REPORT OF THE

INDEPENDENT INQUIRY

INTO THE CARE AND

TREATMENT OF

PATIENT R

AND

PATIENT Y

A Report commissioned by

County Durham and Darlington Health Authority

December 2000

CONTENTS

PREFACE

A panel consisting of the persons listed below was established by the former County Durham Health Authority in February 1999 to undertake an inquiry into the care and treatment of Patient R and Patient Y.

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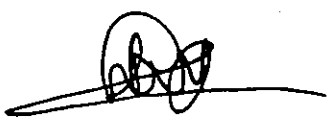
We now present our report, having had regard to the terms of reference set down for us by the Authority, and having adopted the procedure set out in Appendix A.

Anne Galbraith

Christopher Simpson

Adrian Childs



David Parkin

Note : This report was commissioned in February 1999 by County Durham Health Authority. On 1 June 2000 the Authority became County Durham and Darlington Health Authority

CHAPTER ONE

BACKGROUND TO THE INQUIRY

Introduction

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

1.2 The inquiry could only commence once criminal proceedings had been completed. In the case of Patient R, she was charged with the murder of Patient Y on 16 December 1997. The case came to trial in December 1998, when Patient R pleaded not guilty to murder, but guilty to manslaughter on grounds of diminished responsibility. The case was adjourned for sentencing until January 1999, when Patient R was put on probation for three years, with a condition that she live at and participate in an identified Alcohol Project.

1.3 Both Patient Y, the victim of the crime, and Patient R had been receiving mental health services. The terms of reference of the inquiry required the panel to look into care and services in relation to both of them.

1.4 The inquiry panel met on a number of occasions to determine its method of working and to decide which records, documents and publications it required. Work was put in hand to obtain the necessary consents for the release of records and documents, and to establish who should be approached for written statements. Subsequently, these written statements informed the view of the panel in determining which witnesses should be invited to the oral hearings. Dates were fixed well in advance for panel meetings and the oral hearings, in order to minimise delays.

1.5 The approach adopted by the panel was based on experience of earlier panels, both in County Durham and elsewhere. The panel was also mindful of the judgement in Crampton and others v Secretary of State for Health ("the Allitt case"), which set out some important principles to be borne in mind in such proceedings.

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

Terms of Reference for the Inquiry

1.7 The terms of reference established by the former County Durham Health Authority are set out in Appendix B.

Obtaining Records and Documents

1.8 One of the first tasks of the inquiry team was to obtain the necessary consents from Patient R and from the next of kin of Patient Y for the disclosure of all appropriate records. With the very limited information available to the panel members at that early stage, the full extent of Patient Y's family was not known, and initial approaches were made to his parents for the necessary consents.

1.9 Patient R's consent was obtained at a meeting with the Chairman of the inquiry panel, arranged at the Alcohol Centre, when the opportunity was taken to explain the remit of the panel, its modus operandi, the contribution which Patient R herself could make, if she so wished, and the need for her consent in order that the various records could be obtained and made available to the panel.

1.10 It was subsequently realised that the panel may be assisted by medical reports which had been prepared in advance of the sentencing of Patient R. Efforts were made to obtain consent to make these reports available to the panel and, although Patient R herself consented, the solicitor who had commissioned the reports did not feel able to release the reports without seeing Patient R and confirming her consent. As this did not occur, the panel had to accept that these potentially helpful reports could not be made available.

1.11 The panel also drew up a list of Trust and Social Services policies, Government strategy documents and earlier independent inquiry reports which were regarded as essential preparation for the inquiry. These are listed in a bibliography at Appendix C. The compilation of documents and the gathering of the necessary medical and social services records was a significant task of great importance to the ability of the panel to take forward its inquiry.

Witnesses and Written Statements

1.12 Once the panel had determined the list of those whom it wished to approach for written statements, letters were written to 31 people or organisations, inviting them to make a written statement about their involvement with the care of Patient Y and Patient R. The text of the letters varied slightly to accommodate the differing associations with Patient Y and Patient R. A specimen letter is included at Appendix D.

1.13 Useful additional material came forward as a result of these approaches, but it was disappointing to note that some recipients gave notice that they did not wish to appear at the oral hearings. In some cases this was connected with movement out of the NHS or retirement, but in other cases it was connected with stress, particularly associated with earlier experiences of having appeared before similar inquiries.

Preliminary Meetings

1.14 The panel recognised that the inquiry would be stressful for the family of Patient Y, as well as for Patient R herself. It was therefore decided that an offer should be made to the parents of Patient Y for the Chairman of the inquiry to meet with them in advance to explain the terms of reference and to answer any questions they may have. They did not wish to take up this offer.

1.15 A similar offer of a meeting was made to Patient R. At the time of the meeting, she had not given her consent to the release of her records. The meeting therefore also served to explain how important it was for her to agree to give her consent, which she then did. In the event, the meeting was particularly significant, as Patient R subsequently declined to attend the oral hearing of the panel.

Oral Hearings

1.16 The receipt of the witness statements allowed the panel members to form a judgement about who they wished to have the opportunity to meet at the oral hearings. The panel also determined the order in which it wished to meet people, but in some cases this had to be varied to suit availability. The inquiry was greatly assisted by people being able to adhere to the chosen order of the panel because early warning of the dates when we planned to hold the oral hearings had been given. The letter sent to all those invited to attend the the oral hearings is reproduced as Appendix E.

1.17 Inevitably, some key personnel did not attend the oral hearings. In one significant case, this was due to the death of the person concerned, very shortly after his retirement from the Social Services Department.

1.18 A proportion of those attending the oral hearings were accompanied, either by a solicitor, a colleague, or a friend or family member. Some of those interviewed, especially those involved with the Health Services in the area, had changed roles within the service, and many were affected by service reconfigurations which had occurred.

1.19 The panel were anxious to hear from Patient R, both in terms of her view of the service she had received from the various agencies and her perception of the services offered to Patient Y. In the event, Patient R declined to attend the oral hearing. Members of the inquiry panel were prepared to visit her at home, if she would have preferred to meet there, but that request was also declined. Through her social worker and probation officer, the panel were made fully aware of her reasons for declining to attend. It was also made clear that Patient R did not believe that the services could have acted differently because she herself was choosing to drink, and had not been taking any responsibility for her drinking.

1.20 All witnesses were greeted informally by the Chairman in advance of their session. Once introduction of the panel had been effected, the Chairman made the same opening remarks to all who attended, covering the format of the interview, the making of a recording for the purpose of creating transcripts of the interview, the opportunity which would be afforded to correct the draft

transcript, the order in which the panel would ask questions, how the draft report would be prepared, and the opportunity which would be afforded for further comment and response at draft stage to anyone who may be the subject of criticism in the report.

1.21 Those attending the oral hearings were sent a draft transcript of their interview, and invited to make factual corrections. Some also took the opportunity to comment further, where they believed they had not given a sufficiently rounded picture, or where they had subsequently recalled points of significance. All additional material was considered by the panel.

The Report

1.22 At the close of the oral hearings the panel members took the opportunity to formulate their thinking about the key issues which had emerged during the hearings and from the written statements and materials gathered. A working draft of the report was then prepared by the Chairman, with appropriate contributions from members of the panel, which was considered in detail at a meeting of the full panel. Further revisions were made in the light of those discussions. The panel also agreed those sections which needed to be circulated in draft form to parties or organisations who may be subjected to criticism, to allow them a full opportunity to comment further. Responses received as a result of the circulation of parts of the draft were then considered by the panel, and further re-drafting was undertaken where necessary.

Acknowledgements

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

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

CHAPTER TWO

THE INCIDENT AND THE OUTCOME

2.1 Patient Y had moved in to live with Patient R at her home in County Durham. Both of them had divorced their spouses. Both had developed tendencies to drink excessively. Their relationship was a turbulent one. On an occasion in December 1997, in the evening when both of them had been drinking, there was an argument in their home. Patient Y had gone upstairs to bed. Patient R had taken a knife from the kitchen, and followed him upstairs. There, he was fatally stabbed in the chest by Patient R. She immediately summoned help from neighbours, and an ambulance was called. Ambulance personnel sought to resuscitate him, but he was already dead.

2.2 The trial of Patient R took place at Teesside Crown Court in December 1998. Patient R pleaded not guilty to murder, but guilty to manslaughter, on grounds of diminished responsibility. Her defence of diminished responsibility was grounded on the basis of "a combination of chronic alcoholism coupled with a psychiatric history at the time she killed Patient Y, which resulted in an abnormality of mind that was such that it substantially impaired her responsibility" for the killing.

2.3 The trial continued later in December 1998, when it was expected that pre-sentence reports would be available to the court. On that date the court heard the defence lawyer in mitigation, but no disposal was possible, as reports from certain agencies about the availablity of appropriate placement opportunities were not available, and the judge in the case wanted a further assessment made. The case was therefore adjourned again until January 1999, when Patient R was sentenced to three years probation, with a condition that she reside at and participate in the nominated Alcohol Project.

CHAPTER THREE

PATIENT Y

HIS BACKGROUND AND INVOLVEMENT WITH HEALTH AND SOCIAL SERVICES

Introduction

3.1 Patient Y was born in June 1954, the second of a family of four children. He came from a stable family background, and continued to enjoy support from his parents and other relatives up to the time of his death.

3.2 After an undistinguished school career, during part of which he was a pupil at a special school because of dyslexia, he left school to start work. He married when he was aged 20, in 1974. There were three children of the marriage. The marriage ended in divorce in 1986, and the children went to live with their mother.

3.3 For a period of more than twenty years, from leaving school until shortly after his divorce, Patient Y was in regular employment, latterly for more than 11 years with a local brewery. His health over that period appears to have been good, with his general practitioner records revealing a varied range of physical ailments or incidents, but not revealing any consultation or treatment for mental illness.

Medical History between 1987 and 1998

3.4 In April 1987, there is a first mention of "lot of worries, going through divorce proceedings" in the medical notes. By December 1988, the notes say "Severe depression. Suicidal thoughts. Ex wife going down south soon. Sleep very poor. Appetite poor. Lost a lot of weight. Now living with girlfriend." On this occasion, his General Practitioner, Dr D, prescribed the anti-depressant mianserin, and referred Patient Y to Dr C, Locum Consultant Psychiatrist at Hartlepool General Hospital, indicating in his referral letter that "his symptoms probably started a few months ago since he was divorced".

3.5 At that time, December 1988, Patient Y was still employed at the brewery, but his work record deteriorated over the next year, and in February 1990, during a consultation with the GP, he indicated that inquiries were being made by his employer about his health. Subsequently, on 6 March 1990, he reported to the GP that he had received a letter from his employers terminating his employment with three months' pay. The GP notes also record "Nervous debility".

3.6 During this same period, Patient Y was still following through a series of appointments with the psychiatric services, following the first referral to Dr C in December 1988. He had been seen by Dr F, the Senior House Officer to Dr C, on 11 January 1989. Dr F wrote to Dr D, the GP, advising that Patient Y had been offered a short period of hospital admission, which he had

refused. He was started on the anti-depressant amitriptyline, and advised not to drink alcohol while taking this medication. The GP was also informed that if Patient Y experienced further sleep problems, he could be prescribed the sleeping tablet temazepam. Arrangements were made to see him at the out-patient clinic in one month's time.

3.7 Patient Y failed to attend at outpatient appointments in February and May 1989, and was discharged. He was subsequently re-referred by his GP on 14 August 1989. Dr F, the SHO, wrote again to Dr D on 15 November 1989, indicating that Patient Y was drinking 6 - 8 pints of beer each day, and that he found him reluctant to take amitriptyline as he believed it made him more depressed. The letter also comments on the fact that Patient Y was still taking temazepam 10 mgs nocte, and advising that it should not be taken more than 2 to 3 times per week, and requesting that the GP ensure that the patient received only the sufficient supply of temazepam.

3.8 When Patient Y was reviewed again on 21 February 1990, Dr F found that he was still drinking heavily. He recorded in a letter to the GP that in his opinion Patient Y was dependent on alcohol, and unless he was willing to stop drinking, he would not benefit from any medication. The letter made clear that he could go onto the ward for a drying out period, but Dr F expressed doubt that Patient Y would decide to go in.

3.9 It was clear that at that time, Patient Y was beset by problems of debt. The local Citizens' Advice Bureau was trying to assist him with his debt management, and had requested information from Dr C which might assist them at a forthcoming court hearing. In a letter to the Citizens Advice Bureau dated 14 May 1990, Dr C commented that Patient Y "had no motivation for stopping drinking, and once again he refused to see a Social Worker. It was advised his sleeping tablets should be stopped or if used, only sparingly. In conclusion, he is suffering from reactive depression and alcohol dependance. Because of his lack of co-operation and motivation it is difficult to plan any treatment, but he will be seen on an out- patient basis and given advice as required. The prognosis at this point would seem to be poor. I am unable to answer at this stage whether he would be capable of employment in the future."

3.10 The out-patient records, the letters from Dr C and Dr F, and the GP records at this time all show a picture of regular heavy drinking, increased use of temazepam, now prescribed at 30 mgs nocte, lack of motivation on the part of Patient Y to come off alcohol, refusal by him of any help offered, whether in-patient admission, use of the day hospital services, disulfiram therapy (a medication which causes an extremely unpleasant reaction after the ingestion of even small amounts of alcohol), or referral to social services.

3.11 On 13 July 1991, Patient Y was admitted to Hartlepool General Hospital via the Accident and Emergency Department for 24 hours after taking an overdose of temazepam combined with alcohol. He was seen during that admission by Dr H, the Staff Grade Psychiatrist. A number of out-patient appointments were made for Patient Y during the remainder of 1991 and early 1992, which he failed to attend. He was discharged by Dr C on 14 April 1992.

3.12 On receipt of the discharge letter from Dr C, Dr D, the GP, immediately contacted G, the Community Psychiatric Nurse (CPN) based at the Health Centre at Peterlee. The letter to G indicates that Patient Y had a history of alcohol and drug abuse, and that he did not keep hospital appointments and did not like to see doctors. Unfortunately, there were no notes relating to this referral available to the panel. Checks made with the relevant Trust established that they were unable to identify any CPN involvement, despite Dr D's letter to G.

3.13 The pattern of the GP re-referring Patient Y to the psychiatric out-patient department is repeated in subsequent years, and there is a regular report of him failing to attend. His GP noted in a letter to Dr K at Hartlepool General Hospital in September 1994 that Patient Y had been unable to attend because he had had a bad time and could not face people. However, in that letter, he noted that Patient Y had improved to some extent, and had expressed a desire to see Dr K.

3.14 By that time, the waiting list for out-patient appointments in the Peterlee sector was long, and Patient Y was not seen until an extra clinic session, which was arranged for 8 April 1995, where he was seen by Dr J, a Staff Grade Psychiatrist at the Hartlepool Community NHS Trust. At this date, Patient Y indicated that he had been living with his present girlfriend for some seven years, and they had recently had a baby son. Dr J recorded that he considered that Patient Y was suffering from an anxiety/panic disorder leading to avoidant behaviour and secondary depression, and that there was also a past history of alcohol abuse. Dr J also noted that he had advised Patient Y to attend the psychiatric day hospital to work on controlling his anxiety. Dr J's letter was copied to the Hartlepool and East Durham Drug and Alcohol Service (hereafter referred to as The Drug and Alcohol Service), as it was his understanding that Patient Y was attending there with regard to counselling and attempting to reduce his temazepam.

3.15 Patient Y was seen once at the psychiatric day hospital, on 17 April 1995. The nursing note on the multi disciplinary assessment and rehabilitation profile states that Patient Y "had been abusing temazepam. He was on 30 mg tablets, and was taking 3-4 of these a day. He has been referred to Drug and Alcohol team at Peterlee, and now is only taking one at night." At another point in the notes, it is said that he took the pills "to sleep the day away".

3.16 Dr J discharged Patient Y back to his GP on 28 September 1996, because of failure to attend at the psychiatric out-patient clinic. For long periods, the GP was coping alone with the care of Patient Y. There is no evidence available to the panel of any input at this stage from the CPN service. The records available to the panel from the Hartlepool and East Durham Drug and Alcohol Service show that he was seen once, on 5 January 1996. He attended the next appointment on 9 February, only to state that he was unwell and could not stay. Thereafter he did not attend. From the one proper attendance, the counsellor indicated that Patient Y did not accept that he had a drink problem, and thought that his problems were with temazepam, but he did not wish to withdraw from this medication.

3.17 The GP notes show a regular pattern of prescription of temazepam, reducing from 30 mgs nocte in 1995, down to 20 mgs nocte and then reduced again to 10 mgs nocte from the end of 1995. The GP was usually only prescribing for

periods of one week, which appeared to be used as a control mechanism. The other drugs regularly being prescribed in 1996 and 1997 were paracetomol, cloral betaine and diazepam, all prescribed at the same intervals as the temazepam. Dosages were altered from time to time in the prescription record and the notes record that temazepam was discontinued from 10 September 1997.

3.18 Patient Y had moved out of the accommodation he shared with his girlfriend and their baby during the middle of 1996. For a time, he lived in a pub, or with friends, but he then moved in to live with Patient R, whom he had met in a pub. She too had problems with alcohol abuse. Their relationship was quite volatile, especially when both had been drinking. The incident resulting in the death of Patient Y occurred after both had been drinking, and had had a violent argument, on the evening of 16 December 1997.

Relationship of Patient Y with his GP

3.19 Patient Y had been a patient of Dr D since Dr D took over the practice in the 1970s. The panel learnt from Dr D that he remembered Patient Y as a nervous, shy lad when he had first known him. He did not come to the practice much, until he started to have some marital problems, when he became rather depressed. Dr D was aware that Patient Y was getting involved in alcohol and drugs. At that time, there were few specialist support services in that field, and Dr D had referred him to a psychiatrist, but it became clear to him that Patient Y was a non-attender.

3.20 At the time of the breakdown of Patient Y's marriage, the GP recalled that he was well supported by his mother, but once Patient Y moved away from his mother's home, the GP considered that he was becoming more involved in drugs. The GP recalled many occasions when he had sought to encourage Patient Y to cut down on alcohol, and to wean him off temazepam. He was anxious to treat Patient Y, rather than just feed his drug habit, but he recognised that Patient Y was not motivated to change.

3.21 The GP's aims were to deal with his depression, to wean him off drugs and alcohol, and to try to rehabilitate him. He felt that communication with the Psychiatric Department was good, but he did not receive much feedback from the Drug and Alcohol Service. Generally, he felt that local mental health services were not ideal, and there was scope for much improvement.

3.22 On the question of managing the drug regime of Patient Y, the GP felt that his hands were tied in a number of ways. He was continuing to prescribe temazepam in accordance with the recommendations of the Consultant Psychiatrists, but this did not necessarily reflect his own view of what was needed. He was also mindful of the patient's own expressed wishes, particularly in view of the fact that patients are all too ready to move to other practices if thwarted by the GP. Dr D had instituted a rigorous regime of small, regular prescriptions, with review of dosages, resulting in reduction in dose and ultimately withdrawal of temazepam. However, he was of the view that if a patient still wanted the drug, it would be fairly readily obtainable on the local streets.

3.23 For long periods, Patient Y was given a number of different drugs by the GP. As well as temazepam, he was prescribed cloral betaine, which the GP believed was a non-addictive sleeping tablet, and diazepam. The doctor was unsure whether he had commenced the diazepam, or whether it had been recommended at some earlier stage by the Consultant Psychiatrist. He saw this drug as helping to calm someone like Patient Y, who was such an anxious man given to shaking. The GP was aware in prescribing this combination of drugs that he needed to be mindful of Patient Y's alcohol abuse, and he confirmed that he had reflected this in the daily dosage levels of the drugs.

3.24 The GP did not consider that doctors were particularly well supported by the Drug and Alcohol Service, as he believed that the service they provided was mainly of benefit to those who were motivated to use it. Patient Y was not so motivated. In the view of the GP, it is necessary for the Drug and Alcohol Service to work more actively with the families and friends of the patient. He sees the service offered to patients as being a rather soft approach, and feels that there may be merit in withdrawing drugs and alcohol and then assisting the patient with any withdrawal effect. He accepts that a GP alone is in a difficult position to improve the situation of someone like Patient Y when drugs are readily available on the street.

Involvement with the Social Services Department

3.25 The panel confirmed that although Patient Y had had contact with the Social Services Department, this had been in connection with family matters when he was living with a former girlfriend with whom he had a baby. No other record of contact with social services was found.

Involvement with Inpatient Hospital Services

3.26 There were only two relevant admissions for in-patient care. One of these occurred in June 1990, when Patient Y was admitted to Ward 16 of Hartlepool Hospital at the request of his GP as he was feeling depressed, anxious and tense, and was missing his girlfriend as she had made him move out. He stayed for only one night on the ward, and wanted to leave the next day so that he could speak to his girlfriend about their problems. He was discharged against medical advice, and was to be reviewed in the out-patient clinic, which took place in September 1990.

3.27 The other occasion when Patient Y was admitted as an in-patient was in July 1991, when he had overdosed on temazepam, and was admitted to Ward 8. The discharge letter to his GP indicates that he was observed for 24 hours, and no complications developed. The letter also records that he was seen and advised by the psychiatrist.

Involvement with Psychiatric Outpatient Services

3.28 It is difficult for the panel to make a structured judgement about the effectiveness of Patient Y's involvement with out-patient services, as he was such a frequent non-attender. It is clear from the occasions when he did attend that numerous alternative treatment strategies were discussed with

him, including in-patient treatment for his depression (1989), admission to the ward for a drying out period (1990), referral to social services (1990), referral to the day hospital (1991), and disulfiram therapy (1991), all of which he refused.

3.29 Patient Y's GP referred him for an out-patient appointment in September 1994. Due to long waiting lists, Patient Y was not seen until 8 April 1995, by Dr J, the Associate Specialist. Although Dr J had had no previous association with Patient Y, he made a very thorough assessment of his problems and formed an appropriate treatment plan. Patient Y was referred to the Psychiatric Day Unit, where he was assessed by the Staff Nurse there and then while he was attending an out-patient appointment with Dr J. He appears to have attended the Day Unit once during April, and then did not attend again. He did not attend the out-patient appointments which had been made for him.

Involvement with the Hartlepool and East Durham Drug and Alcohol Service

3.30 There were two separate occasions when Patient Y was referred to the Drug and Alcohol Service. The first was in March 1995, when the referral came from Dr J at Hartlepool General Hospital. Patient Y was sent a letter arranging an appointment at his GP's surgery for 28 April 1995. He did not attend this appointment. A further appointment was arranged for 16 June 1995, when he also failed to attend. He was then discharged back to his GP on 30 June 1995.

3.31 Patient Y was referred to the service on a second occasion by his GP, who arranged for him to be seen on 5 January 1996 within the service at the GP's surgery. He attended only two sessions. At the first session, the outreach counsellor formed the view that Patient Y did not see alcohol as a problem, and did not wish to withdraw from temazepam. At a second session, on 2 February 1996, Patient Y turned up but did not stay as he felt unwell. A new appointment was made for him on 9 February, which he did not attend. In consequence, he was discharged back to his GP.

CHAPTER FOUR

ISSUES AND CONCERNS ARISING FROM THE CARE OF PATIENT Y

4.1 The major issues which arise in relation to Patient Y's care and treatment are his alcoholism, his depression, his dependence on temazepam and other drugs, and his repeated failure to engage effectively with a range of services offered to him.

4.2 In relation to his problems with alcohol, those close to Patient Y believe that his drinking pattern appeared to have changed from social drinking to dependent drinking after his divorce in 1986. The reliance on alcohol was probably exacerbated by the fact that at least one of his close friends, with whom he regularly associated, was an alcoholic. Moreover, Patient Y was also being precribed temazepam which, in combination with alcohol, would aggravate the effect.

4.3 There is a significant amount of evidence before the panel that his family, his GP and various hospital specialists all encouraged him to cut down on his consumption of alcohol, and suggested or directed him towards appropriate help. It is also clear to the panel that some of the evidence it heard showed convincingly that Patient Y did not believe he had a problem with alcohol, and did not want to give up drinking. When efforts were made by his family to encourage him to give up, he was stubborn, and they formed the view that it was his way of escape and of not facing reality. He appeared uncommitted in his contact with the Drug and Alcohol Service, expressing the view to them that his problem was with temazepam rather than alcohol, and he did not sustain his connection with the service. He was offered in-patient treatment to assist him to dry out, but he declined. His GP was offering him regular advice on the matter of his levels of drinking, and made one of the referrals to the Drug and Alcohol Service.

4.4 Whilst recognising that the problem of alcoholism was compounded by his other problems, the panel considers that the support offered to Patient Y in respect of his problems with alcohol was in the main timely and appropriate. The lack of effectiveness of this support was largely due to Patient Y's own preferences. However, the panel has reservations about the lack of assertiveness of the Drug and Alcohol Service, and these issues are explored in greater detail in Chapter Eight.

4.5 In relation to Patient Y's depression, the panel accepts that he became an increasingly anxious and nervous person after his drinking increased following the break up of his marriage and subsequent divorce, the loss of regular contact with his children, severe financial worries, and ultimately, as his health deteriorated, increasing anxiety about the security of his employment. The panel considers that the approaches adopted by his GP, involving a limited regime of drug therapy and regular contact, were a genuine attempt to provide appropriate care. The panel considers that this genuine attempt by the GP may have been more effective if the GP had had better support and advice with his prescribing, and would have been more valuable and effective therapeutically if Patient Y had co-operated with the services.

However, the panel recognises that it would not be easy for an insecure man like Patient Y to cooperate without social support.

4.6 Patient Y's consistent pattern of failing to attend appointments and make use of psychiatric services made it difficult to develop sustained and consistent support for him, with the result that he would seek assistance at moments of increased anxiety or crisis, and then withdraw. The panel considers that a number of service areas may need to be reviewed, to reflect different and more assertive approaches to patients who are known to be reluctant attenders. This was certainly known in the case of Patient Y, as his GP had flagged up this propensity on a number of occasions when making referrals.

4.7 Patient Y's reliance on temazepam developed from it being prescribed for him in 1989. Thereafter, the records show that he was receiving prescriptions for the drug regularly, at various rates of dosage, until it was withdrawn by his GP in 1997. As early as March 1991, Dr F was suggesting that Patient Y may have become dependent on the drug, but that the patient wanted to continue the drug as he could not sleep.

4.8 His GP was aware of the problems of dependence on temazepam, and sought to reduce the dosage from time to time and to keep a firm control on the quantity available to Patient Y by prescribing only for short periods. The panel accepts the view of the GP that the drug was probably readily available on the streets, and it is likely that Patient Y was able to obtain additional supplies in that way. Moreover, the panel accepts that if the doctor had refused to prescribe temazepam, he may have lost general oversight of the health problems of the patient, who would have been quite likely to have stopped attending the practice.

4.9 The panel also accepts that it was appropriate for the GP to seek support in the treatment of Patient Y's dependence on drugs and alcohol from the Drug and Alcohol Service. The panel was disappointed to learn that the Drug and Alcohol Service did not seem to operate in an effective partnership with GPs, and that the dialogue between the service and Patient Y's GP appeared to be extremely limited. The panel believes that the service was most appropriate for those patients who were willing to engage effectively with it, which Patient Y was not.

4.10 In the limited contact the Drug and Alcohol Service had with Patient Y, it was possible for them to glean that he considered his principal problem to be dependence on temazepam and that he did not consider he had a problem with alcohol. Efforts were made by the Drug and Alcohol Service to ensure that Patient Y understood the interaction of alcohol and temazepam, and to encourage him to keep his appointments with his consultant. No doubt work with Patient Y could have proceeded effectively had he continued to attend. When he failed to do so, he was discharged back to his GP.

4.11 The relationship between the Drug and Alcohol Service and the GP seemed to be rather haphazard, and there did not appear to be any system for constructive dialogue to discuss ways in which a particular patient might be assisted. A GP is thus faced with receiving back a patient with a rather intractable problem, with few resources other than drugs with which to assist the patient. In the case of Patient Y, the GP was a single handed practitioner, so he did not enjoy the benefit of colleagues with whom he could discuss other strategies.

4.12 The panel accepts that, in general, Dr D would prefer to wean patients off temazepam, and that his notes clearly indicate the number of occasions on which he discussed this matter with his patient, and that he did ultimately withdraw the drug. The panel also accepts the pressure which a GP can face when patients are demanding certain drugs or treatments. However, the panel is of the view that if the GP had received more effective support and more open communication from the Drug and Alcohol Service, it might have been possible to take a more rigorous stance in the prescription of temazepam to Patient Y.

CHAPTER FIVE

PATIENT R

HER BACKGROUND AND MEDICAL HISTORY

Introduction

5.1 From reports available to the panel it appears that Patient R was born in early January 1962, the youngest child of a family of nine. Her father was the Chief Engineer of the local colliery. She grew up in a happy family environment where, as the youngest sibling, she was spoilt by the rest of the family.

5.2 Patient R did well at school, where she enjoyed considerable academic success at the CSE Examinations. She left school at the age of 16, and undertook a pre nursing course in Durham. She did not complete this course as she had shirked her studies. Instead, she took up employment away from home as an auxiliary nurse. Her mother had been a nurse, and two of her sisters had also qualified.

5.3 Patient R was married in 1982 at the age of 20 to a local man from the same village. The husband was away at sea in the Merchant Navy, and by this time Patient R was working locally in a factory. About four years later, her husband left the Navy and came home to work in a pub. Patient R also obtained employment there.

5.4 From reports available to the panel, it appears that the marriage began to be in trouble at this point. Patient R's husband drank heavily, was unfaithful to her and violent during arguments. Her own drinking habits deteriorated in response to her husband's behaviour, although there is some suggestion that she was already drinking heavily during the early years of her marriage, when her husband came home on leave bringing large quantities of alcohol with him.

5.5 There were two children of the marriage. The couple separated early in 1994, following a violent incident when Patient R and her children had to be taken by a Family Court Welfare Officer to stay with her parents. Since then, the children have remained with their grandparents for the majority of the time. The violence between Patient R and her husband was so great that on one occasion he received a short custodial sentence for breaking a court injunction. The couple divorced in 1995.

5.6 Once Patient R had separated from her husband, she stayed for more than two years with her parents. Over this period her drinking habits were of necessity under some measure of control as she did not drink at her parents' home. She had secured her own home during this period but it was some time before she moved into it. Even while she was living with her parents, she would go to her own home to drink, sometimes bingeing there for a few consecutive days.

5.7 When Patient R moved into her own home, she left her children in the care of their grandparents, where she considered that they enjoyed a better quality of life. She maintained daily contact with them. This support for the children offered by her parents was reinforced by support which they continued to give to Patient R herself, although it is apparent in some of the case notes that she found their standards and regimes to be irksome.

5.8 Patient R met Patient Y in Autumn 1996. He was a heavy drinker, and in his company she could not exercise control of her own drinking. Patient Y then moved into Patient R's house. Their relationship appears to have been volatile. They would drink heavily for a period of days until their finances ran out. When both of them had been drinking, they would argue. Patient Y would resort to physical violence, but Patient R would lash out verbally.

5.9 On the day of the incident there had been a row between Patient R and Patient Y early in the day. Patient Y left the house, and Patient R continued to drink. She then discovered that Patient Y had locked her in the house. When he subsequently returned, further violent exchanges occurred, and Patient Y went upstairs to bed. Patient R followed him upstairs with a knife, and fatally stabbed him.

Patient R's Medical History

5.10 Patient R was a longstanding patient of Dr Q, a single handed practitioner in Shotton Colliery. There is nothing particularly remarkable in her GP notes until a first entry dated 14 March 1985, when the comment is made "advised to cut down drinking habit". At this time she was aged 23, and had been married for three years. This comment in her notes pre-dates the birth of her two children, and is also before her husband left the Navy.

5.11 Later that year, the GP notes also make a first mention of depression, on 28 June 1985. This predates the birth of her two children in 1986 and 1988. After the arrival of her first child, the GP notes make reference to post-natal depression in January 1987. Thereafter there are regular entries detailing depression or anxiety, and another specific entry relating to post-natal depression after the birth of the second child, in June 1988. Amongst other drugs prescribed from time to time there were fairly regular prescriptions of flupentixol, an anti-depressant.

5.12 The first referral to specialist services for anxiety and depression came in April 1990. After the GP requested a domiciliary visit, Patient R was seen by Dr C, Locum Consultant Psychiatrist at Hartlepool General Hospital. He admitted her "for a period of drying out", having identified that she had a drink problem as well as marital and family problems. Dr C considered that her problems had caused a chronic anxiety state in her, and he noted that she was depressed and at times talked about harming herself.

5.13 On admission to ward 16, the summary in the record notes that Patient R had been feeling suicidal over the previous two weeks. She considered that her problems had begun over Christmas, during a period of great anxiety about one of her children.

5.14 The nursing notes over the four days of Patient R's in-patient stay indicate that she settled well on the ward and socialised with fellow patients. She appeared to be co-operative with the staff.

5.15 In a discharge letter to the GP dated 27 April 1990, Dr F, the Senior House Officer to Dr C, noted that Patient R had been started on a reducing dose of clomethiazole, and that she had responded very well. There was no evidence of withdrawal symptoms, and her mood had been bright and cheerful. She showed no evidence of any florid psychotic symptoms, and no biological symptoms of depressive illness. She had discharged herself against medical advice, and her husband took full responsibility for her discharge. She was prescribed no medication. The discharge note to Dr Q indicated that Patient R did not wish to come to the out-patient clinic.

5.16 Patient R was again referred to Dr C by her GP in August 1990, and she was informally admitted again on 26 October 1990 for three days. There is some suggestion in the notes of an inadvertent overdose on tablets. The nursing notes during this stay indicate that Dr C spoke very frankly to her about her alcohol abuse and her current abuse of clomethiazole. It is clear that Patient R was already in touch with the North East Council on Addictions, who had agreed to see her on a weekly basis. The panel has no information to show that she ever attended. On discharge from Ward 16, she was given a three day supply of clomethiazole only.

5.17 It is clear from the GP's records that he also attempted to refer Patient R to the Community Psychiatric Nursing service in August 1990. That service was obviously under considerable pressure in Peterlee, as the GP eventually received a letter from the Team Leader, asking him to reassess the need for Community Psychiatric Nursing involvement, and to re-refer if necessary at some future date.

5.18 When Dr C saw Patient R at an out-patient clinic in November 1990, he reported to the GP that he saw a vast improvement in her and that she did not show any sign of depression. She was not on any medication at that point.

5.19 Over a year later, in December 1991, the GP again referred Patient R to Dr C, indicating that she was still suffering from anxiety and depression, was very weepy and was drinking excessively. When Dr C saw her in July 1992, he indicated to the GP that he felt that no progress would be made with Patient R on an out-patient basis, so he was going to arrange to admit her for drying out. There is no evidence in any of the notes available to the panel that this admission ever occurred.

5.20 Throughout 1992 and 1993 Patient R consulted her GP from time to time, and the drug record for that period shows a variety of prescriptions for a number of different ailments, but with no particular emphasis on drugs for depression or alcoholism.

5.21 Early in 1994, the GP asked Dr C to make a domiciliary visit to Patient R. On 9 February 1994 Dr C saw her at her parents' home. He formed the impression that she was not sufficiently motivated to give up alcohol, but decided to admit her to dry her out, although he was of the view that once she was discharged from such an admission she would "go back to square one."

5.22 On admission to Ward 15 on 10 February 1994, the psychiatric condition for which she was admitted was noted in the documentation to be "Alcohol dependency syndrome". Her marital problems with her husband were acute at this stage. The nursing notes indicate that she herself asked for a referral to the Drug and Alcohol Service, in order to have help when she was out of hospital. The notes also make clear that there were occasions during this in-patient stay when she smelt of alcohol on the ward. There were also occasions when she was breaking the ward rules about visitors, and at least one of her visitors came in "the worse for wear for drink".

5.23 Patient R was discharged from hospital on 22 February 1994, with an out-patient appointment fixed for 21 April 1994. She had seen the alcohol counsellor during her stay, and had discussed disulfiram treatment with Dr C, which she had refused. She was discharged on chlordiazepoxide 5 mgs for one week only.

5.24 Despite a number of appointments being offered to Patient R by the Drug and Alcohol Service, she did not attend. The notes for the Drug and Alcohol Service do indicate that the counsellor had a call from Patient R on 15 March 1994, in some distress and wanting to end her life. The counsellor made a home visit, accompanied by the Drug and Alcohol Service Manager. Patient R had calmed down by the time they arrived at her home, and the manager, a Registered Mental Nurse, formed the view that there was no clinical depression. In April 1994, the counsellor discharged her after she failed to attend on a number of occasions.

5.25 Patient R's next in-patient admission to Hartlepool General Hospital was on 7 December 1994. Her GP had requested a domiciliary visit, which was made by Dr K, the Locum Consultant Psychiatrist. She determined that Patient R was in need of emergency admission, for crisis intervention, assessment of paranoid state and alcohol detoxification. After two days, Patient R discharged herself, but she was eventually persuaded by her family to return to the ward. At that stage her behaviour was such that Dr K considered that she should be detained on a section under the Mental Health Act if she attempted to leave the ward again. On some occasions during this in-patient stay, Patient R's behaviour was quite volatile and extreme.

5.26 Patient R remained on Ward 15 until 19 January 1995. Initially she was difficult to manage on the ward. In his discharge letter to the GP, Dr L, the SHO to Dr K, noted that she was displaying "pressure of speech and was unpredictable and also displayed lability of mood. One thought, therefore, that this patient may have an underlying hypomania. She also had a multitude of somatic complaints". He went on to describe her idiosyncratic reaction to even a very small dose of haloperidol, an anti-psychotic drug, which had to be discontinued. She had displayed episodic and unaccountably destructive behaviour on the ward, for which she later apologised. There was a suggestion that she had been drinking during her period of stay, and also when away from the ward on home leave. The discharge arrangements included an out-patient appointment for 4 April 1995.

5.27 During this stay on Ward 15, Patient R was seen by the Drug and Alcohol Counsellor on 16 December 1994. No feedback from this consultation was given to ward staff, and it does not appear to have resulted in any follow-up

by the service, although the discharge notes indicate "Drug and alcohol to be informed".

5.28 Patient R did not attend out-patient appointments in April and July 1995. On 18 August 1995 a probation officer called at Patient R's home to deliver a birthday card for one of her children from the child's father. Patient R "lost control" and became very angry, threatening self harm and harm to her children. As a result of her behaviour, the probation officer called in social services, and asked for an assessment by an Approved Social Worker. It was at this point that S, a social worker with County Durham Social Services Department, became involved in the care of Patient R.

5.29 S visited Patient R the same day. He found her to be in an agitated state and almost clinically paranoid about her husband. He considered that her elderly parents were at the end of their tether with her extremes of behaviour. He considered that she needed to be seen by a Consultant Psychiatrist, and arranged an appointment with Dr J for 25 August 1995 at Peterlee Community Hospital.

5.30 When he called to tell Patient R about this appointment, the social worker found her in an extreme state of agitation, shouting at her mother and berating social services. He believed that Patient R was frustrated by her parents' rigid attitudes and was feeling under pressure because of her relationship with her husband and forthcoming court proceedings. These factors, coupled with her predeliction to turn to alcohol when under stress, were having a deleterious effect on her mental health.

5.31 The social worker accompanied Patient R to her appointment with Dr J on 25 August 1995. She was prescribed the anti-psychotic drug chlorpromazine at that visit. Dr J expected to review her in three weeks time, but in the meantime, the GP had had to request a domiciliary visit from Dr M, Consultant Psychiatrist, which resulted in admission to Ward 16 at Hartlepool General Hospital on 29 August 1995, where she stayed until 9 October 1995.

5.32 During her stay on ward 16, Patient R was very distressed at times, displaying unpredictable and histrionic behaviour. During home leave, she resumed her drinking habits and caused some destruction to her home. When she was discharged, the notes record that she was to have an urgent out-patient appointment at Peterlee, and that there should be Community Psychiatric Nurse (CPN) follow-up. There is no record of any CPN follow-up at this time.

5.33 Patient R was accompanied to an out-patient appointment on 23 November 1995 by her social worker, S. She failed to attend the next appointment in January 1996. However, her GP needed to ask for a domiciliary visit on 6 January, when Patient R was seen by Dr I, Consultant Psychiatrist. He prescribed the sedative chlordiazepoxide with some trazodone, an anti-depressant. He also proposed that she should be seen by Dr N at the Community Hospital in Peterlee.

5.34 On 9 January 1996 Patient R was admitted overnight to Ward 8 of Hartlepool General Hospital, following an overdose. She was alleged to have taken a number of nitrazepam sleeping tablets and chlordiazepoxide tablets.

5.35 Dr N did see Patient R on 11 January 1996, but makes no mention in his letter to the GP of the incident involving the overdose two days earlier. He reviewed her medication, and noted that Dr I was waiting to admit her to a detoxification bed. At a further review on 6 February, Dr N reported to the GP that everything seemed to be going very well for the time being.

5.36 The Drug and Alcohol Service notes contain a record that Patient R was referred to them by the social worker on 18 June 1996. She was assessed by a counsellor at the service to determine her suitability to join an alcohol support group. The plan indicated that she would attend the group on Wednesdays at Peterlee, and could have one to one counselling at her request. There is no record of Patient R attending the group, or ever seeking one to one counselling.

5.37 Later in the year, again at the request of the GP, Dr I made another domiciliary visit on 28 August 1996, at a time when Patient R was again drinking heavily and when she had lost a considerable amount of weight. Dr I wrote to her GP, indicating that "she has been living with her mother who was away on holiday at the time of my visit. Her sister was looking after Patient R's children, but was finding it difficult to look after them and keep an eye on Patient R as well. Patient R had become quite tense and anxious. She has also been low spirited with interrupted sleep and initial insomnia. There was no diurnal variation of mood and I could not elicit any active psychotic features. There was a mild hand tremor, but sensorium was clear and I could not elicit any delusions or hallucinations." As a consequence of this domiciliary visit, she was admitted again to Ward 16, under the care of Dr J.

5.38 Following her admission to hospital, an initial risk assessment to determine a recommendation of likely level of Care Programme Approach (CPA) was completed on 30 August 1996. At this stage, the initial recommendation was mid-level CPA. The checklist which forms part of the assessment form clearly states "NB People being treated for alcohol/drug related or learning disability problems should only be included if they have an identifiable mental illness."

5.39 The initial CPA risk assessment form and other hospital documentation make reference to S as Patient R's social worker, but the files of the Social Services Department show that the case was formally closed by them on 5 July 1996. S may have still had some informal contact with Patient R, as the nursing notes make reference to him bringing her back to the ward on the evening of 4 September. This date was well after the formal close of social services involvement. It is difficult to check what his connection with Patient R was at that time, as S retired from the Social Services Department in September 1996, and died a few months later.

5.40 Over the period of her stay in hospital, Patient R was seen on eight occasions by Dr J. He was suspicious of paranoia but it never reached delusional intensity. Nor could he elicit any psychosis. He thought her problems were alcohol related.

5.41 Patient R was discharged from hospital on 24 September 1996. At some stages during her stay, her behaviour had again been disruptive. There were times when she was suspected of taking alcohol while on leave, and she continued to believe that a variety of people were "ganging up on her". On

one occasion, on 3 September 1996, her reaction to a suggestion that she had been drinking was so extreme that, for the safety of staff and fellow patients, security staff were called to remove her from the ward. She did not return to the ward that night, and was escorted back the next day by her former social worker, S.

5.42 Prior to Patient R's discharge from hospital, Dr J discussed the discharge plan with her mother. At that meeting the ward sister was also present. There was no social worker present, nor anyone representing the CPN team. From the consultant's entries in the records and from the nursing notes, it is clear that the plan on discharge included weekly out-patient appointments at Peterlee to see Dr J, continued attendance at the Drug and Alcohol Service and referral to the CPN service.

5.43 A checklist form relating to the After-Care of Psychiatric Patients was completed in the hospital on 24 September, but the form does not identify who filled it in. In that form, the long term goals on discharge are identified as "To remain mentally well in community with adequate support to meet needs." The plan towards achieving those goals included a note that Patient R had received seven days medication and should contact her GP before her supply ran out. It also indicated that she had been referred to the CPN service, who would contact her shortly with an appointment. The plan also urged her to continue to attend the Drug and Alcohol Centre at Peterlee for counselling and support. Finally, it indicated that "Your Social Worker, S, has retired. You will be allocated another shortly."

5.44 It had been decided that Patient R should be discharged on 25 September. However, on the evening of 23 September, she left the hospital in a taxi and went to her parents' home. Contact was made with the family by telephone by the ward staff, but Patient R did not return to hospital that night. Instead, she came the next day during the afternoon to collect her discharge prescription.

5.45 The discharge letter to the GP, written by Dr L, SHO in Psychiatry, makes particular mention of an interview with the patient's mother, who had advised that Patient R was under severe strain at that time, as she was now divorced and her ex-husband had remarried, and, in consequence, Patient R felt "hard done by". It was confirmed, however, that her family was very supportive of her and her two children. The discharge letter also makes clear that Patient R had been given extensive supportive counselling on the ward. It refers to the review arrangements as "Referred to CPN Department and out-patient appointment", and is marked "cc CPN Office Peterlee". The letter makes no mention of Patient R's behaviour on the ward, or that she had left the ward before her formal discharge. By contrast with an earlier letter written by Dr L, in respect of an in-patient episode in 1995, this letter was lacking in detail and background information.

5.46 There were no notes available to the panel with regard to the CPN service. It subsequently became clear to the panel from evidence they were given from a variety of sources that Patient R was not seen by the CPN service following her discharge. Instead, a decision was taken at a meeting of the Community Mental Health Team to allocate her case to the Drug and Alcohol Service, which was regarded by them as more appropriate in her case, given her history. The only record which can be traced of this decision is a handwritten

list of patients made by the CPN team leader, which shows Patient R's name on it, with a date, 1 October 1996, and the initials D/A beside it.

5.47 No information about this decision to refer Patient R to the Drug and Alcohol Service appears to have been fed back through the CPA administration systems, nor was the key worker informed, as the CPA process would have required. By coincidence, the key worker in Patient R's case at this time was Dr J, because of the retirement of S the social worker. However, well before his retirement, S had closed the case in July 1996. If, on discharge, there was some expectation that Patient R would continue to receive support from a social worker, there does not appear to have been any request made from any source for social services involvement through the allocation of a new social worker. Dr J was entirely unaware that his name had been entered on the CPA form as the key worker.

5.48 Independent of the Community Mental Health Team's decision that Patient R's case was going to be looked after by the Drug and Alcohol Service, there was also a referral form in the Drug and Alcohol Service notes showing that Patient R was referred to them by Sister A, from Ward 16. That note indicated that "Patient R responded to treatment as an in-patient, and is willing to continue counselling for alcohol problems. An early appointment would be appreciated."

5.49 Patient R was sent an appointment with the Drug and Alcohol Service, on 21 November 1996. She did not attend. She was sent a further letter on 20 January 1997, asking her to make contact if she wished to make another appointment with the service. She did not make contact. As she had by then received three letters of invitation to use the service, to which she had not responded, she was discharged in accordance with the department's working standard. There is a discrepancy, however, in that the note indicating that she was being discharged from the service is dated 13 January 1997, whereas the last of the three letters of invitation to her is dated 20 January 1997.

5.50 The other part of the discharge plan when Patient R left hospital on 24 September 1996 was that she should continue to see Dr J regularly. However she failed to attend to see him. As she was also not attending the Drug and Alcohol Service, and had not been allocated a CPN, and no new social worker had been requested , she was therefore effectively out of touch with all support services other than her GP. His records show that Patient R saw him on 4 November 1996 for a medical problem, on 30 December 1996, and on 22 January 1997, in respect of a cough and cold. The GP continued to prescribe a variety of drugs for her until late September 1997. The list of drugs is much diminished from those prescribed in previous years, and is not heavily dominated by drugs for alcoholism or depression and anxiety.

5.51 When Patient R was discharged from Hartlepool General Hospital on 24 September 1996 a mid-level CPA was in place. The panel has seen no notes or records in relation to the CPA process for Patient R, other than the CPA checklist for initial risk assessment which was completed in hospital on 30 August 1996. By virtue of other enquiries and investigations, it has been ascertained that she was discharged from the CPA on 14 October 1997.

5.52 After her discharge from hospital in September 1996, Patient R was living in her own home while her children remained with her parents. At some time during the autumn of that year, Patient Y moved in to live with her. Their volatile relationship ended in a domestic dispute and violent argument on 16 December 1997, when Patient R fatally stabbed Patient Y.

CHAPTER SIX

INVOLVEMENT OF PATIENT R WITH HEALTH AND SOCIAL SERVICES

Involvement with the GP

6.1 Patient R was a longstanding patient of her GP, Dr Q, having been his patient since 1978. Dr Q is a single handed practitioner with premises in three separate towns or villages in Easington district. He was very familiar with Patient R's medical history, and was also acquainted with her parents and several of her brothers and sisters. The GP spoke very highly of Patient R's family and the support which they had given her throughout her life.

6.2 The GP gave a full picture to the panel of the turbulent and violent marriage which Patient R had suffered. He recalled that both husband and wife would be so drunk that they did not know what they were doing. When the marriage had started to break down and Patient R had gone back to live with her parents, the GP remembered that she found it very hard to cope, and continued to drink in spite of everyone advising her to stop. He believes that she thought drink would solve her problems. She was particularly affected whenever some crisis struck in her life, and she found it very hard to tolerate when her former husband found a new girlfriend. Sometimes these crises would result in her attempting to kill herself, by taking overdoses of drugs.

6.3 Dr Q saw her problems as being her drinking habits and her depression and anxiety. In his view, he believes that her anxiety and depression were somewhat improved after September 1996. There appeared to be no corresponding improvement in her problems with alcohol. Any trigger would send her straight back to drinking. The GP was aware that she had a poor record of attendance at out-patient appointments, but he would often learn of her non-attendance some considerable time later.

6.4 In the early stages of her drinking problems, Dr Q had treated Patient R with clomethiazole, but that did not work, as she could not withdraw from it. What is more, he became aware that she was taking the drug and drinking at the same time. In consultation with one of the consultants at Hartlepool General Hospital, Dr Q had changed her drug to chlordiazepoxide early in 1994.

6.5 In Dr Q's view, Patient R had an alcohol problem which became compounded by the unhappiness in her family life which led to anxiety and depression. Despite a stable family life as she grew up with a good family, she was an unhappy person. Although she was motivated at times to stop drinking, she was unable to cope with any crisis.

6.6 The GP had sought regular help from the psychiatrists to assist him to deal with her problems. He sometimes needed to seek that help through crisis intervention, when he would ask the Consultant Psychiatrist to make a domiciliary visit. He believed that there were many advantages in using this route in Patient R's case, because it allowed the consultant to assess the home situation and family inter-relationships, it could occur at speed and it would often facilitate a speedy admission to hospital.

6.7 The GP was of the view that it had been a retrograde step to reduce the number of detoxification beds available in the area. In his opinion, there is a need for a twenty bed ward, separate from psychotic patients. He does not consider it is helpful to mix patients who are attempting to withdraw from alcohol with psychotic patients. He feels particularly strongly that this support should be available immediately it is requested by a GP, to avoid the patient becoming worse and more entrenched in the addiction before treatment commences. It has never been his habit to remove patients with such problems from his list, as he knows that some GPs would be inclined to do. Rather, he seeks to do what he can to try to assist such a patient.

6.8 Dr Q told the panel that, historically, the CPN service was virtually unavailable to his patients, as the service was extremely under resourced in the area, and it was very difficult to get such help for a patient. He was aware that the service had improved, but even with such recent improvements, their increasing workload might mean a delay in seeing a patient. In Patient R's case, it was clear to the panel that Dr Q had had more confidence in referring the patient to the consultant psychiatrist. He recalled some involvement by a CPN, and some communication from the CPN, but there is nothing In the GP records to illustrate any formal communication.

6.9 The panel explored with Dr Q the working relationships which would exist between a GP and the Drug and Alcohol Service. He was clear in his mind that the separate Drug and Alcohol Service was a development which occurred as a result of the closure of some of the detoxification beds. Referrals of Patient R to the service were made by the hospital, and he was aware that she may not have kept her appointments. He had never referred her to the service himself. He indicated that communication with him by the drug and alcohol service was poor.

6.10 Dr Q believes that Patient R's family may have been critical about the level of support which was given to her, both by the CPN service and by social services. He is not inclined to take the same view, as he believes that Patient R was effectively supported by the services. He is also of the view that her family may have formed an unfavourable impression of the treatment she was receiving in hospital, as she was often inclined to be dissatisfied herself, claiming that she was being given medication which she had already tried, and which she knew did not work. The GP had then had to persuade her to continue with the medication, promising that he would take up the matter with the consultant if it did not work after being given a fair try.

6.11 The panel formed the view that Dr Q knew in detail the problems which Patient R was experiencing. He was genuinely caring of her, and strove to support her and find ways forward to deal with her problems. His main resources, other than his own input, were the psychiatrists at Hartlepool General Hospital, and his referrals to them were timely and appropriate. He took appropriate advice and altered her drug regimes when needed but, as a single handed GP, he was without immediate recourse to help and advice of GP colleagues with regard to prescribing. He was aware of the pressure which the CPN service was under, which may inevitably have coloured his view about seeking to make referrals to them. He does not seem to have had great contact with or confidence in the Drug and Alcohol Service, but this is unsurprising, given that they do not appear to have had much direct communication with him.

Involvement with In-patient Services at Hartlepool General Hospital

6.12 Patient R had in-patient admissions in relation to her alcohol problems in April 1990, February 1994, December 1994 to January 1995, August 1995 and August 1996. Over that period, there were a number of consultants, locum consultants, staff grade and junior doctors involved in the care of Patient R, most of whom treated her on more than one occasion. On most occasions it was possible to admit her immediately, and on some occasions she stayed for quite lengthy periods on the ward. The panel had a reasonable overview of the input of medical staff into the care of Patient R through their written statements to the panel and, in one case, through attendance at the oral hearings with the panel.

6.13 Although there are reasonably comprehensive nursing notes covering the periods of in-patient treatment of Patient R at Hartlepool General Hospital, the panel were disappointed not to have the opportunity to meet nursing staff from Wards 15 and 16 at the oral hearings, as those invited declined to attend.

6.14 The panel would have found it particularly helpful to have a more structured picture from those involved in the direct nursing care of Patient R of the pattern of her behaviour on the ward. The notes do indicate a range of behavioural problems which the staff had to manage and, on one occasion on 4 September 1996, nursing staff felt it necessary for Patient R to be removed from the ward by hospital security staff. As this approach would not conform to normal expectations of best practice, it would have been helpful to the panel to have some further explanation of why this step had been necessary. It would also have been helpful to the panel to hear views from the nursing staff about any problems created for them in their management of patients by the mix of general psychiatry and detoxification beds on the wards.

Involvement with Outpatient Services

6.15 Looking back over Patient R's medical history, it is clear that she was not well motivated to attend out-patient appointments. Because her treatment and oversight was not consistent, she therefore fell into a spiral of in-patient treatment, failure to attend out-patients, new crisis, need for further in-patient treatment. There does not appear to have been any procedure for following up patients who failed to attend for out-patient appointments.

Involvement with the CPN service

6.16 There was an unsuccessful attempt to refer Patient R to the CPN service in 1990, when it was grossly overstretched in the area. This problem of lack of sufficient resource in the CPN service was so great that the service had written to GPs to ask them to reassess their patients' needs for the service, in an effort to target the staff more effectively. However, it should be noted that Patient R's GP is of the view that the failure to engage the CPN service in her case in 1990 was not in any way damaging to her care.

6.17 On the discharge plan for Patient R when she left Hartlepool General Hospital in September 1996, it was clear that she was intended to be picked up by the CPN service, by the allocation of a CPN to her case. Indeed the discharge letter to her GP was copied to the CPN service. The discharge letter was rather limited in the amount of information it contained, and, specifically, it did not mention that she had absconded from the ward during her stay, nor did it give any real indication of how bad her behaviour had been on the ward. Thus, the copy sent to the CPN service, lacking as it was in much essential detail, may have coloured the view of the service that her case could be looked after by the Drug and Alcohol Service.

6.18 It is not clear to the panel what other information would have been available to the Community Mental Health Team (CMHT) about Patient R, when they came to consider her case at a Community Mental Health Team meeting. However, at that meeting, it was decided not to involve a CPN in her care, and that instead she should be taken on by the Drug and Alcohol Service. Their decision would not have been informed by the attendance of any member of the CPN team at the discharge meeting in the hospital on 23 September 1996, because it was not normal practice at that time for the CPN to attend the hospital meeting. Thus there was no active CPN input following her September 1996 discharge. It is difficult for the panel to follow through this aspect of the decision making about Patient R's care, as there are no notes available of the CMHT meeting and the decision taken there.

6.19 This decision about transfer to the Drug and Alcohol service, rather than input from a CPN, was not communicated to the key worker. At that time, Patient R was on the mid level of the Care Programme Approach and notionally Dr J, the Consultant Psychiatrist, was her key worker following the retirement of her original key worker, S of the Social Services Department. Dr J was never aware that his name had been added to the CPA form as the key worker. The CPA procedure at that time provided that any change in the treatment plan should have been notified to the key worker. This never occurred.

Involvement with the Drug and Alcohol Service

6.20 There were four attempts to involve Patient R with the Drug and Alcohol Service; in February 1994 after a referral from Ward 16; in September 1995 after a referral by her social worker; in June 1996 after a referral instigated by Dr K, in which the social worker was also involved; and in an undated referral from Ward 16, which from its context seems to indicate that it was in September 1996. In addition, the decision had been taken by the Community Mental Health Team, probably in early October 1996, that Patient R would be looked after by the Drug and Alcohol Service rather than by a CPN. This should have resulted in a further referral to the service. There is a letter dated 15 November 1996 from the Drug and Alcohol Service to Patient R, indicating that she had been referred to them, but it does not indicate by whom. In respect of all of these attempts to engage her with the service, Patient R was discharged because she failed to attend appointments. In relation to the last referral, she was then subject to a mid level CPA, and thus her discharge from the Drug and Alcohol Service should have been notified to the key worker. There is no evidence that it was notified.

Involvement with Social Services

6.21 There had been a short term involvement of the Social Services Department with Patient R during late 1989 on a matter unrelated to her own problems. There was a second short and abortive involvement in late 1994, when Patient R sought the help of the Social Services Department in relation to a gas disconnection, but failed to keep the appointment which was made for her.

6.22 The main involvement of Patient R with the Social Services Department began in August 1995, when a probation worker who had visited her, to take a birthday card for one of the children from their father, asked for an assessment by an Approved Social Worker. This had been requested because when the birthday card was delivered, Patient R "lost control and became angry and aggressive, threatening self harm and harm to her children". It was at this stage that S, Approved Social Worker, became involved.

6.23 There is a full report and assessment completed by S in the Social Service Department files. S remained her social worker and her key worker until the case was closed by the Social Services Department in July 1996. It is known from Patient R herself that she regarded S as an important and significant participant in her care. However, apart from three very brief notes written on 25 August, 30 August and 15 September 1995, there are no other case notes referring to S's involvement with Patient R.

6.24 There is evidence in other medical notes that S was actively involved in supporting Patient R over this period, as he referred her to the Drug and Alcohol Service on one or two occasions, as well as taking her to one of her hospital appointments, and returning her to the ward during one of her in-patient stays. After the date when the case was closed off on the Social Services Department's file, and even after S's retirement, other professionals involved with Patient R's care appear to remember him lending further support to her, but the panel is not convinced that their memory of the dates involved is necessarily accurate.

CHAPTER SEVEN

ISSUES AND CONCERNS ARISING FROM THE CARE OF PATIENT R

7.1 The issues which the panel has identified as being of major concern in relation to Patient R are her alcohol abuse, her anxiety and depression, her failure to engage with health and social services, the crises which arose in her own family and domestic circumstances and her inability to cope with these crises, and the question of whether she was suffering from a mental illness.

7.2 On the question of her abuse of alcohol, there is evidence throughout the notes of Patient R informing those caring for her that she had been drinking heavily since the age of 14. The panel accepts that this became a serious problem during the early stages of her marriage, compounded by her husband also being a heavy drinker and the ready availability of large quantities of cheap alcohol which he brought home with him from the Merchant Navy.

7.3 Although her drinking habits may have started off as social drinking, Patient R was eventually turning to alcohol as a means of escape when any kind of crisis developed in her life. Her GP had identified quite early that she was drinking too much, and had advised her to cut down as early as 1985. He had sought to dry her out with clomethiazole. She was admitted to hospital for a period of drying out in 1990.

7.4 In many of the subsequent admissions for detoxification treatment, Patient R's own inability to conform to the treatment was a major problem. There are well documented examples of her absconding from the ward, and drinking while away, or bringing alcohol on to the ward. In the early stages of her treatment, when she was prescribed the drug clomethiazole, she continued to drink, thereby abusing the drug as well as alcohol.

7.5 Some of the longer hospital admissions do show some success in weaning Patient R off alcohol, but the panel is dismayed by the speed with which she relapsed when back at home. To an extent, this was due to her own lack of engagement with out-patient services and the Drug and Alcohol Service, but the panel believes that the passive nature of those services were not appropriate to support someone with characteristics and tendencies such as those demonstrated by Patient R.

7.6 The Drug and Alcohol Service never became really effectively engaged with Patient R. The panel is left with an impression of a Drug and Alcohol Service which was seriously under resourced, and not well integrated with other services, particularly the mental health service. Communication between the Drug and Alcohol Service and GPs appears to have been patchy, and the service has suffered from being re-structured and having its management arrangements changed on too many occasions. At the time under review, the service appears to have lacked strong professional leadership. The panel was also concerned that in a small community, where it was likely that the counsellors may well be acquainted with clients, there was no clear protocol about whether a counsellor should become involved with such a client.

7.7 Throughout the period under review, Patient R was receiving care from appropriate aspects of the health service, and although the panel has made some criticism of elements of her health care, it is probably true to say that she had inadequate coping skills to sustain her when life became difficult. She had a very turbulent marriage, and was subjected to physical violence. She suffered post-natal depression after the birth of both of her children. However, she enjoyed continuous support from her family, and there was no requirement for social work support until she was assessed by S in August 1995. Despite efforts on S's part, Patient R's engagement with services did not improve.

7.8 So far as Patient R's anxiety and depression are concerned, the panel noted the comment by her GP that there was one relative in her family who had also suffered from severe depression. Her GP, who knew her over a long period, recalls seeing her on many occasions when she would be very weepy, and complaining of the unhappiness in her life. In his view, this unhappiness led on to her anxiety and depression, so much so that she did try to commit suicide by taking overdoses.

7.9 The GP traces the cause of her unhappiness back to her marriage and the problems within it. He does not recall her being unhappy before that time, as she had a very good and stable family. When he sought to treat her anxiety and depression with appropriate medication, another crisis would occur in the family, which together with her alcohol problems would all cause a vicious circle, exacerbated by her further unhappiness that all her troubles could not be corrected immediately with some pill or medication. The GP believes that latterly, during 1996 and 1997, her anxiety and depression were a lot better.

7.10 In seeking to determine whether Patient R was at all relevant times suffering from any mental illness, the panel sought evidence from her medical notes, and directly from those involved in her care. The GP saw her primary diagnosis as the alcohol problem and the unhappiness in her family life, which took her on to anxiety and depression. During her various contacts with psychiatrists over the years, there was doubt over her diagnosis because of her disturbed behaviour. It was thought at times that she was suffering from paranoid psychosis or hypomania as well as alcohol dependence.

7.11 During her last in-patient stay at Hartlepool General Hospital in September 1996, when she was under the care of Dr J, he saw her on a significant number of occasions, quite beyond what would be normal during an in-patient stay. He informed the panel that he could not elicit any depressive symptomology or psychotic features. He was of the opinion that she suffered from severe alcohol dependency, within the setting of longstanding marital problems. From time to time, he noted that her condition exhibited in the form of mood disturbance, paranoid thoughts and depressive episodes, which appeared to be clearly alcohol related on an intermittent basis.

7.12 Dr J further confirmed to the panel that, although Patient R showed a suggestion of paranoia, it never reached delusional intensity. He did not consider that it was a primary illness at that time. She was admitted to a general psychiatric bed in Hartlepool General Hospital, rather than a detoxification bed, because Peterlee only had one bed for detoxification at that time, and it was always full. He did give consideration to whether a dual diagnosis was appropriate in this case, but came to the view that it was not.

7.13 The panel accepts that Patient R developed anxiety and depression secondary to marital problems and alcohol abuse. However, although she had paranoid ideas at times, the panel does not consider that she had a psychotic illness. In this view, the panel concurs with the conclusions reached from the thorough in-patient assessment which was made in September 1996.

7.14 The panel wishes particularly to record that throughout the period of time over which it has reviewed Patient R's health care, members have been impressed by the high level of support and care which she enjoyed from her family. Many of those caring for her have recorded the support which they too received from her family, in particular recording their appreciation of her mother's willingness to attend meetings at the hospital, and to ensure that she was aware of what was being planned for Patient R's care.

7.15 The panel has given consideration to the reasons why Patient R may have failed to engage with the outpatient service and the Drug and Alcohol Service. Although it has identified some problems with the lack of assertiveness of those services, the panel accepts that Patient R was a difficult patient, who was non-compliant and unco-operative on many occasions.

CHAPTER EIGHT

THE RANGE OF SERVICES AVAILABLE AND THEIR ORGANISATION

Introduction

8.1 In the case of Patient Y and Patient R, they were both resident within Easington district. In terms of healthcare, therefore, the commissioning authority at the time of the incident in December 1997 was County Durham Health Authority. Previously, it had been North Durham Health Authority. Any social services requirements they had would be the responsibility of County Durham Social Services Department.

8.2 In the period before 1994 responsibility for the provision of health services to the people of Easington District was shared on a geographical basis between Hartlepool Health Authority, Sunderland Health Authority and Durham (later North Durham) Health Authority; for part of this time responsibilities for the provision of community and hospital services to the same population was split between different Health Authorities. Since 1994 North Durham Health Authority and then its successor County Durham Health Authority (now County Durham and Darlington Health Authority) was responsible for the commissioning of health services for the whole population of Easington.

8.3 This historic pattern of provision of services may account for the long term underfunding of health services in the Easington district. Easington has never had its own large hospital. Service provision for residents of Easington depends on which geographical part of the district the patient lives in. Easington has been recognised for some time as having high levels of deprivation.

8.4 In recognition of some of the historic problems, a joint commissioning board was established in 1993 to bring together all relevant parties to focus on the health and social services needs of Easington, and small amounts of investment were made. Work undertaken by the Sainsbury Centre for Mental Health, who produced a report in December 1999, shows the complexity of service provision for Easington residents, both in terms of numbers of providers of service, but also in terms of the different procedures and paperwork which the various providers use. The conclusions from the report are reproduced at Appendix F.

8.5 On virtually every indicator used in the Sainsbury work, Easington is shown to be below the average on the Sainsbury database. For example, the Royal College of Psychiatrists' recommendation for a population the size of Easington would be 4.4 Psychiatrists, whereas in fact there were 2.3, which included psychotherapists. On funding, the spend per head of population is described by Sainsbury as "an extremely low spend". It is estimated that investment in the health services in the region of £9m would be required to make good the previous deficits which had occurred.

The Issues and Problems Identified

8.6 In relation to the two specific patients being considered by the panel, the issues and problems identified in respect of the period involved included the number of single handed GPs in the Easington area, the relative lack of priority being given to Easington over a number of years by various Health Authorities, a lack of integration between various elements of the health service, and between health services and social services, failure to comply with the CPA process, inadequate Community Psychiatric Nursing services, under-resourced and passive Drug and Alcohol services, difficulty in recruiting and retaining psychiatrists and other key professionals, and, at least on this occasion, the lack of an accurate internal critical incident inquiry and report.

8.7 Some of these issues and problems were identified and explored in detail by those who carried out the Locality Profile of Mental Health Services in Easington, undertaken by the Sainsbury Centre for Mental Health. The panel regards the information contained in the Sainsbury report as supportive of the views it has formed of many aspects of the service. The Sainsbury work was focused on Easington in general, whereas the work of the panel was directed to looking at the care of two specific patients from the Easington area, and identifying how the services had worked in their particular case. There is nothing in the findings of the panel which in any way contradicts or is at variance with the contents of the Sainsbury report. For that reason, much detailed information about the structure of services has been dealt with in more abbreviated form in this report. With the permission of the Sainsbury Centre and the commissioners of their work, their Conclusions from their report are contained in Appendix F, and should be read as an integral part of this report.

Single Handed GPs

8.8 The panel discovered that there are a number of single handed general practitioners in the Easington area, and that under former health service regimes some of them were fundholders. Given the paucity of secondary support services in the Easington area, the panel felt a concern that the burden of difficult patients would fall disproportionately heavily on single handed GPs, who would not have extensive networks of support within their own practices. The panel respects the view of one of the single handed GPs that a single handed practitioner can provide better continuity of care for patients, which may result in a better doctor/patient relationship. However, the panel felt that being single handed could have implications for the time which such GPs could spend on further training and education, and updating of their own skills.

Lack of Priority for Easington

8.9 The panel was given a detailed explanation for the relative lack of priority given to Easington by the Health Authority. In part this was due to the many changes which had occurred in respect of organisational responsibility for health services in Easington. In part, it was also due to the scale of the other agendas with which the Health Authority was coping, including some major

Private Finance Initiative schemes for acute hospitals in Durham and Bishop Auckland.

8.10 However, the impact of the lack of priority given to Easington was clearly felt by those involved with delivering services to residents there. It was referred to as the "forgotten area" or "the black hole" during the oral hearings. When services are sparse and those delivering them are greatly overstretched, the view was expressed to the panel that it can lead to low expectations on the part of those using the services. Moreover, the lack of priority also impacted on the morale of those staff who were working in the area and, in the view of the panel, undoubtedly contributed to the difficulty of recruiting and retaining key staff.

8.11 Mental health services are currently being given a much higher profile by County Durham and Darlington Health Authority, which published its strategy for A Joint Approach to Mental Health for County Durham and Darlington in 1999. When this strategy was being put together, it was recognised that Easington involved additional problems, mainly due to the number of providers of services involved. Additional work would therefore need to be undertaken to inform the development of a strategy for mental health services for Easington - hence the work of the Sainsbury Centre and the publication of their report in December 1999.

8.12 A working group representing all relevant agencies has now been set up to take forward the priorities identified in the Sainsbury report. The focus of attention of the work of the group is to establish community services in Easington, rather than further developing in-patient services in Hartlepool, Durham and Sunderland. In the view of the panel, this process must be supported by adequate on-going resources, to enable high quality staff from all relevant professional backgrounds to be recruited and retained. Retention of staff is particularly important, given the previous history of Easington where there have been as many as 12 consultant psychiatrists, many of them locums, over a period of ten years. It has also proved difficult to recruit to other key posts.

Joint Working between Various Elements of the Health Service

8.13 The decade 1989 to 1999 was a period of great organisational change within the health service. The advent of GP Fundholding was quite significant in the Easington area, where a number of the GPs are also single handed practitioners. Trusts were established, which then underwent a number of mergers over the course of the decade. A number of these Trusts provided services within the Easington District. The Health Authorities were also rationalising and merging. Towards the end of the decade, moves were also afoot to inaugurate Primary Care Groups within the health service.

8.14 Against this background of organisational upheaval, it should be remembered that the geography and historical service provision in Easington meant that residents of the different parts of the district would look to Sunderland, Durham or Hartlepool for their health care. There was virtually no provision of mental health services physically within Easington. Acute mental health services were provided in Hartlepool or Sunderland, although Community Mental Health Teams do operate from within Easington itself.

8.15 When the panel considered the likely needs of patients such as Patient R and Patient Y, the point of entry to the system for their care were their respective general practitioners. Both doctors experienced poor interface and communication with the Drug and Alcohol Service, although they both appeared to find their ability to access acute psychiatric services satisfactory. Patient R's GP made use of domiciliary visits from time to time, and although he was disturbed by the reduction in the number of detoxification beds at Hartlepool, nevertheless he was usually able to secure admission for in-patient treatment when it was required.

8.16 Of more concern to the panel was the experience of Patient R's GP in attempting to make referral to the Community Psychiatric Nursing service. He found a service which was under-resourced and over-stretched, so much so that at one stage the CPN service was writing to local doctors to ask them to reconsider requests for input from the service.

8.17 Once a patient had been admitted for in-patient care, the panel had some concerns about the discharge arrangements prevailing in the mid-1990's. These were evidenced in Patient R's case, when no member of the Community Mental Health Team was present at the discharge meeting at Hartlepool General Hospital in September 1996. In consequence, the Team would be unaware of the linked strands of aftercare which the consultant was seeking to put in place for Patient R, and this resulted in them effectively disregarding the discharge plan. They appeared to operate in something of a vacuum in the way in which they removed her name from their list of potential patients, without informing the key worker as required by the CPA process. Although it seemed that they had referred Patient R to the Drug and Alcohol Service, no provision was made for any exchange of information if she failed to attend for appointments with the Service. In consequence, she was discharged from that service too, with no information about her discharge being passed to the key worker.

8.18 The panel was concerned that the fragmentation of services across Easington, and the consequent differing systems in use with regard to CPA was likely to create confusion among patients and professionals alike. It is also likely that it could create considerable inequity, depending on who the funder and the provider happened to be.

Joint working between Health and Social Services

8.19 On the question of joint working and integration between health and social services in the Easington area, the panel recognised the difficulty caused by the number of Health Authorities and the number of service providers which the Social Services Department had to relate to. This was no doubt exacerbated by constantly changing personnel, especially in the health services. We have already commented on the poor integration of services within the health service itself, and the effect of that was magnified when further integration with social services was necessary. Moreover, there was no well established history of effective joint working. There were also some political stumbling blocks over the period under review, when the advent of NHS Trusts and GP Fundholding were regarded with suspicion or hostility in some areas.

8.20 The Social Services Department had adopted a system of routing all enquiries through a Customer Services loop. This was no doubt helpful to the public in general as a way of accessing the full range of County Council services, but it did not recognise the particular and special inter-relationships necessary between health and social services, and did not therefore facilitate a "joined up service". The process for accessing social services was a feature which many of those speaking to the panel complained about.

8.21 On the ground, integration of services was not assisted by the Social Services Department developing its own separate drug and alcohol services, rather than looking for a joint approach with the health service. Elsewhere in the service, good communication between CPNs and social workers had been better at an earlier time in Easington when both groups were based at the Community Hospital, but the social workers were subsequently re-housed elsewhere. Once that happened, the attendance of social workers at Community Mental Health Team meetings was more sporadic.

CPNs and the Community Mental Health Team

8.22 The CPNs found it frustrating that the social workers were not allowed to take referrals direct from the team meetings, but that instead the referral had to go through the Customer Services loop. The CPNs were disappointed that they would inevitably end up as the key worker, whereas there was clearly a role for social services with many patients, and there needed to be a better sharing of responsibilities in those situations. The weaker relationship of the CPNs with their social work colleagues in County Durham was thrown into sharp relief because they enjoyed a very different situation where the social services input came from Hartlepool. For the future, the historic difficulties of achieving effective integration of health and social services which have been experienced in Easington may make it significantly more time consuming to integrate CPA and care management in the way envisaged by the National Service Framework for Mental Health.

8.23 During the period under review, the panel is of the view that Easington was substantially under-resourced in terms of the number of CPNs working in the adult mental health service. Patient R's GP had sought CPN involvement in her case in 1990, which never occurred because of the pressure the service was under. When she was subsequently referred to the service on her discharge from Hartlepool General Hospital in 1996, the referral was discussed by the Community Mental Health Team, and a decision was taken that her case would be better dealt with by the Drug and Alcohol Service.

8.24 The explanation for the decision not to allocate Patient R to a CPN was first, that they would not become involved if the case was clearly one which should be taken on by the Drug and Alcohol Service, and second, they had such scarce resources that they had had to establish some clear criteria of the category of patients they would accept, the severe and enduring mentally ill, and focus on that particular group.

8.25 Although the panel accepts that there were reasons why Patient R was not accepted on to the case load of a CPN, members are concerned that this decision was made on the basis of very sparse information in a referral letter, and, moreover, no communication of that decision was ever made to the key worker. If such a communication had been made, it would have allowed the

key worker, Dr J, to re-instigate his referral, if he felt that the CPN input was necessary and significant.

8.26 The panel is the more concerned about the lack of CPN input when account is taken of the fact that Patient R was on mid level CPA. In the panel's understanding of the CPA policy which was relevant at that time, Patient R's key worker should have been informed if one of the participants in the CPA process decided to withdraw service. As it so happened, Dr J, the consultant psychiatrist, was named on the form as the key worker, following the retirement of S, the social worker. Dr J was never aware that he had been named as the key worker. No communication was ever made with him about the decision not to input CPN services.

Discharge arrangements

8.27 The inclusion of Dr J's name as the key worker on the discharge of Patient R and on the CPA documentation highlights some issues of concern to the panel over her discharge arrangements. It was good that her mother was involved in a meeting with the consultant and the sister on the ward at Hartlepool General Hospital. However, that meeting did not involve the named nurse. Although the content of the discharge plan was satisfactory, there appears to have been no check or liaison with other professionals who would have to assist in delivering the plan, to ensure that they were happy with it. In consequence, there was no way of knowing that it could be carried out. This lack of liaison points up the weak or non-existing arrangements for liaison at that time.

8.28 It is particularly difficult for the panel to follow through whether this discharge plan was ever communicated to social services, who may have been expected to appoint the successor to S to become the key worker. The difficulty in following through here is caused by a lack of records. The panel has no doubt that the care given by S was good, and members are also confident that he enjoyed an excellent therapeutic relationship with Patient R. However, his records of his work with her peter out after September 1995, although he continued to work with her over the next few months until the formal closure of the case in July 1996. The panel is aware that this example of poor record keeping was identified in supervision, but no improvement occurred.

The Drug and Alcohol Service

8.29 The panel looked at the input of the Drug and Alcohol Service as part of the CPA process after Patient R's discharge from hospital. The records show her being discharged from this service after failing to attend. The panel is struck by the way in which the Drug and Alcohol Service was affected time and time again by moves to new locations, or new management arrangements, or new management personnel. The panel was left with a view that the service had often lacked a professional structure, and was not truly integrated into the mental health service.

8.30 In general, the service does not appear to have had much recognition from or partnership with GPs. For example, the panel could find no evidence of the GP being informed when Patient R was discharged from the Drug and

Alcohol Service when she failed to attend. Her discharge from the service should presumably also have been notified to her key worker named on the CPA documentation, Dr J, but there is no evidence that this was done either. The GPs appear to consider that they did not have good communication with the service, although there was a view that the service is better now. One of the GPs thought that the Drug and Alcohol Service was still inclined to take a "soft" approach to patients with drug and alcohol problems.

8.31 In a small scale service operating within a community, there is always a danger that those referred to the service will be known to those who staff the service. The panel considers that as such a risk is unavoidable, the Drug and Alcohol Service needs to have a strong system of clinical supervision, and should ensure that it has a regularly reviewed protocol about counsellors advising patients whom they know socially.

The Care Programme Approach

8.32 The discharge of Patient R raised a number of issues around the working of the Care Programme Approach, some of which have already been discussed. In overall terms, the view of the panel was that there existed a paper system which did not always work in practice. There was no effective liaison between in-patient care and community care. It was apparent that the Community Mental Health Team felt it could change the content of the CPA. This resulted in Patient R having no community psychiatric nursing input. This was particularly significant, as it appears to the panel that Dr J's motive in asking for that input was to monitor her mental state, not to control her alcohol problems.

8.33 Under the policy for CPA which operated at that time, the panel's understanding is that Patient R could only be discharged from the CPA because of her non-compliance with the plan if there was a review meeting at which the key worker was present. In the case of a discharge, the policy indicates that "every effort must be made to ensure the patient/carer or advocate is aware of how to access services if they so wish/require. It must be fully recorded in the Contact Notes that the patient has been discharged due to non-compliance and all relevant parties are informed of the decision."

8.34 It would seem that Patient R was established on CPA in September 1996, but, to all intents and purposes, this meant nothing in her case. Nothing ever seems to have been triggered by the process, and the panel could not establish the existence of any formal records of the CPA process. Dr J, as the key worker, was not at a meeting of the Community Mental Health Team which effected the discharge of Patient R. From information produced for the panel, a meeting of the Community Mental Health Team took place on 7 October 1997, at which Patient R's case was discussed, and the list from that meeting is annotated "To GP". In seeking to track down the events surrounding the discharge of Patient R, the panel also found a scribbled note on an inappropriate piece of paper which states "Discharge 14.10.97 CMHT". There is no sign of this discharge having been done under the CPA process. This note and the list from the team meeting are at odds with a reference in the Internal Inquiry Report, which states that Patient R was discharged from mid level CPA on 2 October 1997.

8.35 Despite extensive attempts by the panel to obtain more positive evidence of how Patient R's case was dealt with, nothing further of value has been found. It was a feature of the CPA process that on discharge, a standard letter should have been sent to her GP. Although her GP records are generally in good order, no copy of such a letter exists in the records.

8.36 If Patient R was discharged from CPA in October 1997, it seems that the outpatients department was not informed, and in consequence, an appointment letter was sent out to Patient R for 17 December 1997. Quite separately, the Drug and Alcohol Service had already discharged Patient R for her failure to attend.

The Internal Inquiry Report

8.37 An internal report was prepared into the incident involving Patient R on 17 December 1997. The report is undated and does not identify its author, nor the name of the Trust involved. As this internal report was apparently prepared close in time to the date of the incident, when it is likely that the memories of those staff who had been involved in the care of Patient R would be fresher, it was a disappointment to the panel that the report was deficient in some aspects.

8.38 The panel's concerns relate first to the difficulty in identifying those involved in the investigation. The explanation offered to the panel was that the Directorate of Mental Health and Learning Disabilities had agreed that it was important to encourage a no-blame culture in order for issues to be openly discussed and acted on. It was felt within the directorate that this did lead to a culture of significant service development and clinical improvement, as staff felt supported and protected in raising issues. However, there are a number of factual errors in the report. At one point it refers to Patient R being on mid-level CPA, and at another point it refers to minimal level. The report suggests that she has no history of self harm, whereas two suicide attempts are documented in her hospital records. The report also suggests that she had killed her ex husband in a pub, and further, it indicates that S her key worker, despite the file having been closed off by the Social Services Department in July 1996 and despite S having retired from the Social Services Department in September 1996. The panel accepts that the internal inquiry team were working to a constrained time limit, and, furthermore, understands how difficult it would be to check some of the detail because of lack of records relating to some elements of the service delivered to Patient R.

8.39 The panel queried whether a representative of the Social Services Department would have been invited to contribute to the internal inquiry. It heard evidence on the one hand that a representative had been invited to attend, but a contradictory view from the Social Services Department that they were not aware of any invitation, nor did they believe that they had been sent a copy of the report. In the view of the panel, these events surrounding the internal inquiry report highlight some of the deficiencies of communication and cooperation between health and social services which have been commented on elsewhere in this report. Although the panel cannot be certain whether any invitation was extended to the Social Services Department, in its view it would be good practice to invite them in such cases.

8.40 There were three main recommendations made in the internal report, which related to (i) a review of the fail to attend protocol, to ensure pro-active follow-up was considered by the Community Mental Health Team; (ii) a clarification about the inclusion of dual diagnosis patients on the CPA system; and (iii) proper communication about discharge decisions. All of the recommendations had been acted upon or were being progressed by the time the panel held its oral hearings. Copies of new protocols were made available for the panel to see. The panel commends the speedy and effective implementation of the internal report's recommendations.

CHAPTER NINE

RECOMMENDATIONS

The panel has made a number of specific comments in the body of its report, which will no doubt provide cause for reflection and further action by the relevant health services and social services.

The purpose of an inquiry such as this is to learn lessons which will be of benefit for the future. Taking account of earlier comments, and the recommendations which follow, the panel wishes to record that none of the steps recommended would necessarily have prevented the outcome which occurred in relation to the two patients concerned.

It is important to look at the recommendations which follow in the light of the more detailed comments made in the main body of the report.

9.1 The panel recommends that priority be given and appropriate resources allocated to the establishment of sufficient mental health services and facilities in Easington District, which the panel considers is necessary to reduce the fragmentation and lack of co-ordination of services, to raise morale of those working in mental health care, and to encourage recruitment and retention of key staff.

9.2 The panel recommends that County Durham and Darlington Health Authority and County Durham Social Services Department reconsider their provision of Drug and Alcohol Services for Easington, and reinforce their commitment to joint working by a joint approach to the provision of this service.

9.3 The panel recommends that existing Drug and Alcohol Services should consider afresh their interface with other aspects of health and social services, and should seek to integrate more effectively with other service elements when appropriate.

9.4 The panel recommends that County Durham Social Services Department reconsiders its referral mechanisms, bearing in mind the National Service Framework for Mental Health, which suggests a single point of access to mental health services.

9.5 The panel recommends that a review be undertaken to assess how the links between in-patient and community services function, with the aim of reinforcing a seamless service for patients.

9.6 The panel recommends that a re-appraisal of the number of detoxification beds available for residents of Easington should be undertaken, and that consideration should be given to the most appropriate placement of these beds.

9.7 The panel recommends that out-patient services and Drug and Alcohol Services should reconsider their procedures when patients fail to attend, and give consideration to developing a protocol about the assertiveness of the service.

9.8 The panel recommends that attention be given to the practical operation of the CPA process, in particular the development of a joint approach among the Trust providers, and an integrated approach with care management. Initiatives should include the development of joint documentation. The processes also need to pay attention to the role of the key worker, to communication between those professionals involved in delivering the package of care, to effective liaison with the patient's GP, and to discharge from the programme.

9.9 The panel recommends that the Health Authority should give consideration to ways in which effective information, support, training opportunities and networking can be facilitated for single handed GPs, particularly in relation to prescribing, in view of their pivotal role in the on-going care of patients with long term mental health problems.

9.10 The panel recommends that all professional groups reflect on standards of case recording and note keeping. In the view of the panel, the necessary framework for good record keeping was largely in place, but difficulties occurred when staff in various disciplines did not conform to the procedures established. The paucity of records of social services involvement, and the difficulty in tracking down CPA records were two issues which caused the panel particular concern.

9.11 The panel recommends that both the Health Service organisations and County Durham Social Services Department should reinforce to their staff the significance of a prompt and thorough internal inquiry into critical incidents.

APPENDIX A

PROCEDURE ADOPTED BY THE INQUIRY

We substantially adopted the procedure used in the previous independent inquiries commissioned by County Durham Health Authority. Those inquiries had followed the procedure adopted in the earlier Christopher Clunis Inquiry. The detail of the procedure is as follows:

1 We sought the consent of Patient R and from the next of kin of Patient Y for the disclosure of all appropriate records.

2 We studied the clinical and social work notes, together with management and organisational documents, and local and national policies and procedures. From these sources, we identified persons whom we believed may have something useful to contribute to our Inquiry to make written statements to us for our consideration.

3 After consideration of the written statements, we identified those persons whom we wished to invite to the oral hearings of the panel.

4 In the letter inviting people to attend the oral hearings, we informed witnesses that:

- they could be accompanied by a friend, relative, member of a trade union, solicitor or anyone else
- it is the witness who will be asked questions and who will be expected to respond
- they could raise any matters which they felt might be relevant to the Inquiry
- they would receive a transcript of their evidence
- they would be asked to affirm that their statements were true.

5 Sittings of the Inquiry Panel took place in private.

6 Those attending the oral hearings were informed that if the draft report contained any points of potential criticism these would be put to them, giving them a full opportunity to respond. Any response would be considered by the panel, with a view to making any appropriate amendments or corrections to the draft report.

7 Those attending the oral hearings were informed that evidence submitted to the panel would not be made public, except as disclosed in the final report of the panel, and that the recommendations of the inquiry would be made public.

APPENDIX B

TERMS OF REFERENCE

1 To examine all the circumstances surrounding the treatment and care of Patient R and Patient Y by the health services with regard to their mental health, in particular:

(i) the quality and scope of their health, social care and risk assessments;

(ii) the appropriateness of their treatment, care and supervision in respect of:

(a) their assessed health and social care needs;
(b) their assessed risk of potential harm to themselves or others;
(c) their psychiatric history, including any history of drug or alcohol abuse;
(d) the number and nature of any previous court convictions;

(iii) the professional and in-service training of those involved in the care of Patient R and Patient Y, or in the provision of services to them;

(iv) the extent to which the care given to Patient R and Patient Y corresponded to statutory obligations, relevant guidance from the Department of Health including the Care Programme Approach HC(90)23/LASSL(90)11 and discharge guidance HSG(94)27 and local operational policies;

(v) the extent to which their prescribed care plans were:

(a) effectively delivered, and
(b) complied with by Patient R and Patient Y;

(vi) the history of Patient R's and Patient Y's medication and compliance with their regimes.

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

(i) the agencies (Hartlepool and East Durham NHS Trust and its predecessors and Durham County Council Social Services) involved in the care of Patient R and Patient Y or in the provision of services to them, and

(ii) the statutory agencies and Patient R's and Patient Y's families.

3 To prepare a report and make recommendations to County Durham Health Authority.

APPENDIX C

BIBLIOGRAPHY

1 DOCUMENTS AVAILABLE TO THE PANEL

Medical notes relating to Patient R and Patient Y.

Records from Durham Social Services Department relating to Patient R.

Documents provided by Durham County Council Social Services Department.

File of County Durham Probation Services on Patient R.

File of Durham Constabulary.

Witness statement provided by County Durham Probation Service.

Transcript of Proceedings at Crown Court, Teesside re Patient R.

Reports of Serious Untoward Incident involving Patient R and Patient Y by Hartlepool and East Durham NHS Trust.

Durham County Council Care Manager Manual, Social Services Department - Social Services Standard documents relating to Field Work Practice during the period 1994 to 1997.

Report of NHS Executive Northern and Yorkshire to County Durham Health Commission in relation to Mental Health Assessement and Care Programme Approach 1995.

Operational Policy for the Community Mental Health Teams (undated) – Hartlepool and East Durham NHS Trust.

Hartlepool Community Care NHS Trust – Care Programme Approach – related policies and procedures (undated).

Hartlepool Community Care NHS Trust – Aftercare Policies and Procedures 1995.

Joint Policy and Procedures for Hartlepool and East Durham NHS Trust and Hartlepool Social Services – Care Programme Approach – Related Policies and Procedures – May 1997.

Hartlepool and East Durham NHS Trust – Directorate of Mental Health and Learning Disabilities – various policies and procedures.

Operational Policy for the East Durham Drug and Alcohol Service – revised 30.10.98.

1999 A joint approach to mental health – a strategy document for County Durham and Darlington.

2 DOCUMENTS AND PUBLICATIONS CONSIDERED BY THE PANEL

1990 Department of Health HC (90)23/LASSL (90)11 Caring for People. The Care Programme Approach for people with a mental illness referred to the Specialist Psychiatric Services.

1993 Transcript of Crampton and others v Secretary of State for Health (The Beverley Allitt Case).

1994 Department of Health HSG(94)5 : Introduction of Supervision Registers for mentally ill people from 1 April 1994.

1994 Department of Health HSG (94)27 : Guidance on the discharge of mentally disordered people and their continuing care in the community.

1995 Department of Health, Building Bridges – a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people.

1996 NHS Executive LASSL (96)16/HSG(96)6
- The spectrum of care – a summary of comprehensive local services for people with mental health problems.
- 24 hour nursed beds for people with severe and enduring mental illness.
- An Audit Pack for the Care Programme Approach.

1996 Department of Health : The Health of the Nation – Key Area Handbook, Mental Illness 2nd Edition.

1996 Royal College of Psychiatrists – Assessment and Clinical Management of Risk of Harm to other People.

1998 Report of the Independent Inquiry into the Care and Treatment of Adrian Jones and Douglas Heathwaite – County Durham Health Authority.

1998 Department of Health HSC 1998/233 LAC (98)25 Modernising Mental Health Services: Safe, Sound and Supportive.

1998 Medication, Non-Medication, Non-compliance and Mentally Disordered Offenders: A Study of Independent Inquiry Reports – The Zito Trust.

1999 Report of the Independent Inquiry into the Care and Treatment of Patient T – County Durham Health Authority.

1999 Department of Health : CI (99)3 Still Building Bridges – Inspection of Arrangements for the Integration of Care Programme Approach with Care Management.

APPENDIX D

SPECIMEN LETTER TO WITNESSES

[Date]

[Address]

Dear [Name]

Re: Independent Inquiry into the Care and Treatment of Patient R and Patient Y - Request for Evidence

An Independent Inquiry has been set up by County Durham Health Authority following the death in December 1997 of Patient Y. I attach a copy of the remit of the Inquiry from which you will note that the Inquiry will consider the care and treatment of Patient Y and in particular his care and treatment by the mental health services. Patient Y's family has been informed of this Inquiry and consent has been obtained to the disclosure of all the records relating to the medical treatment required by him and the care provided by all agencies with which he came into contact.

I have been appointed as secretary to the Inquiry and am writing to you on behalf of the Inquiry Team. The members of the Inquiry Team are Mrs Anne Galbraith (Chairman), Dr Christopher Simpson, a Consultant Psychiatrist, Adrian Childs, a senior Nurse Manager and David Parkin, a senior Social Work Manager.

The Inquiry Team believes that you may have relevant evidence to contribute to the Inquiry. The Inquiry hearings will be heard in private and are likely to begin on Monday 3 April 2000 at Appleton House and are scheduled to end on Friday 7 April 2000.

In order to help clarify issues before the hearing, the Inquiry Team asks if you would please provide a written statement setting out and providing a commentary on your involvement in the treatment and care of Patient Y and in particular his psychiatric management. I would request that the statement reaches me at the above address within ten days of receipt of this letter.

It is likely that the Inquiry Team will wish you to attend the hearing in order to provide oral evidence. Could you please indicate any dates and times during the period of the Inquiry when you will be unable to attend. Your reasonable travel expenses and subsistence costs arising from attendance at the Inquiry will be reimbursed.

It may be helpful for you to know that the original records have been retained by the agencies concerned. When completing your statement you may wish to refer to those originals to which you are a direct contributor. If there is difficulty about this, I would be grateful if you would please contact me. My direct dial number is stated above. I enclose a stamped addressed envelope for your reply.

The Inquiry Team would be most grateful for your contribution.

Yours sincerely

David Baggott
Authority Secretary

APPENDIX E

INVITATION TO ORAL HEARING

[Date]

[Address]

Dear [Name]

Re Independent Inquiry into the Care and Treatment of Patient R and Patient Y

As you are aware from previous correspondence, the Authority has set up an Independent Inquiry to consider the circumstances leading to the death in December 1997 of Patient Y. I am writing to you in my capacity as Secretary to the Inquiry Panel, which is independent of County Durham Health Authority.

The Chairman and members of the Panel are grateful to you for the information you have already supplied. A further copy of the remit of the Inquiry is attached. The Inquiry Panel will be glad of the opportunity of meeting you and discussing further with you the issues which you will be covering in your written statement or other matters which will assist them to fulfil their remit. There also may be certain matters that you wish to raise with the Panel.

The Inquiry is to be held between Monday 3 April and Thursday 6 April 2000 and I am now scheduling the attendance of those whom the Panel wishes to meet. I am hoping that it will be possible for you to attend to meet the Panel, here at Appleton House on [date]. I have scheduled this for [time] for approximately 45 minutes. You will appreciate that the Panel will need to spend longer with some witnesses than with others and I would therefore be grateful if you could please be available some 15 minutes earlier than the scheduled time and be prepared to stay a little beyond the end of the scheduled time if necessary. I hope that these arrangements are convenient.

I attach a plan showing the location of Appleton House. On arrival at Appleton House please make yourself known to the receptionist who will be expecting you.

The Authority will be glad to refund your travelling expenses, we will make arrangements for this when you arrive.

- The members of the Panel will be:

  Mrs Anne Galbraith, (Chairman of the Panel)
  Dr Christopher Simpson, Consultant Psychiatrist, Friarage Hospital, Northallerton
  Mr Adrian Childs, Trust Nurse Adviser, St George's Hospital, Morpeth
  Mr David Parkin, Divisional Director Community Care, Northumberland Social Services.

- The Inquiry will be held in the Committee Room at Appleton House.

- You may bring with you a friend, relative, member of a trade union, solicitor or anyone else whom you wish.

- It is to you that the members of the Inquiry Panel will address questions and invite an answer; the person accompanying you will not be able to address the Inquiry Panel.

- When you give your oral evidence you may raise any matter which you wish and which you feel might be relevant to the Inquiry.

- You will be asked to confirm that your statements are true.

- If any member of the Inquiry Panel wishes to express any concern to you then you will be given a full opportunity to respond.

- The proceedings of the Inquiry will be recorded and you will be provided with a copy of the transcript of the discussion in which you were involved; you will be invited to indicate any corrections of fact in the transcript within seven days of receipt.

- All sittings of the Inquiry will be held in private.

- The findings of the Inquiry and its recommendations will be made public.

- The Inquiry Panel will not make public any of the evidence submitted either orally or in writing, save as is necessary in the body of the Panel's report.

- The Inquiry Panel will make its findings on the basis of the evidence which it receives.

As the Inquiry Panel will explore with you issues based on your written statement it would be very helpful if you could let me have your written statement as soon as possible.

I would be grateful if you would please confirm at your earliest convenience that you will be able to attend at Appleton House to meet the Inquiry Panel as indicated above. I enclose a pre-paid addressed envelope for your response.

Please telephone me on 0191 333 3350 (my direct line) if you have any doubt or query arising from this letter.

Thank you for your assistance.

Yours sincerely

David Baggott
Authority Secretary

enc:

APPENDIX F

THE SAINSBURY CENTRE FOR MENTAL HEALTH
LOCALITY PROFILE OF MENTAL HEALTH SERVICES IN EASINGTON

CONCLUSIONS FROM THE FINAL REPORT

1 Needs

The level of need for mental health services in Easington is very high. All patches in Easington have exceptionally high levels of deprivation, among the highest encountered by the SCMH Locality Profiles database. The average across Easington is over 30% higher than the national average and no ward is less than 15% above national average. It is likely that the actual prevalence of mental illness is therefore also high.

2 Resources

Expenditure on mental health services in Easington is significantly lower than the national average, indeed only about half that figure, and at the bottom of the range encountered in other Locality profiles by the Sainsbury Centre.

The split between inpatient and community expenditure is 55%:45% for the whole of Easington; none of the individual Trust areas differ from this in any significant way. This is not very different from the Audit Commission's recommended split of 50:50, but is fairly insignificant in the context of the first and main point above.

The key resource issue therefore appears to be one of simple overall under-funding rather than of disproportionate spending, and this is demonstrated in terms of both in-patient and community facilities, ie:

- the number of acute beds available for Easington residents is very low
- day service provision is well below the data base average
- the level and range of supported accommodation is insufficient
- there are no crisis services
- the introduction of assertive outreach appears to be under-resourced (and inequitable across patches within Easington).

In consequence, there is a high proportion of short stay acute admissions across the Trusts, suggesting in-patient facilities are being used

- to compensate for the lack of alternative community provision
- by people with less severe mental health problems (although there was insufficient data to make an analysis of acute bed admissions by diagnosis).

3 Focus on Easington

In planning terms, there has been a historical failure to focus on Easington. The reasons for this seem to be threefold:

- the complexities of organisational boundaries, created by the presence of three Trusts in the district and the lack of integration between Health and Social Services, have seemed insuperable – no one has known what to do about it

- processes around identification and inclusion of stakeholders have been inadequate, the consequences of which are manifested in poor levels of communication at many levels of the service system, in tensions between the different agencies, and in a mismatch between needs and the deployment of existing resources. People have not felt that their views were either sought or valued

- high levels of deprivation combined with local cultural factors contribute to a sense of this being a stigmatised and fragmented area in which to work

The development of mental health services in Easington has depended on local advocates for change rather than on a jointly planned and systematic approach. Approaches to planning and service development have been concerned with the short-term only. However, a process of change required by the NSF has already started as demonstrated by commitment to this locality profiling exercise.

4 Organisational integration at service level

There has been a history of poor inter-agency collaboration and a lack of integration in the provision of services. There is evidence of this between Health and Social Services, between secondary and primary care services, between the statutory and the voluntary sector and between the three Trusts. In each of these cases there are notable exceptions, but they remain exceptions to the overall picture. A culture of competition has evolved at the expense of collaboration. This lack of collaboration has compounded the resource shortfalls making it very difficult to develop an appropriate range of services. Access to and provision of services is inequitable both within the Easington district and between Easington and adjacent localities.

In terms of service development, the first priority for Easington in addressing the gaps in current services for people with severe and enduring mental illness must be to develop integration in leadership and provision.

There are likely to be training needs aimed at improving collaboration of primary care staff internally and of primary care with the various services within the mental health system. This is critically important given the role of GPs and practice staff often as the first point of access to mental health care.

Training needs are particularly apparent in relation to recognising and responding to mental health problems in the context of the local population which is principally from a 'proud', self-sufficient, and sometimes insular culture based in former pit villages, dispossessed of much economic viability, and where people are perceived by some professionals as reluctant to acknowledge mental health problems.

5 Workforce issues

In all the organisations interviewed, there was much praise for the commitment and skills of existing practitioner staff who, it is generally recognised, are doing an excellent job in very difficult conditions.

The recruitment and retention problems faced by many of the agencies interviewed for this project reflect, to some extent, a national picture of similar difficulties. Many of the reasons that interviewees gave to explain the problems will be addressed by investing in and integrating mental health service provision for Easington to bring services up to the comprehensive standards required by the NSF.

In addressing workforce issues, the following principles and aims are set out in the NSF:

- agree clear inter-agency workforce plans
- create workforces that represent the communities they serve
- ensure that education and training emphasise team, inter-disciplinary and inter-agency working. Service users and carers should be involved in planning, providing and evaluation education and training
- provide professional development for staff
- enable strong leadership

6 Services to people from ethnic minority groups

Specific measures to ensure that services meet the needs of people from ethnic minority groups are not seen to be 'an issue' for Easington. This is because a small proportion of the population comes from ethnic minority groups and very small numbers of these present to services. The joint strategy for County Durham and Darlington – A Joint Approach to Mental Health – omits reference to the needs of people from ethnic minority groups living in the county.

The cultural divisions that are observed within the white population in Easington point to a low tolerance of difference and of people perceived to be 'outsiders'. This suggests that particular sensitivity is needed to ensure that mental health services are anti-discriminatory, culturally appropriate and accessible. There can be a heightened risk of discrimination when minority groups are small in number.