REPORT OF THE

INDEPENDENT INQUIRY

INTO THE CARE AND

TREATMENT OF

PATIENT T

A Report commissioned by

County Durham Health Authority

November 1999

CONTENTS

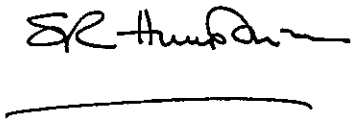
PREFACE

A panel consisting of the persons listed below was established by the County Durham Health Authority in April 1998 to undertake an inquiry into the care and treatment of Patient T.

Mrs Anne Galbraith LL.B. Chairman	Formerly Senior Lecturer in Law in the University of Northumbria and Chairman of the RVI & Associated Hospitals NHS Trust
Dr Stephen R Humphries	Consultant in Adult Psychiatry, St Luke's Hospital, Tees and North East Yorkshire NHS Trust, Middlesbrough
Mr Michael J Shewan	Assistant Chief Executive Wakefield & Pontefract Community Health NHS Trust, Wakefield
Ms Carole Southall	Team Manager (Mental Health), Sunderland Social Services Department Sunderland

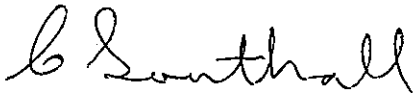
We now present our report, having had regard to the terms of reference set down for us by the Authority, and having adopted the procedure set out in Appendix A.

Anne Galbraith



Dr Stephen Humphries

Michael Shewan



Carole Southall

CHAPTER ONE

BACKGROUND TO THE INQUIRY

Introduction

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

1.2 Inevitably, such inquiries can only commence once all criminal proceedings have been completed. In the case of Patient T, there was a first trial in January 1998, followed by an appeal where a re-trial was ordered. This second trial took place in December 1998, and Patient T pleaded guilty to manslaughter. She was put on probation for two years. Once the second trial was completed, it was possible for our inquiry panel to begin their work.

1.3 The inquiry panel met on a number of occasions, to determine its method of working, to decide which records, documents and publications it required, to set in train the obtaining of necessary consents for the release of records and documents, to establish who should be approached for written statements, and to determine which witnesses should be called to the oral hearings. At each stage, as information became available, this assisted the panel to decide what further material was required. A firm timetable was established at the outset, in order to minimise delays. Five full days were set aside for oral hearings.

1.4 The panel was greatly assisted by sight of an earlier report commissioned by the County Durham Health Authority into the care and treatment of Adrian Jones and Douglas Heathwaite. This report contained useful elements of best practice in the conduct of such inquiries, having drawn extensively from earlier similar inquiry reports, and having taken cognisance of the judgement in Crampton and others v Secretary of State for Health (the Allitt case), which expounded some important principles to be borne in mind in such proceedings.

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

Terms of Reference for the Inquiry

1.6 The terms of reference were drafted by County Durham Health Authority, and established by a decision of their Management Team on 19 May 1998. They are appended in full at Appendix B at the end of this report.

Obtaining Records and Documents

1.7 The first task was to obtain consent from Patient T for the disclosure of her records, which she willingly gave. A transcript of the first trial was obtained, and enquiries were begun to establish whether any social services records were in existence. Patient T had received treatment in another part of the country as well as in County Durham, so further enquiries were set in train to make contact with appropriate authorities there.

1.8 At an early meeting of the panel, a preliminary list of background documents and papers was compiled, which were regarded as essential preparation for the inquiry. These documents are listed in a bibliography at Appendix C. These included major strategy documents from the Department of Health, as well as local operational policies and procedures. This compilation of documents was a significant task of great importance to the ultimate quality of the report. It was meticulously undertaken by David Baggott, Secretary to County Durham Health Authority, with able assistance from Christine Williamson. We are grateful to them both.

Witnesses and Written Statements

1.9 The panel drew up a list of people whom they believed may have useful information to offer the inquiry. Letters were written to 39 people, inviting them to make a written statement about their involvement with the care of Patient T. A specimen letter is included at Appendix D. It was the panel's wish that some appropriate guidance be given in the letters to focus the minds of their recipients about the kind of information which could prove of value to the inquiry. In consequence the text of each letter was individual to its recipient. A significant amount of useful additional material came forward as a result of these approaches.

Preliminary meetings with key witnesses

1.10 The panel recognised that the inquiry would be stressful for the family of the deceased, A. It was therefore regarded as appropriate to arrange a visit by the Chairman of the panel to see members of the family, in advance of the oral hearings, to further explain the terms of reference, and to answer any queries they may have about the process.

1.11 It was also decided that the Chairman should meet with Patient T in advance of the oral hearings, to offer similar explanations to her.

Oral Hearings

1.12 Once the written statements were available, the panel members were then able to judge who they wished to have the opportunity to meet at an oral hearing. It was also decided that it would be helpful to see people in an appropriate order although it was recognised that the dates offered might not always be convenient. In the event, all those interviewed were extremely accommodating in seeking to adhere to the programme we suggested.

1.13 The letters inviting written statements had alerted witnesses to the areas of interest which the panel were likely to pursue. The later letter inviting witnesses to attend the oral hearing laid out many of the key points which they would need to know in advance of the hearing. This is reproduced at Appendix E. As the oral hearings progressed, it was possible to give future witnesses an advance indication of more detailed concerns which were likely to be explored by the panel.

1.14 All witnesses were greeted informally by the Chairman in advance of their session. Once introductions of the panel had been effected, the Chairman made the same opening remarks to all who attended, covering the format of the interview, the making of a recording for the purpose of creating transcripts of the interview, the opportunity which would be afforded to correct the draft transcript, the order in which the panel would ask questions, how the draft report would be prepared, and the opportunity which would be afforded for further comment and response at draft stage to anyone who may be the subject of criticism in the report.

1.15 All the witnesses were asked at the outset to affirm that their statements would be true. A small proportion were accompanied at the hearings. There was always an opportunity afforded for witnesses to make any points which they considered important which had not been covered by the questions asked. A number of those invited declined to attend, on grounds of retirement or moves out of the area. In consequence, the panel met only one member of the executive team of South Durham NHS Trust, the successor to South West Durham Mental Health NHS Trust. Once it was clear who was able and willing to attend, the panel reconsidered the list of those invited, to ensure that all elements of the terms of reference could be adequately assessed.

The Report

1.16 At the close of the oral hearings, the panel took the opportunity to formulate their thinking about the key issues which had been raised in the written statements and during the oral hearings. Working drafts of the report were then prepared by the Chairman with appropriate contributions from the specialist members of the panel. After re-working, a complete draft was available for discussion at a meeting of the full panel, at which decisions were taken about those parts of the report which needed to be circulated in draft form. Once responses to these parts of the draft were received, the panel gave further consideration to the final drafting of the report.

Acknowledgements

1.17 The panel wishes to record its thanks to David Baggott, Christine Williamson, and other supporting staff of County Durham Health Authority who have given help and assistance when required by the panel, whilst carefully observing a proper distance in recognition of the independence of the Inquiry.

1.18 We are also grateful to staff from Harphams for the discreet way in which they worked to make the recordings and transcripts of our oral hearings.

CHAPTER TWO

THE INCIDENT AND THE OUTCOME

2.1 On 5 May 1997 in the evening, Patient T fatally stabbed A with a kitchen knife after a domestic dispute. During that day, Patient T and A had been drinking together in public houses. An argument developed between Patient T and A about Patient T's involvement with her family. Patient T went to the home of her daughters, and returned to her own home about half an hour later. A further argument developed, during which there was some physical violence between Patient T and A. Patient T had made her way to the kitchen, and was followed by A. Patient T picked up a vegetable knife, and as A approached, Patient T stabbed A. Patient T went immediately to a neighbour to summon help. An ambulance was summoned, but when it arrived, the ambulance staff could discern no vital signs.

2.2 On 7 May 1997 Patient T was charged with the murder of A. The trial took place at Teesside Crown Court in January 1998. Patient T was found guilty of murder and sentenced to life imprisonment. An appeal was lodged, which resulted in her conviction being quashed by the Court of Appeal, who ordered a re-trial. At the second trial, Patient T pleaded guilty to an offence of manslaughter, on the basis of no intent and was sentenced to two years Probation.

CHAPTER THREE

THE CARE OF PATIENT T

Introduction

3.1 Patient T was born in 1950 and was one of a family of seven children. Her father died when she was aged 13. Many of her childhood memories are connected with violence in her home. She left school at the age of 15 with no qualifications.

3.2 Her first marriage took place when she was aged 18. The marriage broke up after three years, when Patient T was expecting her first child. She went to live with a former boyfriend. Her first daughter was born soon after, and she subsequently bore a daughter to her boyfriend. When this relationship broke up, she left with her elder daughter, but the younger daughter stayed behind with her father.

3.3 Patient T formed a new relationship with a man who subsequently became her second husband. This marriage lasted for about ten years. During this time, Patient T bore three more daughters. However, the marriage broke down because of violence, and there was a divorce in 1987. Patient T subsequently returned to live with her earlier partner, the father of her second child, as this gave her access to her daughter. Some time later, she left him because of problems between him and her daughters.

3.4 She then met and married her third husband in 1991. For a period they moved to live elsewhere in the country. Their relationship was violent, and ultimately she left him and went to a women's refuge. She was then able to return to the North East, first of all in a women's refuge, but she then got a home of her own.

3.5 She then formed a new relationship with the deceased, A, who moved in to live with her in 1995. Their relationship was also a violent one, due in part to the conflicts of loyalty which Patient T felt to her daughters, her brother who lived with her, and her new partner.

3.6 The history of her relationships is regarded as significant when examining her medical care. In the following analysis of her care, particular emphasis is placed on her involvement with mental health services, although mention is made at some stages of physical problems she was encountering.

The medical care

3.7 From the clinical notes available, the first recorded involvement of Patient T with mental health services is in December 1985, when she was referred to Dr Y at Bishop Auckland General Hospital, for an out-patient appointment. This referral was made by a consultant physician in the Department of Medicine of the General Hospital, Bishop Auckland, after treating Patient T as an in-patient in November 1985, following her admission after taking an overdose of Fesovit and Penicillin V tablets.

3.8 Although this is the first recorded occasion of Patient T being referred to the mental health services, there is evidence in her clinical notes that she had consulted her GP as early as 1971 about depression, when she had been prescribed Valium and Impramine. Again, in 1977, she is recorded as suffering from anxiety state, and there are further entries relating to depression in 1980 and 1982. Comments in the notes suggest that these consultations linked her state of health to on-going family problems, noting for example that she had been beaten up by her husband in 1980.

3.9 In a report prepared by a Consultant Forensic Psychiatrist, in connection with her appeal against conviction, Patient T did indicate that she had taken a number of overdoses of drugs during the 1970's during her second marriage. She did not appear to have sought medical attention on these occasions.

3.10 Following her referral to Dr Y at his out-patient clinic at Bishop Auckland General Hospital, she was seen on 6 December 1985, when a full history was taken. This recorded that her husband had hit her in the past, and came in drunk. It was decided that she should attend the day hospital, and the hospital social worker should be asked to become involved. There is nothing in the notes to indicate that any referral to social services ever took place. However, on 19 December 1985, Patient T took another overdose, of Penicillin, and was admitted to Winterton Hospital, where she stayed as an in-patient until 16 January 1986. The Senior House Officer to Dr Y made an outpatient appointment for her. Appointments were made for her to attend Dr Y's out-patient clinic at Bishop Auckland. There is evidence that she did not attend on 21 February, 14 March and 11 April 1986. Although there is no reference in her clinical notes, it is assumed that she was discharged after her failure to attend.

3.11 Patient T's next recorded contact with mental health services was in March 1992, when she saw her GP, Dr M, who re-referred her to Dr Y as an out-patient at the Lady Eden Day Unit in Bishop Auckland. In his referral letter, Dr M indicated that the patient had an extremely complex past social history, having had several husbands, all of whom would appear to have been violent towards her. He also noted that she had been prescribed various anti-depressants by previous GPs. She was seen on 1 May 1992 by Dr L, an Associate Specialist in Psychiatry, who made extensive reference in his notes to Patient T's problems with relationships with her daughters, as well as her

husband. He referred to her suicidal ideation, and commented that she drank only socially. Dr L thought she would benefit from referral for further counselling and support at Lady Eden Day Unit, where she could attend twice a week. He did not prescribe medication at that stage.

3.12 Patient T attended the Unit on six occasions during July 1992, when she saw either Dr G or Dr B, both of whom were Clinical Assistants. She cancelled an appointment on 4 August 1992, and did not attend on 7 August 1992. The treatment plan is clearly set out in the notes for the visit of 14 July, that Patient T should attend the Unit on two days each week, that an anti-depressant, Amitriptyline 50 mgs, would be prescribed, and routine blood tests and chest x-rays would be undertaken, as there was a suspicion that she was anaemic.

3.13 There is evidence in the clinical notes that Patient T's treatment and progress were discussed at a multi-disciplinary team meeting on 19 August 1992, and that she had attended the Unit on a number of occasions during that month. Many of the discussions recorded in the notes relate to Patient T's relationship with her daughters and her husband. There then follows a significant number of appointments noted where Patient T did not attend. There is comment in the notes that she may have accompanied her husband to another part of the country. By 30 September 1992, the notes suggest that she should be discharged if she does not attend for her next appointment. However, Patient T did attend on 13 October 1992, when it is clear that she had left her husband and returned to County Durham, and on that occasion she was prescribed Trazodone, an anti-depressant. She appears to have informed the specialist that she was being abused by her husband, and seems to have indicated that he was a cause of her non-attendance. It was noted that she should continue to attend twice a week, and that she was also awaiting an appointment to see a specialist in connection with gynaecological problems.

3.14 This visit on 13 October 1992 was then followed by a significant number of appointments where Patient T did not attend. Her case was discussed by Dr G with Dr Y on 6 November 1992, and a decision was taken to discharge her from the Lady Eden Day Unit. The letter to her GP, Dr M, from Dr G indicates that the Lady Eden Day Unit were not sure of the whereabouts of Patient T, but states, "If the GP is still in contact with her, and feels she needs to be seen again, then an appointment should be arranged with Dr Y".

3.15 Over the period between July and November 1992, there are also recorded eleven attendances by Patient T at her GP's surgery. Some of the visits related to prescriptions for Trazodone, and some related to an infected cyst for which she received treatment.

3.16 On 19 January 1993, Patient T had treatment at Bishop Auckland General Hospital as a day case patient for her gynaecological problems. On 28 January 1993, she was admitted to Ward 11 via Accident and Emergency following an overdose, when she had taken seven or eight Co-codamol tablets. She was seen on the ward by the duty Consultant Psychiatrist, the Consultant

in Adolescent Psychiatry, who was of the view that she was not suffering from any major psychiatric illness. His letter to the referring physician from Ward 11, makes clear that the overdose was due to problems which were partly marital and partly related to her family. She was discharged on 30 January 1993, and contacted her GP, Dr M, on 2 February 1993. He sought an urgent review appointment with Dr Y.

3.17 Patient T was seen by Dr Y on 23 February and 9 March 1993. Both visits were followed by letters to the GP, Dr M. Both letters demonstrate that Dr Y was well aware of Patient T's family circumstances and problems, and that she was likely to require support from social services in relation to housing. There is no record of any referral to social services. Dr Y discharged her on 9 March 1993.

3.18 From 27 May 1993, Patient T was registered with a new GP, in another part of the country. On 26 October 1993, his notes indicate that he referred Patient T to a Community Psychiatric Work Team, because of a past history of depression and because she was currently not coping. He noted that she was a vulnerable woman who had little social support. She was seen and assessed by the Senior Occupational Therapist from the team on 10 December 1993, and the outcome of that assessment was reported to the GP on 16 December 1993. The assessment is thorough and well reported, and indicated that Patient T was felt to be quite vulnerable, because she had encountered a number of recent losses over the previous few months, her previous coping mechanisms in times of stress had not always proved to be adequate, and she had a lack of family support where she was living. She had been advised to maintain contact with her GP over the Christmas period, and that she would be contacted with an appointment in the New Year. A Community Psychiatric Nurse (CPN) was appointed to be her key worker and arranged an appointment with Patient T for 4 February 1994.

3.19 There are extensive and thorough notes made by the CPN of her various contacts with Patient T during the period between February and July 1994, at which time Patient T returned to the North East. The CPN was sufficiently concerned by her presentation and suicidal ideation on 7 March 1994 that she spoke with Patient T's GP to secure his agreement for a psychiatric out-patient appointment to be sought. This took place on 5 April 1994, when she was seen by Dr N, a psychiatric Registrar, who wrote a comprehensive report to the GP. The Registrar also proposed to commence a course of Paroxitene 20 mg. Patient T was seen again by the Registrar on 3 May 1994, when the medication was continued. The Registrar also wrote a letter of support to the Director of Housing.

3.20 The CPN continued to see Patient T regularly every three or four weeks during the first half of 1994. Especially during the early stages of these meetings, the notes make clear that Patient T was being supported by the CPN in terms of housing needs and with arrangements for out-patient referral. At this stage, Patient T was living with a friend who seemed keen for her to leave as soon as possible. Then Patient T went to live in a women's aid refuge following a

violent conflict with her husband. She cancelled an appointment on 14 June 1994 with the CPN, who then learnt of her arrival in the women's aid refuge from a keyworker in the refuge. Patient T also failed to attend an outpatient appointment with Dr N on 12 July 1994. The CPN put in hand arrangements for Patient T to be supported by the local Community Mental Health Team and informed the relevant Consultant Psychiatrist and Patient T's GP. She also discovered that Patient T planned to go to a women's refuge in the North East, although Patient T was rather vague about her plans. The CPN provided her with relevant names and telephone numbers of people in the area in which she was living so that once Patient T had made contact with a GP on her return to County Durham, the GP would have the necessary contacts to request any further information needed.

3.21 On her return to the North East, Patient T registered with Dr J, GP, on 18 July 1994. He referred her to the Mental Health Team at the Lady Eden Day Unit on 23 August 1994. The reasons for this referral were stated to be that Patient T was a new patient who appeared to be a chronic depressive. He was aware that she had attended the Lady Eden Day Unit in the past, and, given her tearful state and history of overdoses, he believed she would benefit from continuing support.

3.22 Patient T was assessed by a CPN based at Lady Eden Day Unit, on 2 September 1994. The record of that assessment indicates that problems had been identified with the physical aggression of her husbands, rent arrears, and the desire for a home of her own to get her out of the refuge. The record also indicates that it was known that Patient T had previously been a day patient at the Lady Eden Day Unit, and that she had been seen by Dr Y and Dr G. The records also show that it was known that Patient T had a history of depression, and had made several earlier suicide attempts. The short term goals listed for work with Patient T were to establish a relationship with her, to talk to the social worker with regard to advice on housing and benefits and to help Patient T manage her anxiety levels more appropriately.

3.23 The CPN became the key worker providing care for Patient T. She wrote to the GP, Dr J, on 12 September 1994, informing him that Patient T was agreeable to counselling and to improving her relationship skills. That letter also indicates that Patient T had been referred to a Social Worker for help with housing and benefit difficulties.

3.24 At the stage when Patient T was assessed, it is likely that the Lady Eden Day Unit was working to the Interim Operational Policy for Psychiatric Nurses, which had come into effect in 1991. A new policy was adopted for the Unit with effect from November 1994. In the 1991 policy, the only mention of Care Programme Approach is at the end of a list of details of services provided, where the policy states "Involvement in Care Management, CPA and Section 117". Although differently set out in the 1994 policy, the wording about CPA is identical. In the 1994 policy, the role of the allocated worker is said to include "Reviewing and evaluating cases on a regular basis. This

includes informal and formal discussion with other Team members and professional supervision".

3.25 A revised supervision policy for the Lady Eden Day Unit, dated 1996, states that "Every client must at some stage be discussed". In relation to the documentation about supervision, it states "Supervision sessions to be entered into relevant diary. This will only register that supervision has taken place. An entry should be recorded in patients' notes detailing any areas of concern and action decided upon. Each nurse to have a personal supervision file and a note to be made of the content of supervision, development needs and any issues raised". In the clinical notes relating to Patient T which were available to the panel there are no entries detailing areas of concern.

3.26 Patient T was registered on minimal CPA on 20 October 1995, but there is no record of this or the rationale for it in any of the clinical notes.

3.27 Over the period between September 1994 and May 1997, Patient T was mainly in the care of the CPN. They met regularly at the Lady Eden Day Unit, usually twice a month. At first, the notes of the meetings record problems with housing and money. Then, at a meeting in November 1994, there is a record of Patient T being allocated a new house. The very brief case notes go on through November and December 1994 charting how well Patient T was coping with the DSS, and getting her new home sorted out. The notes are generally positive about her having "no problems at present". After the start of the New Year, the picture created by the brief case notes continues to be one of money problems and occasional disputes with ex husbands or her daughters or her current boyfriend, together with comment about how Patient T might cope with these situations. At one stage, on 3 March 1995, she was referred to the physiotherapist for relaxation therapy. In that referral letter, it was made clear that Patient T "still finds it difficult to unwind and relax". There are occasional examples of Patient T failing to attend for her appointments at Lady Eden Day Unit.

3.28 During the period September 1994 to May 1995, the Social Worker was working with Patient T. The initial referral was made on 9 September 1994 by the CPN. The presenting problem was stated to be "Housing situation, practical and emotional support". This was the stage when Patient T was living in the women's refuge in Bishop Auckland, and the notes state that she had few clothes, as her husband had burnt them when she was living elsewhere in the country. There are detailed notes in the file indicating the steps which the Social Worker took to help with housing, but there were problems caused by earlier arrears still owing, and the low rating she was accorded on the housing list. The Social Worker had made known to the staff of the Housing Department the state of Patient T's mental health, and it was agreed to put the matter to the Director of Housing. Over the period up to May 1995 when the Social Worker discharged Patient T, notes and letters on the file indicate active involvement in Patient T's housing problems, her benefit entitlements, claims to social services for grants for clothing, decorating materials and furniture.

3.29 The Social Worker was regularly in contact with Patient T,at some stages on an almost daily basis, seeing her either at her office or at the women's refuge or accompanying her to purchase furnishings. There is evidence in the notes of the Social Worker being in contact with her supervisor, and on two dates it is noted that supervision meetings had taken place, when Patient T's situation was discussed. When the Social Worker discharged Patient T on 17 May 1995, she wrote to the CPN, indicating that she felt that in view of the support Patient T had from the Lady Eden Day Unit, there was no longer a need for social services input, but making clear that if Patient T required social work support in the future, there should be no hesitation in re-referring her. During a substantial part of the period when social services was involved with Patient T, the Social Worker was based in the Lady Eden Day Unit, but in March 1996 the social workers were relocated away from the Unit.

3.30 In July 1995, Patient T informed her CPN that she had become engaged to A, and that things presently were very stable and her family were very supportive. However, by September it was clear that Patient T was again reporting difficult relationships with her daughters, and, moreover, was in some distress with joint pains. She did not attend the Lady Eden Day Unit between 9 October and 29 November, but her GP records show that she saw him five times over that period, both in respect of prescriptions for her depression (Clomipramine formerly 10mg increased to 25 mg in November) and for her joint pains, for which the GP arranged some acupuncture.

3.31 Patient T attended an appointment with her CPN on 29 November 1995 at which time she was still experiencing problems with her daughters. When she next came to the unit on 13 December 1995, she reported that she had taken a number of sleeping pills the previous weekend, after being out drinking. She had done this because she felt that her daughters did not care for her and that this would make them more caring towards her. She was also concerned that she and her boy friend did not have time for themselves. The CPN recorded in her notes that she had discussed the suicide attempt, discussed any suicidal thoughts or intent, but none were present, discussed ways of coping with her daughters, encouraged her to discuss her problems with her boyfriend, advised her to get herself checked out with her GP, and arranged the next appointment. This appeared to be due to take place on 4 January 1996, but Patient T did not attend. She did however attend at her GP's on 5 January 1996, when his notes record, "States that her boyfriend assaulted her last night and police were called. Says he put his hands around her neck and shook her. No visible bruising this morning. Quite tearful. Going to solicitor to obtain an injunction".

3.32 When Patient T next saw her CPN, on 12 January 1996, it is recorded that she told her that her partner had hit her. On 1 February it is recorded that Patient T had put her partner out of the home. Patient T failed to attend on 15 February 1996. The CPN then went on annual leave, but arranged to see her on 17 April 1996. On that date, her low mood is recorded as being due to issues with her daughters. The notes do not specify what these issues

involved, and there is no record of the CPN having any contact with any of Patient T's family. Between 15 May and 2 October 1996 Patient T was seen on a number of occasions by a support worker, but she also missed a number of appointments. There is nothing in the notes to indicate why the support worker took over at this time, nor what was expected of her.

3.33 Once the CPN resumed her work with Patient T, she next saw her on two occasions in October 1996. At one of these meetings, the notes record that Patient T is presently living apart from A, though he is incorrectly named. Meetings between Patient T and the CPN then took place in November 1996, and in January, February, and March 1997, although there were instances of non-attendance in December 1996, and in February and April 1997. By 1997, new documentation was in use in the Lady Eden Day Unit, containing a box headed "Aim of the visit". For the three visits in 1997, these are all filled in to read "To allow Patient T to express her thoughts and feelings". In the January visit, the notes again mistakenly refer twice to Patient T's partner with an incorrect name.

3.34 Patient T appears to have changed to a new GP sometime after her last recorded visit to Dr J on 14 August 1996. However, up to that time, apart from the original letter from the CPN to Dr J, dated 12 September 1994, there is nothing else in the GP records showing any further contact by the CPN with regard to Patient T's care or her progress. There is nothing recorded in the notes which would indicate that any kind of review of Patient T's case was held.

3.35 The last recorded contact with the CPN was on 20 March 1997. The final entry in Patient T's notes at the Lady Eden Day Unit is dated 6 May 1997, indicating that a telephone call had been received from the Police Surgeon, informing the Unit that Patient T had been arrested for murdering her partner. The incident had occurred the previous evening, 5 May 1997.

CHAPTER FOUR

ISSUES AND CONCLUSIONS ON STRATEGIC AND ORGANISATION MATTERS

Introduction

4.1 In the evidence gathered by the panel, both written and oral, a number of issues emerged time and time again. It is clear that most of these had some impact on the method of providing care and treatment for Patient T, and the quality of that care. The panel acknowledges that it has needed to draw its conclusions on the available evidence, but wishes to note that in some instances the frame of reference was limited by the range of persons prepared to attend the oral hearings or to submit written submissions.

Strategic and operational planning in the provision and delivery of mental health services

4.2 The relevant period for the purposes of this report was 1985 to 1997, during which Patient T received care and treatment from mental health services. This was a time of intense national activity in terms of developing mental health strategy and issuing guidance to the service. Many of the discussion documents, consultation papers, White Papers, Handbooks and Guidance have formed the background to informing the panel about what users of services could reasonably expect them to deliver.

4.3 A key element of national policy was the intention that local integrated and community based mental health services should be created in each district, as the retraction of the large scale mental institutions such as Winterton Hospital took place. Development of local services inevitably depended on the formulation of effective strategies and policies by Health Authorities, in partnership with Social Services and in consultation with local providers. For a number of reasons (variously connected with entrenched attitudes of organisations, lack of cooperation from key groups of staff, innate conservatism of the workforce, a certain parochialism within the area, the culture and history of organisations, fears about unemployment, fragmentation of health service management, local affection for Winterton Hospital as a community resource) it appears that a visionary plan showing how services could be developed, and which could be presented to the staff and the public, was never developed. The panel heard evidence from a number of sources that emphasis appeared to be on "the closure of Winterton Hospital" rather than "the re-provision of Winterton Hospital services and the creation of a community based infrastructure".

4.4 During the period under review, it was also a national imperative that the care programme approach should be well integrated with care management. This

integration required that health services and social services should respectively have fully developed their own aspect of service, before they could successfully expect to integrate the processes. At one stage, it is clear that some good work had taken place in the south west of County Durham between the health service bodies and the Social Services Department with regard to policy integration. The panel believes that this was not well translated into practice. There appeared to be a tendency for each group of staff to retreat into what they knew well and felt familiar with in terms of clinical practice.

4.5 In terms of the strategic development of the service, the picture painted for the panel from a number of sources was of a situation where innovative development of the mental health services was in suspension for a number of years. Services on the ground continued to be provided but there was no real collaborative vision of what the service should be. Social Services had established certain priority groups of service users (the severe and enduring mentally ill) in line with national guidance. However, health workers' case loads continued to consist of patients with less severe illnesses, and as a result of poor joint planning between health and social services, and poor communications at fieldwork level, there was a feeling among health workers that they could not readily access social services support for patients with lower levels of need.

4.6 Throughout our appraisal of the impact of national strategy and the subsequent implementation of policies at a local level, we have attempted to judge whether any aspects of the service were jeopardised due to resource constraints. Although some emphasis was placed on the difficulty of achieving PFI solutions to keep the Winterton Hospital retraction programme to target, the panel has not otherwise found significant issues with regard to resources. When we enquired about availability of training within the Trust, we were assured that suitable training resources had always been available. Similarly, the panel was reassured that resources had not been a constraining issue with County Durham Social Services. They had also not faced any kind of recruitment problem.

4.7 Many of the key themes from this overview of the strategic position are picked up and examined further under the subsequent headings.

Organisational instability

4.8 Over the period 1985 to 1997, the panel is struck by the high level of organisational instability. There is no doubt in our minds that this had a detrimental impact on the ability of staff on the ground to deliver services effectively. This created a sense of diffusion and confusion, decreasing morale and sapping people's initiative. The view expressed at the inquiry was that the changes were so frequent that people lost a sense of direction and vision about where they were going, which had a pervasive effect upon the

development of services. Simple charts showing the organisational structure of Trusts and Health Authorities are included at Appendix F.

4.9 With the advent of Trusts, the South West Durham Mental Health NHS Trust was established in 1993. In 1996 it merged with South Durham Health Care NHS Trust to form the South Durham NHS Trust. Then, in 1998, the mental health service was again restructured and became part of Durham County Priority Services NHS Trust, subsequently renamed in 1999 as County Durham and Darlington Priority Services NHS Trust.

4.10 This move towards a larger Trust spanning the County is significant, and welcomed by the panel, in terms of:

- creating an organisation with a single focus on mental health,
- reducing the number of organisations needing to liaise and collaborate,
- creating a mass of activity sufficiently large to be viable,
- enabling a better environment to assist in the recruitment of consultant psychiatrists,
- avoiding excessive use of locum cover,
- heralding a period of greater stability.

Changes within Health Authorities

4.11 Set against this merger activity within Trusts, the Health Authorities were re-configuring in the County. In 1990 the residents were served by six Health Authorities. By 1996, a single Health Authority was responsible for commissioning health services for the residents of the County. It seemed to the panel that their agenda was heavily dominated by supporting the roll-out of GP fundholding, giving a lead on the merger of Trusts, and moving forward with their own restructuring. Insofar as mental health services were concerned, the agenda appeared to be dominated by the focus on the requirement to close Winterton Hospital, especially in view of the financial burden which the delayed programme of closure might impose on the Health Authority.

4.12 One element of the responsibility of the Health Authorities was to commission mental health services and to monitor the quality of what was being delivered. It appeared to the panel that at times, the emphasis was more towards monitoring quality. Nevertheless, there was sufficient interest in the quality of the service to cause the Health Authority to consider seeking an alternative provider of services in the south west part of the County. Some elements of this exercise were geared to developing ideas of best practice, and seeking to involve users and carers.

4.13 There is no doubt that the exercise seemed appropriate at that time in a service environment where the culture was heavily influenced by ideas of market competition. However, it is clear that if the Health Authority had gone further down this road, it would have impacted seriously on the potential viability of

the Trust. Although the exercise in itself was not successful, it was probably the key to opening up the route to the first Trust merger.

Changes at Regional level

4.14 Not only was there organisational change at Health Authority and Trust level at this time. The Regional Authority (formerly Northern Regional Health Authority) merged in 1994 to become the Northern and Yorkshire Regional Health Authority. The organisation was considerably reduced in size as a forerunner to becoming a Regional Office of the NHS Executive in 1995.

Changes at GP level

4.15 GP fundholding had been introduced in 1991. One of the GP practices involved with the care of Patient T had become a fundholding practice. At this point, the practice will have contracted directly with the Trust for CPN services. It is difficult to assess the extent to which this impacted on the strategic development of services. The panel has no doubt that fundholding opened up the threat of greater fragmentation of services, which could make it more difficult to monitor quality.

4.16 A view was expressed to the panel that the impact of GP fundholding was negative, in the sense that it made it more difficult for the Trusts to target services, and there was perceived to be a drift away from looking after the mentally ill to looking after anyone who was distressed. This certainly resonates with the view of the panel that GPs were increasingly tending to use the CPN service to look after minor mental health and psycho-social problems within primary care. This in turn may have caused the Lady Eden Day Unit to lose focus as part of an integrated service in mental health care. It may also have impacted generally on medical oversight of patients on case loads.

4.17 The advent of GP fundholding may have had important repercussions in changing traditional relationships between GPs and consultants. It also created further volatility for service planning purposes, as fundholders now had some significant impact on purchasing decisions. Certainly, fundholders were beginning to offer additional services within their practices, including counselling.

Changes within Social Services

4.18 In Social Services, not only did they have to contend with the separation of assessment, commissioning and providing of services . In the early 1990's there had been severe cuts in local government expenditure. There was a local government review in 1997, and in that year, as a result of boundary changes, Darlington ceased to be within County Durham Social Services. The Social Services Department was attempting to liaise and collaborate with the

numerous constantly changing health organisations, and during the same period they were also seeking to implement the statutorily imposed care management process. The panel accepts that Social Services were keen to move towards a joint policy on issues such as risk assessment and management, and Section 117, but the lack of any effective joint working mechanisms prevented these developments.

Conclusions with regard to organisational instability

4.19 In the view of the panel, the result of so much change taking place was that many of the key relationships, so necessary to collaborative working, were underdeveloped. Many managers in the health service were reapplying for their jobs for the second and third time. Staff in the field working as CPNs had transferred from the more structured working environment of wards at Winterton Hospital. Some of them may not have been well suited to a more autonomous working routine, especially where supervision arrangements were not well developed.

4.20 In the view of the panel, important tasks such as drafting new proposals for CPA documentation appeared to be delegated to quite a devolved level in the Trust. It was difficult for the panel to understand how this work could ever inform the process of achieving greater uniformity and integration. At every Trust merger or reorganisation, the delivery of the community health service was subjected to a change of local management arrangements, even if these were only changes in the terminology being used to describe the roles.

4.21 At times, the panel is doubtful if some staff even knew who their current employer was. It cannot be over-emphasised how demoralising and destabilising the panel believes this organisational upheaval was in practice, particularly in relation to the health services. Almost all the health service employees who spoke to the panel made reference to the detrimental impact of these organisational changes. The panel accepts that their impact was significant in the delivery of the mental health service.

The Closure of Winterton Hospital

4.22 An extended process of retraction of the services provided by Winterton Hospital was begun by the Health Authority in 1992. Up to that time, the services provided there were held in good regard by the GPs interviewed by the panel, who recalled that they had good relationships with the consultant psychiatrists. Outpatient appointments did not appear to take too long and domiciliary consultations seemed to be readily available. They did not remember any problems with securing beds for emergency admissions.

4.23 From the evidence presented to the panel, it appears that the closure programme clearly occupied the attention and priority of managers in the service, both within the Trust, and at Health Authority level. The focus

appeared to be on buildings and obtaining capital funds, as the major policy objective of the Winterton Hospital closure still had to be delivered, despite the lack of availability of public capital via the Regional Office. This resulted in the need to access capital through the Private Finance Initiative route. In the view of the panel, these preoccupations resulted in lost opportunities to emulate best practice and to develop visionary thinking about future community based models of service.

4.24 The Health Authority at that time was not heavily engaged in the development of the thinking about models of service or service delivery on the ground. They did not appear to the panel to have the particular skills or any dedicated resource to put into mental health. They were however concerned that with the advent of GP fundholding, there was a distinct possibility of fragmentation of services. Fundholders could move elements of service around, resulting in a lack of coherence in the service. The Health Authority also had concerns about service quality and this did cause them to become engaged in the tendering exercise (referred to in paragraph 4.12) to find an alternative provider.

4.25 There was a view amongst a number of the people interviewed by the panel that there were poor levels of engagement and cooperation between the consultant body and managers in the Trust. In consequence, the consultants appeared to be poorly involved in the thinking and planning of new services. Some commentators have observed that they believed the consultants were conservative in their thinking, inward looking and reluctant to see changes in the mental health service.

4.26 At that time, there were national difficulties in recruitment , as psychiatry was a shortage specialty. In consequence it was difficult to recruit to some of the consultant posts in Durham. These difficulties in recruitment meant that there was regular use of locum consultant cover, which generated a lack of stability in the service, as the locums changed regularly. The panel considers that locums were also less likely to be committed to developing the thinking about innovative service developments.

4.27 Nursing staff from Winterton Hospital who had trained and served there for extensive periods were redeployed in the community as CPNs. They were transferring from a structured hierarchical environment where there were clear lines of accountability into an environment in which this was almost entirely lacking, and where they would have to work autonomously. Some of them benefitted from periods of secondment before choosing to work in the community. Various training courses were available but the initiative for selecting training courses appeared to be left to the individual staff member. It did not appear to be an essential requirement for transferring staff to complete the CPN training course, as senior managers in the Trust had concerns about the adequacy and value for money of the national formal training courses available at that time. The panel recognises that individuals showed a commitment to training, but its focus was not necessarily always fully relevant

to the area of their work. In some key developmental areas, such as supervision, there seemed to be a lack of training and support.

Interface between Health and Social Services at operational level

4.28 It was suggested to the panel that culturally there had been no history of joint working in Durham. The panel acknowledges that County Durham Social Services had faced difficulties in seeking to integrate with so many Health Authorities and Trusts. They made clear that they would have preferred to have uniform policies and protocols throughout the County. This was an issue which they sought to resolve from time to time. Not only were they themselves aware of it, but also it was regularly brought up as an issue after visits of the Mental Health Act Commission.

4.29 So far as the panel can judge from the evidence before it, the care management system of County Durham Social Services was a more developed and refined system than the CPA system, and it was well supported by IT systems. There was evidence of effective programmes of staff training and appropriate supervision and appraisal.

4.30 By contrast, the panel heard that the care programme approach in the Trust was not well received by staff, particularly consultants. The training was not well attended, and in an effort to make the system work, the panel is of the view that an over-centralised and disempowering system was adopted, which developed no sense of ownership or commitment among those using the system. The panel believes that a good CPA process should inform and support clinical practice, whilst not being too intrusive. Supervision arrangements at that time set standards for frequency, but not in respect of their content.

4.31 The organisational upheaval which has been commented on earlier in this report impacted adversely on day to day operation of the service. There was no common documentation or shared risk assessment protocol. The health services were operating a completely paper based system, whereas the social services had moved to an integrated IT system, the Social Services Information Database (SSID). The Durham Social Services Department had a central planning section, which was developing the care management processes. It also promoted joint training programmes on basic mental health foundation programmes, on-going refresher training for approved social workers, and training on matters such as the Code of Practice.

4.32 As Trusts were established in the early 1990's, there was a move towards the establishment of an integrated community mental health team in South West Durham. For a time, health and social services staff were based in the same building, the Lady Eden Day Unit, but they maintained separate management arrangements and separate referral procedures. While the social workers were physically based there, it was possible in practice for the CPNs to make direct referrals to them.

4.33 This arrangement lasted for about two years, then the Social Services staff were moved out. There were a number of reasons for the move, including the need to maintain appropriate supervisory and accountability arrangements, as well as ensuring that Social Services staff were adequately supported in all aspects of their role, including meeting their needs for information. The system of direct informal referral which had been operating within the Lady Eden Day Unit had resulted in social workers being unable to access historic information about the clients on their database.

4.34 For a variety of reasons, the Lady Eden Day Unit lost its consultant psychiatric input, as well as psychology and occupational therapy input, which impacted significantly on the effectiveness of the team. With the relocation of the social workers, the steps towards an integrated Community Mental Health Team faltered. What was left was a group of CPNs. In the view of the panel, the framework for a creative and effective team had become dispersed.

4.35 Some joint project work was undertaken between Social Services and the health service within the Community Mental Health teams towards a tentative integration of the care programme approach and care management. Later evaluation of this work tended to show that there was no true integration, rather that Social Services were merely supporting the care programme approach and not adopting care management. When the funding for this work ran out after three years, it was not continued.

4.36 A perceived difficulty of effective integration of Social Services and health services was that each service operated to a different set of priorities in mental health. The emphasis of Durham Social Services was firmly on the severe and enduring mentally ill. The panel were told that this could generate a response from CPNs and GPs that some cases were not suitable for referral to a social worker, that it was a waste of time to try, that their service was difficult to access, with customer service teams that it was difficult to get past. In practice, when the support of a social worker was needed for Patient T, a referral was made and accepted, and the panel has no criticism of the service which she received at that time.

Conclusions on interface between Health and Social Services

4.37 The panel considers that the necessary elements for effective joint working were largely absent in Durham during the period under review. The panel considers that there is a danger that if things get too difficult, each service will retreat into what it knows best. The panel believes that this is what happened over the period in question in this report.

4.38 The panel were however considerably heartened by evidence they heard indicating that a new spirit of collaboration has been established between the Local Authority, Health Authority and the recently established County Durham and Darlington Priority Services NHS Trust, the successor to South

Durham NHS Trust which itself succeeded South West Durham Mental Health NHS Trust. This new collaboration has resulted in a draft strategy for a Joint Approach to Mental Health, published in January 1999.

Management in the Trust

4.39 The panel were only able to meet with one former Senior Manager of the Trust. However, a considerable quantity of evidence was gathered, in terms of policies, reports and Board documents. A number of operational staff were interviewed. The panel regrets that a broader range of views was not available to them.

4.40 Overall, the panel gained an impression of a Trust which was not particularly progressive. It appeared to the panel that the arrangements established by the Board for professional nursing advice and operational management of the nursing staff created an over-diffuse structure for the effective maintenance of standards amongst the nursing staff. The panel was concerned that the nursing issues could be marginalised at Board level, which may have reflected in the levels of support given to staff who were relocating to work in the community.

4.41 When the Trust ordered an internal report into the care of Patient T following the incident, it is not clear to the panel how they heard about the incident, or when the inquiry was ordered. There appeared to be no system in the Trust for staff to report such incidents where the patient was an outpatient. Once the internal inquiry was set up, there appears to have been no date fixed for the production of its report.

4.42 The terms of reference set for the internal inquiry appear to the panel to be satisfactory. The panel sought information about the reasons for the protracted time lag before its production. The only explanation that has been put forward is that the report was sent back for redrafting on a number of occasions.

4.43 Much of the internal report is a historical account of Patient T's care. The recommendations and action plan were regarded by the panel as being rather perfunctory. In their view, the Board minutes of the meeting when the report was presented are minimal.

Operation of the Care Planning Approach Programme

4.44 The panel heard evidence and saw documents which indicated clearly that South West Durham Mental Health Trust was recognised as having a very good document setting out the joint policies and procedure for CPA. They had developed this document in a timely way. To that extent, therefore, they had the basic structure in place to enable the CPA programme to be implemented and to work very effectively.

4.45 The panel learnt that where a patient was registered on minimal CPA at that time, there would have been no standard forms to be completed. The expectation was that information would be kept in the clinical notes, and that a programme of random audit would determine whether the note-keeping was up to standard. It was recognised that this method could produce a result that staff implementing the policy would know that they had done the right things but had failed to make a note of them. The system in that sense could be criticized as lacking rigour, especially when reviews and investigations of the sort being undertaken by the panel were put in hand.

4.46 The panel also learnt that there was no standard risk assessment documentation at that time, and although it is clear that efforts had been made to develop such a tool, the work became a victim of the merger of Trusts. The panel was concerned that at several stages during the period under review, work with Patient T was hampered, or less effective than it should have been, because of poorly developed systems of risk assessment.

4.47 The system in use in the Trust in connection with CPA also lacked clarity about the process for designating patients as minimal CPA. Patient T was entered on the CPA register on 25 October 1995 as minimal CPA, but there is nothing in her medical records to support how this was determined.

4.48 Once Patient T was thus designated, the policy extant at that time provided that her case should be regularly reviewed and evaluated, including formal and informal discussion with other team members and professional supervision. The panel believes that it is likely that Patient T's case was discussed informally from time to time, but the panel has concerns about the system of supervision in use at that time, and also about the lack of regular multi-disciplinary reviews of her case.

4.49 So far as it is possible to judge, without any written records of the supervisions, these were used as opportunities to talk about clients with whom there were problems, and nothing more than a general run-down of other clients occurred. The panel believes that where cases were regarded as quiet or undemanding, it is unlikely that they received much attention in supervisions. The panel recognises that Patient T's case would be likely to be afforded low priority on any CPN's case load, and accepts that such prioritisation is even more likely where CPNs carry high case loads, as appeared to be the case at the Lady Eden Day Unit.

4.50 The supervision undertaken at that time was between the CPN and the locality manager, at some stages known as the team leader or team manager. Given that the post holder also had a clinical case load of about 45 clients, as well as responsibilities for operational management of the service in the locality, and responsibility for adherence to UKCC standards, the panel believes that the span of control of the locality manager was too great. In consequence, the clinical supervision appeared to be of a rather superficial nature, and tended to emphasize the problem cases. Although it was regarded as a compulsory feature of the organisation, it was not well structured. The Trust seemed at

that stage to place more emphasis on recording that supervision had taken place, rather than recording what had actually happened during the supervision.

4.51 The panel has learnt that the system of supervision is now more formalised. This is greatly to be welcomed, as it was inadequate at the time covered by this inquiry.

4.52 In terms of implementation of the CPA programme in practice, the panel heard evidence that certain professionals, namely the consultants, were not wholeheartedly behind the programme, and were reluctant participants in training. In some cases, they also influenced the speed of action by their willingness or otherwise to participate in reviews, especially where they expected these to be attached to ordinary clinical sessions. The panel believes that in an effort to provide a system which was not bureaucratic, the Trust had placed so many initiatives concerning CPA at a central administrative level that it resulted in a lack of ownership of the process by consultants, amongst others.

Record keeping, referral and discharge letters and inter-agency communication

4.53 The panel has seen GP records, acute hospital care records, acute and community mental health records, and Social Services records in relation to the care of Patient T. The panel has also reviewed within those records a number of referral documents and discharge letters.

4.54 For a period, Patient T received care in another part of the country. Generally, the panel was impressed by all the records and documents provided in relation to her care there by GPs, CPNs, social workers and the Consultant Psychiatrist and his team. Those records also show evidence of good liaison and open communication. The panel was particularly impressed by the care and commitment shown in the records of the CPN who had been Patient T's key worker, and the detailed quality of the information contained in letters from Dr N.

4.55 During the periods when Patient T was in the care of the mental health services in Bishop Auckland, the panel considers that the referrals of the GPs, Dr M and Dr J, were timely and appropriate. The information provided by them at referral was satisfactory.

4.56 The early records of Dr Y, Dr G and Dr B during 1992 are thorough, and the decision to discharge Patient T at that time, given the stage of development which the service had reached, was appropriate, especially in view of Patient T's record of non-attendance. Over this same period of treatment, the other records kept by the Lady Eden Day Unit are detailed, and contain evidence of multi disciplinary team reviews at regular intervals.

4.57 Once Patient T was back in the care of the Lady Eden Day Unit, from 1994 until the date of the incident, the panel finds that the records kept are superficial. There is little evidence in the records of alternative methods of psychological management being discussed, or of consideration being given to referrals to other disciplines. There are very limited accounts of appropriate liaison and communication with other professionals. For example, there are no letters to the GP, there are no notes of phone calls, and very limited notes about some key elements of Patient T's problems. There are errors of fact in the records.

4.58 The examination of the records maintained by the social worker involved with Patient T in Bishop Auckland are more detailed, and they indicate an active and thoughtful involvement with the client. The records also contain copy letters and notes of phone calls and meetings. The panel regarded these records as an effective summary of the work undertaken with the client, but they note the lack of reference to CPA status or any multi agency care plan.

4.59 As a general comment about record keeping, there were several examples in the records seen by the panel where the records were not properly dated or did not indicate who had made the relevant note.

CHAPTER FIVE

THE IMPACT ON THE DELIVERY OF CARE TO PATIENT T

Having considered a broad range of issues which emerged as significant during the inquiry, the panel then turned its attention to the impact of these issues on the delivery of care to Patient T. The panel has taken account of Patient T's limited understanding of the mental health services on offer, and, in consequence, her ability to form any considered view of what she needed. Not only did she have on-going relationship problems with her daughters and her husbands or partners, but also she had developing problems associated with her physical health which undoubtedly distressed her. Patient T had housing, financial and other social problems.

5.1 By the time Patient T was referred to the CPN service in August 1994, she had already had a number of earlier contacts with mental health services had already occurred. This information was contained in the referral document from her GP to the Lady Eden Day Unit, but it did not trigger anyone to seek to access any earlier records. The panel believes that it would have been sensible to have procured the earlier notes, and that failure to do so was a significant omission.

5.2 It was also clear from the Lady Eden Day Unit case notes that Patient T's family difficulties with her daughters and her partner were known to the Unit. The panel considers that it would have been helpful in devising and promoting a therapeutic programme of care for Patient T for her CPN to become acquainted with Patient T's home surroundings and with her family and partner. The panel is concerned therefore to find that this had not happened in this case. Moreover, a view was expressed to the panel that such involvement with family or partners was outwith the policy and practice of the Lady Eden Day Unit. This precluded any formation of a different perspective, whereby the panel believes that those working with Patient T would have been assisted in evaluating the seriousness or otherwise of her problems.

5.3 Throughout the period of Patient T's involvement with the Lady Eden Day Unit, it appeared to the panel that the work being undertaken with her was purely supportive and reactive, rather than creative and innovative. No-one appears to have thought through the complexities of the issues, or sought to involve other professionals as appropriate. There was no referral to a psychologist, nor to a consultant psychiatrist, for a review of her medical treatment. Patient T was not involved in dynamic group work to look at assertiveness. There were no attempts at family therapy. One of the CPNs working with Patient T had a self-expressed preference for counselling as an approach, but the panel noted that the GP had told them at interview that in his view this would not be an appropriate approach in Patient T's case. The panel heard that a CPN had sought to undertake some anxiety management work, but this was ineffective as Patient T found it difficult to understand. It also

heard that an offer was made to organise an appointment with a psychiatrist, but Patient T did not feel she needed this. The panel accepts that these steps were taken but could find no mention of them recorded in the notes.

5.4 Although staff at the Lady Eden Day Unit knew that Patient T had taken an overdose of drugs in December 1995, this did not result in any contact being made with her GP. This incident did not prompt any kind of review of her care, any further risk assessment or review of her CPA status, or any steps to seek the involvement of other professionals. It did not prompt any change in the routine of appointments being offered. In the view of the panel, these omissions were a lost opportunity to look more critically at the success or otherwise of the work which was being done with Patient T.

5.5 When Patient T reached times of crisis or inability to cope, this sometimes manifested itself in taking overdoses of medication. Over the years a number of those who have cared for her have noted that she has limited coping skills. Although the period of her care by the mental health services is quite extended, she was not always fully cooperative, in that there are many examples in her notes of her failing to attend appointments. The panel believes that this combination of factors should have precipitated more active review of her care at various times.

5.6 Generally, the panel is satisfied that when Patient T needed help from the mental health services, the referrals from primary care were made in a timely and appropriate way. It should be noted that on at least two occasions, when suggestions were made that social services input would be useful, these referrals were not made.

5.7 There was a point during the period under review when Patient T moved back to the north from elsewhere in the country. The panel has no criticism of the communications at that stage, particularly in the light of the somewhat vague plans which Patient T had formed at that time. However, once she was back in County Durham, communications between all the professionals and agencies involved could have been more structured.

5.8 When Patient T most needed a system of joint working to be effective, at the time when she returned to County Durham, she was living in the women's refuge and was severely lacking in clothing. The referral from the CPN to the Social Worker at that point worked very well in practice, despite the lack of a clear plan in the notes about joint management of her case. Over a period of time, Social Services dealt effectively with her problems and discharged her patient at an appropriate point. In the view of the panel, these joint working arrangements between Social Services and the health services subsequently changed for the worse. However, the panel considers that those later changes did not constitute a cause of any of the problems in this case.

5.9 During the extended period while Patient T was registered on minimal CPA, the notes make clear that there were times when she was observed to be much better and coping well. The panel is concerned that no proper reviews were

undertaken to consider her discharge. However, at times when it is clear from her notes that Patient T was not coping well, for example when she had taken overdoses of drugs, the panel regards the service offered to her as too reactive and passive. At points when it was clear that she was not coping well, the panel considers that opportunities were lost to undertake further risk assessment.

5.10 The panel believes that the treatment and care offered to Patient T was constrained by lack of knowledge and understanding about her home circumstances, and lack of contact with her family and partner. The panel accepts that there is a need to balance seeking information on these matters against the expressed preferences of the patient. However, the panel believes that in a more assertive service, and in the interests of a comprehensive assessment and full assessment of risk, there are occasions when the expressed preferences of a patient may need to be over-ridden.

5.11 The panel wishes to comment that they noted many examples of good practice both in County Durham and in the other part of the country where Patient T lived for a time. Some of these examples relate to the care of Patient T. However, the panel concludes that in her case, there were times when she received a mediocre level of care in County Durham, because of the many forces outlined above, the combination of which created an environment which began to militate against excellent care.

5.12 The panel also wishes to note that a significant number of the matters revealed in this report have already been addressed within the new Trust, or are matters covered by the new draft strategy for mental health in County Durham, published in January 1999.