Report of the

Independent Inquiry into the

Care and Treatment of

Mr Gregory Marden

January 2003

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1 PANEL MEMBERSHIP

Mr Derek Holwill
Barrister and Chairman of the Inquiry Panel.

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Healthcare Consultant.

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Consultant Psychiatrist.

2 ACKNOWLEDGEMENTS

We would like to thank everyone who gave up time to give evidence to the Inquiry Panel and who spoke so freely to us. All of the witnesses who gave evidence to the Inquiry Panel are listed in Appendix 1 to this Report. We would also like to acknowledge the co-operation of the police whose assistance has been valuable in helping the Inquiry Panel to complete its task.

We would also like to take this opportunity to convey our condolences to the Marden family and their friends. We hope that this Inquiry, and the time delay in setting it up, has not added to their distress.

We would also like to thank Mrs Sue Hebden who managed the Inquiry for us with great diligence; as well as looking after all of our needs, whilst we took evidence at the Princess Marina Hospital in Northampton.

3 TERMS OF REFERENCE

This Inquiry's Purpose and Terms of Reference were specified by the Northamptonshire Health Authority and Northamptonshire Social Services and are as follows:

"Purpose of the Inquiry

- To enable any lessons to be learned which may help reduce the possibility of other such tragic events happening.
- To enable any lessons to be learned which may help improve the reporting and appropriate investigation of similarly serious events.

Terms of Reference

1. To examine all circumstances surrounding the assessment of mental health state, treatment and care of Mr Gregory Marden from the NHS and Social Services between around February 1998, when he moved to Northamptonshire to May 1999, the month in which he committed the homicide of his father.

   This should include:
   - The quality and scope of the identification of Mr Gregory Marden's mental health needs.
   - the suitability of Mr Gregory Marden's treatment, care and supervision in the context of:
     - his actual and assessed health and social care needs;
     - his actual and assessed risk of potential harm to himself or others;
     - the history of any medication and compliance with that medication;
     - any previous psychiatric history, including any alcohol and drug misuse;
     - any forensic history.
   - The extent to which Mr Gregory Marden's care complied with statutory obligations, the Mental Health Act Code of Practice, local operational policies, and relevant guidance from the Department of Health (including the Care Programme Approach (HC(90)23/LASSL(90)11), the guidelines on Supervision Registers (HSG(94)5), and discharge

planning and continuing care in the community (HSG(94)27)).

- The extent to which Mr Gregory Marden's prescribed treatment and care plans were:
  - adequate
  - timely
  - documented
  - agreed with him
  - made known to others as necessary
  - carried out
  - complied with by Mr Gregory Marden.

2. To consider the adequacy of the transfer of Mr Gregory Marden's care from services in Kent to those in Northamptonshire.

3. To consider the adequacy of the services available to meet Mr Gregory Marden's needs and the extent these were accessed appropriately, in particular:-

   - The adequacy of the risk assessment training of all staff involved in Mr Gregory Marden's care.
   - The adequacy of the identification of mental disorder in Mr Gregory Marden by primary care and the response by primary care to any identified mental disorder.
   - The adequacy of the collaboration between primary care and secondary care to identify and meet Mr Gregory Marden's needs.
   - Whether the best and most appropriate use of existing secondary psychiatric services was sought by Mr Gregory Marden's GP and accessed/provided by his Consultant Psychiatrist.
   - The extent to which Mr Gregory Marden and his family were sufficiently engaged in the planning of his care.
   - The adequacy of the range and scope of secondary psychiatric services available to meet Mr Gregory Marden's health and social care needs, and the extent to which these were accessible and integrated, and therefore effective in enabling an appropriate response to be obtained, including outside of normal working hours.

4. To consider the adequacy of the support given to Mr Gregory Marden's family by the Community Mental Health

Team and other professionals, following the tragic events of May 1999.

5. To consider issues relating to the appropriate, timely and effective communication of information between agencies and professionals, in particular:

- The reporting of the tragic events of May 1999 to the Trust Executive and the Trust Board.
- The reporting of the conclusions and recommendations of the Trust internal inquiry to the Trust Board and to the Health Authority.
- The monitoring of the implementation of agreed actions.
- Ensuring Mr Gregory Marden's family were kept informed of outcomes and progress.
- The reasons for the delay in convening the independent inquiry into the homicide of Mr Gregory Marden's father.
- The respective and ongoing responsibilities of secondary and tertiary psychiatric services to obtain, provide and appropriately communicate information relating to the change in Mr Gregory Marden's status under the 1983 Mental Health Act.

6. To consider such other matters of relevance that arise out of the above.

7. To prepare a report and to make recommendations to Northamptonshire Health Authority and Northamptonshire Social Services, in respect of any significant deficiencies identified in respect of the above. Any such recommendations to be for the action of Northamptonshire Health Authority, Northamptonshire Healthcare NHS Trust, Northamptonshire Social Care and Health (Social Services), Primary Care Groups and Trusts, as appropriate."

4 INTRODUCTION

4.1. On 3.5.99, Gregory Marden assaulted his father, Mr Richard Marden, hitting him over the head with a gas canister. Mr Marden died of his injuries some three weeks later on 24.5.99. Mr Richard Marden is referred to throughout this Report as "Mr Marden"; and Gregory Marden is referred to as "Greg", the name used by his friends and family.

4.2. On 20.8.99, Greg was convicted of manslaughter on the basis of diminished responsibility and he is at present an in-patient at the local Regional Secure Unit.

4.3. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness defines a "Mental Illness Homicide" as one where the person convicted *"had symptoms of mental illness at the time of the offence."* From the evidence that the Inquiry Panel has heard there is no doubt but that this homicide was a "Mental Illness Homicide" within this definition.

4.4. This Independent Inquiry has been commissioned pursuant to HSG(94)27 which provides that, where there has been a homicide by a patient of the mental health services, it is necessary to hold an inquiry independent of the providers involved. In this instance, there has, regrettably, been considerable delay in setting up this Inquiry. The Inquiry Panel was formally commissioned by the Northamptonshire Health Authority and Northamptonshire Social Services only in July 2001. This delay, mentioned in the Terms of Reference, has inevitably made it more difficult for witnesses accurately to recall the relevant events; and, as the Terms of Reference make clear, one of the issues to be considered in this Report is the reason why such delay has occurred.

5 MENTAL HEALTH SERVICES IN NORTHAMPTONSHIRE

5.1. At the time of the incident, Northampton Community Healthcare NHS Trust ("NCHT") covered the county town of Northampton and the general area of south Northamptonshire. Rockingham Forest NHS Trust covered the north of the county with Northamptonshire Health Authority ("the Health Authority") having responsibility for the whole of the two areas. On 1 April 2001, the position changed with the areas formerly covered by NCHT and Rockingham Forest NHS Trust being covered by a single trust, Northamptonshire Healthcare NHS Trust ("the Trust"). In April 2002, as in other parts of the country, the Health Authority was replaced by a new Strategic Health Authority, Leicestershire, Northamptonshire and Rutland Strategic Health Authority, and by Primary Care Trusts.

5.2. The main centre of population for NCHT was the county town of Northampton. There were 3 Community Mental Health Teams ("CMHTs") covering the town with one CMHT covering Daventry and South Northamptonshire, initially including Brackley. This CMHT was sub-divided into two, with bases at Towcester and Daventry. Its area had boundaries with Trusts in 5 other areas, namely Leicestershire, Warwickshire, Milton Keynes, Oxfordshire and Buckinghamshire. It also had borders with the Northampton section of NCHT and Rockingham Forest Trust. There was a lack of co-terminosity between Health and Social Service provision in the south and the area around Brackley. Services in the Brackley area later became provided by the mental health services in Oxfordshire, although Northamptonshire Social Services still covered this area, as did NCHT for services for older people with mental illness. The Daventry CMHT had users with GPs in Leicestershire, Warwickshire and Oxfordshire.

5.3. The population of Northamptonshire was approximately 600,000, although some of this number fell outside the services of the county. The three CMHTs in Northampton covered a population of approximately 216,000 and the Daventry and South Northants CMHT had a catchment area of approximately 67,000.

5.4. Northamptonshire, on the York Index of psychiatric need, has a low score when compared to the rest of England and Wales, with Northampton town scoring above and Daventry below the county average level of deprivation.

5.5. Local Statutory Services for people with mental health problems were as follows:

- Primary care. At the time of this incident, GPs had links with Community Psychiatric Nurses ("CPNs") through the CMHTs. It is understood that there was counselling available in some practices.

- The four CMHTs referred to above were funded jointly by Social Services and the Trust. They served people with enduring mental health problems. Two of the CMHT leaders were Trust staff and two were from Social Services, reporting respectively to their Trust manager and their Social Services manager.

- NCHT provided a Crisis Intervention Service, 24 hours per day, 7 days a week.

Inpatient Services:

- Acute beds 77
  These were allocated as follows:

I.C.U.	7	
Pendered East		23
Pendered South		21
Pendered West		26

  All patients were under the care of their own consultant psychiatrist from each area.

- Continuing Care 36
  These were all at Princess Marina Hospital.

- Day Hospitals
  Upton House, Northampton - open 5 days a week
  Haddon House, Daventry - adult acute patients 3 days a week

Other "rehabilitation" day services were provided and MIND also provided services across the county.

- St Andrew's (private hospital)
  St Andrew's is a private hospital and is a major provider of mental health services, with 451 beds on its Northampton site. Patients from all over the country receive a range of specialist care which is provided through private health insurance and via NHS service agreements and spot-purchasing, including providing a temporary "overspill" facility when the Northamptonshire Trusts do not have the capacity to take new admissions. St Andrew's estimates that around 13% of all its admissions come from Northamptonshire. A number of its patients are discharged into Northamptonshire, with one CMHT recording a total of 16 patients discharged into their team over the past 5 years. This inevitably adds to the burden on local service providers.

- Services for Mentally Disordered Offenders: There were no forensic services provided within the county by the two Northamptonshire Trusts, but there was a contract for a number of beds with a Regional Secure Unit in a neighbouring county.

6 THE EVENTS

Greg's Family Background

6.1. Greg was born on 8.11.72, the youngest of five children. He has one sister, Linda, and three brothers. His birth and early development have been described as unremarkable although he is said to have always been very shy as a child, with that shyness continuing into adult life.

6.2. Greg's father, Mr Marden, had been in the British Army for many years. On leaving the army in 1969, he managed a public house, but the business failed some time before Greg's birth. Mr Marden then worked in a variety of jobs. Although there are references in the documentation which the Inquiry Panel has seen to Mr Marden being a heavy drinker, resulting in friction and unhappiness at home, Greg did not experience any physical violence or abuse from him. In more recent years, Mr Marden had stopped drinking and family relationships had improved significantly. Indeed, when Greg left school at the age of 16 he went to work with his father, cleaning the boards at the top of oast houses.

6.3. Greg did not do well at school. He found it difficult to make friends. He resented school discipline, was generally unhappy and truanted as he got older. There is some reference in the medical records to Greg having been the victim of sexual abuse on one occasion by a teacher at school.

6.4. Greg has had difficulty in establishing and sustaining relationships with women. He has had homosexual experiences and considers that he may be bisexual. Greg has made it clear that, although at the time of the assault upon Mr Marden, he had a delusional belief that he had been abused by his father, there was in fact no such history.

6.5. Greg left school without any formal qualifications. His subsequent work record was poor. He started to drink at an early age, but describes himself as only a moderate social drinker. He started taking drugs when he was 16 or 17 years old, beginning with cannabis which he used in increasing amounts. As he got older, he experimented with

amphetamines, magic mushrooms and occasionally LSD.

6.6. Two of Greg's brothers suffer from mental disorder. One, who now lives in Ireland, is described as having a severe neurosis. An older brother, who is referred to throughout this report as "LM", suffers from schizophrenia and has been admitted as an in-patient on several occasions. LM was at all of the times which are material for the purposes of this Inquiry, a patient under the care of the mental health services in South Northamptonshire.

6.7. Greg's sister, Linda, is married to Oliver Low. Both gave evidence to this Inquiry. They live in Towcester and were, prior to Greg's assault upon Mr Marden, actively involved in helping with the care of LM. Since the assault and its aftermath, they have been less willing to take so much responsibility and have understandably taken the view that the care of LM should now be left to the mental health services.

6.8. During the time that Greg was in the Northampton area, Mr and Mrs Low saw a good deal of Greg. Mrs Low has said that when he first moved to the area, he was withdrawn and depressed. Although this improved a little as time passed, he remained a quiet person, who did not enjoy small talk or socialising. Mrs Low described herself, in her statement to the police after the assault, as Greg's "best friend". However, both she and Mr Low said that Greg was a difficult person to read.

7 Greg's Contacts with the Mental Health Services

7.1. Greg's first contact with mental health services took place in Kent on 1.12.97. Greg had spent some time in Amsterdam, and shortly after his return, he attended upon his GP, at that time a Dr Davies, complaining of auditory and visual hallucinations. Dr Davies referred him to the Priority House Mental Health Unit (Invicta Community Care NHS Trust) in Maidstone, Kent, where Greg was quickly admitted as a voluntary in-patient.

7.2. Greg gave a history of two months of auditory and visual hallucinations. His presenting complaints are conveniently

set out in the Discharge Summary dated 14.1.98 prepared by a Dr Fafiolu, Senior House Officer to Dr Sivakumar, the Consultant Psychiatrist who had care of Greg during his admission:

> "For the past 2 months he has been seeing and hearing things on and off and he kept falling in love with everybody but was unsure if anyone really loves him. He had a girlfriend ... and he has been seeing her face changing shape in the mirror. He was preoccupied with the fact that he might have AIDS but does not know why, although [he] admitted to being bisexual. His sleep pattern had been poor. He was not eating very well and had lost some weight although he could not say how much weight he had lost. He was noted by his parents to have been behaving very strangely in the last week before admission. He was keeping more to himself and on the day of admission he became very agitated and smashed some kitchen windows in his parents' house. His illness might have been precipitated by the loss of a friend who was killed on the railway line a month ago. Another friend's mother died a week before admission from multiple sclerosis."

7.3. Greg was noted on admission to be clean and tidy but withdrawn and slightly suspicious. His speech was described as hesitant and tangential. His mood was described as flat although subjectively he said he felt happy.

7.4. Later he became distressed and disturbed and he was given diazepam. However, he continued to be agitated and aggressive, at one point smashing a window on the ward. He was at this point re-classified from voluntary status and was held under section 5(2) of the Mental Health Act 1983 as he was considered a danger to himself and others. An intramuscular acuphase injection was given together with lorazepam.

7.5. He remained extensively disturbed with bizarre behaviour. On one occasion it was reported that he tried to dive head first out of a window. He also made several attempts to injure himself and was transferred to the Intensive Care Unit. Whilst in intensive care he went to the toilet and attempted to

smash his genitals with the toilet seat cover. When asked why, he said "I don't want them". In view of his incoherence, lack of insight and inability to give informed consent, and also because of the need for further assessment, the detention under section 5(2) was extended to detention under section 2 of the Mental Health Act 1983.

7.6. Greg gradually settled in the Intensive Care Unit. He was initially very drowsy, saying very little, although he did admit to one of the nursing staff that he had taken some ecstasy tablets. He also expressed concerns about his sexuality. He became preoccupied with thoughts of death and kept talking about the death of Diana, Princess of Wales. He admitted to auditory hallucinations and he was started on droperidol with haloperidol and lorazepam.

7.7. His condition gradually improved and the lorazepam was changed to diazepam. In due course the prescription of haloperidol was changed to sulpiride.

7.8. Greg continued to improve and he was allowed home leave. This went well and on 22.12.97 he was transferred back from the Intensive Care Unit to the open ward. However, on his return to the ward he began to suffer from paranoia again, saying that gypsies were after him. He was also very restless and tense and unable to sleep. The sulpiride was accordingly increased. Greg gradually settled and his insight improved. He had several further visits to his home which went well and at the time of his discharge on 14.1.98, some 6 weeks after his admission, he had, according to the discharge summary, a normal mental state with full insight. He was sleeping well and had a good appetite. His medication on discharge was sulpiride, procyclidine and zimovane.

7.9. An out-patient appointment was made for him for 23.1.98 and he was referred for follow up by a Keyworker at the Kingswood Community Mental Health Centre. A note was made that a representative of Social Services would investigate whether a social worker had already been allocated to Greg and arrangements were made for him to be assessed by a CPN.

7.10. On 23.1.98 Greg was seen as an out-patient by Dr Fafiolu, Dr Sivakumar's Senior House Officer. The notes record that Greg was feeling low in mood with a lack of motivation. His appetite was good but his sleep pattern had been reversed in the last week. He was noted on examination to being casual and unkempt in appearance with only moderate eye to eye contact. His speech was monosyllabic and his mood was described as low. Reference is made in the notes to suicidal thoughts but when asked, Greg stated that he had no suicide plan. There was no note of any delusions or hallucinations. Greg was started on paroxetine for depression, in addition to his other medication. A further appointment was made for him with Dr Sivakumar for 6.3.98.

7.11. In the event Greg did not attend any further appointment with the mental health services in Kent. By 23.2.98 it had been discovered by Invicta's mental health services that Greg had moved to Northamptonshire. He was accordingly discharged from the case load at the Kingswood Community Health Care Centre.

7.12. Comment:
Although no attempt was apparently made by Invicta's mental health services to contact the mental health services in Northamptonshire, it is difficult to see what steps could sensibly have been taken. In the event that Greg did not himself contact the mental health services in Northamptonshire, those services could not reasonably be expected to have known anything of Greg. For practical purposes, if a patient chooses to move from an area without leaving a forwarding address then, unless that patient subsequently contacts the mental health services in his new area, mental health services are dependent upon the patient registering with a new GP, so that details of his medical history can be communicated through the Primary Care system.

7.13. On moving to Towcester, Greg initially moved in with his parents. However, they were living in a bungalow which was provided as sheltered accommodation and Greg had to sleep on a sofa. After a period, Greg moved out and went to stay with his nephew, Mrs Low's elder son, Mr Trevor Atkinson.

7.14. Greg managed to obtain employment in the building trade shortly after his arrival in Towcester. He worked for a while with a Mr Steven Badger, a friend of Mr and Mrs Low. He later went to work with Mr Atkinson.

7.15. Although Greg managed to stay in work, he has been described (retrospectively) by family members as not being completely well during this period. Mr and Mrs Low were interviewed on 22.9.99 by a Ms Anne McWatt. Ms McWatt, who also gave evidence to the Inquiry panel, was the Trust's Client Relations Manager, and had been asked by the Trust to conduct an internal investigation into the events surrounding Greg's assault on Mr Marden. In the course of this interview, Mr and Mrs Low referred to Greg as having been "unnaturally quiet", feeling inadequate in relation to women and being unwilling to talk despite family encouragement. The Inquiry Panel was also told both by Greg and by Mr and Mrs Low in the course of their evidence to the Panel that Greg was very concerned about the possibility of being labelled as "a schizophrenic" because he did not want to see himself being considered to be the same as his brother LM.

7.16. On 26.2.98 Greg went to see a new General Practitioner, Dr Hooker, who gave evidence to the Inquiry Panel. Greg was registered as a new patient at Dr Hooker's practice, the Towcester Medical Centre - actually as a patient of one of Dr Hooker's colleagues there, Dr Sunderland, who also gave evidence to the Inquiry Panel.

7.17. Greg's history of mental health problems was duly recorded by Dr Hooker on this occasion. Greg had been given a copy of his discharge summary from Priority House Mental Health Unit at the time of discharge and he brought this with him to this appointment with Dr Hooker. Dr Hooker did not have Greg's primary care medical records which had still to be transferred from Kent.

7.18. Comment:
It was, in the view of this Inquiry Panel, very good practice for Priority House Mental Health Unit to have provided Greg with a copy of his discharge summary at the time of discharge.

7.19. Dr Hooker made note of the fact that Greg's brother, LM, had schizophrenia - LM was in fact registered as a patient with Dr Hooker's practice. Dr Hooker recorded that Greg told him that his medication was sulpiride and seroxat, but noted also that this was different from what was recorded on the discharge summary. In fact, as noted above, the prescription of seroxat (paroxetine) had been added on 23.1.98.

7.20. Dr Hooker noted that Greg seemed stable, but he nevertheless took steps to expedite the transfer of Greg's medical records from Kent. He prescribed Greg with the medication for which Greg asked, namely sulpiride 400mgs bd and seroxat 20mgs daily.

7.21. Greg told the Inquiry Panel that he found that the medication which he had been prescribed made him feel depressed and gave him impotence problems. He said that after perhaps no more than a month or two following the move from Kent, he stopped taking his medication. Greg also told the Inquiry Panel that, following the acute episode in Kent, he decided that he would not touch hard drugs again, but that he did begin to use cannabis again, initially about once every two weeks or so.

7.22. On 17.3.98, Dr Hooker arranged for Greg to be referred to a Consultant Psychiatrist. Dr Hooker's evidence was that he had not, by this time, received Greg's records from Kent - notwithstanding the request for expedition - but that by 17.3.98, he took the view that, even in the absence of those records, he should now refer Greg, using the information which he already had from Greg and from the copy of the discharge summary which Greg had provided.

7.23. Dr Hooker referred Greg to Dr Berry, a Consultant Psychiatrist in the South Northamptonshire sector of the Northampton NHS Trust since 1996. Dr Berry gave evidence to the Inquiry Panel.

7.24. Dr Hooker sent the discharge summary to Dr Berry with the request for an appointment for Greg. His referral letter of 17.3.98 stated:

"I would be grateful if you would send this man an out-patient appointment to be seen by you. This man has very recently moved into our area from Kent. He is now living at the same address as his brother [LM] who will be well known ... with a diagnosis of paranoid schizophrenia. Gregory had his first admission to a psychiatric hospital in Kent in December 1997 with the onset of paranoid schizophrenia. To assist you I enclose a photocopy of the hospital discharge summary. Gregory has now moved from Kent up to this area as has also his mother. When I saw Gregory recently he appeared to be stable, but no psychiatric arrangements had been made so far as we were both aware for his ongoing care. His current treatment according to the patient is sulpiride 400mg bd and seroxat 20mg 1 daily. I noted that the discharge summary from hospital also mentions the prescription of procyclidine 5mgs tds and zimovane 7.5mg at night but the patient apparently was taking neither of these two drugs. I am sure he will need some ongoing follow up in this area and I would be very grateful if you could see him with a view to arranging some suitable care plan".

7.25. **Comment:**
A total of 800 mgs of sulpiride per day is not a low dose. It is certainly more than a standard maintenance dose and could reasonably be seen as an indication of the seriousness with which Greg's condition had been regarded by Invicta's mental health services. Especially in the context of a recent hospital discharge, the prescription to Greg of this level of medication should have been an indication to the secondary services in Northamptonshire that there was a need for an early appointment.

7.26. Regrettably, there was, however, delay before an out-patient appointment was given to Greg. It is not clear when precisely the appointment was fixed but the letter notifying Greg of the appointment (a letter copied to Dr Hooker) was dated 18.5.98, some two months after Dr Hooker had requested the appointment. The appointment itself was for 10.6.98 - making it almost 3 months from Dr Hooker's request of 17.3.98.

7.27. Dr Berry's evidence to the Inquiry Panel was that he regarded this delay as surprisingly long - or at least at the limit of what was acceptable even for a non-urgent appointment - and in a subsequent letter to the Inquiry panel he has stated that he thinks that this delay was probably a result of pressures on his time, consequent upon his having responsibility at this time, not only for the South Northamptonshire sector, but also one third of the Daventry sector.

7.28. The Inquiry Panel also heard evidence from Dr O'Neill-Kerr, Consultant Psychiatrist, and, at the material times, a Clinical Director with NCHT. Dr O'Neill-Kerr was less surprised by the length of the delay in Greg's initial appointment with the secondary services.

7.29. Comment:
Although Dr Hooker's referral letter did not indicate that there was any immediate urgency about the need for an out-patient appointment, it was made clear that there were issues, including the type of medication which Greg was taking, which did need to be addressed. As commented above, the daily dose of 800mgs of sulpiride was an indication of the seriousness with which Greg's condition had been regarded by Invicta's mental health services. In these circumstances, it is surprising and somewhat concerning that, whatever the pressures on the service, it still took almost 3 months before the out-patient appointment asked for by Dr Hooker was given.

Furthermore, in the absence of any communication at all from the hospital - even an acknowledgement of receipt of the referral letter - prior to 18.5.98, Dr Hooker would not have known whether the delay was merely administrative, or whether his referral letter had, perhaps, gone astray.

7.30. Dr Berry's appointment letter of 18.5.98 was sent to Greg at the address of his sister, Mrs Low, and it asked Greg to attend the appointment on 10.6.98. Mrs Low confirmed that she passed all mail on to Greg on a regular basis, and Greg did not suggest in his evidence to the Inquiry Panel that he

had not received this letter. He did not, however, attend the out-patient appointment on 10.6.98. He told the Inquiry Panel that he was not purposely avoiding seeing Dr Berry, but that he had just not got around to attending the appointment.

7.31. Following Greg's non-attendance on 10.6.98, Dr Berry's notes record that he telephoned Greg's GP, but that the GP was unable to take the call at that time. There is no documentary record of any further attempt being made by Dr Berry to contact Greg's GP about Greg's non-attendance; and there is nothing in the GP's records which indicates that information to the effect that Greg had failed to keep his appointment reached them at this time. Although Dr Berry's notes show that he had intended to follow this up with a further telephone call to the GP, it seems unlikely that he ever made contact, even if he did in fact make a further, undocumented, attempt to speak to Greg's GP.

7.32. Dr Berry did, however, raise Greg's case at a meeting of the South Northamptonshire CMHT on 11.6.98. The evidence to the Inquiry Panel was that there were weekly CMHT meetings which Dr Berry attended as often as he could. At the relevant times in 1998 and 1999, Dr Berry had a junior doctor, a Dr Baez. Dr Baez also gave evidence to the Inquiry Panel and his evidence was that he too attended these weekly meetings if he was able.

7.33. There was general agreement amongst the witnesses who have given evidence to the Inquiry Panel that these meetings were well attended. There was, in particular, no evidence suggesting that there were any serious difficulties in getting the psychiatrists to attend these meetings, although Dr Berry told the Inquiry Panel that there were, as one would expect, occasions when his clinical commitments simply made it impossible for him to attend.

7.34. The notes of the South Northamptonshire CMHT meeting of 11.6.98 recorded that Greg had moved to the area to be with his parents, and that he had been diagnosed with paranoid schizophrenia. It was noted that Greg was to be discussed again in 2 weeks time when LM's CPN, Mr Oelrich, returned - presumably from annual leave.

7.35. Comment:
Bearing in mind that there had already been considerable delay in providing Greg with his initial appointment, it is unfortunate that further delay was permitted at this stage.

7.36. On 2.7.98, Greg was discussed again at a meeting of the South Northamptonshire CMHT. Both Dr Berry and Mr Oelrich were present. The notes made read:

> "[Greg]: Lives with parents in old people's bungalow. Query drug related psychosis and had an admission .... Appears to be better mentally now - according to family. Missed one out-patient appointment with Dr Berry - to be sent another."

7.37. Dr Berry had no detailed recollection of what was discussed at this meeting, but, as Dr Hooker had previously anticipated, Dr Berry already knew Greg's brother, LM, having been involved in his care during LM's admissions as an in-patient and as an out-patient in between admissions. Dr Berry would presumably have sought, therefore, to talk about Greg's situation with LM's CPN, Mr Oelrich, on the basis that he would know at least something about Greg and his family. Dr Berry had, after all, been told by Dr Hooker that Greg was living at the same address as LM, so it would not be an unreasonable assumption that Mr Oelrich would know something of Greg.

7.38. Although Dr Berry could not recall what was actually said about Greg on this occasion, the CMHT notes set out above do suggest that Mr Oelrich must have had some positive information about Greg from his family. Dr Berry confirmed that if he had heard anything of concern about Greg, he would have made a note about it.

7.39. Mr Oelrich, who gave evidence to the Inquiry Panel, told the Panel that his role with LM had indeed meant that he had got to know a good deal about LM's family. He said that he had first heard about Greg's mental health problems, through his relationship with LM, when Greg was admitted to Priority House Mental Health Unit. His understanding was that Greg had been diagnosed as having a drug induced

psychosis. Mr Oelrich was also aware that Mr and Mrs Marden had moved to the Northampton area and that Greg had followed them, initially moving in with them, but then moving out to stay with Mrs Low's elder son, Trevor. Indeed, he told the Inquiry Panel that when Greg had moved to the Northampton area, and when the family had expressed concerns about Greg's mental health, it was he, Mr Oelrich, who had encouraged the family to get Greg to attend a local GP for assessment.

7.40. Mr Oelrich told the Inquiry Panel that he thought that he must have discussed Greg's non-attendance at the appointment with Dr Berry with Greg's family. The note recorded above suggests that this must have been the case, and further indicates that Mr Oelrich had received some reassuring feedback from the family about Greg's current mental state. As Mr Oelrich told the Inquiry Panel that he had never met, or even spoken on the telephone to, Greg's parents, Mr and Mrs Marden, it seems overwhelming likely that his point of contact was Mr and Mrs Low. The Inquiry panel heard from Mr and Mrs Low that, in their capacity as carers for LM, they usually attended LM's CPA review meetings as well as occasional ward rounds. They also met with Mr Oelrich from time to time when he came round to visit LM. However, the CMHT note set out above is the only documented reference in all of the documentation presented to the Inquiry Panel, which pre-dates the assault upon Mr Marden, which records any discussion between Greg's family and representatives of the mental health services.

7.41. Comment:
It is unfortunate that a discussion between Mr Oelrich and members of Greg's family, the content of which appears to have played at least some part in the decisions being made about Greg was not documented, so that it was possible now to see what had been said and by whom which led Mr Oelrich to report to the CMHT meeting on 2.7.98 that Greg appeared to be better mentally.

7.42. It is relevant here to record Mr Oelrich's perception of Mr and Mrs Low. His view was that they were both very articulate; and that they were "pretty thorough about what they

understood of mental health problems", particularly with regard to LM. Dr Berry obviously must also have placed reliance upon the family's assessment of Greg, albeit delivered second hand through Mr Oelrich, in agreeing to adopt the course which was followed after Greg's non-attendance, namely simply sending Greg another out-patient appointment.

7.43. Ms Gillian Horrell, a social worker with the same CMHT who also gave evidence to the Inquiry Panel, commented that she considered that Mrs Low in particular had an excellent understanding of LM's illness.

7.44. Mr and Mrs Low's evidence about their relationship with and knowledge of Greg indicates that any assumption which may have been that they were able properly to assess Greg's mental state, was mistaken. They said that when Greg first moved up to the Northampton area, they did not know him well at all. Even after he had been in the area for a time, they still felt that they could not "read" Greg's state of mind. They both agreed that they were usually able to recognise when LM was becoming ill, because they had lived with him for a long time, but they did not consider that they were able easily to pick up the signs of a deterioration in Greg's condition. In evidence, Mr Low said:

> "... it's not particularly easy to know what's going on in [Greg's] mind, he's very quiet and reserved in any case, so the fact that he might be thinking strange things isn't obvious from his face. Whereas his other brother, LM, who lived with us for a time, quite a time, we were able to recognise he was ill and try and sort something out."

7.45. Furthermore, Mr and Mrs Low both said that they were very anxious not to cause Greg to think that he was like LM, and that as a result they were inclined against seeking medical help for Greg whenever they thought that they perceived deterioration in his mental state. Mrs Low's evidence was:

> "I think really we've tried to avoid asking for help because we ... didn't want Greg to think he's like [LM]."

7.46. Comment:
The Inquiry Panel's view is that there was an assumption on the part of those dealing with Greg and his family that because Mr and Mrs Low had experience of dealing with LM over the years, they were sufficiently knowledgeable about mental health problems that they could be relied upon to pick up any need for an intervention in Greg's case and to know how to access help. This is confirmed by the fact that at this stage in the chronology of events, the mental health services were apparently content, on the basis of the views of family members, as reported by Mr Oelrich - and notwithstanding Greg's history of a recent and severe mental illness - simply to send Greg another out-patients' appointment, rather than make positive efforts to contact him.

However, according to Mr and Mrs Low, their stance at this stage was that they were reluctant further to push Greg towards the mental health services if that could be avoided, because they were fully aware of Greg's anxiety about being put into the same bracket as his brother, LM, and because they did not want to take any steps which might increase that anxiety.

It was not, in the view of the Inquiry Panel, appropriate for the mental health services to assume that Mr and Mrs Low would, in the event that there was a deterioration in Greg's condition, be able to appreciate the need for a further intervention by the mental health services, particularly since there was never any formal attempt to discuss Greg's condition with Mrs and Mrs Low, or to provide them with any sort of guidance as to what aspects of Greg's behaviour might indicate a recurrence of his acute problems and needed to be watched for.

7.47. On 6.7.98, Dr Berry wrote to Greg a second time offering a further out-patient appointment for 26.8.98. This letter does not seem to have been copied to Greg's GP.

7.48. Comment:
The appointment date of 26.8.98 meant further delay in

getting Greg to his first out-patient's appointment in Northamptonshire. It is worth emphasising again that Greg was a patient who had only recently had a very serious mental illness, requiring an extended period as an in-patient, and who had been considered in need of significant ongoing medication. Although there may have been some encouraging feedback from Mr and Mrs Low to Mr Oelrich about how Greg seemed to be getting on, it should have been appreciated that their knowledge of Greg at this stage was actually relatively limited.

Furthermore, contact could and should have been made with Dr Hooker at this stage. At the very least, he should have been kept informed of Greg's non-attendance and of the new out-patient's appointment which had been given to Greg. In addition, however, it would have been sensible to ascertain what further contact, if any, Dr Hooker had had with Greg, in order to obtain a further perspective upon Greg's current mental state. Had someone from the CMHT asked Dr Hooker what further contact, if any, he had had with Greg, the fact that Greg could no longer be taking his medication would probably have come to light - Greg had not been back to see Dr Hooker, or anyone else at his practice since the attendance on 26.2.98 and had not received any repeat prescriptions. The fact that Greg was no longer taking the medication prescribed on his discharge from Priority House Mental Health Unit might in one sense be seen as a positive sign, especially when put together with any encouraging feedback from Greg's family, but it would also have made the need for Greg to be seen as soon as possible all the clearer.

7.49. Greg again failed to attend the out-patient appointment on 26.8.98. Dr Berry subsequently wrote to Greg, on a date which has not been identified, offering Greg a third out-patient appointment for 30.9.98.

7.50. Comment:
The appointment offered was in just over 4 weeks after the appointment letter. It is pleasing to see that appointment times were now apparently somewhat

shorter than had earlier been the case. There does not, however, appear to have been any discussion of Greg's case at any CMHT meeting following the non-attendance on 26.8.98, and it is not clear why no such discussion took place. Neither was the fact of Greg's non-attendance, or his new appointment date, communicated to Dr Hooker.

7.51. Greg failed to attend the third out-patient appointment as well. On 2.10.98, Dr Berry wrote to Dr Hooker advising him that Greg had failed to attend on 30.9.98. Dr Berry's letter to Dr Hooker stated:

> "I saw [Greg's] brother by chance and it appears that Gregory is maintaining well, so the medication is clearly satisfactory. I will send him another appointment as I understand he may have had a job of work to do and thus failed to attend."

7.52. Coincidentally, on the same day, 2.10.98, (and therefore presumably before Dr Berry's letter was received by Dr Hooker) Greg went to see Dr Hooker about a back problem. No reference appears in the notes made by Dr Hooker on this occasion to any mental health problems; or indeed to the previous prescription of medication.

7.53. Comment:
Dr Berry's letter carries with it the implication that a report from LM was relied upon as reassurance that Greg's condition at this time was satisfactory, notwithstanding that there does not appear to have been any strong basis for believing that LM had had any great contact with Greg during this period. Although there is no suggestion that Greg was exhibiting any or any serious problems at this stage, it was nevertheless a questionable basis for reaching the views expressed in Dr Berry's letter. Certainly Dr Berry was mistaken in his assumption that Greg was well because the medication prescribed was satisfactory - by this time, Greg had not been taking the medication for many months. Dr Hooker did not, however, pick up this point.

7.54. The fourth out-patient appointment given by Dr Berry to

Greg was for 11.11.98 and on this occasion Greg did attend. Dr Berry's findings were set out in a comprehensive and very helpful letter to Dr Hooker dated 13.11.98, which was copied to the South Northamptonshire CMHT. This read:

"Problem: index psychotic episode treated at Maidstone in Kent in 1997.
Diagnosis: paranoid psychosis: in remission.
Provocation: probably relates to drug usage.
Probable paranoid schizophrenia
Vulnerable disposition including family history.
Quiet sensitive pre-morbid disposition.
Medication: Mr Marden tells me he is taking no medication at present.
Mr Marden had some impotence problems which may have related to
either the SSRI or major tranquillisers: it is unclear.
No recommendation on medication at present. He has not taken any: Mr Marden's case is well set out in the discharge summary from Maidstone so I will not reiterate. He has always been quiet and rather shy but this seems within normal limits. He is naturally cautious about his brother's illness but not over preoccupied with it. He has used recreational drugs, mostly cannabis but also LSD amongst others over a period of several years but in limited quantities. It is possible that LSD related to his index psychotic episode. In addition to this he had noticed that cannabis had been somewhat more relaxing and more likely to induce a feeling of mild paranoia latterly. He had, on the other hand, been abroad in Amsterdam and the available strength of cannabis would be more than he was used to back in Britain. There does not seem to be any pro-drome of note: he admits to be unoccupied and withdrawn into himself at home in the winters since the age of 20. In these same years he has, however, felt normally social in the summer months. On the balance there are fairly intermediate prognostic signs. I suspect that psychological issues precipitated his index episode against a background of moderate substance misuse. The onset is fairly acute.

Advice and follow up: the prognosis is good should he stay off medication without relapse in 2 years. No medication recommended at present. Sulpiride or chlorpromazine can

be given straight away in threat of relapse. Mr Marden is not keen on medication generally so I did not pursue the possibility of anti-depressive treatment with SSRI which appears to have had some benefit, but also has sexual side effects. I will make an out-patient appointment in about 4-6 months time just to keep in touch. This is Mr Marden's preferred mode of contact. I will inform the Community Mental Health Team but I don't think we need to appoint a key worker as yet."

7.55. It is not altogether clear from this letter whether Dr Berry was aware that Greg was continuing to smoke cannabis. Greg's evidence was that he thought he did tell Dr Berry at this meeting that he was using cannabis.

7.56. Dr Berry's notes of this attendance contain an ambiguous reference to "educational materials". Dr Berry told the Inquiry Panel that it was possible that this note meant that he had provided Greg with literature about his condition on this occasion. He said that his practice was, and still is, to hand out a leaflet entitled "Excerpts from Surviving Schizophrenia" by Dr Fuller Torrey. However, Dr Berry felt that his note, whilst ambiguous, probably meant, not that he had actually given Greg educational materials on this occasion, but rather that it was his intention to provide such materials to Greg on the next occasion that he saw Greg, in 4 months time or thereabouts. Greg's evidence to the Inquiry Panel was that he had not received any such materials from Dr Berry - indeed, his evidence was that he would have welcomed such literature, had it been offered to him.

7.57. Comment:
Whether the educational materials were or were not provided to Greg on this occasion, Dr Berry's practice of providing such materials to patients in order that they can have a better understanding of their illness is to be commended.

7.58. Dr Berry said in evidence that his recollection was that, whilst he would have preferred Greg to have been taking the medication which had been prescribed following the acute episode in Kent, the situation by the time of this appointment was that Greg had been off that medication, and had

apparently been well, for some 6 months. In these circumstances, Dr Berry did not consider it necessary or appropriate to tell Greg to restart the medication as a preventative measure against a possible relapse.

7.59. Comment:
The Inquiry panel do not consider that this decision is one which can be criticised.

7.60. Dr Berry acknowledged that it would be sensible in such circumstances to contact the patient's family, or at least the people with whom the patient was staying, in order to let them know of the course which was being followed and to inform them of the things for which they should keep an eye open as possible indications of relapse. He also acknowledged that this was not done in this case, although he said that he relied upon Mr Oelrich's involvement in the family as a route by which information about Greg would get back to the mental health services. He did not, however, discuss this with Mr Oelrich.

7.61. Dr Berry decided against formally referring Greg to the CMHT, although, as mentioned above, his letter to Dr Hooker of 13.11.98 was copied to the South Northamptonshire CMHT. Dr Berry said of this decision that his view was that Greg was stable, had a supportive family and was a substantially lower risk than other referrals to the service at that time. He made the point that with the family history, namely LM's illness, Greg's family already had contacts with the mental health services. He also said that there were only 2 CPNs in the South Northamptonshire CMHT at that time, and that he took the view that the CMHT was hard pressed enough as things were. In his oral evidence, Dr Berry said that this was probably the major reason for his decision not to refer; and he told the Inquiry Panel that he would have preferred it if it had been possible for Greg to have been followed up by a CPN.

7.62. Comment:
The approach adopted by Dr Berry involved placing considerable reliance upon Mr Oelrich and upon Mr and Mrs Low. There was, however no communication by Dr Berry, formal or otherwise, to Mr and Mrs Low or

Mr Oelrich letting them know that such reliance was being placed upon them. If their involvement in the care of Greg was indeed a significant factor in the decision not to refer Greg to the CMHT, then Dr Berry should have discussed their role in Greg's care with them before placing that reliance upon them. Even if, however, their involvement was something which merely provided a degree of reassurance for Dr Berry in a decision which he would have made in any event, then it would, in our view, still have been preferable for Dr Berry to have discussed Greg's situation with Mr Oelrich and Mr and Mrs Low.

7.63. On the question of whether or not the CMHT was unduly stretched at the time of Dr Berry's decision, it is relevant to record that Dr O'Neill-Kerr, Dr Berry's Clinical Director, shared Dr Berry's perception that the CMHTs were over-stretched at the time. He too told the Inquiry panel that there were occasions when he would have liked to refer a patient to the CMHT but it proved impossible.

7.64. Comment:
It would nevertheless have been better if the decision about whether or not to refer Greg to a CMHT had been made after a formal discussion of Greg's case at a meeting of the South Northamptonshire CMHT. Firstly and most importantly, if Dr Berry's decision not to refer was indeed a result of concerns about whether or not the CMHT had the resources to deal with Greg, then the decision was one to be made by the CMHT itself, not by Dr Berry on its behalf. The team manager would normally be better acquainted with people's workloads, and would accordingly be better placed to judge how well able the team was to take on a particular case. Secondly, if there had been a full discussion about Greg at a CMHT meeting, the discussion would almost certainly have had the result that the nature and extent of Mr Oelrich's knowledge of Greg (which was actually very limited indeed) would have become apparent.

It may therefore be the case that a full discussion in the CMHT would have resulted in a different decision being reached about the appropriateness of a referral

for Greg.

Even if, however, the CMHT was still inclining to an approach which left it up to Greg or his family to contact the mental health services in the event of a deterioration, then there should, in our view, still have been some investigation by representatives of the CMHT into the extent to which Mr and Mrs Low, and the other members of Greg's family, were willing and able to play a role in monitoring Greg's condition. Mr and Mrs Low's reservations about their ability to "read" Greg might well then have come to light. Furthermore, information might have been made available to Greg's family about the warning signs which might indicate that Greg was heading towards a relapse; and they might well also have been advised of the need to ensure that in the event there were any concerns about Greg's mental health, immediate contact should be made with the mental health services so that immediate consideration could be given to starting appropriate medication.

However, although in this instance the Inquiry Panel has taken the view that Dr Berry ought to have ensured that the decision about the need for Greg to be referred to a CMHT was one which should have been made by the CMHT and not by Dr Berry alone, it is right to record that it was acknowledged by, for example, Mr John Lloyd, Unit Manager for Social Services community mental health services, who gave evidence to the Inquiry Panel, that Dr Berry was, in his experience, more community orientated than many other consultants. Mr Lloyd said that Dr Berry was a consultant favourably disposed to multi-disciplinary working who was, accordingly, generally better than others in taking cases for discussion to the CMHT. Mr Lloyd also said that Dr Berry would have had a good awareness of the pressures that the CMHTs were under at the material times.

7.65. Greg told the Inquiry Panel that, around February or March 1999, he began to smoke cannabis more regularly than had previously been the case, at least since his move

to Towcester.

7.66. Greg's condition began to deteriorate. He said that he had paranoid feelings when he smoked. In particular, he had concerns about becoming ill again, and about people talking about him and he said that these persisted for 3-4 hours after a smoke. He told the Inquiry Panel that he thought that, by continuing to smoke, he would get used to taking the drug, and that these feelings would stop, leaving him more relaxed.

7.67. On 29.3.99, Greg went back to his GP. On this occasion he saw Dr Sunderland, the GP with whom he had been formally registered back in February 1998, although this was the first occasion upon which Greg actually met Dr Sunderland. Dr Sunderland gave evidence to the Inquiry Panel.

7.68. Dr Sunderland's note of Greg's attendance on 29.3.99 reads as follows:

> "Wants check over re AIDS test - been with prostitutes. Looking a little sullen. Given GU [genito-urinary clinic] details and number. Says he will make an appointment."

7.69. Dr Sunderland said in evidence to the Inquiry Panel that although Greg appeared rather subdued and introspective, his behaviour was not threatening and he did not appear to be acutely disturbed. He regarded Greg's attendance on this occasion as a self-contained query over a possible sexually transmitted disease. He did not think that an attendance of this nature would have caused him to review Greg's medical records in any great detail. In particular, Dr Sunderland felt it was most unlikely that he would on this occasion have read or reviewed the discharge summary from the Priority House Mental Health Unit, or Dr Berry's letter to Dr Hooker of 30.11.98.

7.70. Comment

Because Dr Sunderland had not seen any reason to review the notes, he was unfortunately unaware of (a) the fact that anxiety about AIDS had been part of Greg's presentation to Priority House Mental Health Unit, and (b) the recommendations which Dr Berry had made with

regard to medication in the event of a possible relapse.

7.71. Greg himself said that he was feeling ill at the time of this visit and that he was experiencing feelings of paranoia in the GP's waiting room. However, he agreed that he had not communicated these feelings to Dr Sunderland. Having been given the number of the genito-urinary clinic, Greg decided that he would discuss his concerns there, at the clinic, rather than with Dr Sunderland.

7.72. Greg told the Inquiry Panel that he had made an appointment at the genito-urinary clinic, and that he believed that the appointment was actually for the day of the assault on Mr Marden, 3.5.99. The Inquiry Panel has not sought to check whether or not this is correct, but it seems unlikely since this date was a public holiday.

7.73. In any event, the following month, on 14.4.99, Greg attended his follow up appointment at Princess Marina Hospital. On this occasion Greg did not see Dr Berry himself but saw his junior doctor, Dr Baez.

7.74. Dr Baez originally qualified in Spain, obtaining his full degree in 1989 and working as a General Practitioner up to 1995. He chose to move to the UK in 1995 in order the better to pursue a career in psychiatry. His role at the material times involved supporting the work of his Consultant, Dr Berry, and working under his supervision. Dr Baez's evidence was that Dr Berry would tend to see patients first, and would then allocate to Dr Baez patients who were perceived to be less problematic.

7.75. Comment:
Concerns were expressed to the Inquiry panel by Mr and Mrs Low about the problem of an inexperienced psychiatrist whose first language was not English, being able to pick up the sort of subtle signs which might have been a pointer towards a deterioration in Greg's mental health around this time. However, all of the professional witnesses who gave evidence to the Inquiry expressed the view that clinically Dr Baez was a very competent psychiatrist. Having had the advantage of interviewing Dr Baez, the Inquiry Panel does not

consider that there was likely to have been any language or communication difficulty between himself and Greg. It is worth commenting, however, that follow-up appointments such as this are usually a great deal shorter than the initial appointment. This inevitably makes it even harder for a doctor who has not seen the patient before to pick up subtle signs or changes.

7.76. The evidence to the Inquiry Panel confirmed that the appointment on 14.4.99 did not last very long. Greg felt that it might have been as short as 5 minutes. Mr and Mrs Low, who came with Greg to the hospital on this occasion, apparently also told Ms McWatt, the Trust's Client Relations Manager, that this was the case in the course of the interview referred to above conducted by Ms McWatt in September 1999 for the purposes of her internal investigation. However, by the time that Mr and Mrs Low saw the Inquiry Panel, they had no recollection of the length of Greg's appointment on this occasion. Dr Baez told the Inquiry panel that he was sure that the appointment would have been longer than 5 minutes, and he thought it might have been a half hour appointment. He told the Inquiry Panel that, in addition to asking questions, he would have used the meeting to try and engage Greg in general conversation.

7.77. In any event, Dr Baez's findings and conclusions were set out in a letter written to Dr Hooker on 21.4.99 which reads as follows:

> "Present state: Gregory said that since he was last seen by Dr Berry in November 1998, his mood, sleep pattern and appetite had been fine. He said he has abstained from the use of any recreational drugs and hardly drinks although he smokes about 25 roll up cigarettes a day. Gregory denied having any hallucinations or bizarre or strange thoughts. To put things in perspective, he said he feels rather apprehensive because his brother, LM, is currently an in-patient ... .
>
> Follow-up: I will review him in 3 months time."

7.78. Dr Baez's perception was, accordingly, that all was well and

that no action was required.

7.79. Mr and Mrs Low described Greg as feeling a bit low around this time. They are recorded as saying, when interviewed by Ms McWatt in September 1999, that Greg had been disappointed to be seen by Dr Baez, as opposed to Dr Berry. They are recorded also as having expressed concerns to Ms McWatt that Dr Baez's examination of Greg may have been a little perfunctory. Ms McWatt's notes indicate that Mr and Mrs Low also said that they had had a conversation with Dr Baez after he had seen Greg, and that he had told them that Greg was "hypersensitive" and that it would not be necessary to see Greg again unless Greg wanted it. Unfortunately, when giving evidence to the Inquiry Panel, over 2 years later, neither Mr nor Mrs Low were able to recall this conversation with Dr Baez. Indeed, Mr and Mrs Low had no recollection of ever meeting Dr Baez in connection with Greg - although they did recollect a meeting with him in connection with LM - and Mr and Mrs Low told the Inquiry Panel that it was possible that Ms McWatt had misunderstood what had been said in the course of the discussion between them in September 1999.

7.80. Comment:
This is one of the problems which are, regrettably, inevitable when there has been such a delay in setting up an Inquiry of this nature.

7.81. Dr Baez's evidence about these suggestions was that he might very well have had a chat with any family members who had come with Greg, but that he did not think that he would have used a word such as "hypersensitive" to the family in any discussions which may have taken place after his meeting with Greg.

7.82. Comment:
Mr and Mrs Low's doubts notwithstanding, it seems probable that there was some form of discussion between Dr Baez and the family members on this occasion. Certainly, if they had attended with Greg it would have been good practice for Dr Baez to have taken the opportunity to ascertain their opinion of Greg. Assuming that there were some discussions, it would

also have been good practice for Dr Baez to have made a note of the fact, and of any relevant information obtained. There is no such note.

7.83. Greg himself told the Inquiry Panel that he was fine at the time of the visit to Dr Baez. However, there was considerable uncertainty in his mind about the precise chronology of events. Greg was sure that the visit to Dr Baez pre-dated both of his visits to Dr Sunderland, as he recalled that those visits were occasioned by what Greg had perceived, correctly, to be a deterioration in his mental state. He said in evidence that he felt fairly ill at the time of the first visit to Dr Sunderland, which was about 2 weeks before the out-patient's appointment with Dr Baez, and he felt that if he had seen Dr Baez after that, he would have told Dr Baez about these feelings and his fear of relapse.

7.84. Whatever the position in this regard, Greg agreed that he did not tell Dr Baez that he was smoking increased amounts of cannabis. Greg did not know why he had not told Dr Baez this - as mentioned above, he said that he believed that he had told Dr Berry about his occasional cannabis use back in November 1998.

7.85. Comment:

Bearing in mind that Dr Baez's evidence that Greg appeared to be fine when Greg saw Dr Baez, and Greg's belief that he was feeling well at the time of this appointment, it seems that the most likely explanation is that Greg's mental state was fluctuating over this period, and that on 14.4.99 Greg was indeed feeling well. It is not possible to ascertain why questioning by Dr Baez did not elicit that Greg had recently had concerns about his health and had been to see his GP. It may well be that Greg simply gave the impression to Dr Baez that all was well, and Dr Baez accordingly did not press the matter. It may be that Greg felt less comfortable, and was accordingly less forthcoming as he was seeing a doctor he had not met before.

There is no reference to educational materials being provided to Greg by Dr Baez, notwithstanding the note which had previously been made by Dr Berry. If, as

Dr Berry suspects, the note recorded his intention to provide educational materials, as opposed to recording that such materials had in fact been provided to Greg, it is disappointing that Dr Berry did not ensure that Dr Baez did provide Greg with the literature which he had intended Greg should receive.

7.86. Whatever Greg's condition at the time of his appointment with Dr Baez on 14.4.99, it is clear that in the following weeks Greg's mental health deteriorated. On 19.4.99, Mrs Marden and Mrs Low went together to York for a holiday, and Greg moved in with Mr Marden for the week to look after him. There is no suggestion that there was any tension between Greg and Mr Marden during this period. Mr Marden was in poor physical health, suffering from breathing problems, and therefore needed some looking after. Greg did this in a satisfactory manner, and the Inquiry Panel heard no evidence to suggest that there was any hostility between Greg and his father during this period. However, on Mrs Marden's return, Greg's mental state was giving cause for concern. In Mrs Marden's witness statement to the police, she said that Greg was displaying signs of paranoia and was becoming very withdrawn. There is also reference in later medical reports to him having experienced mood fluctuations and disturbed sleep together with disturbing thoughts during this period.

7.87. On 30.4.99 Greg was sufficiently concerned about his mental state that he tried to contact Dr Berry direct. There is unfortunately something of a mystery about these attempts. Greg's account was that he had been given a telephone number by Dr Berry which he rang which turned out to be an answerphone which gave him an alternative number to ring. Greg then rang this alternative number and got through to somebody - he recalls that person was female. Greg's evidence was that the woman to whom he spoke wanted to know why it was an emergency and that he was not able to get across to her what he wanted. After a short conversation, Greg felt that he was wasting her time and hung up. Greg was, in his evidence to the Inquiry Panel, quite sure that he had got through to someone appropriate - in other words, his difficulties in accessing help were not a result of him simply having rung a wrong number - but that

he was unable to get across in a sufficiently coherent way what he wanted to convey to the woman at the other end of the line.

7.88. Mrs Low, who was present when Greg was making these attempts, was asked about this telephone call by Ms McWatt in the course of the internal investigation interview on 22.9.99 to which reference is made above. Mrs Low's account then was similar to the account given by Greg, and set out above, although she said then that Greg was a little "difficult" when speaking to the lady at the other end of the telephone and that the phone had been put down on Greg. In her evidence to the Inquiry Panel the account which she gave was a little different - she said that Greg had managed to speak first to a lady who had transferred him to another number which turned out to be an answerphone - but the Inquiry Panel takes the view that the account which she gave in 1999 is likely to be a more accurate recollection of this incident.

7.89. Dr Berry's evidence was that his answerphone would have had, at the material times, a message which, amongst other things, gave the telephone number of the Crisis Team for emergencies. The Crisis Team's telephone lines were at this time in 1999 manned 24 hours a day.

7.90. Exhaustive enquiries have been made by the Trust to ascertain whether or not any incoming telephone call was or might have been made by Greg to the Crisis Team on that day. All such enquiries have reached the conclusion that whomever Greg managed to speak to, it was not the Crisis Team - all such calls are logged, and there is no unexplained call which could perhaps be Greg's call.

7.91. Comment:
Just to whom Greg was speaking during his telephone call will, unfortunately, remain a mystery. It would certainly seem likely that a referral message on an answerphone responding to "out of hours" calls would refer the caller either to a switchboard or directly to the Crisis Team. In the absence of any evidence that Greg made contact with the Crisis Team, the most likely conclusion is that Greg got through to a switchboard,

but was then unable to explain himself sufficiently coherently to get a useful response from the switchboard operator.

7.92. On 1.5.99, a Saturday, Greg, having failed to make contact with Dr Berry, went to see Dr Sunderland a second time.

7.93. This time Greg went with his mother. Dr Sunderland's notes read:

> "Getting anxious re the above [a reference to the concerns which Greg had previously experienced about the possibility that he had AIDS]. A rather confused personality. Came with mum. Situation discussed. Try imipramine."

7.94. Dr Sunderland said in evidence to the Inquiry Panel that he did not consider it particularly out of the ordinary that Greg (then aged 27) had attended on this occasion with his mother. Greg's evidence was that he had discussed the possibility that he had AIDS with his mother, but he could not recall why it was that his mother had gone with him on this occasion. Mr and Mrs Low's view was that Mrs Marden had accompanied Greg because she was worried about his behaviour and what he was saying about AIDS, and also because Greg would not have gone on his own. The Inquiry Panel was not able to explore this further with Mrs Marden who chose not to give evidence to the Inquiry Panel. It is entirely understandable that she would not wish to go through a process which would inevitably re-open her feelings about this family tragedy.

7.95. Dr Sunderland said to the Inquiry Panel that his description of Greg as a rather confused personality meant that Greg's ideation was somewhat confused. He suspected that Greg might perhaps have been fantasising about having been with prostitutes. He said that his note did not imply that he had taken the view that there was any sort of psychiatric component to Greg's problems. He said that he was aware of the fact that Greg had been a psychiatric patient, and that he might have considered the possibility that Greg was presenting with the beginnings of relapse, but he also said

that Greg was not hallucinating or deluding and that he did not appear to have any of the major symptoms of an acute psychiatric episode. There is, however, no evidence that Dr Sunderland actually asked Greg about these matters.

7.96. Dr Sunderland's evidence was that he regarded this attendance as a follow-up to the earlier attendance - in other words, as part of a self-contained issue, namely Greg's concerns about AIDS. Although he agreed that it was illogical for Greg to have re-attended raising the same issue as before, namely anxiety about AIDS, without having followed the advice which Dr Sunderland had previously given about that problem, he explained this on the basis that Greg was "coming to run it past me again". He said that he prescribed imipramine as an anxiolytic. When asked about this approach, Dr Hooker, said this use of imipramine was not unusual.

7.97. Dr Sunderland did not consider that there was any need or justification on this occasion for reading back through Greg's files, and he did not therefore consider that it was likely that he would have looked at Greg's discharge summary. It follows that Dr Sunderland was still not aware of the fact that anxiety about AIDS had been part of Greg's presentation to Priority House Mental Health Unit, or of the recommendations which Dr Berry had made with regard to medication in the event of a possible relapse. He did say, however, that even if he had been aware of Dr Berry's recommendations, he would still have chosen to prescribe imipramine.

7.98. Comment:
The Inquiry Panel did consider it striking that Greg had attended Dr Sunderland on this occasion with his mother, particularly when Greg was expressing concerns about the possibility of a sexually transmitted disease following contact with prostitutes. It may not be unusual for a psychiatric patient to attend a medical appointment with family members, but Dr Sunderland was not looking at Greg as a psychiatric patient - rather he apparently saw Greg as a patient with a single, self-contained concern about AIDS.

Dr Sunderland was aware that Greg had already been to see him in connection with his concerns about AIDS. Dr Sunderland had already given clear and sensible advice - namely that Greg should visit a genito-urinary clinic. The Inquiry Panel takes the view that the fact that Greg was re-attending his GP in respect of precisely the same problem, rather than following the advice previously given, was odd and suggested that Greg might have had other concerns. Furthermore, Dr Sunderland's reference to "a rather confused personality" suggests that Greg's presentation on this occasion was not entirely straightforward. Taken with knowledge of Greg's history of previous mental illness, these unusual features might well have alerted Dr Sunderland to an appreciation that Greg's mental health might once again be deteriorating.

However, it is relevant to look at the context of this examination. Greg was presenting, at least ostensibly, not as a person with psychiatric difficulties, but as someone with concerns about a sexually transmitted disease. It must be acknowledged that what may seem significant from the standpoint of someone interested in, or looking for, psychiatric problems, may well not be noted at all in the context of a request for advice about a sexually transmitted disease.

The Inquiry Panel was nevertheless surprised that Dr Sunderland told the Inquiry Panel that, even if he had known what Dr Berry had suggested by way of medication in the event of a threat of relapse (namely sulpiride or chlorpromazine), he would still have chosen to prescribe imipramine. This is worrying since imipramine can make psychotic symptoms more florid.

7.99. The following day, Sunday 2.5.99, Greg seemed to Mr and Mrs Low to be somewhat improved. Mrs Low's evidence to the Inquiry Panel was that she encouraged Greg to contact the Crisis Team but that Greg did not do so. Mrs Low did not feel that Greg's condition was such that it was necessary or appropriate for her to contact the Crisis Team direct. As mentioned above, she found that Greg was "not easy to read".

7.100. Late in the evening on 2.5.99, Mr Trevor Atkinson contacted Mr and Mrs Low to report that Greg was not feeling well. Mr Low and Mr Steven Badger went to visit Greg who was just lying on his bed staring upwards. He remained withdrawn; and Mr Low and Mr Badger took him back to Mr and Mrs Low's house.

7.101. The evidence of Greg's mother, Mrs Marden, as contained in a witness statement provided to the police dated 25.5.99, was that on the morning of 3.5.99 Greg came round to her house. She asked Greg if he had taken his tablets - a reference to the imipramine prescribed by Dr Sunderland on 1.5.99. Greg told her that he had not and that he had in fact thrown them away. Mrs Marden then went with Greg to Mr and Mrs Low's house where she says she found Greg's tablets in a bin and made him take one. It should be recorded that Greg's evidence to the Inquiry Panel was that he had not actually taken any medication for a considerable time prior to the assault on his father, but it seems clear that he was referring here to the anti-psychotic medication prescribed by Priority House Mental Health Unit and by Dr Hooker, and not to the imipramine prescribed by Dr Sunderland.

7.102. Mr Low and Mr Badger then went with Greg to Finmere Market. The market was, however, not open that day. As the group returned, Greg was behaving in a very odd fashion. He has been described as striding back to his parents' house. Mrs Low and Mrs Marden got into the car and drove after him, asking him to get into the car. Greg ignored these requests and kept walking. Mrs Low and Mrs Marden then drove back to the house, and as they were parking Greg ran past them and into the house. As Mrs Marden approached the house, she heard the front door lock from inside. When she got into the house via the back door, she immediately saw her husband, Mr Marden, lying, apparently unconscious, with blood coming from his mouth and nose. A calor gas canister was lying on the floor beside Mr Marden. Greg had assaulted his father, Mr Marden, hitting him over the head with the canister.

7.103. The police were called and Greg was arrested and taken to

the police station. Ambulance services were of course called and Mr Marden was taken to hospital where, tragically, he died of his injuries on 20.5.99.

7.104. At the police station Greg was seen by Dr Peter Gordon, an approved doctor under section 12 of the Mental Health Act 1983. He examined Greg at 14.30 hours, the initial examination lasting over an hour. Dr Gordon elicited the history of the admission to Priority House Mental Health Unit in Kent together with details of Greg's more recent attendances on his GP, Dr Sunderland. In his witness statement before the police Dr Gordon recorded the following:

> "[Greg] talked about abuse of children in a fairly general way. He wondered if he had been abused himself and I was unable definitely to ascertain that he had been abused though he described some aspects of definite child abuse. ... He described how someone, and then said his father, had given him a "bad seed". He felt this seed had to be destroyed to stop other people misusing it. He had a fear of this "force". He felt things were passing through him. He was clear he was trying to kill his father to get rid of the force. In speaking of how he felt at that time he wasn't sure, but felt he had stopped it passing on."

7.105. Dr Gordon concluded that Greg was fit to be detained in police custody, and was fit to be interviewed with an Appropriate Adult present. Dr Gordon expressed the view that Greg had a significant delusion with no significant insight into his mental disorder. The police asked Social Services to provide an Appropriate Adult so that Greg could be interviewed and a Mr Christopher Arthurs of Social Services duly attended.

7.106. Following Mr Arthurs' arrival at the police station, Greg was interviewed. He admitted without reservation the assault upon his father. He was asked whether his wish to kill his father was a recent thing or something that he had been thinking about for a long while and he replied that it was something he had thought of that morning on the way back from Finmere Market.

7.107. In a subsequent interview on 4.5.99, which was attended by another Social Worker, Ms Gillian Horrell, as Appropriate Adult, Greg was asked about the medication which he had been taking. He told the police that he had taken 6 or 7 of the tablets which Dr Sunderland had prescribed on the Saturday night and a further 2 or 3 tablets on the Sunday morning. He confirmed that he had taken a further tablet on the Monday morning and he then described how, also on the Monday morning, he had read a Roald Dahl book which had triggered or brought back bad memories of sexual abuse. It was whilst reading this book that he started to have suspicions about his father and he had a "flashback" about an incident which he thought he remembered when he had been in a bath.

7.108. In yet a further interview, Greg said:

> "I didn't want to kill my father but I felt as if he was the devil, I thought that he was the devil and I thought he was a paedophile. I know that isn't my father but that's how I felt at the time. I thought he had abused me, now I am sure he did not but I believed it at the time, it was like an evil force was trying to take my mind over, before it happened there were voices in my head, there were like good voices and evil voices. It is just like voices were telling me to kill my dad because he was the devil, I felt that he was going to get bigger. It was going to get bigger, it was like he was trying to take my mind over when I was looking at him."

7.109. A formal Mental Health Act assessment took place at Daventry Police Station on 4.5.99. It was conducted by Dr O'Neill-Kerr, Consultant Psychiatrist, and, as mentioned above, a Clinical Director with NCHT. Ms Gillian Horrell acted as the Approved Social Worker for the purposes of the assessment. Both gave evidence to the Inquiry Panel.

7.110. Comment:
Ms Horrell acted both as Appropriate Adult and as the Approved Social Worker for the purposes of the Mental Health Act assessment. Ms Horrell acknowledged in her evidence to the Inquiry Panel that it is important that a

distinction is maintained between these roles, and that it would have been better practice for another Social Worker to have acted in one or other of these capacities. It is not, however, suggested that her dual role on this occasion had any practical implications whatsoever.

7.111. Following this assessment, Dr O'Neill-Kerr produced a medical report which set out brief details of Greg's medical history. Dr O'Neill-Kerr elicited from Greg a description similar to that set out above concerning the circumstances leading up to the assault upon his father. Dr O'Neill-Kerr described Greg's mental state at the time of his examination of Greg as follows:

> "For most of the interview [Greg] avoided eye contact. What eye contact there was tended to be confrontational. He was soft spoken, often mumbling and often needed to repeat his answers. He was somewhat dishevelled and unshaven at interview (he had been in the police station over 24 hours). There was no loosening of association, tangential thinking, clanging or circumstantiality of speech. The content of his thoughts included thought insertion and symptoms as already described. There was some poverty of content in that his answers were short and without embellishment. He was orientated as to time, place and person. There was no disorder of concentration, attention or memory and his abstract thinking was intact".

7.112. Dr O'Neill-Kerr's assessment was as follows:

> "There was no clear evidence of psychosis apart from [Greg's] description of thought insertion. There were no unequivocal symptoms of schizophrenia. However, given the family psychiatric history (which includes schizophrenia), his past psychiatric history and previous admission for psychosis, and the nature and severity of the assault, I am of the opinion that [Greg] requires a further period of in-patient assessment."

7.113. Dr O'Neill-Kerr recommended that Greg be placed on Section 35 of the Mental Health Act 1983 on the grounds that there was evidence that Greg might be suffering from a

mental illness which required further assessment. Dr O'Neill-Kerr indicated that a bed had been reserved for Greg on the Intensive Care Unit of the Pendered Centre, Northampton.

7.114. However, Dr Berry subsequently formed the view that the Intensive Care Unit was not sufficiently secure and that a forensic assessment was necessary. On 7.5.99, Dr Berry wrote to the Northamptonshire Magistrates Court stating that Greg was not suitable for the Intensive Care Unit. He informed the Court that there were no suitable beds available for Greg - the local Regional Secure Unit had no beds available - and accordingly suggested that Greg be held in custody. As a result, Greg was then transferred to HMP Woodhill.

7.115. As recorded above, Mr Marden died of his injuries on 24.5.99. Mr Oelrich learnt of this through his relationship with the family and passed the information on to Ms Horrell who in turn passed it on to her line manager, Mr Lloyd.

7.116. In August 1999, Greg pleaded guilty to manslaughter on the basis of diminished responsibility and on 20.8.99 he was placed on a Hospital Order under Section 41 of the Mental Health Act 1983, a restriction order without limit of time.

8 The Support given to Greg's Family following the Assault upon Mr Marden

8.1. Mr and Mrs Low told the Inquiry that the family had been offered Victim Support by the police, but that they had not wanted it. They did, however, have high praise for the support of an individual police officer, PC Bell.

8.2. Mr and Mrs Low did not recall offers of support from the local CMHT. They agreed that they did have contact with Mr Oelrich in the period following Greg's assault upon Mr Marden, but they said that this contact was more to do with LM and Mr and Mrs Low's decision that they no longer wished actively to be involved in the care of LM.

8.3. Mr Lloyd, the Unit Manager responsible for Social Services' community mental health services, said in his evidence to the Inquiry Panel that he believed that the local CMHT did offer support to the family but that the offer was not taken up. This was confirmed by Mr Oelrich who told the Inquiry Panel that, after discussions within the CMHT following Mr Marden's death, it was agreed that he should contact the family and offer sympathies and support. His evidence was that he spoke to Mrs Low, both by way of the telephone and on an occasion when he met with her in connection with LM. He said that he expressed his sympathies, and asked if the CMHT could help her or the family in any way. He told the Inquiry Panel that Mrs Low was grateful, but felt that there was nothing that the family wanted at that time. Mr Oelrich said that he had left an open invitation for Mrs Low to get in touch in the future if she felt that she or her family needed support.

8.4. It is not possible now to say with certainty what the precise nature of the contact between Mr Oelrich and Mr and Mrs Low in the aftermath of Greg's assault upon Mr Marden might have been. There is no documentary evidence of the contact so far as it concerned Greg and the assault upon Mr Marden.

8.5. Comment:
From what the Inquiry Panel has seen of Mr and Mrs Low, it seems unlikely that they would have chosen

to receive any counselling or other support from the mental health services following Greg's assault upon Mr Marden or following Mr Marden's death. It is not possible now to be certain whether or not the offer of support referred to by Mr Oelrich was given, although it seems very likely that Mr Oelrich would have made some such offer when he first saw Mr and Mrs Low after the assault, even if he was meeting them in connection with LM. It is unfortunate that there is no documentary evidence confirming that the attempt to offer support or counselling was made. The Inquiry Panel do not know, of course, what may have been said to Mrs Marden in this regard since it did not have the opportunity to interview her.

9 The Subsequent Investigations by the Trust and Health Authority.

9.1. As mentioned at the outset of this report, this Independent Inquiry has been commissioned by Northamptonshire Health Authority pursuant to HSG(94)27 which requires that where there has been a homicide by a patient of the mental health services, it is always necessary to hold an inquiry independent of the providers involved.

9.2. At the time of this homicide Northamptonshire Health Authority had issued guidelines to the Trust for the management of Serious Untoward Incidents. Those guidelines defined a "Serious Untoward Incident" as follows:

> "2. A Serious Untoward Incident is an accident or incident where a patient currently receiving treatment suffers serious injury or unexpected death. It also applies when a member of NHS staff or a member of the public suffers serious injury or unexpected death while on health service premises or where actions of staff or a patient give rise to significant public concerns."

9.3. The assault upon Mr Marden was a "Serious Untoward Incident" within the meaning of these Guidelines.

9.4. Paragraph 5.(III) of the Guidelines stated that once a Serious Untoward Incident has occurred, the Director of Commissioning at the Health Authority, the Director of Performance Management and the Anglia & Oxford Regional Office should be informed. The Guidelines further provided:

> "5.(V) The Provider will carry out a Management Review within 24 hours and take clinical advice on the care of the patient, the family and carers and counselling of those concerned with the incident. The provider will take immediate action to prevent occurrence or copycat incidents.
>
> 5.(VI) Within 72 hours the Provider will send a completed Serious Untoward Incident report to the Director of Commissioning confirming details of the

incident. The report will provide information which describes the person(s) involved, the nature and severity of the incident and the immediate actions taken.

5.(VII) The Provider will commence a full internal Inquiry as soon as possible after the incident, taking note of the guidance in HSG(94)27. The report should address the following:-

- the care the patient was receiving at the time of the incident;
- the suitability of that care in view of the patient's history and mental health and social needs;
- the extent to which that care corresponded with statutory obligations;
- relevant guidance from the Department of Health and local operational policies;
- the exercise of professional judgment;
- the adequacy of the care plan and its monitoring by the key worker.

5.(VIII) The Provider will keep the Authority fully informed of the progress of the Internal Inquiry.

...

7. Are there any occasions when an Independent Inquiry is required?
Independent inquiries must take place in case of a homicide committed by a patient or the result of staff actions but is discretionary in other instances. The Health Authority will convene an independent Inquiry panel to conduct a formal inquiry into events surrounding a Serious Untoward Incident. The composition and remit for the group should follow the recommendations provided in HSG(94)27.

8. What happens if an independent inquiry is required?
The Provider should carry out the same steps until the point of setting up the Inquiry panel. At this point the Health Authority will establish an independent inquiry taking note of the guidance under HSG(94)27. ... The Inquiry cannot start until after any trial.

9. Guidance and Remit for the Independent Inquiry.
A formal independent Inquiry cannot be conducted until legal processes are completed by both the Coroner's Court and/or the criminal courts. ... Since such an Inquiry can take time to establish, steps can be taken while criminal justice proceedings are in progress. This will include agreeing on membership, payment of costs, terms of reference and method of reporting.
The Director of Commissioning will maintain contact with the police to ascertain dates of hearing."

9.5. Unfortunately, Dr O'Neill-Kerr, who was the representative of the Trust involved with Greg in the immediate aftermath of the assault on 3.5.99, did not appreciate that he had an obligation to report the fact that there had been a Serious Untoward Incident to the relevant Trust managers. As a result, the steps envisaged by the Health Authority's Guidelines were not taken immediately following 3.5.99.

9.6. It is right to add that Dr Berry himself also had some involvement in matters after the assault - as mentioned above, he took the view that it was not appropriate for Greg to be accepted onto the Intensive Care Unit because it was not sufficiently secure. He therefore also had an opportunity to report the incident. Dr Berry's view was that his obligation to report a Serious Untoward Incident involved bringing the fact of that incident to the attention of his Clinical Director. As Dr Berry's Clinical Director was Dr O'Neill-Kerr, and as Dr O'Neill-Kerr had obviously had a far closer and more direct involvement with the actual incident than Dr Berry, Dr Berry very reasonably saw no reason to make a formal report to Dr O'Neill-Kerr about something of which Dr O'Neill-Kerr was already fully aware.

9.7. Dr O'Neill-Kerr, when asked about his failure to make the appropriate report about this serious incident, said that when he was asked to carry out the Mental Health Act assessment at the police station, it did not occur to him that he had a reporting responsibility in relation to incident which had led to Greg being in the police station in the first place. Indeed, he very frankly told the Inquiry Panel that he remained unaware of any procedures or systems in place which required him to

report such incidents to the Trust's management.

9.8. Comment:
It was concerning that the individual who had had the primary responsibility to report the assault upon Mr Marden as a Serious Untoward Incident and who might, therefore, be considered to be the person primarily at fault for the delay in the incident coming to the attention of the Trust's management was <u>still</u> unaware of the guidelines in existence which placed a reporting responsibility upon his shoulders. That suggests that whatever steps have been taken by the Trust since May 1999 to ensure that similar problems do not recur have been, at least in part, ineffective. It is also odd that no one saw fit to ascertain why Dr O'Neill-Kerr did not report the incident as he should have done; and it is odd that he was not apparently told, or reminded, after management had become aware of the incident, of the relevant guidelines which placed that responsibility on his shoulders.

9.9. As a result of Dr O'Neill-Kerr's failure to report the incident as a Serious Untoward Incident, it was only as a result of a chance conversation between Mr Lloyd of Social Services, and Ms Cheryl Mitchell, the Patient Services Manager of the Community Mental Health Team that Ms Mitchell learned that Greg had been involved in the incident. Ms Mitchell, who gave evidence to the Inquiry Panel, immediately relayed this information to a Mr Steve Tyman who was, at the relevant times, Director of Mental Health Services for NCHT.

9.10. Mr Tyman also gave evidence to the Inquiry Panel. On learning of the incident, he immediately wrote to the Health Authority on 16.6.99 forwarding a "Preliminary Report". In his covering letter he stated:

> "On examination of the case there does not appear to be any particular issue that raises immediate concern. I will be arranging an internal case review which will give us more detail and will keep you informed of progress. Concerning HSG(94)27, it is clear ... that "in cases of homicide, it will always be necessary to hold an inquiry

which is independent of the procedures involved." I am aware that this is the case "after completion of any legal procedures" which could take some months and that the Department are reviewing a circular as the process has been questioned since its implementation in 1994. It might be that a different approach is possible in this particular case."

9.11. The preliminary report forwarded by Mr Tyman contained the briefest outline of Greg's contact with the mental health services. It did not contain any reference to Greg's visits to his GP in the days/weeks immediately prior to the incident.

9.12. There then followed a meeting between Mr Tyman and Ms Sally Gooch to discuss Greg's case and the Trust's response to it. Ms Gooch had been appointed as the Trust's Nurse Director in March 1999. She also gave evidence to the Inquiry Panel.

9.13. According to a letter from Ms Gooch to Mr Tyman dated 26.7.99, the meeting took place on that date. Ms Gooch's letter to Mr Tyman confirmed the matters discussed. She said, amongst other things:

> "As we agreed, I will be recommending to the Board that a full investigation is completed prior to a decision being taken about the need for a Panel of Enquiry. I am hopeful that if the investigation that has been undertaken is expanded to include all the issues a panel is unlikely to be needed, although there may yet be an external independent Enquiry."

9.14. Ms Gooch's letter went on to make a series of detailed suggestions for the benefit of whoever actually conducted the Internal Inquiry. These included suggestions as to who should be interviewed, and as to the questions to which answers were needed. These questions included the following:

> " - What liaison has there been with Kent about whether he kept his out-patients appointments with them and what would their level of concern have been if he had failed to attend?

- What is their view on his having stopped some of his post-discharge medication by March 1998 and all soon after?
- When he DNA'd on 10.6.98 did Dr Berry write to patient and GP? If not, why not?
- Why wasn't a further letter sent until 6.7.98 with an appointment for 26.8.98?
- Why wasn't a full assessment and CPA screen done on 11.11.98?
- What formal risk assessment was done?
- What information was given to the patient and family about what to do if [Greg's] condition deteriorated?
- Is it reasonable for a referral to the CMHT not to have been made given that Greg was one member of a family with apparently complex social and mental health problems?
- Why didn't the GP who saw Greg after 14.4.99 and before 5.5.99 refer him back to Dr Berry?
- Why did he/she prescribe imipramine instead of one of the two drugs advised by Dr Berry to be used in the event of Greg becoming symptomatic?"

9.15. Ms Gooch's evidence was that she had wanted to try and provide a format for Ms McWatt's internal investigation report.

9.16. Comment:
The Inquiry Panel agrees with the relevance of the various questions which Ms Gooch raised in this letter.

9.17. This letter was shown to Mr Tyman in the course of his evidence to the Inquiry Panel. His evidence was that he could not recall receiving it.

9.18. Comment:
The view of the Inquiry Panel is that it is likely that he did receive it, not least because it is addressed to him and has a receipt stamp. The copy letter which the Inquiry Panel obtained came from Ms McWatt's file of papers, but the letter makes it clear that no-one had, at that stage, been appointed to run the internal

investigation, so it seems unlikely that the letter was simply passed by Mr Tyman to Ms McWatt without his even reading it.

9.19. Sometime after 26.7.99, Mr Tyman appointed the Trust's Client Relations Manager, Ms McWatt, to carry out the internal investigation. Mr John Rom, the Trust's Chief Executive, also gave evidence to the Inquiry Panel. He confirmed in his evidence that he had agreed to Ms McWatt undertaking the internal investigation. He described Ms McWatt as an experienced investigator. Ms Gooch said in her evidence that she thought that she too would have been party to the decision that it should be Ms McWatt who should conduct the internal investigation. She also said that she supported Ms McWatt during the inquiry procedures, meeting with her, discussing her findings, looking through draft reports and helping to structure the final document.

9.20. Ms McWatt interviewed Dr O'Neill-Kerr, Mr Oelrich, Dr Sunderland, Ms Horrell and Dr Berry. Unfortunately Ms McWatt was unable to contact Dr Baez in order to interview him for the purposes of the internal investigation.

9.21. Comment:
Something of a mystery surrounds this since this Inquiry Panel had no difficulty, two years later, in locating Dr Baez and asking him to give evidence. It does seem as though Ms McWatt did not take some of the more obvious steps which could have been taken in an attempt to locate Dr Baez. One of the unfortunate consequences of this failure was that the first that Dr Baez knew of the homicide was when he was contacted by Mrs Hebden, on behalf of the Inquiry Panel, in connection with this Independent Inquiry.

9.22. As mentioned above, Ms McWatt also spoke to Mr and Mrs Low. Ms McWatt's notes of that interview which were conducted on 22.9.99 recorded, amongst other things, the following:

> "Mr and Mrs Low first discussed the events in issue in the days immediately prior to the attack on Mr Richard Marden. Mr Low said that about 3 days before

the incident, Gregory had told them that he had tried to telephone Dr Berry. Dr Berry was not there and instead he got through to the answerphone which gave an emergency phone number. They said that Greg had phoned that number but the person who had answered it had put the phone down on him. They stated that Greg had been difficult on the phone. They said that if the person who had answered the phone had contacted the Crisis Team who could have called Greg it might have made a difference. Both the Lows and Gregory were aware of the Crisis Team. Mr and Mrs Low said that this was the first time they had seen Greg ill but they were not aware how ill he was. Mrs Low said that she had pressed Greg to phone the Crisis Team but he had not done so. The Lows said that Greg had been a bit ill at the end of March and had had an appointment with, they believe, Dr Berry but in the event Greg saw Dr Baez. They said that the appointment was "about 5 minutes" and that this was not enough time. They also said that Dr Baez had had a long chat with them, that he had said that Greg was "hypersensitive" and that he would not need to see Greg again unless he, Greg, wanted to. ...

Mr and Mrs Low said that Greg did not cooperate with people and would not have been "easy to read". They stated that apparently he was well aware of mental illness because Greg's brother, LM, had schizophrenia and had been in the mental health services for a long time. Greg did not want to be seen in the same way as LM. Mr and Mrs Low said that Greg had been "very ill" in Kent and had had a bad time. ...

When asked whether they were aware that [Greg] had been offered appointments but had not attended, they said that they were not aware of this. They stated that he would probably not have attended as he seemed to be doing alright and that he was working. Had they known about the appointments they would have encouraged Greg to attend but would not have been particularly concerned had he not done so. Greg had said that the medication he had been on (from Kent) had made him depressed and impotent and that all he wanted to do when he came to Towcester was to come off the pills.

They stated that Greg had been "unnaturally silent" and the family would ask him to talk, but he would not do so.

Mrs Low believes that it was LM's illness which "set Greg off again" and had LM not been ill, Greg may have gone to the doctor again. Mr and Mrs Low said that when the family had thought Greg was well, he obviously was not. They said that they now think that Greg had been ill since he came to Towcester but not psychotic - nor that he had "problems" and that he had been quiet, too silent, and had felt inadequate about girls. They thought that perhaps counselling may have helped. Mr and Mrs Low had said that Greg had not taken any other drugs recently."

9.23. Mr and Mrs Low made the point to Ms McWatt that the Trust had "now lost two carers" - a reference to the fact that, following Greg's assault, they now felt that they could not have LM at home again because of the potential risks.

9.24. Ms McWatt had only a telephone conversation with Dr Sunderland for the purposes of her internal investigation. He told her that there was nothing in his notes to suggest "bizarre behaviour". Dr Sunderland did tell Ms McWatt, on a confidential basis and not to be "unnecessarily divulged", about Greg's attendance on 29.3.99 in connection with the possibility that he had AIDS; and about the attendance on 1.5.99 and the fact that Greg had been sullen and withdrawn on that occasion.

9.25. On 20.10.99 Ms McWatt produced her investigation report which ran to eight pages. It was, as she told the Inquiry Panel, essentially a fact finding report. The report recorded, correctly, that Greg had entered a plea of manslaughter on the grounds of diminished responsibility, and that the plea had been accepted by the prosecution. It stated, incorrectly, that Greg was, at the time of the report, "awaiting trial". In fact his case had been finally disposed of some two months earlier, on 20.8.99. The report did not address, or did not address properly, the various questions which had been identified by Ms Gooch in her letter to Mr Tyman of 26.7.99.

9.26. Comment:
This is difficult to understand bearing in mind Ms Gooch's involvement in the preparation of the internal investigation report, to which we make more detailed reference below.

9.27. As noted above, HSG(94)27 requires, amongst other things, the consideration of the exercise of clinical judgment. Ms McWatt does not have any clinical background and fully agreed with the Inquiry Panel that she was not qualified to make any judgments as to the adequacy or otherwise of the treatment which Greg had received.

9.28. Comment:
The wording of Ms McWatt's investigation report is somewhat surprising bearing in mind that she accepted that she was not qualified to make any judgments as to the adequacy or otherwise of the treatment which Greg had received. For example, in paragraph 3 of her Conclusions Ms McWatt said:

> **"Dr Berry has stated that with hindsight he may have allocated Mr Marden a community psychiatric nurse. At the time, however, Mr Marden's clinical presentation was such that out-patient follow up and liaison between Dr Berry and Mr Marden's GP was appropriate."**

In paragraph 5 of her Conclusions Ms McWatt stated:

> **"At his appointment on 14.4.99, Mr Marden had presented as well, had restrained from use of recreational drugs and his mood, sleep pattern and appetite were fine. It was therefore not clinically necessary that Mr Marden should be seen by a consultant psychiatrist rather than a junior doctor."**

As drafted, it appears as though these were conclusions reached by the author of the report, Ms McWatt. It is likely that what Ms McWatt intended was to say that this was the information which had been given to her by Dr Berry but it is unfortunate that, as the report was written, it reads as though the author of the report had -

as HSG94(27) required - considered the issue of whether or not the treatment provided to Greg and the decisions made about his management were appropriate and had concluded that they were. It would, of course, be inappropriate for an internal investigation to reach conclusions as to the appropriateness or otherwise of a clinician's management on the basis only of the evidence of the clinician concerned.

9.29. Ms McWatt completed her report on 22.10.99. Ms McWatt's evidence to the Inquiry Panel was that she then presented the report to the Nurse Director, Ms Gooch. Ms McWatt's expectation was that the report would then be presented to the Trust's Board. Ms McWatt also believed that the report would be forwarded to Mr and Mrs Low - Ms McWatt had indeed given Mr and Mrs Low an assurance that this would be the case.

9.30. In the event, however, no further action seems to have been taken in relation to the internal investigation report for a considerable period. Although it was passed to Mr Rom, the Chief Executive, the report was not formally presented to the Trust Board until January 2001. It was not promptly passed on to the Health Authority in accordance with the Health Authority's Guidelines to which reference is made above. It was not communicated to Mr and Mrs Low.

9.31. Comment:
It is plainly most unsatisfactory that the internal investigation report was not provided to Mr and Mrs Low, when an assurance had been given to them by Ms McWatt that it would be provided. If it was thought that there were good reasons why it should not be sent to them, notwithstanding what Ms McWatt had said, it would, at the very least, have been courteous to let them know of this decision. In the event, Mr and Mrs Low heard nothing further until Mr Rom wrote them on 1.2.01 providing a very brief outline of the results of the internal investigation.

10 Liaison Between the Trust and the Health Authority

10.1. Following the original notification from Mr Tyman, the Health Authority recorded details of the incident in its Serious Untoward Incidents log. There were then regular contacts between the Health Authority and the Trust concerning the logged cases, with the list of outstanding cases being sent to the Trust every two months or so. The practice at that time was that this regular communication from the Health Authority was passed to Ms McWatt. She told the Inquiry Panel that she had, on each occasion that it came to her, filled in the form so far as it related to Greg by writing words such as "Still awaiting outcome" or some similar wording - "outcome" in this context referring to the conclusion of the criminal proceedings brought against Greg.

10.2. Ms McWatt agreed that she should, on each such occasion, have taken steps to check the position herself. As the Inquiry Panel understand her, evidence, however, she took the form as a request from the Health Authority for the Trust's latest information about Greg - but she did not interpret the form as a request from the Health Authority to the Trust to take positive steps to find out what the up to date position was *vis a vis* Greg. She accordingly felt that since she was unaware of any developments so far as Greg was concerned, it was appropriate to complete the form in the way that she did.

10.3. Comment:
Ms McWatt's explanation suggests that she had no real understanding of this part of her job. Her interpretation of the communications received from the Health Authority was naive. The Inquiry Panel considers that the Health Authority was entitled to interpret her responses as a representation that the legal processes consequent upon Greg's assault and Mr Marden's subsequent death were still ongoing.

10.4. There is then a conflict in the evidence which was presented to the Inquiry Panel as to what occurred.

10.5. The evidence of Mr Tyman was to the effect that throughout the period from September 1999 onwards, he had had

regular discussions with Ms McWatt about the current position with Greg's criminal proceedings. He said that he was very conscious of the need for an Independent Inquiry to be set up once the criminal proceedings had been concluded and he said that he regularly asked Ms McWatt to check what the position was with regard to those criminal proceedings. Mr Tyman told the Inquiry Panel that Ms McWatt told him that she had made a number of telephone calls through to the local Regional Secure Unit in an attempt to ascertain Greg's current position but that she had not got any or any satisfactory response. Mr Tyman's evidence was that the question of Greg's status was raised in monthly meetings with Ms McWatt and that the answer which he got remained the same - namely that Ms McWatt had been chasing up the position but had received no relevant information about the disposal of Greg's criminal proceedings - until about December 2000.

10.6. Ms McWatt's evidence was, however, very different. She said that it was not until December 2000 that she was asked to take positive steps to ascertain Greg's whereabouts and the current state of his criminal proceedings. Her recollection was that it was following a discussion which she had with Mr Rom, the Trust's Chief Executive, that she was first asked to try and ascertain Greg's whereabouts and what had happened to the criminal proceedings against him. Her recollection is that this conversation with Mr Rom was very shortly prior to her ascertaining, in December 2000, from the Regional Secure Unit that Greg was there and that his criminal proceedings had been disposed of more than a year earlier. She said that as soon as she was asked to ascertain Greg's whereabouts, she immediately contacted the Regional Secure Unit. She said that staff there were helpful and let her know what Greg's position was - although they did require a formal letter from her requesting the information first. Ms McWatt said that she had then sent the letter asked for promptly and that a prompt written reply (dated 3.1.01) was received.

10.7. Ms McWatt certainly did not agree with Mr Tyman's suggestion that she had been told by him on a number of occasions throughout the previous year to ascertain Greg's current whereabouts and situation. She confirmed that there

were no occasions upon which she had attempted to get information from the Regional Secure Unit and found staff there to be uncooperative - on the contrary, she confirmed that as soon as she did raise a query with the Unit in December 2000, she got prompt and helpful replies.

10.8. Comment:

Whilst the Inquiry Panel is satisfied that Ms McWatt's understanding of her role in relation to the form being received every 2 months or so from the Health Authority concerning outstanding Serious Untoward Incidents was naive, it also takes the view that it is unlikely that, given a straightforward request by Mr Tyman to check Greg's whereabouts, she would have failed to do so or would then have told Mr Tyman that she was having problems with Marlborough House when that was not the case. The conclusion reached by the Inquiry Panel is that Mr Tyman did not in fact ask Ms McWatt to check the position *vis a vis* Greg's whereabouts on a regular basis. What may have occurred is that Mr Tyman was aware of the fact that Ms McWatt was handling the regular communications from the Health Authority regarding the outstanding Serious Untoward Incidents, and (reasonably) assumed that as part of her response to those communications, Ms McWatt was in fact checking the position *vis a vis* Greg.

10.9. Following confirmation from Marlborough House that Greg's criminal proceedings had been completed, the Health Authority took prompt steps to set up this Independent Inquiry. Appropriate steps were also taken at this stage to inform Greg's family about the Independent Inquiry being set up and about what would be involved in that process.

11 DISCUSSION

Greg's Transfer from Kent

11.1. When it was discovered by Invicta's mental health services that Greg had moved to Northamptonshire, Greg was discharged from the case load at the Kingswood Community Health Care Centre, with no attempt apparently being made to contact the mental health services in Northamptonshire.

11.2. When a patient who is on what is now known as Enhanced CPA moves areas, it is obviously good practice for there to be a smooth transfer of care between secondary services. This is, however, difficult to achieve when the patient's new location is not known and there is no other point of contact with the patient. It is not practical to expect the mental health services to try to track down patients who leave an area without providing information as to their next address. In such circumstances, it can only be hoped that the patient will re-establish contact with the mental health services in the new location or at least register at some point with a new GP so that a record of his or her involvement with the mental health services will be communicated through the primary care system. Even a national register of those on Enhanced CPA, such as that which has recently been mooted by the Department of Health, would not provide a solution to this problem, unless perhaps access could also be obtained to other records, such as, for example, information held by the Benefits Agency. The technology of records would have to improve for this to happen reliably; it would still not be possible reliably to track all patients; and there are, of course, major ethical and political questions involved. Overall, the Inquiry Panel's conclusion is that there is not a practical way of reliably tracking down all patients who chose to move on from an area without providing information about their whereabouts to the mental health services - there will, therefore, no doubt be cases where contact will be lost with patients who are in need of the continued support of the mental health services.

11.3. In many cases, however, contact could be re-established with a patient through his/her next of kin, and the Inquiry Panel considers that it must be good practice to pursue at

least this avenue in the event of a patient in need of follow-up moving out of the area without providing a forwarding address. In this case, Invicta's mental health services did have contact information for Greg's mother in Kent. However, as she moved to Northamptonshire at about the same time as Greg, it is perhaps unlikely, though not impossible, that these contact details would have provided a means of contacting Greg. There is, however, no record in the papers which have been seen by the Inquiry Panel that an attempt was made to establish contact with Greg by this route. In the event, of course, this mattered not at all, as Greg did register with a new GP, and contact with the mental health services was re-established.

11.4. Comment has been made above on the fact that Greg was able to take to his first appointment with Dr Hooker a copy of his discharge summary from Priority House Mental Health Unit, which he had been given at the time of discharge. This will have provided Dr Hooker with valuable information which would not otherwise have become available to him, until the process of transferring Greg's medical records from Kent had occurred.

Recommendation

11.5. **The Inquiry Panel considers that the practice of providing a patient with a copy of his discharge summary at the time of his discharge is to be commended and it is our recommendation that this step should be considered as a matter of routine whenever a patient is discharged from care as an in-patient.**

12 *Greg's Referral by Dr Hooker to Dr Berry*

12.1. Dr Hooker's referral letter to Dr Berry was dated 17.3.98. He received no acknowledgement of this letter and received no communication at all about the referral until the letter notifying Greg of his appointment dated 18.5.98 was copied to Dr Hooker. This situation is not satisfactory. In the absence of an acknowledgement from the hospital, Dr Hooker could not know whether the delay was administrative, or whether his referral letter had gone astray.

12.2. There seems to us to be no good reason why the Trust cannot institute a policy of ensuring that all referral letters are acknowledged so that a GP can at least know that further delay is a result of delays in fixing the appointment, rather than having to be concerned about the possibility that a referral letter has gone astray.

Recommendation

12.3. **It is therefore our recommendation that the Trust institutes a policy of ensuring that all referral letters are acknowledged within no more than 2 days of their receipt; and develops procedures and secures resources to enable this to happen.**

12.4. Information Technology in the NHS has sometimes been described as consisting of “electronic islands” but it should be possible to move, we would hope rapidly, towards a system whereby GPs can communicate with the secondary services and indeed with the CMHTs by email, so that referral letters, and other communications, can be acknowledged, not by letter, but by a receipt email which can perhaps be automatically generated as soon as the incoming email from the GP is opened by secondary services.

Recommendation

12.5. **It is, therefore, also our recommendation that work on extending electronic links between primary and some aspects of secondary care in the NHS be extended as**

soon as possible to key communications between primary and secondary mental health services.

12.6. There was a three month delay between Dr Hooker's referral letter of 17.3.98 and the date of the first out-patient appointment given to Greg. In the light of the information set out in Dr Hooker's letter about Greg's condition, the delay was too long. It may well be an indication of the extent to which there were particular pressures upon consultants' time at the material times in 1998. It is to be hoped that the new triage system of referrals, referred to below, will assist in easing such pressures.

13 Greg's Out-patients Appointments

13.1. There was inconsistency in the secondary services' response to Greg's failure to attend his out-patients appointments, and ultimately the Inquiry Panel's view is that the response was not adequate.

13.2. On the occasion of Greg's first non-attendance, Dr Berry telephoned Greg's GP to let him now what had occurred, but failed to make contact. As recorded above, it is considered unlikely that Dr Berry then followed this up with a second call to the GP - the GP's records suggest that no information at all was received from Dr Berry about this appointment.

13.3. Dr Berry did, however, raise Greg in discussions at a CMHT meeting on 11.6.98; and there was a further discussion on 2.7.98. The Inquiry Panel considers it surprising that these discussions merely resulted in a decision to give Greg a further out-patients appointment for 26.8.98. As commented above, Greg was a patient who had only recently had a very serious mental illness, requiring an extended period as an in-patient, and who had been considered in need of significant ongoing medication. Further enquiries, perhaps of Greg's GP, may well have brought to light the fact that Greg was no longer taking his medication which should have made the need for Greg to be seen by the secondary services as soon as possible all the clearer.

13.4. Greg failed to attend the next out-patients appointment on 26.8.98. There is no evidence to suggest that Dr Berry notified Greg's GPs of this non-attendance; or that he raised Greg's case at a CMHT meeting.

13.5. Dr Berry must have written to Greg with details of the next appointment fixed for 30.9.98, but the Inquiry Panel has not been able to trace a copy of this letter. The letter does not appear, in any event, to have been copied to Greg's GP. Only following Greg's non-attendance on 30.9.98 did Dr Berry again make contact with Greg's GP, a letter being sent to Dr Hooker on 2.10.98.

13.6. Overall, the conclusion reached by the Inquiry Panel is that there was little or no attempt made to encourage Greg to

attend his appointments with Dr Berry, other than sending him further appointment letters. In the light of the apparent seriousness of Greg's condition, the Inquiry Panel considers this both surprising and disappointing.

13.7. Whether Greg would have responded to further communications from Dr Berry and/or to a visit from a CMHT representative and ended up seeing Dr Berry earlier than was in fact the case, it is impossible to say. There was, however, a substantial delay between Dr Hooker's referral letter of 18.3.98 and the first meeting between Greg and Dr Berry.

13.8. On the face of it, this delay did not actually matter, since Greg was apparently doing well during this period. However, if Dr Berry had seen Greg at an earlier date, there would, in all probability, have been at least one or two more follow-up appointments with Dr Berry and/or Dr Baez in the period before Greg's relapse in April/May 1999. Good engagement obviously requires time and contact as well as good clinical listening skills. It is possible that, if earlier contact had been established with Greg, then Greg's relationship with Dr Berry and/or Dr Baez might have progressed to the extent that Greg would have found it easier to communicate to Dr Berry and/or to Dr Baez the concerns which the Inquiry Panel thinks he had about his mental state in April 1999 - concerns which were evidenced by his visit to Dr Sunderland on 29.3.99.

13.9. It is, therefore, the Inquiry Panel's view that it is unfortunate that there was this extended delay before Dr Hooker's referral letter finally resulted in Greg being seen by Dr Berry. The Inquiry Panel takes the view that something more could and should be done where a patient fails to attend an out-patients appointment and that it should be the invariable practice that any non-attendance by a patient at an out-patients appointment is consistently followed up.

Recommendation

13.10. It is our recommendation that, in the event that a patient of the mental health services who has been newly referred or newly re-referred to the secondary services,

or who is considered to carry significant risk, fails to attend an out-patients appointment, there should be a letter from the secondary mental health services to both the patient and to his/her GP, notifying them of the non-attendance and of the action which is planned following and as a result of that non-attendance.

Recommendation

13.11. **Furthermore, it is our recommendation that consideration should be given by the Consultant concerned in each such case to the possibility of involving the CMHT in following up the patient. Whilst this occurred to some degree in this case following Greg's first non-attendance on 10.6.98, there is no evidence suggesting that it occurred following the subsequent non-attendances by Greg. The action taken following non-attendances in this type of case, and the reasons for that action, should also be fully documented in the patient's medical records.**

13.12. In services where the Psychiatrists and the rest of the CMHT are based together, liaison of the type suggested in the preceding paragraphs is self-evidently considerably easier. The practice of basing Psychiatrists and the rest of the CMHT in the same location is growing and it is the view of this Inquiry Panel that it should be commended and in the view of the Inquiry Panel should, whenever reasonably practicable, be implemented.

Recommendation

13.13. **It is therefore our recommendation that the Trust should, as soon as is practical, aim to locate Psychiatrists and CMHT staff in the same premises in order that they might more easily coordinate the service they provide for their given population, and more easily agree and implement operational protocols and referral systems.**

14 Dr Berry's Decision not to refer Greg to the CMHT

14.1. There are two separate issues to be considered here. The first relates to the way in which the decision not to refer Greg for follow-up by the CMHT was made. The second concerns the merits of the decision not to refer Greg to the CMHT.

The Making of the Decision not to refer Greg

14.2. As commented above, it is the view of this Inquiry Panel that it would have been better if the decision about whether or not to refer Greg to a CMHT had been made after a formal discussion at a CMHT meeting, rather than by Dr Berry alone. This is particularly so if, as Dr Berry told the Inquiry Panel was the case, an important element in his decision not to refer Greg was a concern that the CMHT did not have the resources available to deal with Greg, and that there were other patients who should be prioritised.

14.3. It was observed in some of the evidence given to the Inquiry Panel that some doctors do have a cultural hurdle to overcome when it comes to adopting the multi-disciplinary approach. This may be the case. It may in part be a consequence of the medical training. It may be related in part to issues of patient confidentiality, as was suggested by Mr Lloyd in his evidence to the Inquiry.

14.4. The issue of patient confidentiality is frequently raised as a reason for not having a wider dialogue about a patient. It is, for example, thought by some to be good practice not to have discussions with relatives because of the need to respect patient confidentiality. However, mental health workers should always be prepared to seek out relatives' views. There is no reason why this cannot be done without giving confidential information about the patient - questions merely seeking information should not compromise patient confidentiality The General Medical Council has produced some helpful guidance in respect of information sharing with others providing care, especially if and when it benefits the patients, either directly or indirectly - see "Confidentiality: Protecting and Providing Information", sections 3.9.4 and 5.24, published by the GMC in 2000.

14.5. However, the evidence heard by the Inquiry Panel suggests that, whatever may be the cultural attitude of Consultants generally, it would not be right to level this sort of criticism at Dr Berry. It was acknowledged by more than one of the witnesses interviewed by the Inquiry that Dr Berry was more open to a multi-disciplinary approach than many other Consultants.

14.6. Furthermore, as mentioned above, the evidence which the Inquiry Panel heard also confirmed that there was indeed a perception that the South Northamptonshire CMHT was under considerable pressures at the material times, a fact of which Dr Berry would have been well aware.

14.7. In this connection, it should be recorded that evidence was given to the effect that a new triage system of referrals is being tried out in parts of Northamptonshire. This is generally seen as a positive development, although the Inquiry Panel was told by Dr Berry that this system is in reality only a screening mechanism, and that it does not provide an in-depth assessment. He also told the Inquiry Panel that initial data from the trial suggested that the system has resulted in a reduction of the number of referrals to the CMHT of those requiring follow-up.

14.8. The Mental Health Policy Implementation Guide - Community Mental Health Teams, issued by the Department of Health in 2002, discusses the functions of the CMHT, and makes it clear that the CMHT's role includes providing advice to Primary Care, and a triage function enabling an appropriate referral to be made. The new triage system therefore accords with current thinking at that Department of Health, and we consider it is a development to be welcomed. Properly operated, it is a system that should reduce the bottleneck of first assessments of people referred to the secondary mental health services. Whilst noting Dr Berry's concerns, the Inquiry Panel takes the view that, with time, staff carrying out screening will acquire the skills and experience to make assessments in greater depth. The situation where a Consultant Psychiatrist has to make a unilateral decision whether or not to refer a patient to a CMHT should no longer arise.

The Merits of the Decision not to refer Greg

14.9. The question of whether the decision not to refer Greg was the right one is a difficult one. With the benefits of hindsight, the decision appears unfortunate. The Inquiry Panel is satisfied, however, that there was nothing about Greg's behaviour or presentation prior to 3.5.99 which would have suggested that he was at all likely to commit a violent assault upon his father, or anyone else. Whilst Dr Berry was, in his evidence to the Inquiry Panel, somewhat self-critical and expressed the view that Greg should have been referred to the CMHT, the view reached by the Inquiry Panel is that, in making these remarks, Dr Berry was influenced by his knowledge of the events which followed. The view of Dr Michael Radford, the Consultant Psychiatrist on this Inquiry Panel, was that in Dr Berry's position, and with the information which was available to Dr Berry at the time, he might very well have made the same management decisions as Dr Berry made.

14.10. It should be noted in this connection that there was and remains a difference of medical opinion about continuing follow up of a person after a first episode of psychosis. Approximately one third of patients never have another episode of psychosis; and many Psychiatrists at the material times in 1998 would have taken the view that the danger of a patient feeling stigmatised as a result of medical insistence upon close follow-up following a first episode of psychosis, with the attendant possibility of loss of confidence and possible self-denigration, was such that, at the very least, close follow-up should not be regarded as a high priority.

14.11. Current thinking in the Department of Health is that extra resources should be made available from central funds to provide intensive education of the patient and family designed to help them to understand the condition, its treatment and likely future development; emphasising potential risk factors and signs of early relapse as well as routes into urgent treatment. One of the objectives of this initiative, "Early Intervention in Psychosis", which is to be aimed at younger people such as Greg, is to pick the recurrence of problems before the first relapse. At the time with which this Inquiry is concerned, however, there were too

few resources for this approach to be contemplated, although, as mentioned above, Dr Berry did plan to provide literature for Greg. The leaflet which he had in mind, "Excerpts from Surviving Schizophrenia" by Dr Fuller Torrey, would have been entirely appropriate for Greg, and Dr Berry's intentions in this regard are to be commended. Unfortunately it may well be that this literature was not, in the event, actually supplied to Greg.

14.12. Having said all this, however, if Greg's case had been formally discussed in a CMHT meeting, with the decision about a referral being made by the team, not just by Dr Berry, there would have been at least a possibility that a decision to refer Greg might have been made. The relatively limited extent of Mr Oelrich's involvement with Greg would presumably have been appreciated; and full consideration of the issues involved may have led to discussions with Mr and Mrs Low which might, in turn, have resulted in an appreciation of their relatively limited knowledge of Greg, and of their reservations about their ability to "read" him.

14.13. It is, however, difficult to be sure about this latter point. The firm impression which the Inquiry Panel got was that there was a perception, not just by Dr Berry, but also by other members of the South Northamptonshire CMHT, that Greg had a degree of family support which would have made him a low priority for a referral to the CMHT. A number of witnesses commented upon the fact that Mr and Mrs Low's experience of mental illness, as a result of their active involvement with LM, meant that Greg was better supported, and, accordingly, less at risk, than most. Whilst not the only relevant factor, this perception was, in the view of the Inquiry Panel, a relevant factor in Dr Berry's decision not to refer Greg for follow up by a CMHT; and would probably have been a significant factor in any consideration of Greg's position at a CMHT meeting.

14.14. Greg did have a supportive family and that was certainly a material consideration in any decision about his management. It is right that the experience acquired by Mr and Mrs Low with LM gave them knowledge of the mental health services, and of how to access those services which would be greater than might normally be expected.

The same may well have been true also of Greg's parents, Mr and Mrs Marden. However, before that experience could properly be relied upon as a relevant factor influencing decisions about Greg's management, it was essential to ascertain what contact Mr and Mrs Low, or other family members, had with Greg on a day to day basis; whether they were happy to take on a degree of responsibility in relation to Greg's management; and if so, to what extent. Even if Mr and Mrs Low were prepared to take on some role in relation to Greg, it would still have been necessary for there to be discussion with Greg about this arrangement, not least because it would have been necessary for Mr and Mrs Low to have been given some information about Greg's confidential medical history in order for Mr and Mrs Low to have an appropriate appreciation of the type of problems which Greg had experienced and the type of warning indicators for which they should be keeping an eye open. What would, in particular, have assisted the family in this instance was information about the warning signs which they should look out for which might indicate a deterioration in Greg's condition.

14.15. Overall, the Inquiry Panel takes the view that this was a case where the family were left with too much responsibility on the overly optimistic assumption that the family's involvement with LM meant that they had a higher than usual degree of expertise in picking up the signs and symptoms of mental health illness which would enable them to identify if and when Greg's mental state deteriorated to the extent that further medical intervention was needed. At the very least, the family should have been warned not to under-estimate the seriousness of Greg's condition, even if it did create a risk that Greg might perceive himself as being bracketed with LM as mentally ill with schizophrenia.

14.16. It is relevant at this point to comment also upon the evidence from Mr and Mrs Low about their involvement in CPA review meetings and ward rounds concerning LM. As mentioned above, they regularly attended such meetings. However, their evidence was to the effect that little or no attempt was made to ascertain their views on proposals for LM's management. Mr Low said that with LM they were rarely asked for their own opinions. Mrs Low said:

> "Sometimes it's difficult to ask, I'm not a pushy person. I used to go to the ward meetings every week with LM and I'd sit there and it would be "LM's got to come home this weekend" and it was never "can you cope with that?" I was having to work at the time, and Ollie was working. I'm a bit quiet. ... I used to go to the ward meetings and it would all be arranged that LM would come home and do this and I would think, hold on a minute you haven't asked me whether I can do that at the moment. And I would actually have to say no I can't do that, he'll have to come home at the weekends because we've other things to do."

14.17. When asked what role she was asked to play when she attended CPA review meetings, Mrs Low replied:

> "I don't know, I just sat there. ... I would have found it very helpful if, at the time, in the ward meeting, somebody had said to me - what do you think?"

14.18. These comments come from individuals who are perceived by each of the witnesses who knew them as having a good understanding of LM's condition, and a better than average understanding of the way in which the mental health services operated and should be accessed. If people such as this feel intimidated by the way in which CPA review meetings and ward meetings are conducted, there are important lessons to be learnt for the mental health services about how to deal with family and other carers who are playing a part in the management of the mentally ill. It is also evidence which suggests that even a more formal discussion of Greg's position might well not have resulted in the team obtaining a full appreciation either of the limits of Mr and Mrs Low's knowledge of Greg or of their reservations about their ability to take responsibility for Greg.

14.19. Carers play an important role in helping to look after patients particularly those with severe mental illness. Their contribution has been recognised nationally (Caring about Carers a National Strategy for Carers - 1999) and in the National Service Framework ("NSF") for mental health, one of the standards is specifically about carers and their needs.

Recommendation

14.20. **It is our recommendation that the Trust should ensure that all carers are positively involved in the CPA process and should discuss their needs and how they relate to the task of caring for the patient. To enable carers to be positively involved in the CPA process, we recommend that they should have an appointed care worker who can assess their needs for ongoing support and respite care if and when necessary. It is also our recommendation that, in line with the NSF for mental health, standard 6, carers should have their own care-plan which includes names of key professionals and how to contact them. Furthermore, to facilitate good communications, we recommend that a handbook of all available services should be written and distributed to all families/carers of people in touch with mental health services.**

14.21. What decision might have been made had there been a formal discussion in a CMHT meeting about a possible referral of Greg to the CMHT can, ultimately, only be speculation. The evidence given to the Inquiry Panel suggests, however, that there was a widespread perception that Greg had a significant degree of family support, and this would probably have led to him being regarded as a low priority for a referral to the CMHT, even if there had been such a formal discussion. The assumption was made that Mr and Mrs Low were able to cope with Greg as they had been involved in LM's care for some time; and because, as a result, they had access to Mr Oelrich. These assumptions should have been tested or verified before they were relied upon by the mental health services in making decisions about Greg's management.

15 *Resources and the Rural Areas*

15.1. It is relevant in the context of the issues discussed above to record that the Inquiry Panel heard from a number of witnesses that the resources available in the rural areas of the county were scarce. As mentioned above, this may have played a part in Dr Berry's decision not to refer Greg's case to the local CMHT for discussion as to whether or not there should be a formal referral.

15.2. Both Dr Berry and Dr O'Neill-Kerr had concerns about the number of Psychiatrists employed to cover the rural areas of the county, which Dr O'Neill-Kerr suggested did not meet College guidelines. Dr O'Neill-Kerr did acknowledge, however, that if one adopted the Jarman method of weighting for social morbidity, which tends to result in rural populations having a lower predicted morbidity rate than inner city populations, one could make an argument that the number of Psychiatrists available was adequate.

15.3. Mr Oelrich told the Inquiry Panel that he agreed with Dr Berry's assessment that it was, at the material times, difficult for Dr Berry to make referrals to the Towcester sector of the South Northamptonshire CMHT because of the resources available. Ms Horrell expressed the view that the resourcing for the rural areas of the county failed to take adequate account of the large areas which needed to be covered. Dr Sunderland likewise told the Inquiry Panel that he considered that there were inadequate resources allocated to the psychiatric services in the rural areas of the county, his perception being that resources had been prioritised to the towns, where the problems were greater.

15.4. The evidence from further up the management structure, however, was that these concerns had been noted, that consideration had been given to the respective resourcing of the rural areas and of the rest of the county, and that the conclusion had been reached that in fact the rural areas were appropriately resourced, even after taking account of the size of the area covered (with the consequent implications so far as travelling time and the like were concerned). The Inquiry Panel heard evidence of, and was provided with a copy of, a study carried out by the Sainsbury

Centre for Mental Health in 2000 which had looked into the locality profiling of mental health services in Northamptonshire. The report found that the morbidity in the rural areas was lower than in the towns - a conclusion which was not unexpected - but also concluded that the resourcing for the rural areas, even after taking account of the geographical factors and associated travelling time for CMHT team members, was appropriate. Whilst one can well understand that practitioners dealing with waiting lists and delays will perceive there to be under-resourcing, or at least under-resourcing relative to other areas, it appears therefore that an objective assessment of the need for resources, and the allocation of resources in Northamptonshire, has been carried out and that the results did not confirm the perception that the rural areas were under-resourced in comparison to the towns.

15.5. Some witnesses to the Inquiry Panel were, however, critical of the Sainsbury Report and, in particular, its findings in relation to the resourcing of the rural areas suggesting, amongst other things, that it failed to take appropriate account of the need for there to be a "critical mass" in a specific team or geographical area in order to avoid problems arising during holiday periods and in the event of staff sickness. It is outside the scope of this report to conduct as detailed an investigation into resourcing issues as that which was conducted by the Sainsbury Centre, but it is noted that in 2002, since the Sainsbury Report was prepared, the Department of Health has issued the guidance on Community Mental Health Teams, referred to above. This contains, amongst other things, guidance on appropriate staffing levels for CMHTs. In the light of the continuing concerns which have been expressed to the Inquiry by several witnesses about the resourcing of the rural areas, and in the light of this recent guidance from the Department of Health, it is suggested that consideration now be given to a further review being conducted of staffing levels in the rural areas, taking particular account of the recent Department of Health guidance, of the need to maintain a critical mass of staff in an area or in a team, and of the views of senior clinicians working in the rural areas.

15.6. It is, in any event, clear that there is a significant difference

between the conclusions of central management and the perceptions of at least some of the clinicians working in the rural areas of the county. The following observations may be relevant to these differing points of view.

15.7. Prior to Greg becoming involved with mental health services, the Inquiry Panel was told that there were in the Towcester CMHT three "G" grade nurses and one "E" grade nurse who provided care for people in the Towcester area, including Brackley. However, a decision was taken that mental health services for people living in the Brackley area should be provided by mental health services in Oxfordshire. One "G" grade nurse accordingly left the Towcester CMHT.

15.8. Another of the "G" grade nurses was then seconded to perform other duties. This nurse eventually left the Towcester CMHT altogether and has not been replaced. The Inquiry Panel was also told that, following a reorganisation during 2001, some areas previously covered by the Towcester CMHT began to receive services instead from the Northampton Borough CMHT. The net result has ultimately been that there has been a reduction in the complement of nurses in the Towcester CMHT from three "G" grade nurses and an "E" grade nurse to one "G" grade nurse and one "E" grade nurse; and a reduction also in the areas covered by the Towcester CMHT - although it must be recorded that there was conflicting evidence presented to the Inquiry Panel about whether this actually resulted in a significant reduction in the population being covered. Whatever the position in this regard, Mr Oelrich told the Inquiry Panel that the reduction in the number of nurses did not, in any event, occur at the same time as the reduction in areas covered, with the result that there were periods when the Towcester CMHT was very stretched, particularly as he, the one remaining "G" grade nurse, was having to supervise what he described as a relatively inexperienced "E" grade nurse.

15.9. Furthermore, having had a complement of four nurses reduced to only two would, even if matched by a proportionate reduction in the population covered, inevitably create difficulties for the CMHT. In the absence of a "critical mass", providing cover for holidays and unplanned absences must be very difficult, (although, of course, multi-disciplinary

working does allow for other members of the CMHT to cover for the two nurses).

15.10. It is relevant also that there was an ever increasing amount of Government guidance which meant that there was an expectation that CPNs would be working in greater depth with people with severe and enduring mental illnesses. GPs were having also to cope with the increased expectations of central government, as well as increasing numbers of people with mental illnesses. These problems would no doubt have strengthened the perception that the reduction in the number of nurses left the Towcester CMHT very stretched.

15.11. The position may have been exacerbated by another factor. One of the strengths of having community based nurses is their ability to build relations with both the patient and their families. However, whilst nurses will seek to maintain a professional relationship, the nature of their work is such that it is inevitable that some patients will, to a greater or lesser extent, become dependent upon their nurse. In these circumstances, it can become difficult for a nurse to take the decision to discharge a patient whose needs are not, perhaps, as great as others, particularly when there is no other service to fill the gap left behind. Unless nurses do regularly discharge from their caseload those patients who no longer have a real need for the skills of a CPN, the inevitable result is that nurses continue to increase their workload and become over-stretched.

15.12. We should, in this context, record that Mr Oelrich informed the Inquiry Panel that there was regular clinical supervision and caseload review. He personally did not accept that he had retained patients who no longer needed his skills, and he did not consider that this was a factor explaining why he felt himself to be over-stretched. Other evidence presented to the Inquiry Panel suggested, however, that Mr Oelrich was a very caring CPN, whose concerns about his patients were such that he did, from time to time, have difficulty in discharging those who no longer needed his particular skills, notwithstanding the presence within his team of other support workers to whom he could have delegated. The Inquiry Panel cannot determine the true position in this regard but the evidence to the Inquiry Panel was that there

was at the material times a full complement of social workers and other support staff available in the Towcester CMHT.

15.13. To supplement statutory services and to fill the gap which patients may feel when discharged by their CPN, voluntary organisations, such as MIND, RURAL MIND and the National Schizophrenia Fellowship, have in other parts of the country been successful in setting up support groups and even providing day care facilities. As mentioned above, the Sainsbury Centre for Mental Health reported in 2000 and significantly it commented upon local GPs lack of awareness of the potential value of voluntary organisations in the delivery of mental health services. The Inquiry Panel was told, however, that since the Sainsbury report MIND has introduced a twice weekly service in Towcester, with group sessions of up to 15 people being conducted in the same building as the CMHT. Referrals are accepted from all members of the CMHT as well as from individual GPs. This development is to be welcomed but it must be remembered that patients still have to be motivated to attend and for some the lack of transport in rural areas can be an insuperable hurdle.

15.14. Primary care is now a major recourse for people with mental health problems. In considering the distribution of resources in rural areas, it is clearly important to consider whether working arrangements between primary and secondary care can be revised to solve some of the organisational difficulties mentioned in this section. The Department of Health has not sought to prescribe particular models of relationships between CMHTs and primary care, but it is understood that more resources will be committed over the next few years. This provides an opportunity for Primary Care Trusts and the secondary services to try to develop local solutions to the problems of travelling time, professional cross-cover and the critical mass of mental health services at small town and village level. Initiatives in primary care, such as attached workers and joint case registers, should improve co-working. Information technology has the capability to keep track of whether people are collecting their prescriptions and keeping appointments. Joint training and regular contact between all those involved are likely to result in improvements.

Recommendation

15.15. **It is our recommendation that, in accordance with Department of Health Guidance on CMHTs, set out in "Mental Health Policy Implementation Guide - Community Mental Health Teams" published in 2002, and in the light of the increasing demands from the Department of Health for documentation as well as its ambitions for early intervention in psychosis, the Trust and the commissioners of mental health services should agree a forum with terms of reference:**

(i) To review CMHT caseloads, staffing levels, working practices and clinical supervision in order to ensure appropriate skill mix;

(ii) To discuss all new initiatives and agree the resultant action plan;

(iii) To agree the allocation of new resources;

(iv) To continue to explore ways in which the voluntary sector can be commissioned to provide day care and support services, including transport, to both patients and their families; and

(v) To set up regular training programmes which take account of new ways of working.

16 *The Attendance on Dr Baez*

16.1. Dr Baez and Greg both said in evidence that Greg appeared to be fine when Greg saw Dr Baez. As recorded above, Greg was, however, surprised to be told by the Inquiry Panel that this appointment with Dr Baez followed his first attendance upon Dr Sunderland on 29.3.99, as he, Greg, recalled that his mental state had already begun to deteriorate at the time of that attendance on Dr Sunderland.

16.2. As mentioned above, it is the view of the Inquiry Panel that the most likely explanation is that Greg's mental state was fluctuating over this period, and that as at 14.4.99 Greg was indeed feeling well. Why questioning by Dr Baez did not elicit that Greg had recently had concerns about his health and had been to see his GP cannot now be ascertained. It may well be that Greg simply gave the impression to Dr Baez that all was well, and Dr Baez accordingly did not press the matter. It may be that Greg felt less comfortable, and was accordingly, less forthcoming because he was seeing a doctor he had not met before.

16.3. The view of this Inquiry Panel is that it is better, where it is feasible, for a patient's follow up to be with the same practitioner as saw the patient initially so that a relationship can be built and comparisons made between presentations on successive visits. Other methods of working, however, may have other advantages; and the way in which Dr Berry allocated work between himself and Dr Baez was perfectly reasonable.

16.4. The Inquiry Panel takes the view that it is likely that there was a discussion between Dr Baez and Mr and Mrs Low on this occasion. If this is right, it is unfortunate that there is no note of the fact that such a discussion had taken place or of any relevant information obtained, although this may reflect the fact that, as far as Dr Baez was concerned, nothing of importance emerged in the course of this discussion.

17 *The GP's Involvement*

Dr Sunderland's Involvement

17.1. One striking feature of the chronology of events here is that on 1.5.99, just 2 days before the assault on Mr Marden, Greg was seen by his GP, Dr Sunderland. In view of what the Inquiry Panel was told by Greg and by his family, and in view of what Dr Sunderland himself recorded in his notes, albeit looked at with the benefits of hindsight, it is clear that Greg's mental state had worsened significantly before this last attendance upon Dr Sunderland. Dr Sunderland himself recorded on 1.5.99 that Greg had "a rather confused personality". Although Dr Sunderland said that he did not mean this to imply that he had thought that there was any sort of psychiatric component to Greg's problems, the Inquiry Panel takes the view that it is a note which does suggest that Dr Sunderland did identify that Greg's problems were not confined to concerns about AIDS and that there was something about Greg's presentation which suggested wider concerns.

17.2. Dr Sunderland did not, however, relate his perception of Greg's "somewhat confused personality" to Greg's history of mental illness and did not therefore conclude that there might have been a relapse or deterioration in Greg's mental state. In this context, we should reiterate that Greg was not openly consulting Dr Sunderland about mental health problems but about his concerns with AIDS. As commented above, what may seem significant from the standpoint of someone interested in, or looking for, psychiatric problems, may well not be noted at all in the context of a request for advice about a sexually transmitted disease.

17.3. The Inquiry Panel takes the view, however, that there were indications which should have caused Dr Sunderland to acquaint himself more fully with Greg's background. Whilst Greg's first attendance upon Dr Sunderland, on 29.3.99 - when he first expressed concerns about AIDS - could legitimately be regarded simply as a self-contained enquiry about a self contained problem, there were features about the second visit which could have caused Dr Sunderland to investigate Greg's concerns in a little more detail. Quite

apart from the observations which led Dr Sunderland to make his note of a "rather confused personality", there was the fact that Greg had already attended upon Dr Sunderland in respect of this very problem, but had not apparently taken Dr Sunderland's previous advice, namely to arrange an appointment at the genito-urinary clinic. It is unfortunate that Greg's re-attendance upon Dr Sunderland in these circumstances, raising the same concerns, did not cause Dr Sunderland at least to consider the possibility that this might not be just a simple case of someone with concerns about AIDS.

17.4. In addition, there was the fact that Greg attended on this occasion with his mother - striking in itself with a 27 year old man, but all the more so when the ostensible purpose of the attendance was to seek advice about a sexually transmitted disease.

17.5. Whilst there would inevitably have been difficulties for Dr Sunderland making the correct diagnosis, given the short time available in the surgery, the Inquiry Panel's view is that, if Dr Sunderland had been aware of the fact that Greg's initial presentation with mental health problems to the Priority House Mental Health Unit in Kent, had included paranoid concerns about the possibility that he might have AIDS, that would surely have alerted Dr Sunderland to at least the possibility that Greg was suffering a relapse. GP training nowadays should produce the competency to diagnose acute psychotic relapse. Certainly, with the benefit of hindsight, it can be seen that Greg's concern about AIDS was a clear indication that Greg's paranoid delusions were recurring. Had this been identified, it would, no doubt, have led to Greg being readmitted to hospital before the acute deterioration in his condition which culminated in the assault upon his father.

Primary Care and the Treatment of Mental Health Illness

17.6. Primary care services were recognised as central to the delivery of good mental health services by the World Health Organisation some fifty years ago in 1952. In the UK the policy of separating the treatment and management of those citizens suffering from severe mental health problems had

resulted in such people being excluded from society and from NHS services other than those provided in the mental hospitals. One result of this social exclusion was that the development of primary care services in the new NHS after 1948 tended not to involve care for people with severe and enduring mental illness, and most doctors would typically have very little contact with the management of people with such mental illnesses.

17.7. The policy has been changing over the last fifty years, mainly under the pressure of human rights campaigns. Until recently the extra workload and the extra training needed for primary care professionals consequent on the deinstitutionalisation of people with severe mental illness had not been sufficiently recognised. Awareness of the community treatment and care needs of people with severe and enduring mental illness has gradually increased in more recent years and by the time of the events under review in this Inquiry from early 1999, considerable progress had been made in co-ordinating primary and secondary mental health care. However, much still needed to be done to re-orientate service organisation and professional training. As mentioned above, particularly in rural areas, shared care is crucial in the development of competent mental health services.

17.8. Since 1999, there have been further major policy developments bearing on primary care components of mental health services. The NSF for mental health had two of the six standards oriented to primary care. The NHS Plan promised more workers in primary care mental health. The Workforce Action Team was set up to address workforce planning, education and training needed to deliver these two initiatives. It reported in August 2001 and provided a special report of the issues to be addressed in primary care. The latter recommended a Ministerial Conference which was held in December 2001 and this will shortly result in a guidance paper entitled Fast-Forwarding Primary Care Mental Health. Meanwhile the National Institute of Mental Health (England) ("NIMH(E)") was launched in Newcastle on 25th June 2002 with a message from the Prime Minister. The NIMH(E) will play a number of roles through a regional organisation in developing mental health services, evaluation and training. A chapter on primary care was agreed and is

likely to be influential in the regional bodies now being set up.

17.9. Many of the dilemmas faced by the actors in this Inquiry have been discussed in these forums and publications, most of which are available on the Department of Health website (http//www.doh.gov.uk/mentalhealth).

17.10. The scale of the problems now faced by the primary care services in this regard should not be under-estimated. Mental health problems are common and at any one time around one in six adults has a mental health problem such as anxiety or depression, although less than one per cent of the population suffers from severe mental illness (Modernising Mental Health Services Safe, Sound and Supportive Department of Health, 1998). The NSF for mental health published in 1999 stated that one quarter of routine GP consultations is for people with a mental health problem and around 90% of mental health care is provided solely by primary care.

17.11. Whilst the most common mental health problems to be seen by GPs are depression, eating disorders, and anxiety disorders, many patients who have been in hospital with severe mental illness are now being maintained and monitored by GPs. Home treatment/crisis resolution teams and effective interventions, including medication and psychological therapies, mean that many patients no longer have to be admitted to hospital and will remain in contact with primary care physicians even in acute episodes managed in active liaison with secondary care purchased by Primary Care Trusts.

17.12. The number of people suffering from a mental health problem is similar to the number of people suffering from asthma. Schizophrenia is not a rare condition. It is about as prevalent as insulin dependent diabetes - that is to say, in about 1% of the general population - and it should be picked up in a GP's surgery. Yet the treatment of mental health problems still tends to be seen as the exclusive province of the specialist secondary services, notwithstanding that those with mental illness attend their GPs on a regular basis.

17.13. Only about a third of new GPs have placements in psychiatry as part of their vocational training, though all get training in "primary care mental health" during their registrarship. This is an improvement upon what used to be the case, but there is a case for reviewing the requirements. It is understood that the Royal College of General Practitioners is currently considering the implications of the Workforce Action Team report. Indeed the present Government initiatives for early diagnosis and treatment of psychosis will fail unless this competence is created.

17.14. At present much of the emphasis is on training GPs to diagnose and manage anxiety based disorders and depression since these are more common in the surgery than major mental illness such as psychosis and schizophrenia. More appropriate practices of joint training and co-working will no doubt evolve. An important aspect is to develop listening skills and awareness of the importance of families. Newer training for GPs is very sophisticated and this should improve future service delivery. Indeed Psychiatrists and other secondary care professionals would benefit from the current approaches to training for primary care. Joint training would improve liaison and increase the chances of successful co-working. The NIMH(E) primary care chapter is likely to encourage such initiatives.

Recommendation

17.15. It is our recommendation that the Health Authority and the Trust should identify an ongoing training programme for GPs and practice nurses to be made more aware not only of the more common mental health problems in the community and their treatment but also of the presentation and needs of people with major psychotic illnesses. Consideration should also be given to joint training with CMHT members in order to aid co-working.

18 *Greg's Telephone Call on 1.5.99*

18.1. As recorded above, this will, regrettably, have to remain a mystery. Bearing in mind Greg's evidence that he did not simply dial a wrong number, and the evidence that, whoever he spoke to, it was not the Crisis Team, the most likely explanation is that Greg ended up talking to a switchboard operator/receptionist at the hospital, but was unable to express sufficiently coherently what he wanted for the switchboard operator/receptionist to be able to redirect his call to an appropriate place.

18.2. The job of a switchboard operator/receptionist necessarily involves dealing with incoming calls as quickly as possible so as to ensure that persons telephoning into the hospital are not left an unduly long time before their call is answered. This priority will always make it difficult for receptionists to deal patiently with the less than wholly coherent caller. This problem is not, in all probability, a common one; and it must be emphasised that this may well not have been what happened in this case. However, it would be sensible to ensure that the training of switchboard operators/receptionists working for the Trust included some instruction about this potential problem, and the provision, perhaps, of a series of standard questions that can be put to a caller who is having difficulty in explaining what he or she wants. Such questions might sensibly be angled towards the possibility that the caller might have some form of psychiatric illness. Patients with a mental illness are more likely than other patients to encounter difficulty in explaining coherently what he or she wants, and/or what the problem which has led to the call being made might be. Purely physical problems are usually easier to describe than mental illness.

Recommendation

18.3. It is, therefore, our recommendation that the Trust should ensure that all switchboard staff and receptionists are provided with a check list of questions to be asked of callers who contact the Trust in order to access clinical services. There should always be an option to transfer a call to a duty mental health worker

in order to comply with the requirement for 24-hour access specified in the NSF. Switchboard staff and receptionists should be made aware of this option.

18.4. It is relevant here to note that the Crisis Team as it existed at the time of this incident no longer operates 24 hours a day. Due to a shortage of nurses the overnight service has been withdrawn, so that there is at present no service available between 11.00 pm until 8.00 am.

18.5. Furthermore, it is anticipated that the Crisis Team will in any event shortly be replaced with a different model of service. This new model was described to the Inquiry Panel by Mr Rom, the Trust's Chief executive, as a crisis resolution team. Whereas the Crisis Team would respond to an emergency situation, and then, once the immediate crisis had ended, would pass the patient on to another part of the system, the new service will have a longer term involvement for patients in crisis.

18.6. The fact that the Crisis Team is no longer available 24 hours a day for anyone facing a mental health crisis, and will soon have a different role in any event, makes it, in our view, all the more important that alternative resources are fully publicised.

18.7. In some other areas of the country, there is a practice whereby patients are given a "Crisis Card" which gives the telephone numbers of the people who can be contacted in an emergency. This a sensible scheme, not only because of the ready access which it provides to the appropriate telephone numbers, but also because reference to the Card may in itself alert a switchboard operator to the nature of the call.

Recommendation

18.8. **It is our recommendation that the Trust should introduce a similar scheme, providing a "Crisis Card" or something similar to all users of the mental health services, and to all carers involved with mental health patients, so that they can know whom to contact in an emergency.**

19 *NHS Direct*

19.1. Linked to this issue is the fact that there is now a new resource available to patients seeking help, namely NHS Direct. This might have been an alternative way in which Greg could have sought help in the critical days before the assault, but when this possibility was mentioned to Mr and Mrs Low, they commented that whilst they had heard of the service, it had not occurred to them that it could provide any assistance with mental health problems. It may be unlikely that contact with NHS Direct in this case would have made any significant difference to events - after all, Greg did actually get to see Dr Sunderland after his abortive attempts to contact Dr Berry over the telephone - but what is relevant for the purposes of this report is that neither Greg nor Mr and Mrs Low considered the option in the context of Greg's mental health problems.

19.2. Mr and Mrs Low can fairly be characterised as people with a greater awareness than the average person of the mental health services. The fact that they were unaware of the availability of assistance from NHS Direct suggests that greater publicity is necessary for NHS Direct, and in particular, for the range of problems which it can address.

19.3. NHS Direct is discussed in the forthcoming Department of Health guidance on primary care mental health services (Fast Forwarding Primary Care Mental Health, 2002). It is understood that all call centres now have a mental health lead appointed and training is being provided through Manchester University. Further discussion is happening at Department of Health level of better integration of emergency services including GP out of hours services.

19.4. Bearing in mind the change in the role of the Crisis Team which has occurred since the time of this incident, it is all the more important that patients with mental illness, and those involved in the care of the mentally ill, are made aware of a service which can provide some degree of support 24 hours a day.

Recommendation

19.5. **Our recommendation is, therefore, that the Trust take steps to publicise the range of services available though NHS Direct, and in particular the fact that it is a service which can be relevant even for patients with mental health problems.**

20 *The Internal Investigation*

20.1. The first comment to be made under this heading is that it is very disappointing indeed that Greg's family, in particular Mr and Mrs Low, were not informed of the results of the internal investigation, notwithstanding that Ms McWatt who conducted the Inquiry had told them that they would be given a copy of the report.

20.2. The process of providing support for a victim's family in the aftermath of an incident such as this does not include giving the family assurances that are not then complied with. At least a part of the responsibility for this omission must lie with Ms McWatt who gave the assurances in question. She should have made it her business to find out what was happening in relation to the internal investigation report which she had produced, and to ensure that a copy was provided to the family, as promised. If it transpired that there was good reason for the internal investigation report not to be provided to the family, then at the very least it was Ms McWatt's responsibility to let the family know that, contrary to what had been said to them previously, a copy of the report would not be provided.

20.3. The Inquiry panel does not consider that there were, in this case, good reasons for the internal investigation report to be withheld from the family. A letter written by the Trust's Chief Executive, Mr Rom, to the Health Authority dated 21.3.01, stated:

> "The family have not been provided with a copy of the internal Trust's report as it contains specific information relating to [Greg's] sexual activity prior to the attack on his father. At the request of Dr Sunderland, this has been kept from the family. We believe that the report may cause the family greater distress than is necessary. It is also noted within the report that the family believe that [Greg] had not been taking any illicit substances prior to the incident whereas it is noted in Dr O'Neill-Kerr's assessment that [Greg] had admitted to doing so. Again this information has not been passed to the family to avoid further distress."

20.4. Assuming that these reasons did indeed represent the explanation for the report not being provided to the family, they were misguided. Dr Sunderland had not made a request that the internal investigation report be kept from the family. He had simply imparted some information to Ms McWatt which he said was not to be unnecessarily divulged. As could and should have been ascertained, the family were well aware of Greg's confusion over his sexual identity, and the information about illicit drugs was not, in the view of the Inquiry Panel, something likely to cause the family undue additional distress.

20.5. The Inquiry Panel's view is, therefore, that the Trust fell short of its obligations to the family, in particular to Mr and Mrs Low, in relation to the provision to them of a copy of the internal investigation report.

20.6. None of the witnesses who gave evidence to this Inquiry were able to say who had actually made that decision. Mr Tyman suggested that such a decision would only have been made by the Chief Executive, Mr Rom, after discussion with himself, but Mr Tyman had no recollection of such a discussion. Neither was Ms McWatt able to assist on this question. Mr Rom accepted that he would have been involved in the decision, although he has stated that he believed that the decision would have been made on the basis of information from the clinical staff involved, relayed to him by Ms McWatt.

20.7. The second comment to be made about the internal investigation is that, in order to comply with the Health Authority's guidelines, set out above, it was necessary for the author of the report to address, amongst other things:

- the care the patient was receiving at the time of the incident;
- the suitability of that care in view of the patient's history and mental health and social needs;
- the extent to which that care corresponded with statutory obligations;

- relevant guidance from the Department of Health and local operational policies;

- the exercise of professional judgement;

- the adequacy of the care plan and its monitoring by the key worker.

These requirements are taken directly from HSG(94)27.

20.8. As mentioned above, this internal investigation was conducted by Ms McWatt, the Trust's Client Relations Manager. She was appointed to carry out this task by Mr Tyman after discussion with Ms Gooch, the Nurse Director, and with the agreement of Mr Rom, the Chief Executive. Ms McWatt's background includes a degree in English and History; a number of years working as an Administrative Assistant to the Royal College of Surgeons in Edinburgh (1978 - 82); a number of years managing the commercial department of a legal firm in South Africa; and a number of years (1992 - 95) as a temporary secretary for the Trust. She has no clinical background.

20.9. Ms McWatt described her move to the post as the Trust's Client Relations Manager as follows:

"I had been working as temporary secretary for the then Director of Corporate Affairs and we had a new Chief Executive who had just come in, in about 1995, and she needed someone to set up and start running the new NHS complaints procedure, somebody to start managing the clinical negligence claims that were coming through the development of the NHSLA and I suppose I just happened to be in the corridor at the right, or maybe the wrong, time and I was just asked if I would like to come and help with a few complaints .... That's it. I was just given the title Client Relations Manager and things developed from there, processes were set up."

20.10. Whilst by 1999 Ms McWatt had accumulated considerable practical experience in dealing with complaints against the Trust, she told the Inquiry Panel that this was the first time

she had been asked to handle a homicide inquiry. Although she was provided with HSG(94)27 - a copy of which was on her file in relation to this matter - she was given no formal training or instruction to equip her to deal with this internal investigation.

20.11. Whether Ms McWatt actually took on board the Health Authority's requirements set out above or not, must be doubted. When giving evidence to the Inquiry Panel, Ms McWatt was under no illusions as to her own inability to address issues such as the exercise of clinical judgement. It is our view that if she had appreciated that she was expected to offer judgements upon each of the various matters outlined above, she would have expressed concern that to do so was outside of her competence without expert assistance. In order properly to conduct this internal investigation, Ms McWatt needed to obtain advice upon clinical matters from someone with the appropriate expertise. It reflects poorly on the training that Ms McWatt was given for her position that she did not appreciate this need when she conducted this internal investigation. It also reflects poorly upon the supervision and support which she received when she conducted this internal investigation. It is right, however, to add that Ms McWatt told the Inquiry Panel that the position now, in 2002, was that she had two Consultant Psychiatrists to whom she could and would turn for independent medical advice.

20.12. It is difficult to understand how Mr Rom or Mr Tyman or Ms Gooch can have thought that Ms McWatt alone (that is to say, without obtaining independent advice upon clinical matters from someone with the appropriate expertise) could properly prepare an internal investigation report which addressed the various questions raised in Ms Gooch's letter of 26.7.99 or complied with the Guidelines issued by the Health Authority. It may be relevant to note that Mr Tyman's letter of 16.6.99, enclosing his preliminary report, appears to convey the hope that it would not be necessary in this instance for there to be an external Independent Inquiry. Whilst he referred to HSG(94)27, and to the need for "an inquiry which is independent of the procedures involved", Mr Tyman went on to refer to a possible review of the requirement that there should be an Independent Inquiry.

The concluding words:

> "It might be that a different approach is possible in this particular case"

indicate that he considered that it might be possible to avoid the need for an Independent Inquiry in this particular case. Whether this influenced his decision to select Ms McWatt to conduct the internal investigation, cannot now be determined.

20.13. The report which Ms McWatt produced following her internal investigation was brief, running to 8 pages of text, almost all of which was a summary of the perceived facts. Indeed, Ms McWatt stated in her evidence to this Inquiry Panel that she regarded her internal investigation as essentially a fact finding exercise, not an exercise in which she was considering the exercise of judgement by the various clinicians who had been in contact with Greg in the months leading up to the assault.

20.14. As commented above, notwithstanding these limitations, the "Conclusions" section of the report, as finally drafted, nevertheless suggested that the exercise of clinical judgement had been considered; and that the view had been reached that the author of the report was satisfied that clinical judgement had been exercised properly. It is the view of this Inquiry Panel, that, as drafted, the internal investigation report does not reflect Ms McWatt's evidence to the Inquiry Panel that she did not consider herself qualified to comment upon clinical matters.

20.15. The evidence to the Inquiry Panel was that Ms McWatt prepared this report with the assistance of Ms Gooch, the Nurse Director. Ms Gooch was provided with a draft copy of Ms McWatt's report and she made a number of suggestions as to how it could be re-drafted. Far from drawing attention to the need for Ms McWatt to seek advice upon clinical matters, or commenting upon the drafting which suggested that the author of the report was satisfied that clinical judgment had been exercised appropriately, or drawing attention to the need to address the various questions outlined in her earlier letter of 26.7.99, Ms Gooch made a

manuscript note on the cover page of the draft report as follows:

> *"Really good Anne. My scribble suggests otherwise but close to perfect report. Sally"*

20.16. The view of this Inquiry Panel is that it ought to have been plain to Ms Gooch, and later to Mr Tyman and Mr Rom, when a copy of the report was passed to them:

(i) That Ms McWatt did not have the necessary expertise to express any view about the exercise of clinical judgement as was required under the Guidelines issued by the Health Authority.

(ii) That Ms McWatt had not enlisted independent medical advice to enable her properly to address the issue of whether or not clinical judgement had been exercised appropriately in this case.

(iii) That the drafting of the report - specifically the fact that it appeared to conclude that, having duly considered the exercise of clinical judgement by the various clinicians involved, Ms McWatt was satisfied that that judgement had been exercised properly - could be taken as being misleading.

20.17. However, neither Mr Rom nor Mr Tyman nor Ms Gooch raised any substantive comment or query over the content of the internal investigation report. In view of the points discussed above, this absence of comment is startling, as is Ms Gooch's written comment that it was a "close to perfect" report. Each must have known that the internal investigation report had not - could not - have covered the points which it was obliged to cover in order to meet the Health Authority's Guidelines. The absence of substantive comment is all the more surprising when, as noted above, Ms Gooch had written to Mr Tyman on 26.7.99 drawing his attention, in writing, to a number of questions which needed to be addressed in the internal investigation report.

20.18. Mr Tyman was not able to give the Inquiry Panel an explanation as to why he had not expressed concern about

these points when he read the internal investigation report. Our view is that Mr Tyman was content that the internal investigation report did not, on its face, seek to attribute blame to any one of the Trust's employees, and he was unconcerned by the fact that the conclusions, purporting, on their face, to endorse the exercise of clinical judgement of all concerned, were conclusions expressed by someone without the background or expertise to pass judgement one way or the other upon clinical matters.

20.19. Ms Gooch's evidence was that she was aware of the fact that Ms McWatt did not have a clinical background, and that she was, therefore, aware that Ms McWatt would be unable to express an opinion about the exercise of clinical judgement. Notwithstanding this awareness, and notwithstanding that she was, in effect, supervising Ms McWatt's work, Ms Gooch did not advise Ms McWatt that she ought to enlist expert medical advice to enable her, Ms McWatt, properly to form a view about the adequacy or otherwise of the treatment which Greg had received. This was a surprising omission by Ms Gooch.

20.20. Ms Gooch's explanation of this omission to the Inquiry Panel was initially that there was no pool of independent doctors to whom it was possible to turn; and that there was a culture of not asking one Psychiatrist to offer a judgement about the way in which another had performed. She said that if a Psychiatrist had been asked to offer such a judgement that Psychiatrist would not have given an independent, objective assessment as required by the Health Authority guidelines. This view was, she said derived from "intuition based on experience", but not upon any specific attempt having been made, unsuccessfully, to get an independent and objective view.

20.21. These replies caused the Inquiry Panel great concern. Firstly, it is not the experience of the members of this panel that Psychiatrists are unwilling or unable to provide independent and objective opinions on the conduct of others, and it is regrettable that Ms Gooch appears to take such a pessimistic view of their objectivity and integrity. Secondly, for Ms Gooch to have considered that it was preferable for Ms McWatt not even to try and obtain such

independent advice is depressing, particularly as Ms Gooch was new to the area and was in the process of seeking to raise standards in relation to the management of Serious Untoward Incidents to an acceptable level. Thirdly, the concept of obtaining independent clinical advice ought to have been a familiar one both to Ms McWatt and Ms Gooch, as this is a regular part of the local resolution process for dealing with clinical complaints under the NHS complaints procedure, set out in "Complaints: Listening ... Acting ... Improving: Guidance on implementation of the NHS Complaints Procedure" produced by the NHS Executive in March 1996.

20.22. The internal investigation was formally completed on 22.10.99. Ms McWatt said that she would then have presented the final version to Ms Gooch, and at that stage her responsibilities in relation to the report ended. Ms Gooch agreed that the report would have been given to her, but she was unable to explain why it was that the report did not then get presented to the Trust Board.

20.23. In this connection, it should be noted that, on the same page as Ms Gooch recorded that she regarded Ms McWatt's report as *"close to perfect"*, she also wrote: *"No report to Board needed Anne - done at that level".* This suggests that Ms Gooch may have taken the view that there was no need for the report to be taken to the Trust's Board, but unfortunately Ms Gooch was unable to recall the circumstances in which this note had been made.

20.24. Mr Tyman had, of course, been responsible for commissioning the internal investigation from Ms McWatt, but he was not an executive member of the Board. On the face of it, one would have expected that it would have been Ms Gooch who was responsible for the presentation of the internal investigation to the Board. Unfortunately, in the absence of her files, and with the lapse of time since October 1999, she was unable to recall why the report was never formally presented to the Trust Board.

20.25. The report had gone to the Chief Executive, Mr Rom, upon its completion. His explanation for why the report had never been formally presented to the Trust Board was that it was

felt that the report should only be formally presented as and when there was a final disposal of the criminal proceedings. He said that as no one at the Trust actually found out until December 2000 that the criminal proceedings against Greg had been completed in August 1999, the internal investigation report was not processed further.

20.26. The Inquiry Panel considered this to be a surprising explanation. The findings of the internal investigation were in no sense contingent upon the criminal proceedings against Greg. The findings of fact made and the conclusions reached were never realistically going to be affected by whether or not Greg was convicted. Mr Rom said in his evidence that:

> *"If [Greg] was let off for some reason we didn't know, it might have been a different outcome. That's the approach we take."*

20.27. Mr Rom drew the Inquiry Panel's attention to the fact that he was unaware that Greg had admitted his responsibility to the police and to Dr O'Neill-Kerr; and he also said that he was not willing to pre-empt the outcome of the legal process.

20.28. However, it is clear that he was aware that Greg had entered a plea of manslaughter on the grounds of diminished responsibility and that that plea had been accepted by the prosecution - this information was included within Ms McWatt's report. He knew, therefore, that there had been a serious assault for which Greg had formally accepted responsibility. Even without knowledge of the final outcome of Greg's criminal proceedings, therefore, the Inquiry Panel considers that there was no good reason not to take the next step of presenting the internal investigation report to the Trust Board.

20.29. Not only did the internal investigation report not go to the Trust Board, it was not forwarded to the Health Authority either until 2001, notwithstanding that paragraph 5.(VIII) of the Health Authority Guidelines, referred to above, obliged the Trust to keep the Health Authority informed of progress.

20.30. The Inquiry Panel was unable to establish who at the Trust

had responsibility for ensuring that this obligation was fulfilled. Ms Gooch was unable to assist. Mr Tyman did not consider that it was his responsibility. Ms McWatt considered that her responsibilities ended with her presentation of her report to Ms Gooch.

20.31. Ultimately, responsibility must lie with the Chief Executive, Mr Rom, who must take responsibility for the confusion which apparently existed in complying with quite straightforward guidelines issued by the Health Authority.

21 *The Setting up of this Independent Inquiry*

21.1. Mr Tyman referred in his letter of 16.6.99 to the need for an Independent Inquiry. As commented above, his letter seemed, however, to imply that in this case it might be possible to deal with matters without the need for an Independent Inquiry. Mr Tyman said in his evidence to the Inquiry Panel that he always appreciated that an Independent Inquiry was going to be necessary and that he never took the view that there was a chance that such an Inquiry might be avoided in this case; but it is difficult to reconcile this evidence with the passage in his letter of 16.6.99 referred to above.

21.2. Be that as it may, an Independent Inquiry cannot commence its investigations until the legal proceedings have been finally disposed of. In this case that was on 20.8.99, when the Hospital Order was made in respect of Greg following his conviction for manslaughter. What requires explanation is why the fact that Greg's criminal proceedings had come to an end in August 1999 was not appreciated at that point, or indeed at any time prior to early December 2000.

21.3. The first oddity is that Ms McWatt did not discover this when she conducted her investigations for the purpose of the internal investigation. She interviewed Mr and Mrs Low in September 1999, after Greg's case had been concluded, and she accepted that it was an oversight on her part that she did not ask them what the current position was in relation to Greg. That she failed to do so seems to us to be another illustration of the inexperience and lack of training which she had to equip her for the task of carrying out the type of internal investigation which the Trust was obliged to carry out under the Health Authority's guidelines.

21.4. Secondly, however, is the long gap between September 1999 and December 2000. Formal responsibility for liaising with the police about hearing dates lay with the Health Authority's Director of Commissioning, Ms Sally Johnson. She has frankly accepted in correspondence with the Inquiry Panel that she was unaware of this responsibility. However, Ms Johnson did say that she asked Mr Tyman to let the Health Authority know when the court proceedings were

concluded so that an Independent Inquiry could be established, if required.

21.5. Furthermore, as mentioned above, the Health Authority was in regular communication with the Trust over the outstanding Serious Untoward Incidents from time to time with the list of outstanding cases being sent to the Trust on a regular basis, every two months or so. Ms McWatt's response to this, on behalf of the Trust, was to fill in the form, so far as it related to Greg by saying "Still awaiting outcome" or some similar wording. The Health Authority was entitled to interpret her response as a representation that Greg's case was still ongoing, and the view of this Inquiry panel is, therefore, that the Health Authority was not responsible for the failure to appreciate that the criminal proceedings had been completed and that the Independent Inquiry could accordingly proceed. We do not consider that it was unreasonable for the Director of Commissioning at the Health Authority to discharge the obligation to maintain contact with the police by having in place a system whereby information about the current status of the criminal proceedings was sought from the Trust on a regular basis, and by then relying upon the information received

21.6. The view of the Inquiry Panel is that the responsibility must lie with Ms McWatt, for her naive interpretation of the Health Authority's regular communications, and with those responsible for leaving Ms McWatt and Ms McWatt alone to deal with these communications without appropriate guidance or supervision as to what steps she should be taking in response to these communications. The Inquiry Panel is conscious of the fact that Ms McWatt started her work as Client Relations Manager for the Trust with an administrative/secretarial background. She did not receive training for the post, and it is inevitable that there was a large degree of learning on the job for her. Ultimately, again, this is a matter for which the Chief Executive must bear responsibility.

22 *The Trust's Employees' Awareness of the Serious Untoward Incident Policy*

22.1. Ms Gooch's evidence to the Inquiry Panel was that shortly after she started work as the Trust's Nurse Director in March 1999, she identified the need to review the arrangements for the reporting of Serious Untoward Incidents. She had come to the Trust from Tower Hamlets Healthcare NHS Trust which she said had had a robust set of procedures for dealing with such incidents, and she wished to see similar procedures in Northamptonshire. She also commented that Clinical Governance was not in place when she joined the Trust, and so she was concerned to ensure that at least the procedures for reporting Serious Untoward Incidents were in place - indeed her evidence was that this was part of her responsibilities when she started work with the Trust.

22.2. There did exist a Trust policy document dealing with the reporting of Serious Untoward Incidents. It was a short document but one which did make the necessity of ensuring that such incidents were reported clear.

22.3. It has since been substantially expanded and up-dated in a policy document drafted by Ms Gooch. This new policy is certainly more than sufficient for its purposes. However, what concerned the Inquiry Panel was that Dr O'Neill-Kerr was still not aware, even at the time when he gave evidence to the Inquiry Panel, of his obligations in this respect. This suggests, regrettably, that whatever steps have been made to communicate the existence and content of this new policy to staff, they have not been wholly successful. It is doubly surprising that Dr O'Neill-Kerr, a Clinical Director, was not aware of the relevant procedures. Since he had been responsible for the original failure to report the incident involving Greg, one would have thought that he, above all others would have been told or reminded him of the applicable procedures. The internal investigation report did identify that the incident had not been appropriately reported, and it is startling to find out that the person who had been responsible was not apparently even aware that this was the case. Clearly, the education or instruction of staff in relation to the management of Serious Untoward Incidents needs to be re-visited.

Recommendation

22.4. **It is our recommendation that the Trust takes immediate steps to ensure that all staff are made aware of or are reminded of the relevant policies in place, and, if and insofar as necessary, this Independent Inquiry report can be used as a vehicle for further training of all staff in the management of Serious Untoward Incidents.**

23 *Support for Families*

23.1. Safer Services National Confidential Inquiry into homicides and suicides by people with Mental Illness (issued by the Department of Health in 1999) shows that extreme crimes of violence such as murder or manslaughter were more likely to be committed by a family member than against a stranger. Carers need help with dealing with the crisis they find themselves in and to be reassured about the future action to be taken.

23.2. In May 1999 Northamptonshire Health Authority published a report, the Licorish Report, into the care and treatment of another young mentally ill man who committed a homicide in another part of the county. Two of the recommendations focused on the future of such inquiries and the support to families who were affected by this kind of tragedy. The first of these recommendations was to agree an appropriate strategy for providing support to families affected by a homicide committed by a person with a mental health illness and putting them in touch with relevant organisations. The second recommendation was for local mental health services to develop a method of identifying families affected by this kind of tragic incident and requiring support.

23.3. In October 1999, in response to the Licorish Report and its recommendations, a document entitled "Policy for the Support of families following Homicide or Suicide" was agreed between Northamptonshire Health and Social Services, Rockingham Forest NHS Trust and NCHT. The policy sets a minimum standard for offering support and counselling to families, and it sets out the managerial responsibility and actions to be taken. It provides for an initial clinical review in order to determine what needs to be done in a particular case and to decide how best to support affected families. It is also stated that liaison with the police and/or the coroner's office should be established.

23.4. This policy document was, in the view of this Inquiry Panel, an appropriate response to the recommendations of the Licorish Inquiry. Unfortunately, the policy was only produced after Greg's assault upon Mr Marden. However, if this liaison function had been in place at the relevant times, then

it is likely that the fact that Greg's case had been dealt with by the Courts would have come to light much earlier.

23.5. In response to the second recommendation referred to above, Northamptonshire Health Authority has produced a leaflet "Bereavement Support". The leaflet helpfully lists a series of organisations who provide help and counselling as well as Health Authority contact numbers. The Inquiry Panel has not been able to ascertain, however, when precisely this leaflet came into operation or whether anyone from the Health Authority gave a copy to Greg's family. The family have no recollection of being provided with such a leaflet, although this does not mean necessarily that it was not provided to them.

23.6. In 1995 the Home Office published a folder entitled "Information for Families of Homicide Victims". This folder includes the useful leaflet, "The Work of the Coroner, Going to Court, Coping when someone has been killed" as well as leaflets about the criminal justice system and information about organisations which can help. This publication does not appear to have been widely distributed, but it is the type of information which could sensibly be distributed to families at, for example, the time of dealing with the death certificate.

23.7. The Inquiry Panel was told in the course of this Inquiry that the Trust is to develop a similar information giving leaflet. This is to be welcomed and the publication referred to above may provide a useful point of reference.

Recommendation

23.8. It is our recommendation that, following production of this new leaflet, the Trust implements a staff training programme which takes account of the sensitive nature of providing support to bereaved families.

Recommendation

23.9. It is worth commenting in this context on the role which the voluntary sector can play in the provision of support to the families of homicide victims. It is our

recommendation that the voluntary sector should be involved in, or at least consulted in relation to, the content of the leaflet being prepared, together with any associated training programme.

23.10. The Inquiry Panel was informed that the family had received helpful support from the police officer assigned to them for the duration of the criminal proceedings, P.C. Bell, but Mr and Mrs Low did not recall offers of support from the local CMHT or other representatives of the mental health services. As mentioned above, however, it is thought very likely that there was contact with and some offer of support, albeit undocumented, from Mr Oelrich. With the passage of time, it would not be surprising if Mr and Mrs Low could no longer recall this.

23.11. The Inquiry Panel does consider that early contact with and offers of support to a victim's family in the aftermath of an incident such as this is very important and should be documented. Mr Oelrich made the very fair point to the Inquiry Panel that in the absence of a CMHT file for Greg, there was no obvious place to record such contacts. As recorded above, however, the guidelines issued by the Northamptonshire Health Authority for the management of Serious Untoward Incidents provide, amongst other things, for the Provider to send to the Director of Commissioning a completed Serious Untoward Incident report confirming details of the incident within 72 hours.

Recommendation

23.12. It is our recommendation that contacts with the victim's family, including telephone contacts, should be recorded in the Serious Untoward Incident report sent to the Health Authority. If no such contacts have taken place at the time of this report, then senior management will be alerted to the need to ensure that appropriate offers of support are then made. Details of contacts and offers of support made subsequent to the preparation of the Serious Untoward Incident report should be forwarded to the Trust representative responsible for the preparation of the Serious Untoward Incident report.

23.13. Efforts should also be made to keep families involved in this type of situation informed about the Inquiry processes. Greg's family were interviewed as part of the internal investigation in 1999 and were assured they would be given more information. However, as already recorded, in the event no further information was given to the family from either the Trust or the Health Authority until steps were taken to set up this Inquiry.

23.14. The Inquiry Panel were provided by the Trust with a policy document entitled "Major Incident Policy" dated January 2002. It is pleasing that there was a section dealing with relatives and carers. This provides that the Chief Executive or the Medical Director has responsibility for the provision of help and support to the bereaved family. Though this is laudable it might be more beneficial if, once initial contact has been made, another, less elevated, individual is appointed who will, perhaps, have the time to provide support for the family over a longer period of time.

Recommendation

23.15. It is our recommendation that, where the need for an external independent inquiry arises, the Trust should appoint a senior person to make and maintain contact with the family until that independent inquiry has been appointed. This individual should be responsible, amongst other things, for: (a) keeping the family informed and up to date in relation to all investigations and proceedings consequent upon the event, including internal investigations, court hearings, and the possibility of an external independent inquiry; and (b) arranging access for the family to appropriate care, support and counselling services.

RECOMMENDATIONS

1. **That the Health Authority and the Trust should identify an ongoing training programme for GPs and practice nurses to be made more aware not only of the more common mental health problems in the community and their treatment but also of the presentation and needs of people with major psychotic illnesses. Consideration should also be given to joint training with CMHT members in order to aid co-working. (Para 22.4)**

2. **That, in accordance with Department of Health Guidance on CMHTs, set out in "Mental Health Policy Implementation Guide - Community Mental Health Teams" published in 2002, and in the light of the increasing demands from the Department of Health for documentation as well as its ambitions for early intervention in psychosis, the Trust and the commissioners of mental health services should agree a forum with terms of reference:**

    (i) **To review CMHT caseloads, staffing levels, working practices and clinical supervision in order to ensure appropriate skill mix.**
    (ii) **To discuss all new initiatives and agree the resultant action plan;**
    (iii) **To agree the allocation of new resources;**
    (iv) **To continue to explore ways in which the voluntary sector can be commissioned to provide day care and support services, including transport, to both patients and their families; and**
    (v) **To set up regular training programmes which take account of new ways of working. (Para 15.15)**

3. **That the Trust should ensure that all carers are positively involved in the CPA process and should ensure that there is a full discussion with them of their needs and of how they relate to the task of caring for the patient. (Para 14.20)**

4. **That carers should have an appointed care worker who can assess their needs for ongoing support and respite care if and when necessary. (Para 14.20)**

5. **That carers should have their own care-plan which includes names of key professionals and how to contact them.(Para 14.20)**

6. **That a handbook of all available services should be written and distributed to all families/carers of people in touch with mental health services.(Para 14.20)**

7. **That the Trust take steps to publicise the range of services available though NHS Direct, and in particular the fact that it is a service which can be relevant even for patients with mental health problems.(Para 19.5)**

8. **That the Trust institutes a policy of ensuring that all referral letters are acknowledged within no more 2 days of their receipt; and develops procedures and secures resources to enable this to happen.(Para 12.3)**

9. **That work on extending electronic links between primary and some aspects of secondary care in the NHS be extended as soon as possible to key communications between primary and secondary mental health services.(Para 12.5)**

10. **That, in the event that a patient of the mental health services who has been newly referred or newly re-referred to the secondary services, or who is considered to carry significant risk, fails to attend an out-patient's appointment:**

    (i) There should be a letter from the secondary mental health services to both the patient and to his/her GP, notifying them of the non-attendance and of the action which is planned following and as a result of that non-attendance.

    (ii) Consideration should be given by the consultant concerned in each such case to the possibility of involving the CMHT in following up the patient.

    (iii) The action taken following any non-attendance, and the reasons for that action, should be

documented in the patient's medical records.(Paras 13.10;13.11)

11. **That the provision to a patient of a copy of his Discharge Summary at the time of his discharge should be considered as a matter of routine whenever a patient is discharged from care as an in-patient.(Para 11.5)**

12. **That the Trust should, as soon as is practical, aim to locate psychiatrists and CMHT staff in the same premises in order that they might more easily coordinate the service they provide for their given population, and more easily agree and implement operational protocols and referral systems.(Para 13.3)**

13. **That the Trust should ensure that all switchboard staff and receptionists are provided with a check list of questions to be asked of callers who contact the Trust in order to access clinical services.(Para 18.3)**

14. **That the Trust should ensure that switchboard staff and receptionists always have the option of transferring a call to a duty mental health worker and should be trained so that they are aware of the existence of this option.(Para 18.3)**

15. **That the Trust should introduce a scheme whereby a "Crisis Card" or something similar is provided to all users of the mental health services, and to all carers involved with mental health patients, giving details of the person(s) to contact in the event of an emergency.(Para 18.8)**

16 **That the Trust take immediate steps to ensure that all staff are made aware of or are reminded of the policies in place with regard to the management of Serious Untoward incidents, and, if and insofar as necessary, this Independent Inquiry report be used as a vehicle for further training of all staff in the management of Serious Untoward Incidents.(Para 22.4)**

17. **That where the need for an external independent inquiry arises, the Trust should appoint a senior person to make and maintain contact with the family until that independent inquiry has been appointed. This individual should be**

responsible, amongst other things, for: (a) keeping the family informed and up to date in relation to all investigations and proceedings consequent upon the event, including internal investigations, court hearings, and the possibility of an external independent inquiry; and (b) arranging access for the family to appropriate care support and counselling services.(Para 23.15)

18. **That in the event of a Serious Untoward Incident, contacts with and offers of support to the victim's family, including telephone contacts, should be documented and recorded in the Serious Untoward Incident report sent to the Health Authority. Details of contacts and offers of support made subsequent to the preparation of the Serious Untoward Incident report should be forwarded to the Trust representative responsible for the preparation of the Serious Untoward Incident report.(Para 23.12)**

19. **That, following production of the new leaflet which it is proposed should be available to the families of victims of homicides, the Trust implements a staff training programme which takes account of the sensitive nature of providing support to bereaved families; and that the voluntary sector be involved in, or at least consulted in relation to, the content of the leaflet being prepared, together with any associated training programme.(Paras 23.8; 23.9)**

APPENDIX 1

WITNESSES GIVING EVIDENCE

The Family	
Mr Gregory Marden (Greg)	The client
Mr and Mrs O. Low	Greg's sister and brother-in-law
Northamptonshire Health Authority	
Ms S Johnson	Director of Commissioning (not interviewed but statement by letter)
Mr A Northall	Manager, Mental Health Provision, MDO and Learning Difficulties
Invicta Community Care NHS Trust	
Mr J Wiles	Chief Executive (not interviewed but statement by letter)
(Priority House Mental Health Unit) Dr Fafioulu	SHO to Dr Sivakumar, Consultant Psychiatrist (notes from Mr Wiles)
Dr Davies	GP in Kent, not interviewed but statement by letter
Northamptonshire Healthcare NHS Trust (formerly Northampton Community Healthcare NHS Trust)	Chief Executive
Mr J. Rom	Director of Nursing
Ms.S. Gooch	Medical Director of merged Trusts from March 2001 to present day
Dr A V Camp	Medical Director of Trust during 1999
Dr Abu Kmeil	Director of Mental Health Services
Mr S Tyman	Client Relations Manager
Ms A McWatt	Clinical Director/Consultant Psychiatrist
Dr A O'Neill-Kerr	Consultant Psychiatrist
Dr D Berry	Clinical Assistant to Dr Berry
Dr A Baez	Community Psychiatric Nurse
Mr T Oelrich	Patient Services Manager
Ms C Mitchell	
Social Services	
Mr J Lloyd	Unit Manager, Community Mental Health Services
Mr C Arthur	Approved Social Worker. First Appropriate Adult, not interviewed, statement used from report from Northamptonshire Social Services
Ms G Horrell	Approved Social Worker. Second Appropriate Adult

Primary Care Services (in Northamptonshire) Dr A Hooker Dr J Sunderland	 GP Towcester Medical Centre GP Towcester Medical Centre
Northamptonshire Police Dr P Gordon	 Police Surgeon (not interviewed, Witness Statement before the police used)

APPENDIX 2

CHRONOLOGY OF EVENTS

Name:	Gregory Marden	Document:
Autumn 1997	Living in Holland	
1.12.97	Inpatient in care of Invicta CMHT Trust, Kent	
14.1.98	Discharged	
23.1.98	• Attended outpatient appointment at Kingswood Community Mental Health Centre • Did not attend psychiatrist appointment • Did not attend Community Psychiatric Nurse (CPN) at Kingswood	
Feb.98	Moved to Towcester, living with parents initially, then moved in with cousin	
23.4.98	**Invicta discovered Greg had moved to Northamptonshire, therefore removed from Kingswood caseload**	
26.2.98	• Saw GP, Dr Hooker, to register as new patient *note:* he is actually registered with Dr Sutherland • Dr Hooker notes him as seeming stable • No previous medical notes available at that meeting, Dr Hooker therefore expedited these • Dr Hooker referred him to Consultant Psychiatrist, Dr Berry for follow up	
17.3.98	Referral as mentioned above made to Dr Berry although Dr Hooker still had not received medical notes from Kent	3.3
18.5.98	Appointment arranged for 10.6.98 *note:* not "99" as in Northampton Community Mental Healthcare Trust Report. Delay by NCHT in making this appointment, no communication with Dr Hooker	3.4
10.6.98	Did not attend appointment with Dr Berry. Following DNA Dr Berry rang Dr Hooker, did not manage to speak with him and there is no record of this phonecall.	3.18

11.6.98	At CMHT meeting Dr Berry discussed GM – advising team of previous inpatient episode. Community Psychiatric Nurse not present.	3.18
2.7.98	Tony Olreich (CPN) present GM discussed again. Dr Berry reported previous admission drug related and that family believed he was OK.	3.18
6.7.98	Follow up by Dr Berry with appointment 26.8.98. Not copied to Dr Hooker.	3.5
26.8.98	No records of what happened to this appointment or follow up letter, but Greg offered appointment for 30.9.98.	
30.9.98	Did not attend.	
2.10.98	Dr Berry informed GP that GM DNA on 30th September. Also sent firm letter to GM with appointment for 11th November.	3.6 3.7
2.10.98	Greg saw Dr Hooker with back problem, no reference made to mental health state in notes.	
11.11.98	Dr Berry saw Greg. Full report, diagnosis paranoid psychosis in remission with follow up of 4-6 months, which was set out in letter to Dr Hooker	3.8
No date Assume 11/98	Following above CPA referral form one filled in Note address to be established Outreach Surveillance and GP/Consultant liaison planned No sign of action taken.	3.9
29.3.99	Saw Dr Sutherland (GP) at Towcester (his registered GP),fear of AIDS GU appointment suggested with GM to action	3.0 page 5 consultation notes
14.4.99	• Follow up appointment fro 11th November appointment with Dr Berry • Saw Dr Antonio Baez, Clinical Assistant • Worried about his brother, Lloyd, being in Pendered Unit, • Dr Baez reported GM as "well" and findings and conclusions set out in letter to Dr Hooker dated 21.4.99 • Believed to be some discussion between Mr and Mrs Low and Dr Baez although recollections were now dim, some two	3.10

years later, when asked about this.

- Greg himself believed himself to be fine at the time of this visit although there was considerable uncertainty in his mind as to the chronology of events.

19.4.99 — Mrs Marden and Mrs Low went on holiday and left Greg looking after his father. No suggestion of tensions at that time.

30.4.99 – 1.5.99 — According to Mr and Mrs Low GM tried to contact Dr Berry, not known whether out of hours or on Bank Holiday weekend. They say he was put through to Dr Berry's office but GM was difficult and whoever he spoke to put the telephone down on him. Call not traceable. Switchboard staff say that he would have been given Crisis Team phone number

1.5.99

- Visited Dr Sutherland for a second time, this time with his mother
- Dr S noted he was obsessed with his sexual health, mainly his worries of AIDS
- Dr S did not refer back through Greg's files
- Prescribed imipramine to calm him down

2.5.99

- GM told family he was feeling better
- Encouraged by sister to contact Crisis Team but did not do so.
- Greg reported as feeling more ill later in day.
- Waiting until 4th May (after bank holiday) to get help

3.5.99 — Greg came round to Mrs Marden's and told her he had thrown away the imipramine. They both returned to Mrs Low's house to retrieve the tablets and she insisted he take one.
Mr & Mrs Low and family friend took Greg to Finmere Market. Greg behaving in odd fashion on his return. He walked off to his parents' house and Mrs Low and Mrs

	Marden followed in car. He arrived first. He hit his father over the head with gas cylinder, rendering him unconscious. Police called.	
3.5.99	Initial assessment carried out Dr Gordon, Police Surgeon. Police interview carried out with Chris Arthurs (Approved Social Worker) present as Appropriate Adult	7.2.1
4.5.99	• Dr Berry on leave therefore Dr O'Neill Kerr, Consultant Psychiatrist carried out assessment and Gillian Horrell (ASW) as Appropriate Adult. She carried out second assessment for purposes of Mental Health assessment in role of Approved Social Worker • Detained under Section 35 of MHA	3.11
7.5.99	• Dr Berry wrote to Magistrates Court saying GM unsuitable for Pendered Unit, advising Marlborough House or St Andrews • No beds in either therefore transferred to HMP Woodhill	3.12
Shortly after assuming at present 4.5.99	• Gillian Horrell reported incident to superiors in Social Services, (John Lloyd and on to Mr Philip Douglas) • GH stated CMHT were aware soon after incident as were ward nursing staff	3.18
24.5.99	Mr Marden died of his injuries.	
21.7.99	Greg transferred to Marlborough House R.S.U.	
20.8.99	Greg pleaded guilty to manslaughter on the basis of diminished responsibility and was place on Hospital Order under section 41 of the Mental Health Act 1983, a restriction order without limit of time.	
	Subsequent Investigation:	
June 99	Mrs Cheryl Mitchell (Patient Service Manager	Witness

	NCHT) learns of incident in chance conversation in car park with Mr Lloyd. Immediately informed Mr Tyman and Mrs McWatt.	statement
16.6.99	Mr Tyman (Director of Mental Health NHCT) wrote to Health Authority with a preliminary report of the incident and informing them internal case review to take place and that "completion of any legal procedures which could take some months".	
26.7.99	Mrs Gooch (Director of Nursing NHCT) wrote to Mr Tyman giving detailed suggestions for benefit of whomsoever was to conduct internal investigation, a letter Mr Tyman denies receiving.	
August 1999	Following this letter Mrs Anne McWatt, (Client Relations Manager) appointed by Mrs Gooch to carry out investigation.	
22.10.99	Reported completed by Mrs McWatt and presented to Mrs Gooch. Mrs McWatt believed the report would be forwarded to Mr and Mrs Low, she had told them that it would be although in the statement written for the investigation she states "Mr and Mrs Low were informed that a report would be done for the Trust Board in October 1999 and that they would be advised of the outcome of the Trust Board's discussions. She also believed the report would be presented to the Trust Board.	
December 2000	Mrs McWatt asked by Mr Rom (Chief Executive) to ascertain Greg's whereabouts and what had happened to the criminal proceedings against him.	
3.1.99	Received confirmation from the RSU that Greg was there.	
January 2001	Report formally presented to Trust Board.	
16.6.99	Original notification by Mr Tyman.	
June 99	Recorded incident in Serious Untoward Incidents Log, regularly bi-monthly contact between Trust and H.A. concerning logged	

cases. The H.A. communicated with Mrs McWatt regarding outstanding cases. On each occasion the query came to her she wrote "still awaiting outcome", referring to outcome of criminal proceedings against Greg, these were not checked by her.

9.1.2001 Mr Rom wrote to Mr David Sissling (Chief Executive, Northamptonshire Health Authority) informing him fully of the incident and prompt steps were taken to set up this Independent Inquiry.

APPENDIX 3

DOCUMENTS CONSIDERED BY THE PANEL

Gregory Marden

1. Medical Records.
2. Witness Statement taken at the time of the incident.
3. Witness Statement taken by the panel.

The Family

4. Witness Statements taken at the time of the incident.
5. Witness Statements taken by the panel from Mr and Mrs Oliver Low (sister and brother-in-law).

Northamptonshire Health Authority

6. Terms of Reference for an Independent Inquiry into the Care and Treatment of Gregory Marden.
7. Correspondence between the Health Authority and the NHCT relating to the reporting of the incident, January 2001.
8. Correspondence from Eastern Regional Office relating to reporting of incident . 14.02.01.
9. Serious Untoward Incident Guidelines, undated.
10. Serious Untoward Incident Policy, undated, fax date 11.06.97.
11. Correspondence with Northamptonshire Social Services, 03.04.01.
12. Press cuttings.
13. Wayne Licorish Joint Action Plan, Northamptonshire Health Authority, Rockingham Forest NHS Trust, Northamptonshire Social Care & Health Directorate, 2001.
14. Service specifications.

Northamptonshire Social Services

15. Complaints and Representations Handbook.
16. Notes on CPA referral
17. Social Service Handbook, November 1997.

Northamptonshire Healthcare NHS Trust

18. Investigation Report on Incident involving Gregory Marden on 3rd May 1999, completed by Client Relations Manager, 07.10.99.
19. Medical notes from Consultant Psychiatrist, 1998/99.

20. CPA review notes, 1998/99.
21. Crisis Intervention Policy, draft, final and working protocols.
22. Service Plan, Mental Health, 1999/2000.
23. CMHT Operational Policy
24. CPA Section 117 Operational Policy
25. Integrated CPA, 10.06.98.
26. Guideline for discharge of patients from psychiatric outpatient clinic, 11.06.98
27. Minutes of CMHT meetings 11.06.98, 18.06.98, 02.07.98.
28. Handling of Serious Untoward Incident Policy,06.05.98..
29. Incident Reporting of Serious or Potentially Serious Untoward Incidents, June 2000.
30. Complaints Procedure, August 1998, reviewed August 2000.
31. Minutes of Trust Board meeting 30.06.99
32. Minutes of Trust Board meeting 31.0.01.
33. The Sainsbury Centre for Mental Health – Locality Profile of Mental Health Services in Northamptonshire, September 2000.
34. Correspondence from Dr A. V. Camp, including
    a. details of Beacon project
    b. Policy for Support of Families following Homicide or Suicide, 28.10.99.
    c. Bereavement Support, undated.
35. Correspondence from Ms S. Gooch, including
    a. Launch letter of Serious Incident Policy
    b. First Annual Report of Serious Incidents 1999/2000
    c. Trust Projects
36. Northamptonshire Healthcare NHS Trust, Strategic Direction 2002-04, October 2001.
37. Major Incident Policy (Jan 2002)

Invicta Healthcare NHS Trust

38. Case notes, discharge and after care plan, December/January 1998.
39. Care Approach Manual, July 1997.

Crown Prosecution Service and Police

40. Copies of selection of case papers.
41. Case summary.
42. Report of crime.
43. Letter to Woodhill re interview with GM.
44. Indictment and brief outline of allegation.
45. Witness statements.
46. Record of interviews with GM.
47. Case summary.

48. Post mortem.
49. SHO Woodhill assessment of GM.

Witness Statements

50. Full witness interviews and statements taken by panel.

Department of Health

The Care Programme Approach HSG(90)23 / LASSL(90)11, 1990.
Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG(94)27, 1994.
Building Bridges A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, 1995.
Modernising Mental Health Services, Safe, Sound and Supportive, 1998.
A National Service Framework for mental health, 1999.
Code of Practice Mental Health Act 1983, HMSO, 1994 and 1999.
Effective Care Co-ordination in Mental Health Services, A Policy Booklet, 1999.
Still Building Bridges, The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management, 1999.
Caring for Carers a National Strategy for Carers, 1999.
Safer Services “National Confidential Inquiry into Homicides and Suicides by people with mental illness”, 1999.
Nation Health Service Framework for Mental Health 1999
An Organisation with a Memory, Report of an expert group on learning from adverse events in the NHS, 2000.
The NHS Plan, 2000.
Building a Safer NHS for Patients – implementing An Organisation with a Memory, 2001.
Safety First Five-Year Report of the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness, 2001.
Mental Health Policy Implementation Guide – Community Mental Health Teams, 2002 .
The Journey to Recovery – The Government's vision for mental health care, 2002.
Early Intervention in Psychosis, 2002 .
Fast Forwarding Primary Care Mental Health, 'Gateway Workers', 2002 .
Final Report by Workforce Action Team 2001.
Website Address: http//www.doh.gov.uk/mentalhealth

APPENDIX 4

Reference:

General Medical Council
Confidentiality: Protecting and Providing Information, 2000.

Home Office
Information for families of Homicide Victims, Home Office Communications Directorate, 1995.

Royal College of Psychiatrists
Curriculum for basic special training and the MRCPsych examination, Council Report CR95, 2001.

Jones, Richard, Mental Health Act Manual, sixth edition, Sweet & Maxwell, London, 1999.