South West London NHS
Strategic Health Authority

THE EXECUTIVE SUMMARY OF THE REPORT OF AN INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF PS

Report commissioned by Merton Sutton and Wandsworth Health Authority

INDEX

ACKNOWLEDGEMENTS

We are grateful to all of the witnesses who came to talk to us. It is never easy to give evidence in such a matter, especially when as in this case there had already been an internal inquiry process to which many of the witnesses had been subjected. We thank them all.

The task of co-ordinating this Inquiry was undertaken by Brian Morden with great patience and efficiency. We are indebted to him for his support over a much longer period than anyone anticipated and for his unquestioning assistance even when not in the most robust of health.

We would also like to thank the wonderful team from Harry Counsell & Company for their tireless efforts in recording and transcribing the evidence for us. It was at times a daunting task, always performed with efficient good humour.

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TERMS OF REFERENCE

1 To examine all the circumstances surrounding the care and treatment of PS, in particular:

1.1 The quality and scope of his health and social care and any assessment of risk of potential harm to himself or to others

1.2 The appropriateness of any care plan treatment or supervision provided by statutory agencies or others, having regard to:

(a) his frequent excursions from, and periods of domicile outside the UK

(b) his past family history

(c) his forensic history, and the nature and extent of any previous criminal involvement and Court convictions in the UK and in Spain

(d) his past psychiatric history

(e) links between the GP and other services, in particular, psychiatric and social services

(f) his assessed health and social care needs

(g) the history of his prescribed medication and his compliance with such medication

(h) the use of illegal substances and alcohol

(i) any later care or treatment provided to him after the index offence of 20.08.2000 insofar as it may be relevant

1.3 The extent to which his care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health [including the Care Programme Approach HC[90}23/LASSL [90]11 the Discharge Guidance HSG[94] 27, and local operational policies

1.4 The extent to which his care and treatment plans

(a) reflected any element of risk
(b) were effectively drawn up, communicated monitored and delivered
(c) were complied with by PS

2 To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between the various agencies involved in the care and treatment of PS, or in the provision of services to him, in particular whether all relevant information was effectively and efficiently passed between the agencies, and, whether such information, as communicated, was adequately acted upon.

3 To examine the adequacy of the communication and collaboration between the statutory agencies and PS's family including the support offered and given following the index offence.

4 To examine and review the report of the Internal Inquiry into the care and treatment of PS, and determine to what extent the Recommendations of the Internal Inquiry have been implemented.

5 To prepare an independent report and make recommendations as may be appropriate to Merton, Sutton and Wandsworth Health Authority, the London Borough of Merton and all other relevant agencies.

THE EXECUTIVE SUMMARY REPORT

Shortly after midnight on 19th/20th August 2000, PS killed his 68-year-old mother. He strangled her in her home in Mitcham Park, in the London borough of Merton.

At the time he was staying with her on weekend leave from Springfield Hospital, in the borough of Wandsworth in South West London.

He had been an inpatient on the acute general psychiatric ward since July 1999, but at the time of the homicide he was an informal (voluntary) patient who was due to be discharged once suitable accommodation could be found for him.

PS first showed signs of mental disorder in his late teens and had been known to Social Services in South West London from 1987 and to the psychiatric services at Springfield Hospital since November 1990 when he was first compulsorily detained under the Mental Health Act 1983 (MHA).

PS was born in Barcelona, Spain in 1965 and lived there until he was six years old when his parents separated and his British mother brought him and his sister and two brothers to England. His father, who was Spanish, remained in Barcelona and P was sent back to Barcelona when he was 15 where he remained until he was about 21.

In the Spring of 1992 P returned to Spain and his mental health deteriorated to such an extent that his mother flew out to Spain to try to get psychiatric help for her son. He was subsequently detained in a psychiatric unit in Barcelona in early February 1993.

In September 1993, when on day leave from the unit to his father's home, P attacked his father with a knife, seriously wounding him.

At his trial for wounding his father he was found guilty of the offence but held to have a 'total lack of criminal responsibility by reason of insanity'. Psychiatric reports prepared for the trial gave a diagnosis of paranoid schizophrenia.

He was sent to a psychiatric hospital in Barcelona where he remained for two years until August 1995 when he was transferred to Springfield Hospital, initially as an informal patient, but because he kept leaving the hospital and was still considered to be unwell, he was compulsorily detained under the MHA and was transferred to the care of the forensic psychiatric team.

He remained under compulsory detention for a further year until the end of September 1996 and then remained in hospital as a voluntary inpatient until December 1996 when he was discharged to a hostel in Wimbledon, still under the care of the forensic psychiatric team.

The next couple of years were the most stable P had known for many years, although he had a tendency to disappear to Spain without warning or permission.

On the whole, he was compliant with his medication and regularly attended outpatient appointments with Dr Gillian Mezey, Consultant Forensic Psychiatrist.

In early 1999 the forensic team handed P's care over to the general adult psychiatric team under Dr Leon Rozewicz, General Adult Consultant Psychiatrist.

In May 1999 P disappeared to Spain again, and while he was there he attacked an acquaintance with a hammer (it is not clear if this was a small jewellery hammer or a 'normal' one), was arrested and again admitted to a psychiatric hospital in Barcelona.

He was returned to Springfield Hospital in July 1999 and, although initially he was admitted as an informal patient, he was compulsorily detained three weeks later because of his mental condition.

He remained detained under section until February 2000.

In March 2000 P was transferred to Seacole Ward, a newly-opened acute general psychiatric ward at Springfield Hospital. For the previous five months he had been at the Atkinson Morley Hospital in Wimbledon, still under the care of Dr Rozewicz.

At the time of his transfer to Seacole Ward, P was considered by the nursing staff to be on the 'Delayed Discharge' list, which in effect meant that he was well enough to be discharged but his accommodation had not yet been arranged. Several offers of accommodation had been made but P had rejected them all.

In June 2000, Dr Rozewicz, the consultant psychiatrist responsible for P's care, was so concerned about alleged threatening behaviour by P towards his mother that he once again compulsorily detained him. The nursing staff on Seacole Ward did not agree with this decision and felt that the consultant had over-reacted and was over-anxious.

After a review by Dr Mezey (the forensic team consultant who had been responsible for P's care when he had lived in the community between 1996 and 1999) at the request of Dr Rozewicz, the section was discharged on 3rd August 2000.

This was less than three weeks before the homicide and it might seem on the face of it as though the decision to discharge the section was tragically wrong.

However, even if P had still been compulsorily detained on 19th August, he would probably still have been allowed leave to visit his mother if she wished him to. He had often visited her in the past whilst he was compulsorily detained without any untoward incident.

Indeed, only the previous weekend he had stayed with her without any reported incident.

It must be remembered that the most serious previous violent attack - the one on his father in 1993 - came at a time when P was a compulsorily detained patient who was considered well enough to be allowed leave to go to his father's house.

One of the major problems in the care of P was that because both the acts of violence prior to the homicide were committed abroad, the English courts had not been party to the sentences he received.

The Panel are in no doubt that, if P had come before the English courts following these serious offences, he would probably have been subject to a Hospital Order with restrictions on discharge attached (Sections 37 and 41 of the Mental Health Act 1983).

Had he been subject to such a Hospital Order, decisions relating to his medication regime and his accommodation would have been much easier on his subsequent discharges from hospital.

Those responsible for making such decisions were handicapped by the fact that there was no such restriction on his discharge from hospital and they could therefore not attach conditions to his discharge which would enable them to impose medication and accommodation regimes.

Although the Inquiry Panel has, during the course of its investigation, identified many causes for concern, in particular during the last six months leading up to the homicide, they are satisfied that such a tragic outcome could not have been predicted by those responsible for PS's care during this period.

It is possible that a different approach might have prevented the homicide, but it is only the benefit of hindsight that permits such comment. No-one will ever know whether anything could have altered the outcome.

P admitted to taking both cannabis and amphetamines on the evening of the homicide and evidence of both was found in blood samples taken several hours after the event.

The Panel feel that it is possible that drugs 'tipped the balance' that night, at a time when P's mental health was already fragile.

Before the criminal trial at the Old Bailey in July 2001, P had been found by a jury to be 'unfit to plead'. He had sacked three firms of solicitors and represented himself at the trial. He claimed that he had killed his mother in self-defence after she had tried to stab him with a knife.

Because he had been found 'unfit to plead' he could not be called to give evidence himself and the Court appointed a QC (Senior Barrister) to represent his interests.

The evidence which was put before the jury consisted of oral or written evidence from the clinical staff at Springfield Hospital who had seen P immediately after the homicide, police officers, forensic investigators and neighbours of Mrs S.

The pathologist who carried out the post mortem examination confirmed that Mrs S had died from manual strangulation. He said that her neck must have been held for at least 20 seconds, for about half of which she would probably have been unconscious.

In his summing-up, the judge told the jury that they had to decide whether the Prosecution had satisfied them so that they were sure that (i) the strangulation was no accident and caused Mrs S's death and (ii) whether P strangled his mother other than in lawful self-defence.

The jury found that P had committed the act of murder and he was sent to Broadmoor Special Hospital where he has been ever since.

Under the provisions of Section 5 of the Criminal Procedure (Insanity) Act 1964 and Schedule 1 to the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, he is treated as if he were subject to a hospital order with restrictions under Sections 37 and 41 of the Mental Health Act 1983.

The Panel would normally have started the Inquiry process by going to see P to hear his views on the care and treatment he was given by the professionals responsible for looking after his mental health.

However, P refused to see the Panel and his consultant psychiatrist also considered him to be too unwell to do so. The Panel never met P. This was a considerable handicap and one which made their task even more difficult.

But the Panel interviewed 22 witnesses who included almost all the professionals from both the forensic and the general adult psychiatric teams and social services who were involved in P's care.

Anyone adversely criticised in the report was given the opportunity to read the draft Commentary & Analysis Section of the report and to address the Panel again in response to what had been said.

P is an intelligent and passionate individual who has suffered from paranoid schizophrenia since his late teens. He seems to have learned over the years how to mask his illness except when he was obviously and floridly unwell.

It is clear with the benefit of hindsight that P was never completely 'well'. There were times when he was as well as the doctors had seen him, but his illness was always there below the surface.

It must also be remembered that both of the acts of violence which preceded his mother's death took place in Spain. Immediately after both assaults P was said to have been markedly paranoid and overtly unwell, but none of the clinicians in England ever saw him 'at his worst' and it was therefore perhaps more difficult to recognise the signs of relapse.

Another significant fact is that P spent a total of five years between 1990 and 2000 as an inpatient. This is a very long period of time. For more than three and a half years of this time P was under compulsory detention under the MHA.

For the twelve months prior to the homicide he was an inpatient on an acute general psychiatric ward. This was an unusually long stay on such a ward where the average length of stay would be three to four weeks and the nursing staff had virtually no experience of looking after patients with a forensic history.

P was not an easy patient to manage. He pushed the boundaries whenever he could and did not behave like a 'normal' acute general ward patient.

However the Panel found that the nursing staff had underestimated P's past 'dangerousness'. The problem was that none of them seemed to know the full extent of his forensic history and therefore could not properly appreciate his degree of risk.

The Panel have no real criticism of the care and treatment P received while under the forensic team, nor during his two-year stay in the community other than that they consider that more detailed information about P's forensic history should have been passed between the two services on the handover of his care.

They found, however, that greater consideration should have been given to transferring P back to the forensic team after he was returned from the psychiatric hospital in Spain in July 1999 having carried out his second violent attack. Dr Rozewicz had thought this should happen and therefore requested a forensic assessment of P, but the forensic team did not consider that it was necessary.

The Panel consider that there was a change in P's risk profile because of the second attack and that he should have been transferred back to the forensic team in July 1999.

Had he been transferred to the forensic team it is possible that the homicide might have been prevented.

The most serious remaining concerns centre on the care that P received in the last five months leading up to the homicide when he was an inpatient on the general adult ward, Seacole Ward, at Springfield Hospital.

The main criticisms are in relation to clinical teamwork, clinical leadership, clinical supervision and risk assessment.

Team Cohesion

Seacole Ward had only just opened at the time when P and some 15 other patients were transferred there from the Atkinson Morley Hospital in Wimbledon. The ward had 23 beds. Patients transferred from Narcissus Ward at Springfield Hospital, which had just been closed, occupied the rest.

Most of the nursing staff on Seacole Ward had no previous knowledge of P and his consultant Dr Rozewicz was unknown to all but the three nurses who had transferred from Atkinson Morley. His way of doing things was apparently quite different from that of the consultant the Springfield nurses had been used to.

When the Ward Manager was asked if it was fair to say that Leon Rozewicz 'did not quite fit in', he agreed it was and that it was not an easy time for the consultant or the nursing staff.

It was also clear from what the Panel heard from him and the other nurses that they did not really like the change from the consultant whose way of doing things they were used to and that they did not really approve of Dr Rozewicz's way of doing things.

The Panel were sympathetic to the fact that it must have been an anxious time for the nurses who were starting off on a new ward, with the majority of the patients unknown to them and a new consultant psychiatrist who was also an 'unknown quantity'.

However this was a time when cohesion and guidance were of paramount importance, and the Panel found that, unfortunately, there was neither.

They found that there was a lack of respect among the nursing staff for Dr Rozewicz and his SHO, Dr Tsapakis. However the Panel acknowledge that the nursing staff believed that their professional opinions were ignored or undermined by the doctors.

Breakdowns in relationships such as were apparent to the Panel between the Seacole Ward staff and the doctors can lead to clinical errors being made. At the very least they can lead to the clinical team being fractured and dysfunctional.

The Panel found that this had happened. The Seacole team did not function properly as a clinical team. The Panel are concerned that this should not happen in the future.

Personal and/or professional antagonism should never be allowed to interfere with good clinical practice.

Good clinical practice is often rooted in and born of effective clinical supervision.

Clinical Supervision

The Panel found that one of the major problems was a lack of clinical supervision at every level.

The Ward Manager of Seacole Ward did not appear to be getting any clinical supervision (although he was getting management supervision) at a particularly difficult time for him. That should not have been allowed to happen.

The Panel were unable to satisfy themselves that there was any organised clinical supervision on Seacole Ward or indeed any organisational arrangements in place in the Trust for the delivery of systematic clinical supervision at that time.

Clinical Leadership

The Inquiry Panel visited Seacole Ward as part of the Inquiry process. They also visited Jupiter Ward, a 'mirror image' of Seacole Ward on the same floor of the hospital wing. They were commissioned and opened at the same time.

The Panel was struck by the contrast between the two wards and feel that something should be done to make Seacole Ward more therapeutic, both in its appearance and in clinical management.

When Seacole Ward opened, the Ward Manager Chris Cook was under considerable pressure to see that it was safe, which meant dealing with a long list of 'snagging' problems as there was no proper project management of the opening of the two new wards.

Chris Cook should not have been responsible for solving the snagging problems. It meant that he did not have time for clinical leadership of the nurses or to see how the ward was running.

Although the Panel have some sympathy for him in that practical matters linked to the opening of the ward put extra pressure on him and the nursing staff, they feel that he was too preoccupied with these concerns and he took his eye off the ball when it came to the way that the ward was being run from the nursing point of view.

The Ward Manager is the pivotal member of the clinical team and it is essential that he remains in control of his nursing team, maintains good practice and promotes clinical team cohesion.

The Panel found that the Seacole Ward nursing staff allowed the personal antipathy which at that time they felt towards Dr Rozewicz to cloud their clinical judgment.

The nursing team's lack of confidence in their consultant and his SHO was not only allowed to exist but perhaps was influenced on occasion by the attitude of their Ward Manager.

However, the ultimate responsibility for clinical leadership lies with the consultant on the team.

The Panel is aware that Dr Rozewicz was unknown to most of the nursing team when Seacole Ward opened and he was also unused to working with them, but they feel that the tension between the nursing staff and him should not have been allowed to develop as it did.

The Panel find it hard to believe that Dr Rozewicz was as unaware of the depth of feeling among the nurses as he told them he was, and feel that it was his responsibility to know what was going on in his clinical team.

The period immediately after the opening of Seacole Ward cannot have been easy for any of the team – from Dr Rozewicz down to the most junior member – but the Panel strongly feel that proper clinical supervision and strong clinical leadership could have helped to smooth the stormy waters.

Risk Assessment

One of the main concerns of the Panel was the complete absence of risk assessment.

A number of the professionals responsible for P's care – both in the psychiatric service and social services – lacked sufficiently detailed knowledge of his forensic history and the events which precipitated the major violent episodes.

Almost all of the nurses from Seacole Ward whom the Panel interviewed said that they did not think that P needed to be in hospital and that as far as they were concerned he was a 'bed blocker' who was in hospital only because suitable accommodation had not yet been found for him.

The Panel found that, unfortunately, that view of P – that he should not really be in hospital and he was blocking a bed needed by someone more 'worthy' than him – pervaded and influenced the management of P by the nursing team during the months prior to the homicide.

The Seacole Ward nurses had no forensic experience, and although they were aware that P had a forensic history, the Panel felt that they did not fully appreciate his potential dangerousness.

The majority of patients on the acute general adult ward would have been acutely ill on admission, would respond to treatment fairly rapidly and therefore would have remained on the ward for only a short time.

The nurses on Seacole Ward were used to such short-stay patients who were often very ill and very disturbed but posed a low risk of danger to others.

They were used to equating overt psychosis with dangerousness. P was quite different. He may not have appeared to be very ill but that did not mean that he wasn't dangerous.

They failed to appreciate that he might not present as disturbed but was nonetheless a very high-risk patient. He was in hospital because he was dangerous.

He was also the longest-staying inpatient and the Panel felt that perhaps the nurses looking after him 'downgraded' his risk, influenced by the fact that it was considered that he need no longer remain a forensic patient.

Some of the nurses also considered that the fact that the very serious attack on his father had happened some six years previously meant that the incident had lost relevance as far as risk was concerned.

Because the nursing staff perceived P as a bed blocker from the outset, he was not really considered to be a 'patient' and in the Panel's opinion no-one actually nursed him.

Failure to regard P as a 'patient' led to a failure to engage with him on a therapeutic level or to make a proper assessment of his needs and risk.

P was never completely well. There was always an underlying mental disorder.

The psychiatrists were fully aware of this. The Panel believe that the nursing staff did not appear to understand that he had persistent paranoid delusions.

The Panel were concerned that when they interviewed the nursing staff from Seacole Ward, even on reflection three years after the homicide, some of them still did not believe that P had had such delusions whilst in their care.

There was apparently no risk assessment procedure in place at the time. One has been devised and implemented as a result of the homicide.

The use of a formal risk assessment procedure would have enabled the available information to have been communicated better within the team. This might have

prevented some of the disagreements within the team and might have led to a care plan for P which was more focused on the known risks.

The Panel have made several recommendations about risk assessment.

There are several other areas of concern that are highlighted in the report.

- **The nursing staff missed classic symptoms of relapse in P's mental health from the end of April 2000 despite the symptoms being recorded by them in the notes.**

  These included:

  - He continued to accuse other patients of intimidation and bullying and refused to stay on the ward if they were not transferred to another ward.

    This happened, for instance, on 23.4.00 just before midnight. When the other patient was not transferred, P threatened to smash the ward if the nursing staff did not open the door so that he could go to his mother's house. He was allowed to go and left at midnight.

    The Panel found it extraordinary that P was allowed to go to his mother's home in a very aroused state in the middle of the night, when it should have been well known that Mrs S was not in good health, had a volatile relationship with P and was at risk when her son was unwell.

    The clinical notes record that this episode was '*reflective of P's paranoid ideation in similar incidents in the past*', but he was still allowed to go.

  - In the weeks before the homicide he was refusing to eat any hospital food and was drinking excessive quantities of water.

From May 2000 the nursing notes refer on almost a daily basis to the fact that P was no longer eating the regular hospital food but was either cooking for himself or ordering take-away meals, mostly the latter.

The nurses were specifically asked about P not eating anything other than take-away meals and drinking excessive quantities of water, but although all of them acknowledged that P was doing both these things in the weeks leading up the homicide, none of the nurses thought – even with the benefit of hindsight – that this behaviour might be a sign of paranoia.

Most of them said that effectively 'it was just P being P.'

Since (a) none of the nurses had managed to form any kind of therapeutic relationship with P since he had been on Seacole Ward, (b) very few of them had known P before he was admitted to Seacole Ward in March 2000 and (c) P spent most of the time in bed when he was not off the ward, the Panel could not see how the nurses could be so sure that this was just 'P being P'. None of them seemed to know anything about him, let alone what was 'normal' behaviour for him.

Psychiatric reports prepared for the criminal proceedings recount how while he was in prison immediately after the homicide, P believed that others were trying to kill him by poisoning his food.

He went on hunger strike in prison from 26.8.00 to the beginning of September and again from 18.9.00. He would take only fluids. He started eating selected foods on 12.10.00 but within a week stopped eating again and again took only fluids.

It is clear that P had paranoid delusions about food at this time, and he probably had them earlier on whilst on Seacole Ward.

The Panel were also surprised that P was allowed to order takeaway meals extremely late at night, often long after midnight. They did not consider that it is safe practice to allow deliveries to be made to an acute psychiatric ward in the middle of the night.

- He was pacing up and down the ward in an agitated manner on a regular basis. When asked about it, the nurses told the Panel that they put it down to P's frustration at being compulsorily detained by Dr Rozewicz (wrongly according to the nurses) in June 2000.

  None of them thought that the pacing might be a sign of deteriorating mental health.

  Once again, perhaps their clinical judgement was clouded by their conviction that Dr Rozewicz was wrong to detain P compulsorily.

- **The nurses failed to engage with P.**

  There was no evidence in the records that P's Named Nurse met with him on a regular basis or that anyone in fact spent any time with him, discussing his care, his treatment or his intended discharge.

  P seemed to have been very much left to his own devices. He was allowed to stay in bed most of the time when he was on the ward.

  Time and time again the nursing notes record that it had not been possible to assess P's mental state because he was either in bed or off the ward. This also meant that he regularly missed ward rounds.

  It cannot be good clinical practice to allow a situation where a patient's mental state cannot be assessed because he is allowed too much freedom to dictate his own routine on the ward.

Clear boundaries should have been identified from the outset and P should have been made to adhere to them.

- **P was shuttled between different wards 12 times within a three month period from the end of March to the end of June.**

  Most of the transfers were at P's request because he said that he was being threatened and intimidated by other patients, but some transfers were because of bed shortages.

  It cannot be good practice to allow a patient to dictate where he wants to be and to disrupt wards in this way.

- **P's use of alcohol and drugs while an inpatient was never monitored nor clinically managed despite frequently being noted.**

  Had there been a greater awareness of the risk of dual diagnosis of mental illness and drug/alcohol misuse, it is possible that the homicide might have been prevented as the Panel consider that the fact that P had taken both cannabis and amphetamines shortly before he killed his mother may have had some influence on the tragic outcome.

- **The clinical team failed to engage P's family in the risk assessment / information gathering process.**

  Previously unknown details about both of the assaults in Spain were found in witness statements made for the criminal proceedings and received at a late stage of the Inquiry .

  If what was said in these statements is correct, the assault by P on his father was more premeditated and more violent than had previously been thought by the professionals caring for P, and the second incident was clearly driven by delusions and more premeditated than had been previously understood.

It is possible that, if there had been a stronger emphasis on formal risk assessment and greater involvement of P's family, these details would have come to light sooner and may have affected clinical decisions about the care and treatment of P.

The Panel acknowledge that P was reluctant to involve members of his family and they were extremely anxious that he was not made aware of any communications that they had with the clinical team, but it was felt that the team should have made a greater effort to obtain information from the family about P's behaviour outside hospital.

- **There was no allocated point of contact for Mrs S in the nursing team.**

Dr Rozewicz told the Panel that Mrs S would phone him whenever P was unwell and that he spoke to her about every six to eight weeks.

Some of the nursing staff resented the fact that Dr Rozewicz took it upon himself to be the point of contact with Mrs S. Again, they felt that that undermined them.

The Panel acknowledge the importance of Dr Rozewicz's 'hands-on' approach to dealing with Mrs S, but can understand the nurses' frustration and feeling that he was undermining their role.

However, there was no team decision as to who should be the point of contact for Mrs S. It had been highlighted in previous admissions that she needed a point of contact, but no-one other than Dr Rozewicz seemed to be prepared to adopt that role. It may well be that they were not given the chance to do so.

It is a great pity that there was not a more shared and common approach between the ward staff and the consultant at this time.

The nurses should have told Dr Rozewicz if they felt he was undermining them.

Mrs S's well-being and safety should have taken priority over their own feelings.

- **There was a very poor level of activities for patients on the general adult wards.**

  It had been established during P's earlier admissions that he needed a high level of daily activities to occupy him and keep him motivated.

  Throughout the whole of his 13-month stay as an inpatient on the general acute wards there was virtually nothing for him to do. As a result he spent most of his time either in bed, playing pool, watching TV, or out of the hospital, depending on whether he had leave to do so. He occasionally played badminton or other sports.

  Special consideration should be given to those who are in hospital for long periods and resources allocated to ensure that they have adequate activities to motivate, stimulate and rehabilitate them.

  The Panel recommend that resources should be allocated to providing a more comprehensive programme of activities, including occupational therapy, especially for long-term patients.

- **There was a lack of proper discharge / aftercare planning.**

  When P was transferred from the forensic team to the general adult team at the beginning of 1999 he should have been identified as having long-term needs and those needs should have been identified and addressed.

  A whole rehabilitation programme needed to have been developed for him.

On more than one occasion, consideration was given to referring P to the Rehabilitation Service, but it was never followed through.

The Panel were told that there was a 'year's waiting list' for the service at that time, but they consider that this may well have been the best solution for P and that more thought and greater effort should have been put into his rehabilitation into the community.

The Panel found that any Rehabilitation Service that has a year's waiting list is not functioning properly.

The Rehabilitation Service at Springfield is a model of good practice and would no doubt have made active decisions about P's discharge which were completely absent in the Care Plans which were being formulated for P in 2000.

Only his accommodation was really being thought about. What he would do with himself in the community was not.

The Panel sympathised with the fact that P rejected every suggestion of accommodation which was found for him. He was not an easy patient to rehabilitate or accommodate, but they felt that at the very least the general adult team could have sought out and drawn upon the expertise of the Rehabilitation Service to get advice on what to do with P, both on the ward and in planning for his discharge.

The Panel present this Report confident that they have done their best to piece together all the important and relevant information from over a considerable period of time and that they have carefully considered all that they have learned, so that their findings and recommendations can highlight what needs to be

addressed to try to ensure that the tragedy that occurred in this case is not repeated in the future.

The Panel were struck by the fact that almost none of the nurses they interviewed felt that they were in any way in the wrong or - even more worryingly - that there were really any lessons to be learned from this incident as far as they were concerned.

Lessons can only be learned if steps are taken to address any shortcomings and if the policies and protocols put in place to meet those shortcomings are adhered to and closely audited.

The Panel sincerely hope that the Strategic Health Authority will agree and implement an Action Plan with the Trust to meet the Recommendations which we have made, and that the staff affected by any consequent changes in policy and procedure will appreciate the importance of those changes and implement them.

If lessons are truly learned from this distressing case, then it could be said that some good had emerged from the tragedy of Mrs S's death.

RECOMMENDATIONS

These Recommendations are addressed to the current agencies now responsible for the services which were involved with the care and treatment of PS. We are fully aware that since the homicide of PS's mother and the initial internal inquiry, steps have been taken by all the agencies concerned to address the issues highlighted by the incident and that some of the recommendations which we make may already have been implemented or at least considered. We applaud such steps as may have been taken However, it is imperative that regular audits are carried out to ensure that policies are being implemented. We would therefore expect that the Action Plan which will be developed in response to this Report will include an audit cycle which addresses these Recommendations, as just developing policies without proper follow-up cannot guarantee a change in practice.

These Recommendations may seem very basic, but this perhaps illustrates some of the fundamental shortcomings of basic care in this case.

	Recommendation	Organisation(s) Concerned
1	The Trust should ensure that their mental health service is organised in such a way that the health and social care elements are fully integrated and jointly managed	Trust and Local Authority
2	Seacole Ward should be subjected to a review by the Chief Nurse as a matter of urgency and a report submitted to the Trust Board and the Strategic Health Authority by the end of July 2005 so that the Trust can satisfy itself that conditions and clinical leadership have improved since the homicide	Trust
3	The Risk Assessment form should be kept separately from the rest of the notes in a prominent section of the notes so that it is a dynamic and easily accessible document and preferably should be colour-coded so that it is immediately recognizable	Trust

4	Consideration should be given to the development of a nationally standardized proforma Risk Assessment	NHSE
5	Every Risk Assessment form should be signed off by the patient's consultant	Trust
6	The patients' Risk Assessment should be regularly reviewed and updated at least every 6 months	Trust
7	Where risk to others has been identified, especially risk of physical harm, a management plan must be drawn up to deal with such risk, in keeping with the requirements of adult and vulnerable adult protection	Trust and Local Authority
8	When a patient is handed over by the forensic mental health team to the general team, a Risk Assessment form signed off by the consultant should be prepared and handed over. We recommend that attached to the Risk Assessment form there should be a 'bullet-point' list of the key factual elements known about the patient (such as those at the end of Period One and Period 2 of the Commentary and Analysis section of this report) prepared by the patient's Named Nurse on the forensic team	Trust
9	Consideration should be given to the establishment of an appeal system in the event of a request for a referral from the general service to the forensic service being refused	Trust
10	Where a serious incident involving a patient takes place outside the hospital, the clinical staff should use their best endeavours to obtain precise and full details of the incident so that an appropriate risk assessment can be made	Trust
11	There should be a designated member of the mental health and social care team whose responsibility it is to develop and maintain contact with family or carers or anyone who can provide valuable information about the patient	Trust
12	Consideration should be given to whether there should be a Trust protocol to cover Recommendation 8 so that such	Trust

	designated liaison team member can reassure the 'informant' that this is Trust policy in every case and not personal to their case	
13	There should be a separate section in each patient's notes for third party information in order to protect the confidentiality of the informant	Trust
14	Each ward should have an agreed operational policy which should be developed through discussion with the multi-disciplinary team and the relevant directorate. The operational policy philosophy should then be translated into a set of operating standards which are compatible with effective therapeutic practice	Trust
15	The Trust should assess the degree to which they have made available clinical leadership and ward management development opportunity in order to ascertain • how much already exists • whether it is adequate • what more they need to do	Trust
16	If such assessment as described in Recommendation (15)highlights any deficiencies in any of these areas, they should be addressed and redressed as soon as possible	Trust
17	A development programme which secures effective team-based clinical and managerial leadership should be implemented systematically throughout the Trust on an ongoing basis	Trust
18	The Trust should review the adequacy of the length of time and quality of ward handovers to ensure that sufficient time is made available for effective clinical communication and teaching	Trust
19	All Named Nurses should arrange one to one time with each patient for whom they are responsible at least once a week, and a record of any conversation should be recorded in the notes	Trust

20	All members of the multidisciplinary team should have access to clinical and casework supervision and consultation	Trust and Local Authority
21	Clinical supervision must be addressed, monitored and audited, possibly through the clinical governance mechanism	Trust
22	The guidelines as to the role of a Named Nurse should be clarified and should incorporate the previous Recommendation	Trust
23	When patients are allocated to the care of certain nurses, on each shift throughout the 24 hour period, the nurses should make specific time to engage with the patients in his/her charge. If there is a persistent problem from the patient's side in achieving this, this should be reported as a significant feature of the patient's clinical presentation and a plan of action should be drawn up to address the problem	Trust
24	Where a patient is consistently not eating the food provided by the hospital, this should also be reported as a significant feature of the patient's presentation and a therapeutic strategy should be devised to address this difficulty	Trust
25	No deliveries should be allowed to the wards after 22.00 hours	Trust
26	There should be an agreed policy, based on the principle of no blame, to address interpersonal conflicts which, if left unresolved, place patients and staff at risk	Trust
27	Any long term patient with complex needs should have a thorough assessment which identifies and addresses their rehabilitation needs, taking into consideration any previous participation in rehabilitative programmes and any current expressed preferences	Trust
28	In accordance with such assessment, appropriate activities should be made available on and off the ward, and priority should be given and resources applied to providing sufficient activities to meet demands	Trust

29	The Rehabilitation Service should be reviewed and appropriately resourced to ensure that those in need of its services do not have to wait long periods of time to be assessed and assisted	Trust
30	Every matter which is considered significant enough to be reported in a ward round should be recorded in the notes	Trust
31	All telephone calls made to a member of the clinical staff from relatives or friends of a patient which are in any way relevant to a patient must be recorded in the notes and detail of the content given	Trust
32	Patients who present with dual diagnosis involving misuse of illicit substances and/or alcohol should be referred for specialist assessment to secure an appropriate clinical management plan, or at the very least be subjected to routine screening for such substances	Trust
33	Moves between wards/hospitals should only take place within the context of the treatment plan, except in an emergency or when ward closure is the reason for the move	Trust
34	The Trust should draw up an Action Plan in the light of these Recommendations	Trust
35	The PCT responsible for commissioning Trust services should consider the resource implications of the Recommendations made in this Report and draw up an investment plan accordingly	PCT
36	The Inquiry Panel should be invited to meet with the Trust in 12 months time to see what progress has been made in addressing the problems highlighted in this Report and its Recommendations	Trust

LIST OF WITNESSES

The witnesses are described by the positions they held at the time of the homicide.

Peter Barry	Capital Projects Manager at Springfield Hospital
Dr Annie Bartlett	Consultant Forensic Psychiatrist at Springfield Hospital
Christopher Butler	Deputy Chief Executive & Director of Operations at Springfield Hospital
Christopher Cook	Ward Manager of Seacole Ward at Springfield Hospital
Bryony Cairnes	Service Manager at Springfield Hospital
Lucy Fife	Senior Occupational Therapist: Wimbledon Community Mental Health Team
Nigel Fisher	Medical Director at Springfield Hospital
Colum Friel	Forensic CPN & Team Leader SWL & St George's NHS Trust
Janet Handy	Social Worker
Joanne Lake	CPN Wimbledon Community Health Team
Dr Gillian Mezey	Forensic Consultant Psychiatrist & Senior Lecturer SWL & St George's NHS Trust
Stephen Morris	Director of Planning SWL & St George's NHS Trust

Roberta Routledge	Former Chief Executive Blessed Trinity Housing Association
Dr Leon Rozewicz	Consultant Psychiatrist SWL & St George's NHS Trust
Duncan Selbie	Chief Executive Springfield Hospital SWL & St G NHS Trust
Kevin Stubbs	Staff Nurse on Seacole Ward formerly on Narcissus Ward
Robson Tanhara	Deputy Ward Manager of Seacole Ward formerly on Narcissus Ward Springfield Hospital
Dr Eva Tsapakis	Senior House Officer to Dr Rozewicz at Springfield Hospital & Atkinson Morley Hospital
Louise Tucker	Staff Nurse Seacole Ward formerly on Curran Ward Atkinson Morley Hospital
Magdalena Viera	Staff Nurse Jupiter Ward Springfield Hospital
Sanjaya Warnatilake	Staff Nurse Seacole Ward Springfield Hospital
Thomas White	Approved Social Worker Wimbledon Team