Barking and Havering
Health Authority
and the
London Borough of
Havering Social Services Department

Independent Inquiry *into the* Care and Treatment *of a* mental health client

April 2001

Barking and Havering Health Authority/London
Borough of Havering Social Services Department

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF A MENTAL HEALTH CLIENT

Introduction

1. This Report has been prepared by the Independent Inquiry Panel commissioned by the Barking and Havering Health Authority and the London Borough of Havering Social Services pursuant to Health Service Guidelines HSG (94) 27, which require that an independent inquiry is held when a psychiatric patient commits homicide. The Panel consisted of representatives from Probation, Psychiatry, Social Work, Nursing and Management, details in Appendix 1, and their purpose was to review the care and treatment received by a mental health client ('the client'). Each Panel member has had previous experience in undertaking inquiries.

2. The purpose of any inquiry is to improve the future safety of patients and the public through the translation of findings into improved practice. The Panel investigated the events leading up to the death of the client's brother in order to establish what lessons can be learned which may minimise the possibility of a recurrence of such a tragic event. Inevitably the Panel focused on the negative aspects of the interventions. It is important, however, to note that there was evidence of some very good practice and, where possible, this has been highlighted.

The Process

3. The Inquiry Panel undertook a two-stage process. The first consisted of consideration of all of the relevant documentation provided from each of the agencies involved with the care of the client. In addition, account was taken of the reports, conclusions and recommendations of each of the internal inquiries, as well as the Barking, Havering and Brentwood (BHB) Community Health Care NHS Trust Action Plan reported to the Health Authority. Stage two consisted of a series of interviews with key individuals to clarify issues identified within the first desktop research stage. The procedure used in Stage 2 is outlined in Appendix 11. This Report contains an outline of the interventions by staff in each of the agencies, together with the conclusions and recommendations of the Panel.

Terms of Reference

4. The Terms of Reference for the Inquiry were:

   a. To examine all circumstances surrounding the treatment and care the client by the Mental Health Services and Social Services, from 1997 until the death of the client's brother.

   b. To consider the appropriateness of the treatment, care and supervision provided to the client by all agencies with particular regard to

      i. His assessed social and health care needs

      ii. His assessed risk of potential harm

      iii. His previous psychiatric and forensic history

      iv. His previous court convictions.

   c. To consider the extent to which the client's care corresponded to statutory obligations, relevant guidance from the Department of Health and others, discharge guidance, local operational policies and recognised good practice.

   d. To consider the appropriateness of the client's care and treatment plan and the mechanisms for measuring the effectiveness of its delivery within each of the agencies.

   e. To examine the adequacy of the collaboration and communication between all the agencies involved in the care and support of the client and between the statutory agencies and the client's family.

   f. To report on the findings and conclusions from the Independent Inquiry and make recommendations.

5. This Report outlines the key events, as well as the issues that the Panel considered. From these the Panel has drawn a number of conclusions and has made recommendations about how these should be addressed in the future.

Background

6. The client grew up in the North East London area and was the fourth child of his mother and her first husband. In total there were six children, four boys and two girls. They have all experienced a close relationship with their mother. The client had previously worked but over recent years had been mostly unemployed. The client had had a girlfriend but had ended this relationship due to concerns that this increased the risk to himself.

7. The client lived in a flat in Dagenham. He redecorated the flat and at this time it was kept neat and tidy. The client was described by his mother and sister as generally sensitive and caring to all of the family, but most especially to his mother and his nieces and nephews.

8. The client had been in trouble with the law since the age of 17, mostly for car offences and the offence of theft. Over the years he had been subject to supervision by the Probation Service and undertaken a Community Service Order. He was sentenced to three years in a Young Offender Institution at the age of 20 for two offences of violence. In 1995 he was sentenced to 2 years imprisonment for offences of dishonesty. His list of offences also included two convictions for Driving whilst Under the Influence of Drink, with subsequent periods of disqualification.

9. The client was diagnosed as having paranoid schizophrenia in September 1997. He was 27 years old at the time. Two other members of the family had also been previously diagnosed with paranoid schizophrenia and were treated at Runwell and Goodmayes Hospitals.

10. Three points are worth noting when considering the events covered by this inquiry:

    a. The client's mother had substantial experience of caring for family members diagnosed as having schizophrenia, even before the client became ill. She was therefore a very knowledgeable informant to the services.

    b. The client had seen the effects of medication on his brother and was therefore very reluctant to be placed in the same state.

    c. The client had a lot of experience of the criminal justice system and dealing with those in authority. This appears to have taught him how to comply on the surface without revealing too much of himself.

PRACTICE

May 1997 to December 1997

First contact with the mental health services to admission to a medium secure unit

11. On the 21st May 1997 the client's mother rang the local Community Mental Health Team (CMHT) expressing concerns about her son, saying he had recently been expressing paranoid ideas, such as of being followed. Both the client's father and brother were already receiving treatment and care from the mental health services, and had a Social Worker within the borough. That Social Worker, KD, had met the client on occasion and also knew his mother well. Although the client and his mother both lived in other parts of the borough and would not normally have been the responsibility of KD's team, after discussion between the relevant managers, it was agreed that she would undertake an assessment.

12. Before the Social Worker had made contact, and unknown to any of the Mental Health Services, on the 8th June 1997 the client was arrested for Criminal Damage, Affray and Threatening Behaviour. This case involved a dispute with a man who he thought was watching him in the street. The client had become aggressive with him. When the man drove after the client in order to remonstrate with him the client had got out of his car and slashed the other man's car tyres.

13. On the 30th July KD contacted the client's mother who was asking for support for her son. She was very concerned because he was abusive to people in the street, she said that a couple of months previously a car next to her son's had caught fire and the client thought it was meant to be his car and had been feeling increasingly paranoid ever since.

14. Although the client did not feel that he had any mental problems, he agreed to meet with KD because his brother knew her and told the client that it would be all right. KD saw him and undertook an assessment on the 8th August 1997. She noted the paranoid feelings that had been going on since he was in prison the previous year. He was feeling he was being watched and believed that his flat had been broken into. He subsequently finished a relationship with his girl friend in September 1997, as he felt that they might get at him through her.

15. As a result of this assessment and after consultation with her manager, BH, KD contacted the client's General Practitioner (GP), Dr B, and arranged a domiciliary visit with the Responsible Medical Officer (RMO), Dr M. On the 15th September Dr M and KD met with the client at his home. They found that the client was experiencing persecutory delusions. He described how he felt under threat and was afraid of people

who wished to harm him. Dr M prescribed oral anti-psychotic medication, Risperidone and arranged to see the client at his outpatient clinic.

16. Before there was any further contact the client was arrested and charged with Driving under the Influence of Excess Alcohol. He spent from the 9th to the 30th October 1997 on remand in Pentonville Prison. KD was informed of this by the client's mother on 10th October 1997. KD liaised with the prison's Medical Officer and the Probation Officer (PO) who was expected to prepare a Pre-sentence Report (in practice this never happened as the officer concerned was unable to get an appointment at Pentonville in time). KD also made contact by fax with the defence barrister. When the client reappeared in Court on 30th October 1997, he was sentenced to six weeks imprisonment, but released as the time had been served on remand. He was also banned from driving for 3 years.

17. On 3rd November 1997 the client's mother again contacted KD as she was very concerned about her son's behaviour. She told KD, in confidence, that the client had confronted a man in a pub in a way that she felt to be an over-reaction. She was also concerned that he was carrying a knife, and had heard from other people that he had access to a gun.

18. Following the discussion on 3rd November 1997 KD discussed this with her manager, BH. Formal arrangements existed between that CMHT and the local police, and BH had discussions with a police representative who felt that there was nothing the police could act on at that time.

19. The client's mother also phoned the CMHT Duty Officer on 4th November 1997 regarding her concerns and spoke with two more professionals, one a Social Worker and one a Community Psychiatric Nurse (CPN). The Emergency Social Worker's Report states that the client's mother was concerned for her son who was released from prison on bail the previous day (Friday). "She is concerned about him as she feels he is unwell and paranoid and she feels he could harm himself or others."

20. The manager, BH and KD agreed to see the client at their office on 5th November 1997 together with the RMO. The client came to the office to meet with them but the RMO had gone to the client's house by mistake so a full meeting did not take place and was rearranged for 7th November 1997.

21. On 7th November 1997, KD and the RMO, Dr M, met the client at his home for assessment and persuaded him to enter Warley Hospital on a voluntary basis three days later. However, in the interim the police had realised there was an outstanding warrant relating to the client 's arrest in June 1997 and they raided his flat. They found a gun and ammunition. On 11th November 1997 the client was arrested and taken into custody in Pentonville Prison.

22. In his letter to the GP, (Dr B) informing her what had happened. The RMO, Dr M, noted that the client had ceased to take his medication after two days because it made him drowsy. The RMO also contacted the Consultant Psychiatrist at the Regional Secure Unit, saying that he felt the client was too high risk to be admitted to Warley Hospital and he needed to be in a Medium Secure Unit. On 9th December 1997 the client was transferred from Pentonville to the John Howard Centre (Medium Secure Unit) under Section 48 of the Mental Health Act 1983.

COMMENT

23. *From the work undertaken during this period by the Community Mental Health Team, the Panel noted a number of examples of good practice :-*

    a. *The flexibility within the organisation in the use of staff across boundaries to enable an assessment to be made by someone already known and trusted by the family.*
    b. *A thorough assessment made by a worker who knew how to evaluate information from both the individual and family.*
    c. *Good backup from the RMO, real multi-disciplinary working*
    d. *The Social Worker made good links with both prison staff and probation staff when the client was remanded in custody, and linked up with his solicitor.*
    e. *There was sensitive but decisive handling of information which the client's mother gave, in confidence, to the Social Worker, but which indicated an increased public risk. Arrangements were made for a domiciliary visit by the RMO and parallel discussions were undertaken with the police; this was made much easier by the fact that liaison systems were already in place.*
    f. *There was good support from KD's supervisor, BH. It was a matter of good luck that he also had direct previous knowledge of the family, but he also used his role well to support KD through supervision, to undertake a joint interview where appropriate, and to liaise with the police over sensitive information.*

24. *Also during this period a number of issues emerged which were relevant to later care:*

    i. *The client's dislike of medication and reluctance to comply within the community.*

    ii. *The client's potential for getting into disputes with people in the streets or pubs once he became really paranoid.*

    iii. *His heavy drinking in the period leading up to his arrest.*

    iv. *The client's involvement with the criminal justice system in parallel with the Mental Health Services.*

25. *The offences of Criminal Damage, Threatening Behaviour and Affray were directly linked with the client's mental health. Knowledge of these offences could have provided insight into the client's behaviour but failed to do so. The charges were eventually dealt with at the same court hearing as those for carrying a knife and possession of a gun and ammunition. He was also arrested during this period for Driving Whilst Under the Influence of Alcohol. This may or may not have been directly linked with his mental health. The client had a number of previous convictions involving motor vehicles and one for refusing a breath test.*

26. *From May 1997 the client was saying that his symptoms of illness had started while in prison in 1996. There is no reason to doubt his account, but there is no reference to this in prison or Probation through care records covering this period. This suggests that the client could hide his symptoms at that time.*

27. *If evidence of his behaviour at that time had been documented and kept available for staff, his developing symptoms could have been identified, as a part of an ongoing risk assessment, and this would have helped to show when the pattern began to repeat itself.*

January 1998 to August 1998

Period at the John Howard Medium Secure Unit, Transfer To Warley Hospital and Discharge Back Into The Community

28. On 26th January 1998 the client appeared in court, and following convictions for fire arms offences, criminal damage and affray, he was ordered to be detained under Section 37 of the Mental Health Act 1983, and returned to the John Howard Unit. By the time of the Admission Conference on the 2nd February 1998, the Registrar in Forensic Psychiatry noted that "he has partly responded to anti-psychotic medication and from being in a safe environment, but there is still evidence of persecutory delusions. At this stage he therefore warrants a further period of detention in hospital". For the purposes of that Case Conference very thorough assessments were undertaken by all departments. The reports presented include information that could have been useful for later workers when the client was back in the community, for example:-

    a. The report by the Specialist Registrar in Forensic Psychiatry, dated 29th January 1998, gave a detailed account of events leading up to the offences of criminal damage, as well as the client's account of the feeling of conspiracy to harm him which existed in prison and in the community, leading to his need to get the gun. This report gives a clear picture of how the client was behaving as he became more suspicious of those around him.

    b. The nursing assessment, prepared by a Staff Nurse from Broadgate Ward dated 2nd February 1998, emphasised the client's drug and alcohol use in the months before his arrest.

    c. The report by the Psychologist, dated 28th January 1998, notes the client's high score on the "Antisocial Personality Scale".

29. One area the reports do not address is the client's earlier offences of violence which had led to him being imprisoned for a total of over three years at the age of 20.

30. By March 1998 the Consultant in Forensic Psychiatry was sufficiently satisfied with the client's progress to write to the RMO at Warley Hospital asking him to assess the client to see if he could accept him in a non-secure setting. The report was passed to a Consultant who had not seen him previously, Dr S. He concluded that he would accept the client at Warley Hospital but with a view to his going home almost immediately. His assessment notes that the client was trying to

negotiate a move out of the area as he felt that would get him away from the people who were following him.

31. On 18th May 1998 a further Case Conference was held in the Forensic Unit which was effectively a discharge conference in the light of the agreement to transfer the client to Warley Hospital. Again reports were available from all departments. The Registrar noted the improvements in the client's mental health as a result of medication and said there was no evidence of active psychotic illness. He found some insight by the client into his paranoia and noted that the client had acknowledged the benefits of taking medication, particularly Risperidone, and had expressed the wish to continue on it indefinitely. Other concerns noted by the Specialist Registrar regarded possible temporal lobe epilepsy. Of all the reports available, only the Psychologist commented on the moderate risk of possible future violence.

32. On 27th May 1998 the client was transferred to Warley Hospital. There is no indication from the records whether the continuation of his Section 37 status (of the Mental Health Act 1983) was discussed prior to transfer.

33. On 27th May 1998 the Senior House Officer (SHO) at the John Howard Unit wrote to the RMO at Warley Hospital confirming transfer and forwarding reports prepared whilst at the Secure Unit. He also notes the need for an EEG. Further information followed on 7th July 1998 when the Consultant, Dr B, sent a Discharge Summary to the RMO at Warley Hospital. This consisted of a brief summary of the Case Conference on 18th May 1998 in which he said it had been concluded "that he (the client) no longer required treatment in conditions of medium security. It was however, considered that there would be a potential risk to others if there was a relapse of mental illness. This could be along the lines of defending himself against perceived threat, or through paranoid irritability. The essential component of aftercare would therefore be monitoring his mental state and early intervention in the event of a relapse."

34. While not questioning the accuracy of any of these comments, the Panel felt that insufficient use was made of the extensive amount of information gathered at the time of admission. This should have been used to establish the degree of potential risk and to build up a fuller assessment once the client was in the community.

35. The client settled quickly into the ward at Warley Hospital. The following day, 28th May 1998, he was granted leave for three days. The nursing notes recorded that he was undecided where he wanted to live and would start looking for accommodation. He returned to the hospital but was then again granted weekend

leave to go to his mother's on 4th June 1998 for five days, and on 11th June 1998 for five days.

36. On 10th June 1998 a Care Programme Approach (CPA) Review Meeting was held at which the client, ward staff, the SHO and KD, as Care Co-ordinator, were present. There is no formal record of this meeting. A Nursing Care Plan drawn up on the 12th June 1998 notes that housing was identified as the main issue. KD, who knew him, notes her concerns about discharge, in that if the client was too unwell to cope with going back to his own flat, perhaps he was too unwell to be discharged. The client's mother had also contacted her before this meeting, expressing concern and querying whether the client needed more medication. Clinical notes do not record any dissent and say that the client "is quite well to go back to the community". An actual Care Plan was not drawn up until the beginning of August 1998 when it was agreed between KD and the client. On the 11th June the client went on extended leave to his mother's, to return by the 15th June 1998 for an EEG.

37. On 13th June 1998 staff on the ward received a phone call from the police, the client having been stopped outside the hospital in a vehicle, he had refused to take a breathalyser test and was therefore taken to the police station. The client returned to the ward on 15th June 1998 and on the 16th was seen at the ward round. He said he had accommodation with his mother and would arrange longer term accommodation following discharge. He was therefore discharged on that date. In the Nursing Discharge Summary dated 21st June 1998 the nurse records that the client's mental state had been settled whilst on the ward, with no hint of paranoia. It also notes that during the period of extended leave the client had visited the ward and it was "felt he was involved in the selling of illicit drugs to fellow patients", the incident with the police is also noted.

38. On 18th June 1998 the Discharge Checklist was completed. This recorded the CPA being at Level II. It is not clear how or when this was decided. Level II applies to "users who have a more serious mental illness and have more complex care needs, likely to require intervention of more than one professional (aside from the GP), often from more than one agency. They have needs which are unlikely to remain stable. A Care Co-ordinator who is an appropriately qualified field professional will be necessary to co-ordinate and monitor the Care Plan, which will be more detailed and complex than for Level I. Reviews will involve all the contributors to the Care Plan". (BHB Care Programme Approach and CMHT Operational Policy Resource Pack)

39. Some time later a letter was sent to the client's GP in Dagenham, Dr B, informing her that the client had been discharged and was being prescribed Risperidone at 2mg

daily. He was later sent an Out Patient appointment to see Dr S on 27th August 1998.

40. The client was admitted to Warley Hospital still subject to a Section 37 (Mental Health Act 1983) Hospital Order. There is no indication from the records that this was discussed prior to the client's discharge. There is no record at Warley Hospital to indicate that legal procedures were followed with regard to Section 37 and it would appear that this was simply allowed to lapse.

41. Under the Care Programme Approach, after-care arrangements for a Level II patient detained under The Mental Health Act 1983 should be subject to regular reviews and multi-disciplinary conferences. In the case of the client, it was in fact left entirely to the Social Worker, KD, to draw up the Care Plan after he had been discharged, and there was no system for subsequent reviews.

42. Although the discharge had been planned, the client finally left the ward unexpectedly quickly and without having the housing problem resolved. The Housing Authorities made it clear that he was unlikely to be a high enough priority for re-housing for a long time. His mother agreed to take him back, and consideration was given to helping him seek private rented accommodation. The situation was further complicated by the fact that the client now had to go to Grays Magistrates Court. There then started a lengthy series of adjournments in this case, which was not resolved until February 1999.

43. By 15th July 1998 the client had negotiated for himself a housing exchange, to move to a flat in Harold Hill in approximately 6-8 weeks time.

44. KD saw the client at his mother's house on 3rd August 1998 and completed the Care Plan.

45. KD noted that the client was saying he felt a little stressed and paranoid and nervous, particularly about the possibility of receiving a prison sentence as that is where his problems started. She also noted that he now seemed to have some insight into his illness; he had said he was now unsure whether it was paranoia or reality, whereas previously he had maintained it was completely reality. KD tried to see the client again on 17th August 1998 but he was not in so the above appears to have been her last contact with him.

46. On 20th August 1998 KD prepared a report for the Court and sent it to the defence solicitors, and sent a copy to the PO who was preparing a Pre-Sentence Report. KD's report recommended continued treatment in the community.

47. On 20th August 1998 the client appeared at Grays Magistrates Court. He was remanded on bail for a psychiatric report.

48. On 27th August 1998 the client kept his appointment with Dr S at Warley Hospital. He found him to be stable and compliant with medication.

49. On 4th September 1998 KD left her post to undertake ASW training. She and her manager, BH, recognised that there was no point in transferring the client within the team as his move to Harold Hill would take him into a different catchment area. BH agreed to 'hold' the case until the client moved.

50. KD and the client together summarised his ongoing needs in the Care Plan agreed on 3rd August 1998. There were 3 main aims:

    1. To help the client manage/lessen his continuing symptoms.
    2. To give the client support with his pending court case.
    3. To ensure a smooth transfer of the client's care to the relevant locality when he moved house.

COMMENT

51. ***Given the client's sudden discharge from Warley Hospital and the potential problems of homelessness, things went surprisingly smoothly in the three months after he left hospital. This was in part undoubtedly due to his mother's continuing support and willingness to have him living with her. KD continued to give frequent support and help to both the client and his mother.***

52. ***In other respects the care planning was not as satisfactory. The client was discharged from Warley Hospital with no decision noted regarding the Section 37 (MHA) and with arrangements for after-care under Section 117 (MHA) unclear. This contributed to the subsequent loss of focus on risk.***

53. Up to this point there had been, for the most part, good liaison between the family and the professionals regarding the client's care. From September 1998 this became less true. In particular a gap developed between the views of the family and those of medical and CMHT staff. In addition another agency, the Probation Service, was now involved. GP services were significantly not involved. From this point we therefore look at the chronology of events within each specialisation.

September 1998 To April 1999 - Supported in the Community in a New Area - The Community Mental Health Team

54. In September 1998 the client moved to his new flat in Harold Hill. He was now living in an area covered by a different mental health team, he was also seen by a different RMO at Warley Hospital. None of the personnel now involved in his care had any previous contact with the family. BH, KD's line manager, who had been holding the relevant papers since her departure, contacted the new CMHT with a transfer summary. A decision was made by the new CMHT to allocate the case to a Community Psychiatric Nurse (CPN), LS, with the support of the Clinical Nurse Specialist (CNS).

55. This CNS has a background in forensic work and it was explained to the Panel that his job was to provide expert advice to other CPN's where there was a forensic history and/or "challenging behaviour". The CNS, NK knew that the client had been subject to a Section 37 (MHA 1983) Hospital Order and intended to undertake a full risk assessment. However, this was never completed. In evidence he said to the Panel that he had access to the criminal records of the client but that he was not sure that he had read the full reports available from the Forensic Unit. These reports would have given a clear picture of the client and his behaviour in 1997, prior to his admission to the Medium Secure Unit and might have helped in recognising deterioration in the early months of 1999.

56. Between the beginning of October and the middle of December, the CPN, LS and CNS, NK sought to maintain close contact with the client. They saw him at home on three occasions and also made three other pre-arranged visits but the client was not at home. There was also telephone contact. Work focused on encouraging the client to take his medication and to get himself registered with a GP in the new area. However there was no direct input given to help him achieve this. The client appeared to be stable during this period and there were no particular concerns over his mental state by these workers. However it was recognised that he was reluctant to take medication. This was also brought to their attention by his mother on at least two occasions.

57. During this period the client also appeared in court on several occasions in connection with the charge of Driving Whilst Disqualified. He was also re-arrested and a further charge was brought of Driving Whilst Disqualified. The CNS, NK, made contact with the PO and also arranged with the Consultant Psychiatrist, Dr C, to provide the necessary report for the Court. Appropriate groundwork was done for the making of the Probation Order with condition of outpatient treatment, which was finally ordered by Grays Magistrates Court in February 1999.

58. A Case Conference following up the Care Plan drawn up in August 1998 should have been held in November. However there were no procedures in place for regular Case Conferences, there was no GP and review consisted of informal feedback from NK to Dr C.

59. In December the CPN, LS, left the service. After a slight break the case was re-allocated to another CPN, TM. TM was reported to have been somewhat reluctant to take on the case because of his current workload, reported to be between 45 and 50 cases. It was also reported that he agreed to take this case on the basis that involvement would probably to be short term, given the client's Court cases and the likelihood of a prison sentence. The Panel was unable to confirm this with TM.

60. On 16th December 1998 the client phoned NK to ask him to visit him at home, saying that he was feeling that he needed to be admitted to hospital. NK visited the following day. NK records of that visit "he told me he had not been taking his medication. He said he sees people standing on street corners, and on occasions, they have followed him. He is frightened. He went to Southampton to get away from it all but these people still followed him and he could not get a job." NK then liaised with his GP from his previous area and arranged a domiciliary visit by the RMO, Dr C.

61. In evidence to the Panel, NK said that he did not think that it was essential that the client was in hospital at this point but he recognised that he was concerned about the forthcoming court case and therefore supported admission. Dr C visited the client at home on the following day and admitted him to Warley Hospital on an informal basis. The court case scheduled for 23rd December was, in fact, adjourned until 14th January 1999 because the client was in hospital.

62. On 24th December 1998 the client requested leave until 26th, and this was granted. He returned to hospital on 27th and nursing staff felt that he was all right. On 28th he approached Dr C to ask, "when can I be released". Dr C explained to him that he had not felt he needed admission and it was the client himself who requested

this, but he advised the client to stay in hospital until 4th January 1999 when his CPN returned from leave. In the meantime he could go on leave if his mother was agreeable. His mother was later said to have contacted the ward and agreed for the client to go on leave until 4th January 1999.

63. On 29th December 1998 the Manager of the CMHT, MM, contacted the ward, saying that the client's mother had been in touch stating that he was not taking his medication. On 4th January 1999 the client returned to the ward, nursing notes record, "he stated that his mother is too concerned about him for no reason, he did not have enough medication when on leave". He again proceeded on leave, care of his mother.

64. On 7th January 1999 (or 6th - Case Records disagree) NK and TM visited the client at his home. TM met the client for the first time. Medication was discussed. The client said that he was taking the oral medication regularly, NK tried to persuade him that he should have a depot injection but the client did not want this. NK notes that he "appeared fairly stable in mental state". The client remained on leave from the hospital, returning periodically but usually missing the ward round. He also failed to attend Court on 14th January 1999 and his Court case was again adjourned until 10th February 1999.

65. The client appeared to be functioning quite well and on 22nd January 1999 was telling hospital staff that he was feeling much better and was having no more paranoid ideas or suicidal thoughts. He was again claiming to staff that his mother was too over protective and saying this resulted in arguments between them. On 25th January 1999 the client was discharged from hospital on the understanding that he would return to hospital for a Case Conference on 2nd February 1999.

COMMENT

66. ***Several points emerged from this admission to hospital;***

    a. ***It was at the client's wish that he was admitted, both the RMO and the Clinical Nurse Specialist felt that he could still have been treated in the community. This doubtless affected their willingness to let him go on leave with only occasional appearances at the hospital.***

b. *The staff perceived him as being quickly stabilised on medication within the hospital and he was not presenting staff with any disturbed behaviour.*

c. *His mother continued to express concerns both to staff at the hospital and to the Community Mental Health Team but the client was assuring them that she was always over anxious. None of the staff now involved had sufficiently long-term contact with the family to be able to make an accurate assessment of the information that was coming from the client's mother or from the client.*

67. On 2nd February 1999 a Case Conference was convened at the hospital in accordance with the Care Programme Approach. Present at that conference were, the client, Dr B, the Clinical Assistant, Staff Nurse on the Ward and Clinical Nurse Specialist NK. CPN TM who was the designated Co-ordinator for the client as unable to be present and so was the RMO, Dr C. It is unacceptable practice to organise a Case Conference without the key players present. It was agreed that medication was to be continued at 2-3 mg Risperidone daily, the outline plan (as noted by NK), was as follows:

i. CPN, TM, to monitor mental state, initially every two weeks.

ii. Outpatient appointments to follow.

iii. Regular follow-up care and medication dispensation from GP.

iv. To register with a GP.

68. Between 2nd February 1999 and 24th February 1999 there was no input from either the CNS or the Care Co-ordinator.

69. On 24th February 1999 the client's mother phoned his ex-Social Worker, KD, expressing her concern that his mental health was deteriorating and he might soon pose a risk to others. KD phoned NK to pass on the information she had received from the client's mother. She followed up the phone call with a letter in which she details the concerns, i.e. the client's mother thought that the client was not taking his medication; when he was out in the street he was frequently looking over his shoulder; he was drinking alcohol in increased amounts, and still fearing that somebody was trying to kill him. The client's mother had also told KD that the client was carrying a knife for self-defence. She had also found out from a family member that the client had asked his brother-in-law to get hold of a gun for him. The client's mother was not prepared for the information she had given KD to be discussed with her son as it might harm their relationship.

70. The CNS (NK) contacted the CPN (TM) with this information, he also asked about recent visits and ascertained that the client had not been seen since the Case Conference. It was agreed that TM and NK would do a joint home visit which was arranged for 2nd March 1999. On that date TM was sick. NK visited the client at home but he was not in. The following day the client phoned NK to apologise, saying that the bailiffs were calling regarding unpaid Council Tax. NK passed this information on to TM for him to act on it. TM spoke to the client and agreed to assist with the Council Tax.

71. Meanwhile on 4th March 1999 NK had written to TM expressing concern that TM had not prepared the full Care Plan nor resolved the issues regarding tax arrears. In this letter he states, "I am concerned about the risk that this man may cause given that there is a documented history of past unpredictable behaviour and carrying of loaded firearms and knives. If the agreed care plan is not fully implemented the risk will be further increased, therefore as his Care Co-ordinator I am notifying you that I am suspending my specialist input into his care until such time as the following is carried out".

72. After discussion with his line manager, MM, the CPN, TM, responded to NK in writing. After further discussions MM agreed that NK should suspend his input into the case and in a letter dated 9th March 1999 NK wrote to TM stating that he had spoken with MM and that the matter would be raised in case note supervision. TM's notes record that on 12th March 2001 the matter was discussed .in supervision with his manager. He states "Mr K feels his clinical expertise should be suspended until the CPA Review". In the event, the decision that NK should suspend his input was overtaken by a further letter from NK to TM stating that he had discharged the client from his caseload.

73. In evidence to the Panel both MM and NK stated that the action to withdraw had been by agreement and recognising the CPN, TM, was competent to deal with the risks posed by the client. However, it appears to the Panel that there was a problem in the working relationship between NK and TM that had an impact on the care of the client. This highlights a perceived weakness in the structure within the CMHT where management and supervision should have prevented this. The organisational issues arising from a structure that allows one member of the team to decide unilaterally to withdraw from a case are discussed later. In evidence to the Panel both MM and NK said that under revised guidelines the CNS would have stayed on the case until the next CPA review.

COMMENT

74. *This dispute between NK and TM distracted both workers from focusing on the client's deteriorating mental state and the increased risk he was posing, and from making use of the information that the client's mother was giving them.*

75. *The withdrawal of the CNS removed the worker who had the longest contact with the client (and who was therefore in the best position to see changes in his condition) as well as being the worker, who, because of his background, should have had the best understanding of the client's forensic history, and its' implication for risk. The Panel felt that the withdrawal of the CNS at this stage was inappropriate and should have been prevented by line management.*

76. *One of the factors that the client's mother had noted as a matter of concern was the client's increased drinking. All the workers who gave evidence to the Panel said that the client did not show any signs of having a serious drink problem. In fact staff should have been aware that on admission to the Medium Secure Unit in October 1997 the client told staff that he had been drinking 10 pints a day, plus brandy at weekends, in the months leading up to his arrest. There was additional evidence in that he had two convictions leading to lengthy bans while Driving under the Influence of Drink. It is accepted that he was not alcohol dependent: nevertheless there are indications throughout his history of periodic problematic alcohol use. Staff should have taken more seriously the comments made by the client's mother.*

77. Over the next few weeks TM became more active. He intervened and stopped the bailiffs distraining goods, he liaised with the PO who was now supervising the client, and arranged a Court Report from Dr C. He made temporary arrangements with the client 's previous GP until such time as he could become registered with a local GP, and sought to get the client registered appropriately.

78. During this period TM was clearly becoming increasingly concerned about the client, mainly as a result of his non-compliance with medication. He noted the client's reluctance to discuss medication, and also noted that he felt the client at points was telling him what he wanted to hear. He noted that there was some drinking but saw no indication of excess. In his evidence to the internal inquiry TM commented that the client was guarded and did not open up; he felt it would have taken a long time to develop a fruitful and more open relationship with the client because of his paranoia.

79. Despite his concerns TM did not feel that the client was showing sufficient evidence that his condition represented a threat to himself or other people to warrant an urgent

assessment under the Mental Health Act 1983 with a view to compulsory admission. At the same time he hoped that the client's forthcoming Court appearance at Mildenhall could be used to get the Court to make a Hospital Order. On 7th April 1999 he had discussions with the PO writing the report telling her of his concerns about non-compliance with medication and potential for dangerousness and recommending an application for a Hospital order under Section 37 of the Mental Health Act 1983. TM asked her to put his concerns in her report.

80. The Panel was surprised that a worker of TM's experience did not know the provisions of the Mental Health Act with respect to Section 37 application, i.e. it must be recommended by two doctors, in other words the same as for a civil Section.

81. When the CPN saw the client again on 21st April 1999, he was sceptical about whether the client was in fact taking medication as he claimed, and was sufficiently concerned at the client 's lack of progress in getting a GP for himself that he said he would write to the Health Authority and request a change of GP for him.

82. TM discussed his concerns regarding the client in supervision with his manager the following day, but no immediate action was agreed. TM was to continue to visit two-weekly, to contact the Health Authority and to continue his efforts to convene a case conference; he had been trying to do this for some weeks but had been thwarted by relevant people being on holiday. It is surprising that the alternative course of requesting assessment under the Mental Health Act does not appear to have been considered in this supervision session.

83. Before TM could take any further action, on 26th April 1999 the client's mother phoned to tell him that the previous day the client had stabbed his eldest brother in the chest.

COMMENT:

84. ***Because of the lack of an established pattern of CPA reviews, and the decision not to offer other Out Patient appointments, the CPN was left as the sole worker from the Mental Health Services making an assessment of the client's state.***

85. ***The Panel recognised the conscientious and sensitive efforts that the CPN was making in trying to get the client to comply with his medication and in helping him deal with a range of practical issues. However it seemed to the Panel, that there was enough indication of deterioration in the client to have warranted a full assessment under the Mental Health Act 1983 with a view to compulsory admission to hospital. The Panel would like to have explored with TM his reasons for thinking that such a course of action would have been unsuccessful,***

but were unable to do so due to TM not being well enough to input into the Inquiry.

86. *It appears that there was confusion among the various agencies and professionals as to who had the power and responsibility to make sure that the client had the treatment which all agreed he needed. The recommendations to the court were of doubtful legality, and certainly impracticable and unenforceable.*

87. *There seems to be good evidence that statutory powers under the MHA 1983 could and should have been used on the grounds that the client had a mental illness (as defined by the Act), that he would not accept treatment on a voluntary basis, and that this treatment was necessary for the health and safety of the patient and/or the protection of others.*

88. *Under Section 2 of the MHA, admission for assessment or assessment followed by treatment, he could have been detained for up to 28 days, on the grounds that he had a mental disorder of a nature or degree which warranted detention in hospital in the interests of his own health or safety or that of others.*

89. *Section 3, which was probably the most appropriate Order at the time, is an admission for treatment, and would have been made on the grounds that he had a mental illness of a nature or degree which made it appropriate for him to receive medical treatment in hospital, this being necessary for the health or safety of the patient and or the protection of others.*

Responsible Medical Officer, Dr C

90. When the client moved to Harold Hill, responsibility for his oversight transferred within Warley Hospital to Dr C who worked with the relevant Community Mental Health Team. On transfer Dr C was given no particular reason to consider that the client was high risk.

91. Dr C's first personal contact with the client was when he was asked to undertake a domiciliary visit by NK on 21st December 1998, when the client was asking to come into hospital. Dr C thought that hospital admission was unnecessary and that the client could have been treated in the community, but agreed to admission in the light of the client's anxiety and the fact that he was going to court. This assessment doubtless affected his willingness to grant home leave as requested by the client during the time he was an informal patient at Warley Hospital. Dr C actually saw the client three times in that period.

92. Dr C was not present at the Discharge Case Conference in January, and did not see the client again. He told the Inquiry Panel that he had decided not to offer outpatient appointments because of very long waiting lists, but rather to see the client at Case Conferences. No Case Conference was convened before the incident at the end of April. TM had been attempting to convene one from March onwards but was unable to do so because of a lack of availability of colleagues.

93. On 10th February 1999, the client was made subject to a Probation Order with a Condition of Outpatient treatment by Dr C. There was evidence that Dr C knew that this order had been made even though at interview he was unable to recall whether he had ever known.

94. Dr C was not located with the CMHT, nor an active member of its meetings, but was kept informed of progress on the client, first by NK and subsequently by TM. He accepted their assessments. In March he was asked to write a further Court Report [eventually dated 24th March 1999], for Mildenhall Court. In this report Dr C outlines the progress of the client's illness, he describes the client's paranoia, and how his improvement or deterioration depended on whether he was taking medication. He links the client's offences with his illness and states that he will remain under treatment for an indefinite period. He also states "the client is well supported in the community and seen regularly by our CMH Team. He would also be reviewed by myself on a regular basis". The report does not give any indication of concern about deteriorating mental health.

95. From the notes of the CPN, Dr C appears, by the 7th April 1999, to share TM's concerns about the client's deterioration, and had told the PO that the client should be in hospital, agreeing however that his report did not support this. He appears from the PO's notes, to have supported the making of (another) Probation Order, this time with a condition to take medication as directed.

96. Dr C was unable to remember clearly the sequence of events and advice given, or when he had become aware of the increasing concerns. From his evidence to the Panel, by the beginning of April, Dr C did recognise the client's potential dangerousness but felt powerless to act. He accepted the CPN, TM's advice, that the client was not sectionable under the Mental Health Act, and did not seek to make his own assessment.

COMMENT

97. ***It appeared to the Panel that the Responsible Medical Officer's care of the client fell below acceptable professional standards. He appears to have been ignorant of, or ignored, the relevant history and clinical information, failed to assess risk adequately, in spite of the evidence, and inappropriately advised probation***

officers who sought his specialist help. He failed to provide adequate and appropriate after-care under the Care Programme Approach.

Primary Care

98. In assessing the involvement of primary care services in this case the Panel were hampered by the very poor standard of GP notes. In particular none of the records we saw were signed, many were undated, and most illegible.

99. From the records and discussion with staff interviewed, it appears that the client had sporadic contact during this period, but that he did not register with a local GP after his move to Harold Hill. There are two records of his obtaining prescriptions for Risperidone in Dagenham. There is a record of a temporary registration in Romford (the Heaton Avenue practice) on 26th March 1999. It appears that he tried to register here, but when TM spoke with the practice receptionist on 26th March 1999, according to his notes, he was told that the books were full.

COMMENT

100. ***It is ironic that when the client eventually accepted the need to register with a local GP, as CPNs had been urging him to do for several months, the Practice he chose would not take him. In a case where compliance with medication was identified as crucial and the patient was, at best, ambivalent about taking it, the difficulties of GP registration placed an unnecessary hurdle.***

Probation Service

101. In July 1998 the client appeared before Grays Magistrates Court on the charge of Driving Whilst Disqualified for the offence committed in June 1998 and a Pre-Sentence Report was requested. The Probation Officer (PO) writing the report appears to have liaised with the Social Worker, KD, but there was no psychiatric report available when the client returned to Court and no specific recommendation by the PO. She, by this time, had left the Probation Service: the case was further adjourned and a new PO (RS) took on the work.

102. There followed a series of adjournments of this case, on occasion because the PO had not been able to get to see the client (who was at that point remanded in Pentonville Prison), on another occasion for the purpose of a more detailed proposal of treatment by the Psychiatrist, then because the client was in hospital (December 1998) and again in January 1999 because he failed to appear. The case was finally heard on 10th February 1999, when a Probation Order was made with a condition to receive outpatient

treatment under Dr C. During this period the PO, RS, had contact with the CNS, NK. There was no responsibility for supervision by the Probation Service during this period, and she had no contact with the client after the initial interview for preparation of the report. RS moved to other work within the Service before the order was made.

103. The Inquiry Panel was concerned that neither of the POs involved in the preparation of the Pre-Sentence Report (PSR) had made use of the client's previous probation records in seeking to understand his history of offending. Since the age of 17 he had been on a supervision order, on licence from Detention Centre then from a Young Offenders Institution, subject to a Community Service Order, and, in 1996-7, on licence for 6 months following a two year prison sentence. In evidence to the Inquiry, RS explained how she had tried to trace earlier files and records of previous convictions but secretarial staff had been unable to find them. Three Probation Offices had merged into the present office a year previously and administrative systems had not yet been fully integrated - meaning that in practice it was impossible to link some incoming work with past records. There is a reference in the PSR to convictions for violence at the age of 20 and to the fact that, at that time the client said his drinking was out of control. A consideration of previous records would have enabled the writer to explore the relevance (or otherwise) of the violence. It should also have made the POs involved consider more closely the part played by alcohol in the client's offending. There were two convictions for driving under the influence of drink which had led to lengthy bans from driving.

104. The Probation Order was finally made in February 1999. There is one indication on the case file that the client was seen on 12th February. There is a standard North East London Probation Service (NELPS) leaflet signed by the client and dated 12th February that would indicate that he must have been seen on that date. The leaflet also indicates that the probation Order was explained to him. However, there is no other record on the file of his having been seen on that day or any indication who saw him. The case was passed to a Duty Officer under a holding scheme for the first two interviews. It was explained to the Panel that this was an arrangement that had been set up in the area in order to avoid unacceptable delays in making initial contact with people placed on probation, and to meet National Standards for the Probation Service. These require that anyone placed on probation should be seen within 5 working days of the making of the order. In practice this Duty Officer never saw the client because she sent the appointment letters to an earlier address in Dagenham and he did not receive them.

105. While understanding the problems of allocation when the office was short-staffed, the Panel considered this arrangement very unhelpful. It introduced yet another worker without contributing to either assessment or supervision. We were glad to note that the arrangement has now been discontinued, except where the allocated PO is unavailable or where the allocated officer is not known at the time of the court appearance, when the first appointment should be given.

106. Before the Probation Order was made, a further Pre-Sentence Report was requested from the Probation Service for the client's forthcoming appearance at Mildenhall Court on charges of Driving Whilst Disqualified and Unlawful Entry. Preparation of this report, and subsequently the supervision of the Probation Order with a condition of treatment as an outpatient, was allocated to RL who was in her first year in the Probation Service.

107. As a first-year officer RL held a limited caseload and her work was subject to detailed supervision by her Senior Probation Officer (SPO). This was her first case involving joint working with the mental health services. RL took over supervision on 10th March. Not having heard from anyone by that time the client himself contacted the office, giving his address in Harold Hill, and asking for an appointment. Unfortunately RL also made a mistake in the address to which the letters were sent, so again the client did not receive them.

108. The client again contacted the office to confirm the date of his appointment, but came to the office on 25th March 1999 at the wrong time and the PO was not available. RL therefore saw the client for the first time on 30th March 1999. The focus of her interview with him was on his forthcoming Court case at Mildenhall Court on 12th April 1999. She saw the client again at the office on 6th April 1999 and noted that he was asking for appointments on different days of the week to avoid any pattern which could be picked up by people following him. She also noted that the client acknowledged that his CPN, TM, wanted him to go back into hospital for assessment but that he did not want to go though she had hoped that with encouragement he would.

109. During this period RL was becoming increasingly worried about working with the client after his CPN, TM, informed her of the extent of his concerns about the risks that the client posed. As her manager was away from the office at that point, she received support and advice from another Senior Probation Officer; on her return to the office RL's manager, (YD), decided she would co-work the case with RL.

110. RL had little time in which to get to know the client. The Risk Assessment and Supervision Plan drawn up during this period as required under National Standards, are both sound but represent an early stage of work. the client's offending at this time is seen as dictated by his illness, but the risks are clearly documented.

111. RL's immediate concern was the preparation of a report for Mildenhall Court, and what recommendations she should make. The CPN, TM, had made clear to her the extent of his concerns and he was urging her to ask the Court to make a Hospital Order. Her manager told her this was not possible without the recommendation from the Psychiatrist. RL and YD gave evidence that RL phoned Dr C in YD's presence and sought his advice. RL informed the Panel that Dr C had said a) that he could not now

recommend a Hospital Order and b) that the client needed to be on injections as he was not taking his tablets. She said that on that basis he advised her to make a recommendation for a Probation Order with a condition to take medication as directed by Dr C. She was unaware at that time that there was no legal provision for such a recommendation. Her SPO said that, having only heard RL's end of the conversation, she had understood the advice was to ask for a further condition of out patient treatment.

112. It is clear that the PO wanted the Court to pass a non-custodial sentence in order to avoid the possible negative side effects of prison, and also to allow her to go on working the Probation Order in conjunction with the health services. From her limited contact with the client, at that stage it seemed that the client was willing to comply with the reporting requirements of the order. But this leaves questions about the recommendation to the Court.

113. The client was already subject to a condition of treatment as an out-patient of Dr C and was not complying in terms of taking medication. There is no power of compulsory treatment in the community and the proposed condition was therefore unenforceable in law and added nothing to the condition already in force. Her Pre-sentence Report spells out the issues clearly, and would have supported a remand to hospital for assessment. The Court was not the best route for ensuring the client got treatment (in the view of the Panel there were already grounds for assessment under the MHA 1983 with a view to a compulsory admission to hospital), but had the Court been made aware of the full extent of the need for intervention, a more appropriate course of action might have been worked out.

114. Both RL and YD said in evidence that, as the client was already receiving treatment, they felt they should follow the Psychiatrist's advice. Neither of these staff had any training in working with mentally disordered offenders. Given greater confidence in this area of work or access to appropriate consultation within the Probation Office, the SPO might have felt able to challenge the Psychiatrist or ensure the Court was made aware of the need for more urgent intervention.

115. The Panel was informed that more recently an arrangement has been agreed whereby a Forensic Outreach Worker attends the Probation Office one day a week to act as consultant in relation to any Probation clients from the Barking and Dagenham area with mental health problems. Two of the Probation staff who gave evidence commented on how valuable this had proved to be and how appropriate consultation would have been in the case of the client. A measure of the demand for the service can be gauged from the fact that the worker's attendance at the office started as one morning every fortnight and has now grown to one day a week.

116. RL had asked the Court Duty Officer at Mildenhall to give the client a further appointment at the Probation Office on 19th April 1999, but it was unclear whether he was told this. He did not come to the office on that day. She sent him a further appointment but this fell after the incident and she did not see the client again.

COMMENTS

117. *All Probation staff sought to fulfil their roles conscientiously and work undertaken met the requirements of National Standards, apart from the delay in making initial contact; senior staff were supportive to an inexperienced member of staff who herself sought guidance appropriately. However, there were a number of factors, mostly outside the control of individual staff, which meant that the contribution by the Probation Service was not as good as could have been expected;-*

a. *Poor administrative systems meant that records were not available to the Probation officers when writing reports, thereby limiting the analysis they could undertake.*

b. *The Duty Officer initial appointment system (compounded by sending letters to wrong addresses) meant there were significant delays before the supervising officer met the client and got involved in the case. As a result when the Probation officer liaised with the CPN it was only to hear his concerns, rather than to take an active part in ensuring treatment was available and case conferences were convened.*

c. *The lack of training or availability of consultation meant that Probation staff did not have the knowledge or confidence to challenge the mental health specialists when the latter were pushing for inappropriate lines of action through the Court, or to make alternative suggestions. We comment later on the importance (to other Services as well as to the Probation service) of ensuring appropriate systems are in place to equip staff to deal with such situations.*

Family

118. The client and his family were very close and spent a lot of time together. They had significant experience of mental illness as three family members had been diagnosed with

schizophrenia. As a result the client's mother, in particular, was able to detect changes in her son's condition and alert the professionals. This was very important as the initial contact, highlighting the client's symptoms, came from the client's mother, and this continued throughout his treatment and care, to the extent that there are 25 documented contacts with the client's mother.

119. During the early contact with the Mental Health Services, and especially with KD, account was taken of the importance of the client's mother's observations. The Panel felt that this was considered of less value by those who followed, who had less experience of the family and, it appeared to the Panel, accepted the explanation from the client that his mother was 'always anxious'. More account should have been taken of the information from the client's mother.

Events of 24th and 25th April 1999:

120. The client spent Saturday 24th April 1999 with his older brother and his family in Dagenham. He and his brother had been drinking beer and spirits, as they generally did. They watched a film on TV, and at the end of the evening the client went back to his flat, accompanied by his brother's two older children who often went to stay with him.

121. He brought the children back about 1.00 pm the following day, and he and his brother got in cans of beer and a bottle of rum which they drank during the afternoon. the client was said to have "had a few drinks and was very merry". the client's sister and her family joined them for a while, and the client phoned his younger brother and his girlfriend to come round. Before they arrived, the client went out to buy some more beer and wine. Whilst at the shops, he saw a young man, the brother of his younger brother's girlfriend, who the client said owed him money, and who he thought "blanked him" outside the shop.

122. The client returned to his older brother's house with the shopping, and left quickly to go to his younger brother's house a short walk away, where he saw the young man again. He became angry, asked if the young man had the money he owed, and demanded to know why he had ignored him. Tempers became high, and the client began shouting and got more aggressive, inviting first the young man and then his brother outside for a fight. They got him out of the house, and he returned to his older brother's in an angry state. He went to take his shopping and return home, but his older brother was concerned about him driving because "he had had too much to drink and was too wound up".

123. As the client left the house and was crossing the nearby car park, his younger brother arrived, and an angry fight ensued. It was known in the family that the client regularly carried a knife "because he thought people were out to get him, it was part of his

paranoia". In the course of the fight, the client's younger brother was stabbed in the leg with a knife. His older brother came out of the house to try to stop the fight and calm the brothers down; the client turned and struck him in the chest. The client's older brother was taken to hospital and placed on a ventilator, but he died later as a result of the stabbing. After the incident, the client initially went on the run, but with the co-operation of his family he gave himself up on 29th April 1999, was arrested and questioned by the police, and later charged.

124. It is clear from the accounts of these events that the client's behaviour was strongly affected both by the paranoid and suspicious reactions caused by his mental illness, and by the effects of the amount of beer and rum he had drunk.

ORGANISATIONAL ISSUES

Introduction

125. Over and above the practice of individual workers, there were a number of organisational issues which affected the quality of care received by the client.

Risk Assessment

126. "Risk assessment is an essential and ongoing element of good mental health practice. Risk assessment is not however a simple mechanical process of completing a proforma. Risk assessment is an ongoing and essential part of the CPA process. All members of the team, when in contact with service users, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations." (Department of Health Modernising the Care Programme Approach'.)

127. In this case there were weaknesses in the approach to risk management by all the agencies. At the time of the incident Barking, Havering and Brentwood Community Health Care NHS Trust had no policy in place regarding risk assessment and it was not integrated into care planning. In practice there was a steady loss of focus on risk as time went on and responsibility for after-care transferred to different staff, so that by the time the client was re-admitted to Warley Hospital in December 1998 he was not seen as posing any serious risk. Two particular factors are worth noting in this process.

a. The failure by BHB Community Health Care NHS Trust through its CMHT staff to use previous records. At the time of admission to the Medium Secure Unit, very full assessment reports were prepared. These gave:-

    i. A clear picture as the client deteriorated prior to his arrest and admission
    ii. Details of his alcohol use at the time
    iii. The psychologist's assessment of future possible violence

    All this information was relevant to workers involved in later care. It was passed to Warley Hospital but the discharge summary by the Forensic Consultant emphasised only the risk posed if the client failed to comply with medication. Staff involved later do not appear to have made use of the additional material.

b. Lack of regular multi-agency conferences. The sharing of different perceptions could have helped keep this history in focus.

128. In the Probation Service risk assessment was already a requirement and better integrated into case management. Assessments were undertaken at the time of initial contact for the Pre-Sentence Report and again at the start of supervision. The second assessment was written after hearing the concerns of the CPN in March 1999 and is a good record of currently perceived risks.

129. However, Probation practice was considerably weakened by not having full details of the client 's previous convictions available nor his previous records of Probation supervision. An understanding of previous behaviour is an essential part of risk assessment and in this case was missing. Access to records would have allowed proper consideration of the offences of violence when the client was 20 years old, and would also have highlighted the issue of alcohol misuse through the convictions for driving under the influence of drink. This information should have contributed to multi-agency planning.

130. Since the incident, Barking, Havering and Brentwood Community Health Care NHS Trust has introduced a system of risk assessment. The Panel was able to consider the 'tool' now in use. It is very long, requiring staff to complete 15 pages. The Panel, whilst recognising the need to capture the necessary information to back up assessment, considered the new, present arrangements also inadequate. Paperwork alone is not enough to achieve successful implementation and staff training in risk assessment is essential. Successful risk management involves changes to the culture of the service so that staff routinely think of risk when drawing up action plans.

COMMENT

131. ***In this case there were a number of significant failures in the different agencies:-***

i. Failure to use adequate and appropriate available information, for example, previous records and assessment documents.

ii. The failure to connect the violence, alcohol use and mental illness within and across agencies.

132. ***These contributed to a loss of focus on risk and meant that when the CPN recognised that the client was deteriorating in March 1999 there was no agreed inter-agency plan for action.***

Failure to use the appropriate structures for after care

133. At the time of discharge from Warley Hospital, the Order made under Section 37 of the Mental Health Act 1983 was allowed to lapse. The Panel had no access to the

appropriate documents but it would appear that no active decision was taken about whether or not the Section 37 should continue. There were no after care services under Section 117 provided. The Panel were informed that this was subsumed in the Care Programme Approach but in practice it meant that once the client had changed area and new personnel were involved, the importance of regular inter-agency conferences was lost.

Inter-Agency Working:

134. Since 1990, there has been increasing acceptance that a significant proportion of those going through the criminal justice system (Police, Prison and Probation) have mental health problems. This has implications for Health as well as criminal justice agencies in terms of managing referrals, accessing services and joint care. The client clearly belongs in the group of clients who are the joint responsibility of Health, Social Services and Probation.

135. A succession of circulars from the Department of Health and the Home Office have required and encouraged these agencies to have in place plans for working with this group, including agreements regarding joint planning of services and joint management of service delivery in individual cases .

136. During the period under consideration in this Inquiry, May 1997 - April 1999, there were no agreements in place between Barking, Havering and Brentwood Community Health Care NHS Trust and the Probation Service. Individual CPNs talked to individual Probation Officers but this was not underpinned by any structure for ensuring sharing of information, joint planning or access to consultation.

137. So far as the Panel could ascertain, services for mentally disordered offenders did not form part of the Barking and Havering Health Authority Plan for 1997-8 or 1998-9. Responsibility for ensuring there is good inter-agency working is divided between the Health Authority and the Trust. The Health Authority carries the responsibility for setting the strategic framework for service delivery but can only play a facilitative role in relation to the Trust, which has responsibility for ensuring implementation. With respect to mentally disordered offenders, the panel were informed that until last year issues relating to the client group had been discussed at commissioning monitoring meetings with City & Hackney Community Trust and Barking, Havering and Brentwood Community Health Care NHS Trust. In 2000 Barking and Havering Health Authority set up a Multi-Agency Forum for work with mentally disordered offenders, in line with the National Service Framework. This has met once at the time of writing.

138. The Panel considered that the Trust should be more pro-active in developing inter-agency links. However, it also concluded that the Health Authority should take a stronger lead and provide support to ensure the appropriate structures are in place

139. One very positive initiative has been the arrangements for a Forensic Outreach CPN to attend the local Probation Office and provide advice to probation officers or direct service to clients from Barking and Dagenham. This service was developed through joint discussion between the Health Authority and the Trusts. A measure of the success of this service is that it has grown from one morning a fortnight to one day a week in response to demand. It is clearly much valued by workers and needs to be both extended more widely and put on a sounder organisational footing.

140. In the Probation Service, since 1999 the North East London Probation Service (NELPS) Board has accepted a policy statement and strategy for implementation regarding mentally disordered offenders. Within this, staff training and inter-agency working are seen as priorities. The Assistant Chief Probation Officer (ACPO) responsible has been seeking agreements with each relevant Health Authority regarding:-

1. Joint care planning.
2. Joint risk assessment.
3. Information sharing.
4. Consultation and support for probation officers.
5. Multi-disciplinary training.
6. Court diversion schemes.

141. So far agreement has not been reached with Trusts within the area of Barking and Havering Health Authority. The ACPO noted the steps that had been taken in the last year but felt that progress was slow because mentally disordered offenders appeared to be low on the Health Authority agenda. She commented on the valuable contribution being made by the Forensic Outreach Worker, but felt it depended too heavily on one particular worker and that there was a need for the service to be placed within a formal structure and made available to all probation teams.

Training and Staff Development:

142. From the events in this case, a number of training needs relating to work with mentally disordered offenders emerged among staff both in the Trust and in Probation. The RMO and two of the staff within the CMHT appeared ill-informed about the powers of the Courts and were consequently seeking to take inappropriate action. Probation staff lacked the confidence in working with someone who was mentally ill and therefore did not challenge mental health colleagues when they should have done or propose alternative action.

143. Barking and Havering Health Authority is required to ensure through contracts that staff are adequately trained in the Care Programme Approach and in risk assessment and management (HSG (94)27). They must also make sure that suitable arrangements are in

place for the management and clinical support of staff in CMHTs. These arrangements should give priority to those with a severe mental health problem, which must include those patients/clients who are also offenders. These requirements are translated into practice by the Trust.

144. The evidence given to the Panel did not give us any information about steps being taken to fill the perceived gaps within Health and Social Services. The responsibility of Barking and Havering Health Authority in this would be through contracts and service level agreements; while the responsibility for delivery of a comprehensive training programme lies with the BHB Community Health Care NHS Trust. Training did not appear in the Action Plan drawn up by the Trust as a result of the Internal Inquiry.

145. The necessary knowledge and skills exist within the Forensic Services but are not readily available in the Community Mental Health Teams. The role of the CNS may well have been an attempt to address the problem but in this case failed to do so.

146. More is now happening in the Probation Service. However, at the time of the incident the only post-qualifying training available to NELPS staff (apart from one-off conferences) was an agreement with the Tavistock Clinic to provide consultation for POs and their Seniors, or team events, focusing on risk and mental illness. None of the probation staff directly involved with the client's care had had any experience or training in working with the mentally ill.

147. In December 1999 Practice Guidelines were circulated to staff, giving a source of reference regarding legislation and good practice in supervision.

148. In the Autumn of 1999 a Home Office - funded Training Pack on working with mentally disordered offenders was launched. Mandatory training for all probation officers began in NELPS in June 2000 consisting of 2 days training run by the Tavistock Clinic in conjunction with NELPS training unit and focussing on interviewing skills to assess disorder plus the use of some of the hand-outs from the Training pack.

149. It is regrettable that the Training Pack does not include material covering practice when supervising a probation order with a requirement of treatment and that the material on risk is limited.

150. It was recognised in NELPS that the 2-day training alone was not sufficient. Other necessary elements include inter-agency training. The Assistant Chief Probation Officer (ACPO) with responsibility for mentally disordered offenders is trying to negotiate this with each Local Authority. This has not yet been agreed in Barking and Dagenham. The

Panel was also told of a local initiative in Dagenham where managers are taking part in the training of each other's agencies.

151. The consultation provided by the Forensic Outreach Worker, referred to under Inter-Agency Working, provides an important source of on-going staff development and this is one of the reasons we urge its continuation and expansion.

CMHT ARRANGEMENTS:

152. Within the area covered by the Barking and Havering Health Authority, four CMHTs operate in Havering and three in Barking and Dagenham. Each CMHT has a defined geographical patch from which it takes referrals. Where a patient/client moves from one patch to another, responsibility for his/her care would normally be transferred to the team covering the patch to which he/she had moved, and teams rarely work with clients outside their own borough boundary. When the client moved from his mother's home to his own flat in Harold Hill, he moved from Barking and Dagenham to Havering into the catchment area of CMHT 2.

153. The CMHTs contain CPN, Occupational Therapist, psychology and social work professionals and assistants, individual specialists and an administration team, and may include between 12 and 20 staff. According to the policy, medical staff are linked to the CMHT and included in its personnel, but in practice they remain outside the CMHT structure. Some teams are on split sites.

154. The designated CMHT manager has day to day responsibility for managing the work of the team. Line management and supervision structures are relatively complex, with separate arrangements for workload management, line management, professional and clinical supervision. The CMHT manager is responsible for allocating referrals, reviewing progress on cases and workloads, deciding case closure and team priorities and policies. Professional supervision is provided to each team member by the senior professional of their discipline, who may be within or outside the team. Clinical supervision may take place on a multi-disciplinary basis. All team members are expected to attend weekly allocation meetings and team business meetings. A named member of the CMHT is designated liaison link with each primary care team.

155. CMHT policy agreed between Health and Social Services is to focus on the needs of those with severe mental illness. The CMHT gives priority to people who need rapid, intensive involvement, including those at continuing risk of relapse and readmission to hospital, and those with high support needs. The team undertakes assessments, develops care plans and arranges coordinated services which should be subject to review at least every six months. Services provided are categorised as statutory (including Section 117 and Section 37/41 work), contractual (on contracts with GPs and purchasers) and

developmental (e.g. developing group work with people with similar needs). Social Worker members of CMHTs also work as Approved Social Workers on a borough-wide basis and provide the ASW duty service. The Care Co-ordinator for a particular client can come from a CPN, Social Worker or other background. If statutory intervention under the Mental Health Act were required, this would normally be dealt with by a duty ASW.

156. The CMHT structure brings together a range of mental health professionals, but it is not clear that teams have developed an integrated approach to their work. In this case the key problems perceived within CMHT (2) were:

1. Lack of a common base for all members of the team.
2. The need for two sets of records because of operating on split sites.
3. The fact that the RMO was not fully part of the team.
4. Complex and divisive supervision arrangements.

157. There is also a question about how effectively the CMHT manager was able to manage and provide leadership, given the size of the team and the complex structures for supervision. Where team members receive supervision from others, the team manager's knowledge of their workload and of individual cases may be quite limited. As well as the variety of professions, where CMHTs contain specialists such as the clinical nurse specialist, their greater seniority and independence may make effective supervision of their work more difficult, as it seems to have done in this case.

Changes in Staff and Continuity of Care

158. Over a period of less than two years the following professionals were involved in the care of the client:-

1 Consultant and Clinical team at John Howard Centre
3 Consultant Psychiatrists and two different clinical teams
1 Social Worker
1 Team Manager
2 CPNs
1 Clinical Nurse Specialist
4 Probation Officers (one never met him)
1 Senior Probation Officer.
2 GPs (both in Dagenham, none in Harold Hill).

159. The Consultant Psychiatrist who first treated the client in 1997 did not cover the area for his mother's address to which he was discharged in May 1999. The Consultant Psychiatrist who then took responsibility passed the case over to another Consultant when the client moved to Harold Hill. A different team then cared for him when he was admitted in December 1998. The third Consultant saw him three times, once prior to admission and twice in hospital.

160. The client's care by the CMHTs involved slightly less changes, thanks to a sensitive management decision in 1997 that the client should be seen by the Social Worker who already knew the family, even though the client actually lived in a different locality within the borough. The Social Worker was therefore able to provide some continuity through his admission to hospital and return home. From August 1998 changes became inevitable:

1. The Social Worker was going on a full time training course.
2. The client was moving to a different borough, Havering, although he stayed within the catchment area of Warley Hospital.

161. In the new area a CPN was assigned to work with the client with back-up from the CNS. However the CPN left after 2 months, necessitating another change of CPN. The CNS withdrew from the client's care in February 1999, leaving a CPN who had only seen him twice at that point, with sole responsibility for the client's care.

162. There was even less continuity of care in the Probation Service. Two PO's were involved in the preparation of the PSR recommending a Probation Order with a Condition of Out Patient Treatment. Neither was subsequently responsible for supervising the order. The case was referred to the Duty Officer under a 'holding scheme'. That Officer attempted (but failed because of administrative errors) to see the client twice. A 'permanent' PO (RL) then took over supervision. The client had always lived in the area covered by that team and had been supervised for extensive periods in the past, but none of the workers involved in 1998-9 had any prior knowledge of him.

163. Most of these changes were inevitable in the sense that they resulted from staff leaving posts or from the client changing residential areas – the question is less whether there should have been as many changes as how well they were managed. Here the picture is very variable. In no instance was there a formal handover, and in only one, an introduction to the client of the new worker (when the CNS introduced the new CPN in January 1999). Information between workers in the community based services varied, the Social Worker and the first CPN left summaries for the next worker. In the Probation Service no notes were handed on from one worker to the next, though there

was some discussion between the supervising PO and the officer who wrote the Pre-Sentence Report.

164. Transfer between Consultants consisted of letters, plus an action plan and previous reports when the client moved from the John Howard Unit to Warley Hospital. At least in that instance the Warley Consultant was able to meet and assess the client prior to transfer.

CONCLUSIONS AND RECOMMENDATIONS

165. Every organisation aims to provide high quality services to all of its customers at all times, however, sometimes things go wrong, as in the case of the client. On 25th April 1999 the client inflicted a fatal wound on his brother. He had been receiving treatment and care from the Mental Health Services since July 1997. The Inquiry established to consider the appropriateness of the treatment, care and supervision provided to the client by all agencies has now considered all of the information available and has arrived at the following conclusions and recommendations:

General

166. The panel concluded that no-one could reasonably have been expected to foresee that the client would commit an act of violence towards his own family, particularly not towards his brother. The client was particularly close to his older brother, visiting most days and helping to care for his children. There was no evidence of any animosity between them. The question is rather whether the client's mental state had deteriorated to a point where he was likely to act violently towards anyone with whom he was in any conflict and, if so, whether he should have been admitted to hospital for his own or other people's safety prior to the incident.

167. The Internal Inquiry conducted by the BHB Community Health Care NHS Trust after the incident concluded:-

a. "The Panel did not specifically identify any contributory factors, in terms of the care plan treatment and supervision, which had any direct consequence on the incident of the 25th April 1999.

b. From the information provided to the Panel, both from the case notes and the evidence of the witnesses called, it is concluded that alcohol consumption appears to have contributed to the behaviour which led to the incident. Given that from documentary and verbal evidence, there is no history of excessive alcohol consumption causing aggressive behaviour in the past, this act could not have been predicted.

c. Paul has been closely and regularly monitored by an experienced and appropriately qualified Community Psychiatric Nurse in the weeks leading up to the incident and indeed was seen by him four days prior to the incident when the client's mental health was stable and there was no cause for concern. Although the client has consistently experienced paranoid feelings that someone was after him, it was

never directed to a family member. His relationships with his family were seen as positive and supportive. There was nothing to suggest from the information provided, by those involved in his care, that his mental state was deteriorating.

d. In view of the client's history the Panel concluded that the Responsible Medical Officer (or his deputy) should have taken responsibility for monitoring his discharge and for taking a more pro-active role in the management of his follow up care. The role of the forensic Community Psychiatric Nurse was not clearly defined and his withdrawal from the case should have been managed and decided upon through a multi- disciplinary meeting. All aspects of the client's care and treatment would have benefited from a greater multi-disciplinary discussion.

e. As professional line manager of the Clinical Nurse Specialist, the Community Mental Health Team Manager did not have the detailed knowledge of the Clinical Nurse Specialist's cases and work practices which the Panel felt might reasonably have been expected."

168. The Panel Members were unable to support these conclusions. From the enquiries undertaken, the Panel have concluded that:

a. There was sufficient evidence of deteriorating mental health before the incident to warrant the client's assessment under the Mental Health Act 1983 with a view to compulsory admission to hospital and that the RMO should have taken action.

b. There was a loss of focus on the risk the client could offer.

c. The withdrawal of the worker who was the specialist in challenging behaviour, the CNS, added to an already worsening situation.

d. There were enough signs of problem drinking for workers to have taken any information regarding increasing usage as an indicator of increased risk of violence.

169. The Independent Panel recognise that the information available to them exceeds that which was available to all of the internal inquiries, and in particular that at the time of the internal Inquiry the family chose not to meet with or in any way contribute to the process despite invitations to do so. The Independent Inquiry was able to benefit from discussions with members of the family, and have access to additional documentation

that they provided. Whilst this enabled the Panel to have a greater understanding of the circumstances, it did not alter the panel's view that the Internal Inquiry had sufficient information to reach the same conclusions.

170. There were also a number of weaknesses in organisational performance, which contributed to the failures by individual staff or meant that staff did not deliver as high a standard of service as could reasonably be expected. We discuss all these elements below. In addition, we comment on the failure of the professionals to take adequate note of all the concerns voiced by members of the family.

Care of the client by the Trust and the CMHT

171. The panel concluded that much of the care and treatment that the client received was very good. This was certainly true during the period before his admission to the Medium Secure Unit, while he was in the Unit, for the brief period at Warley Hospital in May 1998 and for the first 3 months of his return to the community (whilst he was still living in Barking). The panel was particularly impressed by the work done by the Social Worker, KD, throughout this period.

172. Although individual members of staff worked conscientiously after the client's move to Harold Hill, the services were never so well co-ordinated and there was no effective programme of care. Various members of the CMHT staff showed a lack of knowledge regarding the application to practice of the Mental Health Act, the Care Programme Approach and the powers of the Courts.

173. When responsibility for the client's after-care transferred to CMHT (2), the team covering the client's new address, a decision was made that a CPN would become Care Co-ordinator with the backing of the Clinical Nurse Specialist (CNS). This CNS, NK, had a background in forensic nursing and his involvement in the case was an acknowledgement of the client's earlier admission under Section 37 of the MH Act 1983, and of his offending history. He should have contributed a particular understanding of the risks posed by someone with the client's history. A major element of the role is education and training, and the individual CNS carries a small caseload to allow training and supervision to other multi-professional staff from a variety of agencies including Probation Services, Social Services, Local Authority and GPs. In this case there was no evidence that he was fulfilling this role, on the contrary there was evidence that he was not.

174. By February 1999 the role of Care Co-ordinator had passed to another CPN, TM. Towards the end of February the client's mother contacted his former Social Worker, KD, because she was concerned about the deterioration in the client's mental health and was feeling that the current workers were not listening to her concerns. The information she gave indicated a serious increase in the risk posed by the client. She said he was

becoming increasingly paranoid, was carrying a knife, he was drinking more heavily and she thought he was not taking his medication. This information was passed to NK who in turn shared it with TM. Instead of using the information to ensure an assessment was undertaken and appropriate action followed, NK became involved in a dispute with TM over the latter's input. NK attempted to visit the client but he was not at home. Shortly after this he withdrew from the case.

175. The Panel accepted that the decision to suspend his input was taken after discussion with the CMHT Manager and in the knowledge that the CPN responsible for the case was very experienced. Nevertheless, the Panel considered that this and his subsequent decision to withdraw were ill judged. The Panel were also of the opinion that the system within the CMHT should not have allowed this unilateral action.

176. NK was aware of increasing concerns from a number of professionals about the client, as specified in his letter of 4th March 1999. In his position as a CNS, he should have been in a position to act. Rather than doing so he withdrew. In part it was due to a lack of effective clinical and or management supervision that he was able to withdraw at this crucial time without redress.

177. TM, as Care Co-ordinator, continued his involvement with the client. He became increasingly concerned, eventually considering that the client should be in hospital. Nevertheless, he felt that the client's mental state had not deteriorated sufficiently to warrant the client's assessment under the Mental Health Act 1983 with a view to compulsory admission. It would appear that TM had decided that the client's forthcoming Court case provided an opportunity for the PO to recommend to the Court that the client should be returned to hospital.

178. The Panel considered that TM was incorrect on both counts - the Court could only act on the basis of a recommendation of a Consultant Psychiatrist and the Panel believes there were sufficient indications of illness to warrant an assessment and admission under the Mental Health Act.

179. The Panel had considerable sympathy for TM, who had taken on the responsibility for this case on the mistaken belief that this would be for a short time only, due to the likelihood of a custodial sentence. The reality was that he was left carrying responsibility for this increasingly worrying situation, with support but no real help from his line management and an RMO who did not actively participate in the management of the case.

180. From the evidence regarding CMHT 2's involvement in the care of the client, it was concluded that there were some weaknesses in the management and organisation of the

CMHT and its external relationships which need to be addressed. The Panel found a lack of clarity about roles and responsibilities within the team, exacerbated by an over-complex structure of supervision.

181. The lack of effective input by the RMO, Dr C, was the matter of most concern to the Panel. An RMO should be an active member of the CMHT. In this instance Dr C. saw the client once on a domiciliary visit in Dec 1998, then twice while he was in hospital, but appears to have had little influence on his management. He was aware of concerns about the client's mental state, that he was not taking medication which he thought he needed, and wanted to find a way of making sure he did, by depot injection.

182. Following the client's return home he relied completely on reports from NK then TM. From his evidence to the panel, by the beginning of April, Dr C. did recognise the client's potential for dangerousness but felt powerless to act. He accepted the CPN, TM's advice that the client was not Sectionable under the Mental Health Act and did not seek to make his own assessment. He appears to have advised a Probation Order with condition to take medication as directed, at a time when there was already a Probation Order with a condition of treatment in place, but not being effective.

183. The Panel believe that the RMO's care of the client fell below acceptable professional standards. He appears to have been ignorant of, or ignored the relevant history and clinical information, failed to assess risk adequately, in spite of the evidence and inappropriately advised probation officers who sought his specialist help. He failed to provide adequate after-care under the Care Programme Approach.

Recommendations

184. The Trust and Social Services Department should review the clinical supervision and management and operations of the CMHT, to promote a more co-ordinated approach and ensure professional roles and boundaries do not reduce the teams' overall effectiveness. In future the RMO should be an active member of the CMHT and play a full part in its practice and development.

185. The Panel believe that the RMO, Dr C, failed in his duty of care, and recommend that appropriate remedial procedures should be considered.

186. The decision making process of the CMHT, which allowed the withdrawal of the CNS from the care of the client at a time of increasing risk, sanctioned by the manager, should be reviewed and a more effective mechanism introduced.

187. The CNS showed poor judgement that significantly impacted on the care of the client and left the panel with concerns about his practice. We recommend the re-examination of his job description, retraining and much closer, more effective supervision.

Failure to recognise problems of alcohol misuse

188. All the workers who gave evidence to the panel and the internal Inquiry said that the client did not show any signs of having a serious drink problem. Whist there is no evidence that the client was alcohol dependent, there are indications throughout his history that heavy alcohol use was periodically associated with criminal/anti-social behaviour. The information from the client's mother that he was drinking more heavily should have acted as an alarm bell for workers. And in fact, TM recorded on 21st April 1999, following a visit to the client, that the flat was untidy, and there were signs of drinking the night before.

189. The Panel was very concerned at the inability of the professionals to differentiate between drunkenness, alcohol dependence, and harmful drinking, as it seems to the Panel that they ignored obvious evidence of the latter. Given that the misuse of alcohol is known to increase significantly the chance of violent behaviour, particularly in someone with active symptoms of mental illness, it is important that staff are trained to recognise the signals and act upon them.

Recommendation:

190. Both the Barking, Havering and Brentwood Community Health Care NHS Trust and the Probation Service should ensure that training of professionals adequately prepares them to address the issue of harmful drinking, particularly in those who are mentally ill.

Limited input from the Probation Service

191. The local Probation Service had had extensive contact with the client from 1988 to 1996 ie. only 18 months before their involvement in the events detailed here. Given this, the overall contribution to the management of this case in the last few months before the incident was less authoritative than it should have been.

192. There were a number of ways in which the Probation service should have made an important contribution to the care and treatment of the client over and above immediate supervision, in particular:-

i. Providing details of any previous convictions and probation supervision.

ii. A thorough assessment of his offending including violent incidents, and the implications of this when combined with his illness.

iii. Active participation in inter-agency planning.

iv. Informed advice to colleagues in other agencies regarding courses of action which might be taken by the Courts.

193. In practice, although individual staff sought to fulfil their roles conscientiously, the contribution by the Probation service was less than could have been expected;-

i. Poor administrative systems meant that records were not available to the Probation officers when writing reports, thereby limiting the analysis they could undertake particularly relating to risk.

ii. The Duty Officer initial appointment system (compounded by sending letters to wrong addresses) meant there were significant delays before the supervising officer met the client and got involved in the case. As a result when the Probation officer liaised with the CPN it was only to hear his concerns, rather than to take an active part in ensuring treatment was available and case conferences were convened.

iii. The lack of training or availability of consultation meant that Probation staff did not have the knowledge or confidence to challenge the mental health specialists when the latter were pushing for inappropriate lines of action through the Court, or to make alternative suggestions.

Recommendations:

194. The Probation Service needs to ensure that previous records of supervision are available to officers preparing reports.

195. The Panel were pleased to hear that the Duty Officer system which had been felt to be actively unhelpful, is now restricted in medium or high risk cases to instances where the allocated officer or backup officer is not available.

196. The training issues are addressed below.

Lack of input by a General Practitioner (GP)

197. The client had little contact with GPs during the period covered by this inquiry, and indeed he was not registered with a local GP for most of the time after discharge from Warley Hospital. A central issue was whether or not the client was taking medication, which he could not get except from a GP. The Panel find it hard to see how "Care in the Community" can possibly work without the active involvement of the Primary Care Services. We consider that members of the CMHT (2) should have been more pro-active earlier in ensuring the client was registered with a GP in Harold Hill.

198. Although it may not be strictly relevant to this case, we must comment on the standard of GP clinical record keeping to which we have had access. This is quite appalling, and if typical, must pose a serious threat to medical care. Records were, in the main, indecipherable, unsigned and unattributable. Many entries were undated.

Recommendation

199. The Panel note the commitment by the Trust in its Action Plan to ensuring that in future GP registration forms part of the Care Plan of any individual under the care of the mental health service. The Panel recommend that the Trust undertake periodic audits to ensure that all patients are registered prior to discharge from hospital or within two weeks of changing geographical area.

Loss of Focus on Risk

200. In this case there were a number of significant failures in the different agencies which contributed to a loss of focus on risk and meant that when the CPN recognised that the client was deteriorating in March 1999 there was no agreed multi-agency plan for action. The failures revolved primarily around not using available information about past behaviour. This was compounded by the lack of structure for multi-agency conferences.

201. At the time the Barking, Havering and Brentwood Community Health Care NHS Trust had no policy regarding risk assessment. This has since been introduced but the Panel was concerned that further work remained to be done to ensure it becomes an integral part of practice and does not remain a paper exercise.

202. Risk assessment was better integrated into Probation practice but was weakened in this case by failures in administrative systems which meant that important information was not available.

Recommendations

203. The Barking, Havering and Brentwood Community Health Care NHS Trust needs to continue its work on risk assessment in line with Modernising the Care Programme Approach. Attention needs to be paid to raising the awareness of all CMHT staff regarding the importance of continuing re-assessment of risk, including the use of available information about previous behaviour, and integration into action plans.

204. The Probation Service needs to examine its administrative systems to ensure important information is not 'lost'.

Failure to use the appropriate structures for after-care

205. The client was still subject to an order under Section 37 of the Mental Health Act when he was transferred from the Medium Secure Unit to Warley Hospital. He should therefore have been subject to regular case conferences as well as support from individual workers. Although this was said to have been subsumed under the Care Programme approach, in practice CPA review meetings were not held regularly after he returned to the community. This had a number of implications:-

a. There was no effective structure for his care in the community.
b. There was no effective medical involvement.
c. Too much responsibility was left to the judgement of one worker (the CPN) in the final months when the client was deteriorating.

Recommendation

206. Health and Social Services need to ensure that there are effective systems for after care, particularly of those who have been detained under the Mental Health Act, and should have systems for monitoring these arrangements.

Inter-Agency Working

207. Despite the efforts of individuals, including the CPN who was Care Co-ordinator for the client, organisational links with primary care, the hospital-based medical staff and the probation service were poorly developed. This made it very difficult to achieve co-ordinated support and effective assessment of needs and risks across professional and agency boundaries.

208. At the time of the incident mentally ill clients who were also the responsibility of the Probation Service appear to have been a low priority in each of the agencies concerned. No agreements for multi-agency working were in place. Since then some steps have been taken but the Panel considered that much more needed to be done by the Trust and that Barking and Havering Health Authority should take a stronger lead in ensuring structures were in place. The agreements being sought by the Probation Service appeared to the Panel appropriate and could form the basis for future joint working.

209. The Panel was impressed by the initiative for the Forensic Outreach Worker to undertake work within the Probation office and thought this scheme should be extended. It also needs to be built in to the organisational structures to avoid the risk of collapse when an individual worker leaves.

Recommendations

210. Both Barking and Havering Health Authority and the BHB Community Health Care NHS Trust should give higher priority to mentally ill clients who are also the responsibility of criminal justice agencies and should, with greater urgency, take a lead in ensuring agreements which would assist genuine multi-agency care planning are in place. The agenda formulated by the Probation Service appears to be a sound starting point.

211. The service provided by the Forensic Outreach worker in the Probation Office should be made permanent, expanded and extended to clients throughout the area.

Gaps in Staff Training

212. In the CMHT various staff showed a lack of knowledge regarding the powers of the Courts and it is unclear whether any training had ever been offered. The panel received no evidence that the gaps in training were being addressed by the Health Authority or the Trust. Training did not appear in the Action Plan drawn up by the Trust as a result of the Internal Inquiry.

213. The appointment of the CNS appears to have been an attempt to enhance the work of the CMHT in relation to clients with forensic backgrounds. A major element of the role is education and training. In this case there was no evidence that he was fulfilling this role. In the Probation Service neither the PO supervising the client nor her Senior had had any training in working with offenders who were mentally ill, nor in joint working with colleagues in the Health Service. This led to an over-reliance on the views of the CPN and the advice of the Psychiatrist.

214. At the same time, there was no provision for Probation staff to have access to consultation from local Mental Health workers. Advice from a worker familiar with both agencies would have been extremely helpful in this case.

Recommendations

215. The Health and Social Services need to ensure that staff, including Consultants, are trained and supported in working with difficult to engage clients who are also involved with the criminal justice system, on an inter-agency basis.

216. Expectations of the Clinical Nurse Specialist (CNS) in contributing to the training of staff within the Community Mental Health Team, and in other agencies, need to be clarified.

217. The Probation Service needs to recognise that post-qualifying training in this area of work is essential. At the same time, provision needs to be made for all probation officers working with this group of clients to have easy local access to consultation from a mental health professional along the lines of that now being provided by one of the Forensic Outreach workers for offenders in Barking, Dagenham and Havering at the Romford Probation Office.

Lack of continuity of care

218. Good continuity of care was provided in the first year of the client's contact with the Mental Health Services, while he was in Barking. This was in part because flexibility was shown by the CMHT in allocating the case to a worker known to the family although outside her usual catchment area. This Social Worker provided effective support both before the client's admission to the John Howard Unit and in the crucial months after he was discharged.

219. After the client's move to Harold Hill this link was lost. Over the next six months he experienced a change of Consultant, two new community psychiatric nurses, a clinical nurse specialist, two probation officers and a different team of hospital staff. Had there been a GP, that would have made one more. Not surprisingly, he does not appear to have formed a close relationship with any of them. And inevitably, it was difficult for any of them to assess changes in his mental state.

220. Given the needs of agencies to operate services on a geographical basis and given the rapid staff turnover in this area, these changes can be seen as inevitable. However, they undoubtedly also militate against engaging in services clients who are reluctant to admit

they have a problem or who are, for whatever reason, resistant to accepting medication or other treatment.

Recommendation

221. The Panel could see no easy solution to this general problem. An assertive outreach service with a cross boundary remit would be more effective in engaging and maintaining contact with clients like the client. Until or unless this exists the Panel highlights the importance of good documentation and systems for transfer. In this case practice was of a variable standard - some very good, some adequate and some poor.

Disregard of the family experience and expertise

222. The client's mother has significant experience of supporting three family members diagnosed as having schizophrenia. It was in fact the client's mother that first alerted the mental health services to the client's developing symptoms, as she was able to recognise these from her observations of other family members. However, although the value of the information provided by the client's mother was recognised during the initial period of care, this diminished as responsibility was taken over by professionals less familiar with the family, and less knowledgeable about the client himself.

223. Although there is no way of predicting the impact on the final outcome of more attention being paid to this experienced informant, it is likely that the increasing risk of the client causing harm to himself or others may have been identified at a much earlier stage, and acted upon.

Recommendations

224. The Trust and Social Services should remind all staff of the importance of partnerships between those providing services and the individuals and their families affected by mental illness. A focus on highlighting 'inclusion' should take place during all education programmes, case conferences and during the management of care. There should also be an emphasis on monitoring the translation of this into practice through both management and supervisory mechanisms.

225. The contribution of such an experienced informant cannot be underestimated and emphasis must be placed on communicating the value that such an individual brings to the management of care and supporting the delivery of satisfactory outcomes.

APPENDICES

APPENDIX I

The Panel members are as follows:

- Mrs Sheila Roy, (Chair) Independent Healthcare Consultant

- Ms Megan Rhys, formerly Assistant Chief Probation Officer, Inner London Probation Service (retired)

- Mr Donald Brand, Director of Policy and Workforce Development, National Institute for Social Work

- Dr Kenneth Craig, Consultant in General & Community Psychiatry.

APPENDIX II

Procedure adopted by the Independent Inquiry Panel

1. Every witness of fact received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement as the basis of their evidence to the inquiry and inform them:

    a. Of the terms of reference and the procedure adopted by the inquiry.

    b. Of the areas and matters to be covered with them.

    c. That when they give oral evidence they may raise any matter they wish which they feel might be relevant to the inquiry.

    d. That they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness.

    e. That it is the witness who will be asked questions and who will be expected to answer.

    f. That their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact were asked either to affirm or confirm that their evidence is true.

3. Any points of potential criticism were put to witnesses of fact, either verbally when they first gave evidence, or in writing at a later time, and that they were given a full opportunity to respond.

   All sittings of the inquiry were held in private.

4. The draft report will be made available to the commissioners of the Inquiry, the Health Authority and Social Services, and other relevant parties agreed by the commissioners, for any comments as to points of fact.

5. The evidence submitted to the inquiry either orally or in writing will not be made public by the inquiry, except insofar as it is disclosed within the body of the inquiry's report.

6. Findings of fact will be made on the basis of the evidence received by the inquiry. Comments which appear within the narrative of the report and any recommendations will be based on that evidence.

APPENDIX III

WITNESSES

FAMILY	
The client	
The client's mother	
The client's sister	
BARKING, HAVERING AND BRENTWOOD COMMUNITY HEALTHCARE NHS TRUST	
Ms YC	Chair – Internal Inquiry
Mr NK	Clinical Nurse Specialist
Mr MMcG	Manager CMHT 2
Dr C	Consultant Psychiatrist
Mr TM	Community Psychiatric Nurse Not seen by the Panel but TM took the opportunity of seeing the Final Draft Report but did not submit any comments to the Inquiry
SOCIAL SERVICES	
Mr BH	Team Manager (Acting Manager, Dagenham Community Mental Health Team 7)
Ms KD	Former Care Co-ordinator and now Approved Social Worker (Community Mental Health Team 6)
PROBATION SERVICES	
Ms RL	Probation Officer
Ms RS	Probation Officer
Mr PB	Assistant Chief Probation Officer
Ms SC	Assistant Chief Probation Officer
Ms LD	Assistant Chief Probation Officer
BARKING AND HAVERING HEALTH AUTHORITY	
Mr MB	Deputy Director Mental Health

APPENDIX IV

DOCUMENTS CONSIDERED BY THE PANEL

THE FAMILY

1. Comments on the Internal Management Investigation into the Care and Management of the Client
2. Witness statements taken at the time of the incident
3. Copies of Communications from the client's mother to the Judge

BARKING, HAVERING AND BRENTWOOD COMMUNITY HEALTH CARE NHS TRUST AND SOCIAL SERVICES

4. Internal Management Investigation into the Care and Management of the Client
5. Witness Statements taken at the time of the incident
6. Warley Hospital Case Records
7. Community Mental Health Team Case Records
8. Barking, Havering and Brentwood Community Health Care NHS Trust Community Operational Policies
9. Community Mental Health Team Operational Policy
10. Action Plan from Barking, Havering and Brentwood Community Health Care NHS Trust
11. Updated Action Plan, Barking, Havering and Brentwood Community Health Care NHS Trust to Barking and Havering Chief Executive Officer
12. Line Management Structure
13. Risk Assessment Tool

JOHN HOWARD MEDIUM SECURE UNIT

14 Case Records for the Client

PROBATION SERVICE

15 North East London Probation Service Management Review of Services

16 Probation Service Circular No 71/1998 Serious Incident Report Analysis

17 Case Notes of the Client

18 Previous Records of Supervision of the Client

19 Policy/Strategy for Working with Mentally Disordered Offenders

20 Guidance on working with Mentally Disordered Offenders

21 Outline for Training for Probation Officers

22 Home Office Training Pack for Working with Mentally Disordered Offenders