister." **It is unclear to the panel** why a telephone call of this sort did not generate the need to complete the usual referral process using form SS598.

Effectiveness of the referral procedures

4.121 The referral process in use in social services operated through an Assessment and Information team (the A and I team) based at Dryburn Hospital. Where a referral was made by telephone, as it was in the case of Patient Q on 11 August 1999, details would be entered on to the departmental computer system (SSID), and where it was a new referral, it would go to the duty worker on the A and I team on Form SS598. From the department's guidelines in force at that time, (CM/010) it is made clear that all elements of Referral must be completed. **The panel has noted** that this was not done in the case of Patient Q in August.

4.122 Where sections of the form had been completed, the level of detail does not appear to conform to the guidelines. For example, at section 4, relating to the presenting problem, the guidelines note that "This section will contain vital information. The information should be actively gathered by asking questions, seeking clarification and not passively waiting for the information to be given. A good quality referral contains all relevant details in order to determine complexity of needs and who should deal with the referral and when. It should include information about the health of the client as this is an integral part of the assessment process and helps to prioritise work. The referral taker needs to be aware of and make use of screening tools, eligibility criteria and risk policy."

4.123 **The panel considers** that the information contained in the "presenting problem" part of the form was totally inadequate to permit any proper judgement to be made about Patient Q's situation. It refers to her having "alcohol problems" but gives no idea of the scale of this problem, nor the length of time over which it had endured. The entry states that Patient Q has a daughter who has a social worker. This

does not make clear the age of the child, nor why the social worker is involved with her. The section refers to her having taken at least one overdose, but gives no further details. Further on in the form, the Family/Carer details section is blank. **The panel is concerned** that there did not appear to be any management supervision and control system in place to monitor the quality of information being used to support referrals.

4.124 **In the view of the panel,** the failure to clarify some of the information, and to seek further details, with at least a phone call to CPN EB, or to the social worker involved with Patient Q's daughter, Ms ER, left the A and I Team in a position where they could not exercise a proper judgement about the type of social work support which Patient Q may need. At that point, CPN EB had just been on a home visit to Patient Q, along with Dr P and Ms ER. He would therefore be aware of the information which was contained in a follow up letter which Dr P wrote to the GP on 12 August. This letter was copied to Ms ER, and contained helpful background to Patient Q's case, as well as giving an indication of the magnitude of her problems.

4.125 **It is unclear to the panel** what arrangements prevailed within social services to permit information to flow between various teams, and whether information sent to Ms ER would be shared with others in the department. The letter of 12 August is clearly on the daughter's file in social services, and clearly states Dr P's view that he considers it important that either or both Patient Q and her daughter are given social work support. **It is also unclear to the panel** what was the outcome of this first referral to social services.

4.126 As a consequence of this August referral, Patient Q was then on the SSID system in social services. When a second referral occurred in September 1999, the message from the primary nurse at the hospital was received by Ms TS, who was aware of the concern being expressed by the nurse because of the earlier suicide of Patient Q's husband. Ms TS discussed this case with the Team Manager, Ms SL, asking her to secure priority for the referral with the Team Manager of the Substance Misuse Team, Ms LN, "given Patient Q's special circumstances (her husband recently took his own life.)". The panel has not seen any notes made by Ms SL, and have only been able to refer to a brief handwritten note made by Ms LN, together with learning of Ms LN's recall of her conversation with Ms SL. It appears that the form SS598 originally completed on 11 August was the basis on which the referral was subsequently passed to the Substance Misuse Team by the A and I Team.

4.127 The substance misuse team was relatively newly formed at that time, and had immediately been overtaken by a large number of referrals. When Ms SL sought to refer the case to Ms LN's team, drawing attention to Patient Q's mental health problems and her suicidal tendencies, Ms LN had protested, as she believed from what she was being told that Patient Q's case appeared to be a mental health

priority rather than an alcohol priority. In view of the approach being taken in social services at that time, whereby anyone with a dual diagnosis should be allocated to the Mental Health Team, **the panel is concerned** that this did not happen in Patient Q's case, especially in view of the apparent emphasis being given to mental health issues.

4.128 When the Substance Misuse Team received this referral, seeking a social work assessment for Patient Q, the very limited information contained in the referral led to the case being given a low priority, as there were other health professionals involved, and a Child Care social worker. If fuller information had been available to Ms LN on the referral form, **the panel considers** that she may have taken a different view of priority, set against the eligibility criteria that she was using at that time. Out of six criteria, Patient Q may well have satisfied a number of them. They were: Established addiction; people with chaotic or unstable, risky lifestyle with low levels of community support; chronic users with high support needs; and people whose use of substances impacts on the welfare of other vulnerable groups eg children.

4.129 **The panel considers** that Ms LN was seriously hampered in making an appropriate assessment by the lack of information on the referral form, and further hampered by the significant pressure of work being experienced by her team, which was newly established, and which had quickly become inundated with referrals. Ms LN had been active in seeking to bring these problems to the attention of her superiors.

4.130 In forming its view on these matters, **the panel has taken into account** that Substance Misuse Teams were in their infancy at the time of this incident, and recognises that the social services department were probably ahead of developments in this field occurring elsewhere, and their progressive approach was to be applauded.

4.131 After a lengthy discussion with Ms SL, Ms LN agreed to take the referral, and agreed to try to allocate the case as soon as possible. **The panel accepts** that there was limited information available to Ms LN on the form SS598, which did not appear to have been significantly amplified by her conversation with Ms SL. Nothing appears to have been done at that point to change the priority being accorded to Patient Q by the Substance Misuse Team, nor to make contact with others working with Patient Q and her daughter, to gain a more holistic understanding of their plight. **In the view of the panel,** this more holistic understanding could have been done by the principal handling the allocations, before making the call to the Substance Misuse Team.

4.132 **The panel consider** that the Team Manager of the Substance Misuse Team was entitled to rely on professional judgements made by the A and I Team, which in this case was based on inadequate information. This is all the more disappointing when other useful information was readily available. **The panel also wishes to note** that its own ability to understand the processes and steps being taken in relation to Patient Q was seriously hindered by a lack of any detailed records.

4.133 Once responsibility for the case had been passed to the Substance Misuse Team in Social Services, they were not part of the care programme approach, nor were their information systems linked to PIN health information. There was therefore no way in which the Substance Misuse Team could readily access mental health information. The Team is not part of mental health services, and is separately managed. The Team is still outwith the system of care co-ordination. **The panel is concerned** that there is still the potential for difficulties to occur in the Substance Misuse Team having ready access to important information.

Communication between specialist social services teams

4.134 As the panel understands the organisation of social services at that time, there were a number of specialist teams. **The panel accepts** that good work has been undertaken with Patient Q's daughter by the child protection team, and that the daughter has continued to benefit from on-going work of the children and families team. These elements of service provision are outside the scope of the terms of reference of this inquiry. However, the panel has been concerned to consider whether at any time, staff from those teams, who would have had contact with Patient Q, should have involved colleagues from the mental health team or adult services, and whether the prevailing culture in the social services department at that time was one of "silo working", as it was described to the panel.

4.135 The panel has considered first the input from the child protection team, in particular the input from Ms ER, who first became involved with the family in March 1999 after a referral had come from the police. She had contact at that stage with both Patient Q and her husband. Ms ER remained involved until the case was closed after the death of Patient Q's husband. She subsequently became involved again, covering until the case could be picked up by the Children and Families Team, when Patient Q was admitted to hospital, and an urgent foster place was required for her daughter. During Patient Q's stay in hospital, Ms ER needed to see her while she was there in connection with arrangements for the daughter. She later assisted in setting up an introductory visit for the daughter to her new foster carers, until the new social worker, Ms RA, could take over the daughter's care.

4.136 Over the period that Ms ER was involved with the family, it was her view that Patient Q enjoyed a good relationship with her GP, she was supported by her family, she had CPN support, she was in contact with the in-patient service at the County Hospital, and she was financially secure. In her view, there was no reason at that stage to suppose that a social worker from an adult team could have achieved anything for Patient Q. Her problem at that time was a crisis in relation to her abuse of alcohol, and she was receiving help with that situation.

4.137 **The panel considers** that at the early stages of Patient Q's care, when Ms ER was actively involved with her daughter, her assessment of Patient Q's needs was appropriate, and she cannot be criticised for not seeking wider social services support for Patient Q. Her support for Patient Q's daughter was carried out in a most professional way, especially in continuing to support and provide continuity of care whilst other social services support was put in place for the daughter. In her referral to the Children and Families team, it may have been Ms ER' expectation that it would be possible for a more holistic view to be taken of the needs of both Patient Q and her daughter. In the event, **the panel considers** that this more holistic approach did not materialise.

4.138 The social worker who took over from Ms ER was Ms RA, from the Children and Families Team. Her involvement began in early September 1999. It was after this date that **the panel had some concerns** that a wider view of the needs of the family as a whole was not triggered. There are two occasions in particular which might have acted as a prompt to involve other social services professionals. The first of these was a home visit which Ms RA made to see Patient Q on 17 September.

4.139 This visit was prompted by the daughter being extremely upset at finding Patient G at her home, and discovering him wearing clothes belonging to her deceased father. She had asked Ms RA to discuss this with her mother. When Ms RA turned up at the house, Patient G was there. She had to ask him to wait in the kitchen until she spoke to Patient Q. She made clear to Patient Q how upset her daughter was, indicated that social services knew nothing about Patient G, and attempted to establish what Patient Q's relationship with him was. She further made clear that the daughter would not return home if Patient G was living there.

4.140 Nothing further seems to have happened as a result of this visit. **The panel is disappointed** that the obvious distress of the daughter and the fact that social services knew nothing about this man did not trigger a discussion about whether to hold a review in this case, especially as one of the objectives for social services at that time was to rehabilitate the daughter at home with her mother. **The panel accepts** that RA would have a limited opportunity to form a view about Patient G, but nevertheless considers that her focus was rather narrowly directed towards the daughter, and did not fully take into account the wider perspective of the dynamics developing in the home at that point, which could also have had important repercussions for the safety of the daughter.

4.141 Nor did this visit appear to influence the Looked After Review which was held on 20 September, just three days after Ms RA's visit to Patient Q's home. The notes in the daughter's file of the Looked After Review meeting do not contain an attendance list, but the text indicates that

Patient Q was present at the meeting, along with her daughter, the foster mother, Mr IY, the Drug and Alcohol CPN, the daughter's school nurse and her year tutor, as well as Ms RA. There is nothing in the record of discussion at this meeting to indicate that there were any concerns about the daughter's distress, clearly recorded in Ms RA's notes of 17 September, nor to indicate any knowledge of or response to her anxiety about visiting or staying at home if Patient G was there. The only reference to visits home states that her daughter "visited for tea one night and has had one overnight stay. Daughter felt that visits went well. Patient Q respects her daughter's wishes to take things slowly."

4.142 **The panel is concerned** that there appears to have been no discussion of the issue of Patient Q's relationship with Patient G, nor the daughter's concerns on this matter. If such a discussion was considered to be inappropriate in front of the list of persons present at the Looked After Review, then **in the view of the panel** a separate discussion involving key professionals involved with the family should have been convened. **The panel considers** that this date represented a key opportunity for social services to have become more actively involved with Patient Q, or to have sought to share their concerns with others involved in her care, and believes that this was an opportunity lost.

4.143 The second occasion which could have triggered some debate about whether to hold a case conference was 1 October. On this occasion, a welfare assistant from the child protection team met the daughter and learnt some disturbing information. The daughter was indicating that her mother had telephoned her earlier in the week, saying that she had been raped by a friend of Patient G's and that the police had been involved. The daughter was expressing fears that her mother was "involved" with Patient G, and indicating that she did not want to see her mother if Patient G was there. The daughter was due to make an overnight stay with her mother, and it was made clear to her by the welfare assistant that she should not stay over if Patient G was at the house. **The panel accepts** that this was sensible advice, but can find no evidence in the file that suggests that the welfare assistant discussed this matter with a supervisor or qualified social worker. **In the view of the** panel, such a discussion would have been a sensible step.

4.144 **In the view of the panel**, this was a further significant development in terms of the stability of home arrangements and possible deterioration of Patient Q which could have prompted wider consideration at a review. If such a review had been convened, it would have been possible to involve the CPN, the GP, the consultant, the Drug and Alcohol CPN, possibly the Cruse counsellor, the team leader of the Substance Misuse Team at social services, as well as those from the Children and Families Team. Even if all of these people were not invited to a review, it would have been possible to seek information from them.

4.145 **The panel considers** that the services being offered by the Children and Families Team for the daughter were supportive to her, but did not take account of the wider family perspective. **The panel therefore considers** that there was limited communication between departments in social services.

4.146 **The panel has been considerably hampered** in its efforts to form proper judgements about the appropriateness of services in this case because of the lack of information about the referrals relating to Patient Q. Even with the benefit of consent to the release of the daughter's file, the task of the panel has been considerably increased by the poor quality of some of the record keeping. This is greatly to be regretted, as a key feature of such inquiries should be to evaluate practice, where in this case the panel often felt hampered.

Chapter Five

Issues and concerns relating to Patient G

Introduction

5.1 The panel have approached the care of Patient G by examining each aspect of the service separately. Issues with regard to the organisation of services and effective collaboration between services are considered in Chapter Six.

Care from the General Practitioner

5.2 Patient G was a recent patient of Dr N, having registered with him on 22 April 1999. His notes were not available to Dr N immediately. Over the period that he cared for Patient G, there were numerous occasions when he failed to attend appointments at the surgery. Despite his rather chaotic use of the GP service, **the panel considers** that the GP had made a full early assessment of his problems with regard to diazepam use and alcohol abuse, that he was alert to the possible need for psychiatric help in relation to flashbacks caused by an earlier traumatic event, that he made an appropriate and timely referral to the County Hospital Day Unit, and he made efforts to control and reduce reliance on diazepam.

5.3 The GP's only awareness of what services were being offered to Patient G came from a letter from Dr T, locum consultant at the County Hospital Day Unit, who wrote to him on 3 August 1999, indicating that daily contact with the Day Hospital, to assist in weaning him off alcohol, was being offered. Once such a routine was established, the plan was to commence a slow withdrawal programme from diazepam.

5.4 The next communication with the GP was a discharge notification from the Rushford Ward at the County Hospital, dated 8 September 1999. In discussion with Dr N, it was clear that he had been unaware of this admission. He did not have contact with Patient G after his discharge. **The panel considers** that Dr N acted entirely appropriately in relation to this patient, and offered a good standard of care to him.

Contact with Day Hospital

5.5 Following referral by his GP to see the consultant at the County Day Hospital, Patient G attended on a number of occasions in August. His primary nurse was CPN AR, who made a full nursing assessment on 13 August. Notes and records of his Day Hospital contacts are good. He was meant to attend on a daily basis to be breathalysed, but because of non-compliance, and because of his use of diazepam, it was decided he needed an in-patient detoxification, for which he was admitted on 27 August to Rushford Ward.

5.6 During the period when he was using the Day Hospital services, there are good notes of his attendance. **The panel accepts** that Patient G's attendance was sporadic, that he sometimes indicated that he had drunk on the previous evening. **The panel agrees** with a view put forward by his primary nurse that Patient G may not personally have been highly committed to detoxification, but had undertaken the programme to satisfy the requirements of his hostel accommodation about controlling his drinking.

5.7 From the available evidence, **the panel has formed the view** that there were good internal relationships between the in-patient wards and the Day Hospital, and that nurses in the Day Hospital had excellent working relationships with Dr T. However, the panel also has an impression that the Day Hospital was quite insular in its approach at that time, having few regular contacts with outside agencies or organisations, for example DASH, the hostel where Patient G stayed. It is recognised that contact with others would be made where necessary, but regular communication in the round does not seem to have part of the culture of the Day Hospital at that time.

5.8 After an in-patient stay, Patient G was discharged from Rushford Ward on 8 September, with the intention that there should be Day Unit follow up. This had been discussed with him at discharge, and he was agreeable to attend there. An appointment was made for 14 September, which Patient G failed to attend. Messages were left for him at DASH, but he did not make contact with the unit. CPN AR met him by chance in Durham, and urged him to come back to the unit. Patient G then rang the unit and an appointment was made for him to attend on 27 September. He did attend on that date, but he did not wait to be seen. The nurse rang DASH on 30 September, attempting to contact Patient G, but learnt that he had been evicted from the hostel that day. A message was left, should he return to DASH, asking him to contact the Day Hospital.

5.9 **The panel accepts** that staff at the Day Hospital did take steps to encourage Patient G's attendance, and did make efforts to contact him when he failed to attend. In the circumstances of his chaotic existence, **the panel accepts** that staff acted reasonably in respect of his non-attendance.

Care as an in-patient at the County Hospital

5.10 Patient G was a patient on Rushford Ward between 27 August and 8 September. The impression formed from the evidence received by the panel is that he was an amiable and compliant patient. The aim was to complete a detoxification, and also to wean him off diazepam.

5.11 The nursing notes for Patient G's stay are quite sparse. They do note that he spends a lot of time off the ward, socialising with patients from Harding Ward. Particular mention is made of female patients. This entry first appears on 2 September, when the panel has determined from a range of evidence that it is likely that he got to know Patient Q at this time. There is no evidence in the notes that any advice was offered to Patient G about relationships with other patients, especially those who were also attempting to cope with their own alcohol problems.

5.12 Nor is there any detailed review in the notes of the success or otherwise of the weekend leave which Patient G had been out for over the weekend of 4 to 6 September. DASH had made contact with the ward on 6 September, because of the state that Patient G had left his accommodation in, and asked to be informed about the result of his breathalyser test, which turned out to be negative.

5.13 **The panel considers** that the issue about relationships, and the issue about drinking while on leave were both sufficiently significant to have deserved mention in the notes. **The panel regrets** the lack of information on these aspects of Patient G's stay.

5.14 **The panel accepts** that there is a form in the nursing notes about risk, but is concerned that the detail elicited from Patient G appears only to be documented in the medical history. There, it indicates that he has been in prison three times in respect of shoplifting offences, and although he had been charged with grievous bodily harm, he had escaped with probation. **The panel considers** that the form in use at that time in the County Hospital for assessment of risk was inadequate to permit a sufficiently detailed and rigorous evaluation. Its tick box format was not conducive to staff following up issues in further detail.

5.15 Even if Patient G was not imprisoned in respect of a charge of grievous bodily harm, it would seem to the panel to be appropriate to follow up who had been the victim of his attack, and in what circumstances. The panel is mindful of the general duty of care owed to other patients, where a patient is admitted who has a propensity to violence. **The panel considers** that as some of Patient G's previous history was apparent to staff on the ward, some greater effort to learn about his past history and behaviour should have been made.

5.16 The medical notes for Patient G's stay show that he was seen on the ward on three occasions. On admission, a good history was taken, but it does not identify the doctor who took it. On a second occasion

when Patient G was seen, it appears to have been a consultation more concerned with his gout. On the third occasion, it was the day of his discharge. Other than the history, **the panel considers** that the medical notes are somewhat thin.

5.17 This problem is exacerbated **in the view of the panel** by the very limited discharge information which it has been able to find. There is no discharge letter to the GP. All that exists is a discharge notification sheet to the GP, incomplete with regard to date of admission and discharge. **The panel has set out its concerns** about discharge procedures at the County Hospital in relation to Patient Q, and they are equally valid in relation to Patient G.

Chapter Six

Organisation of Services

Organisation of Health services

6.1 At the time of the incident at the heart of this inquiry, the relevant health service organisation delivering much of the care to Patient Q and Patient G was the County Durham and Darlington Priority Services NHS Trust. It was a Trust which had been formed in April 1998 by a merger of two former trusts in County Durham, which in turn had themselves been involved in previous mergers. The Chief Executive took up post in the Trust in June 1998. It was immediately apparent to him that the cultures and working practices of the two former trusts had been radically different. One of his first tasks was to create a trust wide culture, and to effect some standardisation and common approach to clinical policies and procedures, and to clinical practice.

6.2 Many key managers were not in post in the new organisation for almost a year following the merger. This was in part due to the fact that a county wide approach to appointments had been agreed, and in consequence, appointments within the trust were linked to what was happening in the local acute and community trusts, all of which were affected by the mergers and organisational changes which were occurring. Progress occurred only at the pace of the slowest organisation, and in consequence, this had a destabilising effect on services.

6.3 In addition, the trust was carrying a considerable number of consultant vacancies. Even had those vacancies been filled, the trust had still been operating below the norms established by the Royal College of Psychiatrists. This resulted in the trust relying excessively on locums, and on established consultants carrying loads in excess of College norms. The panel heard evidence that the situation with regard to consultant appointments has now improved considerably, and the Trust felt that it had recruited a critical mass of good staff, who would act as a catalyst to attract other good people to come.

6.4 The panel sought to understand how the County Hospital would be functioning at the time in question. It was a busy in-patient facility, with large wards, in outdated and unsuitable premises. Figures supplied by the Trust to the panel show that at the time of the incident, occupancy in the two wards at the County during August and September 1999

were at levels of 81.4% for Rushford Ward and 66.1% for Harding. The panel accepts that within these averages, there will have been peaks and troughs affecting bed availability on a day to day basis.

6.5 Mental Health Act Commission Reports from 1999 show that visits were regularly made by them to the County Hospital. Of the two wards which are involved in this incident, more attention is paid in those Reports to Rushford Ward. In June 1999, it attracted the comment that almost half the patients on Rushford on the day of the visit were being treated for drug and alcohol problems. The Commissioners wondered about the potential benefit of a unit specialising in the addictive disorders. They also noted a lack of occupational activity. The Occupational Therapist had left some months earlier and had not been replaced. In respect of Harding Ward, the comments related to rooms which remained multi-occupancy.

6.6 The Trust's response to the Commission's report, written in August 1999, reflects that "the issue of patients with drug and alcohol problems being treated on acute admission wards is a growing problem and has already been identified as an area of concern by the Trust".

6.7 From information available to the panel, it is evident that there had been considerable under resourcing of mental health services in the area. Resources had not flowed to community activity, and in consequence, the ratio of CPNs was poor, a fact which is borne out by work undertaken by the Sainsbury Centre for Mental Health and detailed in a report published by them in February 1999.

6.8 The work undertaken by the Sainsbury Centre contains a helpful and informative picture of mental health services generally within the area of the Trust at a key point in relation to the incident under review. An extract from this report, the Executive Summary, providing further context for the work undertaken by the panel, is appended at Appendix D. In particular, it draws attention to the need for additional development work in relation to the care for people with drug and alcohol problems, where clearer, more strategic management is said to be needed for this group of patients. The more detailed commentary in the Report relating to Drug and Alcohol Services as they existed in the Trust in February 1999 is also reproduced in Appendix D.

Organisation of Social Services

6.9 During the period under review, it was a time of intense activity in relation to mental health, so far as Social Services were concerned. Work was underway between the Health Authority, the Trust and Social Services to put in place a new strategy for mental health services across the whole county. At the same time, a fresh look was

being taken at substance misuse services, and the need to create a dedicated team for that work. It was recognised that the creation of such a service would need to be carefully managed, in terms of prioritising work, given the likely high levels of demand.

6.10 Work was also underway to effectively integrate the Care Programme Approach and Care Management, moving towards the establishment of integrated teams. So far as a common understanding of risk issues was concerned, Social Services had a mental health principal officer in their standards and development section who acted as the interface on policy and practice matters with the other agencies. A similar approach would be taken to the development of eligibility criteria and priority categories, although in all of these aspects, work progressed at a much faster pace later when the teams became fully integrated.

6.11 At the time of the incident in 1999, therefore, work was directed towards these external agendas. The social services department itself was relatively stable, both in terms of organisational structure and stable workforce and management. It was also ahead of health services in terms of its computerisation of information.

6.12 The Sainsbury Report referred to earlier also contains useful background information with regard to organisational structures and interfaces at this time. This aspect of their report gives a useful snapshot of services at that time, and is included as Appendix D.

6.13 Although the panel has formed a general view that social services appeared to be ahead of the health services in having good procedures and guidelines in place, it was disappointing to find examples where they did not adhere to them. Moreover, the panel was uncertain what systems existed to monitor and supervise compliance with procedures.

Joint working between Health Services and Social Services

6.14 It was clear to the panel during the course of its inquiries that considerable progress has been made in the last two years towards more integrated working between the health services and social services. There are now joint integrated community mental health teams for adults, and in the case of many of the teams, they are now co-located. Managers of the teams are drawn from both health and social services backgrounds. Information sharing is still somewhat impeded by some incompatibility in IT systems, with the social services SSID system being better established than the PIMS system in health services.

6.15 However, the panel is aware that at the time of the incident under review, the teams were not integrated, and in the view of the panel, health and social services tended to be working in “silos”, with very little vision of the benefits which could be secured by joint working. This

silo working was exacerbated by the fact that each element of the health services and each element of social services also worked in isolation from each other. So, in each service, and at every level in each service, this silo approach militated against a supportive and holistic solution for Patient Q.

6.16 This approach is possibly most acute in relation to drug and alcohol services, and the panel is not convinced that the situation is currently any more integrated than it was in 1999. Some of these issues with regard to integration appear to the panel to relate to lack of clarity with regard to the role of the Drugs Action Team, and where services should fit around their work. It was clear that available resources had previously been targeted at education work, whereas there was a feeling that they should have been more targeted towards treatment services. Moreover, there was a feeling that as between drug and alcohol abuse, too little resource was directed towards alcohol. The services also needed to relate well to the non-statutory sector, particularly North East Council for Addictions, who provide much support for individuals.

6.17 Another aspect of lack of joint working which was of concern to the panel was the failure to hold any kind of joint review between health services and social services in respect of this incident. The Trust held a reasonably thorough review, focussed particularly on the services offered to Patient Q and Patient G by the Trust. There was no social services involvement in the review, and the terms of reference set for it did not embrace issues around joint working, or the lack of it. There was also no invitation to appropriate voluntary agencies, in this case DASH.

6.18 Social Services did not hold such a formal internal review, although they did look at what lessons could be learned for social services. There is no written report of their reflection on this case. Their principal reason for not holding a more formal review appears to have been their view that they were not centrally involved in this case. It was accepted that they were involved from a child care perspective, and also recognised that there had been referrals of Patient Q to the mental health team and the substance misuse team.

6.19 The panel considers that this lack of a formal internal review by Social Services illustrates the panel's concern about silo working. The panel is also concerned that the Trust and Social Services department did not recognise the benefits which could have accrued from holding a wider ranging joint review. There were key issues about eligibility criteria, risk assessment, sharing of information, communication, referral routes, interface of mental health and drug and alcohol services across health and social services, all of which could have been reviewed in such an internal inquiry.

6.20 One disappointing feature of some staff being inclined to be narrowly focussed on their own particular element of involvement with the patient was that these staff did not benefit from the awareness and information which other workers involved with Patient Q could have shared and passed on. Some of the examples where this occurred could be explained because there was a handover of the case. There were some examples where handovers were done effectively, but in other cases, information of relevance did exist in files, but seems to have been minimised or ignored.

6.21 Another difficulty in relation to Patient Q was the number of people involved in her care over a very short period of time. This was not likely to be helpful to her family, who could often feel very unsure about where to turn for help.

6.22 The panel sought to establish whether the impact of earlier inquiries had been felt by the organisations concerned, and whether learning from those earlier inquiries had now informed their practice. In health, it was encouraging to hear how earlier inquiries had focussed attention on better risk assessment, improved systems in relation to incident reporting, and improvements in relation to joint working with social services. In social services, issues relating to case recording, single point of access to the service, and joint working in relation to drug and alcohol abuse had all received renewed attention following those inquiries. The panel recognised that it was unlikely that work promoted as a result of earlier inquiries would have had time to make any significant impact by the time the incident involved in this inquiry occurred.

Chapter Seven

Key Findings and Conclusions of the Panel

Throughout this report, the panel has sought to comment on matters as they have been raised in the narrative. These comments are highlighted in bold in the text of earlier chapters. We now list our key findings:

General Practitioner involvement

7.1 The care afforded to Patient Q and Patient G by their respective general practitioners was appropriate, timely and satisfactory.

7.2 Communications with Patient Q's general practitioners were inadequate after August 1999.

Care and Treatment

7.3 During the period under review, Patient Q was not suffering from clinical depression.

7.4 There was a lack of continuity of care from consultants and CPNs in relation to Patient Q.

7.5 The role of Patient Q's daughters as carers was not recognised by staff at the County Hospital.

7.6 Patient Q's daughters were not appropriately involved in decisions with regard to the care of their mother.

7.7 During the period under review, it was not at any time appropriate to use the powers under the Mental Health Act 1983 in relation to Patient Q.

7.8 Patient Q's medication was appropriate, and appropriately reviewed.

7.9 Clinical staff had limited understanding of Patient Q's compliance with the regimes for her medication.

7.10 The CPNs involved in Patient Q's care made efforts to support her which were well beyond what should have been required under Level 1 CPA.

7.11 The Drug and Alcohol CPN made efforts to support Patient Q well beyond what could have been expected from such a specialist worker.

7.12 The staff of the DASH hostel made efforts to protect and support Patient Q beyond what could have been expected from them, given that she had never been a client of their hostel.

7.13 Patient G did not suffer from any mental illness.

Risk Assessment and management

7.14 The risk assessment undertaken at the County Hospital in relation to Patient G was inadequate.
7.15 The risk assessment methods used in the County Hospital at that time were inadequate.
7.16 The arrangements to review the progress of patients having leave from the County Hospital were inadequate, having regard to the duty of care owed to patients.

Systems and processes

7.17 The appropriate grading within the CPA processes was not used in Patient Q's case.
7.18 Discharge arrangements prevailing at the County Hospital at the time of the incident were inadequate.
7.19 Arrangements for professional supervision of staff in the trust were inadequate at that time.
7.20 Social Services referral procedures did not work effectively in Patient Q's case.
7.21 There was inadequate use of multi disciplinary team meetings.
7.22 There was inadequate use made of review mechanisms.
7.23 Some aspects of the note taking, in both health and social services, were inadequate.

Communication and Inter agency working

7.24 Liaison and communication with the family of Patient Q was inadequate.
7.25 There is inadequate liaison between the in-patient ward and DASH.
7.26 The interface of the drug and alcohol service with other aspects of the work of the community mental health teams is unsatisfactory.
7.27 There was inadequate communication and liaison between social services teams, in particular the mental health team and the drug and alcohol team.
7.28 Significant information relating to Patient Q was not effectively passed on to appropriate personnel.
7.29 No joint review was held by health services and social services after this incident occurred.

Cultural and organisational issues

7.30 The culture of the in-patient wards at the County Hospital and across mental health services at the time of the incident was reactive.
7.31 Organisational upheaval in the health service at that time had had a deleterious effect on the morale of staff and had affected service development.

7.32 There was inadequate clinical leadership from the consultants involved in this case.

7.33 Social Services staff were preoccupied with the child protection issues in this case, and in consequence were insufficiently focussed on Patient Q's needs.

Conclusions

Based on the findings listed above, the panel has concluded that at the time when Patient Q and Patient G were receiving care and treatment, there were shortcomings in both Health Services and Social Services in how they functioned and inter-related. There were clear examples of failings, principally in systems and in some cases, in the personal practice of staff. In the latter event, lack of professional supervision compounded some examples of poor practice.

In consequence of these failings, there were times at which Patient Q received less than optimal care. However, the panel has concluded that the services offered to Patient G resulted in an adequate standard of care in his case.

At a number of points, identified in the text of our report, there are opportunities lost to share information, to respond appropriately to such information as was shared, to call together key personnel, and to reassess risk, which, if handled differently, may have resulted in the subsequent management of the case being different.

The panel has concluded that these problems were exacerbated by the lack of information which Patient Q's daughters had available to them about sources of help and support, and by the failure of many staff to listen to the daughters. The panel has further concluded that the problems were exacerbated by the lack of truly integrated working between health and social services, and by some relationship problems existing within teams.

In forming its conclusions, the panel has been mindful that Patient Q was an intelligent woman, and is mindful that she had opportunities when staff sought to help her to remove Patient G from her home, which she ignored. It is further mindful that she voluntarily returned to an unsafe environment at the DASH hostel, and that she chose to allow Patient G to stay at her home, at the cost of her daughter having to leave. The panel has balanced against these factors the fact that Patient Q had not had a proper opportunity to discover from staff what kind of risk Patient G might have posed to her, because of the inadequacy of the risk assessments which had been undertaken. However, her own knowledge of his behaviour over the short

period of her acquaintance with him should have alerted her to the nature of some of the risks.

The panel has concluded that a number of alternative steps could have been considered if everyone had been in fuller possession of all the facts, and had been working together more effectively as a group of partner agencies. These would have included the possibility of a domiciliary visit by the consultant, an offer of further voluntary admission to hospital, a formal assessment of the possibility of using the Mental Health Act provisions at that time, passing on information about women's refuge services, and the holding of a full case review meeting with all relevant health and social services staff in attendance, together with key family members.

The panel acknowledges that during the period under review, the Trust was attempting to provide a wide range of services to patients with alcohol related problems, who might not receive such high priority in other mental health services that focus more on the needs of patients with severe mental illness. It is likely that attempts to help Patient Q and Patient G may not have been as assertive had they resided elsewhere. To this extent, the efforts of the Trust and the staff involved should be commended.

In view of the factors outlined above, the panel cannot say that the incident would have been prevented if the shortcomings identified had not occurred.

Chapter Eight

Recommendations

8.1 Social services should review its processes for accepting referrals.

8.2 Social services should review its inter team working.

8.3 Social services should make more use of case review meetings.

8.4 The trust and social services should review the inter relationship of substance misuse services across their organisations.

8.5 The substance misuse team should be more integrated into the care management processes.

8.6 Social services should review its approach to looked after children where their parents have mental health or substance abuse problems.

8.7 Staff in both health and social services should be reminded of the need to take a holistic approach to care, and to work together effectively with partner agencies, including voluntary agencies.

8.8 Management of the trust should ensure that the County Hospital has proper policies and guidance in place on key aspects, including breach of the patient contract, confiscation of alcohol, relationships between patients, contact with families and carers, leave arrangements, risk assessment, professional supervision, and discharge arrangements.

8.9 Management of the trust should ensure that audit and monitoring arrangements are in place to ensure that the policies and guidance are being implemented.

8.10 There should be steps taken to bring about better integration of the Drug and Alcohol team into the care planning processes.

APPENDIX A

COUNTY DURHAM AND DARLINGTON HEALTH AUTHORITY

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF

PATIENT Q AND PATIENT G:

TERMS OF REFERENCE

1 To examine all the circumstances surrounding the treatment and care of Patient Q and Patient G by the health services with regard to their mental health, in particular:

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

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

(a) their assessed health and social care needs;
(b) their assessed risk of potential harm to themselves or others;
(c) their psychiatric history, including any history of drug or alchol abuse;
(d) the number and nature of any previous court convictions

(iii) the professional and in-service training of those involved in the care of Patient Q and Patient G or in the provision of services to them

(iv) the extent to which the care given to Patient Q and Patient G corresponded to statutory obligations, relevant guidance from the Department of Health including the Care Programme Approach HC(90)23/LASSL(90)11 and discharge guidance HSG(94)27, and local operational policies

(v) the extent to which their prescribed care plans were:

(a) effectively delivered, and
(b) complied with by Patient Q and Patient G

(vi) the history of Patient Q's and Patient G's medication and compliance with their regimes

2 To examine the adequacy of the collaboration and communication between:

(i) the agencies (County Durham and Darlington Priority Services NHS Trust and its predecessors and Durham County Council Social Services) involved in the care of Patient Q and Patient G or in the provision of services to them, and

(ii) the statutory agencies and Patient Q's and Patient G's families.

3 To prepare a report and make recommendations to County Durham and Tees Valley Strategic Health Authority as the successor body to County Durham and Darlington Health Authority.

APPENDIX B

BIBLIOGRAPHY

1. Medical notes relating to Patient Q
2. Medical notes relating to Patient G
3. HSG (94)27
4. Transcript of trial of Patient G
5. Internal report on Serious Untoward Incident May 2001
6. Social Services records relating to Patient Q
7. Organisation charts for the Trust, and the Substance Misuse Services
8. CPA Policy 1999
9. Current Care Co-ordination Policy
10. Discharge Policy for 1999
11. Service specification for Community Mental Health Teams
12. Dual Diagnosis Good Practice Guide, Dept of Health
13. Mental Health Act Commission Reports for January and June 1999
14. County Day Unit Operational Policy
15. Philosophy of the Day Unit
16. Bed occupancy rates for the County Hospital August, September 1999
17. Care Plan information for Patient Q and Patient G
18. Police statements
19. Durham Action on Single Housing (DASH) policies and procedures
20. HC (90) 23 " Caring for People"
21. Social Services organisational structure chart
22. Social Services referral guidelines
23. Social Services Inspectorate report published 1999
24. Organisation chart for Substance Misuse Team 1999
25. Substance Misuse Strategy Adult Services April 1998
26. Risk Policy – Adults living in the community
27. Care Co-ordination in County Durham and Darlington
28. Action plans from earlier reviews

APPENDIX C

STANDARD LETTER
REQUESTING ATTENDANCE AT HEARING

Ref:

(Date)

(Address)

CONFIDENTIAL

Dear **(Name)**

Independent Inquiry into the Care and Treatment of Patient Q and Patient G

As you are aware from previous correspondence, the Authority has set up an Independent Inquiry to consider the circumstances leading to the death of Patient Q on 5 October 1999. I have been appointed as manager to the Inquiry. The Chairman and members of the panel are grateful to you for the information you have already supplied.

A further copy of the remit of the Inquiry is attached.

The Inquiry Panel will be glad of the opportunity of meeting you and discussing further with you the issues which you have covered or will be covering in your written statement.

The Inquiry is to be held between (**Dates**) and I am now scheduling the attendance of those whom the panel wishes to meet.

I am hoping that it will be possible for you to attend the meeting of the panel, here at Appleton House on (**Date**). I have scheduled this for (**time**) for approximately 45 minutes. You will appreciate that the panel will need to spend longer with some witnesses than with others and I would therefore be glad if you could please arrive at Appleton House some 15 minutes earlier than the scheduled time and be prepared to stay a little beyond the end of the scheduled time if necessary. I hope that these arrangements are convenient.

I attach a plan showing the location of Appleton House. On arrival at Appleton House please make yourself known to the receptionist who will be expecting you.

I would be grateful if you would please note the following points:

? The members of the Panel will be:
Mrs Anne Galbraith (Chairman of the Panel)
Dr Jim Isherwood, Consultant Psychiatrist, York Health Services NHS Trust
Mr Simon Rippon, Nurse Consultant, Hull & East Riding Community Health NHS Trust
Mr Keith Murray, Director of Social Services, Leeds Social Services
? The Inquiry will be held in one of the Committee Rooms in Appleton House
? You may bring with you a friend, relative, member of a trade union, solicitor or anyone else whom you wish

- ? It is to you that the members of the Inquiry Panel will address questions and invite an answer, the person accompanying you will not be able to address the Inquiry Panel
- ? When you give your oral evidence you may wish to raise any matter which you wish and which you feel might be relevant to the Inquiry
- ? You will be asked to affirm that your statements are true
- ? If any member of the Inquiry Panel wishes to express any concern to you then you will be given a full opportunity to respond
- ? The proceedings of the Inquiry will be recorded on tape; the tape will be transcribed as soon as possible after the discussion concerned and you will be provided with a copy of the transcript of the discussion in which you were involved; you will be invited to indicate any concerns which you may have with the transcript within 7 days of receipt
- ? The Inquiry Panel has invited written representations from various interested parties to advise on arrangements for persons in similar circumstances to Patient Q and Patient G and to make any recommendations they may have for the future
- ? All sittings of the Inquiry will be held in private
- ? The findings of the Inquiry and its recommendations will be made public
- ? The Inquiry Panel will not make public of any of the evidence submitted with orally or in writing, save as it is necessary in the body of the Panel's report
- ? The Inquiry Panel will make its findings on the basis of the evidence which it receives.

I would be grateful if you would please confirm at your earliest convenience that you will be able to attend at Appleton House to meet the Inquiry Team as indicated above. I enclose a pre-addressed envelope for your response.

Please telephone me on 0191 333 3350 (my direct line) if you have any doubt or query arising from this letter.

Thank you for your assistance.

Yours sincerely

David Baggott
Authority Secretary

APPENDIX D

EXTRACTS FROM THE SAINSBURY REPORT