CARING FOR THE CARER

Report of
Committee of Inquiry
to
Tees Health Authority

CONTENTS

INTRODUCTION

1 On 16 February 1995 Keith Taylor stabbed his father, William Taylor, and killed him at the family home in Normanby. On 17 July 1995 Keith Taylor appeared at Teesside Crown Court charged with the murder of his father but pleaded guilty to manslaughter on the grounds of diminished responsibility, which plea the prosecution accepted. A hospital order was made under section 37 of the Mental Health Act 1983 and a restriction order was made under section 41 of that Act. Keith Taylor is currently detained indefinitely at the Hutton Centre secure unit at St Luke's Hospital, Middlesbrough.

2 At the hearing of the case against Keith Taylor Mr Justice Keene described the case as a very sad one and it was indeed a tragedy for the whole Taylor family.

3 Keith Taylor is the third child of William and Dorina Taylor. He has two older sisters and a younger brother. All except Keith Taylor are married and have families of their own.

4 Keith Taylor was born on 18 February 1948 and has suffered from epilepsy since early infancy. It appears that he was always protected from life's difficulties by his parents who regarded him as in need of protection and

he led a sheltered and somewhat isolated existence both in childhood and afterwards. He always lived at home and had few friends. He lived a quiet and apparently contented life. His only interests outside his home were taking his dog (and after it died, his neighbour's dog) for long walks.

5 His epilepsy did not significantly disable him and he is of average intelligence. He worked for the Gas Board and later British Gas from the age of 16 until shortly before the tragedy of February 1995.

6 Mrs Dorina Taylor had a history of psychiatric problems and had at one time suffered from alcohol abuse, although it seems she had overcome this some years before her death, and she suffered from agoraphobia for many years. She died on 22 March 1994 after suffering from lung cancer for some time. Shortly before her death her family had gained the impression that she had been cured. We were not able to identify how this belief arose, it may have been because Mrs Taylor simply told her family it was so in an attempt to save them from pain, or because they had misunderstood the contents of a letter which they believed she had received from the hospital where she was being treated, or in some other way. It matters not how it arose but the belief was of some significance because it meant that when she died her death came as a shock to the whole family even though they might otherwise have been expecting it.

7 At the same time Mr William Taylor was suffering from

multi infarct dementia. He had been admitted to Wells Villa (part of St Luke's Hospital) in December 1993 because he was in a confused state and was kept in hospital for over a month, being discharged on 2 February 1994. When he returned home his wife was still there and it seems that the extent of his confusion was not particularly obvious to Keith Taylor because Mrs Taylor gave her husband instructions about what needed doing and he was able to carry these out, thus unintentionally disguising the extent of William Taylor's mental impairment.

8 When Mrs Taylor died in March, Keith Taylor was presented with the unexpected death of his mother and the responsibility of caring for his demented father whose condition probably seemed to have suddenly worsened, though in fact it had been worse than Keith Taylor realised for some time. At that time Keith Taylor was still working full time. Thus an isolated man who had been sheltered from difficulty throughout his life was presented with a situation where the support he had received was suddenly withdrawn and, to his credit, rather than abandon his father, he tried his best to look after him. It might have been the most rational course to place William Taylor in residential care but Keith Taylor decided that the time had come to repay the devotion of his parents. As he put it to us when we saw him "Giving my father what I could as best as I could was what gave me the most pleasure". Keith Taylor spent a good deal of his money on his parents' home. After his mother's death he had a conservatory extension built and

was planning to take his father to Cyprus, where he had served in the forces, for a holiday.

9 In fact, the strain of looking after his father was much greater than Keith Taylor realised. At first he continued to work at the Gas Board and home care was arranged but this was not satisfactory to Keith Taylor because the carer did not arrive before he left for work and he did not want to leave his father alone in the house. Then Keith Taylor's sister had her father at her home during the week and Keith Taylor had him at home at the weekends but this arrangement stopped when Keith Taylor objected to the fact that his sister arranged some respite care for her father. Eventually Keith Taylor gave up work and had his father at home full time, taking him with him whenever he went shopping in case he wandered; staying awake until his father went to sleep in case he left the house and being reminded frequently of the death of his mother, whom his father enquired about constantly in his confused state, not being aware of her death. Keith Taylor had been too preoccupied with looking after his father to complete the grieving process for his mother and the constant reminders of her death affected him more than might otherwise have been the case. Eventually Keith Taylor's mental health broke down with the tragic consequences already referred to.

10 We have set out the basic history of Keith Taylor's life by way of introduction, without reference to the medical and other care he received, because although our terms of reference are mainly concerned with issues of care,

treatment and assessment of needs it is important to remember that the treatment of patients and the provision of services provided for people living in the community who have suffered mental ill health are provided for individuals. Although we are required to consider the adequacy of care, treatment and assessment of needs against a background of guidelines and circulars, we hope that it will be constantly kept in mind that if Keith Taylor's care, treatment or assessment was inadequate then it was he and his father who were let down. Whether the care provided was adequate cannot be examined without also examining whether it was provided in accordance with the guidelines and circulars and good professional and management practice. Lessons can and should be learnt from a real tragedy.

11. As the inquiry proceeded we identified two basic areas of concern. First, was the question of the formal implementation of the CPA[1]. Second, was the question whether, quite irrespective of the implementation of the CPA, the patients we were concerned with had received reasonable levels of support and care after discharge. There is an inherent risk in emphasising formal processes at the expense of individual care. All staff at all levels have a responsibility to observe good practice and concern for their patients which cannot be achieved only by rigidly following procedures.

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[1] CPA is the care programme approach, the nature of which is described in Chapter 1.

TERMS OF REFERENCE, PROCEDURE ETC.

CONSTITUTION OF THE INQUIRY

The inquiry was established by Tees District Health Authority[2] in order to comply with the requirements of Health Service Guidelines contained in circular HSG(94)27[3] which requires an immediate internal investigation in all cases where a violent incident occurs after the discharge from the specialist mental health services of mentally ill patients; subject to delay if Court proceedings may be prejudiced. Where the incident is serious, an independent inquiry may be set up after the internal inquiry is completed and one must be set up where there is a homicide. This inquiry is the independent one following completion of the internal inquiry and it has no statutory powers.

Membership of the inquiry was as follows:-

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[2] Hereafter referred to as Tees Health.

[3] "Guidance on the discharge of mentally disordered people and their continuing care in the community" issued on 10 May 1994 addressed to District Health Authorities and others.

RICHARD BARLOW	Barrister. (Who acted as Chairman).
JOHN CROOK (now deceased)	Consultant in social work and former director of Bradford City Social Services.
DAVID KINGDON	Consultant psychiatrist, Bassetlaw Hospital & Community Services NHS Trust.
PETER McGINNIS	Director of nursing quality at Leeds Community and Mental Health NHS Trust.

PROCEDURE

We adopted an informal procedure and decided before the inquiry commenced that we would not ask Tees Health to provide a transcript of the evidence we heard. We were mindful of the fact that other Tribunals manage without a transcript being taken and that to obtain and transcribe a verbatim account of the evidence would slow down the proceedings considerably and would be expensive, although we would like to record the fact that Tees Health were quite prepared to provide a transcript had we wished to have one and indeed that we have not been constrained in any way by financial considerations.

Having decided against a transcript we adopted the procedure of sending a copy of the Chairman's notes of the evidence of each witness to that witness and gave them an opportunity to correct or expand upon what had been recorded and a number of witnesses availed

themselves of that opportunity.

We attempted to identify which witnesses we would wish to see before the inquiry began and in the main we succeeded in doing so although a few witnesses were requested to attend after they were identified as potentially useful witnesses during the course of the inquiry.

Each witness was invited to attend by letter and Tees Health wrote to them inviting their attendance. It was made clear to them what the inquiry's terms of reference were and that they could be accompanied by a friend, trade union representative, solicitor or other person. Some were accompanied, others were not. Each witness was asked to affirm[4]. No witness who was invited to attend declined to do so and we were grateful to all the witnesses for their evidence. We do not think that any of the witnesses withheld any evidence nor do we think that any of them told any untruths.

Where possible each witness was questioned first by the member of the panel whose own professional responsibilities most closely matched those of the witness.

A list of documentary evidence and material placed before the inquiry and considered by it appears at the Appendix.

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[4] We used the following form of affirmation "I solemnly and sincerely declare and affirm that I will answer truthfully the questions I am asked".

The inquiry sat for 4 full days and 1 half day to take evidence and had extensive discussions before drawing up a draft report.

TERMS OF REFERENCE

1. To examine all the circumstances surrounding the care and treatment of Keith and William Taylor by the mental health services in particular:

- ♦ the quality and scope of their health social care and risk assessments.

- ♦ the appropriateness of their treatment, care and supervision in respect of:
  - their assessed health and social care needs;
  - their risk assessment (in terms of the risk of harm to themselves and/or others);
  - any previous psychiatric history, including drug or alcohol abuse;
  - the nature of any previous involvement with the criminal justice system including the outcomes;

- ♦ the appropriateness of the professional and in-service training of those involved in the care of Keith and William Taylor or in the provision of services to them;

- ♦ the extent to which statutory obligations were met;

- ♦ the extent to which local policies were adhered to in care plans;

- ♦ the extent to which care plans were:
  - effectively drawn up;
  - effectively delivered;
  - complied with by Keith and William Taylor;

- the details of any medication including retrospective information and the patients' compliance.

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

- the agencies involved in the care and treatment of Keith and William Taylor or in the provision of services to them;

- the agencies and the Taylor family.

3. To prepare a report and make recommendations to Tees Health.

ACKNOWLEDGEMENTS

We are grateful to all the witnesses who gave evidence for the time and trouble they took in attending.

We are especially grateful also to Mrs Avril Rhodes of Tees Health who organised the inquiry with great efficiency and dedication. She provided us with a great deal of documentary evidence, often at short notice, and she attended to the arrangements both for the inquiry sittings and for the attendance of witnesses with both efficiency and tact. Without her our task would have been much more difficult.

CHAPTER ONE

THE CARE PROGRAMME APPROACH AND ITS IMPLEMENTATION

In this Chapter we review the roles of the Trust and Social Services separately. The Trust had drawn up a joint Care Programme Approach Policy in collaboration with Social Services and a protocol was agreed between the Trust and Social Services (and others) by which the CPA was to be implemented by 31 August 1994. A major issue for the inquiry team was whether it had been implemented and if not why not.

THE TRUST

1 The Joint Health/Social Services circular HC(90)23 which was issued in September 1990 required the care programme approach[5] to be implemented by 1 April 1991 by all district health authorities in respect of patients suffering from mental illness including dementia who had been referred to the specialist psychiatric services.

1.1 The CPA was itself a development from HC(89)5 which dealt with discharges of patients and had been envisaged by

[5] Hereafter referred to as "the CPA".

HC(88)43.

1.1.1 Both HC(90)23 and HC(89)5 proceed on the basis that before a patient is discharged from hospital the arrangements for the continuing care of that patient in the community must be in place. The 1990 circular dealt with mentally ill patients and they were specifically mentioned in the booklet issued with the 1989 circular as having special needs. In any event, it is obvious that a mentally ill patient who requires continuing care in the community should not be discharged from hospital until that care has been arranged and that there must be an assessment of what is required in the case of an individual patient before release. The patients themselves cannot necessarily be left to seek help and may not even realise they need it. Naturally much will depend on the circumstances of the patient. A patient returning to live with a spouse who is in good mental and physical health is in a very different position from one returning to live alone in a bed-sit.

1.2 So much is common sense and good professional practice and although the circulars are helpful and necessary we would not accept that a patient could properly be discharged without some thought being given to such matters even if there had been no circulars. This is an issue to which we will return later in the report.

1.3 Before turning specifically to the cases of William and

Keith Taylor we will look at how Tees Health[6] and the South Tees Community and Mental Health Trust[7] implemented the circular HC(90)23.

1.3.1 The main responsibility for the implementation of the CPA lay with the Health Authority to whom it was addressed rather than to Social Services who were only asked to collaborate with the Health Authorities.

1.3.2 We have examined the Tees Health specifications for Adult Mental Health Services and for the Elderly with Mental Health Conditions[8] for the years 1993/94, 1994/95 and 1995/96.

1.3.3 The Adult Mental Health specification for 1993/94 does not specifically refer to CPA by name but there is specific reference to the HC(89)5 and HC(90)23 circulars and to "community care plans". The 1994/95 Adult Mental Health specification is absolutely specific in requiring that the CPA "will be fully implemented within 1994/95".

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[6] Tees Health is the name by which the Cleveland Family Health Services Authority and the Tees District Health Authority were known. For part of the period covered by the events described in this report the South Tees Health Authority was the relevant authority but for convenience we make no distinction and simply refer to Tees Health throughout. The Cleveland Family Health Services Authority and Tees District Health Authority were subsequently merged in April 1996 and are now known as Tees Health Authority,

[7] Hereafter referred to as "the Trust".

[8] Psychiatry of Old Age for 1995/6.

1.3.4 The Commissioning Specification for the Elderly follows a similar approach except that specific reference to CPA, by name, only occurs in the 1995/96 specification.

1.4 We had access to a detailed summary prepared by Mrs Oliver showing that training sessions, including one specifically for Dr Moslehuddin's team on 15 October 1994, and seminars had been held concerning the implementation of the CPA. Also, on 6 April 1994 Mr Farrar, divisional manager, had advised a meeting of the Mental Health Act Steering Group, which had been set up on 6 January 1993, that the CPA was being identified as the main vehicle for implementing the continuing care of mental patients after discharge.

1.4.1 Mrs Britton, chief executive of the Trust, told us that there had been a lot of training given to the staff. We accept that. However it is also clear that, as Mrs Britton put it in evidence, the CPA had not been put into place as much as the management thought and given that it had been identified as the main vehicle for the continuing care of the patients on discharge this was in our opinion a failure on the part of the Trust. Whether or not the CPA was implemented, good practice required that thought should have been given to the care of any patient discharged from the mental wards.

1.5 There is no doubt that the Trust knew, before any of the significant events in this case occurred, that the CPA should have been implemented. In October 1993 the Trust distributed a document entitled "Care Plan Approach"

which set criteria for inclusion in the CPA and set 1 January 1994 as the date for full implementation.

1.5.1 We acknowledge that many other Trusts were as far behind in their implementation as was the Trust and that the management of the Trust had taken quite a lot of steps towards the implementation of the CPA.

1.6 The Trust's criteria for application of the CPA to a patient were:

- that the patient had been detained under the Mental Health Act (except sections 3 and 37);
- that the patient had stayed in hospital for 3 months or more;
- that the patient had 3 or more admissions in the last year;
- that the patient had 2 or more episodes of serious DSH (deliberate self harm) in the last 12 months;
- that the patient had an enduring mental illness with an emphasis on those with a history of poor compliance.

1.6.1 Our understanding of that document is that the criterion for application of the CPA would be met if any one of the criteria applied. In a later document issued jointly in collaboration with Cleveland County Council these criteria were repeated and more details were given about how the CPA should be implemented. This document makes it clear that all patients should have a CPA and that the application of the criteria set out in para 1.6 would

lead to a "full" CPA being drawn up. In fact this later document says that the criteria for deciding which patients would need a full CPA should be determined according to clinical need and that it should include the criteria set out. The criteria were not therefore exhaustive.

1.7 There is no doubt that before Keith Taylor killed his father he met the criteria for a full CPA, if only because he had by then had three admissions within a year.

1.8 Whether William Taylor qualified for a full CPA under the Trust's policy is more doubtful. He had an enduring mental illness but whether he would have met the criteria would depend on how much weight was given to the words "with an emphasis on those with a history of poor compliance". That qualification does not seem to us to be in accordance with the annex to HC(90)23 where there is an emphasis on continuing care in the community including systematic arrangements for regularly reviewing the social care needs of the patient being treated in the community.

1.8.1 William Taylor was suffering from a mental illness of such severity that his family had been advised to seek residential care for him; under the national CPA guidelines he required a full multidisciplinary CPA, which he effectively got prior to discharge. His care after discharge was complex and involved different informal carers in two localities, a variety of Social

Services home and day care workers with medical support. A care review on a three to six monthly basis would not have been unduly time consuming and would have ensured good communication between those concerned, including the family who would surely have mentioned the fact that Keith Taylor had been admitted to hospital for the second and third times.

1.8.2 Mr Farrar, divisional manager at St Luke's hospital agreed that the CPA had not been fully implemented in 1994. An action plan following a review in June 1995 led to full implementation around 31 December 1995. We note that a CPA officer was appointed in May 1995 to monitor and ensure compliance. The evidence we heard shows that implementation was well behind schedule on any view and both the Trust and the Authority must share the responsibility for this. The delay relates both to the timetable set by the Department of Health and the implementation dates set by the Authority and the Trust, which were themselves later than those set by the Department.

1.8.3 Mr James Paterson, director of nursing development for the Trust, agreed that there had been no significant involvement of staff with CPA until October 1994 and that this was a major deficit. Mr James Ennis, nursing services manager, said that although the Trust had a CPA policy from 1993 no major progress towards its implementation actually occurred until November 1994. We do not consider the slight variations in the dates the witnesses recollected is significant and the conclusion

that the CPA was not fully implemented until the end of 1995 is inescapable.

1.9 We have seen a document dated April 1994 which is a draft protocol for the implementation of CPA and Supervision Registers and a protocol for that implementation requiring them to be implemented by August 1994 (the CPA) and September 1994 (the registers). A Tees Health document called a "Brief:Update" for the implementation dated November 1994 shows that in South Tees staff had still to be briefed about CPA's in October 1994. It is clear therefore that implementation was well behind the schedule set by the document referred to at paragraph 1.5 above.

SOCIAL SERVICES

1.10 As we have already pointed out, the responsibility for introducing CPA lay with the Health Authority and it delegated this to the Trust by including it in the specifications. There was a joint duty on both the Trust and Social Services to ensure this under LA SSL 90(11)[9].

1.11 We heard evidence from Service Manager for Cleveland Council Social Services[10]. She told us that there had been a review of the CPA in January 1994 and that at that

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[9] Equivalent to HC (90) 23 but addressed to Local Authorities.

[10] Local government has subsequently been reorganised but we refer to the Authorities and posts held by their staff as they were at the time.

time there was no CPA in place although the Trust had said that there would be a CPA in place by then, at least for people who had been detained under the Mental Health Act 1983. Discussions took place with the Trust in March 1994 and the Trust said no detailed CPA was in force by then except for people who had been detained under the Mental Health Act 1983. She described the Trust as being in a state of rapid change at the time and that all the managers had been changed in the period in question. She said Social Services management had done what it could to encourage the implementation of the CPA. Individuals within Social Services found themselves unable to influence the multi-disciplinary teams in the hospitals, of which social workers were only a small part, sufficiently to ensure the implementation of CPA.

1.11.1 Community Mental Health Social Work Team Manager for Langbaurgh, told us that the CPA was virtually non-existent in early 1994 and that Social Services had been pressing hard for its implementation by the Trust from the Summer of 1993. Eventually a joint working group was set up in the Summer of 1994 which did lead to the implementation of CPA about November 1994.

1.12 We accept that Social Services could not implement a CPA system independently of the hospital. We were told by witnesses from the Trust that Social Services had been fully involved. We cannot resolve the conflict, if there is one, about how far Social Services were involved in the discussions about CPA but the primary responsibility for its implementation, or lack of it, must rest with the

Trust.

1.13 We will deal with the actual application of the CPA in the cases of William and Keith Taylor in later Chapters.

RESOURCES

1.14 We identified no lack of resources or under funding of services which was in any way relevant to the events we inquired into[11]. We acknowledge that the management of the trust had put considerable efforts into this aspect of its responsibilities and had succeeded, for example, in recruiting a full complement of consultants, something which other Trusts had not all managed to achieve.

[11] See Chapter 9 paragraph 9.2.

CHAPTER 2

WILLIAM TAYLOR'S CARE

INITIAL ASSESSMENT

2 William Taylor was admitted to Wells Villa at St Luke's Hospital on 14 December 1993 and was under the care of Dr Noah Miguda, consultant in the psychiatry of old age. The admission was arranged by Dr Cornford who was William Taylor's general practitioner because William Taylor was in an acute confusional state. A CT scan was carried out on the same day and it disclosed generalised cerebral atrophy with discrete infarcts.

2.1 We have examined the medical and nursing notes kept during the admission and it is clear that throughout his stay William Taylor's condition was assessed both thoroughly and continuously. Ward round/case conference sheets were completed as were various types of assessment sheets and a care plan record. The care plan record was not actually in the form the Trust had adopted for the CPA as such but we are quite satisfied that the records kept would have served perfectly adequately as a record for CPA purposes as well as for the other purposes necessary to the proper care and assessment of the patient.

2.2 Dr Miguda told us that the team included two social workers and four community nurses and we heard evidence from Social Worker A who became William Taylor's social worker. She had many years experience, was qualified by a diploma in social work counselling and had completed a two year course in mental health. She had worked in the unit for 8 years or thereabouts.

2.3 On 5 January 1994 the ward round/case conference record shows that the "full team" discussed William Taylor and that he had been seen by Dr Miguda for the purpose of that case conference. It was decided to invite William Taylor's family to a conference at the ward round on 12 January.

2.3.1 On 12 January Mrs Dorina Taylor, Keith Taylor and his sister attended the ward round as did Social Worker A and the Social Services records show that the case was treated as referred to the Social Services department from that date. The family were advised that William Taylor's condition was such that a place should be found for him in a nursing home but they clearly expressed a preference for him to return to live at home. It was decided to send William Taylor home for a week's trial period during which the family would receive assistance from the Social Services.

2.3.2 Social Worker A visited the family at their home on 17 January 1994 and recorded that the family were adamant that William Taylor should return home despite the recommendation from the hospital that he should go to a

nursing home. The Social Services record shows a care package was devised to include 5 days home care (i.e. Monday to Friday) comprised of a daily lunch call, and assistance with shopping and collecting pensions as well as maximum meals on wheels service for Dorina and William Taylor. It was also noted that a daughter would visit daily. Keith Taylor was shown to be the main carer at home with Dorina Taylor and it was recorded that Mrs Dorina Taylor was suffering from cancer.

2.3.3 William Taylor was sent home on 19 January for the trial period but he was not discharged. The clinical notes and the ward round notes show that William Taylor was discussed again at the hospital on 26 January 1994. He was still at home and it is recorded that the family had expressed some confusion as to whether he had been discharged or was on leave from the hospital. It was arranged that Social Worker A would visit the family again and she did so the next day.

2.3.4 On 2 February 1994 William Taylor was discussed again at the ward round and Social Worker A reported on her home visit of 27 January. It was recorded in the ward round record that Mr Taylor was "OK at home with full support" and he was discharged on 2 February, although he had not actually been in the hospital since 19 January. The discharge letter to Dr Cornford was not sent until 7 March 1994 but it accurately summarised the position and referred to the involvement of Social Services.

2.4 Social Worker A was specifically recorded as the

keyworker in the record of the 19 January ward round. She knew that she was the keyworker for William Taylor and that this would continue to be the case thereafter and she remained his keyworker until his death.

2.5 We are quite satisfied that William Taylor's health, social care needs and any risk factors which might have operated at the time of his admission and discharge were all properly assessed. We are also satisfied that the care plan for his discharge was effectively drawn up and delivered at that time. We have no doubt that there was proper and adequate liaison between the hospital and Social Services and between them and the Taylor family leading up to the discharge. There was a slight delay in notifying his general practitioner of the discharge but as no input was required from him immediately after the discharge this had no particular significance. We have no reason to think that any of the staff dealing with William Taylor are or were in need of any training they had not already had except in respect of the CPA itself which we will deal with in our recommendations below.

CHAPTER 3

CONTINUING CARE OF WILLIAM TAYLOR AFTER DISCHARGE

OUTPATIENTS

3 William Taylor attended an outpatient's appointment on 12 May 1994 accompanied by his younger daughter and was seen by Dr Miguda. By now Mrs Taylor had died and Keith Taylor had been admitted and discharged from St Luke's Hospital for the first time. William Taylor had gone to stay with his daughter during the week.

3.1 Dr Miguda's notes include the following "daughter wants to keep him -residential care is out appears OK with daughter - plan (1) continue on thioridazine (2) support daughter (3) see in 3 months". The words "residential care is out" are in quotes in the original notes and appear to be a direct quote from Mr Taylor's daughter. The notes also make it clear that Dr Miguda knew of Keith Taylor's admission and refer to the fact that William Taylor was staying with his daughter until he was well enough to go back home and that he was having panic attacks while he was alone.

3.2 Dr Miguda wrote to Dr Cornford on 16 May 1994 and told him about the outpatient's appointment and refers to the fact that he discussed with Mr Taylor's daughter the support that she might need and that it was agreed that Social Worker A would continue to give her support. He said the situation would be reviewed in three months.

3.2.1 It is not clear from the notes whether Dr Miguda then spoke to Social Worker A about the developments which had occurred but we are satisfied that he must have done because of the contents of the letter to Dr Cornford and because Social Worker A visited Mr Taylor's daughter the day after that letter was written. (We would add that Social Worker A had already been informed about these developments anyway and we will deal with this below).

3.3 A further outpatient's appointment was made for William Taylor for 25 August 1994 but he did not attend. A further appointment was then made for 25 November 1994 which was cancelled by the hospital and another was arranged for 5 January 1995 which was also cancelled. That appointment was rearranged for 9 March but by then William Taylor had been killed.

3.3.1 Dr Miguda mentioned to the social worker, who was present at one of the regular multi-disciplinary meetings held to discuss his patients, that William Taylor had failed to attend the outpatient's appointment on 25 August but the social worker reported, as was the case, that at that time William Taylor was attending a day centre 5 days a

week[12] and that nothing was happening which warranted a further outpatient attendance.

3.3.2 We think it was reasonable for Dr Miguda to conclude that there was no particular cause for concern in William Taylor's failure to attend the outpatients' clinic. There was no obvious medical need for him to attend; Social Services were obviously still keeping in touch with the family and a care programme was in place.

3.4 Thereafter, Dr Miguda told us, William Taylor was mentioned from time to time by the keyworker at the multi-disciplinary meetings and no concerns were expressed about the situation. He knew that at some point William Taylor moved back home to live with Keith Taylor and again he was unaware of any problems.

3.5 Apart from the failure to implement the CPA, we do not think Dr Miguda, or anyone else in the medical team at Wells Villa, failed to take any appropriate action in the aftercare arrangements for William Taylor. The situation might have been very different if they had known the full extent of Keith Taylor's psychiatric problems, or even if they had known that William and Keith Taylor were living at home together with virtually no outside support. Had the CPA been implemented for William Taylor it is most unlikely that Keith Taylor's problems would not have been mentioned at a review meeting, if only by a family member, or by an exchange of minutes between the two

[12] See paragraph 2.3.2.

teams.

3.5.1 There comes a point at which the medical team effectively hands over the main responsibility for supporting the patient to others and unless something later happens which would require them to take back that responsibility they cannot be criticised if things go wrong for reasons outside their control or knowledge.

SOCIAL SERVICES

3.6 William Taylor was discharged home and the care initially provided for him is set out at paragraph 2.3.2 above. That situation applied until Mrs Dorina Taylor died on 22 March 1994. On 7 April 1994 Social Worker A was told of Mrs Taylor's death and she contacted Keith Taylor straight away and visited him on 11 April. At that time Keith Taylor wanted to continue to care for his father at home but he also wished to continue working.

3.6.1 In order to enable him to do that it was arranged that William Taylor would go to a day care centre called Farm Lodge and that a home care call would be arranged in the mornings so that a care assistant would call at the house to prepare William Taylor for the day care centre thus allowing Keith Taylor to go to work at his normal time. We heard evidence from the Home Care Assistant who attended in the mornings. She was already well known to the family as she had provided home care assistance for Mrs Dorina Taylor during her illness. She told us that she arrived at about 7.30 am to prepare William Taylor to

go out by which time Keith Taylor had left for work.

3.6.2 It seems that Keith Taylor was dissatisfied with this arrangement because he did not like to leave his father alone in the house. Whilst it is easy to sympathise with Keith Taylor in that respect The Home Care Assistant told us that William Taylor had never wandered from the house or done himself any harm in the period between Keith Taylor leaving and her arrival.

3.7 No criticism can be made of the Social Services Department for the arrangements which were made in the period immediately after William Taylor's discharge or in the period after his wife's death.

3.8 When Keith Taylor was first admitted to Trent Ward on 30 April 1994 Social Worker C, Senior Social Worker in the emergency duty team, (who gave evidence) sent a fax message to Social Worker A to let her know that Keith Taylor had been admitted. At this point Mr Taylor's daughter took over as her father's principal carer and he went to live with her in Redcar, although this was quite a strain for her because she had her own family and her husband was not in the best of health.

3.8.1 Social Worker A went to Trent Ward on 2 May and saw Keith Taylor. It is worth noting that she was not in any way officially designated as a key worker for Keith Taylor though she told us that when she visited the hospital the ward manager told her that Keith Taylor had said he did not want a social worker allocated and that he wanted her

to carry on as the social worker. In effect she became, as she put it, the family's social worker.

3.8.2 We regard it as unacceptable practice for the clinical team to have allowed the situation to arise where Social Worker A was informally regarded as the social worker for Keith Taylor but no-one was officially designated as his key worker (as to which see Chapter 5 below). We do not regard this as a criticism of Social Worker A but it is undoubtedly the case that as the person who came nearest to being the social worker assigned to Keith Taylor and, as that was the role the clinical team saw her as filling, she should have been kept informed by the clinical team of developments but was not kept informed (in particular she was not told about Keith Taylor's second and third admissions).

3.8.3 When she visited Keith Taylor in Trent Ward on 2 May 1994 Social Worker A found him to be in good health and quite normal. She told us that she was surprised that he had been detained under the Mental Health Act 1983. She talked to him about the stresses of looking after his father and about the death of his mother. The fact that she found him to be quite well so soon after his admission and the fact that she knew his admission was quite a short one are relevant to what happened later. As she did not know about the later admissions and as this admission seemed not to involve any significant degree of illness her assessment of the situation later was not unreasonable. Had she known the full extent of Keith Taylor's psychiatric history she might have been

expected to react differently later, especially when he took redundancy and had his father at home full time under his sole care.

3.9 On 17 May she visited Mr Taylor's daughter at her home to re-examine the care plan. She arranged for William Taylor to have day care at Wheatacres Day Centre but only two days a week were available. This commenced on 23 May. She later arranged for him to attend the Alzheimer's Disease Society as well on other days. That commenced on 13 July.

3.10 By the time of Social Worker A's visit on 17 May Keith Taylor had been discharged from hospital after his first admission and had returned to work. It was intended that William Taylor would stay with his daughter during the week having the day care which had been arranged (though not by then actually started) and would spend the weekends at home with Keith Taylor.

3.11 Social Worker A visited Mr Taylor's daughter again on 4 August to discuss some practical help that she had requested (a telephone and a bannister rail). The care plan was still for day care as before and there were no apparent difficulties. By then, Keith Taylor had been re-admitted and discharged from hospital but Social Worker A had not been informed of this by anyone at the hospital and nor did his sister mention it to her.

3.11.1 Social Worker A had regular weekly meetings at St Luke's with other social workers and there were multi-

disciplinary meetings but there was no regular review of cases unless they came up because of actual problems. Discussion of cases, it seemed to us, was generated only as a reaction to events rather than as a matter of systematic review. In this way, because Keith Taylor and William Taylor were not raised by anyone, Social Worker A remained in ignorance of the fact that Keith Taylor had been admitted on the second and third occasions. Social Worker A told us that the CPA was not fully implemented until November 1994.

3.12 On 15 and 21 September Social Worker A visited Mr Taylor's daughter again in connection with her application for financial assistance for a telephone. On the second visit his daughter discussed a proposal for William Taylor to be offered a period of respite care which she said Keith Taylor agreed to. The respite care was originally suggested by Social Services Day Centre Manager of the Wheatacres Day Centre, who gave evidence, and who told us that she had suggested it because Mr Taylor's daughter seemed near to breaking point.

3.12.1 Social Worker A arranged the respite care at Kirkdale, a home operated by the Alzheimer's Disease Society. William Taylor went there on 15 October, by which time Keith Taylor had been admitted and discharged from hospital for the third time, again unknown to Social Worker A.

3.12.2 On 20 October Keith Taylor removed his father from Kirkdale and took him home. He told us that he had not

really agreed with his sister putting their father in the day care centres but that he could not object because he had to go to work, so she had to have him at her house during the week. He also told us that he thought the arrangements for day care while he had lived at home were not satisfactory because the home care worker did not arrive before he left for work.

3.12.3 Keith Taylor told us that when he found out that his sister had put his father in the respite home for a fortnight he was at work and his "head was going round". He said he went to the home and took his father out straight away. He had not stopped to see what the home was like.

3.13 The staff at Kirkdale informed Social Worker A on 20 October that Keith Taylor had taken his father out of the home and she visited his daughter and Keith Taylor the next day. Keith Taylor then told her he would take redundancy from work in order to look after his father although it seems that Mr Taylor's daughter looked after her father in the few weeks it took for the redundancy to be arranged, continuing with the day care as before.

3.14 At this point, the information in Social Worker A's possession as far as Keith Taylor's medical history was concerned, was as described in paragraph 3.8.3 above.

3.15 She was informed on 21 December 1994 by Jane Dickinson of the Alzheimer's Disease Society that William Taylor had moved back to his home and that Keith Taylor had said

that day care was no longer needed. We commend Mrs Dickinson for taking the trouble to follow up the withdrawal of William Taylor from the day care by ensuring that the Social Services knew about the change in the situation.

3.16 Wheatacres Day Centre also took action. The Social Services Day Centre Manager, who gave evidence, told us that William Taylor stopped attending the centre after the Christmas party and at first she thought he must be attending the Alzheimer's Disease Society day centre in stead of Wheatacres but she checked with them and was told that he had gone to live with his son. She told us that her reaction was "Oh has he? Oh dear". She contacted Keith Taylor and recommended day care should continue to which he seemed amenable, so she contacted Social Worker A on 16 January 1995 and told her about this.

3.17 We regard the actions of both the Alzheimer's Disease Society and Wheatacres Day Centre as entirely appropriate. Neither regarded the situation whereby William Taylor had gone back to his son's full time care as immediately dangerous, nor had they any reason to, and both acted quickly to ensure that Social Services were aware of the situation.

3.18 Social Worker A visited Keith Taylor on 20 January at his home. She had already arranged to visit him when he telephoned to ask for advice concerning attendance allowance. She then visited him and took the opportunity

to discuss day care with him. In fact he was offered the same package of care as had been offered while William Taylor had been living with his daughter i.e. daily day care, although it would have been at different centres. Keith Taylor said it was unnecessary and declined the offer. At the time of that visit Social Worker A saw nothing which gave her any cause for concern. The house was in order and Keith Taylor seemed to be managing.

3.19 We have to ask whether Social Services should have done more to persuade Keith Taylor to take extra help.

3.19.1 It is easy to conclude with the benefit of hindsight that he needed it and indeed when we saw him he expressed it in this way:

> "If I'd wanted help I would have contacted Social Worker A but I didn't think of it. I just didn't have time to phone, I wanted to see to him myself anyhow. I did phone Social Worker A once. I can't remember what about but we probably talked about day care. I didn't know there was something wrong. ... Social Worker A is a nice lass. I think she's a smashing lass. She'll give help but if you're too frigging daft to ask for it, it's your own fault. We were always independent. She knew I was coping alright but I was worse than I realised."

3.19.2 It should be remembered that Keith Taylor had only been looking after his father, full time, for a short period; Social Worker A had no reason to think things were going wrong; the home was in order and Keith Taylor was apparently coping; nor did she know his full psychiatric history. There would have come a time when the situation

should have been reviewed because it would be obvious that the strain on Keith Taylor would build up. The homicide occurred on 16 February 1995 which was less than four weeks after the last visit by the social worker. We have no hesitation in concluding that the time which had elapsed was not by then such as to call for another visit.

3.20 Had the full CPA been applied, as it should have been, to the case of William Taylor the role of the community key worker as set out in the Trust's document of 29 October 1993[13] would have included the following:

> B. [The keyworker] must liaise and co-ordinate with other professional colleagues, voluntary agencies and other statutory agencies if and when appropriate and make them aware of any changes.
>
> C. They are responsible for calling regular review meetings to monitor progress and make changes as necessary.

3.21 If a full CPA had been in place regular review meetings would have occurred and it seems inevitable that such a meeting would have been called when William Taylor went to live with Keith Taylor and health and Social Services support ceased[14]. In those circumstances it is at least possible that more Social Services involvement with the Taylor family would have identified warning signs that Keith Taylor was under severe stress. It is also the

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[13] See paragraph 1.5 above.

[14] This is dealt with in paragraphs 3.18 to 3.19.2 above.

case that those entrusted with William Taylor's care would then have known that Keith Taylor had been admitted to hospital for the second and third times.

3.22 Social Worker A told us that the arrangement in place at the relevant time was that cases would be discussed in the multi-disciplinary team meetings which were held regularly but that there was no system for raising cases routinely or regularly and that individual cases would only come up for discussion if a problem was known to have arisen.

3.22.1 However, although communication within the team looking after William Taylor and between that team and his family were good (albeit outside the CPA); there was a relative lack of liaison with the team caring for Keith Taylor. This is how the team caring for William Taylor failed to become aware of Keith Taylor's second and third admissions to hospital.

CHAPTER 4

KEITH TAYLOR'S CARE

RELEVANT HISTORY

4 Keith Taylor's medical history and the history of his care needs are closely linked and fall into four distinct phases:

(1) His upbringing.

(2) The period of his mother's illness and death.

(3) From his mother's death until his redundancy.

(4) After his redundancy.

UPBRINGING

4.1 As already mentioned in the introduction Keith Taylor was epileptic from an early age. His medical notes include a reference to convulsions for which he was admitted to hospital aged 17 months and by age 4 there is specific reference to petit mal epilepsy. The family gave us a history which suggested the onset of the seizures followed a head injury but this is not borne out by the medical records. There was an apparently minor head injury at age 6 but the seizures had started well before that.

4.1.1 The frequency of seizures varied from time to time and by the time he was 11 years old Keith Taylor had been seen by a psychiatrist for the first time. It is not clear why he was referred to the psychiatrist but he was referred to her by a paediatrician. She reported as follows:

> "There are emotional factors present which could well be an additional factor in the onset of the attacks. The boy is tense but mother is even worse. She has apparently suffered with her "nerves for years" and now gives a history of panic attacks of fairly severe intensity. In fact the position is that she appears to be suffering from an anxiety state ... Keith is well aware of these feelings experienced by his mother and is over protective towards his mother and in addition very insecure in himself because of his mother's illness".

4.1.2 Four years later a consultant psychiatrist, reported that Dorina Taylor was herself an in-patient at St Luke's. It is also clear that Keith Taylor had been followed up in the psychiatric clinic in the meantime. In 1968 when Keith Taylor was 20 years old there is a reference by another psychiatrist to the fact that Keith Taylor had been referred to the psychiatric hospital although there was never any evidence that he was psychiatrically disturbed. He was then told he had no need to come to the psychiatric hospital. The letter refers to Dorina Taylor having a chronic phobic anxiety state for which she was being treated.

4.1.3 For several years thereafter (until he was 32) there is nothing significant in the medical history except for one

further unexplained referral to a psychiatrist (who said the referral was unnecessary) and occasional references to the fact that Keith Taylor had been advised that he should not drink alcohol because of the medication he was taking for epilepsy. The levels of alcohol apparently referred to are not such as would be a problem in themselves.

4.1.4 In 1980 there is reference to "a fair amount of domestic worry, particularly now, because his mother is ill". After that for many years little of relevance appears in the records and indeed in the 1980's Keith Taylor was free from seizures for many years.

4.1.5 Keith Taylor told us that when he was 23 his grandmother, who herself ran a Spiritualist Church, had died. He had had an argument with her shortly before her death which was about a letter she had sent criticising his mother for spending money in a way which she thought foolish. About a week later the grandmother died and Keith Taylor told us that he thought he had "finished her off" though there was no suggestion that he had hurt her in any way. He also told us that he is now no longer sure whether he blames himself for her death. The significance of this apparently unrelated event is that Keith Taylor held the belief that something significant would happen to him while he was 46 and 69, being twice and three times his age at the time of the incident just described. He killed his father two days before his 47th birthday which would have ended the "significant year". Keith Taylor's brother, confirmed that Keith had talked about these

significant ages from time to time.

4.1.6 One further fact about Keith Taylor's upbringing which we should mention is that about 5 years before the homicide, so he told us, his parents had discussed a suicide pact and his mother told him about it but said that they had decided against it because they did not know how he would manage without them. We do not think that Keith Taylor made this story up as his sister offered some corroboration of it. She said that shortly before her death her mother had said something about dying at the same time as her husband and even suggested that it was his idea. She said that by then William Taylor's mental deterioration would not have permitted him to make such a suggestion.

MOTHER'S DEATH

4.2 In July 1993 there is reference in Keith Taylor's medical records to minor attacks which he attributed to stress over his mother whose cancer was by then being investigated.

4.2.1 We have already referred to the fact that Mrs Taylor's death was unexpected because of the misconceived idea the family had developed that her cancer had been cured.

4.2.2 Keith Taylor was described to us, by all the witnesses who were able to offer an opinion, as a quiet and undemonstrative loner who had no real friends and who lived both for and under the protection of his parents to

whom he was devoted.

4.2.3 William Taylor's medical records suggest that there was no significant build up to the dementia he suffered. It either developed slowly but went unnoticed because his wife would instruct him around the house or it developed quickly as a result of a stroke or strokes. He was referred to Dr Miguda in December 1993 and none of the family really realised how much he had deteriorated until he was unable to understand that his wife had died and he constantly asked about her.

4.2.4 It is easy to see that the death of Keith Taylor's mother and the sudden awareness of just how far his father had deteriorated brought about a catastrophic deterioration in his mental condition.

PERIOD UP TO REDUNDANCY

4.3 The general situation between the death of Mrs Dorina Taylor and the redundancy is already fully described in Chapter 3 above.

4.3.1 We should add that Keith Taylor, at least now, realises that because he was trying to look after his father and work at the same time he had no opportunity to grieve for and deal with the death of his mother. When his father was at home he was incontinent every second day or so while in bed and his dementia had reached the stage where he could not follow a TV programme or understand that his wife had died.

PERIOD AFTER REDUNDANCY

4.4 This period is also described in Chapter 3. At this period Keith Taylor was looking after his father full time and as he put it "I thought I was managing OK".

CHAPTER 5

KEITH TAYLOR'S CARE

FIRST HOSPITAL ADMISSION

5. Keith Taylor's first admission to hospital was on 30 April 1994. He was admitted to Trent Ward after Dr McKeown, his general practitioner, had been called in by the family. The precise circumstances are recalled differently by the family and Dr McKeown but it is quite clear that admission was necessary and we see nothing to criticise in the way in which Dr McKeown dealt with the case. He told us that once he had decided that admission was necessary he set about arranging it.

5.1 He told us that his usual practice in cases where admission to the psychiatric hospital was necessary was to telephone and speak to the admitting officer who would be the Senior House Officer. The SHO might then refer to the consultant but Dr McKeown said he had never encountered any significant problems in getting a patient admitted when he thought it necessary. Delays did not usually exceed an hour or so. (He also told us that where a domiciliary visit by a psychiatrist was called for he did not encounter any difficulty in obtaining one).

5.2 On this occasion Keith Taylor was detained under section

2 of the Mental Health Act 1983. The correct papers are on file from 2 doctors recommending admission for assessment and an application from an approved social worker. The reasons given for formal admission are that Keith Taylor's condition required treatment and that he had developed an acute psychotic illness and was angry and hostile but he was denying that he was ill and he was refusing to stay.

5.2.1 The hospital records contain the following forms: admission details, an in-patient assessment, care plan, care plan evaluation, multi-disciplinary decisions and various Neuman Model forms. It is clear that the CPA forms were not used and nor did those actually in use serve the same purpose.

5.3 The care plan and care plan form was used to plan how he would be treated in the ward and certainly neither served the purpose of planning for his discharge nor for assessing his needs after discharge. The care plan evaluation form was not really used to evaluate any care plan and mainly consists of a narrative of how Keith Taylor spent his time in hospital. It does however contain the following entries:

> "4/5/94 Keith able to discuss the pressure he has been under without feeling tearful. Relieved that his stay in hospital will prompt us to liaise with other agencies to put care package together to help him to care for his father at home. ...
>
> 9/5/94 Keith was seen by Dr Moslehuddin am/his section 2 will lapse. He's to see the doctor

again on Wednesday next. ...:"

In one of the Neuman Model papers there are the following entries:

> 4/5/94 "W/R [Ward round]
> Behaviour over weekend discussed and the pressure he had been under with the death of his mother and looking after his ill father. Also the increase in his epileptic seizures.
> Plan: (1) For Phenytoin to be reviewed ...
> (2) SW [social worker] B will see SW A today to organise care package for father prior to his discharge home.
> (3) To remain in hospital for continued assessment. Review next week.
>
> 11/5/92 "WARD [?Ward round?] Keith-can be discharged sometime today letter for OPA [outpatient's appointment] in four weeks: to refrain from work for a few days".

5.3.1 There is a minor discrepancy between the Social Services' records and the entry for 4/5/94 in the Neuman Model papers in that Social Worker B's social service records show that she "discovered" on 5/5/94 that Social Worker A was involved with the family and that a package of care had already been arranged. This seems inconsistent with the fact, as recorded in the hospital notes, that she was to see Social Worker A on 4/5/94 to organise the care plan. Such discrepancies are in themselves unimportant except that they seem to indicate that liaison was more a question of luck than actual organisation. Proper implementation of the CPA would have ensured that such liaison occurred without fail and it is in this sense that filling in the CPA forms is not just a question of

paperwork for its own sake.

5.3.2 The clinical notes for 10/5/94 contain an entry which reads "Now his father will be looked after in day centre every day". That entry is immediately before the one referring to discharge.

5.4 By the time of this admission the CPA documents called for by the Trust's instructions dated 29 October 1993 should have been completed. On this occasion Keith Taylor was arguably not liable to be treated as requiring a "full CPA" under those instructions. On the other hand although nothing was formalised or put in writing a reasonable plan had been devised and was put in place.

5.4.1 On this admission the assessment of Keith Taylor's medical condition was full. He was seen by a neurologist and an ECG was carried out. It is clear that the focus of attention was on epilepsy as his main problem.

5.4.2 The discharge letter sent to Dr McKeown, which is dated 12 July 1994 should have been copied to Dr Miguda, as William Taylor's doctor, or at least its contents should have been communicated to him. This should have been done by the hospital rather than by Dr McKeown. The medical and nursing notes do not seem to refer directly to the fact that William Taylor was a patient, although there are references to his ill health. If the lack of communication with the team looking after William Taylor was because it was not realised that he was a patient of Dr Miguda then we would regard it as a failure on the

part of the team looking after Keith Taylor that they had failed to discover this significant fact.

5.5 There were some suggestions in the course of the evidence that there were doubts about what impact the requirements of confidentiality would have on liaison between teams assisting different patients.

5.5.1 Mr Farrar, divisional manager at St Luke's, said that a possibility was that a single case record could be kept where two patients were connected and that questions of confidentiality were being considered but had not yet been resolved. Judith Oliver, director of operational services for the Trust, said that conflicts about confidentiality could affect multidisciplinary working and mentioned that psychologists in particular seemed to have some doubts about what information they can share. The doubts expressed were not apparently a concern for the staff who actually dealt with patients and seem to be confined to the management. They do not seem to have any actual impact in the case of Keith and William Taylor.

5.6 The British Gas medical adviser had written to Dr McKeown on 9 May 1994 about concerns being experienced at British Gas concerning Keith Taylor's behaviour, including offensive and threatening telephone calls to managers and aggressive and uncontrollable behaviour at work. In our opinion that letter should have been copied, or its contents should have been communicated to the hospital at the time of the admission. They form part of the medical picture and it might have assisted the hospital staff to

have the information. The British Gas medical adviser acted correctly in writing to Dr McKeown and we are not suggesting he should have written to the hospital as well.

CHAPTER 6

KEITH TAYLOR'S CARE

SECOND HOSPITAL ADMISSION

6 Keith Taylor was admitted to Trent Ward at St Luke's Hospital for the second time on 25 May 1994. On this occasion the admission was informal and was because Keith Taylor was feeling suicidal. The same forms were used as before.

6.1 On this occasion the care plan, drawn up by a nurse on his admission, for treatment while he was in hospital was to discuss his problems with him and to encourage him to talk them over with staff as much as possible. It seems clear that the plan was drawn up on the assumption that he would stay in the hospital for some time, which did not happen.

6.1.1 The care plan evaluation shows that during the following week or so staff observed Keith Taylor who was interacting reasonably well with other patients and with the staff but was largely keeping himself to himself and there is no evidence that any of the staff actually attempted to put the plan into effect by talking his problems over with him.

6.1.2 The entry in the nursing notes for 25 May is quite detailed and a full assessment was carried out but thereafter during this stay in the hospital there are only two brief entries and there is no evidence that any particular plan of treatment was ever adopted or put into effect.

6.2 On the original assessment form there is a reference to Keith Taylor having said "My gran was a spiritualist. I don't know if it's something to do with that. It might all be something to do with that my imagination, my head going round". We do not think any criticism can be made of the nurse who made this assessment but here was a reference, however oblique, to something which later featured quite prominently in Keith Taylor's case. Delusions about his grandmother or others making him act in an odd way and about the significance of his 46th year later came to the fore. If more had actually been done on this admission to the hospital it is at least possible that the course of Keith Taylor's illness would have run differently.

6.2.1 In the care plan evaluation there are entries as follows:

> 29.5.94 Approached Keith this morning and asked him how he felt. He says he feels mixed up and unsure exactly how he feels at the moment.
> pm Appears low, little facial expression, showing concern for other patients and their conditions. Interacting with others and playing pool and going for walks.
>
> 30.5.94 pm Keith has been quiet and had a walk off the ward with a friend. Appears to be low in

mood but pleasant on approach.

31.5.94 Interacting with others appropriately but still appears flat in affect, he still feels unsure of what he feels, sat watching videos with others but concentration appears to waver after a few minutes.

The record ends at that point except for one entry in the "Factors occurring outside the individual" form which we will deal with in the next paragraph. The clinical notes contain no entries after 27 May.

6.2.2 The final entry in the nursing notes reads:

1/6/94 Ward round Keith relayed the problems that had brought him into hospital and admitted that the phone call re medical board app tomorrow may have been the triggering factor. He felt he needed to get back to work as he was feeling tired as he wasn't getting any exercise.
Plan: (1) Discharge home today to OPD
(2) Keith will contact his boss to reaffirm he can attend tomorrow's medical board.

6.2.3 Keith Taylor saw the medical adviser at British Gas, where he worked, on 2 June and was allowed to return to his post.

6.3 During the second admission to hospital there is no evidence that anyone even considered any arrangements, other than the outpatient's appointment, for continuing care after discharge, which in light of the original care plan was clearly a requirement. It may be that a social worker had made some contribution to the ward round but

there is no evidence of it and in light of the fact that the team social worker was on holiday it seems unlikely.

6.3.1 The point at issue here is not just one of record keeping. It was clear that whatever had been put in place after the first admission needed to be carefully reviewed because there was a serious and obvious risk that it was not working as it should have been. A second admission so soon after the first must indicate at least a serious question whether Keith Taylor would be able to cope with the situation at home after his discharge and there was a total failure to deal with this question.

6.3.2 Had the CPA been applied as it should have been there would have been proper thought given to this.

6.4 On this admission we have to conclude that Keith Taylor was simply overlooked because he was quiet and compliant and when he asked to go home because of the medical appointment at work he was simply discharged without much thought and with no planned aftercare.

6.4.1 Keith Taylor was discharged without any arrangements for follow up treatment except an outpatients' appointment. He was discharged without the initial plan for treatment being carried out. As we have already pointed out that would have involved a longer stay in hospital. We do not say that the decision to discharge Keith Taylor was wrong as such but, in the circumstances, at the very least, thought should have been given to how a care plan taking account of his psychological and social needs after

discharge could be put into effect. Such a plan could have included further counselling. Keith Taylor had expressed views about his loneliness and worries about the future and counselling and/or the appointment of a community psychiatric nurse to play a role in the case would have been appropriate.

6.4.2 The result of the way in which this admission was handled, after the initial assessment, was that Keith Taylor was treated as a person whose only problem was epilepsy, which was simply not the case, and we have concluded that this was the result of passive practice, by which we mean that the quiet and undemanding patient was not given as much attention as he should have been and there was a general failure to treat him adequately.

6.4.3 We regard this as a failure of the team as a whole rather than of an individual. The case was discussed at the ward round and had the ward round been operating effectively someone would surely have suggested a need for more aftercare.

6.4.4 Dr Moslehuddin told us that there was no particular system for ensuring that social workers followed up patients and it was left to members of the team to raise issues about patients at ward rounds if they had concerns about them. It seems to us that whether a patient was discussed depended on chance rather than any routine consideration of their needs. This is borne out by the fact that Dr Moslehuddin told us he had left it to Social Worker B, the social worker attached to the ward, to

arrange what would happen after Keith Taylor's discharge. However, at the time of his second admission, she was on holiday and it seems to have been left to chance whether any such follow up would occur.

CHAPTER 7

KEITH TAYLOR'S CARE

THIRD HOSPITAL ADMISSION

7 Keith Taylor was admitted to hospital for the third time on 26 September 1994 after Dr McKeown had been called to his home because he was behaving irrationally. On this occasion he was taken to Ward 4 of South Cleveland Hospital[15] where he was verbally abusive and assaulted a consultant. The medical notes say that he smelled of alcohol and was blaming the hospital for his mother's death.

7.1 We have been unable to reach any firm conclusion about whether Keith Taylor had been drinking to excess before this admission. Most of the evidence suggests that he had not. No-one who was able to speak about his home situation thought that Keith Taylor kept any significant amount of alcohol there and Dr McKeown did not notice a smell of alcohol when he visited to arrange the admission. It may be that his behaviour, coupled with a smell of alcohol, not in itself suggestive of excessive consumption, led the staff at ward 4 to conclude he had consumed a large quantity.

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[15] A general hospital run by the South Tees Acute Trust.

7.2 Keith Taylor was quickly transferred to Exeter Ward where he was unable to give a full history but did mention his mother's death, his grandmother's death, his father's health and the fact that he claimed to be in communication with his grandmother. A fuller account was taken the next day. The basic problem, as recorded in the medical notes, was still seen as his epilepsy but the record also contains reference to psychosis, albeit of a post-ictal nature and possible schizophreniform or schizoid personality disorder.

7.2.1 No care plan was drawn up until three days after Keith Taylor's admission.

7.2.2 In the nursing record, which is again in the same form as for the earlier admissions, there is some emphasis on personal problems related to grieving for his mother and the stress of looking after his father. Again, the care plan seems to have assumed there would be a fairly long period of treatment. It refers specifically to achieving the plan within 1 month and to weekly reviews. On the assumption Keith Taylor would stay in hospital for some time this was a reasonable plan.

7.2.3 After the initial assessments the records, both medical and nursing, are sparse. In the medical record there is a record of steps taken to assess the type of treatment being given for epilepsy and there are references to changes in medication but there is little more. In the medical notes there is a reference dated 29/9/94 which reads:

"No psychotic ideas or behaviour. No fits noted by staff. For W/E [weekend] leave and review Monday - altering epileptic treatment main plan"

7.3 In the nursing notes there is a record that Keith Taylor returned prematurely from his weekend leave "saying his tablets have run out. Wants to see doctor tomorrow."

7.4 He did see the doctor the next day and the record reads:

"Good W/E. No fits, no psychosis. Therefore D/C [discharge] on carbamazepine ... Review for blood level 10/10/94 and ↑ ↓ [increase or decrease] medication".

7.4.1 Following that entry it appears that Keith Taylor was discharged without any further discussion or planning. His case had been discussed at a ward round on 27 September but the discussion was then about his medication and certainly no planning for his discharge occurred at that stage. In fact, although the records do not show it, some thought had been given to discharge and the Senior House Officer recalls discussing the matter with nursing staff and Dr Moslehuddin and that it was a significant factor that Keith Taylor was anxious to return to work. She told us, and we accept it is the case, that she was unaware of the fact that he had returned early from his weekend leave.

7.4.2 The interim medical discharge report and prescription form dated 3/10/94 gives the diagnosis as "post ictal psychosis, settling over 48 hours". The discharge letter to Dr McKeown which is dated 16 October refers to the two earlier admissions and to the reaction to stress having

occasioned them but makes no reference to any follow up by Social Services or any reference to CPA.

7.5 It is significant that the outpatients' appointment itself was intended as a review of the effect of the medication and a review of Keith Taylor's mental condition but insufficient assessment of his social situation occurred.

7.6 On this admission Staff Nurse C was appointed, in his absence, as Keith Taylor's keyworker (or primary nurse) while he was in the hospital and he told us that in that role at that time he would have acted as the patient's advocate at the ward round if necessary but, of course, no ward round at which discharge was discussed occurred.

7.6.1 Staff Nurse A, who dealt with Keith Taylor's admission on this occasion, told us that the method of allocation of keyworker was to allocate by rotation so that it could happen that the keyworker would not even be on duty at the time the ward round occurred. Mr James Paterson, director of nursing development, who carried out the internal inquiry after the homicide, confirmed that Staff Nurse C was not on duty for three days after the day on which Keith Taylor was admitted. Nurse David Roach also confirmed this.

7.6.2 The nurse in charge of the ward on the morning after Keith Taylor's admission (Staff Nurse B) should have ensured that an initial care plan was drawn up that day

and that other activities were set in motion to lead to the drawing up of a comprehensive care plan.

7.6.3 Staff Nurse C's assessment was contained on a single form (headed "care plan"). The Neuman model forms were not fully completed. The plan was not comprehensive. Before the time Staff Nurse C returned to duty a plan should have been drawn up but by the time he returned Keith Taylor's condition had settled down and the Senior House Officer had identified the problem as post ictal psychosis on the basis that his epilepsy had shown poor control with increasing fit frequency and episodes of bizarre behaviour in the post ictal (fit) period. Accordingly, we do not think Staff Nurse C was at fault in drawing up the plan he did.

7.6.4 We do not feel that any criticism of Staff Nurse C personally would be appropriate because he was not at fault in failing to advocate anything on Keith Taylor's behalf when, as it turned out, he was discharged without discussion at any ward round and indeed Staff Nurse C was not present for much of the relevant time as he was on leave for three days after the day of Keith Taylor's admission.

7.6.5 The way in which Exeter Ward was operating at that time meant that when Keith Taylor was discharged no-one picked up the need for a keyworker to be appointed to deal with his care after discharge. This was because there was no systematic review of the care plan at discharge.

7.6.6 Some degree of fault lies with the staff who discharged Keith Taylor without giving much thought to his aftercare in the community. The Senior House Officer did discuss the case with nursing staff and the decision was taken by Dr Moslehuddin after she had reported to him. The Senior House Officer was in her first month of her second psychiatric placement - having seven months experience in the specialty, however at that time she had received no training in CPA.

7.6.7 We do think Dr Moslehuddin should have made enquiries about whether any aftercare in the community was needed before he decided to discharge Keith Taylor. He told us when he gave evidence that he had great faith in Social Worker B, the social worker, and his faith may well be justified but it is entirely inappropriate for a doctor whose patient has had three spells of mental illness in a short period to discharge him in the hope that the Social Services will become aware of the case and be able to assess the patient's needs. After having given evidence, Dr Moslehuddin, like all the witnesses, was invited to expand on or correct the Chairman's notes of evidence and he submitted the following comments (amongst others):

> "8. Social Worker B would likely know Keith had been admitted because she usually comes to the ward rounds. She is usually aware of admission of patients because of her attendance at ward rounds.
>
> 9. I am sure Social Worker B would have been aware of most discharges.

10. Usually I would leave it to Social Worker B what would happen after a patient's discharge."

Given that Social Worker B told us that her only involvement with Keith Taylor was in April 1994 (which is borne out by the Social Services records), Dr Moslehuddin's expectations are clearly unjustified, which we do not regard as a criticism of Social Worker B, as she could not be expected to pick up cases which are neither referred to her nor mentioned at ward rounds. We have already referred to the fact that there was no systematic examination of cases at ward rounds and they were only mentioned if any one saw a need to do so.

7.7 It is quite certain that even on the criteria adopted by Tees Health a full CPA was required on this admission as it was the third admission. The comments we have made above about the need for more support for Keith Taylor after he left the hospital on the earlier occasions apply with greater force on this occasion but he was given none and no planning was put in place to provide it. Dr Moslehuddin said he followed the procedure in practice at the relevant time. We accept this was so but we do not accept that the practice then in place was sufficient.

7.8 These failures were not limited to the completion of CPA procedures, none of the steps which common sense would have indicated were necessary, were put in place under any other guise. It should also be remembered that the CPA involves assessment, a plan, allocation of a key

worker and regular reviews[16]. The responsibility of the hospital does not cease at the point of discharge and continues while the patient is an outpatient.

[16] See HSG(94)27 page 3.

CHAPTER 8

KEITH TAYLOR'S CARE AFTER DISCHARGE

8 After his discharge from hospital for the third time Keith Taylor received offers of support from Social Services, as we have already identified, which he declined. We have already concluded that Social Services were not at fault in not having taken any further action. He did not see Dr McKeown again until after he was arrested but we see nothing to criticise Dr McKeown for in that. It is of course primarily the responsibility of patients to contact their GP and even where a patient is not fully able to look after his own health the GP is not expected to take the initiative, which is no doubt in part why Social Services and community psychiatric nurses are appointed as keyworkers in such cases. Furthermore, he was under the care of the hospital as an outpatient and Dr McKeown was receiving satisfactory reports following outpatient appointments. We now turn to those outpatient appointments to complete the medical picture.

8.1 On 10 October 1994 a note in the medical records shows the results of a blood test but nothing more.

8.2 On 31 October 1994 a further note records an outpatient's

appointment where Keith Taylor reported stress of looking after his father as the cause of the one seizure he had by then suffered after discharge. In the letter which she sent to Dr McKeown about this appointment, which is dated 10 November, the Senior House Officer also mentioned that Keith Taylor had taken his father out of the nursing home which his sister had arranged. She told us when she gave evidence that Keith Taylor had said he was coping; that she was unaware that Dr Miguda was involved with the father's care and that she presumed there would be a social worker for the father because he had been in a home but that she did not know what benefit it would be for Keith Taylor to have a social worker as he was, so far as she knew, in full time work and out all day.

8.2.1 At this appointment, although Keith Taylor was fairly uncommunicative generally, the Senior House Officer managed to get him to talk rather more than before and he expressed some of his beliefs about the significance for him of being aged 46. She referred to this in the letter to Dr McKeown. We do not think that anything which was said about such beliefs at the outpatients' appointment was such as to call for any further action in itself or that the Senior House Officer was wrong to describe this as "psychotic ideas but nothing florid" as she did in the medical notes. But the fact that the Senior House Officer was able to get Keith Taylor to talk about this at the short outpatients' appointment does suggest that if he had been treated more actively previously such thoughts might have been examined more closely at that

stage by the mental health team then being charged with his care.

8.3 Finally, Keith Taylor was seen in outpatients on 9 January. He had by now told the Senior House Officer that he had stopped work and was still talking about the special age of 46 but again she thought these delusions were not florid and when she wrote to Dr McKeown following the visit she described him as "not obviously delusional". At this stage the medical notes do not suggest that Keith Taylor was under any great stress and although the letter to Dr McKeown mentions the stress of family problems it would appear that nothing unduly worrying appeared to be happening.

8.4 The next appointment was set for 27 March 1995 but by that date Keith Taylor had killed his father. It seems obvious that his condition deteriorated rapidly after the last outpatients' appointment but we do not see any reason to criticise the time which elapsed between appointments. Had a keyworker been visiting the family things might have turned out differently but we see no reason to think that an earlier outpatients' appointment would have had any significant impact.

CHAPTER 9

MANAGEMENT OF EXETER WARD

9 Mrs Britton, chief executive of the Trust told us that the management of the Trust had a track record for taking decisive action when necessary where resistance to change was encountered and when staff, including consultants, were giving a below standard performance. She also told us that the Trust had had considerable success in building new services.

9.1 At the material time Exeter Ward was within the management responsibility of Mr Martin Farrar, divisional manager of St Luke's Hospital. Under him, Mr James Ennis, nursing services manager had responsibility for Exeter Ward and the ward manager was Mr David Roach. All three gave evidence.

9.2 A re-organisation had occurred on 17 September 1994 under which Exeter Ward, which before then only had male patients, became a ward for adults of both sexes and some staff changes occurred. Staffing levels were normal and bed occupancy was between 57% and 68% during Keith Taylor's final admission[17]. We were told that community psychiatric nurses and social workers were attached to the ward and we have not been made aware of any factor

[17] Of 19 beds between 11 and 13 were occupied.

which would indicate that the way in which Keith Taylor was treated was affected by any lack of resources. It was suggested by one of the nurses who gave evidence that the organisation of the ward was in transition at the time because of the reorganisation but we do not accept that that caused the failure to implement the CPA, let alone that it would excuse any failure to deal with Keith Taylor properly. Mr Ennis told us that the reorganisation had been planned and was implemented over a period of a year and with bed occupancy rates as described it would be difficult to see how the planned change could have caused problems such as to explain what happened. In any event it was accepted by various witnesses that the CPA had not been implemented and this was a failure over a period of time not of a particular week in which change had occurred.

9.2.1 One particular problem was that the psychiatrist and social worker were based at different locations but although that in itself might have been an inconvenience we do not accept that it was an excuse for the non-implementation of the CPA or the failure to devise a plan of any sort when Keith Taylor was discharged for the third time. Ward rounds were bound to be on the wards and all the relevant personnel both could and should have attended, indeed as far as we know they did attend so the geographical inconvenience was not a cause of any failure.

9.3 We were told that Exeter Ward[18] was behind other wards in implementing the CPA and that the interaction between members of different disciplines was not as good as in some other wards. It is at least partly a matter of impression but our conclusion is that there was more resistance to change in Exeter Ward than elsewhere and that although the management within the Trust were trying to improve matters they were taking the line that as long as there was some progress they were not too concerned about how quickly it was taking place. We have to say that this was a failure of the senior management at the level of Mr Farrar and above rather than of the junior management. Mr Farrar himself was only appointed as divisional manager in May 1994 and Mrs Judith Oliver, director of operational services to whom he reported, said he was "thrown in at the deep end" because she was on maternity leave at the time. The CPA should have been fully implemented before Mr Farrar was even appointed to that post and we do not know what other problems and priorities he was faced with when he was appointed. Whilst we believe the responsibility for the failure to implement the CPA lies at senior levels in the sense that it was at those levels that action should have been taken, we therefore do not feel able to say that any particular individual was at fault.

9.3.1 Mrs Judith Oliver, director of operational services for the Trust, made the valid point that the physical

[18] Exeter Ward had been reorganised but we do not consider that a comparison with other wards is thereby rendered impossible, there was a reasonable degree of continuity.

separation of the psychiatrist and the social worker from each other and other team members might have had an influence on the fact that in Exeter Ward there was less cohesion between the different professional groups but we think that at least part of the cause was that Dr Moslehuddin was slow to change and as a senior consultant he ought to have been leading change in the light of the care in the community approach.

9.3.2 We do not accept that it was appropriate for the Trust's managers to take the view that as long as some progress was being made there was no problem requiring their intervention, which is the impression we gained from the evidence we heard. The Trust managers seemed to be unaware of the fact that little if any progress had been made towards actual implementation. Following the events with which we are directly concerned it appears that more effective steps have been taken to implement the CPA but that only goes to show that decisive action before those events could have been effective.

9.4 Any criticism of the management of the Trust which we make cannot excuse the medical staff whom we have criticised elsewhere for their failure to implement common sense - practical steps to assist their patients upon discharge, whether under the name CPA or something else.

9.5 We were told by Social Services managers who gave evidence that they had been advocating better implementation of CPA for some time and we see scope for

some arrangement to be made for more effective representation of Social Services views to the Trust.

CONCLUSIONS

1. We preface our conclusions with an acknowledgement that we cannot say that the tragedy would have been averted if the CPA had been fully implemented. The most that can be said is that the chances of avoiding it might have been improved.

2. We also wish to record the fact that we believe that, at least in respect of Keith Taylor's second and third admissions, best clinical practice and common sense would have required that more was done by way of planning for his care in the community after his discharge, than was in fact done, quite independently of any of the formal requirements of the CPA.

3. The CPA is not an alternative to best practice and common sense. It should be seen as an enhancement of best practice and common sense and may act as a check and a framework within which the adoption of best practice and common sense can be ensured.

4. The failure of the staff at St Luke's to ensure that Keith Taylor received support after his second and third discharges is not a purely technical failure relating to the keeping of records or the completion of forms, it went well beyond that.

5. The system of allocating keyworkers on the patient's admission, based as it was on a rotation amongst the

staff regardless of whether they were actually on duty, led to the situation in which a care plan was not drawn up until some time after Keith Taylor's third admission and contributed to the inadequacy of the plan when it was drawn up.

6. The failures were not the result of any lack of resources, understaffing or over-occupancy. The changes taking place in the Ward at about the time of the third admission of Keith Taylor do not in our view excuse or even explain what happened, indeed we think they had very little impact.

7. We were told that some members of the mental health team were based at locations remote from the Ward. This had some impact on how far the various members of staff regarded themselves as members of a team.

8. The Trust's managers should have done more to ensure the implementation of good practice including the CPA. We acknowledge that other Trusts had also failed to implement the CPA.

9. Senior management in the Trust assumed that high level action including seminars and the development of policies led to implementation on the ground. Other Trusts may have made this assumption. However the important message from this report is that action at management level does not necessarily translate into action by staff dealing with patients. There is a duty on management to discover what is actually happening and to discover whether it is

sufficient.

10. The CPA had not been fully implemented within the Wards where Keith Taylor was admitted. The Health Authority, the Trust and Social Services had a collective duty to ensure the implementation of the CPA which was not met. The Trust management and the Health Authority share responsibility in this respect. The major responsibility rests with the Trust but the Health Authority has not met its responsibility to ensure that central policy was implemented. We were told that the Health Authority had taken action in 1994 to attempt to ensure the implementation of the CPA and we have seen documents referring to this.

11. Local Social Services staff attempted unsuccessfully to encourage the Trust to implement the CPA but were not in a position to force its implementation. They also provided such care as was required on the facts as known to them.

12. Although an impressive care package was set up for William Taylor on his discharge from hospital, had a formal CPA been in place and had it been correctly operated, William Taylor's carers would have become aware of Keith Taylor's second and third admissions to hospital and the fact that Keith Taylor had given up work to care for his father without assistance. Had they been aware of these facts and had they been properly discussed at a formal review of the case, more may well have been done to avert the tragedy.

13. Lack of liaison between the mental health teams looking after Keith and William Taylor was a factor which may have contributed to the tragedy (although we cannot conclude with certainty that liaison would have avoided it). This failure principally arose from the failure of the team caring for Keith Taylor to take the necessary steps to set up liaison. It is surprising that the mental health team caring for him on his second and third admissions took no steps to inform his father's social worker about his re-admission, even though she had taken the trouble to visit him on his first admission.

14. There was a lack of clarity on the part of some members of staff about questions of confidentiality and sharing of information between teams. We do not think this had any actual affect on what happened.

15. A formal CPA for either Keith or William Taylor would have involved a review of the care of both, in practice, and would have resulted in an after care co-ordinator being identified. His or her role would have involved reviewing Keith Taylor's progress and might well have identified any deterioration in his condition or home or family circumstances.

16. During his three admissions Keith Taylor's psychiatric problems were treated as being largely related to his epilepsy and, particularly on the second and third occasions, passive practice appears to have played a part in the decision making process. Although we accept that he made a quick recovery from his admitting symptoms we

do think that more should have been done in terms of diagnosis and inquiry about his mental condition, social circumstances and reasons for the deterioration of his mental condition.

17. We find it difficult to understand how, regardless of the failure to implement the CPA, there could be such limited attention to the life of the patient outside hospital and in particular to his own role as a carer. The failure to have regard to Keith Taylor's role as a carer was a major deficit in this case.

18. We heard a certain amount of evidence about management or audit tools. We were shown some documents of this type, for example the Exeter Ward Audit. We assume that one of the objects of the Trust management with regard to the wards where Keith and William Taylor were admitted was to ensure that their patients were not discharged without adequate care packages being in place for them. That adequate care packages were not in place when Keith Taylor was discharged for the second and third occasions is clear. That the CPA was not implemented in respect of any of the discharges of either patient is also clear. The conclusion that the management tools, whatever they were, had failed to identify this deficit is unavoidable. We are convinced that audit tools consisting of forms and records can never be sufficient in themselves to ensure that staff dealing with patients are carrying out the aims required of them, however well those tools are designed. Management can only be sure that staff are carrying out their objectives by actual examination of

what is happening in practice at the level of patient care and by actual physical inspection at the workplace.

19. It will be apparent that we have not reached specific conclusions about every one of the terms of reference of the inquiry but where no specific conclusion is reached we have felt it unnecessary to report the absence of conclusions. The terms of reference are widely drawn and are in a fairly standard form. No purpose would be served in setting out those that are in fact not relevant.

RECOMMENDATIONS

1. We recommend that the Health Authority and Social Services should jointly review to what extent the Trust has now implemented the CPA. We were told that it has now been fully implemented and we do not suggest that there is any reason to doubt that but we do think the Authority and Social Services should satisfy themselves of that fact. The NHSE CPA monitoring tool may be an appropriate method of examining this.

2. We recommend that the Trust should make it part of the task of each of its managers to identify whether its staff are carrying into actual effect its basic aims, like providing care in accordance with best practice. Wherever possible any monitoring carried out by managers should have, as a specific object, the identification of success or failure in such areas. Even though monitoring success or failure in these respects is not as easy as in some other aspects of the work of a hospital, because it is not as easily analysed in a statistical fashion, it must be recognised that they are the raison d'être of a hospital and must therefore be at the forefront of management's concerns.

3. We recommend that the Health Authority should set up a formal procedure by which Social Services, the Trust and the Health Authority can monitor the implementation of the Care Programme Approach and any other similar policies which concern all three agencies. Within that

procedure there should be a clearly defined process by which each agency can raise matters of concern about such implementation. This procedure should focus on examples of, and the need for, good practice.

4. We recommend that operational managers should periodically review multi-disciplinary working and circulate their reviews to managers responsible for the other disciplines within the team inviting their comments with a view to sustaining the involvement of those other groups.

5. We recommend that the Trust should carry out a review of current practice for aftercare planning, to take account of patients' carers and patients as carers with a view to giving more weight to their needs in those contexts. The review could form part of the planning for the implementation of the Carers (Recognition and Services) Act 1995 and would then involve Social Services.

6. We recommend that a system should be established within the Trust whereby all cases subject to CPA should be raised specifically at a ward round or other multi-disciplinary meeting before the patient's discharge and thereafter at suitable intervals (which should be fixed before the patient is discharged) for so long as the patient is subject to the CPA.

7. We recommend that nursing keyworkers should never be appointed from amongst staff who will be absent for any significant part of a patient's stay in hospital and that

the appointed keyworker should always be someone who will be on duty for, say, a full shift within the first 24 hours after the patient's admission. We further recommend that the Authority should include this or a similar requirement in its commissioning agreements.

8. We recommend that risk assessment should be specifically mentioned in any forms used as CPA documentation and that the risk assessment should be recorded there.

9. We recommend that if there are any areas of doubt about confidentiality between separate teams looking after patients who are related or one of whom depends upon the other as carer, those doubts should be clarified by the Trust. The Trust and the Authority should carry out a brief exercise to identify any such areas of doubt. Guidance should, in due course, be given to members of staff affected.

10. We recommend that the Trust management should carry out a review of Exeter Ward to identify any areas where the interactions of staff from different disciplines can be improved and what steps need to be taken to improve those interactions.

11. We recommend that the Trust management should consider whether the location of members of the community mental health team has any adverse consequences for teamwork and generally how teamwork can be improved between the community mental health team and the staff in the ward.