Report of the Inquiry into the Treatment and Care of Gilbert Kopernik-Steckel

A Report Commissioned by Croydon Health Authority

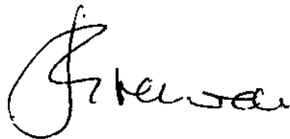
CROYDON Health

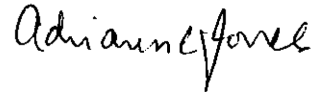
July 1997

Preface

We were commissioned in December 1996 by Croydon Health Authority to undertake this inquiry into the Treatment and Care of Gilbert Kopernik-Steckel.

We now present our report, having followed the Terms of Reference which were supplied to us in January 1997 and the procedure which was subsequently adopted and issued to all witnesses.





Jeffrey Greenwell
CBE
Chairman

Andrew Procter
MA, MBBS, PhD, MRCPsych
Member

Adrianne Jones
CBE
Member

THE STONE COTTAGE
CHAPEL CORNER
POTTER HEIGHAM
NORFOLK NR29 5LR
01692-670772 (PHONE/FAX)

Janet Dickson
Clerk to the Inquiry

Acknowledgements

My grateful thanks are due to all the witnesses who gave oral and written evidence for their frankness and willingness to co-operate in a process which was personally demanding and at times stressful.

The quality of any Inquiry's report depends upon the drafting skills and organising ability of the Inquiry's secretariat. It is the view of my colleagues and myself, as members of this Independent Inquiry, that we were fortunate in the appointment of Mrs Janet Dickson as our Clerk. From the outset she contacted potential witnesses and invited the submission of evidence, both written and oral, and ensured that by programming the appearance of witnesses we made the best use of the time available. She assembled the records and documents relevant to our Inquiry.

Predominantly, however, we wish to pay tribute to the excellence of Mrs Dickson's drafting of this report. Mrs Dickson contributed significantly to the formulation and encapsulation of a number of the recommendations and was in every sense a member of our team. We could not have covered so much ground in the time available without her hard work and commitment to the finished product.

I also commend the shorthand writers from Marten Walsh Cherer Ltd who provided timely and accurate transcripts of the evidence of witnesses, and the management and staff of the Croydon Park Hotel for excellent facilities and hospitality.

Finally, I wish to thank my fellow members, Adrianne Jones, former Director of Social Services, Birmingham City Council, and Andrew Procter, Consultant Psychiatrist, Manchester Royal Infirmary, for their vital professional input. Their expertise and sensitivity in questioning of witnesses, professional viewpoint on procedures and practices were invaluable and demonstrated the wisdom of including people with backgrounds in social services and psychiatry in Independent Inquiries.

Jeffrey Greenwell
Chairman

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Chapter 1

1.0 Introduction

1.0.1 At the Inquest held at the Coroner's Court in Croydon on the 18th January 1996 and by adjournment on the 24th September 1996, the Coroner formally recorded that *'Gilbert Kopernik-Steckel had a psychotic episode at his home address on Sunday 14th January 1996. He killed his mother by stabbing her with a knife. He then took his own life by means of stabbing himself also'.*

1.0.2 The Coroner concluded that Gilbert Kopernik-Steckel took his life whilst the balance of his mind was disturbed and that his mother, Suzanne Kopernik-Steckel, was unlawfully killed.

1.0.3 The health and social services involvement in the few days preceding the event was as follows. On the evening of 11th January 1996, Gilbert visited a general practitioner with whom he registered as a temporary resident. On the afternoon of 12th January 1996, he was visited at his parents' home by that GP and the duty mental health consultant from the Bethlem and Maudsley NHS Trust. They completed medical recommendations for admission for assessment under Section 2 of the Mental Health Act 1983 that afternoon.

1.0.4 A duty approved social worker was contacted on 12th January with a view to undertaking an assessment for an application for admission under Section 2 of the Mental Health Act. The emergency duty approved social worker was contacted twice on 14th January, firstly when Gilbert left the hospital and again when he arrived at the family home that evening.

1.0.5 Gilbert was admitted to a psychiatric ward at the Mayday Hospital, part of the Bethlem and Maudsley Trust, as an informal patient on the evening of 12th January. He left the ward the following morning. He was admitted again as an informal patient on the morning of 14th January, but left the hospital again that afternoon. Gilbert had received psychiatric services at the Maudsley Hospital in 1980, but had no further contact until the period Friday 12th January to Sunday 14th January 1996.

1.1 Independent Inquiry

1.1.1 Immediately after the event, an Internal Inquiry was set up by the Bethlem and Maudsley NHS Trust. Croydon Social Services were invited to send a representative and to contribute evidence. Following the completion of this Inquiry and of the Inquest, the Croydon Health Authority established an Independent Inquiry.

1.1.2 We were appointed at the end of the year. A public notice was issued at the beginning of February 1997 announcing the Inquiry and its Terms of Reference, which are reproduced at Appendix A of this report. A full description of the procedure adopted, which follows that advocated in the reports of the Inquiries into the Care and Treatment of Christopher Clunis(1) and Raymond Sinclair(2), is reproduced at Appendix B.

1.1.3 Copies of the report of the Internal Inquiry and the transcript of the proceedings of the Inquest were made available to us. Other documents were supplied on request; to our knowledge, no documents were withheld from us by any party. We also studied and compared the case records from every agency and reviewed operational policies, procedures and reports provided by the agencies. We received written and oral evidence from a number of key witnesses, listed in Appendix C. We were unable to contact the nurse who admitted Gilbert to hospital on the first occasion (Amanda Bartesco) but all of those people we did contact (copy of letter attached at Appendix D) agreed to give evidence with the exception of the duty consultant psychiatrist, Dr Lawrence. He informed Croydon Health Authority that he declined to give evidence to us on the basis that he had nothing further to add to that which he had already given at the Inquest and to the Internal Inquiry. A copy of the letter from the Chairman of the Inquiry to Dr Lawrence is attached at Appendix E. We regret that Dr Lawrence did not attend before the Independent Inquiry to give direct oral testimony. In accordance with the procedure adopted for this Inquiry (Appendix B, paragraph 3), relevant extracts from this report were sent to Dr Lawrence prior to publication. We have based the report of the events that involve him on his statements to the Internal Inquiry and to the Coroner and on the evidence given to us by others. We also took into account a letter submitted by him dated 12th May 1997. In preparing the final report, we have taken into account all the written responses of the witnesses of fact who were sent relevant extracts from this report for comment.

1.1.4 We first sat to hear evidence on 11th February 1997; the last day we heard evidence was 28th April 1997. All of the oral evidence was heard at the Croydon Park Hotel. We made one site visit, to Woodcote Ward at Mayday Hospital where Gilbert was admitted briefly on two occasions.

1.1.5 The Chairman met Mr Kopernik-Steckel, Gilbert's father, and his two daughters informally prior to the commencement of formal proceedings, in order to explain to them our appointment by the Croydon Health Authority, the Terms of Reference and the procedure which would be adopted. They were offered the opportunity to give formal evidence to the Inquiry which they accepted.

1.1.6 We wish to extend our thanks to all those who gave evidence to us, particularly to Mr Kopernik-Steckel and his daughters, Joanna and Christina. They painted a picture of Gilbert, the family background and of the events of that fateful weekend. It is clear that there are unresolved issues for the family and their grief at such a devastating loss is apparent. We hope that this report will elucidate what happened and provide some of the answers they are looking for. We share their hope that, by highlighting some of the shortcomings in the response the family received to the crisis and in making recommendations, such incidents can be avoided as far as possible in the future.

Chapter 2

2.0 The Life of Gilbert Kopernik-Steckel up to January 1996

2.0.1 We concur with the view expressed in the Report of the Inquiry into the Treatment and Care of Raymond Sinclair (2) that any Inquiry into the treatment and care of a person suffering from mental illness is bound to review his personal history for the following reasons:-

- 'to familiarise the inquirers with the person and the background to his situation and circumstances;
- to identify predisposing factors and events which may have influenced his behaviour and the course of his illness;
- to establish the extent to which those responsible for providing treatment and care have taken account of those factors and events in forming their judgements, determining their actions and providing advice to other people involved in that treatment and care'.

2.0.2 The information about Gilbert Kopernik-Steckel's personal and family history was provided to us by his family and friends. Gilbert was born on 17th May 1962 in London; shortly after, his family moved to Cypress Road, Croydon. Gilbert was the second of three children, having one sister two years older and another twelve years younger. His father practised as an architect; his mother was a teacher in a local school.

2.0.3 Gilbert is described as a quiet, private, sensible, studious person who set high standards for himself and others. From an early age, he was interested in mechanics and engineering. He went to Dulwich College where he obtained excellent 'A' Level examination results. After taking a year out of education, he went to Cambridge University and on to architectural college. He is described as a very good architect, intelligent, gentle, with a wry sense of humour and a slightly different view of things. It also appears that, at times, he could be hot tempered, volatile, intolerant and prone to bouts of depression. He appears to have had few close friends, although he did keep in touch with some of his fellow students.

2.0.4 When he qualified, Gilbert planned to work in three important architectural capitals of Europe, Paris, Vienna and Prague, before returning to practise in London. In the event, he worked for some years in Paris before moving to Berlin where he was working before he set off on a holiday to the Far East and Australia, arriving home to spend Christmas 1995 with his family. He liked to travel and had done so extensively. He kept in touch with his family and returned to spend time at home when working abroad. He appears to have had a good social life in Berlin and to have been highly thought of by his employer there.

2.0.5 Gilbert's only previous contact with mental health services so far as we are able to ascertain was in 1980, when he was referred to a consultant psychiatrist at the Maudsley Hospital following a conviction for shop-lifting. His GP at the time, Dr Dowling, suspected underlying depression. The consultant's report to Dr Dowling

stated that it was evident that Gilbert had a severe personality disorder and difficulty with relationships, especially with his peer group and with those he identified as authority figures. He was unable to engage in psychotherapeutic relationships largely because he identified the consultant as an authority figure. He was ambivalent about attending and very critical of the psychiatrist's approach, so he discontinued treatment. The psychiatrist was of the view that he was set for a very difficult early adult life.

2.0.6 The only other hint of any nervous or mental problem comes from his friends' reports of the period he spent working in Paris, when it appears he had some sort of a crisis or breakdown. It is not known whether or not he received treatment at that time.

Chapter 3

3.0 The Statutory Services in Croydon

3.1.1 The NHS Trust

The Croydon Mental Health Unit, formerly a directly managed unit of the Croydon Health Authority, became part of the Bethlem and Maudsley NHS Trust in April 1995. The Unit provides a range of mental health services, including general, old age, child and adolescent psychiatry, for the 320,000 residents of Croydon, under contract with the Croydon Health Authority. The latter has responsibility for assessing the needs of the population, commissioning services to meet those needs and monitoring contract compliance, including quality standards.

3.1.2 General psychiatric services are organised into three geographically defined sectors, north, central and south Croydon. There are a number of specialist services dealing with patients from all three sectors, including a close supervision unit and a rehabilitation hostel. Services for the psychiatry of old age are arranged in two areas each with a community mental health team based at a resource centre, and an in-patient unit.

3.1.3 Each general psychiatry sector has a community mental health team based at one of three resource centres, under the clinical leadership of two consultant psychiatrists. These teams provide a weekend service of duty community psychiatric nurses for patients known to the service or who are on leave from Warlingham Park Hospital or Woodcote Ward which is on the Mayday Hospital site.

3.1.4 Acute admissions from the three sectors are to either Warlingham Park Hospital or Woodcote Ward (to which Gilbert was admitted). At Warlingham Park there is also a close supervision unit, the Farleigh Unit, which provides treatment for acutely ill patients with special needs or who require a secure environment. Criteria for placement on the unit include patients referred from the courts, prisons and special hospitals, as well as those *'patients within the hospital who become acutely disturbed presenting a danger to themselves or others and requiring a short period of intensive care and treatment'.*

3.1.5 Emergency psychiatric services for Croydon were (in 1996) and still are provided in several ways in Croydon. A duty consultant psychiatrist from a rota of the eight consultants in general and old age psychiatry is available to make domiciliary visits at the request of a general practitioner. Patients can also be assessed by a senior house officer or registrar in psychiatry in the Accident and Emergency Department at Mayday Hospital as a result of a GP referral or self-presentation at the department. A "Crisis Team" consisting of members of the three community mental health teams on a rota basis is available to deal with urgent referrals to any of the teams. There is also a telephone helpline (Crisis Line), staffed by psychiatric nurses available to provide telephone advice to people in mental crisis.

3.1.6 There are two consultants specialising in psychiatry of old age and six specialising in adult mental illness; the latter divide their work between the in-patient services, community mental health teams and a specialist service. There is junior doctor support from both trainees and staff grade doctors. Junior doctors work a rota covering either Woodcote Ward and the Accident and Emergency Department at Mayday Hospital or the wards at Warlingham Park Hospital.

3.1.7 In 1996, Woodcote Ward was a 16 bedded psychiatric ward on the Mayday Hospital site. The operational policy describes it as an *'acute admission ward specialising in liaison psychiatry'* for patients who are suffering from *'acute psychiatric illness'*. It also provided a service for drug and alcohol detoxification and patients with eating disorders, although we understand that the latter have recently been moved, reducing the number of available beds to 14.

3.1.8 Patients on Woodcote Ward are under the care of a consultant who is assisted by a trainee psychiatrist and a full time staff grade doctor. The multi-disciplinary team also includes nursing and therapy staff. Nurse staffing levels allow at least three nurses to be on duty at any time. Therapy staff include an occupational therapist, physiotherapist, art therapist and a social worker.

3.1.9 There were 219 admissions to Woodcote Ward during 1996; bed occupancy rate in January 1996 was approximately 85%, slightly lower than for other psychiatric wards in the Croydon Mental Health Unit which tend to operate at 100% occupancy or even more.

3.1.10 The hospital services for people with mental illness are, and have been for some time, undergoing substantial change. Warlingham Park Hospital is being decommissioned; it is planned to reprovide acute in-patient services on the Bethlem Royal Hospital and other sites.

3.1.11 The future of Woodcote Ward is unclear; there are ongoing discussions between the Trust and the Croydon Health Authority on the appropriateness of locating a psychiatric facility on a general acute hospital site. The physical environment has been the subject of adverse comments by the Mental Health Act Commission on recent visits and by the Internal Inquiry.

Comment:

3.1.12 The arrangements for emergency psychiatric medical cover in Croydon are unsatisfactory. Even within normal working hours (9-5 Monday to Friday), consultant cover for general psychiatry is at times provided by one of two psychogeriatricians (as it was on the day that Gilbert was assessed); these psychogeriatricians are already responsible for a catchment area for psychiatry of old age which is twice the recommended size. Junior doctors at Mayday Hospital have conflicting responsibilities for the psychiatric patients attending the Accident and Emergency Department and patients on Woodcote Ward. It does appear that the former are given priority; one of the doctors to whom we spoke was under the impression that

psychiatric patients referred from casualty had to be seen within a specified time regardless of clinical urgency, although this was not confirmed by service managers or written policies. The Accident and Emergency Department is located several minutes walk away from Woodcote Ward.

3.1.13 The facilities and fabric of Woodcote Ward are extremely poor. At the time of our visit, the entrances were cluttered and unwelcoming; there were inappropriate and unfriendly notices posted in the hallway. There is little privacy for patients and poor facilities for staff to interview and talk to patients. There is no space for ward-based activities. The telephone "Crisis Line" occupies valuable space which could be more appropriately used. It seems unlikely that there will be any investment to improve the present facilities which it is anticipated will remain operational for another two years or so, although we were of the view that some improvement could be made for relatively little investment.

3.1.14 Most importantly, we are of the opinion that the Woodcote Ward is unsuitable for acute admissions, due to its size and isolation from other psychiatric facilities. There is no back-up from other psychiatry staff in the event of a psychiatric emergency, such as acute behavioural disturbance, as would be available on a larger unit. Trainee doctors with very little training or experience in psychiatry are left in charge on occasions.

3.2 The Social Services Department

3.2.1 The headquarters of the Social Services Department are at Taberner House in the centre of Croydon. There are three Divisions; Adult Provider Services, Family Services and Community Care and Strategy. The specialist mental health services are part of the Community Care and Strategy Division.

3.2.2 Three Mental Health Teams cover the Borough. All three teams are based at Rees House; the teams cover north, south and central Croydon and are coterminous with the Trust's Community Mental Health Teams. There are plans to co-locate these teams in resource centres alongside the Trust's community staff, but these have not yet come to fruition.

3.2.3 One of the three teams provides two duty approved social workers to cover emergencies for the whole Borough one week in three, Monday to Friday from 9am to 5pm. Duty office cover is provided by a third social worker.

3.2.4 The Emergency Duty Team, which is part of the Family Services Directorate, provides emergency cover out of office hours. This is a generic team, dealing with all emergencies, including child protection, elderly people and homelessness as well as Mental Health Act referrals. From 5pm until midnight, a duty co-ordinator, who is always an approved social worker, is on duty, backed up by a standby senior social worker who may or may not be approved under the Mental Health Act. From midnight until 9am, the co-ordinator is on duty alone.

3.2.5 Staff on duty out of hours work from home; calls are directed via the security desk at Taberner House, where papers may also be left for collection and transfer.

Comment:

3.2.6 **We are of the opinion that these basic arrangements were and are satisfactory.**

3.2.7 **We support and wish to encourage the implementation of plans to co-locate Health and Social Services Mental Health Teams together in the resource centres. There seems to be a resigned acceptance that the plans to co-locate are not attainable because of practical obstacles such as the restrictions imposed by the requirements of the fire prevention officer. Given determination and adequate resources, these difficulties are surely capable of being overcome; attention at the most senior level in the Trust and Local Authority is required to see that this is resolved.**

3.3 Policies, Procedures and Training

3.3.1 In January 1996, there were a number of policies and procedures in the Trust which were pertinent to the treatment and care of Gilbert. The written policies which we were able to examine relate mainly to the actions of nursing rather than medical staff; issues such as admission and discharge, absconding and search, observation of patients "at risk", record keeping, ward reports and the operation of the weekend community psychiatric nursing service are covered.

3.3.2 The hospital records include space for a standardised assessment of suicide risk and for the recording of other risks within the nursing record section of the notes.

3.3.3 Trainee psychiatrists have an induction course on commencing in post. This is aimed at familiarisation with the sites and the scheme, as well as issues such as the use of the Mental Health Act. General practice vocational trainees start at a different time of year and a similar course is not available for them. There is no written information or junior doctor handbook containing information regarding the policies, procedures and protocols. Junior doctors are able to attend appropriate courses of post-graduate education and receive regular supervision from their educational supervisors. Nursing staff also have access to in service training and education, although in 1996 this was haphazard and not based on a systematic review of individual training needs by senior management.

3.3.4 In Social Services, all approved social workers were (and are still) issued with their own personal copy of the Mental Health Act and the Code of Practice; the Department held the view hitherto that this, together with the specialist training which approved social workers undertake, was sufficient and that detailed local policies and procedures were unnecessary. Following recommendations by the Internal Inquiry, guidelines in relation to assessment which may lead to application for admission to hospital under the Mental Health Act have been agreed jointly between Social Services and the Trust.

3.3.5 Training for approved social workers is regulated by the Central Council for Education and Training in Social Work. Social Services departments must submit their arrangements for training and the assessment of competence to the Central Council for approval. Croydon Social Services approval of one of the social workers involved in this case was based on a managerial assessment of her competence, refresher training and her previous and continuing involvement in mental health work. She was not required to undertake the current 60 days minimum training.

Comment:

3.3.6 Following their visit on 6th November 1995, the Mental Health Act Commission heavily criticised a number of record keeping and administrative procedures operating in the Mental Health Unit; Woodcote Ward was not excluded from this criticism. A subsequent visit in June 1996 confirmed that no substantial improvement had been made; in addition, a report of an independent consultant dated 8th August 1996 highlighted the fact that policies and procedures relating to Mental Health Act issues had not been developed and that training in the same was ad hoc and inadequate. It is important to note that this was the situation at the time that Gilbert was admitted.

3.3.7 We concur with these views; we found relatively little evidence that things have improved. There was, and still is, a lack of understanding on behalf of staff regarding basic policies and procedures, particularly relating to discharge, absconding and the use of sections 5(2) and 5(4) of the Mental Health Act.

3.3.8 The quality of assessment, note taking and care planning by both medical and nursing staff at the time of the incident was poor. Nursing and medical notes were (and we believe still are) kept in separate files and there is little evidence of joint discussion and shared care planning between doctors and nurses. Handover procedures were (and we believe still are) ad hoc and generally poor.

3.3.9 The role of the crisis team, weekend community psychiatric nursing team and the telephone helpline are not clearly understood even now, despite the fact that there is a very clear statement of the purpose of the weekend service and the method of referral. It is unfortunate that there was a complete lack of understanding of this policy by staff involved in Gilbert's care.

3.3.10 Nursing staff training was haphazard and lacking an overall strategy based on the training needs of individual staff and relating to their roles and responsibilities. Staff on Woodcote Ward were not routinely trained in techniques for dealing with behaviourally disturbed patients, including safe techniques for physical restraint. The same situation applied to training in the use of the Mental Health Act.

3.3.11 Junior medical staff in particular seemed unaware of many of the procedures involved in the assessment, management and recording of risk

within Woodcote Ward and of aftercare arrangements. There is a lack of clarity regarding roles and responsibilities between nursing and medical staff; the junior doctors appear to rely heavily on the advice of nursing staff which is apparently of dubious accuracy at times. Their emergency work is relatively unsupervised and there seems to be no expectation that they contact their immediate superior to discuss major treatment plans, including admission to hospital.

3.3.12 We are of the opinion that the development of local guidelines to augment the Code of Practice is essential; these guidelines should set out the roles and expectations on all professionals involved in assessments under the Mental Health Act and should be jointly agreed and implemented. We commend those developed by Cheshire Social Services as an example of good approved social worker practice (3).

3.3.13 We are concerned about the lack of clarity regarding the transfer of approved social work referrals from the day time team to the out-of-hours emergency duty team. However, we have had sight of draft procedures produced since this incident, which cover the handover of referrals between mental health care management and the emergency duty team. Joint guidelines for assessment, which include communication between doctors and social workers, have also been produced. We recommend that the effectiveness of these procedures should be audited on a regular basis.

3.3.14 Croydon Social Services Department took the view that the approved social worker involved initially in this case was an experienced worker, competent to deal with the professional aspects of her appointment. We concur with their view of her ability.

Chapter 4

4.0 The Events from Christmas 1995 to 11 January 1996

4.0.1 The Kopernik-Steckel family describe spending an enjoyable Christmas together at the family home in Cypress Road. Gilbert had purchased presents for everyone during his recent travels. Although it appears that he was perhaps drinking a little more than usual when at home (his alcohol intake was generally modest), it was apparently a happy time for the family.

4.0.2 Early in the New Year, around January 5th, Gilbert attended an interview with an architectural firm in London. He was keen to return to this country, keyed up about the interview and disappointed when he failed to receive a firm offer of employment prior to his anticipated return to Berlin.

4.0.3 Sometime in the next few days, he received a telephone call from a former girlfriend, who told him that she had cancer of the throat. According to his family and friends, this upset Gilbert considerably. Around the same time, he also began to talk about a friend who had committed suicide whilst at Cambridge some 10 years previously; it seems clear that both events were preying heavily on his mind.

4.0.4 Gilbert's friends and family noticed some degree of unusual behaviour during the week beginning January 7th. This included strange conversations with his friends on the telephone and in person, a broken lunch engagement with his sister Joanna and an odd reaction when she telephoned him about it. It also appears that, sometime during the week, Gilbert dismantled his bed and took part of it to the loft where he constructed some sort of platform for the water tank. He also declined to drive his father, who was scheduled to leave for a holiday in Tenerife on Friday 12th January, to the airport, although this is less unusual as Gilbert apparently disliked driving.

4.0.5 On Thursday 11th January, the day before Gilbert was due to return to Berlin and his father left on holiday, he complained to his father that he was feeling unwell. His father recommended some Evening Primrose tablets as a tonic, and suggested that he should go and see the family GP, thinking perhaps he would get some tranquillisers as he was a bit keyed up.

4.1 Visit to the GP on 11 January 1996

4.1.1 At 6.00 pm, Gilbert saw Dr Heyer, the family GP. Although Gilbert had been a previous patient of the practice, his notes had been returned to the Health Authority as he was no longer resident in Croydon. The GP who would have known him best had retired; Dr Heyer had seen him only once before, for vaccinations prior to overseas travel.

4.1.2 Gilbert registered as a temporary resident. Dr Heyer suspected that he was depressed and anxious regarding his return to Germany. Although he was calm and his manner normal, she did recognise that he was being slightly illogical for an intelligent man in that he was very concerned about whether the vitamin tablets his father had given him

could do him some harm. She reassured, him, suggested that perhaps he needed some treatment for his depression and advised him that she could treat him if he stayed in the country.

4.1.3 Gilbert returned home and told his father that he was fine, felt better and would return to Germany the following day as planned.

Comment:

4.1.4 **Dr Heyer told us that, had Gilbert planned on staying in the country, she would have arranged to see him again with a view to prescribing medication, probably anti-depressants. Had she given him that medication immediately, it would have taken time to take effect and would almost certainly not have been sufficient to alter the course of events. We consider her actions appropriate.**

4.2 The Morning of Friday 12 January

4.2.1 Early in the morning, Gilbert went to his parent's bedroom and told them that he was feeling cold and shivery. As Mr Kopernik-Steckel was about to leave for the airport with Joanna and his wife was also up, he suggested that Gilbert should get into their bed. Later that morning, after everyone except Gilbert and Christina had left, Gilbert packed ready to leave for Berlin but was unable to find his passport and papers. After helping with the search, Christina suggested he should telephone Mrs Kopernik-Steckel at work; she herself left for work.

4.2.2 According to the police statement, they were called at around mid-day (although Dr Heyer's evidence suggests it was rather earlier as she recalls being disturbed during morning surgery) by neighbours who reported that Gilbert was behaving strangely in the garden and creating a disturbance. The police arrived to find the kitchen window broken and the door pulled from its hinges. Gilbert had been drinking, but it was clear to them that he was displaying signs of mental instability. The officers arrested him for breach of the peace, with a view to getting him to a place of safety, but Mrs Kopernik-Steckel persuaded them to de-arrest him and leave him in her care. The officers agreed, on condition that Mrs Kopernik-Steckel called the GP, which she did. The officers left.

4.2.3 Dr Heyer spoke to Mrs Kopernik-Steckel who confirmed that she felt that Gilbert was mentally ill. Dr Heyer told us that she telephoned the Crisis Team, part of the Community Mental Health Service, and was advised that it was likely Gilbert needed admission to hospital and that she should contact the duty consultant psychiatrist, Dr Lawrence. Neither the Crisis Team nor the Crisis Helpline have any record of a conversation with Dr Heyer; they were unable, therefore, to confirm what advice had been given.

4.2.4 At about mid-day, Dr Heyer spoke to Dr Lawrence and they agreed to do a joint visit at approximately 2.45pm that afternoon. In view of the fact that the GP had described Gilbert as behaving violently, Dr Lawrence postponed an urgent visit to an elderly patient and followed his usual procedure of checking the availability of beds. He was advised that there were none on the secure Farleigh Ward but that there was a bed on

Woodcote Ward. Crucially, the duty approved social worker was not informed or asked to accompany the doctors on this visit. Both Dr Heyer and Dr Lawrence subsequently told us that this was because they went to see Gilbert with open minds regarding the need for hospitalisation.

Comment:

4.2.5 **Having considered all of the evidence available to us, in our opinion, the sequence of events indicates that compulsory admission under the Mental Health Act was being considered at an early stage. According to Dr Heyer, she formed the opinion that Gilbert was mentally ill, based on what Mrs Kopernik-Steckel had said on the telephone and on her own observations of the night before. She could have made a house call to assess the situation for herself, but apparently on the advice of the Crisis Team, she decided to seek specialist advice. Dr Lawrence agreed to visit without Gilbert being seen by Dr Heyer or a community psychiatric nurse, postponing an urgent visit to an elderly patient in order to do so.**

4.2.6 **From this point, Dr Heyer relied on Dr Lawrence to decide the appropriate action and to involve an approved social worker if he considered it necessary. We were advised by an independent General Practitioner that he would not expect an average GP to know the importance of having a social worker present. However, the Code of Practice is clear on this issue and it is a cause for concern that, given three hours from the time the doctors made their arrangements and the time of the planned visit, neither contacted the duty approved social worker to arrange for her to join them or even to advise that a presence might be required at some point. The approved social worker on duty told us that, had she been asked at mid-day, she would have been able to be at Cypress Road at 3pm.**

4.2.7 **Arranging for the approved social worker to be present would not only have been in line with the Code of Practice, it would have meant that the whole process was completed at that stage; the social worker would have gone with Gilbert to hospital and the papers would have been delivered there. She would have been able to brief the hospital staff on the reasons for admission, any history obtained and the home situation. Gilbert and his mother would not have been left alone and the whole course of events may have been altered. In our opinion, the failure of either doctor to contact the approved social worker was significant.**

4.3 The Domiciliary Medical Assessment, Friday 12 January

4.3.1 At about 3pm, Dr Heyer and Dr Lawrence met at the house in Cypress Road. It was apparent that Gilbert had been drinking; in fact Mrs Kopernik-Steckel showed them bottles of vodka and gin which were three-quarters empty and said Gilbert had drunk all of it. Gilbert was rude and verbally threatening to his mother, who he apparently thought had hidden his passport and papers.

4.3.2 In his evidence to the Coroner, Dr Lawrence stated *'It was obvious to me ...... that he* (Gilbert) *was extremely disturbed. He was entertaining persecutory delusions - he believed that people were after him - he was talking about Nazi Germany, that people were trying to harm him, that Dr Heyer and myself were there to do something nasty to him...... He was thought disordered, which means he would start a sentence and then go on to something else, but he was extremely tense, staring, looking through us, and the more I asked questions, the more Dr Heyer asked questions, the worse he was getting'.*

4.3.3 There was only a brief opportunity for the doctors to speak to Mrs Kopernik-Steckel on her own, when Gilbert went to telephone his friend Marcus Beale. She was able to give them a scant outline of what had been going on, before he returned. Gilbert was very disturbed and rapidly became even more agitated. It was clear that he was not going to agree to go to hospital voluntarily. At Dr Lawrence's instigation, the interview terminated after only 20 minutes or so; Dr Lawrence thought it inadvisable to tell Gilbert he should go to hospital, but managed to promise Mrs Kopernik-Steckel, as she showed him out, that they would complete the process and get him admitted quickly. The doctors withdrew to Dr Lawrence's car and completed the papers recommending admission for assessment under Section 2 of the Mental Health Act. Dr Lawrence stated on the statutory form that *'The patient is agitated and unpredictable, expressing paranoid ideas. Has damaged mother's front door. Unwilling to be admitted informally. Requires assessment as an inpatient for his own care and his mother's safety'.* Dr Heyer stated that *'Patient has thought disorder and agitation with paranoia. He is unwilling to be admitted informally'.*

4.3.4 Dr Lawrence used his mobile telephone to call his secretary, Mrs Doreen Barnett. He informed her that he would return to his office in Purley with the completed forms. He asked her to contact the duty approved social worker to undertake an assessment and to advise Woodcote Ward to expect an admission. Dr Lawrence apparently went on from Purley to make the visit to the elderly patient which he had postponed in order to see Gilbert. Dr Heyer went home for an hour but remained on call, before returning to carry out evening surgery at 5 pm. Gilbert was left alone with his mother.

4.3.5 According to Dr Lawrence's statement at the Inquest, later that evening he told the Registrar on Woodcote Ward that *".....basically I feel this guy is psychotic, that he can explode, I feel that he is dangerous to himself and to - on the Section papers I actually wrote that he was dangerous to his mother, because of the interaction I saw between the two of them".*

Comment:

4.3.6 We consider that it should have been possible for two doctors to find an opportunity to talk to Mrs Kopernik-Steckel on her own, perhaps by one of them talking to Gilbert while the other spoke to his mother. This would have provided an opportunity for an explanation of the situation and the next steps to be given to the mother; at the same time, Mrs Kopernik-Steckel could have been advised of her rights under the Mental Health Act to apply for admission as Gilbert's next of kin.

4.3.7 The only clinical record of the case made by either doctor at the time appears to have been the section paper. It would have been good practice for both doctors to have made notes at the conclusion of their discussion. Dr Heyer's notes simply record the day's events. The only additional clinical record appears to have been a letter to Dr Heyer recorded by Dr Lawrence on his Dictaphone which he left to be typed on the following Monday. Dr Lawrence did state in correspondence to us that he had made additional notes, but we were unable to locate these; no such notes were made available to others to assist with Gilbert's care. A hand-written note from Dr Lawrence could have been sent immediately to the approved social worker, the admitting doctor and nursing staff on Woodcote Ward, if necessary by using facsimile transmission. This would have assisted them in making a fuller assessment of Gilbert's condition and thereby a better informed care plan for his hospital admission and treatment could have been developed.

4.3.8 We find it difficult to reconcile Dr Lawrence's statement made at the Inquest (para 4.3.5 above) with the decision to leave Mrs Kopernik-Steckel alone in the house with Gilbert. In addition, Dr Lawrence opted to telephone his secretary on his mobile telephone to ask her to contact the approved social worker; he did not telephone her himself to discuss the case and to explain the urgency of the situation. This is in direct contravention of the Code of Practice which states that it is essential for at least one of the doctors to discuss the patient with the approved social worker.

4.3.9 We consider it to be an extraordinary decision on Dr Lawrence's part to take the papers back to his office in Purley. Although he wrote giving reasons for this decision, we had no opportunity to discuss these with Dr Lawrence since he declined to give evidence to the Inquiry. He apparently expected the social worker to collect them, despite the fact that it was in the opposite direction from her office to Cypress Road and the fact that he himself must have driven very close to both Rees House and Taberner House on the way. He could have left them at Dr Heyer's surgery. Mayday Hospital was also a relatively convenient and appropriate place to leave the papers; taking them there would have given him the opportunity to brief the ward staff personally; this would constitute good practice.

4.3.10 We consider that it was reasonable for the GP to consider that the consultant psychiatrist would take responsibility for the patient following the completion of the domiciliary visit. We consider that it was Dr Lawrence's responsibility to communicate himself with the approved social worker and Woodcote Ward and to ensure that everyone was fully cognisant with the situation. It was not appropriate to ask his secretary to convey important clinical information under these or any other circumstances, although an instruction to her to fax the papers to the approved social worker and the hospital could have helped and may indeed have changed the course of events.

4.3.11 In our opinion, the failure to discuss the case with the approved social worker was a major failure. This was compounded by the decision to take the papers to Purley.

4.4 Social Services Involvement, Friday 12 January

4.4.1 At 3.20pm Dr Lawrence's secretary rang the duty approved social worker's office. She spoke to the team clerk, who took the details. The clerk checked the social services client database, ascertained that Gilbert and his family were unknown to the department and passed the referral on to the duty approved social worker, Mrs Brenda Phipp. Mrs Phipp was told that Gilbert was agitated, that he had been drinking and that she might need the police.

4.4.2 At 3.30pm Mrs Phipp telephoned Dr Lawrence's secretary and asked to speak to him. She was told that he was not available and that he was delivering the completed papers to the office in Purley. She asked if it was possible for him to leave them anywhere more convenient and was told it was not. This immediately presented Mrs Phipp with a problem; the medical recommendations were being delivered to a point in the opposite direction to Cypress Road and she was not able to speak to the consultant. Mrs Phipp told us that she tried to telephone the GP at her surgery at around 3.45pm and was advised that Dr Heyer would not be available until 5pm. However, the receptionists to whom we spoke could not remember or find a record of this call, despite knowing that Dr Heyer had arranged a domiciliary visit by the consultant psychiatrist, this being a relatively unusual occurrence for the practice and one of which the significance was recognised.

4.4.3 Having been unsuccessful in her attempts to contact either the consultant or the GP, Mrs Phipp decided to telephone Mrs Kopernik-Steckel. She was somewhat surprised when Gilbert himself answered the telephone. He was obviously very drunk and his language was appalling (something she described as 'not fitting' with his professional accent), but he was polite and handed the telephone to his mother when requested. Mrs Kopernik-Steckel said that Gilbert was behaving strangely, but she sounded relatively unconcerned; she thought he would 'crash out in a moment' and that she would be able to persuade him to go to hospital. As she did not seem too worried, Mrs Phipp explained that she had to go to collect the medical recommendations. Mrs Phipp also believes that she gave Mrs Kopernik-Steckel contact telephone numbers, which she described as 'normal practice'.

4.4.4 At approximately 4pm, Dr Lawrence returned to his office with the papers; his secretary telephoned Brenda Phipp who immediately asked if she could speak to him. She was told he had left and that there was no way to get in touch with him. She was not told that he had a mobile phone or given the number. Mrs Barnett read out Dr Lawrence's recommendation from the statutory form, but Mrs Phipp does not recall the final sentence being relayed, i.e. *'Requires assessment as an in-patient for his own and his mother's safety'* perhaps because of an interruption. Mrs Barnett was unable to remember clearly what was said, given the length of time since the event.

4.4.5 Mrs Phipp told us that, had she been given to understand that there was an immediate danger, she probably would have gone straight to the house, even without the medical

recommendations. She did not know quite what she could have done then as she had already trawled the office without success to see if anyone else could go to Purley for the papers and bring them to her at Cypress Road; in addition, she had not been able to speak to one of the doctors. She decided to go to collect the forms herself.

4.4.6 Mrs Phipp arrived at Purley at 4.50pm, the journey having taken 40 minutes through the busy Friday afternoon traffic. She had to make the decision whether to go straight to Cypress Road and do the assessment herself or go back to the office and try to make contact with the doctors and possibly pass the referral on to the emergency duty team. In the event, she decided to take the papers to Taberner House where they could be picked up by whoever went out to do the assessment. She returned to her office in Rees House and again telephoned the GP. There is some discrepancy over the timing of this call; Mrs Phipp stated that it was about 5.45pm and certainly no later than 6pm when she got back to the office, but Dr Heyer stated that it was 6.35pm.

4.4.7 Dr Heyer told Mrs Phipp that Mrs Kopernik-Steckel had said that she thought Gilbert might go to hospital voluntarily and that she should telephone the house first before going out to do an assessment. Dr Heyer did not mention anything about her own or Dr Lawrence's view of the possible risk of dangerousness, but she did convey that she thought he was mentally ill and needed to be in hospital and that he was not just drunk. Mrs Phipp was in no doubt whatsoever that Gilbert needed an assessment but, not having seen him, felt that it was appropriate for him to go in voluntarily if possible, as he had no known psychiatric history.

4.4.8 At that point, Mrs Phipp decided to hand the case over to the emergency duty team. She did not phone Mrs Kopernik-Steckel herself, feeling confident that her colleague would do so as soon as she received the referral. At approximately 6.15pm, she telephoned Woodcote Ward to advise them that she was handing the case over to the emergency duty team. Having tried unsuccessfully to reach Lorna Adeboyeku, the team manager who was on duty that weekend, at home, she faxed a briefing note outlining her concerns and actions regarding Gilbert to the contact point at Taberner House. Lorna Adeboyeku was, in fact, in Taberner House at a meeting; her fax machine at home was not on; this was routine policy, a safety precaution to ensure that anyone trying to contact the emergency duty team was immediately aware that the message had not been picked up.

4.4.9 Lorna Adeboyeku collected the fax and the medical recommendations from the security desk at Taberner House as soon as she left the meeting at between 6.30 and 6.45pm. At approximately 7.15pm, a call came through to the security desk for the duty approved social worker to ring Woodcote Ward.

4.4.10 When Mrs Adeboyeku returned the call, she was told that Dr Clive Timehin, the registrar on duty, was interviewing Gilbert and that he would ring back when he had finished. When Dr Timehin called back, he reported that Gilbert had been admitted as an informal patient. He said that he was co-operative and willing to stay on the ward. As there had been problems with other patients leaving Woodcote Ward, Mrs Adeboyeku pointed out that two medical recommendations had been signed with a view to placing Gilbert on a Section 2 and asked what would happen if he tried to leave. Dr Timehin still felt that informal admission was appropriate and said that if

Gilbert attempted to leave, he would be held under Section 5(2) of the Mental Health Act. Mrs Adeboyeku confirmed that if this happened, an approved social worker would attend Woodcote Ward to assess Gilbert with a view to making an application for him to be held under Section 2.

Comment:

4.4.11 The referral was received in Social Services at 3.20 pm. The team clerk acted correctly by checking the client database; the message was passed to the duty approved social worker within minutes. Mrs Phipp tried unsuccessfully to contact Dr Lawrence. She also told us that she tried to contact Dr Heyer, although there is a discrepancy in the evidence regarding this call. In our opinion, the two receptionists to whom we spoke had difficulty in recalling events precisely, probably due to the passage of time. Neither could remember a social worker telephoning at any time, despite the fact that we know she did get through sometime between 5.45 and 6.35. We conclude that their recollection could be flawed, and that the balance of probability is that the approved social worker's evidence to the Internal Inquiry within days of the event is correct.

4.4.12 Mrs Phipp's hands were tied until she had the medical recommendations in her possession; she asked for these to be delivered to a more convenient location and pointed out that, given the traffic, she would not be able to pick them up until 5pm. She tried to find a colleague who could collect them for her while she went to the house but was unable to arrange this.

4.4.13 Mrs Phipp took the only course of action left open to her; she telephoned Mrs Kopernik-Steckel as the only person able to give her information directly. In the event, Gilbert's mother indicated that she was able to cope with her son, something which she apparently did more than once over the weekend.

4.4.14 Mrs Phipp acted on the information she had available; Gilbert was clearly heavily intoxicated, his mother seemed in control and the doctors had presumably felt it was appropriate to leave Mrs Kopernik-Steckel alone in the house with Gilbert. The emergency suggested by the medical assessment had failed to be conveyed to her. In order to comply with the Code of Practice in what was likely to be a difficult assessment of an intoxicated man, Brenda Phipp decided it was appropriate to delay the assessment until she had more information from the doctors, and had their forms in her possession.

4.4.15 Having collected the papers, Mrs Phipp took them to Taberner House, where they would be available to the emergency duty approved social worker. In our opinion, going straight from the office in Purley to Cypress Road would not have been appropriate; she still had not spoken to a doctor, she had been told by Dr Lawrence's secretary that she may need the police and certainly going alone to section Gilbert would not have been good practice.

4.4.16 Although there is a discrepancy over the timing of the call, by the time Mrs Phipp did manage to speak to Dr Heyer, she was told that Mrs Kopernik-Steckel probably would be able to persuade Gilbert to go to

hospital as an informal patient. She knew that Gilbert had been drinking and that some delay while he sobered up would make the assessment more reliable. She made the decision to hand over to the emergency duty team. We consider this to be appropriate, given that the assessment had not been started by six o'clock. She telephoned Woodcote Ward and told them what she was going to do. It is unfortunate that she did not telephone Mrs Kopernik-Steckel again at this stage to tell her what was happening.

4.4.17 By the time Mrs Adeboyeku made contact, Gilbert was at the hospital. Given the apparent agreement of Dr Lawrence and Dr Timehin to an informal admission, in our opinion she responded appropriately in confirming that he would be held if he tried to leave and that she would undertake the assessment at that stage if required.

4.4.18 In our opinion, both approved social workers acted in a way which was consistent with the Code of Practice and displayed pragmatic common sense.

4.4.19 We understand that, subsequently, Croydon Social Services have drafted a policy to deal with future situations where an approved social worker might need to act to undertake an application for admission under Section 2 of the Mental Health Act after a patient has agreed to go in as a voluntary patient. This would require the approved social worker to attend the hospital and assess the patient as soon as he/she is advised of the informal admission. We were told that Croydon MIND and the user group have reservations about the implications of this for civil liberties. We understand their reservations and recommend that the department should rethink the proposed policy jointly with the Trust and ensure that steps which need to be taken to secure the compulsory detention of patients are initiated by or on behalf of the consultant in charge of the patient under whatever section of the Mental Health Act is most appropriate.

4.5 The Admission to Hospital, Friday 12 January

4.5.1 At around midday, Gilbert telephoned his friend Marcus Beale at his office. Mr Beale realised that he was mentally ill and agreed to meet him the following day for *'tea and a long chat'*.

4.5.2 While Dr Heyer and Dr Lawrence were at the house, Gilbert telephoned Mr Beale again. By this time, Mr Beale realised that Gilbert was *'in the midst of a severe nervous breakdown'*; he left work immediately and took a mini-cab to Cypress Road. It was the first time he had visited the house. He said that *'it was a very, very scary house I arrived at'*. Mrs Kopernik-Steckel had locked Gilbert in as she was clearly aware that he was a danger. Gilbert had started to wreck the place. At some point, he tried to light a fire in the kitchen sink; his friend stopped him and doused the flames. Marcus Beale described the house as *'like a pressure cooker'*. Gilbert was intimidating his mother and being quite abusive of her. His friend decided to get him out of the house for a while and they went for a walk. During the walk, Gilbert was verbally abusive to a man walking his dog; Mr Beale pulled him away and apologised.

4.5.3 When they returned to the house, the approved social worker had still not arrived. Mrs Kopernik-Steckel telephoned Dr Heyer to find out what was happening and told her that Gilbert's friend had arrived and that they hoped to get him to hospital voluntarily. Gilbert was clearly terrified of being locked up, but Marcus Beale managed to persuade Gilbert to go with him to hospital in a mini-cab; Mrs Kopernik-Steckel saw them off in the cab and telephoned Woodcote Ward to let them know they were on their way.

4.5.4 When they arrived at the hospital, Gilbert and his friend went first to the Accident and Emergency Department. As soon as they realised who Gilbert was, they were sent to Woodcote Ward. Gilbert was interviewed by nurse Amanda Bartesco at 6.50 pm. She recorded that *'Gilbert was seen at home by Dr Lawrence after Gilbert was at his mother's house extremely agitated, smashing furniture. He agreed to come into the ward informally. He stated on admission that he had been drinking alcohol and he was upset over hearing news that someone he was at university with had committed suicide. On admission he appeared slightly intoxicated. He appeared calm and was answering questions without any signs of delusions. He said he is not low in mood and he did not appear to be suffering from any depressive symptoms. Gilbert had good eye contact, he was using appropriate verbal and non verbal communication. No signs of agitation'.* Mr Beale sat in on this interview and was trying to prompt Gilbert, while giving him moral support; he told us that by this time Gilbert was calm *'but obviously very ill'.*

4.5.5 Marcus Beale sat with Gilbert in the day room. The television was on and Gilbert had delusions that the programmes were about him. After half an hour or so, Gilbert went off to be interviewed by Dr Timehin and Mr Beale left the ward convinced that he was in the appropriate place and in safe hands.

4.5.6 Prior to the interview with Gilbert, Dr Timehin telephoned Dr Lawrence for information and advice. Dr Timehin told us that he was sure that Dr Lawrence did not say anything about Gilbert being suicidal or threatening to harm his mother or others. Indeed, there was no mention of dangerousness in the record that Dr Timehin made of the conversation with Dr Lawrence in Gilbert's medical notes, although Dr Lawrence, in his statement to the Inquest, clearly stated otherwise (see para 4.3.5 above). Dr Timehin's impression was that Gilbert's health was at risk and that Dr Lawrence thought this could be the beginning of a schizophrenic illness. It was agreed that Gilbert should be admitted informally, but that if he tried to leave the ward, he would be detained under Section 5(2) of the Mental Health Act.

4.5.7 Dr Timehin told us that it was very hard to obtain a history from Gilbert. He tended to go over certain material or information time and time again; it was difficult to put a timeframe on the things he was saying because it would switch from home to Germany, to his father and so on. Dr Timehin felt that alcohol intoxication was clouding the assessment, but that there were indications of psychotic illness. He decided to prescribe Temazepam to give Gilbert a good night's sleep and to assess him again in the morning. Dr Timehin did not talk to Marcus Beale or telephone Mrs Kopernik-Steckel to obtain further information. He told us that he thought that he had briefed one of the nursing staff regarding the need to hold Gilbert if he tried to leave, although he could not recall which nurse was involved. Dr Timehin told us that he assumed that the nurse would pass the information on to colleagues.

4.5.8 The nurse on duty that night, Sandra Wilkinson, reported that Gilbert spent a restless night. He wanted to go out. At 10pm he was given some medication to help him sleep, but by 11pm he was wandering around and pacing up and down. He returned to bed for a while but was up again at 1am. He had a drink and chatted to the staff nurse. He talked about his father, Germany and the fact that some people suggested his name was Jewish. He seemed upset. He went back to bed at 3.30am, having refused medication but then agreeing to take it.

Comment:

4.5.9 In our opinion, the events as they unfolded in the hospital were the next major failing in the system. Firstly, none of the staff took the opportunity to seek information on what was going on at home from Marcus, who was with Gilbert when he was admitted, neither did they telephone Mrs Kopernik-Steckel for her views or to tell her what was happening.

4.5.10 Dr Lawrence failed to make the home situation or the level of danger clear to the hospital staff. He was not proactive in providing any information for them; we have already said that we are surprised that, apparently, no notes were made at the time of the domiciliary visit and that no record of the findings of that assessment were sent to the ward. In addition, he accepted an informal admission perhaps too easily and certainly without proper discussion with Gilbert of the expectations and implications having taken place.

4.5.11 Many staff, both medical and nursing, are concerned about clinical management plans which include statements such as 'for section 5(2) if he tries to leave' which could be interpreted as bland instructions from one clinician to another which could override professional judgement. Clarification is required and the Mental Health Act Commission may feel it appropriate to produce advice. In the meantime, it would be helpful if entries in the notes were more detailed and included a statement of the three statutory requirements for a compulsory admission, together with criteria in relation to each which would indicate a requirement for compulsory detention.

4.5.12 The nursing assessment was done separately from the medical assessment and there is no indication that the registrar and the primary nurse discussed Gilbert or that they developed jointly a care plan which included the need to hold him if he tried to leave. The Care Programme Approach was not adopted in a way which was consistent with department policy; this may be because it is viewed as a bureaucratic tool. In our view, it is more a way of thinking; a care plan should be adopted and communicated from the outset of any involvement and should be regarded as a fluid and dynamic approach to treatment and care which can be changed as and when necessary, providing that significant changes are communicated to all those who need to know, which may include the patient, family and staff in other agencies.

4.6 Saturday 13 January

4.6.1 At 9 am, Dr Timehin handed over to Dr Holt in the main office at Woodcote Ward. Dr Timehin told Dr Holt that Gilbert had been drinking when he was admitted and that it had not been possible to assess him properly. The plan was for Dr Holt to assess him later that day; meanwhile there were two patients in the Accident and Emergency Department who were in need of psychiatric assessment. They were to be given priority. Neither Dr Holt or Dr Timehin can recall mentioning the need to hold Gilbert under Section 5(2) if he tried to leave. Dr Timehin had completed the card on the front of the notes, indicating that Gilbert was at risk of absconding but rating the risk and nursing action as nil. The recommendation that he should be held under Section 5(2) if he tried to leave was clearly included in the body of the medical notes in which Dr Timehin's care management plan states *'Admit to Woodcote Ward. Temazepam 10mg ...... For observation for fear of absconding. For Section 5(2) if he tries to leave'.* As already noted (para 4.5.6 above), there was no mention of dangerousness in the body of these notes.

4.6.2 The nursing handover was between nurse Sandra Wilkinson, who had been on night duty, and the day team, Amanda Bartesco, who had seen Gilbert on admission, and deputy charge nurse Stuart Thompson. She briefed them on the events of the night concerning Gilbert; Stuart Thompson told us that he had no recollection of being told that Gilbert should be held if he tried to leave. He did not read the medical notes at any stage.

4.6.3 At around 11am, Gilbert went to the nursing office and said that he wanted to leave the ward. He wanted to go home and apologise to his mother for his actions the day before. Stuart Thompson tried to persuade him to stay to see the doctor. Gilbert said he was anxious to see his mother because he felt he had really upset her. Mr Thompson asked him if he would agree to a visit from a community psychiatric nurse and/or an out-patient's appointment, which Gilbert did.

4.6.4 Stuart Thompson telephoned Dr Holt, who was in the Accident and Emergency Department, and advised him that Gilbert had left the ward. He told Dr Holt what had happened, that Gilbert was calm, rational and had no psychotic ideas. Dr Holt told us that he understood this to be absconding rather than a discharge and that he assumed that the nursing staff had taken action in line with the laid down procedures. Stuart Thompson, on the other hand, clearly thought that the patient had been discharged and that Dr Holt concurred. He telephoned Mrs Kopernik-Steckel and told her that Gilbert was on his way home and that a visit from a community psychiatric nurse and an out-patients appointment would be arranged. Gilbert's sisters reported that the family were reassured by this; if the hospital felt that Gilbert was well enough to return home, he must be better. Stuart Thompson went off duty at 2.30pm without contacting the weekend community psychiatric nursing service.

4.6.5 The duty approved social worker, Lorna Adeboyeku, the police and Dr Lawrence were not informed that Gilbert had left the ward.

4.6.6 When Gilbert arrived home, his sister Joanna was there with Mrs Kopernik-Steckel. The atmosphere was quite strange, with everyone trying to ignore the events of the previous 24 hours. There was some discussion about Gilbert returning to Berlin; he

had to change his tickets as he had planned to leave the day before but had not done so. He rang his friend Marcus Beale and invited him over for a meal that evening. The family decided to tidy up the house and prepare some food. Mr Beale arrived at about 6 o'clock. Gilbert was quiet, subdued and introverted, as he had been all day; it was a strange meal. Mrs Kopernik-Steckel was trying to keep the conversation going; it was Mr Beale who raised the issue of further treatment for Gilbert and whether or not he should to return to Berlin or stay in London for a while. Mrs Kopernik-Steckel, while acknowledging that Gilbert needed help, seemed to think that he did not need to go back to hospital. She seems to have been thinking that the family could deal with it.

4.6.7 Mr Beale left at about 9.45pm. He told us that he was not concerned as Joanna was there. He had been convinced from the beginning that the danger was Gilbert being alone with his mother. He promised to telephone the next day.

4.6.8 When he had gone, Gilbert said to his sister *'Joanna, please say I don't have to stay here tonight'*. Joanna reassured him that she would stay as well. Mrs Kopernik-Steckel went off to bed, leaving Joanna and Gilbert watching television. Gilbert was behaving very strangely; he was getting all his papers together and trying to keep them on his person. He was reacting strongly to the television programmes. Joanna was relieved when her younger sister, Christina returned home. Christina had bought some flowers for Gilbert; she gave them to him at the door and then put them in a vase that she had given him. He was clearly upset by this, staring at them with a very strange expression; in the end, they took the flowers and the vase out of the house to the dustbin. Since Gilbert obviously did not want to go to bed, they stayed up with him. At one point, Christina went to her room and played some music. Gilbert reacted badly; he took the tape and the tape recorder away from her. Joanna persuaded Christina to come back downstairs so that she was not alone with Gilbert.

4.6.9 At another point, Gilbert insisted that the electricity should be turned off in the house because it was dangerous. Joanna managed to dissuade him. Eventually, Mrs Kopernik-Steckel came downstairs and told them all to go to bed - by this time it was perhaps two or three o'clock in the morning. However, Gilbert had a restless night; Joanna found him in the kitchen making coffee in the early hours.

4.6.10 Joanna and Christina both told us that neither they or their mother had been given any indication that Gilbert might be dangerous or what to do if he or they needed further help. In Christina's words, by Saturday evening Gilbert was *'on another planet'*.

Comment:

4.6.11 By Saturday morning, the failure of communication between the medical and nursing staff was complete. The oral handover between Dr Timehin and Dr Holt was scant, with neither recalling discussion of the need to hold Gilbert if he tried to leave. The nursing handover, which was separate from the medical handover, also failed to convey anything other than descriptive details of the night's events. We were informed that duty rotas often do not allow sufficient time for proper handover; we were told of one occasion where the doctor arriving on duty found the bleep lying on the desk in the doctor's office. This is not satisfactory.

4.6.12 The charge nurse had not read the medical notes (which were kept separate from the nursing notes) when Gilbert appeared and insisted on

going home. He allowed him to go on the basis of the nursing observation of the preceding 16 hours. When he reported his departure to Dr Holt, there were clearly two views of events; Stuart Thompson thought that Gilbert was discharged whilst Dr Holt believed he had absconded. Dr Holt told us that he assumed that appropriate procedures (which included informing the approved social worker and the police) would be followed. In the event, the charge nurse failed to take any action related to either discharge or absconding. Given her discussion with Dr Timehin and the fact that she was holding two medical recommendations, if the approved social worker had been contacted, we believe she may have taken steps to assess Gilbert. Had Mr Thompson made a referral to the weekend community psychiatric nurse as he suggested to Gilbert, a visit might have been made to the home that afternoon and the situation recognised. As it was, that referral was not started until the following morning.

4.6.13 Stuart Thompson did telephone Mrs Kopernik-Steckel; this was a reassuring call which encouraged the family to believe that the events of the previous day were a one off and that any danger had significantly lessened. They were completely unprepared to recognise the extent of Gilbert's illness.

4.6.14 Whilst we do understand the pressures on the staff, particularly given the need to provide psychiatric cover for the A & E department, the overall impression is that Gilbert's case was not taken seriously. We had reservations about the overall management of the ward, including standards of work, communication and the tendency for over-reliance on decisions of nursing staff which failed to take account of the situation of the previous day and the circumstances to which Gilbert was returning.

4.7 Sunday 14 January

4.7.1 Gilbert was up very early; he wanted to start a bonfire in the garden. He had several items he wanted to burn, including the flowers and the vase from the night before, Christina's tape and recorder, a red and white blanket which he said reminded him of blood, a pair of his own shoes, photographs from his holiday in Australia and his father's mathematical notebook and ID card.

4.7.2 Mrs Kopernik-Steckel tried to persuade him not to start the fire but to come in and have some breakfast.

4.7.3 At that point, Gilbert went next door and knocked at his neighbours house; he asked him to take him to hospital. Shortly thereafter, Mrs Kopernik-Steckel came to the door and Gilbert ran off. The neighbour promised Mrs Kopernik-Steckel that he would go and look for Gilbert and advised her that if he came home, she should not open the door to him. She commented that he was her son and she could not do this.

4.7.4 Christina ran after Gilbert and caught up with him; he said he was walking to Mayday Hospital. Christina walked along with him; as they passed South Norwood Police Station, Gilbert decided to go in and ask for a lift to the hospital. According to the police statement, it was 9.10 am. He explained in detail who he was, showing his passport and his father's old ID card. He told WPC Bell that he wanted to go

voluntarily to hospital; he explained that he had been in Woodcote Ward on Friday after he lost his temper. He asked if she would keep his papers. He insisted he trusted nobody but the police and said that his mother was trying to control his life and that he wanted to go to Prague via Berlin but that she did not want him to.

4.7.5 WPC Bell decided to telephone Woodcote Ward. She spoke to the doctor on duty who said that he had just read Gilbert's file. WPC Bell was relieved when the hospital readily agreed to take him as she was becoming concerned that she may have to use a Section 136 to detain Gilbert. He was calm but, in her words *'on the edge'*.

4.7.6 WPC Bell called her colleague, WPC Bishop, and asked her to drive Gilbert and his sister to the hospital. After they left she telephoned Woodcote Ward to let them know they were on the way.

4.7.7 On the way to the hospital, Gilbert suddenly asked WPC Bishop if she would take him home as he wanted to collect something. For some reason she could not explain, she thought this would not be a good idea and managed to persuade him that Christina could collect anything he needed later. When they arrived at the hospital, Gilbert refused to cross the threshold. He insisted that WPC Bishop should sign a piece of paper which said *'Gilbert Conrad Jan Kopernik-Steckel submits himself voluntarily to Woodcote Ward Mayday Hospital'*. He made Christina sign a similar declaration, then asked WPC Bishop to go and make photocopies. This went on for about half an hour, with Gilbert refusing to enter the ward. During this time, Joanna arrived. She told us that there were *'loads of pieces of paper that Gilbert was writing on and he was adamant about getting signatures from the police and the doctors'*. Eventually, he got one he was satisfied with and he agreed to go in with the doctor.

4.7.8 The doctor on duty that morning was Dr Eoin Donahue. The first he knew of Gilbert was when he was asked by the nursing staff to ring the community psychiatric nurse to put in place the arrangements for a home visit. The time was about 9.45 am. While he was waiting for a return call, Gilbert arrived at the ward with Christina and WPC Bishop. Dr Donahue went to greet him, checked that the WPC was happy to stay with him for a while and returned to the office.

4.7.9 Dr Donahue checked the medical notes and formed the impression that Gilbert was suffering from a psychotic episode. He did not consider contacting Dr Lawrence; the nursing staff told him that Gilbert had been stable the day before. He had a brief chat with Christina, who was very upset and can recall little of the conversation other than being told that Woodcote Ward is a voluntary ward and that Gilbert could leave. She does not recall anything being said about the previous admission, or any Section orders. He did not ask about the events of the past 24 hours.

4.7.10 At around 11 o'clock, Dr Donahue saw Gilbert. Gilbert asked for his sister Joanna to be present. Dr Donahue told us that the interview was notable because of Gilbert's changeable emotions; he thought he was psychotic, fragmenting and that he had lost contact with reality. Gilbert refused medication. Dr Donahue decided that he should be observed and detained if he tried to leave. Joanna remembers little of the conversation; both Joanna and Dr Donahue agree that she was not asked about what had been going on at home.

4.7.11 Dr Donahue left the ward at around mid-day. He returned at 1.00 pm and spent the first part of the afternoon in the office seeing other patients. Meanwhile, Gilbert and his sisters sat in the day room or went out to the garden. They thought Gilbert was

more likely to stay if they were with him. Both commented on the condition of the ward. Joanna described it as *'the most dreadful place I have ever been in'*. They were left on their own with Gilbert; none of the nursing staff spoke to them, although at one point someone who she took to be a member of staff told Christina *'not to let him* (Gilbert) *be sectioned as he would go to Warlingham and that is a terrible place. He will never get out'*.

4.7.12 Both Joanna and Christina left the hospital for short periods. Joanna returned home to collect some newspapers and to tell her mother what was happening. Joanna told us that earlier in the morning her mother had telephoned Dr Heyer and left a message for her to ring back, which she did after Joanna had gone to the hospital. Dr Heyer spoke to Mrs Kopernik-Steckel who told her what was going on, but said that Gilbert had gone to the police and that they were going to take him back to hospital. Dr Heyer felt there was nothing more she could do. Mr Ford, the next door neighbour, told us that Mrs Kopernik-Steckel had felt unsupported and had gone to him very upset. When her mother expressed concern to Joanna on her return, Joanna suggested that she telephone the hospital herself, which she did. They assured her that Gilbert would not be released again.

4.7.13 Joanna returned to the hospital. She told Christina that Gilbert would not be allowed to leave and they agreed to try to get him to stay voluntarily. At some point, Gilbert said that they should all go home and see their mother. His sisters suggested that they would go and collect her and bring her to the hospital; eventually he agreed to go and telephone her. He went in to the office to make the call. It was not an easy conversation and Gilbert was clearly upset by it. He tried, without success, to telephone Marcus Beale.

4.7.14 By this time, Dr Donahue decided to contact Dr Lawrence and seek authorisation to detain Gilbert under Section. Dr Lawrence initially suggested detention under Section 2 of the Mental Health Act, but Dr Donahue indicated that there was no time for this. They agreed to detention under Section 5(2). Meanwhile, Gilbert had gone back to his sisters and tried to get them to leave with him; they tried to persuade him to see the doctor again, but Gilbert was determined that, if they would not go with him, he was going alone. He left the ward. Both sisters were expecting staff to restrain him. Stuart Thompson started to go after him, but was delayed by another patient. He arrived at the door and shouted to Gilbert to stop, but by this time Gilbert was running to the main road, with Christina following him. She saw him jump on a bus heading for Brixton. It was shortly after 3pm.

4.7.15 Dr Donahue and Stuart Thompson telephoned Mrs Kopernik-Steckel, the police, Dr Lawrence and Lorna Adeboyeku. Lorna Adeboyeku asked how this could have happened, as she had been assured on Friday evening by Dr Timehin that if Gilbert tried to leave he would be detained and she would be called to undertake an assessment. She did not know that this was the second time Gilbert had left the ward. However, as Gilbert's whereabouts were not known, there was little she could do until he was found.

4.7.16 Joanna and Christina returned home. The hospital had telephoned, so his mother knew that Gilbert had left. She was upset and annoyed that he had not been detained or given any medication. She was angry because she thought the section papers were locked in Taberner House.

4.7.17 The three of them sat around talking, worrying about where Gilbert had gone and what might happen. They were not clear about what they should do if he came home and were still not sure of how serious his illness was. They did not have a clear idea of what was going on.

4.7.18 Sometime before 8 pm Gilbert returned home. Initially, the family were relieved. Gilbert was very slow and deliberate, saying little but every word was weighted. They did not know where he had been but his sisters did not think he had been drinking. At 8 pm, Gilbert telephoned Marcus Beale. He said *'I must be the most alienated person in the world'*. There were long silences. The last thing he said was *'I'm sorry, I've got to finish it'* and he put the telephone down. Mr Beale tried to ring back but got no reply. Gilbert went to the kitchen and his sister Joanna saw him take a knife from the drawer. He went upstairs with it.

4.7.19 Just prior to this, Mrs Kopernik-Steckel telephoned Woodcote Ward and told Stuart Thompson that Gilbert had returned. He said that he would telephone the duty approved social worker and that she would go to the house. He air-paged Lorna Adeboyeku via Taberner House, but before she got back to him, Mrs Kopernik-Steckel telephoned again to say that Gilbert had a knife and that he was in the bathroom. Stuart Thompson told her to telephone the police immediately. By the time Lorna Adeboyeku returned the call, Stuart Thompson was only able to tell her that Gilbert was at home and had a knife. Mrs Adeboyeku's expectation was that the police would get there quickly and that they were the appropriate people to deal with the situation. She assumed that they would take Gilbert to a place of safety and that they would then call on her to do an assessment.

4.7.20 Meanwhile, Mrs Kopernik-Steckel and Christina tried to distract Gilbert while Joanna telephoned the police. While she was on the telephone, Gilbert started running down the stairs. Mrs Kopernik-Steckel and Christina ran out of the house screaming. Joanna could hear the sirens coming. Christina ran next door for help and Joanna slammed the front door shut. By the time the police arrived, Mrs Kopernik-Steckel was lying motionless in the drive. Gilbert was badly wounded. He had killed his mother and himself.

Comment:

4.7.21 **On Sunday morning there was another chance to change the course of events. Unfortunately, this was not to be. Fortuitously, Dr Donahue had read Gilbert's notes, since he had been asked to make the referral to the weekend community psychiatric nurse. He was therefore aware of the recommendations that Gilbert should be detained under a section of the Mental Health Act and presumably realised that he had left the ward inappropriately the day before. However, the seriousness of the situation appears still not to have registered, despite Gilbert's bizarre behaviour when he arrived, with a police escort.**

4.7.22 **During that morning and early afternoon, there was ample opportunity for the staff to find out what had gone on since Gilbert left the day before from his two sisters who stayed with him most of the time. At some point, Dr Donahue prescribed anti-psychotic drugs, but Gilbert refused treatment and these were never given. His notes indicate that he recognised a shift in the nature of Gilbert's illness from the day before. We**

were surprised that he did not telephone Dr Lawrence immediately for advice on a difficult clinical situation. He did not make that call until it was too late, Gilbert was already leaving; the call was only made then, it seems, because the procedure says that the consultant must give consent for the use of Section 5(2).

4.7.23 All the evidence suggests that Gilbert was aware that he needed help from someone. In our opinion, he should have been given a clear and explicit explanation of the expectations and implications of an informal admission and of the plans for his treatment and care. This was not done, so far as we can tell, on either Friday evening or on Sunday. It is most likely that he would not have agreed to the plan; the need for detention for assessment would immediately have been highlighted.

4.7.24 We do not feel that he should have been held on locked ward initially. It may well have been that very minimal restraint procedures would have been sufficient to prevent him leaving. However, it is clear that there were insufficient staff available and that they were not trained to deal safely and effectively with control and restraint should the situation escalate. It is because of this, in our opinion, that staff felt unable to confront Gilbert with their assessment of his need for admission and treatment or to detain him when he tried to leave.

4.7.25 Although this time the procedure relating to absconding was followed and all the appropriate parties contacted, a plan of action was still not developed with the family to prepare them to deal with the situation should Gilbert return home. Moreover, given Dr Lawrence's statement at the Inquest that Mrs Kopernik-Steckel was *'a sitting duck'*, we are surprised that he did not offer any advice either directly or via the police that she should be given protection or advised to leave the house for her own safety.

4.8 The Follow-up

4.8.1 At 9.30pm, Dr Donahue took a call from the South Norwood Police Station. He was asked about Gilbert and informed the officer accordingly. He was not told what had transpired. At around 10.00 pm he telephoned Warlingham Park Hospital to see if Gilbert had been admitted. He was bleeped at 7.00am the following morning and told what had happened. At 7.40am he telephoned Dr Lawrence and informed him.

4.8.2 Lorna Adeboyeku tried to telephone the police later on Sunday evening, but could not get through. The following morning, she handed Gilbert's file over to the duty social worker, who tried several times to telephone Mrs Kopernik-Steckel. At around 3pm, the social worker decided to go to the house; when she arrived she realised that something was seriously amiss. She went to the police station and, after she had identified herself, was told what had happened.

4.8.3 The police arranged for Victim Support to visit Joanna, Christina and their father. None of the other statutory agencies made any attempt to contact the family. Mr Kopernik-Steckel subsequently changed the family GP.

Comment:

4.8.4 Whilst we understand that it was a busy evening, we are surprised that, having heard that Gilbert was at home with a knife, Mrs Adeboyeku did not persist with trying to contact the police in order to ascertain the outcome. It might have been necessary for her to attend either at the police station or the family home with the medical recommendations for compulsory hospital admission. The police attending the scene could have been in ignorance of the fact that two medical recommendations had been made. If the police had arrived in time to disarm Gilbert, they would probably have contacted Mrs Adeboyeku, but she was in no position, by not positively contacting the police, to ascertain what was happening or whether she could be helpful. In the event, had she found out about the suicide and homicide, she would have been able to offer immediate support to the two sisters and to establish on-going contact with the family.

4.8.5 Equally, we are surprised that the police did not see fit to tell the hospital what had happened or to make contact with the social worker who could have been of assistance. In our view, this reflects adversely on the interagency culture and inevitably colours relationships.

4.8.6 We are dismayed to discover that there was no contact with the family from health, social services or the family GP, following the incident. There was not even a letter of condolence, much less an offer of help or support. We were told by the Trust and Social Services that the police gave out the message that the family had left the area and were not contactable. They were not told about the Internal Inquiry, other than by Marcus Beale, neither were they aware that there would be an Independent Inquiry until they were advised by our chairman - a year after the tragic events. The family had every reason to feel that the statutory agencies had indeed failed and abandoned them.

Chapter 5

5.0 Inquiries into the Event

5.1 Internal Inquiry

5.1.1 An Internal Inquiry was set up immediately following the incident. The panel comprised Mrs Margot Croft (Chair), Non-Executive Director of the Bethlem and Maudsley Trust, Mr Ken Dixon, independent representative for Croydon Social Services, Dr Frank Holloway, Consultant Psychiatrist, the Bethlem and Maudsley Trust and Mrs Pamela Tibbles, Head of Nursing, the Bethlem and Maudsley Trust. None of the members of the panel had any involvement in the incident.

5.1.2 The Inquiry was conducted in accordance with the Trust's Untoward Incident Inquiry Procedure, a copy of which is attached at Appendix F. The panel first met on January 26 1996. Eight witnesses were interviewed on that day. The panel met again in March and May. The final report was prepared in June and presented to the Trust Board and Croydon Health Authority in September.

5.1.3 The Chair of the Inquiry told us that she was advised by the Trust that Gilbert's family were not contactable and did not wish to give evidence; Mr Kopernik-Steckel and his daughters told us that they were not aware of the Internal Inquiry, neither were they offered the opportunity to talk to the panel. Marcus Beale found out about the Inquiry and he did talk to the panel, which was appreciated and useful to the Inquiry.

Comment:

5.1.4 **We commend the decision to involve Social Services in the Internal Inquiry into the incident, which in our view was entirely appropriate and correct in this case. It subsequently emerged that there were different views about whether or not it was a truly joint report or whether the Social Services Department had merely contributed to the Trust's report. This was exacerbated by confusion regarding the precise Terms of Reference for the Inquiry and misunderstanding over the proposed circulation of the report.**

5.1.5 **With this exception, the Trust's Untoward Incident Procedure was followed precisely. This immediately led the panel into a broad arena; formal evidence was requested and witnesses were informed that the findings would be made available to the Coroner. The expectation that the Inquiry could be done in two hours was clearly totally unrealistic; as a result, there was no timetable or proper plan developed at the outset. Inevitably, this caused considerable delays, which were exacerbated by difficulties of getting people together, the lack of clerical support, the untimely loss of information held on computer due to theft, and the need for the report to be examined by the Trust's lawyers prior to it being made available to selected parties.**

5.1.6 In our opinion, the Trust's procedure does not comply with the recommendations of HSG(94)27 which states that:-

'If a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event, action by local management must include an immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach'.

5.1.7 We consider that an immediate review undertaken by senior operational managers with their teams would have been much more appropriate. This would have given all concerned an opportunity to look at their own practice, to gain greater understanding of what went wrong, to examine objectively the events surrounding the incident and to highlight areas of practice which should be clarified or reconsidered. The resulting management reports could have formed the basis of the response of the Chief Executive to the family and the press; there was no need for a detailed report to be released at this stage. The process could have been completed within a few days and the recommendations implemented immediately.

5.1.8 The procedure shows that there is confusion regarding the relative roles and responsibilities of the internal review and the Independent Inquiry; the internal investigation clearly covered areas more appropriate to the Independent Inquiry, despite the fact that it is clear from HSG(94)27 that an Independent Inquiry would be set up in view of the fact that a homicide had occurred.

5.2 Independent Inquiry

5.2.1 This Inquiry was given the Terms of Reference used by the Inquiry into the Treatment and Care of Raymond Sinclair and we adopted the same procedures as that earlier Inquiry.

5.2.2 We had the benefit of professional input and advice which allowed us to evaluate the evidence presented to us and to form our conclusions. In addition, we sought the opinion of an independent General Practitioner, nominated by the Royal College of General Practitioners. We had no powers to compel witnesses to give evidence, we did not meet in public and although witnesses were encouraged to bring legal representatives, there was no opportunity for these representatives to cross examine witnesses. We aimed to avoid unnecessary formality. The questioning was led by the most appropriate member of the team with other members able to participate as and when they considered necessary. The witnesses were not restricted to answering questions but were invited to raise any other matters they considered relevant.

5.2.3 Our aim throughout has been to identify failures in practices and procedures which should be corrected, rather than to apportion blame. Inevitably, an Inquiry such as this uncovers some failings in the performance of individuals in the carrying out of their professional responsibilities. Our conclusions should enable those individuals and their managers to identify how their performance might be improved for the future.

Comment:

5.2.4 We are aware that there is growing criticism of the number and style of inquiries of this nature. We concur with the view expressed in the Sinclair report that this is, in part, due to the fact that there are no recommendations or stipulations governing the conduct of such inquiries. We consider that the procedure which we followed was appropriate and effective; we commend it for use in further inquiries of this kind.

5.2.5 We believe that it is important that independent inquiries should continue. We concur with the views expressed by Adrian Grounds(4) that such an inquiry is important for the bereaved family, firstly so they can know what really happened and secondly so they can receive some assurance that measures will be taken to try to ensure that what happened to them will not happen to anyone else. Psychiatry needs inquiries in order to raise the profile and public understanding of mental health issues and as a lever for improvement and change. The public needs to understand the facts and to have confidence that failures in procedures and practices have been identified and highlighted for rectification by the appropriate authorities. An inquiry report may also be the vehicle for correcting unfair criticism of individuals that often characterise early press reports, as we believe happened in this case.

5.2.6 We are of the opinion that the relationship between Independent Inquiries and Inquests should be clarified so as to make it clear whether the report of the Independent Inquiry should be available to the Coroner before the Inquest is concluded, or the summoning of the Inquiry should be delayed until after the Coroner's verdict. In any event, we feel it is important that the Independent Inquiry should be established within three months of the event.

Chapter 6

6.0 Conclusions and Recommendations

6.0.1 We do not believe that the seriousness of this incident could have been predicted, particularly as there was no known history of mental illness; Gilbert's health deteriorated incredibly quickly. We do, however, believe that the tragic outcome was not inevitable.

6.0.2 One of the core functions of a Mental Health Service is to deal with psychiatric emergencies and to provide for the safe and effective admission to hospital of those patients who require this, where necessary, under the Mental Health Act. For a period of little over 48 hours the Croydon Mental Health Unit failed to do this for Gilbert, in spite of there being no dissent from the view that he was experiencing an acute psychotic episode, that he twice came to Woodcote Ward of his own volition and that the duty consultant had recognised him as presenting a danger to himself or others, particularly his mother.

6.0.3 We note the following comment by Dr John Reed(5) :-

'The importance of continuity of care and of staying in touch is a central lesson to be learned from recent inquiry reports'.

Although he was referring to reports concerning patients in contact with services over a long period, the same principles apply equally in the case of short period of contact such as that of Gilbert.

6.0.4 We were asked to investigate:-

- All the circumstances surrounding the treatment and care of Gilbert Kopernik-Steckel, including the quality and scope of his assessments, the appropriateness of his treatment, care and supervision, the professional and in-service training of those involved in the provision of services to him, and the quality of and adherence to his care plans;
- The adequacy of the collaboration and communication between all of the agencies involved and between those agencies and Gilbert's family;
- The extent to which the internal inquiry undertaken by the Bethlem and Maudsley NHS Trust met the requirements of HSG(94)27.

6.0.5 Our findings indicate that there were considerable failings in all of these areas. In particular, we have grave concerns regarding:-

- the process of the initial assessment and the comprehensiveness of subsequent assessments;
- the training of some of those involved;
- the poor quality of and adherence to any kind of a clinical management plan;
- the lack of understanding of and adherence to basic procedures.

6.0.6 We discovered an overwhelming failure in communications, within and between agencies and with the family both during and after the event. There was evidence of a culture lacking in mutual professional respect and co-operation. Services appeared to us to work in isolation and there was little evidence of effective team working within and between agencies.

6.0.7 One of the independent witnesses told us:-

'The reality of my experience was that it was much more to do with how individual people responded to or took responsibility for certain situations. I am concerned for somehow improving institutional culture within services by which they actually see each other as colleagues. One of the things I learnt in the aftermath was that the police have a very low opinion of social services. There is no professional mutual respect between the various bodies involved'.

Our findings support this view entirely; we can only agree.

6.0.8 We recognise that services are under considerable pressure and that individuals face overwhelming demands on their time and conflicting priorities. We heard a lot from the Trust about lack of resources. This is adequately illustrated by the poor quality of the environment of Woodcote Ward which must have a detrimental effect on the morale and recruitment of staff. In this context, it is essential that the most effective and efficient use is made of the resources that are available.

6.0.9 Whilst acknowledging the reality of these resource problems, our findings lead us to conclude that, in this case, the failings were primarily about procedures, professional practice and communications. Unless these basic problems are addressed by management at all levels, we can have no confidence that an allocation of additional resources would, of itself, prevent a further tragedy. For example, we learned that, since the medical staff review, a new junior doctor has been appointed but there has been no change in the on-call arrangements whereby one doctor covers Accident and Emergency at Mayday and Woodcote Ward. This in turn fails to allow adequate time for handovers involving junior medical staff at weekends.

6.0.10 The evidence presented to us indicates that, whilst there has been considerable activity at senior management level, there has been little change in culture and practice on the ground since the event. Our major concern is that, if history were to repeat itself, the outcome today could be no different. Our findings about the quality of services available to Gilbert suggest that failings in the treatment and care provided to him prevail elsewhere in the services for mentally ill people in Croydon. Our recommendations need to be implemented across all of those services in order to improve conditions for other patients. We urge all the agencies concerned to take our findings seriously.

Recommendations

6.0.11 The Inquiry's recommendations 1-9 are directed principally to the Bethlem and Maudsley NHS Trust and the Croydon Health Authority although it is likely that these recommendations will have application throughout the country, particularly in relation to mental health policies, procedures and staff training.

1. **The Trust should be proactive in ensuring that all junior medical and nursing staff have their training needs properly identified, that they receive continuing and specific training which is appropriate for their roles and responsibilities, that they are given regular and recorded supervision and have access to advice and support from a superior at all times. Specific attention should be given to:-**

   - **basic policies and procedures relating to discharge, absconding, the assessment and management of risk, control and restraint;**
   - **assessment, note taking and care planning, with particular attention to the team approach and of involvement of the patient and the family, if appropriate;**
   - **handover and briefing procedures within and between medical and nursing teams;**
   - **provision and availability of written information, for example a handbook for junior doctors;**
   - **opportunities for joint training with other agencies, including GPs and approved social workers.**

   We would commend the use of this report as case study for training and development purposes.

2. **The Trust should ensure that the medical and nursing notes are amalgamated and that they are organised in a way which makes it easy to access essential details.**

3. **The accountability, roles and responsibilities of medical and nursing staff should be reviewed and clarified.**

4. **Measures should be introduced to record, audit and explore the reasons for and prevent the high level of absconding from Woodcote and other psychiatric wards.**

5. **The Trust should review arrangements for out of hours and weekend psychiatric services, in particular ensuring that:-**

   - **consultant cover is appropriate to the specialty;**
   - **conflicting demands on junior doctors to cover the Accident and Emergency Department while on duty on Woodcote Ward are reduced;**
   - **the roles of the Crisis Team, weekend community psychiatric nursing team and the telephone Crisis Line are clarified and disseminated to users;**
   - **staff have adequate training and experience in psychiatry, commensurate with their assigned duties.**

   Regular monitoring, auditing and review should be built into the culture of the organisations. Senior management should not assume that changes have been implemented effectively and that practice has improved.

6. **The Trust and the Croydon Health Authority should review the use of Woodcote Ward; preferably, it should be used only for patients who are unlikely to present severe behavioural problems. Ways of improving the physical environment in the short term should be considered urgently, pending the implementation of longer term plans.**

7. **The Trust and Croydon Health Authority should build on the promising work undertaken on bed utilisation and continue to look at the most effective use of available resources, including skill mix, particularly in relation to:-**

   - **consultant cover and rotas;**
   - **admission procedures to psychiatric services and the role of junior doctors in this;**
   - **the impact of absconding on bed availability;**
   - **psychiatric cover for the Accident and Emergency Department;**
   - **the telephone helpline.**

8. **Croydon Health Authority should ensure that psychiatric service providers have in place demonstrable measures of quality, possibly through the use of external tools such as Charter Mark, ISO 9001 and/or Investors in People.**

9. **The Trust should rewrite its Procedure for Untoward Incident Inquiries as a management review procedure, in line with the recommendations of HSG(94)27 in order to avoid the delays and confusion which occurred in this case.**

6.0.12 Recommendations 10-14 are primarily directed to the Bethlem and Maudsley NHS Trust, the Croydon Health Authority and the Croydon Borough Council. They are likely to have resonances nationally as they focus particularly on communications and improving inter-agency collaboration.

10. **Measures should be introduced to improve communication and co-operation through joint agency, multi-disciplinary team building which includes the consultants, local GPs, hospital and community health and social services staff. This could be expedited by implementation of the proposals to co-locate health and social services mental health teams together in area based resource centres, an issue which should be addressed as soon as possible.**

11. **Local guidelines for assessment under the Mental Health Act should be jointly developed and implemented. These guidelines should spell out the roles of all those involved and should be monitored and audited regularly. A shared understanding of risk assessment within and between different service settings should be developed.**

12. **The process which should be followed to ensure that a patient gives informed consent to voluntary admission should be clarified and agreed between agencies. The implications for the process of compulsory admission should be elucidated.**

13. **The Chief Executives of Croydon Health Authority, the Bethlem and Maudsley Trust, Croydon Borough Council and the Assistant Commissioner of the Metropolitan Police should meet to work out a programme aimed at improving relationships and developing understanding and co-operation between their agencies at all levels. Particular attention should be focused on developing an understanding of each agency's responsibilities to victims of serious incidents and of agreeing appropriate ways forward.**

14. **A joint local action plan should be developed from these recommendations, which should be regularly reviewed and monitored at Board/Authority level by the local agencies.**

6.0.13 Recommendations 15-17 are directed to the National Health Service Executive, the Mental Health Act Commissioners and the Social Services Inspectorate.

15. **This report should be sent to the Mental Health Act Commission, the Social Services Inspectorate and the Regional Office of the NHSE and monitored by those listed above during their routine visits. The Mental Health Act Commission should produce advice on the use of statements such as 'For Section 5(2) if he tries to leave', instructions from one clinician to another which are considered by many medical and nursing staff to override professional judgement.**

16. **In order that lessons may be learned from the substantial body of inquiry reports, reports of this and all similar inquiries should be sent to the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. This body should prepare and widely disseminate summaries of the key findings and recommendations.**

17. **The Department of Health and the Home Office should be asked to develop nationally agreed procedures for the handling of inquiries in order to clarify the relationship between independent inquiries and inquests.**

References

1. *The Report of the Inquiry into the Care and Treatment of Christopher Clunis,* HMSO, February 1994.

2. *Report of the Inquiry into the Treatment and Care of Raymond Sinclair,* West Kent Health Authority, June 1996.

3. *Role of Approved Social Worker ASW Assessment Procedures,* Director of Social Services, Cheshire County Council.

4. Grounds, A., Commentary on *"Inquiries: who needs them?",* Psychiatric Bulletin (1997), 21, 134-135.

5. Reed, J., *Risk Assessment and clinical risk management: the lessons from recent Inquiries,* British Journal of Psychiatry (1997) 170 (suppl. 32), 4-7.

Appendix A

CROYDON HEALTH AUTHORITY

GILBERT KOPERNIK-STECKEL -
INDEPENDENT INQUIRY TERMS OF REFERENCE

1. To examine all the circumstances surrounding the treatment and care of Gilbert Kopernik-Steckel, in particular:

1.1 the quality and scope of his health, social care and risk assessments;

1.2 the appropriateness of his treatment, care and supervision in respect of:

1.2.1 his assessed health and social care needs;

1.2.2 his assessed risk of potential harm to himself and others;

1.2.3 his psychiatric history;

1.4 the professional and in-service training of those involved in the care of Gilbert Kopernik-Steckel, and/or in the provision of services to him;

1.5 the extent to which Gilbert Kopernik-Steckel's care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health, and local operational policies;

1.6 the extent to which Gilbert Kopernik-Steckel's care plans were:

1.6.1 effectively drawn up;

1.6.2 delivered;

1.6.3 complied with;

2. To examine the adequacy of the collaboration and communication between;

2.1 the Bethlem and Maudsley NHS Trust, Croydon Social Services Department, Gilbert Kopernik-Steckel's General Practitioner, and any other agencies who were, or might appropriately have been, involved in the care of Gilbert Kopernik-Steckel or the provision of services to him;

2.2 the relevant agencies and Gilbert Kopernik-Steckel's family;

3. To consider the extent to which the internal inquiry undertaken by the Bethlem and Maudsley Trust met the requirements of HSG(94)27.

4. To prepare a report and make recommendations to Croydon Health Authority.

Appendix B

CROYDON HEALTH AUTHORITY

GILBERT KOPERNIK-STECKEL -
PROCEDURE FOR INDEPENDENT INQUIRY

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

1.1 of the terms of reference and the procedure adopted by the Inquiry;

1.2 of the areas and matters to be covered with them;

1.3 requesting them to provide written statements to form the basis of their evidence to the Inquiry;

1.4 that when they give oral evidence they may raise any other matter they wish, and which they feel might be relevant to the Inquiry;

1.5 that they may bring with them a friend or relative, member of a trades union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness;

1.6 that it is the witness who will be asked questions and be expected to answer;

1.7 that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact will be asked to confirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

4. Written representations may be invited from expert witnesses regarding best practice for persons in similar circumstances to Gilbert Kopernik-Steckel and for any recommendations they may have for the future. These witnesses may be asked to give oral evidence about their views and recommendations.

5. Anyone else who feels they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

6. All sitting of the Inquiry will be held in private.

7. The findings of the Inquiry and any recommendations will be made public.

8. The evidence which is submitted to the Inquiry orally or in writing will not be made public by the Inquiry, save as it is disclosed within the body of the Inquiry's final Report.

9. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.

Appendix C

LIST OF WITNESSES CALLED

Name	Position	Accompanied by
Adeboyeku, Mrs L	Team Manager, SSD	Mrs M. Stantiall
Barnett, Mrs D	Medical Secretary, B&M NHS Trust	Mr Barnett
Beale, Mr M	Friend of Gilbert Kopernik-Steckel	
Byers, Mr E	Chief Executive, B&M NHS Trust	
Cordell, Mrs H	Receptionist, Dr Heyer's practice	
Croft, Mrs M	Vice-Chair of the Trust Board	
Donahue, Dr E	Registrar, B&M NHS Trust	Dr S. Bown
Hanafin, Mr T	Chief Executive, CHA	
Hellicar, Mrs J	Receptionist, Dr Heyer's practice	Ms. C. Wilson
Heyer, Dr E	General Practitioner	Ms. C. Wilson
Hill, Mr S	MH Purchasing Manager, SSD	
Holt, Dr N	SHO, B&M NHS Trust	
Kopernik-Steckel, Ms C	Sister of Gilbert Kopernik-Steckel	
Kopernik-Steckel, Ms J	Sister of Gilbert Kopernik-Steckel	
Kopernik-Steckel, Mr K	Father of Gilbert Kopernik-Steckel	
Phipp, Mrs B	Team Manager, SSD	Mr M. Fletcher
Timehin, Dr C	Registrar, B&M NHS Trust	
Townsend, Mr D	Director of Social Services	
Thompson, Mr S	Deputy Charge Nurse, B&M NHS Trust	
Wilkinson, Ms T	General Manager, B&M NHS Trust	

Written statements were received from DI James Mould, WPC Ann Bell and WPC Pamela Bell, all of the Metropolitan Police; Ms Sandra Wilkinson, RMN, B&M NHS Trust; Mr W Ford, of 58 Cypress Road.

Appendix D

Letter to Witnesses

INDEPENDENT INQUIRY
ESTABLISHED BY CROYDON HEALTH AUTHORITY

Dear

Independent Inquiry into the Care and Treatment of Gilbert Kopernik-Steckel

Request for Evidence from Witnesses

The Croydon Health Authority has set up this Inquiry. The members of the Inquiry Committee are Mr Jeffrey Greenwell (Chairman), a solicitor and former Chief Executive of Northamptonshire County Council, Dr Andrew Procter, a Consultant Psychiatrist and Clinical Manager at Manchester Healthcare NHS Trust, Ms Adrianne Jones, a former Director of Social Services. I have been appointed Clerk to the Inquiry.

Copies of the Terms of Reference and of the Procedure adopted for the Inquiry are attached for your information.

Members of the Inquiry have been supplied with the confidential Final Report of the Health and Social Services Joint Inquiry into the Care and Treatment of Gilbert Kopernik-Steckel, the transcript of the Inquests held on January 18th 1996 and 24th September 1996 and other relevant documents. From their initial examination of these reports, the Inquiry team considers that you have relevant evidence to give to the Inquiry. We would therefore request you to attend a Hearing on in order to provide oral evidence. If however, this is not possible, could you please indicate other dates when you would be able to attend on the list enclosed herewith and return this to me as soon as possible. Your reasonable travel expenses and subsistence costs arising from your attendance at the Inquiry will be reimbursed. The Hearings will be held at the Croydon Park Hotel, Altyre Road, Croydon.

When giving this evidence you may be accompanied by a friend or relative, trade union representative, lawyer or member of a defence organisation, or anyone else with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. Your oral evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign and return.

In order to shorten the time on oral evidence, and to help clarify issues before the Hearing, we would ask you to provide a written statement in advance. This should set out and provide a commentary upon your involvement with Gilbert Kopernik-Steckel, including the reasons for your contact with him. In particular, please describe your involvement in his treatment and care in the period from Thursday 11th January 1996 to Sunday 14th January 1996. In addition, you will have a full opportunity at the Hearing to raise any matter you wish and which you feel might be relevant to the Inquiry.

I would be grateful if your written statement could reach me as soon as possible and in any event not less than 5 days before the time you are due to attend the Hearing.

We would like to thank you for your co-operation and assistance. If there is any matter in addition to the above on which I can give further explanation, please let me know.

I look forward to receiving your statement and details of the dates when you will be available to attend a Hearing of the Inquiry,

Yours sincerely

Janet Dickson (Mrs)
Clerk to the Inquiry

Appendix E

Letter to Dr R. Lawrence

INDEPENDENT INQUIRY
ESTABLISHED BY CROYDON HEALTH AUTHORITY

Dr Robert M. Lawrence

Consultant Psychiatrist

6th February 1997

Dear Dr Lawrence

Independent Inquiry Established by Croydon Health Authority

As you know from Mrs Mehta's letter of 27th January 1997 the Croydon Health Authority have appointed an independent panel to examine all the circumstances surrounding the treatment and care of Gilbert Kopernik-Steckel. The panel consists of Dr Andrew Procter, consultant psychiatrist at Manchester Royal Infirmary, Adrianne Jones, former Director of Social Services for Birmingham and myself, former Chief Executive of Northamptonshire County Council.

Mrs Mehta has given me a copy of your letter to her of 30th January 1997 in which you decline the invitation to participate in the independent inquiry. I am writing, as chairman of the inquiry, to ask you to re-consider your decision. We have received the report of the internal inquiry by the Trust Board and the transcript of the Coroner's Inquest into the deaths of Gilbert and his mother. In order to consider making findings of fact and our recommendations to the Croydon Health Authority we do need to have both written and oral evidence from those who were directly concerned in these tragic events. A number of others have agreed to give evidence and it would be unfortunate if we did not have the opportunity of receiving your account of your involvement.

The inquiry has no powers to compel anyone to appear and therefore will have to come to its findings on the basis of the information available and the evidence of those who do appear. We have no means of knowing at this stage what other witnesses are going to say but there is a possibility that they may give an account which is at variance with your re-collection of events and it seems only fair that in these circumstances you should have an opportunity to rebut their evidence.

If you stand by your decision not to submit evidence, the inquiry will have to base its finding on the evidence of those who appear before us and we may have to reach findings about your involvement in the case based on what others have to tell us. May I urge you to reconsider your decision. I would emphasise that I and my colleagues are entirely independent of the Croydon Health Authority and that our duty is to receive evidence, record our findings and to submit recommendations to the Health Authority. If you have appointed a solicitor to advise you, please show this letter to your solicitor and take his/her advice as to how to respond.

I enclose a copy of our Terms of Reference and Procedure for your information. The clerk to the Inquiry is Mrs Janet Dickson. If you change your mind and would like to submit evidence, please let Mrs Dickson know. We look forward to hearing from you.

Yours sincerely,

Jeffrey Greenwell
Chairman

Enc.: Terms of Reference
Procedure

cc Mrs J. Dickson

Appendix F

THE BETHLEM & MAUDSLEY NHS TRUST

PROCEDURE FOR UNTOWARD INCIDENT INQUIRIES

1. Introduction

Untoward and unexpected incidents occur when treating psychiatric patients in hospital or the community. To gain a greater understanding of how and when these incidents take place, the Bethlem & Maudsley NHS Trust routinely carries out inquiries into incidents which involve patients of the Trust. The purpose of these inquiries is to examine objectively the events surrounding the incident and to highlight areas of practice which should be clarified or reconsidered.

2. Incidents leading to inquiries

Inquiries will automatically be held into all incidents of suicide or unexpected deaths of current inpatients and recently discharged patients, and suicides of recent outpatients, if the Trust is informed of the death.

Inquiries may also be held into incidents of sexual assault, parasuicide or serious violence, if they fall into one or more of the following categories:

i. the incident is felt to be of a serious nature by the Consultant, Ward Manager or Quality and Audit Manager; AND
ii. the incident has implications for the whole organisation; OR
iii. the police have been involved; OR
iv. there is believed to have been a major breakdown of established procedures.

Such incidents will be reported to the Quality and Audit Strategy Group for decision. Where an untoward incident inquiry is not considered to be appropriate an audit investigation may be held into the incident.

3. Prior to the Inquiry

The Quality Assurance Officer will co-ordinate convening the inquiry. All relevant staff will be asked to make written statements. These must be typed, signed and dated.

The notes of all patients involved in the incident must be made available to the Quality Assurance Officer so that a detailed summary of the event can be compiled and relevant parts of the notes photocopied. If necessary the notes will be collected from and returned to the ward at agreed times.

4. The inquiry panel

The panel consists of a non-executive Trust member, a Consultant and a Senior Nurse. The Quality Assurance Officer will also be in attendance.

5. The inquiry

The inquiry will normally last for two hours including an hour interviewing relevant members of staff. Those staff members who are asked to attend **must** do so and will normally be given two weeks notice.

In general the following will be expected to attend:

- The consultant in charge of the patient
- The ward manager (if the patient is an inpatient)

- The primary nurse or CPN
- The senior nurse in charge of the ward at the time of the incident (for inpatients)
- Any other staff who were involved in the incident or who the panel feel can shed light on the incident

Staff may be interviewed singularly or with other members of staff at the discretion of the panel.

6. After the inquiry

After the inquiry a report is produced which will include any recommendations made by the panel. This report will be sent to:

- the inquiry panel, for information
- the relevant consultant and ward manager, for information/action
- the Quality & Audit Strategy Group, for information/action
- all Directorate Managers, for information/action
- the Head of Nursing Practice, for information/action
- the Trust Board, for information

A summary of the recommendations will also be circulated to relevant parties at the discretion of the panel chair.

All reports and summaries will be anonymised.

A database of recommendations and actions will be maintained by the Quality Assurance Officer and these will be reported, by the Director of Quality, on a six-monthly basis to the Trust Board.