Report of the Independent Inquiry into the Care and Treatment of Ms Justine Cummings

A report commissioned by
Somerset Health Authority and
Somerset Social Services

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Membership of Inquiry Team

Lord Laming	Chairman
Ms Denise Claydon	Community Psychiatric Nurse and Unit Manager of Green Lane Hospital, Devizes, Wiltshire
Dr Cyril Davies	Consultant Psychiatrist
Mrs Justine Womack	Administrator

Terms of Reference

1. To examine all the circumstances surrounding the treatment and care of Ms Justine Cummings by the mental health service from 4 July 1996 to October 1997, taking into account her earlier mental health history, in particular:

   i. the quality and scope of her health, social care and risk assessments;

   ii. the appropriateness of her treatment, care and supervision in respect of:

      a) her assessed health and social care needs,
      b) her assessed risk of potential harm to herself or others,
      c) any previous psychiatric history, including drug and alcohol use,
      d) the number and nature of any previous court convictions.

   iii. the extent to which Ms Cummings' care responded to statutory obligations; relevant guidance from the Department of Health (including the care programme approach, HC(90)23/LASSL(90)11, supervision registers, HSG(94)5, and the discharge guidance HSG(94)27; and local operational policies;

   iv. the extent to which her prescribed care plans were:

      a) effectively drawn up,
      b) delivered,
      c) complied with by Ms Cummings.

2. The appropriateness of the professional and clinical supervision of those involved in the care of Ms Cummings or in the provision of services to her and, where appropriate, consideration of in service training.

3. To examine the adequacy of the collaboration and communication between the agencies involved in the care of Ms Cummings or in the provision of services to her.

4. To prepare and make public a report on the Inquiry's findings, which will include recommendations to Somerset Health Authority and Somerset County Council.

Chapter 1

1. Foreword

1.1 In May 1998 Justine Cummings was convicted of the manslaughter of her fiance Peter Lewis in Taunton, Somerset, an offence which took place at the end of October 1997. She is currently in Broadmoor Hospital. At the time the offence was committed Ms Cummings was a patient of mental health services in Somerset.

1.2 Following the completion of legal proceedings we were commissioned by Somerset Health Authority and Somerset Social Services to examine the care that Justine Cummings received during the time she spent in Somerset and to identify any lessons that could be drawn in order to improve services. It quickly became evident that this could not be undertaken without:

- a detailed knowledge of her early family life
- an understanding of her experiences in the care of a local authority and the care and treatment she received from the mental health services in London
- an understanding of the circumstances that resulted in her move to Somerset

1.3 Ms Cummings has experienced a great deal of misfortune and sadness in her relatively young life. The impact of being brought up in a seriously dysfunctional family has a left a lasting imprint on her. Hers is a blighted life resulting in profound and enduring mental health problems. As a teenager, she spent time in specialist psychiatric units for disturbed adolescents. As an adult, she has been in need of continuous support and treatment. Her long-standing pattern of deliberate self-harm and attempted suicide reflect the degree of inner turmoil and desperation she experienced. Her inner conflicts need neither dramatising nor embellishing. They had a crippling effect upon her personality and her relationships. In 1997 she invited a Community Psychiatric Nurse to read her diary and this prompted him, understandably, to state in a letter to her family doctor 'it's enough to make you weep'. This illustrates well her tragic life. She needs both compassion and understanding.

1.4 We have no wish to add to her difficulties by revealing more than is necessary about her life but we do need to convey that Ms Cummings had enduring problems which would have taxed the resources of any local mental health services. She required time, specialist care and consistent and intensive help, which would be a strain on local services. Suffice to say that her life and the untimely death of Peter Lewis are tragedies for them and their families. We were full of admiration for the way in which the parents of Peter Lewis have coped with this terrible event and the understanding they have shown.

1.5 Although we are satisfied that the death of Peter Lewis could not have been predicted or prevented, we nevertheless conclude that there were a number of

shortcomings in the ways in which the different services conducted their work. We make a number of recommendations for improvement that we hope will be acted upon with some vigour. We do, however, acknowledge that since the death of Peter Lewis in October 1997 there have been a number of important changes in the arrangements for providing mental health services in Somerset. In particular, a new joint health and social care Trust has been set up. It will be for the authorities to consider what further action is necessary in the light of the changes that have already taken place. The Government is rightly committed to reducing the rate of suicide in this country. In our view, patients with a pattern of frequent deliberate self-harm should be given particular attention. Their actions should not be seen as a 'gesture' but rather as a clear indication of the need for intensive help and skilled intervention.

1.6 The only witness that the Inquiry called who did not come forward to give evidence was Mr Ian Few. Despite the efforts made by the Inquiry, it was only able to receive confirmation from his mother that he was aware of the Inquiry but was not going to attend. In this report the Inquiry team cannot help but make frequent references to Mr Few because he played a central role in Ms Cummings move to Somerset and in the treatment, care and support she was given. He had an important impact on her life both as her partner and her carer.

1.7 There is another matter on which I wish to comment. Conducting an Inquiry of this kind is difficult enough without witnesses causing delays in the process. For example, despite several weeks notice to a witness, on the last working day before the appointment, a senior member of staff at the South London and Maudsley NHS Trust, Human Resources Co-ordinator Mr Malcolm Philip, instructed the witness not to appear. Although this matter was resolved, it illustrates the frustration that can be experienced in work of this kind. The letter written by Mr Philip to the Inquiry is attached as Appendix C. I understand that the Secretary of State has commissioned a review of inquiries of this kind, which is to be welcomed. I hope in future there will be no doubt about the authority of inquiries or of the requirement of public servants and others to account for their actions and co-operate fully in the process. It is also important that there are robust procedures in place for carrying out internal reviews.

1.8 Finally may I pay a heart-felt tribute to my colleagues. Ms Denise Claydon and Dr Cyril Davies brought a wealth of knowledge and experience to the task. I drew heavily upon their skills and upon their personal qualities. We were particularly fortunate to have such an able and hard working administrator in Mrs Justine Womack. The National Health Service is fortunate to have staff of her calibre. Her professional and personal qualities opened many doors, ensured we proceeded in an orderly manner and clarified the essential points. Investigating a matter of great sadness such as this was made easier by such excellent colleagues and I am very grateful to each of them.

Herbert Laming

Chapter 2

2. Background of Justine Cummings

2.1 Justine Cummings came from a severely dysfunctional family and from the age of 13 received no formal education. From the age of 14 she lived in children's homes, at her sister's home, at Cumberlow Lodge Assessment Centre, St Andrew's Hospital secure unit and the Atkinson Morley Hospital in South London. She appeared to have suffered a serious sexual assault at the age of 15. She has never been in paid employment other than a six-month job at a supermarket in her teens.

2.2 She began to experience panic attacks at the age of 13 and by the age of 16 had begun cutting herself. She first came under the care of the Bethlem and Maudsley NHS Trust, now the South London and Maudsley NHS Trust, when she was 18 and was seen as an outpatient of the Maudsley Hospital and supported by a social worker. In 1992 she was admitted to the Crisis Recovery Unit for people who deliberately self-harm at the Bethlem Royal Hospital under the care of Dr Michael Crowe.

2.3 Dr Crowe diagnosed Ms Cummings as suffering from an emotionally unstable personality disorder of borderline type. (ICD-10, World Health Organisation 1992) Borderline personality disorders are often very severe and mimic the symptoms of serious mental illnesses. Ms Cummings also showed symptoms of anorexia nervosa, panic disorder and agoraphobia.

2.4 Dr Crowe set up the inpatient Crisis Recovery Unit in 1990. The unit admits patients from all over the country with self-harming behaviour. They have a policy of asking patients to take responsibility for their own safety. The unit aims to increase the self-esteem and confidence of people who harm themselves and help them understand that self-harm is not something that can be cured overnight but is likely to recur.

2.5 According to Dr Crowe, there are a number of different motivations for people who harm themselves. In some of the most severe cases it is in response to hallucinations, such as the voice of a previous abuser telling the person they are worthless and that they should harm themselves. In other cases it may be an obsessive phenomenon in which the person feels the urge to harm himself or herself when there is a build up of tension. This tension is increased by stress. It is often intense. The motivation for self-harm by cutting in most people is to relieve tension rather than to seek attention.

2.6 Ms Cummings discharged herself from the Crisis Recovery Unit early but continued to see a social worker in times of crisis. In 1994 she was attacked and seriously sexually assaulted. During a period of great stress following this traumatic event she tied a man up and cut him. Following this, Ms Cummings was admitted again to the Crisis Recovery Unit at the Bethlem Royal Hospital

for a period of five months in 1995. It was during this admission to hospital that she met Mr Ian Few, a staff nurse, who worked on the unit for four years.

2.7 During her time in the unit Ms Cummings made real progress, engaging in the therapeutic programme and growing in confidence and self-esteem. She was discharged from the unit in August 1995 and her care was transferred to the district psychiatric service for Nunhead and Peckham under the Care Programme Approach. However, Dr Crowe noted that in her last five to six weeks at the unit she began to withdraw and was less involved with the programmes and did not attend groups as much.

2.8 A couple of weeks after Ms Cummings' discharge from the Crisis Recovery Unit staff were informed about a personal relationship between her and Mr Few. This issue was taken up with Mr Few by his line manager Ms Jane Bunclark, the nurse in charge of the unit. Mr Few admitted to Ms Bunclark that he was having a relationship with Ms Cummings but said that it had started after she had left the unit. In her evidence Ms Cummings was quite clear that the relationship began while she was a patient. She described meeting Mr Few when he was off duty and she took time out of the unit. She described their meetings in a local park.

2.9 Ms Bunclark reported the matter to her manager Mr Michael Smee, the Directorate Manager of the National Clinical Directorate. Mr Smee met with Mr Few and then discussed the matter with Mr Ben Thomas, Chief Nurse and Director of Clinical Services, and the Personnel Department at the Bethlem and Maudsley NHS Trust.

2.10 The Trust decided against a formal investigation and against referring the matter to the UKCC, the professional regulatory body, because senior management without proper investigation considered there was nothing to suggest the relationship had started prior to Ms Cummings' discharge. As a result no one, other than Mr Few, was interviewed about the matter. Mr Few chose to resign and was transferred to another ward to work out his notice period. Because this matter was never investigated, and Mr Few was unwilling to give evidence to the Inquiry, we have been unable to ascertain the precise nature of the relationship or when it began. It potentially raised issues of unprofessional conduct and possibly even a matter for police investigation under section 128 of the 1959 Mental Health Act. (see Appendix D)

2.11 Mr Thomas told the Inquiry that with hindsight he believed an investigation should have been carried out by the Trust.

2.12 The Inquiry was told that soon after Ms Cummings' discharge from hospital Mr Few moved into her flat. His employment with the Bethlem and Maudsley NHS Trust ended in December 1995.

Chapter 3

3. The Move From London to Somerset

3.1 Justine Cummings moved to Somerset with Mr Few, who had taken up a position as an E grade staff nurse at Southwood House, an outpatient unit that was part of Avalon NHS Trust, now Somerset Partnership NHS & Social Care Trust. Southwood House is the base of the Bridgwater Community Mental Health Team and provides non-residential assessment and treatment for adults with acute mental health problems.

3.2 She first came in to contact with health services in Somerset when she registered with a GP in Bridgwater on 1 July 1996.

3.3 Although the Inquiry's remit is to look at the care Ms Cummings' received in Somerset, it has had to consider her relationship with Mr Few for a number of reasons. Firstly, because it was the relationship and his taking up a post at the Avalon NHS Trust that prompted her move to Somerset and her coming under the care of local services.

3.4 Secondly, the Inquiry has had to consider the relationship because it affected the way in which Ms Cummings' was provided with services in Somerset.

3.5 Thirdly, the Inquiry could not ignore the fact that the personal relationship between Ms Cummings and Mr Few appeared to breach patient/professional boundaries and the way the Bethlem and Maudsley NHS Trust chose to deal with this matter.

3.6 And, fourthly, the Inquiry has had to consider the relationship because of its concerns about the way the Avalon NHS Trust chose to deal with allegations of misconduct made against Mr Few during his employment at that Trust.

3.7 The Inquiry considers these matters inextricably linked to the care that Ms Cummings received and that it would be a dereliction of its duty not to bring these matters to the attention of the authorities.

The Employment of Mr Few by Avalon NHS Trust

3.8 Mr Few was one of two candidates that applied for the post at Southwood House in March 1996. He had been unemployed since leaving the Bethlem and Maudsley NHS Trust. As part of the appointment process the Personnel Department at Avalon NHS Trust sought references from the Bethlem and Maudsley NHS Trust.

3.9 They received two, almost identical, references. One from Mr Smee, the Directorate Manager of the National Clinical Directorate and the other from Ms Sharon Fox, Clinical Charge Nurse, on Aubrey Lewis 3 Ward at the Maudsley Hospital where Mr Few had been transferred in order to work out

his notice. (Appendix E and F) The references stated where he had worked, the position he had held and his sickness record (57 days in 18 months). There was no mention of the fact that he had resigned following the Trust becoming aware of his relationship with a former patient on the unit where he worked. Ms Bunclark, who had been Mr Few's line manager for four years, was not asked to provide, or contribute to, either reference. The references ignored the questions posed by the Avalon NHS Trust.

3.10 Staff in the Personnel Department at Avalon NHS Trust were rightly concerned about receiving two almost identical references. As a result the Personnel Manager telephoned Mr Smee at the Bethlem Royal Hospital. He apparently gave verbal assurances that Mr Few had been experiencing some domestic issues in his life but by the time he left those domestic issues had been resolved.

3.11 There is however no written record of this telephone conversation. But the verbal assurances were accepted despite the inadequate references and Mr Few was appointed to the post at Southwood House. However, because of the Trust's concerns about Mr Few's sick leave, he was initially issued with a temporary contract, which would only be extended after a period of satisfactory performance and a good health record. The contract was extended after Mr Few was deemed suitable on health grounds by Occupational Health. The Head of Personnel was not clear whether Occupational Health saw Mr Few or what standard they used to decide whether or not to see an employee to confirm their fitness for employment.

3.12 The Inquiry also wishes to record the way the Bethlem and Maudsley NHS Trust responded to later requests from Avalon NHS Trust for information about Mr Few.

3.13 Following allegations made against Mr Few in March 1997 Mr Marcus Adam from the Personnel Department at Avalon NHS Trust wrote to Mr Philip, then Director of Personnel at the Bethlem and Maudsley NHS Trust. He asked him to make clear the circumstances under which Mr Few had left the employment of the Bethlem and Maudsley and advise the Avalon NHS Trust of any issues that he felt might be of relevance to them as Mr Few's employer. (Appendix G)

3.14 The Personnel Manager at South London and Maudsley NHS Trust, Ms Sally Dibben, replied to Mr Adams. She stated that she could confirm there was nothing in his personnel file apart from a verbal warning recorded against Mr Few and another nurse because of a drug error, which dated back to 1990. (Appendix H.) We have no knowledge of the seriousness of this matter.

3.15 However, following an investigation into Mr Few's conduct in October 1998 Mr Bill Guild, a Service Manager at Avalon NHS Trust wrote again to Mr Philip asking him about Mr Few's employment. The response from Mr Philip, which was two and a half years after the initial requests for references, stated that Mr Few had been asked to leave the Bethlem and Maudsley NHS Trust and as a result no disciplinary process was instigated. He stated that the action

arose after Mr Few admitted to a relationship with an ex-patient some time after her discharge from the unit. (Appendix I)

3.16 From the evidence the Inquiry received it believes that the personal relationship between Ms Cummings and Mr Few did begin as a result of their patient/professional relationship on the ward of the Bethlem Royal Hospital. Although not her key worker, he had a responsibility for all patients on the ward. When it came to the Trust's notice that he had formed a personal relationship with a patient the Trust chose not to investigate the matter or to take any disciplinary action. Instead they simply accepted an offer of resignation and, for reasons we cannot understand, transferred him to another ward to work out his notice.

3.17 Then to compound the failure to conduct a formal investigation, the Bethlem and Maudsley NHS Trust gave references to another NHS Trust that made no mention of this very important information. It was not until a year after the death of Peter Lewis and when they were pressed that they acknowledged all of this had happened. It would appear that there was an extremely serious and deliberate intent by the Bethlem and Maudsley NHS Trust to mislead another NHS organisation.

Chapter 4

4. Primary Care Services in Somerset

4.1 From July 1996 to April 1997, when Ms Cummings was living in Bridgwater, she came under the care of GP Dr Michael Smart, of Brent House Surgery in Bridgwater. When she moved to Taunton in April 1997 she came under the care of GP Dr Lucy Pendered at Clifton Lodge Surgery in Taunton.

4.2 Dr Smart was first made aware of Ms Cummings need for psychiatric help after receiving a letter from Mr Michael Furlong from the Deliberate Self-Harm Team, a social work team based at Musgrove Park Hospital, part of Taunton and Somerset NHS Trust.

4.3 Ms Cummings had been seen by Mr Furlong after being admitted to the hospital having taken an overdose on 4 July. This was the first of 18 attendances at the Accident and Emergency Department at Musgrove Park Hospital in 16 months.

4.4 It was unusual for Dr Smart to receive a letter from this team. However, Mr Furlong had identified from his assessment of Ms Cummings that although she had registered with a GP she had not seen a doctor in Somerset other than in Musgrove Park Hospital and she needed help. In his letter, Mr Furlong asked Dr Smart to refer her to the Community Mental Health Team in Taunton.

4.5 This was significant because in the normal course of events someone who lived in Bridgwater would have been referred to the Community Mental Health Team in Bridgwater, based at Southwood House, where Mr Few worked.

4.6 When Mr Furlong assessed Ms Cummings in Musgrove Park he noted that she wanted to be referred to the Community Mental Health Team in Bridgwater. However, by the time Mr Furlong wrote a letter to Dr Smart, he said that the couple felt that given Mr Few's employment at Southwood House, her attendance there would be difficult to manage.

4.7 Dr Smart told the Inquiry that although he could not draw on his familiarity with local psychiatric services in Bridgwater he had heard of Dr Poole, a Consultant Psychiatrist based in Chard, who saw outpatients at Musgrove Park Hospital in Taunton and referred Ms Cummings to him. Dr Smart told the Inquiry that he referred her to a Consultant Psychiatrist because she had been seeing a Consultant Psychiatrist in London, which indicated her need for specialist help. In his letter Dr Smart said: "Please would you take on the psychiatric follow up of this 24-year-old woman who recently moved to Bridgwater from London when her boyfriend, who is a Community Psychiatric Nurse, got a job at Southwood House. She is keen not to be followed up in Bridgwater." Dr Smart felt that if Ms Cummings did require an

inpatient admission, the fact that she was already familiar with a Consultant Psychiatrist would be helpful.

4.8 Dr Smart told the Inquiry that when he refers a patient to a Consultant Psychiatrist they usually recommend to him the course of action he should follow or the medication that he should prescribe. He explained that it varies whether it is the psychiatrist who writes the prescription or the GP. With the Consultant Psychiatrist in Bridgwater, who Dr Smart normally deals with, if it is a serious or difficult case where the psychiatrist is seeing the patient every few weeks, the psychiatrist will prescribe the medication himself.

4.9 Dr Smart was clear that Ms Cummings' self-harm was deep-seated. He noted that her arms that were completely covered in scars and this set her apart as being unusual and serious. He saw her prognosis as poor but felt that when she took overdoses she was not trying to kill herself because she always brought it to someone's attention.

4.10 Dr Poole saw Ms Cummings for about 40 minutes. He did not provide Dr Smart with a diagnosis or a formal psychiatric assessment. Dr Poole recommended to Dr Smart that Ms Cummings have individual psychotherapy with a private practitioner Dr Woolf and set about arranging the extra contractual referral (ECR) required with the Medical Director of the Trust and Somerset Health Authority. Dr Smart then referred Ms Cummings to Dr Woolf.

4.11 Ms Cummings did not receive any treatment from the mental health services during the three months it took to make the arrangements. Ms Cummings treatment by Dr Woolf lasted for nine sessions and by February 1997 Ms Cummings had withdrawn from the treatment. The referral to Dr Woolf will be discussed further in chapter 7.

4.12 Dr Smart then referred Ms Cummings to the Community Mental Health Team in Taunton at her request.

4.13 Dr Smart and Dr Pendered were kept informed of all Ms Cummings' visits to the Accident and Emergency Department through a standard letter outlining the treatment she had received. If Ms Cummings had been admitted to hospital as an inpatient a more detailed letter outlining her treatment would be sent to her GP although after a delay of several weeks.

4.14 Dr Smart told the Inquiry he thought the fact that Mr Few was a psychiatric nurse and Ms Cummings was a psychiatric patient skewed their relationship. He did not think the move from London to Bridgwater had been helpful to her. Dr Smart told the Inquiry that Dr Woolf considered Mr Few to be domineering and said he had followed Ms Cummings around Bridgwater. He also stated that Mr Few had been involved in Ms Cummings' treatment twice, once via a telephone call and the second time by letter and he seemed to be acting on her behalf.

4.15 Although a number of professionals within mental health services considered Dr Smart and Dr Pendered to be clinically responsible for Ms Cummings, neither was ever invited to a case conference about her because none was arranged.

4.16 The Inquiry believes Dr Smart and Dr Pendered did their best to help a patient with extremely complex needs. Like all General Practitioners managing the care of psychiatric patients they needed support from local specialist psychiatric services.

4.17 "Still Building Bridges", the report of the national inspection of arrangements for the integration of the Care Programme Approach with Care Management published in March 1999, asks these questions of local services:

- *Have you agreed the boundaries between primary and secondary services to support people in the community?*
- *Are there agreed systems with primary health care to provide advice, support and assessment?*

Chapter 5

5. Accident and Emergency Services in Somerset

5.1 Justine Cummings attended the Accident and Emergency department at Musgrove Park Hospital 18 times in 16 months.

5.2 People attending Accident and Emergency departments have a wide variety of needs and arrive in an unplanned way. Last year the Accident and Emergency Department at Musgrove Park Hospital saw approximately 38,000 patients. Of these, 1,192 people required treatment as a result of harming themselves. The department does not know how many of these were people who visited repeatedly. Patients who self-harm are responsible for a third of all admissions to the medical ward.

5.3 Mrs Jenny Fogg, the Nurse Resource Manager, and Mr Christopher Cutting, the former Consultant in charge of the Accident and Emergency Department at Musgrove Park Hospital, described their department's job as crisis intervention; treating people where possible and referring patients on to relevant specialists to expand their care.

5.4 Mrs Fogg told the Inquiry that distressed psychiatric patients can take up a considerable amount of nursing time. She explained that psychiatric patients often wander around the unit because they are agitated and need to be escorted by a member of staff. In short they can disrupt the work of the department and require staff with specialist skills.

5.5 Despite this nurses at the Accident and Emergency Department are sometimes so worried about patients who self-harm that they will invite them to come back to talk if they are concerned that further self-harm is being contemplated. Justine Cummings did, in fact, attend the Accident and Emergency Department on one occasion because she felt like cutting herself again and needed to talk about her anxieties.

5.6 While the Inquiry acknowledges the commitment and dedication of these nurses, who are clearly aware of the complexity of the needs of the patients they are seeing, the Inquiry considers this to be a matter of real concern. A busy Accident and Emergency Department lacking specialist mental health staff is not the ideal place for people who harm themselves to access therapeutic help. It is acknowledged that people who self-harm and others with mental health problems often experience a crisis point in the middle of the night. Part of the reason they go to Accident and Emergency is that they have no where else to go.

5.7 In Taunton, when a patient was not admitted to hospital they would be treated in Accident and Emergency and discharged with a green card that had details of how to contact the Deliberate Self-Harm Team.

5.8 It was for staff in the Accident and Emergency department to contact a duty psychiatrist or approved social worker if they considered a patient needed a psychiatric assessment that might lead to an application for them to be detained under the Mental Health Act.

5.9 Mr Cutting told the Inquiry that the Accident and Emergency Department saw deliberate self-harm as a cry for help rather than a deliberate attempt at suicide. He referred to deliberate self-harm as 'gestures' but acknowledged that Ms Cummings' 'gestures' were 'significant gestures'.

5.10 Dr Crowe, a specialist in self-harm, explained to the Inquiry that Accident and Emergency Departments need to distinguish between people who harm with suicidal intent and people who harm with intent to relieve tension and perhaps scar themselves. The patient should be seen by the duty psychiatrist or a nurse who takes on that role within the department and it is important that follow-up is arranged.

5.11 Each time Ms Cummings attended the Accident and Emergency Department in Taunton a separate record card was generated for her. Although appropriate treatment was delivered on each separate occasion she visited, it was a matter of chance in the department whether the record of her previous visits was identified. There was no secure mechanism for automatically bringing together a full record on a patient.

5.12 Mr Cutting told the Inquiry that staff in the department would have recognised that a patient like Ms Cummings had been in before. However, he told the Inquiry there was no system for ensuring that staff automatically receive the records of a patients who were visiting the Accident and Emergency Department regularly. He told the Inquiry that if there had been a new receptionist in the department there would have been a possibility that staff would not have known that Ms Cummings had attended previously. The Accident and Emergency Department would not have known who was responsible for Ms Cummings' care other than her GP. As a result there was an over-reliance on the patient history that was taken at the time.

5.13 The Inquiry was told that professionals working in the Accident and Emergency Department were not automatically informed of care plans for mental health patients. Neither Accident and Emergency staff nor the Deliberate Self-Harm Team were asked to participate in a case conference about Ms Cummings. This meant a full picture of Ms Cummings' needs was never formed. The isolation of Accident and Emergency services from psychiatric services made it difficult for them to undertake a full evaluation of her needs and make an appropriate assessment of risk.

5.14 Despite the numbers of people attending the Accident and Emergency Department as a result of self-harm, training for staff on this issue was limited. There was a small amount of training carried out by the Deliberate Self-Harm Team for Senior House Officers, which was not held at a time convenient for nurses. There was no training for nursing staff on dealing with patients who

self-harm and neither they nor the doctors used any formal assessment scales to assess patients and the risk they presented.

5.15 At the time Ms Cummings was a patient, there was one Consultant Psychiatrist available out of office hours to provide psychiatric cover for the county. The Inquiry was told that this meant it could be some time before a Consultant Psychiatrist could get to the Accident and Emergency Department. Mrs Fogg expressed concern about whether this cover was adequate.

5.16 Ms Cummings told the Inquiry of an excellent service provided by the Emergency Clinic at the Maudsley Hospital in London. It provided a 24-hour, drop-in facility where she could go and talk to a trained nurse and have a cup of tea when she felt the urge to harm herself.

5.17 Liaison meetings between Accident and Emergency staff and psychiatric staff did not take place at the time Ms Cummings was a patient although the Inquiry was told that such meetings do now take place. Mr Cutting told the Inquiry that the separation of acute and mental health services meant that he did not know his Consultant Psychiatrist colleagues. Mrs Fogg was optimistic that a new liaison group, which includes Somerset Partnership NHS & Social Care Trust and Taunton and Somerset NHS Trust, will help to address issues of collaborative working between the two organisations. She told the Inquiry that the Accident and Emergency Department is keen to build stronger and better links with their colleagues in the mental health Trust. The terms of reference of that group were not made clear to the Inquiry but we were concerned that perceptions between Mrs Fogg and Mr Bill Guild, a Locality Manager from Somerset Partnership NHS & Social Care Trust, about the group appeared to differ.

Recommendations

1. **The Accident and Emergency Department at Musgrove Park Hospital should have a system in place that guarantees any previous visits of a patient attending Accident and Emergency are listed automatically to ensure relevant information can be used in the assessment and diagnostic process.**

2. **The Accident and Emergency Department at Musgrove Park Hospital should develop a system to alert mental health care co-ordinators that clients have attended the Accident and Emergency Department.**

3. **The Taunton and Somerset NHS Trust, Somerset Partnership NHS & Social Care Trust and Somerset Health Authority should jointly consider whether its Accident and Emergency Department would benefit from having more specialist mental health skills made available to it. The two Trusts should have liaison arrangements in place such as psychiatric liaison nurses based at Accident and Emergency to assess patients, intervene, liase with other agencies and support and educate Accident and Emergency staff.**

Chapter 6

6. The Deliberate Self-Harm Team

6.1 The Deliberate Self-Harm Team, a social work team based at Musgrove Park Hospital, part of Taunton and Somerset NHS Trust, was set up in October 1994 by Somerset Social Services. The Inquiry was told its purpose was to assess patients admitted to hospital after attending the Accident and Emergency Department for injuries resulting from deliberately harming themselves and to refer them on for appropriate follow-up. At the time Ms Cummings was a patient there were two full-time members of staff.

6.2 The Deliberate Self-Harm Team's objectives were:

- To provide a seven-day a week service to improve the capacity to follow-up people who are admitted to hospital following attempted suicide.
- To improve the service to those people who are treated in the Accident and Emergency Department without being admitted to a hospital bed and to reduce the number of people who return to hospital with a repeated episode.
- To provide a fully comprehensive social work service to people experiencing mental health difficulties whilst receiving inpatient treatment at Musgrove Park Hospital including a formal assessment where necessary under the Mental Health Act.
- To set up and maintain a database on people with deliberate self-harm attending the hospital for treatment.

6.3 The Inquiry was not provided with any evidence to suggest that the second objective had been met in relation to Ms Cummings. She was only seen by the Deliberate Self-Harm Team if she was admitted to hospital after attending the Accident and Emergency Department. She was not assessed by the Deliberate Self-Harm Team when she was treated and discharged without being admitted to hospital.

6.4 The Accident and Emergency Department sent a letter to Ms Cummings' GP each time she attended but no such letter was sent to the Deliberate Self-Harm Team every time she visited the department as a result of harming herself.

6.5 Mr Michael Furlong, a senior social worker in the team, was not aware of 12 of Ms Cummings' attendance at the Accident and Emergency Department, which were all for self-harm. As a result, it was extremely difficult for the Deliberate Self-Harm Team to build up a picture of Ms Cummings' level of self-harm and pattern of behaviour.

6.6 The Deliberate Self-Harm Team did refer Ms Cummings on to other services on two occasions but the Inquiry has some concerns about the recording of assessments of her. The social workers did operate according to the guidance they had been provided with. This outlined the headings they should use for

completing the written initial social work assessment – a document included in medical notes. However, in Ms Cummings' notes there was some variation in the terminology used. For example Mr Furlong logs a 'forward plan' at the end of his notes while in one of his colleague's notes there is no 'forward plan' simply 'comments'.

6.7 The assessments made by the Deliberate Self-Harm Team did not link in to Ms Cummings' care plan.

6.8 When Ms Cummings cut herself and did not need to be admitted to hospital she was given a green card with the number of the Deliberate Self-Harm Team. When she took an overdose she was admitted to hospital and was seen by the Deliberate Self-Harm Team.

6.9 Ms Cummings could also phone the Deliberate Self-Harm Team directly and arrange to go and see them, which she did on one occasion. Mr Furlong told the Inquiry that his team did not usually invite people to come and see them but sometimes patients decided they wanted to. This could happen when a patient was waiting to get an appointment with the Community Mental Health Team. In Mr Furlong's words 'I would not actually deal in a therapeutic way with what they were being referred to the team for but I would hold the crisis.'

6.10 Mr Furlong told the Inquiry that he was well supported by other health professionals. However, when Mr Furlong spoke to Dr Poole about Ms Cummings' care after she took an overdose in January 1997 he recorded in his notes that Dr Poole's response was that she had a perfectly good therapist in Dr Woolf and should re-establish contact with her. He also noted that Ms Cummings' did not want this. In his evidence Mr Furlong told the Inquiry that Dr Poole was saying 'if Dr Woolf can't help her then who can?'

6.11 The Inquiry considers it important to record that Mr Furlong observed the difficulties that Ms Cummings' relationship with Mr Few presented to professionals working with her. He noted that Ms Cummings' referral out of the area was set up to protect Mr Few. He told the Inquiry that Mr Few had felt very uncomfortable about Ms Cummings being referred to Southwood House because he felt it would compromise his position. He added that Mr Few never volunteered any information about Ms Cummings other than what Mr Furlong needed to know at the time. He added that he sees many relatives who are anxious to sit down and talk about their concerns but that he never achieved that with Mr Few. His colleague Ms Ransome told the Inquiry that the situation was embarrassing because Mr Few was a colleague and they had to work together with other patients. She stressed it was embarrassing because of Mr Few's attitude towards her.

Management of the Deliberate Self-Harm Team

6.12 In 1996 the manager responsible for the Deliberate Self-Harm Team was Mrs Angela Williamson, Assistant Head of Service for the eastern half of Somerset, who had responsibility for mental health services. However, the Deliberate Self-Harm Team was located in the western half of the county. Mrs

Williamson told the Inquiry that managers in Social Services recognised the potential for managerial confusion of the service.

6.13 She decided to maintain a watching brief and support the team where possible. She attempted to do this by linking Mr Furlong with a Mental Health Team leader in a bid to strengthen the link between the Deliberate Self-Harm Team and the Social Services Mental Health Team. She told the Inquiry that a full evaluation of the service had to wait until the following year because of a review of mental health services in the county that was being carried out at the time.

6.14 The Inquiry was told that in 1997 the difficulties of management arrangements within Social Services became clear and an additional Assistant Head of Service post was created to concentrate exclusively on mental health, drugs and alcohol services. This new post was also designed to give additional time to the review of mental health services and was filled by Mrs Williamson.

6.15 An evaluation of the Deliberate Self-Harm Team was conducted and reported in October 1997. Plans for a revised and re-targeted service were endorsed in March 1998. The plans stated the team should provide a seven-day a week service but over shorter days and that the scheme should be extended to Yeovil District Hospital.

The Current Position of the Deliberate Self-Team

6.16 Although the Deliberate Self-Harm Team is still based at Musgrove Park Hospital, it is now managerially incorporated into one of the three Community Mental Health Teams in Taunton, which are part of the new Somerset Partnership NHS & Social Care Trust.

6.17 Mr Furlong told the Inquiry that one of the main problems at the time Ms Cummings was a patient in Somerset was that mental health teams and social work teams were separate and this is now being addressed by the new Somerset Partnership NHS & Social Care Trust.

6.18 He explained that his Community Mental Health Team has a weekly meeting with the Consultant Psychiatrist to discuss referrals and on-going problems and concerns. If Mr Furlong makes a referral to another Community Mental Health Team it would be discussed at their team meeting and he would be reliant on the team manager to let him know the outcome. He has been invited to some other Community Mental Health Team meetings to discuss referrals recently and has been briefed verbally and in writing about the care plans of other patients he has referred.

6.19 However, Mr Furlong said that holiday cover had been, and continues to be, particularly difficult because people in the hospital social work team, who are supposed to provide this cover, are not comfortable about doing this. This is because they consider the work too specialised. Mr Furlong said he was always worried about what would happen when he or his colleague where not there. He said some people would be dealt with by social workers, others by

the duty psychiatrist or at weekends the emergency duty team would carry out a formal mental health assessment.

6.20 Mr Furlong believes part of the reason other social workers do not want to get involved is that deliberate self-harm is a difficult area to work in. He told the Inquiry that even working within the hospital, he sees that incidents of deliberate self-harm create a great deal of anxiety among professional staff. He also told the Inquiry that there were different interpretations of self-harm. He explained that some professionals do not see deliberate self-harm as a form of mental illness. His view is that people who are in good mental health do not harm themselves or take overdoses.

6.21 Mr Furlong told the Inquiry that there are now plans for two Community Psychiatric Nurses, who are interested in self-harm, to undertake one session for the Deliberate Self-Harm Team each week. This is to ensure there is some cover for the team when Mr Furlong and his colleague are on leave. However, the Inquiry is uncertain about the viability of these arrangements.

Recommendations

4. **Somerset Health Authority should review the approach to deliberate self-harm including attempted suicide in Somerset to consider the most effective way of providing services. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health, in particular Standard Seven: Preventing Suicide.**

5. **There should be a thorough review of organisational arrangements and the composition, management and effectiveness of the Deliberate Self-Harm Team.**

Chapter 7

7. Mental Health Services in Somerset

Referral to Dr Alan Poole

7.1 Ms Cummings was first referred to specialist mental health services in Somerset by her GP Dr Smart in July 1996. In his referral letter Dr Smart explained that Ms Cummings had been a patient of Dr Crowe at the Bethlem and Maudsley NHS Trust both as an inpatient and that she had been having follow-up outpatient appointments. He described her taking overdoses and noted that he was struck by the multiple laceration scars the length of both arms which were a result of her cutting.(Appendix J)

7.2 Dr Poole was based in Chard rather than Bridgwater but Dr Smart referred her there because her relationship with Mr Few appeared to preclude her from being seen by her local Community Mental Health Team, the Bridgwater team based at Southwood House where Mr Few worked. Because of the way in which the service accommodated Mr Few, Ms Cummings was referred out of her local area. Ms Cummings told the Inquiry that Mr Few said she could not have a Community Psychiatric Nurse in Bridgwater. Dr Poole was willing to accept her as a patient even though she lived outside his catchment area.

7.3 Dr Poole made an assessment of Ms Cummings during a 40-minute interview. The notes of the assessment were confined to a brief description of what she had told him of her previous psychiatric and medical history. They did not include information about her background history and he did not take a family history. In his assessment he did not record Ms Cummings' mental state. Dr Poole stated he was mindful of her relationship with Mr Few and explained that he only recorded the features that were particularly important and that he did not record the negative features only the positive ones. There was no record in his assessment of whether Ms Cummings received benefit in the past from medication. He did not record a diagnosis. Dr Poole said he recorded some things and kept other things in his head.

7.4 Dr Poole did not consider it necessary to get Ms Cummings' notes from the Bethlem and Maudsley NHS Trust. However, he told the Inquiry he would have done so if he had been taking her on personally for psychotherapy. At that time he considered they should get on with a different plan and make a new start.

7.5 Dr Poole told the Inquiry that the best indicator of risk is past behaviour yet it is difficult to see that he made an adequate risk assessment by choosing not to request Ms Cummings' previous medical notes.

7.6 Health Service Guidance (95)56 "Building Bridges", a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people, states:

The key principle of risk assessment is to use all available sources of information *– a proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour.....*

It is often possible to identify circumstances under which, based on past experience, it is likely that an individual will present an increased risk. An assessment can then go on to indicate what must change to reduce this risk, to propose how these changes might be brought about and to comment on the likelihood of interventions successfully reducing risk.

7.7 In addition, HSG(94)27 states:

A proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning and also his or her past behaviour. It is essential to take account of all relevant information, whatever its source. As well as the treatment team and the patient, sources may include relatives, carers, friends, the police, probation officers, housing departments, and social workers, and also local press reports and concerns expressed by neighbours.

7.8 Dr Poole said he had an open mind about Ms Cummings' medication or even whether she should take any at all. He left it to the GP to decide. He admitted that he 'sat on the fence'.

Extra Contractual Referral to Dr Woolf

7.9 Dr Poole did not draw up a specific care plan but referred Ms Cummings to Dr Philippa Woolf, a private practitioner, for individual psychotherapy. Dr Poole told the Inquiry he decided to do this because Ms Cummings had been receiving psychotherapy in London and she needed someone who was very competent with considerable experience. However, Dr Poole did not think it appropriate to give Ms Cummings individual psychotherapy himself. Dr Poole told the Inquiry that Ms Cummings was someone that nurses or social workers would not be able to cope with. There was no record of this in his notes.

7.10 Dr Poole told the Inquiry that the Avalon NHS Trust did not have an individual psychotherapy component, he said psychotherapy was given by trainee psychiatrists, consultant psychiatrists, psychologists, community nurses and social workers but that there was no uniformity in the approach. He said some areas had a greater psychotherapy component in services than others but that this would change as consultant psychiatrists moved.

7.11 Dr Woolf previously worked in the NHS in Somerset. She has no recognised qualification in psychiatry although she is a qualified doctor and has been practising for 51 years. Ms Cummings saw Dr Woolf nine times over a period of approximately four months before deciding that she no longer wished to pursue psychotherapy with her. Dr Woolf was not having supervision of any kind at the time Ms Cummings was a patient.

7.12 Dr Woolf lost Ms Cummings notes and they were not available for the Inquiry to see. As far as the Inquiry can determine, Dr Woolf's notes on Ms Cummings were not shared with any other health professional.

Clinical Responsibility

7.13 It is from this referral outside the NHS that confusion over who was clinically responsible for Ms Cummings flowed.

7.14 Ms Cummings' GP Dr Smart wrote to Dr Woolf as part of the extra-contractual referral (ECR) process, the process for referring patients outside of the NHS for treatment. When Ms Cummings withdrew from that treatment in February 1997, Dr Poole considered that responsibility for her care went back to Dr Smart because Ms Cummings had withdrawn from the treatment he recommended. However, Dr Woolf wrote back to inform Dr Poole as well as Dr Smart that Ms Cummings' treatment had stopped.

"Building Bridges" states:

...a referring GP will retain medical responsibility for a patient referred direct to a non-medical member of the team.

However, Dr Smart referred Ms Cummings to Dr Poole a medical member of staff. The Inquiry is also aware that "Building Bridges" states that a formal review of care should take place at least every six months.

7.15 Ms Cummings and Mr Few contacted Dr Smart after she decided she no longer wished to see Dr Woolf and asked for her to be referred to the Community Mental Health Team in Taunton, which was based at Ivor House. Dr Poole did not consider that he had any formal links with Ivor House in Taunton.

"Building Bridges" states:

The rest of the team should also be contributing to the monitoring and possibly the reviewing of a patient's care.

Referral to the Taunton Community Mental Health Team

7.16 On 4 March 1997 Ms Cummings was assessed by Mr Ian Turner, a Community Psychiatric Nurse within the Taunton Community Mental Health Team, who told the Inquiry he was 'cornered in a corridor' and asked to take her on. He said his impression was that other team members were anxious about taking her case. Mr Turner admitted the team did not apply any definitions of serious mental illness such as those found in the guidance "Building Bridges" to screen referrals although he said he was aware of these definitions.

7.17 The letter from Dr Smart to the Taunton Community Mental Health Team did not refer to Ms Cummings' previous treatment. Mr Turner carried out an

assessment of Ms Cummings and drew up a care plan entitled minimum care plan. He recorded her name wrongly calling her Janine and also recorded a level three CPA tier, which would be a priority case. According to Mr Turner this was an error on his part caused by confusion over the two systems operating in Somerset at the time. Mr Turner told the Inquiry the policy at the time was that unless several professionals were involved directly in a patient's care that patient would be put on a minimum care plan.

7.18 According to "Building Bridges":

A minimal CPA would apply to patients who have limited disability/health care needs arising from their illness and have low support needs which are likely to remain stable. They will often need regular attention from only one practitioner. If the patient needs a medium level of support, a more complex CPA would be appropriate. This may be because the person is likely to need more than one type of service, or because their needs are less likely to remain stable.

7.19 The Inquiry was told that the application of the Care Programme Approach in Somerset at the time Ms Cummings was a patient was extremely patchy. It was told there were differences of opinion among consultant psychiatrists about the number of tiers that should be used in the Care Programme Approach. The outcome was that some consultant psychiatrists used four tiers while others used three. Mr Turner told the Inquiry that Ms Cummings was put on a minimum care plan because her only contacts were himself and the GP. This reflected the Avalon NHS Trust Care Programme Approach policy at that time. It is significant that Ms Cummings had been receiving treatment for some nine months before the first reference was made to the Care Programme Approach.

Assessment by Dr Waqar Ahmed

7.20 However, on 24 June 1997 another mental health professional became involved in Ms Cummings' care when Mr Turner asked a Consultant Psychiatrist in the Taunton Community Mental Health Team Dr Waqar Ahmed to assess Ms Cummings.

7.21 Dr Ahmed diagnosed her as having a borderline personality disorder. This was the first time this clinical diagnosis was made in relation to Ms Cummings in Somerset. Dr Poole's diagnosis, in a letter to the Medical Director of Avalon NHS Trust requesting an ECR to Dr Woolf, was that Ms Cummings' problems were 'neurotic'.

7.22 Dr Ahmed did not consider it necessary to see Ms Cummings again but decided the most appropriate way forward was for Mr Turner and the GP to continue to see her and to try to engage her. This was because it would give her the opportunity to relate to a couple of people she could trust and, from there, bring in other services. His hope was to engage her for long enough to bring in more help. He told the Inquiry that he was trying to tease out from Ms Cummings the bits of her personality disorder which were treatable. He said

some psychiatrists would say that personality disorder is not amenable to treatment at all. The Care Programme Approach tier that Ms Cummings was on was not reviewed following the involvement of Dr Ahmed.

7.23 Dr Ahmed told the Inquiry that Ms Cummings was exceptional as an individual but that there would be about 120 patients in Somerset with similar problems to her. Dr Iles at Broadmoor Hospital, is of the opinion that Ms Cummings is exceptional and a person who is 'extremely damaged'.

Clinical Responsibility

7.24 Dr Ahmed saw his involvement with Ms Cummings as a 'favour' to Mr Turner who was a member of the same Community Mental Health Team. Dr Ahmed clarified that by 'favour' he meant expediency because the members of his team sometimes found it easier make an inter team referral to him rather than asking the patient's GP to refer that patient to a Consultant Psychiatrist who might have been in a different team. Ms Cummings was technically in the patch of Dr Ahmed's Consultant Psychiatrist colleague Dr Moloney. The reason for this was that between Dr Smart's referral of Ms Cummings to the Taunton Community Mental Health Team and her receiving care from that team she moved from Bridgwater to Taunton. Her GP in Taunton was Dr Lucy Pendered whose patients were usually seen by Dr Moloney.

7.25 Dr Ahmed told the Inquiry that Ms Cummings was not under the care of a Consultant Psychiatrist because although she had been seen initially by Dr Poole and later by himself, she would have been classified as under the care of Dr Moloney's team. This was because of the system of patch psychiatry. However, Ms Cummings was never referred to Dr Moloney. Dr Ahmed considered her to be under the care of her GP, like fifty per cent of patients under the care of the Community Mental Health Team. He said the GP could mobilise further help as necessary.

7.26 Mr Turner told the Inquiry that Dr Ahmed saw her as 'a favour' to him because he did not think the Consultant Psychiatrist responsible for the GP practice she was then registered with would see her. Mr Turner saw himself as being clinically responsible for Ms Cummings' care as her key worker.

7.27 The guidance "Building Bridges" states:

What is required is an agreed scheme of responsibilities, so that, on the one hand, key workers know the limits within which their authority operates, and on the other, that there are protocols that govern the way in which other professionals and agencies will respond to requests from the key worker for modifications to their contribution to the agreed care plan. Authorities and professionals remain individually responsible for the services they contribute to care plans, even though responsibility for overall co-ordination may lie elsewhere.

First Referral to Day Care

7.28 On 11 August 1997 Ms Cummings was assessed by Dr Miraldene Rosser, Dr Ahmed's staff grade doctor, who was responsible for assessing patients for day care. This followed a referral from Mr Turner. Dr Rosser suggested that Ms Cummings take a course at Somerset College of Art and Technology (SCAT), attend day care and be transferred to Dr Moloney's team.

7.29 Although Ms Cummings initially attended SCAT, she was unable to continue because of her difficulty in dealing with large numbers of people. She did not attend her first day care appointment on 18 August but her patient notes record she left a message saying she was moving house. She did not attend four other day care appointments so her day care was cancelled and Dr Rosser noted that she had been referred to Dr Moloney's team and that Mr Turner would follow her up.

7.30 Mr Turner told the Inquiry Ms Cummings did not engage with this first series of day care because she was asked to attend groups that caused her anxiety. He explained that the day care staff would only tell him if a patient had not turned up if it caused them some concern otherwise they would tell him at the end of the week if a patient had not attended for day care. Mr Turner said it was normal for him not to see clients while they attended day care.

7.31 In September 1997 Mr Turner discussed Ms Cummings' medication with both her and Dr Pendered. They agreed to try medication, which a Consultant Psychiatrist in Somerset was using to help people who harm themselves to stop cutting. Mr Turner also recorded in his notes from 10 September that visits should be increased to twice weekly although his records did not indicate that visits began to be increased until mid October.

Specialist Approach to Patients Who Cut Themselves

7.32 Both Dr Woolf and Mr Turner asked Ms Cummings to promise not to cut as part of their work with her. However, Dr Crowe said that on his specialist unit one of its unusual aspects is that they do not confiscate razor blades so that people have access to their razor blades the whole time they are on the unit. This is because the unit has a policy of people taking responsibility for their own safety. It also deals with overdoses on the ward giving people an antidote and checking the blood levels of paracetamol. Patients only go to Accident and Emergency if they cannot be cared for under these conditions. Dr Iles emphasised that one of things you <u>don't</u> do with people who deliberately self-harm is tell them not to do it.

7.33 She told the Inquiry that professionals need to work with patients who self-harm to help them gradually over a period of time. She said the first thing is to get in touch with their emotional language because they do not always know when they are feeling angry and violent. They have to learn to identify the thoughts and feelings that lead up to an act of self- harm and learn ways of dealing with the thoughts and feelings so that it can become less serious, until they finally decide they don't need to do it.

7.34 Ms Cummings told us that instructions not to cut simply increased her frustration and gave her the impression that people did not understand why she was doing this.

7.35 Mr Turner told the Inquiry he was pursuing a number of strategies to help Ms Cummings stop cutting herself including encouraging her to seek alternative support, addressing her misuse of drugs and alcohol, encouraging her to go out and trying new medication. However, Mr Turner was not recording whether Ms Cummings' cutting was increasing or reducing. Mr Turner was also not aware of the frequency of Ms Cummings attendance at the Accident and Emergency Department. He said he would not normally have been informed and he could only have found out if it had come up in conversation with Ms Cummings or if he had specifically asked her. He said if members of the team did share information services might be improved but he said that in this case there was not a multidisciplinary case conference.

Attempt to Discharge Ms Cummings

7.36 On 25 September 1997 Ian Turner sent Ms Cummings a letter saying that as she had not attended her last couple of appointments he was wondering whether she still wanted to see him. He said that if he did not hear from her he would assume things were better and discharge her from his caseload. (Appendix K)

7.37 She wrote back two days later saying that she did still wish to see him that she had not been aware that she had an appointment recently and that she thought she was supposed to see him once she had started taking her medication. She wrote: 'I'm sorry for whatever I've done wrong, things are not better in fact, they're much worse so please don't discharge me from your caseload.' (Appendix L) This resulted in another appointment being made.

7.38 Mr Turner said the approach to following up someone who did not attend an appointment varied. If he was particularly worried about a patient he might follow them up by going round to their house and leaving a message. For other patients he would not do this.

"Building Bridges" states:

Keeping in touch must also be assertive; key workers shouldn't rely on the patient contacting them.

Admission to a Psychiatric Unit

7.39 On October 1 Ms Cummings, having attended the Accident and Emergency Department, was transferred from Musgrove Park Hospital to Rydon House, a psychiatric unit, where she was detained under section 5(2) of the Mental Health Act and transferred to another psychiatric unit Holford House. She was discharged on 2 October by medical staff who discussed her condition with Mr Turner and Mr Lewis. The notes said that Mr Turner was to see her the following day although there is no record that he did.

7.40 The assessment made at Holford House was that Ms Cummings did not suffer from any form of mental disorder. Mr Turner did not consider that she had any needs which could be treated at Holford House at the time. However, he did not record in her notes any changes in her mental state.

7.41 "Still Building Bridges", the report of a national inspection of arrangements for the integration of the Care Programme Approach with Care Management published in March 1999, states:

Of the care plans we saw, few provided the necessary information about:

- *Assessed need*
- *The level of expected informal support*
- *Services to be provided to complement informal support*
- *Indicators of improvement, maintenance or deterioration of the users condition*
- *Action to be taken if the plan did not provide sufficient support or aspects of it began to fail*

Ms Cummings Diary

7.42 Throughout October 1997 Ms Cummings seemed to go through a period of intense turmoil. Her only way of finding relief was to take an overdose or cut herself. Her cutting worsened considerably during the month and on one occasion she had to have 100 stitches or another occasion she had 70 stitches. During this period she also moved from cutting her arms to cutting her legs.

7.43 It was at this point that she gave her diary to Mr Turner. He had asked her to write about her thoughts and feelings regarding cutting but she gave him the diary she had kept before he had asked her to record these matters. He wrote a letter to her GP Dr Pendered saying that she had given him her diary and that 'it's enough to make you weep.'

7.44 Ms Cummings told us she hoped that if she gave Mr Turner the diary it would show him what she was going through. She said that she wrote in her diary that time was running out and that something was going to happen. She has also told the Inquiry that when she was in Bridgwater she attacked Mr Few with a knife and broke his nose. She said Mr Few could have told someone but he did not. She felt that her behaviour was an indication that she needed more help even if it meant her being detained in hospital under the Mental Health Act.

7.45 According to Mr Turner he was not able to read the diary in any depth or to use it in any way. Mr Neil Scott, Ms Cummings' solicitor, who had access to her diary in his preparation of her legal defence noted that on the front, it said 'In the event that something happens to me please hand it to Ian Turner my Community Psychiatric Nurse.' He also noted that her diary had a reference to not only harming herself but also harming Mr Lewis.

Second Referral to Day Care

7.46 During this period of turmoil Ms Cummings attended a second series of day care sessions that were arranged for her. She attended three times. Her last day care session was on the day before the death of Mr Lewis. She also had an appointment with Mr Turner on the same day. The day care focused on taking part in arts and crafts activities.

Inquiry's Observations on Day Care

7.47 The Inquiry found it extremely unclear how day care fitted in to the work of the Somerset Community Mental Health Teams. Dr Ahmed said that he made use of day care and had developed it since he had been in Somerset. He told the Inquiry that patients were transferred from inpatient care to day care quickly and it worked well. However, Dr Ahmed had Dr Rosser to do assessments for day care while other Consultant Psychiatrists did not use their staff grade doctors in the same way.

7.48 Dr Ahmed told the Inquiry that other Consultant Psychiatrists do not have as many reviews of patients as he does although there is a system of review. He said day care had been developed on the back of the Mental Health Team organising some day groups. Dr Ahmed said day care provided an opportunity to monitor mental state, to formalise complex care that might be given to people leaving inpatient care, to provide focused help on things like anxiety management and to enable people to be supported while other care is delivered. He told the Inquiry that at a simple level day care was used as social care to engage people who may be withdrawn.

"Still Building Bridges" underlines the importance of day care stating:

For other people opportunities for structured day care gave their lives a framework which helped them to maintain medication programmes and keep regular contact with staff.

Clinical Responsibility in Day Care

7.49 Mr Turner said that when a patient was referred to day care clinical responsibility was a 'mixed bag'. He explained that if he was the key worker of a client and referred them to day care services the patient would attend up to five days a week so he would not see them. He told the Inquiry day care staff wanted him to remain the key worker but in essence he may not have seen the client. He said clinical responsibility would ultimately be with Dr Ahmed because in day care a patient would be seen by one of the doctors under Dr Ahmed's supervision.

7.50 However Mr Turner also told the Inquiry that if Dr Ahmed was not directly involved with a patient the responsibility for that patient lay with the GP. In Ms Cummings' case Dr Ahmed considered that clinical responsibility lay with her GP.

7.51 Mr Turner was only aware that Dr Ahmed saw Ms Cummings once. In fact he saw her twice, the second time was at Accident and Emergency after being called in as the duty psychiatrist on 17 October 1997.

7.52 Although the services Ms Cummings received in October changed with her being an inpatient for a short time and at other times attending day care her care plan was not reviewed and there was no change to the level of the Care Programme Approach.

Management of the Taunton Community Mental Health Team

7.53 Mr Turner effectively had three managers. A team co-ordinator Mrs Kate Glenholmes, who like him was a G grade nurse, Mr Jim Wilson, a psychotherapist and Mr Bill Guild, the Service Manager for Taunton.

7.54 Mrs Glenholmes was responsible for caseload supervision and management and allocation of work to E grade staff nurses and occupational therapists. She provided clinical supervision, quality assurance and monitoring of clinical records. She acted as the co-ordinator for the wider Community Mental Health Team but did not have managerial responsibility for their activities.

7.55 Mr Turner described Mrs Glenholmes as managing the team although Dr Ahmed said she did not manage him or the whole team. She was solely responsible for the nurses. However, Mr Turner said Mrs Glenholmes did not manage him although she managed the team. Later in his evidence he said there was no team leader for the Community Mental Health Team based at Ivor House.

7.56 Mr Jim Wilson, a psychotherapist in private practice, was contracted to provide clinical supervision for Mr Turner and other staff. And Mr Bill Guild, whose span of responsibility included all mental health services in Taunton, had overall line management responsibility for the team including Mr Turner.

7.57 Dr Ahmed told the Inquiry nurses do not like having leaders. He said the team operated a flattened hierarchy with the Consultant Psychiatrist being the leader when it came to making decisions about responsibility or having psychiatric opinions.

Observations on Services Required by Patients like Ms Cummings

7.58 Dr Iles at Broadmoor Hospital gave the Inquiry useful information about how the care of patients like Ms Cummings can be organised that the Inquiry considers it should record.

7.59 Dr Iles made it clear to the Inquiry that it is extremely difficult for local services to meet the needs of a patient like Ms Cummings because patients like her need special provision. She said that these are 'heart sink' patients because people don't know deep down what they can do. She said patients with personality disorders are not rewarding, which is why she suspects that in

the past psychiatrists have used – and still use – treatability as a let out not to detain such people in hospital.

7.60 Dr Iles outlined a system for dealing with patients like Ms Cummings that consists of a multidisciplinary service starting on an outpatient basis with community outreach and day centres. There may need to be planned admissions to inpatient beds for a number of months when treatment can be provided only in that setting.

7.61 She said there may be a need for local psychiatric services to have access to a specialised facility, which could be part of or separate from the regional inpatient forensic service. This specialised facility would have a range of levels of security for female patients with personality disorders if they become a threat to themselves or others in ways that meant they could no longer be contained by local services. Such specialist services could provide more intensive treatment and offer advice and support to help local services manage risk. She said: 'Risk assessment is to do with assembling reliable and effective information.'

7.62 Mr Neil Scott, Ms Cummings' solicitor, while not an expert in psychiatric care, had dealings with a number of specialists in his preparation and delivery of Ms Cummings' defence. He believes Ms Cummings fits in to the category of person who could have benefited from being in a medium-secure psychiatric facility for women but sadly there is no such facility in the South West. His view is that she seemed to have a 'cocktail of problems' which were probably too complex and too severe for a local rural psychiatric service to cope with. However, although Mr Scott raised the issue of whether Ms Cummings should have had a forensic referral, he acknowledged it would be hard to know what could have been done in the absence of specialist facilities. He also raised the need for a 24-hour drop in facility.

Recommendations

<u>Clinical Responsibility</u>

6. **There should be an overt statement of who has clinical responsibility for a patient like Ms Cummings at all times. It should not be assumed that the GP has clinical responsibility by default. Mental health services should make it clear to General Practitioners whether they are taking over the care of a patient or simply providing an opinion on how the GP should manage the patient's care.**

7. **General Practitioners should be provided with a formal assessment of a patient they refer including a diagnosis, risk assessment and treatment plan. Somerset Partnership NHS & Social Care Trust needs to consider whether it should introduce a standard format for the assessment that mental health professionals should provide to General Practitioners.**

<u>Out of hours services</u>

8. **Consideration should be given to developing a 24-hour, drop-in facility for mental health patients particularly those who deliberately self-harm.**

9. **Consideration should be given to the adequacy of out-of-hours psychiatric cover in the county. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.**

Standard three of the National Service Framework for Mental Health states:
"Any individual with a common mental health problem should:

- **Be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care**
- **Be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or local services"**

<u>The Care Programme Approach</u>

10. **There should be a thorough review of the way the Care Programme Approach is applied across services in Somerset in order to ensure arrangements are in place for its proper implementation. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.**

Standard Four of the National Service Framework for Mental Health states:
"All mental health service users on CPA should:

- **Receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk**
- **Have a copy of a written care plan which:**
  - **includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator**
  - **advises their GP how they should respond if the service user needs additional help**
  - **is regularly reviewed by their care co-ordinator**
  - **is able to access services 24 hours a day, 365 days a year"**

Standard Five of the National Service Framework for Mental Health states:
"Each service user who is assessed as requiring a period of care away from their home should have:

- **timely access to an appropriate hospital bed or alternative bed or place, which is:**
  - **In the least restrictive environment consistent with the need to protect them and the public**
  - **As close to home as possible**
- **a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis."**

The National Service Framework for Mental Health also states in relation to preventing suicide among people with severe mental illness:
"As set out in Standards four and five, local health and social care communities need to ensure that:

- **care plans are reviewed at a frequency which reflects assessments made of the risks identified for individuals"**

Community Mental Health Teams

11. Somerset Partnership NHS & Social Care Trust should review the composition, management and effectiveness of Community Mental Health Teams. It should ensure the following:
    - There is a framework for allocating and reviewing patient's care using the full resources of the team
    - Professionals have a clear understanding of their role and accountability
    - There are agreed procedures in place outlining how to involve other professionals within the team in a patient's care plan. These procedures should also outline how to involve colleagues in other Community Mental Health Teams or in other parts of the health and social care system in a care plan where necessary.
    - The teams are implementing the practices outlined in Building Bridges, Still Building Bridges and National Service Framework for Mental Health.
    - There are arrangements in place for auditing the work of the teams

Day Care

12. There should be a review of the purpose and effectiveness of day care services and the way the Community Mental Health Teams link into these services. Particular attention should be given to a single access point, clinical responsibility and effective communication with other services.

Care Plan Responsibility

13. If a mental health patient's initial treatment plan proves ineffective the originator of that plan has a responsibility to review the care being given and ensure the provision of an alternative treatment plan. Somerset Partnership NHS & Social Care Trust should introduce a policy to ensure all professionals comply with this standard.

Evidence Based Practice

14. Practitioners should use available evidence to inform and develop practice. They should update their clinical practice and make informed decisions by re-evaluating the relevance of a particular intervention.

Training

15. Somerset Partnership NHS & Social Care Trust should review the training it provides to staff on the application of the Care Programme Approach and on record keeping, risk assessment and care planning.

16. Taunton and Somerset NHS Trust should review the training needs of staff in the Accident and Emergency Department on managing patients with mental health problems.

17. This is an opportunity for local health and social care communities to ensure that primary care staff have the training to enable them to assess and manage depression including the risk of suicide. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.

The National Service Framework for Mental Health states on preventing suicide among people with severe mental illness:
"As set out in Standards four and five, local health and social care communities need to ensure that:

- **training for staff in specialist mental health services in risk assessment and management is a priority, and is updated at least every three years"**

Supervision

18. **An effective and efficient system should be in place to ensure all professional staff receive appropriate supervision of their work and have their work regularly reviewed. Independent practitioners should operate to the same standards. The system should balance managerial, educational and clinical supervision of staff and provide an opportunity to reflect on and explore clinical standards, case analysis and staff workloads.**

Referrals Out of the NHS

19. **Somerset Health Authority should review the way patients are referred for treatment outside of the NHS to ensure the referral is appropriate, the treatment suitable and the quality of the treatment is monitored.**

Chapter 8

8. Multidisciplinary Working and Record Keeping

8.1 The more the Inquiry looked at the experience of Ms Cummings the more it became clear that Accident and Emergency did a good job in tackling the immediate problems she presented with but that it had little connection with any service other than primary care.

8.2 The Inquiry has serious concerns about the failure to apply the Care Programme Approach to Ms Cummings and about the poor assembling of information about her. Decisions about her care seemed to be made on an ad hoc basis with Ms Cummings being referred to Mr Turner in a corridor because no one else wanted the case.

8.3 The fact that Ms Cummings was assessed as requiring a minimum Care Programme Approach in April 1997 resulted in no multidisciplinary case conference or assessment of her needs being conducted.

8.4 It is clear that mental health professionals did not try to access Ms Cummings' previous notes until very late on. Ms Cummings notes were not even available when she was detained under the Mental Health Act and taken to Holford House. The records there, unbelievably, say no previous contact with services. According to Dr Poole it is 'pot luck' whether all the relevant information is available even in the acute stage like an admission to an intensive care unit.

8.5 Mr Turner told the Inquiry professionals do not routinely access patients previous medical records. He said he could have asked to see Dr Poole's notes but he did not. He said he would not go in and look at the GP notes of everyone who is referred to him. He did not feel there was any need to go and see Ms Cummings' GP notes.

8.6 While the Inquiry understands the pressures on mental health professionals, the Inquiry considers that if information is assembled and there is a proper risk assessment made about patients with intense needs such as Ms Cummings, there would be less chance of things going wrong. Far from utilising more resources there would be a cost benefit in agreeing who is responsible for care and who is doing what in this process. It is valuable for all the agencies involved with a patient like Ms Cummings to agree a way forward and contribute information about the patient and know the care plan.

8.7 Mr Turner told the Inquiry there was not a senior nurse in the Trust at that time providing advice or auditing notes. It is important that the quality of the notes being kept about a patient are regularly audited to ensure that they are meeting established standards.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting Guidelines for records and record keeping state:

The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice....

It is an invaluable way of promoting communication within the health care team and between practitioners and their patients or clients. Good record keeping is, therefore, both the product of good team work and an important tool in promoting high quality health care....

Patient and client records should:

- *provide clear evidence of the care planned, the decisions made, the care delivered and the information shared....*

By auditing your records, you can assess the standard of the record and identify areas for improvement and staff development.

8.8 As the Inquiry has stated earlier we have concerns about the management arrangements of the Community Mental Health Team in Taunton at the time. In particular that staff worked in isolation, there was confusion about role responsibility and they were not using established definitions of mental illness.

8.9 We understand and welcome the fact that a liaison group has now been set up to improve joint working between Accident and Emergency services and psychiatric services and we hope that roles and responsibilities will be clarified and ways sought of working together more effectively.

8.10 Attention also needs to be given to note keeping of practitioners operating outside of the NHS in view of the fact that Dr Woolf lost Ms Cummings' notes so these were not available to the Community Mental Health Team who took over her care – even if they had requested them.

Recommendations

20. When a patient first presents to a psychiatric service every effort should be made by staff to gather all information relating to their psychiatric history, including previous notes, in order to make an informed diagnosis and risk assessment and develop an appropriate care plan. Somerset Partnership NHS & Social Care Trust needs to introduce and monitor a policy on the assembling of information to ensure all professionals comply with this standard.

21. Somerset Partnership NHS & Social Care Trust needs to consider as a matter of urgency introducing a system to ensure a confidential, multidisciplinary record is maintained for each patient to ensure that relevant information is shared.

22. **Clear guidance should be given to mental health professionals on effective case recording. Notes and record keeping should be audited periodically to ensure that standards are being met.**

23. **In view of the many changes that have taken place in recent years, the authorities should ensure there are effective organisation and communication systems in place between Taunton and Somerset NHS Trust, Somerset Partnership NHS & Social Care Trust and primary care. This will tackle the current fragmentation of mental health services and ensure information is shared about clinical responsibility, risk assessment and care plans.**

24. **Somerset Partnership NHS & Social Care Trust should develop and publish an organisation chart and framework that is kept up to date to ensure that patients and other health professionals know where different services are located and how they link together.**

Chapter 9

9. Complaints and Disciplinary Proceedings

9.1 The Inquiry referred in chapters 2 and 3 to the circumstances relating to the resignation of Mr Few and Ms Cummings' move to Somerset.

9.2 On 26 March 1997 Ms Cummings brought it to the attention of Mr Turner her Community Psychiatric Nurse in Taunton that she met Mr Few when she was a patient on the ward at the Bethlem and Maudsley NHS Trust where he worked as a staff nurse. Mr Turner reported the matter to the Personnel Department who said they would investigate.

9.3 As already recorded, Personnel Manager Marcus Adams wrote to the Bethlem and Maudsley NHS Trust and received a letter back from them on 17 April 1997 saying there was nothing in Mr Few's file other than a verbal warning about a drug error.

9.4 A couple of days after this Ms Cummings made allegations to Mr Turner about Mr Few stealing needles from Southwood House for her. Mr Turner discussed it with his supervisor and reported it to the Personnel Department.

9.5 Mr Turner then spoke about the allegations to Mr Ian Halsey who was the Service Manager responsible for Southwood House where Mr Few worked. They agreed Mr Turner should 'confront' Ms Cummings about these allegations. She made further allegations that Mr Few had borrowed money from Southwood House, used the Trust's equipment at weekends and was buying cannabis from one of his patients.

9.6 Mr Turner also reported this to Mr Michael Donnelly, then Director of Operations at the Avalon NHS Trust. Mr Donnelly and Mrs Joanne Perry, Head of Personnel, asked Mr Halsey to look into the allegations. Two further allegations had been made at this point including that Mr Few was stealing benzodiazepines from Southwood House for his own use and that he was using the unit's video equipment to make personal video tapes.

9.7 However, Mr Halsey chose not to investigate these matters formally because Ms Cummings said she did not want to make a complaint and get Mr Few into trouble and that if he knew she had made these allegation he would torture her cat, which he was looking after. Mr Halsey told the Inquiry this put him in a difficult position.

9.8 Instead he chose investigate the issues without making it known why he was asking questions. He told the Inquiry his aim was to see whether the allegations were true or not without interviewing Mr Few. Mr Halsey told the Inquiry that this was a formal investigation, however, Mr Few was never informed that he was being investigated. Mr Halsey said he considered it to be quite a low-key investigation but if he had found more information it would

have been stepped up. Mr Donnelly agreed with this course of action. Mr Halsey told the Inquiry this was an unusual situation and that they would normally make people aware of the allegations against them.

9.9 However, Avalon NHS Trust's Disciplinary Policy, (Appendix M) which was in place at the time states:

Investigation of alleged breaches of the disciplinary rules must be undertaken with the purpose of establishing whether there is a case to answer prior to setting up a formal hearing. The member of staff will be informed, in writing, of the allegation. Such investigations are carried out without prejudice to any subsequent disciplinary proceedings....

The Personnel Department will inform the member of staff, in writing, of the precise allegations and details of the procedure to be followed. The member of staff will be requested by Personnel to provide a statement to the Investigating Officer.

The disciplinary rules apply to theft and gross carelessness/negligence.

9.10 Mr Halsey concluded that he could find no evidence to substantiate the allegations. He told the Inquiry that there was not a problem with needles going missing after tracking needle usage through the Trust's requisitioning process. However, Mr Halsey acknowledged that this was not precise enough to determine whether a few needles were missing.

9.11 Mr Halsey concluded that very little money was kept at Southwood House and that he could not find any evidence that money was missing from the safe. He said benzodiazepines were not kept at Southwood House. He told the Inquiry that staff he spoke to, without telling them about the investigation, said Mr Few did not regularly use the video equipment.

9.12 From this he drew the conclusion the allegations were malicious. It was at this time that he became aware of the relationship between Mr Few and Ms Cummings

9.13 In July 1998, some nine months after the death of Mr Lewis, Mr Halsey was given a videotape that appeared to show Mr Few and Ms Cummings smoking cannabis. This had been found in a camcorder which was the property of Southwood House but apparently it had become practice for staff to borrow it for their own personal use. The tape was passed to police and Mr Few was suspended.

9.14 Mr Bill Guild, the Service Manager for Taunton, was asked to investigate the matter. We were told the Trust often asks a manager from outside the immediate area in which a matter is being investigated to conduct investigations. It is not clear why this had not been the case in the earlier investigation into Mr Few other than Mr Halsey thought it was easiest for him to look into the matter.

9.15 To the best of Mr Halsey's knowledge he informed Mr Guild about the earlier complaints against Mr Few, although, there is no record of this because it had been a low-key investigation that had found no evidence to substantiate the allegations.

9.16 Mr Guild's told the Inquiry that given the evidence he had gathered and the information he managed to get from the Bethlem and Maudsley NHS Trust he had very little doubt that Mr Few would have been dismissed and reported to the UKCC.

9.17 Disciplinary proceedings against Mr Few were not carried out by the Avalon NHS Trust because Mr Few resigned. His final day of employment is recorded as 2 September 1998, the date that he was moved from paid to unpaid suspension pending investigation. Unpaid suspension was invoked following Mr Few's non-compliance with the terms of his suspension in that he did not remain in contact with the investigating officer at the time. The Trust did not hold a disciplinary hearing. The Avalon NHS Trust sent its file on Mr Few to the UKCC but Mr Few has not renewed his registration. This was the fourth complaint made against Mr Few. Only one was investigated but we were not given any details of what this, a 'drug error', entailed.

9.18 The result of an employee's resignation in circumstances of this kind is that no disciplinary finding is made, and that no sanctions can be imposed or recorded. This is unsatisfactory. Disciplinary proceedings should take place despite resignation, with the member of staff being allowed every opportunity to present a full defence. When this matter was reported to the UKCC it took a similar view that because Mr Few had allowed his registration to lapse it could not proceed with disciplinary action. This compounded the problem. Mr Few could still be working with very vulnerable people in employment that does not require a nursing qualification. This is just not good enough.

9.19 The situation in which a person in a position of responsibility is alleged to have acted unprofessionally but where management and the professional body allow resignation or the lapse of registration to preclude disciplinary action is unacceptable.

9.20 Managers should not investigate matters without following proper procedures. Proper procedures allow individuals to defend themselves against complaints about their behaviour. If they refuse to do so then management is entitled to form a view about their behaviour. Resigning is not an alternative to disciplinary procedures.

9.21 There was a procedure in place in the Avalon NHS Trust at the time for dealing with complaints but the Inquiry was told that unless there was a formal complaint these proceedings would not be followed. However, Avalon NHS Trust's Complaints Policy states:

The Trust recognises the importance of separating the complaints procedure from disciplinary procedures. The complaints procedure will only be concerned with resolving complaints and not with the investigation of

disciplinary matters.....consideration as to whether or not disciplinary action is warranted is a separate matter for management, outside the complaints procedure, and will be subject to a separate process of investigation.

9.22 Confidentiality was used to justify why complaints were not pursued unless the patient made a formal statement. By doing this management avoided the responsibilities they carry and placed the onus on the patient. Verbal complaints can be made under the NHS Complaints Procedure.

9.23 Mr Turner also informed the Inquiry that a year after the death of Mr Lewis when Ms Cummings was in custody he contacted the Information Technology Department about discharging her case from the electronic system. He told the Inquiry there was a clear indication on the screen that someone had been trying to access Ms Cummings' electronic notes at about 6am on a Bank Holiday weekend. He said this was at a time when Mr Few was still employed by the Trust. The Inquiry can only express concern about this matter.

Recommendations

25. **South London and Maudsley NHS Trust and the Somerset Partnership NHS & Social Care Trust should conduct formal investigations into all allegations of misconduct by staff and follow the disciplinary procedures laid down. Inappropriate behaviour should be confronted and properly recorded. All cases of serious misconduct should be referred to the appropriate professional regulatory body. Resignation should not be seen as an alternative to the application of disciplinary procedures.**

26. **Any allegation of a personal relationship between professional staff and patients should be taken extremely seriously as stated in section 128 of the 1959 Mental Health Act. The authorities will be assisted by the recent UKCC publication Practitioner Client Relationships and the Prevention of Abuse.**

27. **Employment references provided for health professionals should be reliable, honest and comprehensive.**

28. **Somerset Partnership NHS and Social Care Trust should review its personnel policies and practices in particular:**
    - **The operation of the complaints and disciplinary procedures.**
    - **The roles and responsibilities of the personnel department and managers.**
    - **The application of recruitment procedures in particular the recording of information provided verbally and the completion of reference forms by previous employers.**

29. **Somerset Partnership NHS & Social Care Trust should review the standards operated by the Occupational Health Department in determining a person's fitness for employment.**

Chapter 10

10. Peter Lewis

10.1 The Inquiry felt that it was important that Peter Lewis was represented in some way and is extremely grateful to his father for meeting with the panel.

10.2 We were told that his parents spent the day with their son and Ms Cummings before the evening of his death. They noticed that all the talk about the couple's impending marriage seemed to be coming from their son. The Right Reverend Lewis told the Inquiry that he and his wife felt Ms Cummings seemed to be uncertain about the possibility of marriage but that it was difficult to gauge her feelings because she spoke and communicated very little.

10.3 Mr Lewis' father told the Inquiry that his family did not really know Ms Cummings and his son had told the family only bits about her past which sounded 'pretty horrendous'. He said that his son did say Ms Cummings was his 'project' and his father had a sense that he thought he could work things out with her.

10.4 Mr Lewis' father praised the treatment his son had received from the mental health services in Bridgwater before meeting Ms Cummings. He also praised Avon and Somerset Police's practice of allocating families in their situation a liaison person who had provided them with information, help and advice. These matters had been handled with great sensitivity and care by the police.

Chapter 11

11. Inquiry's Findings

11.1 The tragic event that led to the untimely death of Peter Lewis could not have been anticipated or prevented. But during the course of this Inquiry we have had evidence put to us that leads us to conclude that there were a number of areas of poor practice in mental health services in Somerset that now need to be addressed.

11.2 We were particularly concerned about:

- Fragmentation of services
- People in different disciplines working in isolation
- Poor assessment and assembling of information
- Poor application of the Care Programme Approach
- Poor record keeping
- Weak personnel and management practices

11.3 The two General Practitioners who provided care for Ms Cummings did their best to help a patient with complex needs. They referred her to specialist mental health services and supported the work of those services. However, they were given inadequate guidance on the management of Ms Cummings' care and there was a lack of clarity as to who had clinical responsibility for that care. While "Still Building Bridges", the report of a national inspection of arrangements for the integration of the Care Programme Approach with Care Management, was published in March 1999, it encourages local services to think about the following:

- *Have you agreed the boundaries between primary and secondary services to support people in the community?*
- *Are there agreed systems with primary health care to provide advice, support and assessment?*

11.4 The Accident and Emergency Department provided appropriate crisis care. However, its system of generating a new record every time a patient attended meant it was a matter of chance whether staff became aware that a patient regularly attended with deliberate self-harm. The Accident and Emergency Department lacked staff with specialist mental health skills. The Inquiry found that it provided little training for staff on mental health issues. Professionals in the Accident and Emergency Department were never asked to provide information to multidisciplinary case conferences for patients like Ms Cummings. There was a significant lack of joint working between the acute and the mental health Trusts, which meant that a whole picture of Ms Cummings as a patient was never established.

11.5 The Inquiry found that the deliberate self-harm services Ms Cummings received were inadequate. This is not a reflection on the individuals in the Deliberate Self-Harm Team who tried to help her but on the fact that their efforts were not adequately linked into wider therapeutic services because of the way services were organised. It appears that the Deliberate Self-Harm Team relied on the commitment and integrity of Mr Furlong, nothing more formal. Significantly, Mr Furlong told the Inquiry he is not sure what would happen if he left. Mr Cutting and Mrs Fogg from the Accident and Emergency Department both praised the work of the Deliberate Self-Harm Team highly but referred to the fact that it may be due to the personalities involved in the team.

11.6 The Inquiry finds it extremely concerning if development of the team is to be carried out in an ad hoc way, on the back of the specific interest and commitment of individual members of staff. This paves the way for clear gaps in the service during staff absence and in the event of staff leaving.

11.7 The Inquiry found it extremely difficult to see how the Deliberate Self-Harm Team met its objectives and how it related in a structured way to other health and social care services. Although the two members of staff in the Deliberate Self-Harm Team technically had a line manager during the time Ms Cummings was a patient of the service, in reality they received inadequate supervision.

11.8 The Inquiry believes that the Deliberate Self-Harm Team was set up with good intentions but that it was far too small to be able to fulfil its objectives. It appeared, and still appears, to be operating in an area of work that other social workers and Community Mental Health Teams do not want to be involved. The Deliberate Self-Harm Team is only able to act as a referral agency and even this is limited by the information it receives from Accident and Emergency and the support and response it receives from mental health services.

11.9 However, because of the delay in case allocation the staff at the Deliberate Self-Harm Team often maintain contact with the patient and 'hold the crisis' until the work load of the Community Mental Health Team enables a worker to be allocated. In addition, the Deliberate Self-Harm Team sees patients who turn up during office hours on an ad hoc basis because they feel that they have nowhere else to go.

11.10 Although it seems the Deliberate Self-Harm Team was set up to address the needs of a group of patients not receiving care, they were actually generating work through referrals. This is a clear example of how you cannot simply change practice by just writing a policy. Setting up a new service requires training and supervision for staff to make sure it operates as an effective unit and it needs to be linked into the wider network of services rather than operating in isolation. Mrs Fogg has indicated that she would like a mental health liaison nurse in Accident and Emergency. What the Inquiry believes is careful thought should be given about how communication can be improved

between agencies before appointing another person who may be stranded between organisations.

11.11 From the evidence provided to the Inquiry we have concluded that the Deliberate Self-Harm Team was not able to provide a service that substantially reduced Ms Cummings attendance at the Accident and Emergency Department.

11.12 There appeared to be little training for staff on deliberate self-harm and a lack of awareness by services as to how to treat people exhibiting the behaviour shown by Ms Cummings. Ms Cummings was told by those providing her care not to cut something that she was not able to do and which deepened her sense that professionals did not understand her. The Inquiry found the evidence of a number of specialists such as Dr Susan Iles at Broadmoor Hospital and Dr Michael Crowe at the South London and Maudsley Trust extremely helpful; both have done a great deal of work in this area. The Inquiry also noted that the High Security Psychiatric Services Commissioning Team is currently reviewing the services for female forensic patients and is likely to be highlighting examples of good practice in the provision of services for patients similar to Ms Cummings.

11.13 The Inquiry is deeply concerned at the way Ms Cummings was referred outside of the NHS for treatment and at the inadequacy of the arrangements for record keeping and supervision of private practitioners. The referral to Dr Woolf was made as an extra contractual referral (ECR) and it would appear that this was required because individual psychotherapy for Ms Cummings was not available within the NHS in Somerset. The health authority agreed to the ECR which the Medical Director of the Avalon NHS Trust considered to be appropriate. However, the health authority said it would pay for half of the psychotherapy and then require a report from Dr Woolf before authorising further funding.

11.14 The system for processing an ECR should enable the authorities to ask questions about why a service is not available within the NHS and to examine the qualifications of the person the patient is being referred to. It is a useful opportunity to identify gaps in the service. There should be clarity about how a patient is referred out of the NHS. Consideration should be given to practitioner's skills and the standards of training and supervision that they are receiving.

"Building Bridges" states:

The independent sector is playing an increasing role in providing high quality services for mentally ill people. Where a health care purchaser is contracting with a private provider, the purchaser should ensure that the provider observes government policy for mental health services (for example in implementing the CPA and observing proper procedures with regard to confidentiality) and liaises closely with the local specialist services.

11.15 The Inquiry is also concerned about the record keeping of people working outside the NHS.

"Building Bridges" states:

As a matter of good practice, the sharing of relevant information is vital is multi-disciplinary and inter-agency care is to function effectively.

11.16 There was a woeful lack of assembling even basic information about Ms Cummings. While it is clear that it was impossible to predict the action that led to the death of Mr Lewis, local services made no attempt to collect the information that would have allowed them to make a proper assessment of the risk she posed.

11.17 The Inquiry finds it deeply worrying that there was such confusion about who had clinical responsibility for a patient with such a severe and enduring history of mental illness. There was a lack of clarity about clinical responsibility and the way specialist psychiatric services relate to GPs and the support they gave to primary care.

11.18 Some witnesses suggested to the Inquiry that Ms Cummings did not pose a risk but the Inquiry would question how they could conclude this when information about her background was not requested even from services in Somerset.

11.19 Clearly Somerset Partnership NHS & Social Care Trust is a local, rural psychiatric service which has limited resources available to it. However, given this, it is essential that professionals work together, gather information and share it, record their assessments adequately so that their colleagues can benefit from their work. Instead there was a system of different individuals working in different ways within an incoherent organisational framework.

11.20 The Inquiry team had considerable concerns about the management of the Taunton Community Mental Health Team at that time. The Inquiry believes there were no clear lines of responsibility and that staff worked in isolation. There was no attempt to apply rigorous definitions of mental illness or to manage cases in a multidisciplinary way. There seemed to be no adequate supervision of the management of patients and there was a lack of training to raise awareness among staff about the complexity of this work. There was considerable confusion about role responsibility.

11.21 The Inquiry found there was a lack of clarity as to which professional had clinical responsibility for Ms Cummings care. This resulted in inadequate monitoring of changes in her mental state, inadequate planning of appropriate therapeutic services and inadequate review of the care that she was receiving. There was no serious attempt to apply the definitions of mental illness in relation to Ms Cummings other than by Dr Ahmed who diagnosed her as having borderline personality disorder.

11.22 Communication between different parts of the Avalon NHS Trust was poor

and the Inquiry found it difficult to understand how the different parts of the Trust linked together. The fact the Trust did not have an organisation chart is significant.

11.23 Record keeping by professionals was poor and was not apparently subject to audit, which could have picked up any failings.

11.24 There was a lack of uniformity about the way day care and psychotherapy services were provided at the time Ms Cummings was a patient. Access to day care needs to be reviewed and formalised.

11.25 There was no evidence of multidisciplinary working other than by Mr Turner in his enlisting the assistance of his Consultant Psychiatrist colleague, his dialogue with the GP and his colleagues providing Day Care services.

11.26 The Inquiry found management and disciplinary processes within both the Bethlem and Maudsley NHS Trust and the Avalon NHS Trust were unacceptable. Ms Cummings access to services was seriously affected by her relationship with a health professional that developed while she was a patient. The failure to follow through disciplinary procedures leaves room for such a situation to develop again.

11.27 The Inquiry acknowledges that considerable changes have already been made to the way mental health services are provided in Somerset with the setting up of the new health and social care Trust. It may well be that since this tragic event action has been taken to address some of these issues, we hope that the services will reflect on whether the actions taken are sufficient. To help them do this we make a number of recommendations.

Chapter 12

12. Recommendations

Accident and Emergency Services

1. The Accident and Emergency Department at Musgrove Park Hospital should have a system in place that guarantees any previous visits of a patient attending Accident and Emergency are listed automatically to ensure relevant information can be used in the assessment and diagnostic process.

2. The Accident and Emergency Department at Musgrove Park Hospital should develop a system to alert mental health care co-ordinators that clients have attended the Accident and Emergency Department.

3. The Taunton and Somerset NHS Trust, Somerset Partnership NHS & Social Care Trust and Somerset Health Authority should jointly consider whether its Accident and Emergency Department would benefit from having more specialist mental health skills made available to it. The two Trusts should have liaison arrangements in place such as psychiatric liaison nurses based at Accident and Emergency to assess patients, intervene, liase with other agencies and support and educate Accident and Emergency staff.

Deliberate Self-Harm Services

4. Somerset Health Authority should review the approach to deliberate self-harm including attempted suicide in Somerset to consider the most effective way of providing services. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health, in particular Standard Seven: Preventing Suicide.

5. There should be a thorough review of organisational arrangements and the composition, management and effectiveness of the Deliberate Self-Harm Team.

Mental Health Services

Clinical Responsibility

6. There should be an overt statement of who has clinical responsibility for a patient like Ms Cummings at all times. It should not be assumed that the GP has clinical responsibility by default. Mental health services should make it clear to General Practitioners whether they are taking over the care of a patient or simply providing an opinion on how the GP should manage the patient's care.

7. General Practitioners should be provided with a formal assessment of a patient they refer including a diagnosis, risk assessment and treatment plan. Somerset

Partnership NHS & Social Care Trust needs to consider whether it should introduce a standard format for the assessment that mental health professionals should provide to General Practitioners.

Out of hours services

8. Consideration should be given to developing a 24-hour, drop-in facility for mental health patients particularly those who deliberately self-harm.

9. Consideration should be given to the adequacy of out-of-hours psychiatric cover in the county. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.

Standard Three of the National Service Framework for Mental Health states:
"Any individual with a common mental health problem should:

- Be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
- Be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or local services "

The Care Programme Approach

10. There should be a thorough review of the way the Care Programme Approach is applied across services in Somerset in order to ensure arrangements are in place for its proper implementation. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.

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- Receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk
- Have a copy of a written care plan which:
  - includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator
  - advises their GP how they should respond if the service user needs additional help
  - is regularly reviewed by their care co-ordinator
  - is able to access services 24 hours a day, 365 days a year "

Standard Five of the National Service Framework for Mental Health states:
"Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is:
  - In the least restrictive environment consistent with the need to protect them and the public
  - As close to home as possible
- a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis."

The National Service Framework for Mental Health also states in relation to preventing suicide among people with severe mental illness:
"As set out in Standards four and five, local health and social care communities need to ensure that:

- care plans are reviewed at a frequency which reflects assessments made of the risks identified for individuals "

Community Mental Health Teams

11. Somerset Partnership NHS & Social Care Trust should review the composition, management and effectiveness of Community Mental Health Teams. It should ensure the following:
    - There is a framework for allocating and reviewing patient's care using the full resources of the team
    - Professionals have a clear understanding of their role and accountability
    - There are agreed procedures in place outlining how to involve other professionals within the team in a patient's care plan. These procedures should also outline how to involve colleagues in other Community Mental Health Teams or in other parts of the health and social care system in a care plan where necessary.
    - The teams are implementing the practices outlined in Building Bridges, Still Building Bridges and National Service Framework for Mental Health.
    - There are arrangements in place for auditing the work of the teams

Day Care

12. There should be a review of the purpose and effectiveness of day care services and the way the Community Mental Health Teams link into these services. Particular attention should be given to a single access point, clinical responsibility and effective communication with other services.

Care Plan Responsibility

13. If a mental health patient's initial treatment plan proves ineffective the originator of that plan has a responsibility to review the care being given and ensure the provision of an alternative treatment plan. Somerset Partnership NHS & Social Care Trust should introduce a policy to ensure all professionals comply with this standard.

Evidence Based Practice

14. Practitioners should use available evidence to inform and develop practice. They should update their clinical practice and make informed decisions by re-evaluating the relevance of a particular intervention.

Training

15. Somerset Partnership NHS & Social Care Trust should review the training it provides to staff on the application of the Care Programme Approach and on record keeping, risk assessment and care planning.

16. Taunton and Somerset NHS Trust should review the training needs of staff in the Accident and Emergency Department on managing patients with mental health problems.

This is an opportunity for local health and social care communities to ensure that primary care staff have the training and to enable them to assess and manage depression including the risk of suicide. The authorities will no doubt be assisted by the recently published National Service Framework for Mental Health.

The National Service Framework for Mental Health states on preventing suicide among people with severe mental illness:
"As set out in Standards four and five, local health and social care communities need to ensure that:

- training for staff in specialist mental health services in risk assessment and management is a priority, and is updated at least every three years "

Supervision

18. An effective and efficient system should be in place to ensure all professional staff receive appropriate supervision of their work and have their work regularly reviewed. Independent practitioners should operate to the same standards. The system should balance managerial, educational and clinical supervision of staff and provide an opportunity to reflect on and explore clinical standards, case analysis and staff workloads.

Referrals Out of the NHS

19. Somerset Health Authority should review the way patients are referred for treatment outside of the NHS to ensure the referral is appropriate, the treatment suitable and the quality of the treatment is monitored.

Multidisciplinary Working and Record Keeping

20. When a patient first presents to a psychiatric service every effort should be made by staff to gather all information relating to their psychiatric history, including previous notes, in order to make an informed diagnosis and risk assessment and develop an appropriate care plan. Somerset Partnership NHS & Social Care Trust needs to introduce and monitor a policy on the assembling of information to ensure all professionals comply with this standard.

21. Somerset Partnership NHS & Social Care Trust needs to consider as a matter of urgency introducing a system to ensure a confidential, multidisciplinary record is maintained for each patient to ensure that relevant information is shared.

22. Clear guidance should be given to mental health professionals on effective case recording. Notes and record keeping should be audited periodically to ensure that standards are being met.

23. In view of the many changes that have taken place in recent years, the authorities should ensure there are effective organisation and communication systems in place between Taunton and Somerset NHS Trust, Somerset Partnership NHS & Social Care Trust and primary care. This will tackle the

current fragmentation of mental health services and ensure information is shared about clinical responsibility, risk assessment and care plans.

24. Somerset Partnership NHS & Social Care Trust should develop and publish an organisation chart and framework that is kept up to date to ensure that patients and other health professionals know where different services are located and how they link together.

Personnel and Disciplinary Matters

25. South London and Maudsley NHS Trust and the Somerset Partnership NHS & Social Care Trust should conduct formal investigations into all allegations of misconduct by staff and follow the disciplinary procedures laid down. Inappropriate behaviour should be confronted and properly recorded. All cases of serious misconduct should be referred to the appropriate professional regulatory body. Resignation should not be seen as an alternative to the application of disciplinary procedures.

26. Any allegation of a personal relationship between professional staff and patients should be taken extremely seriously as stated in section 128 of the 1959 Mental Health Act.The authorities will be assisted by the recent UKCC publication Practitioner Client Relationships and the Prevention of Abuse.

27. Employment references provided for health professionals should be reliable, honest and comprehensive.

28. Somerset Partnership NHS and Social Care Trust should review its personnel policies and practices in particular:
    - The operation of the complaints and disciplinary procedures.
    - The roles and responsibilities of the personnel department and managers.
    - The application of recruitment procedures in particular the recording of information provided verbally and the completion of reference forms by previous employers.

29. Somerset Partnership NHS & Social Care Trust should review the standards operated by the Occupational Health Department in determining a person's fitness for employment.