THE VINER REPORT

The report of the independent Inquiry into the circumstances surrounding the deaths of Robert and Muriel Viner

March 1996

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Appendices

LIST OF ABBREVIATIONS

GP	=	General practitioner
CMHT	=	Community mental health team
OT	=	Occupational therapist
CPN	=	Community psychiatric nurse
MISG	=	Mental Illness Specific Grant
CPA	=	Care Programme Approach
NSF	=	National Schizophrenia Fellowship
ASW	=	Approved social worker

1. INQUIRY PROCESS

Introduction

1.1 Muriel and Robert Viner almost certainly died on the evening of 19 April 1995. Muriel Viner was unlawfully killed. Robert Viner died of a drug overdose. All the evidence indicates that Robert Viner killed Muriel Viner. In cases of homicide committed by a mentally disordered person, the secretary of state for health has decided that it will always be necessary to hold an external inquiry, which should be independent of the service providers involved.[1]

1.2 The Dorset Health Commission purchases health services for the people of Dorset. One of its particular functions is to purchase specialist mental health services, and it was, therefore, this agency which assumed responsibility for setting up an external inquiry. A remit for the inquiry was agreed by the Dorset Health Commission and the chairman of the inquiry (Appendix 1). The inquiry team members appointed by the Commission were as follows:

- Anthony Harbour (solicitor and inquiry chairman);
- Dr John Brunning (consultant psychiatrist);
- Linda Bolter (social services manager and Mental Health Act Commissioner);
- Helen Hally (director of nursing Lewisham & Guy's Mental Health NHS Trust).

Diana Churchill, from the Dorset Health Commission, was appointed as secretary to the inquiry.

1.3 The team first met together in London on 20 September 1995. Subsequent team meetings took place either in London or Dorset. The team heard evidence from witnesses over seven days in late November and early December 1995. (A list of the witnesses who gave evidence is appended to this report - Appendix 2). The draft report was sent to all the agencies involved, including the Dorset HealthCare NHS Trust and the Dorset Social Services Department, on 28 February 1996. Comments were invited on the draft, prior to the final draft being submitted to the Dorset Health Commission on 13 March 1996.

Terminology

1.4 It was a matter of some discussion amongst ourselves as to how Robert and Muriel Viner should be referred to throughout the text. In particular, it was noted that, when they were discussed, Robert Viner was often referred to as "Rob" and Muriel Viner was invariably referred to as "Mrs Viner". Although the use of this nomenclature was resonant in relation to the people involved, it was decided that, partly for the sake of consistency, the references in the text should simply be to Robert Viner and Muriel Viner. Also as this report is the work of a team, we have used "we" as an impersonal form.

Methods of work and investigation

1.5 We were assisted by an internal review, which was initiated by the mental health clinical management team within the Dorset HealthCare NHS Trust. This team prepared an internal review document, case history and chronology. The conclusions of the review are dealt with below. One of the benefits of the internal inquiry process was that much of the relevant documentation had been assembled prior to the start of our investigation.

1.6 We were provided with documentation from the following sources:

- Dorset HealthCare NHS Trust medical records;
- Dorset HealthCare NHS Trust Herrison Hospital notes;
- East Dorset Housing Association;
- Knightstone Housing Association;
- Dorset HealthCare NHS Trust community nursing records;
- Dr Hutchinson's notes;
- Dr Dudding's notes;
- Dorset Social Services Department records.

1.7 During the course of the inquiry additional documentation was obtained including the following:

- Robert Viner's diary and other notes and records kept and made by him;
- Dorset HealthCare NHS Trust OT records;
- correspondence with housing associations;
- numerous policy and planning documents, correspondence, committee minutes, job descriptions.

1.8 Having evaluated these documents, we decided which witnesses should be asked to give evidence.

1.9 The timetable which was established to hear evidence was demanding, and put both the team members and the witnesses under pressure. However, this was the consequence of a deliberate decision to use the time available efficiently. We wanted to cause as little disruption as possible to staff and services. Also we wanted the process to be economical, knowing that the inquiry had to be seen in the context of the availability of finite resources for the provision of effective services. "When considering the scale of inquiry, purchasers should balance the need for a searching inquiry into the operation of the mental health services in any particular case, which will also satisfy public interest requirements, with the need to divert a minimum of resources from service provision".[2]

Expert evidence

1.10 We obtained a written appraisal of some of the documentary evidence from Richard Jones. His qualifications and excerpts from his written report are contained in an appendix. (Appendix 3).

Areas of evidence

1.11 Prior to each witness giving evidence, they were sent a letter identifying particular areas for discussion. The witness was also invited to provide a written report in advance of attending the hearings. The witnesses were informed that they could bring with them a friend, relative, other representative or lawyer. The majority of witnesses decided to be accompanied.

1.12 The letters sent to each witness also contained the following information:

> "It is the practice in inquiries of this nature to sometimes arrange to send out warning letters to individuals. This will happen if it is considered that that person is likely to be criticised for any of their actions in relation to the events being investigated. On assessing the written material that has so far been made available, the inquiry team have decided not to send out any such letters. However, should it emerge during the continuing course of the inquiry that any witness is vulnerable to criticism, then that witness will be notified without delay and be given an opportunity to deal with any criticism accordingly".

1.13 Good practice and fairness require that any witness involved in an inquiry of this nature is given an opportunity to deal with any criticism. However the reality of dealing with this issue is not as simple as it may appear. It may not be possible to identify the areas of criticism until a witness has actually given evidence. This will impact both on the witness and the organisation to which they belong.

1.14 We wanted the process of inquiry to be as constructive as possible and so we have avoided, as far as we were able, singling out individuals for particular criticism. The concerns we have formulated as a result of this investigative process are focused mainly on the services themselves, their interrelationships and methods of communication. However, at times there was insufficient communication between individual professionals and we have made reference to this in the text.

1.15 The keyworker will usually be the professional who has the most dealings with the client. Inevitably, when things go wrong that person will receive most comment, as any inquiry will address the points of contact between the client and the service. As a consequence, Lesley Moon, as the CPN with the most frequent involvement with Robert Viner and Muriel Viner, receives greater attention in this report than any other individual professional. This should not be taken as indicating that we regard her as particularly susceptible to criticism. Indeed, as the professional who had sustained contact with Robert Viner and Muriel Viner over a nineteen month period she developed a positive and caring relationship with them both. As we state elsewhere in this text we consider her input was both positive and constructive.

1.16 We sent the draft report to the key agencies involved to enable them to respond on behalf of their respective organisations and their staff to any perceived criticisms. We agreed that we would take all these responses into consideration prior to final submission of the report.

Resources

1.17 A thread running throughout our investigation is the issue of resources - in particular the inexorable pressure of resource availability on all areas of mental health service provision. We have not addressed this as an area for particular discussion. Rather we recognize it as a key factor underpinning any investigation of this nature and we have discussed the problem of resource allocation in our concluding chapter.

The hearings

1.18 The hearings were conducted in private. The process of inquiry was "inquisitorial", with witnesses being examined by the team members, and then being invited to respond at the conclusion of the examination. All the evidence was transcribed and the transcriptions were made available to the individual witnesses. All witnesses were informed that their evidence would, or could be, quoted in the final report.

1.19 We are aware of the ongoing debate as to whether inquiries of this nature should be conducted in public or private. This inquiry was a "hybrid", with the hearings being conducted in private, but the report being publicly available and the evidence of witnesses being freely quoted in the report. Our decision to conduct the inquiry in this fashion took into account the resource implications of conducting public hearings and also the wishes of the relatives. There can be no general rules about how inquiries of this nature should be conducted. For instance, the public interest may require that hearings are held in public. However, we decided that the remit of this inquiry could best be fulfilled by the inquisitorial investigation which we conducted.

Preparation for the inquiry

1.20 The process of an organisation, and the individuals within it, being subjected to external inquiry, can be a difficult and uncomfortable experience. Without exception, everybody who was involved with the inquiry process co-operated fully. All professional witnesses gave helpful statements and presented their evidence conscientiously. We were constantly aware of the pressure that the inquiry process was putting on the organisations and individuals involved and we wish to thank them all.

1.21 We consider that those involved in giving evidence were not fully prepared for the impact of this form of investigation. This may partly reflect the fact that this was the first inquiry of this nature in Dorset. However it is a fact of life that, tragically, such inquiries will continue to take place. It is therefore incumbent on purchasers and providers to be aware of the potential impact of this type of inquiry, and its effect on staff. Staff should be fully appraised of the nature of the inquiry and should be given support throughout the process. They ought to be made aware that the rigorous conduct of an inquiry should not be viewed automatically as threatening, but as part of a necessary evaluative process.

The family and friends

1.22 Throughout the course of the inquiry Robert and Muriel Viner's relatives, friends and neighbours gave great assistance to the team. In particular, Deborah Greaves (Muriel Viner's daughter and Robert Viner's sister) and her husband, Colin Greaves, provided invaluable information to us and gave evidence in a balanced and sensitive way. We would like to thank them for all their assistance and express the hope that their involvement in the inquiry process may in some way have assisted them in coping with their bereavement.

Acknowledgments

1.23 Apart from generally acknowledging the co-operation of all professional staff, and the relatives, friends and neighbours of Robert and Muriel Viner, we would like to thank the Dorset Health Commission for providing facilities and resources for the smooth running of the inquiry. June Martin and Ivan Trussler provided a highly competent efficient transcription service. Joan Killoch, Ann Stone and Debbie Nonnemacher from Dorset Health Commission were of great assistance with the preparatory work. In particular, we would like to thank Diana Churchill, from the Dorset Health Commission who acted as the secretary to the inquiry. She took on a difficult job, along with her other responsibilities, with great skill and efficiency.

1. Guidance on the discharge of mentally disordered people and their continuing care in the community (NHS Executive HSG(94)27)
2. Building Bridges, page 82

2. BACKGROUND AND HISTORY

Introduction

2.1 On 19 April 1995, Robert Viner, aged forty-two, killed his mother, Muriel Viner, aged seventy-six.

2.2 While sitting in an armchair in her living room, Muriel Viner received more than twelve blows to the head from a heavy metal disc which was found on the floor near her body. Robert Viner died some time later from an overdose of drugs. His body was found in the bath upstairs.

2.3 Robert and Muriel Viner had lived together in her house at Corfe Mullen, Dorset, for nearly twenty years. Mrs Viner had moved there from Witney, Oxfordshire, in 1974. Her husband, Robert's father, had died in 1971 and Muriel Viner wanted to live in the Bournemouth area where she had spent part of her childhood.

2.4 Muriel Viner had two children - Deborah Greaves, married and living in Birmingham with her husband and two daughters, and Robert, who was two years younger. Muriel Viner had not particularly expected her unmarried son to join her in Corfe Mullen. Robert Viner was completing a degree in civil engineering at the time of her move to Dorset. Following his degree, there were work difficulties and the expectation seemed to be that he would move on when these were solved; in fact, they never were.

2.5 Robert Viner had shown symptoms of mental illness from his late teens; by the time he arrived in Dorset the presence of a substantial disorder was evident.

Robert Viner's illness

2.6 The first referral for a psychiatric opinion was to Dr Seymour Spencer in Oxford in March 1971 - at the age of eighteen. The GP had hinted at the possibility of a developing psychosis. The psychiatric assessment was of hypochondriasis associated with an introspective personality. Robert Viner was taking pills for sea-sickness (which are sold without prescription) in order to calm himself. Dr Seymour Spencer suggested an alternative. No specific diagnosis was made, though he was seen more than once.

2.7 The next assessment by a psychiatrist was arranged by the Student Health Service at Manchester when Robert Viner was about to take his final degree examinations in May 1975. He was self-medicating with sea-sickness pills and cough linctus. He reported paranoid symptoms - believing others could tell when he was using hydrocortisone ointment for his eczema. He knew this because people would give a sniff as he passed them: "as if he was being very autocratic". The diagnosis was immature personality combined with multiple drug misuse. A second appointment was made but he failed to attend.

2.8 Following these two inconclusive referrals for psychiatric help, all that was important in the treatment and outcome of Robert Viner's illness took place in Dorset.

Visits to see Dr Gumbrell

2.9 Dr Mulholland, Robert Viner's GP, wrote to Dr Gumbrell, consultant psychiatrist, who saw Robert Viner at an out-patient clinic at St Ann's Hospital in April 1976. Dr Gumbrell did not consider Robert Viner had schizophrenia although the symptoms, including thought broadcasting (the belief that others can read one's thoughts) could have suggested this. Nevertheless, treatment with Stelazine tablets (an often effective drug for schizophrenia) was recommended. At the next appointment, three months later, Robert Viner's mental state seemed to have improved. He had, however, lost his job but was about to start another in Birmingham. It was recommended that he be seen by a psychiatrist in the Midlands but no arrangements were made for this to happen.

2.10 The next appointment was a year later - in April 1977. The job in Birmingham had lasted for three months. Treatment with Stelazine tablets had continued, though it is not known how regularly. Robert Viner said he thought they helped although the main symptoms, feelings of persecution and ideas of reference (believing that neutral events have a special significance) continued. The plan was to review the case in a few months time, but this did not happen and there is no explanation recorded in the notes. It was almost three years before Robert Viner was seen again - in January 1980. Dr Mulholland wrote again, recounting the, by now, familiar symptoms but adding significantly, "His mother has threatened to sell up the house and move away, rendering him homeless, unless he obtains effective medical treatment."

2.11 Dr Gumbrell saw Robert Viner on 3 January 1980, first by himself and then with Muriel Viner who reported that he was spending most of the day in bed, listening repeatedly to the same part of a pop record. Following the visit, Dr Gumbrell wrote to Dr Mulholland saying that he had told Robert Viner that he "thought he would be better away from his mother, but he refuses to countenance this as he is very comfortably placed". The suggestion was that any occupation outside the home would be valuable and the possibility of a course of Industrial Rehabilitation was mentioned. Nothing came directly from these ideas but the discussion probably had some effect. Seen four weeks later, Robert Viner had started to apply for jobs and "he seemed more positive than last time". Thereafter, he was seen regularly at the clinic, his symptoms started to reduce and he began a course in computer operating at Windsor in late June. This lasted only six weeks; he said he had been "thrown off because of lack of progress".

2.12 By January 1981, Robert Viner was working as a draughtsman but told Dr Gumbrell that he found his work companions intellectually inferior and therefore boring. In April 1981, he was still working but the paranoid symptoms had intensified. The dose of Stelazine was increased and he felt slowed down so he obtained an anti-depressive drug from his GP. He continued with both drugs and this marked the start of a trend. From that time, Robert Viner took an increasing number of different drugs. The majority were prescribed, but the net effect was that he had available to him what his GP later described as a "cornucopia of drugs" from which he would make a daily selection according to his own appraisal of his mental state.

Admissions to the Herrison Hospital

2.13 By June 1981 Robert Viner was again unemployed. Both Muriel Viner and Deborah Greaves, his married sister, had written to Dr Gumbrell describing a worsening mental state. Robert Viner was admitted informally to the Herrison Hospital on 23 July and stayed until 4 August when he was discharged at this own request. His complaints, on admission, were depression and inability to mix with others; he found it difficult to communicate and felt anxious and exposed to ridicule. The entry in the nursing notes on 25 July read: "Started to behave in a very demanding manner. Going out and having few drinks in the pub." On 3 August: "I do not want to go to TV room because people can hear me thinking". 4 August: "wants his discharge - agreed". The medication was changed. A depot injection was added to the oral medication for the first time - to be given every two weeks, at his home, by a CPN. The result, either from the experience of admission, or the medication was satisfactory. By November 1981, the main symptoms of the illness had resolved and there was even some social activity - joining the Bournemouth Casino Club for a while. Unfortunately, this improved mental state did not last. In March 1982, Robert Viner felt he could do without the depot injection as it might impair his performance at a job interview. Five months later, he was re-admitted to the Herrison Hospital.

2.14 The second admission was at Robert Viner's request; he was troubled by hearing voices. He was admitted on 20 August 1982 and discharged on 7 September. The last entry in the medical notes made during his stay recorded that he was "participating in OT and socialising. Cheerful. Not hallucinated". His medication regime was augmented to three anti-schizophrenia drugs and two types of anti-depressive, all to be taken by mouth.

Home visits by Dr Gumbrell

2.15 Muriel Viner wrote to Dr Gumbrell in September 1984 asking him to see Robert Viner. An appointment was made for him to be seen at the out-patient clinic but he asked for a home visit because people made fun of him at the clinic. Dr Gumbrell visited the home on 17 October and found him in bed in mid-afternoon. They discussed the current symptoms which included hearing voices and ideas of reference. Dr Gumbrell's letter to the GP finished: "At the moment there is nothing I can suggest to help him but I hope my visit will do something to reassure his mother".

2.16 The next contact was in August 1986 - at Robert Viner's request. Dr Gumbrell called at the home on 20 August and spoke first to Muriel Viner. Robert Viner was still in bed; she said that her son lay in bed all day and failed to wash. Her daughter, Mrs Greaves, and family had stayed at the house during a recent visit. Robert Viner had found them so "formidable" that he consumed more than four bottles of whisky in the week preceding the visit. Dr Gumbrell, having heard Robert Viner's account of his symptoms, recommended a substantial increase in the dose of one of the several anti-schizophrenia drugs he was taking. ~Eleven days following the visit, he wrote a letter to Dr Gumbrell asking how the increased dose (of Largactil) should be combined with other medication: "I want to know where I stand with these drugs". He added that he had read of the use of antibiotics for his state: "Possibly some types of schizophrenia are due to an infectious cause".

2.17 Dr Gumbrell replied with a letter about the nature of schizophrenia, then called at the home again on 1 October. The plan was that Robert Viner should telephone his secretary if he wanted another meeting; he never did this. Letters were exchanged - the last from Dr Gumbrell, on 15 May 1987, asked whether Robert Viner "might feel a bit better if you had more company than that of your mother?", concluding with an invitation to attend the Herbert Day Hospital or a further admission to the Herrison Hospital. Robert Viner was not seen by a psychiatrist, or any mental health worker, from 1 October 1986 until his first visit to see Dr Ford on 18 July 1988.

Relationship between Muriel Viner and Robert Viner

2.18 What can be achieved in medical treatment depends on the personal and social resources of patient and carer, as well as the nature and severity of the underlying disorder; this is especially true of psychiatric illness.

2.19 We heard from twenty-four people, relations, friends and professionals, who knew either Muriel or Robert Viner - often both. Muriel Viner was described with consistent regard; there were no detractors. She was admired for the resolute care she gave to Robert Viner, despite her increasing age and the fetters he placed on her social life. She hardly complained of her task; saying no more than the minimum.

2.20 In 1979 she developed symptoms of cardiac strain - found to be caused by severely raised blood pressure. Treatment was subject to a regular review. During a review in 1992 she mentioned having chest pain to Dr Hutchinson, her GP, and for the first time told her about her son's illness. Her local friends were aware that Robert Viner's illness had social consequences for his parent. Otherwise, Mrs Viner was a friendly person whose company was enjoyable to others - as theirs was to her.

2.21 Robert Viner's personality emerged less clearly. The descriptions given by those who might have known him best were not vivid - but they were consistent. His high intelligence was obvious, as was his tendency to social withdrawal. Grant Silk, a friend from undergraduate days, usually made a yearly visit to Corfe Mullen. Although Mr Silk was his closest, perhaps only, friend, Robert would soon retreat to his room after his friend's arrival on the pretext that he wanted to smoke. Robert Viner's smoking habit was a recurrent source of comment. He had a special room, effectively a study, upstairs next to his bedroom where smoking was allowed - though not approved of. He had managed to stop smoking for many months by the end of 1994 and had told Muriel Viner that his abstinence depended on what amounted to a ban on his sister, Mrs Greaves, and her family, coming to stay. It may be that Robert Viner's need to get away from people was quite as strong as his desire to smoke; two impulses satisfied by one item of behaviour. He had a parallel difficulty with alcohol.

2.22 Robert Viner used alcohol as a tranquilliser in much the same way as he used his prescribed, and non-prescribed, drugs. There was no real evidence to suggest that he became aggressive while drinking, despite taking fairly large amounts at intervals. The pattern of his drinking would be best described as one of psychological dependence. Alcoholism is diagnosed when there are persistent harmful consequences, which may be psychological, physical, social, economic, in varying proportion, which arise from drinking alcohol.

2.23 In Robert Viner's case, it would be fair to say that the situation was one of developing, rather than established, alcoholism. There was a degree of fatty infiltration of the liver found at post-mortem examination - a finding which is common among heavy social drinkers and may never lead to physical symptoms. There was no alcohol found in the blood at post-mortem and this argues against the homicide occurring in a state of alcohol induced intoxication. Nevertheless, Robert Viner had reservations about his drinking. He wrote to Dr Michael Ford, consultant psychiatrist, a few days after their first meeting in July 1988. A section of the letter, which described his experience of different sorts of medication, listed the effect of alcohol, ending: "_ bottle of whisky will usually stop almost all halluc. (sic) voices or else make you feel like you don't care anyway. However, it's too expensive (for me) and you can't get it on prescription or drive on it".

2.24 The details of the relationship between Robert Viner and Muriel Viner were not easy to discern. There may have been discordant periods interspersed with phases of lesser tension. The impression was that Muriel Viner took care to avoid conflict. When there were visits, such as from the CPN, Robert Viner would seem to put himself in a position where he could overhear the conversation. When Deborah Greaves spoke to her mother on the telephone and enquired about her brother, Muriel Viner's replies would be guarded and non-committal. Nevertheless, she did not say she felt physically threatened. Her friend, Eve Hamlin, told us that with this possibility in mind, she offered Muriel Viner emergency refuge in the event of a crisis: the response was "Well, I can manage him". There was just one reported exception. Deborah and Colin Greaves, mentioned an occasion when Muriel Viner had put away the kitchen knives. A collection of kitchen knives were also found to be moved from their ordinary place when the bodies were discovered.

2.25 Even apart from crises, the relationship between Robert Viner and Muriel Viner was out of balance; he had most of the benefits - she had mainly obligations. Because of his mental illness, Robert Viner was plainly dependent on Muriel Viner for everyday care. He lacked the necessary drive and practicality to look after himself.

2.26 His time was spent unproductively, often staying in bed until the afternoon. When awake, he was usually alone in his study. He spent days composing mechanical drawings in the hopeless pursuit of a device for perpetual motion. Fond of reading children's books, he wrote one himself at one stage.

2.27 The fact that Robert Viner and Muriel Viner managed to survive together for so many years was, perhaps, a measure of her tolerance and stability. Had she been less capable and conscientious, or had less adequate accommodation, the pressure for an alternative solution would have become acute at an earlier stage.

2.28 Two notes were found in the house following the tragedy which were suggestive of the nature of the relationship between Robert Viner and Muriel Viner - at least in the final stage. Robert Viner's was in the form of a letter to this sister:

> Dear Deb
>
> I hear that Moo has invited you here from 17.4.95 for a few days. Please don't come. If you come here - it only means upset for me. Inevitably the old cow will turn funny on me making me very, very angry and hate her. Also if you come I've got all the nuisance of changing bedrooms, and moving beds and drawers. Added to that, the cost of drink and the danger of resorting to smoking. If you want to see her - then you ask her up to your place.
>
> Yours Rob.

2.29 Why this was not sent is open to conjecture. It is possible that he simply thought better of it. It may be that the note, or its existence, was revealed to Muriel Viner and he was persuaded not to send it.

2.30 Muriel Viner's note read:

> 13.3.95 "BOTTLE WINE - SUNDAY MORE DRINK MONDAY Because I hadn't renewed soap in bathroom I was called a Clever Fucking Dick WENT UPSTAIRS DOZENS OF CLOTHES THROWN ON FLOOR OUT OF AIRING CUPBOARD - ASKED WHAT THAT WAS ALL ABOUT - SAID HE DIDN'T KNOW HAD BLACKMAILED ME PREVIOUS DAY ABOUT WAR PENSION SO TOLD HIM TO DO IT - TOLD ME TO PISS OFF AND FUCK OFF"

2.31 Again, the content is easy to understand, but whether this was characteristic of their relationship is open to supposition.

The Greaves visit

2.32 In late December 1994, Deborah Greaves, a district nurse, was involved in a road accident while driving her car. She received multiple injuries - so severe that, at first, there was a question whether she would survive. Inevitably, Muriel Viner was greatly worried and visited her daughter in hospital at Birmingham, as soon as possible. Robert Viner did not accompany her. Over the succeeding months, Muriel Viner made about four visits to Birmingham, staying a few days at a time. Deborah Greaves thought it possible that Muriel Viner's note, quoted above, was written on the train when she travelled to Birmingham for the last time.

2.33 As was customary when she went away, prepared meals were left for Robert Viner. On her return, she found unwashed dishes and general disarray. This was ordinary - probably not a response to the special reason for her absences during this time.

2.34 The visit of the Greaves family that Easter was made with fairly short notice. Deborah Greaves telephoned on Wednesday, 12 April, to say they would be able to arrive on Sunday, 16 - Easter Day. Apart from the ordinary wishes for a family visit, there was reason to celebrate Deborah Greaves' continuing physical recovery from her accident as well as Colin Greaves' promotion - he is a university lecturer.

2.35 Robert Viner's misgivings about the visit may have shown partial expression in that he continued to use his bedroom, rather than sleep in the smaller room he used as a study - which would have been a more convenient arrangement. It is not known whether this was a particular nuisance for Muriel Viner. It was certainly ordinary for Robert Viner to be inflexible and also, perhaps, for her to adapt to a situation which she would not have chosen.

2.36 In the event, the atmosphere during the Easter weekend was not marked by unexpected behaviour on the part of Robert Viner. He drank a certain amount of alcohol and spent much of the time in night attire but this was his custom over some years.

2.37 The Greaves family visit was, as planned, quite brief. Having arrived on Easter Sunday, they departed on Tuesday, 18 April. Deborah Greaves telephoned her mother later to say she arrived home safely. She asked about her brother: "Has he sobered up yet?" Muriel Viner made no reply to this, they went on to talk of other things "but she sounded perfectly normal".

2.38 We were provided with a description of a meeting with Muriel Viner following the visit. Lilian Cheeseman wrote to the secretary to the inquiry and was later invited to give evidence. She had been a close friend of Muriel Viner for eighteen years. Her letter described the call she made at Muriel Viner's house on Tuesday, 18 April 1995: "She was slumped in her armchair, really looking as if she'd reached the end of her tether."

Events of 19 April

2.39 At nine-thirty to ten o'clock on the morning of Wednesday, 19 April, Anita Paul, CPN, made her last visit to the Viner home. She told us that, generally, Muriel Viner would make a friendly greeting on coming to the door and then: "we would have a couple of minutes of pleasantries in the hallway". On this occasion: "she opened the door and she was quite angry. She said to me, 'I have had a terrible time with him, he is upstairs'. I remember her going down through the hallway and just going into her room and I thought that was really out of character for her."

2.40 Anita Paul then went upstairs to give Robert Viner a depot injection (of Haldol). He followed Anita Paul on her way down, obviously angry because she had said she would have a chat with his mother. By the time Anita Paul reached the hall, with Robert Viner close behind, Muriel Viner, still downstairs said, in a voice raised with anger, that she had "had an awful weekend with him. Her grand-daughters had been to stay and he had disrupted the whole weekend". All three then went into the lounge. Robert Viner and Muriel Viner were shouting at each other - mainly about his drinking. Muriel Viner asked Anita Paul into the kitchen to see two large dustbin liners filled with bottles - all retrieved by her during the previous week. This led to Robert Viner and Muriel Viner exchanging more angry words.

2.41 All three returned to the lounge. Muriel Viner was crying and said she had "had enough of him" and that she "could not cope any more". Anita Paul then said to Robert Viner she would contact Dr Ford and "that maybe the best way to handle the situation was for Robert to just be parted from his mum to give her a break". No response to this suggestion was recorded in the notes.

2.42 Anita Paul had been told by her colleague, Lesley Moon, from whom she had taken over the case, that the relationship between Robert Viner and Muriel Viner could be heated but things usually simmered down. Muriel Viner had told Anita Paul on a number of occasions that there had been arguments between them.

2.43 Later that morning, Anita Paul contacted Dr Ford at Alderney Hospital, which was the office base for the CMHT and where the out-patient clinics were held. The plan was to offer Robert Viner admission to St Ann's Hospital. While he was in hospital, Muriel Viner could be visited to offer support in coming to a decision about Robert Viner's future.

2.44 Anita Paul telephoned Dr Ford's secretary, asking for a bed at St Ann's Hospital reasonably soon - that is, not necessarily the same day but within a few days at most. Anita Paul then telephoned Muriel Viner, who said she could not talk because Robert Viner was listening. She sounded distressed but was not crying and there were no sounds of argument in the background. Anita Paul said she would telephone the next day - which she did, but there was no reply then or on the following day, Friday.

2.45 There was another caller to the house on Wednesday morning - a Jehovah's Witness, not known to Muriel Viner but accompanied by the young son of Janet Vause. Janet and Elizabeth Vause (who had known the Viners for several years) were calling at other houses in the street; Muriel Viner waved and spoke a friendly greeting as they walked by.

2.46 It was said that Muriel Viner was seen in Bournemouth during the afternoon of the 19th by two of her friends from the sequence dancing group, to which she had belonged for many years. They did not speak to her; she was going into a shop. This was reported by Eve Hamlin, who remembered a time when Muriel Viner, having found her home in a disorganised state after a few days away, immediately went to the shops in Bournemouth - possibly to escape from domestic tension.

Events following 19 April

2.47 Also on Wednesday, 19 April, Deborah Greaves arranged for a gift of flowers to be delivered to her mother on Thursday. There was no acknowledgement and no reply when she telephoned. Robert Viner hardly ever answered the telephone; it was assumed Muriel Viner was out of the house. On Friday, 21 April, the florist made contact to say she had been unable to deliver the flowers. Deborah and Colin Greaves became increasingly concerned; they rang repeatedly on Friday evening to no avail. Colin Greaves suggested going back to Dorset that evening; they decided he should return on Saturday morning.

2.48 Inevitably, there was no reply following his arrival at the house. With the help of a neighbour, Colin Greaves got through a bedroom window on the first floor and discovered the bodies. He informed the police; their investigations led eventually to this inquiry.

Summary

2.49 Robert Viner first received medical treatment for mental illness in 1971. In 1976 he moved to Dorset to live with his mother. She had purchased a house in Corfe Mullen in 1974. Apart from two brief inpatient admissions to the Herrison Hospital in 1981 and 1982 he lived with, and was cared for by his mother, until their deaths in 1995. From 1976 onwards he had contact with the mental health services in Dorset. The degree and nature of this contact varied over the years. Between 1988 and 1995 Robert Viner generally attended 3 monthly outpatient appointments with Dr Ford and from 1993 onwards he had regular visits from CPNs. Also during this period he saw his GP at regular intervals and had contact with other services, including the OT service and the social services department. Until April 1995 the pattern of his life in the community appeared unexceptional, for example he had no history of any sort of offending. It was the tragic events in April 1995 which initiated a number of different investigations including this inquiry. The remit of this inquiry requires us to examine the circumstances surrounding the deaths of Robert and Muriel Viner. (See Appendix 1 for the full remit of the inquiry).

3. HEALTH MANAGEMENT

Mental Health Team

3.1 Robert Viner first met Dr Ford, at the Alderney Hospital, on 18 July 1988; his GP, Dr Dudding, had written saying that he was concerned about the pattern of medication: "...he is constantly writing to me requesting Valium or Lentizol which he takes on a rather ad hoc basis believing that they help suppress voices that he hears. More recently he has been anxious to try antibiotics to help his condition. At the present time he takes Moditen 5 mg tds, Lentizol 25 mg bd and Nitrazepam 5 mg tds, at least this is his official medication".

3.2 Robert Viner wrote to Dr Ford on 9 July 1988, following Dr Dudding's referral letter of 30 June, describing his mental state. Robert Viner asked whether he could be seen at home - not at the out-patient clinic. He explains his reason for this request: "I can't stand waiting in waiting rooms. One of my symptoms is that I think people can hear me thinking and also that I can hear some of other people's thoughts - by telepathy. When I'm in a waiting room, the atmosphere gets very tense and quiet, and the tension "drives me mad" i.e. I can't stand it. This is a genuine problem, and I always do my best to avoid it, by, for example, not using public transport."

3.3 There was no recorded reply to this letter and Robert Viner was seen at the out-patient clinic on 18 July. This meant that he was not seen at his home by a health professional between Dr Gumbrell's visit on 1 October 1986 until the assessment by Augusta Wilson, an OT, on 26 November 1992 - a six year gap.

3.4 Dr Ford's outpatient clinic assessment was relayed to Dr Dudding in a letter written on 18 July. He notes "clear and substantial symptoms of major schizophrenic illness, starting in 1970, including persistent and distressing voices and telepathy, together with a desire to withdraw from people. ..... He is presently living with his mother with whom he has a reasonably satisfactory relationship."

3.5 The plan was to reduce the amount of minor tranquillisers he was taking and rationalise the phenothiazine drugs (specific treatment for symptoms of schizophrenia); Robert Viner was asked to make a report on his previous medication. He did this in a long letter - which included his observations on the place of alcohol (quoted earlier) as well as the effects, and side-effects, of anti-schizophrenia and anti-depressive drugs. Dr Ford continued to see Robert Viner regularly until the last appointment on 1 March 1995; he was due to be seen again in three months time. Generally, his response to treatment was minimal, despite changes to the medication regime prescribed by Dr Ford. The illness remained at a stable level, without obvious crises or phases of remission. In 1991, there was a trial of a depot injection (Depixol), given at the GP's surgery. Dr Dudding thought that there was some response to this; however, Robert Viner, according to a letter from Dr Ford, (November 1991) "found it very difficult waiting even a few minutes in the surgery"; so he gave it up. In the same letter: "He still lives with his mother who is rather domineering".

3.6 The problem of future accommodation was added to the continuing features of Robert Viner's illness. In July 1992, Dr Ford arranged a home assessment from a community OT to find out how he might be able to cope in the event of his mother's death: "... I'm aware that he does very little in the family home because his mother tends to take over responsibility and it may be that some adjustment in this arrangement would be beneficial in the long run, allowing him a certain amount of independence, so that should his house be sold on his mother's death, he would have the choice of actually living and looking after himself, rather than being dependent upon other accommodation being found for him".

3.7 Augusta Wilson visited the home on 26 November and wrote to Dr Ford on 17 December: "I have the impression that Robert has been experiencing more of his psychotic symptoms since November, which seems to be affecting his daily living and his relationship with his mother... **Although Robert denied it, Mrs Viner reported that he has become aggressive with her and she is anxious about this.** ... Both Robert and Mrs Viner agreed for me to alert you to Robert's mental deterioration... He would like to live independently and I feel that warden-assisted accommodation would be most suitable".

3.8 Also on 17 December, Dr Dudding left a message with Dr Ford's secretary with similar information about Robert Viner banging on the wall and telephoning the neighbour at 3.30 am.

3.9 Dr Ford saw Robert Viner at the Alderney Hospital on 23 December. He said that his hallucinations and delusions had worsened and agreed to a trial of a depot injection (Haldol) to be given monthly, at his home, by a CPN. There was also talk about accommodation, "I discussed this with Robert who is worried that should he move out of his mother's home she would move to live with her daughter in Birmingham and that Robert would thereby lose almost all contact with her. ..... His mother also cooks and washes for him and on balance he does find some support in their relationship even though they row at times".

3.10 On 15 January 1993, a CPN, Maria Caundle, visited Robert Viner, made an assessment and gave the first injection of Haldol. Over the next two years this pattern of visiting continued. By 1 March, he showed signs of improvement in that he was getting up at an ordinary time. However, the OT stopped visiting because she had been unsuccessful in persuading him to accept some sort of day care. In June 1993, Lesley Moon had taken over the home visits. His mental state remained more or less unchanged until February 1994 when Lesley Moon observed that the auditory hallucinations, which took the form of distressing voices aimed at him, were with him every day. Lesley Moon "Spoke with mother who broke down in tears, she cannot cope any more". The dose of Haldol injection was increased; he seemed to improve.

3.11 Lesley Moon visited in June 1994 when Muriel Viner was away on a week's holiday in Yorkshire with her widowed brother, Dennis Flynn. The nursing note read: "Robert appears to be coping well". During 1994 and 1995, the process of applications for alternative accommodation was discussed repeatedly.

3.12 On 22 December 1994, Lesley Moon visited and found Robert Viner alone; Muriel Viner was in Birmingham seeing Deborah Greaves after the accident. On 19 January 1995, Lesley Moon's note read: "Remains the same mentally. Continues to drink quite excessively, emphasised the need to cut back. Gave mum support. She says if Robert doesn't move of his own volition she will evict him. Form sent to Knightstone Housing Association".

3.13 From February 1995, Anita Paul took over as CPN she already knew Robert Viner and Muriel Viner having visited for several months from February 1993. Anita Paul made five visits - the last on 19 April. During this period, there was no apparent change in Robert Viner's mental state. Dr Ford saw him at Alderney Hospital on 1 March and thought that, although paranoid symptoms continued, there was a slight improvement overall.

Medication

3.14 A number of drugs were found at the house following Robert Viner's death. In addition to medication for asthma and eczema, there were supplies of:

- Largactil;
- Stelazine;
- Atarax;
- Lentizol;
- Nitrazepam;
- Loxapine;
- Aspirin;
- Stugeron;
- Paracetamol.

3.15 The last three drugs are available without prescription. Stugeron is an anti-histamine taken for motion sickness, which he had used as a tranquilliser for many years. Atarax is also an anti-histamine - available on prescription only. It was originally suggested by Dr Seymour Spencer in 1971 as a treatment for symptoms of anxiety because of a lesser propensity for causing dependence than the minor tranquillisers more commonly used at that time. It is also used as a partial treatment for eczema and it may be that Robert Viner used this as a pretext for continued prescriptions although he took it for its calming effect.

3.16 Most of the drugs listed were found in his blood post-mortem, as well as Valium (a tranquilliser chemically similar to Nitrazepam) which he had been prescribed in the past for a period of years. In addition, a repeat prescription, issued on 20 March 1995, for the following, not yet obtained, was discovered:

- Largactil;
- Nitrazepam;
- Lentizol;
- Kemadrin (for side effects of Largactil and Haldol);
- Loxapine;
- Atarax;
- Balneum (bath oil);
- Aqueous cream;
- Dermovate ointment with Neomycin.

3.17 The basic medication for Robert Viner's paranoid schizophrenia was the depot injection of Haldol administered by the community nurse.

3.18 The pathologist's opinion, accepted by the coroner, was that death was caused by a combination of drugs. The post-mortem blood levels of Nitrazepam (a sleeping tablet often marketed as Mogadon) and Lentizol, an anti-depressive, were in the potentially harmful range but it is not possible to identify a prime cause of death from such a mixture.

3.19 Dr Ford told us that he had been trying to rationalize Robert Viner's medication since 1988. He did not succeed. The explanation for this is contained in Dr Ford's description of attempting to persuade Robert Viner to reduce his medication, "the overall pattern was that he was not actually prepared to make a great deal of concession".[1] In practice, it can be difficult to persuade patients of the need to change from long-established prescriptions; it was well known that Robert Viner liked to develop his own scheme as to the times and frequency when he took his medication. The obvious disadvantage of such a situation is the difficulty of relating the observations of the mental state to the amount and type of prescribed medication with so many variables - especially combined with intermittently heavy use of alcohol.

OT service

3.20 Robert Viner's case was referred to the OT service at a time when there was a considerable waiting list for allocation in the acute OT service. The acute service had two groups of staff - those hospital based at St. Ann's , who worked with in-patients, both adult and elderly, and those whose prime function was to work with people in the community, and who were based at Alderney Hospital. Priority for allocation to community-based OTs was given to clients who had recently been discharged from hospital. As Robert Viner had been living in the community for several years, he was therefore not seen as a priority.

CHRONOLOGY OF THE INVOLVEMENT OF THE OT SERVICE WITH ROBERT VINER

July 1992
Dr. Ford referred Robert Viner's case to the community OT service, which was based at Alderney Hospital, requesting a home assessment of his ability to shop, cook, do the housework and care for his finances.

November 1992
Augusta Wilson paid her first visit to Robert Viner on 26 November to undertake an assessment. She made notes for her treatment plan as follows:-

- Accommodation
- More responsibility at home
- Day support
- Alert Dr. Ford/Dudding (re) neighbour

December 1992 to March 1993
Augusta Wilson recorded seven home visits during this period. Various activities were undertaken including :- identifying aids to daily living; provision of information on accommodation; discussion on alcohol consumption; support to Muriel Viner and attempting to involve Robert Viner in activity outside the home.

March 1993
Augusta Wilson wrote a referral letter to the rehabilitation OT service. The reason given for the referral was "for support and to monitor Robert's progress regarding activities of daily living, but on a less regular basis. Without continued support there is a possibility that Robert may lose motivation to keep up the progress he has made." A joint visit was made by Augusta Wilson and Anne Staite, the new OT, at the end of March.

April 1993
Anne Staite visited Robert Viner,taking with her a programme from Brownsea (social services day activity centre in Poole.) He said he was not interested in this, or in any other of her suggestions of activities outside of the home. She said that she would visit again, having given him time to think over her suggestions.

May 1993
When Anne Staite rang to confirm their meeting, Robert Viner said he had written to say that he wanted to cancel it, and did not wish to make another appointment. She asked him to confirm this in writing, as he had apparently sent the letter to the social services department in error. Anne Staite subsequently wrote to Dr Ford informing him she had closed the case, as Robert Viner had not been interested in the day facilities or in her continued visits.

3.21 The rehabilitation OT service was based at Hahnemann House and at Nightingale House. Staff also worked at other locally-based day units. The focus for this service was, and is, to support people with severe mental illness who otherwise would be supported in more traditional models of "asylum care." The majority of patients supported by the rehabilitation OTs would have already experienced a period of in-patient rehabilitation. This work is then supplemented by the community rehabilitation team. This team follows up patients, after discharge, for a minimum of three months often in their own homes. The rehabilitation service also supports individuals who live in the community and who attend day units as part of their overall care plan.

3.22 We were told by Anne Staite that, although she worked solely with clients who were attending day units, there were community OTs within the rehabilitation service who did work with people on an individual basis, in their own homes. June Wood, the manager of the rehabilitation OT service, gave us a different impression - she doubted that she would have had sufficient staff to enable work to be done with Robert Viner in his own home. The expectation was very much that a client should be encouraged to attend a day unit , but they would be given a choice as to how they used their time there.

3.23 Robert Viner was, we believe, quite appropriately referred to the acute OT service, as there was a request for an assessment of his daily living skills, followed by an intensive period of input, to assist him in learning the skills identified as being in need of development. It seemed reasonable, given that the concept of CMHT was gaining acceptance, that the case should be allocated to a hospital-based worker, to enable her to develop experience of working with people in the community. It also helped to solve the problem of the long waiting list. Also, Augusta Wilson, as a relatively inexperienced worker, was given the opportunity to develop her community experience and was able to provide intensive input over a relatively short period. She received regular and helpful supervision in this unfamiliar setting. For instance, she was able to discuss the availability and breadth of accommodation for people with mental health problems and discussed her reasons for, and method of, transfer of the case to another worker. Possibly this change was accelerated as she was making an internal move within the service.

3.24 Augusta Wilson discussed the referral to the rehabilitation service, both with one of their OT staff, and latterly with June Wood. She followed up her discussion with a referral letter. She told us that she was hoping an OT would visit at home and continue to review his targets. She also did her best to prepare a reluctant Robert Viner for the handover, and made a joint visit with the new worker, Anne Staite. During the four months in which she worked with Robert Viner, it seems that she had considerable success in persuading him to undertake domestic tasks, which he had not been motivated to do before. Despite considerable persuasion, however, she did not convince him to join in any activity outside of the home. When Anne Staite closed the case, she said that the reason for Augusta Wilson's referral had been to see if she could "help find a placement at some day facility". This was not the reason that Augusta Wilson gave us for the onward referral.

3.25 It appeared to us that Robert Viner's needs did not fit neatly into either OT service. The aim of Augusta Wilson's intervention with him was primarily to assist Robert Viner in developing those domestic skills which would enable him to lead a life independent from his mother. Her experience of trying to introduce Robert Viner to a day resource demonstrated that it would be difficult to work with him to develop social skills outside of the home.

3.26 There was confusion over the specific onward referral of Robert Viner's case within the OT service which may reflect the fact that his needs did not fit neatly into the scope of activity of either of the services which existed at that time. We wonder whether Augusta Wilson's expectation of how the referral might be dealt with was beyond the resources and the philosophy of the OT service during this period.

Primary health care teams

3.27 The referrals made by Dr Tomlinson of Witney and Drs Mulholland and Dudding of Corfe Mullen in respect of Robert Viner's mental state were appropriate and well timed. His symptoms were always taken seriously and efforts were made to accommodate his requests - for example, when he asked to be seen at home by Dr Gumbrell. It was especially helpful to us that there were no gaps in the GPs' records and that Robert Viner's many letters to Dr Dudding were preserved.

3.28 Muriel Viner's records were equally complete - back to her treatment at the Radcliffe Hospital, Oxford in May 1949. Dr Hutchinson successfully managed the treatment of Muriel Viner's high blood pressure and her cataracts. It was unfortunate that Muriel Viner's reticence did not allow her to confide more about her difficulties to Dr Hutchinson despite a timely invitation.

Conclusions and recommendations

OT service

3.29 We are told that the acute OT staff are now fully integrated into the CMHTs, and so there may now be the opportunity to undertake work with a client in a needs-based rather than a service-led way. The rehabilitation OT service, however, remains separate both from the acute OT service and from the CMHTs. We assume that the rehabilitation OT service will continue to work with some individuals who are subject to the CPA and cared for by keyworkers within the CMHTs. This underlines the need for all agencies to have a clear understanding of the role of the rehabilitation OT service. We were also told that bringing the services professionally closer would promote a more efficient service.

Primary health care teams

3.30 It is essential that the GP for a patient subject to the CPA is provided with a copy of any care plan and informed of any change to that plan.

3.31 We are aware that both Robert and Muriel Viner had their own GP. There is nothing unusual about this and it may have conveyed positive advantage to them both. However, where the person cared for is subject to the CPA then, subject to consent (we have discussed the issue of confidentiality below) the keyworker ought to ensure that the carer's GP is provided with a copy of the care plan.

3.32 Although there was regular contact between Robert Viner's CPN and his GP, there was no formal arrangement for routine joint review of all the practice clients who were in receipt of care from the specialist mental health team. Consequently, because Robert Viner did not present with significant difficulties, he was never discussed at the practice meetings that the CPNs attended. This may not have had any bearing on the way in which Robert Viner's care was managed, but it remains a deficit that should be addressed in future planning.

1. Ford transcript, page 23

4. ACCOMMODATION ISSUES

Introduction

4.1 We regarded the management of Robert Viner's accommodation needs as an important test of the effectiveness of multi-agency working.

Chronology

1974 Muriel Viner moved to Corfe Mullen from Witney hoping to make a new start in an area which she had enjoyed in her younger days. When she moved she had no expectation that her son would wish to return to live with her. However, in 1976 Robert Viner moved to Corfe Mullen where he was to remain until his death.

1981 The discharge letter, following Robert Viner's hospital stay, mentioned that one of the reasons for his admission had been his mother's inability to cope with him at home.

1989 Robert Viner was having ideas about leaving home. According to his sister, this may well have been a pipe dream, but we saw a copy of a letter, apparently sent to an estate agent, asking for details of country properties, in rural and secluded locations. We understood that his preferred area was Wales, because it was both cheap and sufficiently quiet for his purposes. We have no evidence, however, that this idea was pursued any further.

July 1990 Robert Viner made an application to East Dorset District Council for council housing. We are unclear what prompted this action at this particular time, but he mentioned on the form that his mother "has threatened to chuck me out of the house". He also stated that he was "a schizophrenic. This was first diagnosed in April 1976. This disease stops me working."

October 1990 Robert Viner wrote to the East Dorset District Council indicating that he had been accepted onto the waiting list, asking how many points he had been awarded and how soon he would reach the top of the list. As a result of the letter, a visiting officer's report was completed. The officer noted that there was occasional friction in the house and that "Mr Viner was worried what may happen in the future if his mother dies." Under the heading of "Doctor's Support", both GP and psychiatrist were mentioned by name. The officer also noted the health problems of Robert Viner and wrote that the applicant had both schizophrenia and eczema. This report was dated 2 November 1990.

December 1990 In line with central government policy, the East Dorset District Council formally transferred its housing stock to the newly formed East Dorset Housing Association, under the provisions known as "large scale voluntary transfer". Thus, roles traditionally undertaken by a housing authority, such as maintaining a waiting list, allocation of properties for rent, nomination to other (possibly specialist) housing associations and assistance to homeless persons, became the responsibility of East Dorset Housing Association under an agency agreement with the East Dorset District Council. It seems, therefore, that Robert Viner's name was transferred on to the East Dorset Housing Association's waiting list, but we can find no copy of correspondence giving an answer to the two questions posed in his October letter, although there is a print-out showing that he had been awarded 34 points.

June to September 1991 Hanover Housing Association

Hanover Housing Association

Under their nominations agreement, Hanover Housing Association, a specialist association for elderly people, asked East Dorset Housing Association for nominations to fill a vacancy which had occurred in Moorhills in Wimborne. Although the vast majority of their properties are for elderly people, there are six units of accommodation on their Wimborne development which are classed as general needs, because they are on the second floor. East Dorset Housing Association apparently supplied a list of four nominees, of which Robert Viner was the third. Hanover Housing Association no longer have records of these nominations and what offers were made in respect of them. Patrick Shelley, (Hanover Housing Association's Regional Director for the South of England) told us what he considered was most likely to have happened. Tenancies would have been offered in the order of the nomination sheets provided by East Dorset Housing Association. He thought that a tenancy was offered to Robert Viner, probably in early August which was not taken up. This particular tenancy was ultimately taken up on 15 September 1991 by someone from their own waiting list. We were surprised by this information as it did not correspond with what we had previously been led to believe.

Dr Ford received a letter from Hanover Housing Association on 2 August, asking if he could provide a report detailing Robert Viner's ability to lead an independent life, in view of the fact that the accommodation was not warden supervised. As a consequence of this request, Dr Ford wrote to Robert Viner, seeking his permission to send the report and also asking him to indicate, to him, his current situation and abilities. Once Robert Viner had written back and given his permission, he asked the social worker, Alwyne Cross, to undertake an assessment of his ability to cope with independent living.

She duly made a home visit, met with him and his mother and ascertained that Muriel Viner would be willing to offer support to her son in order to facilitate this move to independence. She noted that he could not visualise living close to elderly persons being a problem - "although he unrealistically feels they will be a quiet docile group with whom he will have no contact".

On 9 September Alwyne Cross telephoned Hanover Housing Association . In her case notes it is recorded that "Mr Viner would be offered accommodation on the second floor."

Hanover Housing Association (continued)

On 16 September, Dr Ford wrote back to Hanover Housing Association indicating that he supported the nomination and enclosed, additionally, a copy of Alwyne Cross's letter, which she had written to Dr Ford detailing her assessment.

It would appear that all concerned thought that the nomination had been unsuccessful and had not been transformed into a specific offer. Alwyne Cross told us (before we had heard evidence from Patrick Shelley) that she thought it would take between 18 months and 2 years for this type of accommodation to be allocated.

This is of course at variance with what we were told about an offer of tenancy being made to Robert Viner. However, we do know that the particular tenancy was offered to someone else on 15 September.

It seems to us unlikely that Robert Viner either knew about this specific offer of a tenancy, or as was suggested to us by Patrick Shelley, effectively turned it down by failing to turn up to view. We noted that, when he renewed his application to East Dorset Housing Association in 1992 in a covering letter (dated 21 August 1992) he stated that he has been in contact with Hanover Housing Association "Hanover Housing Association tell me that when a general needs flat becomes vacant at Moorhills in Wimborne, they ask for nominations from East Dorset Housing Association. Thus could you consider nominating me again for such a flat. You nominated me to Hanover Housing Association in June 1991"

We accept that Patrick Shelley was simply providing us with an appraisal of the likely course of events, on the basis of the written material he had seen, and also from discussions with members of his staff, who were employed by Hanover Housing Association in 1991. What does concern us about this sequence of events is the absence of records, the lack of clear procedures in dealing with a nomination of this nature and the lack of communication between the agencies who were assisting Robert Viner. We believe that these factors all contributed to a missed opportunity to assist both Robert Viner, and also as a result, Muriel Viner.

July 1991 Robert Viner renewed his application to East Dorset Housing Association and once more mentioned the fact that he "had been a paranoid schizophrenic since 1975" and needed council housing.

July 1992 Robert Viner and Dr Ford met in outpatients on 22 July 1992. Discussions took place with regard to Robert Viner's future. It seems that Dr Ford may have misconstrued the Hanover Housing Association application, as he described it, in his letter to the GP, as an application to live in an old people's home. They also discussed the possibility of Robert Viner being left half of his mother's house, in the event of her death, and therefore his ability to look after himself was once more called into question. For this reason, Dr. Ford made a referral to the community OT service to see if they would conduct a home assessment of his ability to shop, cook, do the housework and care for his finances. This referral was made following this meeting.

November 1992

Augusta Wilson was assigned to Robert Viner. She undertook a thorough assessment of his present strengths and needs and consequently set him a series of mutually agreed targets, to assist him towards the possibility of independent living. She also gave him details of housing associations, namely Raglan, Shelter and Knightstone Housing Association, to which he might apply to heighten his chances of securing his own place.

The most appropriate of these would appear to have been Knightstone Housing Association. At their developments at Cedar Court and Cornelia Lodge at Westbourne and Parkstone respectively, they provide secure tenancies in supported independent housing for 28 adults, who are experiencing, or recovering from, a mental illness.

Both of the Knightstone Housing Association projects are managed by the team leader, who is assisted by two full time project workers. Staff are able to offer support, counselling and advocacy to the tenants and are on duty from Monday to Friday. There is no evening, night or weekend cover, although we heard that the staff do operate a pager system over the weekend. All tenants have the number, and if there is an emergency or a significant problem, they are able to bleep the staff member on call.

1993

The application process to Knightstone Housing Association, although allowing for self-referral, had to be supported by a professional. Robert Viner completed his form on 18 January and Augusta Wilson sent hers on 11 February. He indicated that he was planning ahead, in order to avoid the possibility of becoming homeless, should his mother need residential or nursing care in the future. It was Robert Viner's belief that the house would have to be sold, given the above eventuality, in order to pay for the care fees. He did, however, have an understanding that his sister and he would each inherit half of the house, in the event of their mother's death. In her covering letter to Knightstone Housing Association, Augusta Wilson indicated that Robert Viner's need was not, as yet, immediate or urgent, because of his mother's good health and her willingness for him to remain at home for a while.

She asked therefore for him to be placed on a waiting list. This did, in fact, occur, as Augusta Wilson received a telephone call from Knightstone Housing Association later that month indicating that Robert Viner was now on their waiting list.

There was little progress or activity on the housing front during the rest of 1993. Robert Viner did, however, renew his application to East Dorset Housing Association in July, again stating that he was "a paranoid schizophrenic" and that when his mother dies he will "probably become homeless." East Dorset Housing Association records show that, once more, Robert Viner asked to be nominated to Hanover Housing Association. A reply was sent, indicating that, due to a large demand for vacancies, they were unable to say when he would be re-housed. They promised, however, to contact him should there be any developments regarding his application.

February 1994

During a routine visit by the CPN, Lesley Moon, Muriel Viner apparently broke down in tears, indicating that she could no longer cope. Lesley Moon ascertained that Robert Viner was on the waiting list for Knightstone Housing Association and subsequently contacted the team leader to clarify his position. Apparently, waiting lists were due to be updated within the next few weeks.

March 1994

On subsequent CPN visits, accommodation issues were again discussed with both mother and son, and Robert Viner accordingly renewed his Knightstone Housing Association application on 24 March. Again he indicated that he felt he would be homeless should his mother need residential or nursing care, or should she die. This would, he thought, necessitate the sale of the house in order to divide the proceeds between himself and his sister. In a supporting application, completed by Lesley Moon, she indicated that Muriel Viner now no longer felt able to cope with her son. "Robert's mother also supports this application as she is no longer able to offer him a home. She is though able to offer Robert her support in the community". Lesley Moon also wrote that there would be continued support from a CPN, should his application be successful.

July 1994

On 6 July, the day prior to her planned visit to Robert Viner, Lesley Moon telephoned Sue Butler at Knightstone Housing Association for a progress report on the application. She was told that he was unlikely to be offered a flat in the near future. It seemed, therefore, that Lesley Moon felt the search for accommodation should be broadened, and her CPN notes indicate that she consequently "telephoned social services mental health team and requested an assessment for Robert Viner". In fact her referral was taken by the adult duty worker, who on that day was Sue Jures. The referral was interpreted, specifically, as a request for a sheltered lodgings assessment and was consequently passed, by the duty team manager, to the rehabilitation team and allocated to Gerry Stickley, senior practitioner in that team.

The following day, during her visit, Lesley Moon heard from Muriel Viner that Robert Viner had been argumentative and that their relationship was not good at present. She fed back to them that she had made a referral to the social services department. On 14 July, Gerry Stickley telephoned Lesley Moon indicating that he was going to assess Robert Viner. Lesley Moon told us that she was under the impression that the assessment was to consider a wide range of alternative forms of accommodation. Gerry Stickley, as a member of the rehabilitation team, only has a very specific brief, to assess suitability for the sheltered lodgings scheme, and believed that the referrer was fully aware of his limited brief.

Gerry Stickley, accompanied by a newly appointed social work assistant, Teresa Breckenridge, visited Robert Viner on 21 July. Muriel Viner was present. The purpose of the visit was to assess his suitability for a sheltered lodgings placement. The notes made of the visit include the following: "It was apparent that Mrs Viner was finding it increasingly difficult to cope with Robert and his demands. Robert, on the other hand, is quite happy to remain living with his mother and does not see a problem." During the course of the interview, Muriel Viner enquired what the position would be were she to be admitted to residential or nursing care, in respect of her son's ability to remain in the house. Gerry Stickley explained that he could continue to live there, but that the social services department may put a charge on the estate when Muriel Viner died. On hearing this, Robert Viner appeared happy, and Gerry Stickley concluded that he would, therefore, not consider alternatives at the present time. Hence, the assessment for sheltered lodgings was not even started. This information was conveyed to Lesley Moon by telephone, and it was agreed that there would be no further action by the social services department at this time.

August 1994

On a subsequent visit to Robert Viner, Lesley Moon attempted to persuade him to seek further information about more independent accommodation from Gerry Stickley. In fact Robert Viner had written to Gerry Stickley on 6 August requesting a list of housing associations within the Poole/Bournemouth area "who provide flats for Schizophrenics like me." He then indicated his intention to seek placement on their waiting lists. In response to this letter, Teresa Breckenridge sent him a list of housing associations.

September 1994

The case was closed by the social services department on 6 September although Teresa Breckenridge had said, in her letter, that Robert Viner should not hesitate to contact her should he need further assistance.

Lesley Moon continued to enquire of Robert Viner about his attempts to secure alternative accommodation. She also noted that his mother was still keen for him to get his own place. Robert Viner continued his own enquiries of Gerry Stickley and, in a further letter, (16 September) sought an explanation as to how housing associations choose tenants, particularly those with a mental health problem. "Are they, for example, chosen on the recommendation of someone at your office or on that of a doctor" He stated he did not want to write to each association, although Teresa Breckenridge told us that she only remembered highlighting Knightstone Housing Association, and possibly Raglan, as most appropriate to his needs.

After failing to reach Robert Viner by telephone, Teresa Breckenridge wrote to him on 20 September, suggesting that he put his name on Poole Borough Council's waiting list. She reiterated the need to apply to each individual housing association, who would have their own procedures for allocating properties. She also said that it would help if a letter from his GP, or psychiatrist, was included with the application. Again she offered further assistance to him, should he choose to seek it.

October and November 1994

Lesley Moon continued to encourage Robert Viner to write to housing associations and recommended that he made further contact with the social services department to look into alternative accommodation. She noted that he was on several waiting lists and that he continued to have arguments with his mother.

Teresa Breckenridge received a letter from Robert Viner on 29 November, in which he indicated that he was on the waiting lists of several associations. Apparently, at Lesley Moon's instigation, he sought further information on the sheltered lodgings scheme. He then asked for further clarification on the position in which he would be placed were his mother to require nursing care, as he understood Lesley Moon to have said that the house would have to be sold to pay for the fees. He also queried her suggestion that he should place himself on Poole Borough Council's waiting list, in view of the fact that he lived in the area of East Dorset District Council, on whose list he already was, (albeit that he believed them to have "admitted that they can't re-house me"). He sought a written reply to his letter.

December 1994

Teresa Breckenridge discussed the letter with Gerry Stickley, and it was agreed that the case would be allocated to her, but they would jointly visit Robert Viner on 12 December to discuss how they could help him. During the visit they discussed the contents of his letter and it apparently transpired that he did not want sheltered accommodation (i.e. sheltered lodgings), but instead wanted his own place. Although he had joined the lists of several housing associations, he felt that his CPN was persuading him to move, whereas he did not wish to, as he was happy living with his mother. They were able to give him a leaflet entitled "Residential and Nursing Home Costs for Older People", prepared by the Dorset Social Services Department, which reassured him that he would not be homeless should his mother need residential or nursing home care.

On the same day, Lesley Moon accompanied Robert Viner to his outpatient appointment with Dr Ford. The latter wrote in his letter to the GP, Dr Dudding - "he is also looking for accommodation, probably supportive lodgings, as his mother finds it difficult to cope. In this respect he is not keen on leaving the family home and not keen on supportive lodgings either.... ". He then indicated that his mother would benefit from him leaving and that he would be unlikely to cope in fully independent accommodation, given the length of the time that she had been looking after him.

January 1995

Teresa Breckenridge sent a letter to Lesley Moon on 11 January. She enclosed a copy of the leaflet given to Robert Viner in December and reiterated that he was not interested in moving home at this time as he was happy living with his mother. Teresa Breckenridge wrote, in her letter that "they get along very well", but told us, in her evidence, that was Robert Viner's perception of the situation. She further went on to say that, if in the future he did decide to move, he would choose his own flat and not sheltered accommodation. Teresa Beckenridge then wrote of her intention to close the case, but offered to be of further assistance if required.

Lesley Moon, in fact, telephoned Teresa Breckenridge that day and so they were able to discuss the contents of the letter. Lesley Moon then stated that Muriel Viner wanted her son to leave, as he had alienated both family and friends by his difficult behaviour. It was agreed, however, that without Robert Viner's co-operation and agreement, nothing further could be done. If he were rendered homeless, the social services department would apparently not be able to make an emergency placement, but he would be offered bed and breakfast accommodation or a place in a hostel for the homeless. (We were told in evidence by Irene Corrigan that the

use of bed and breakfast had been avoided for over two years. She also informed us that she thought that a placement in a homeless hostel would be totally unacceptable for someone as vulnerable as Robert Viner).

The case was closed to the social services department on 13 January 1995 and the department had no further involvement with Robert Viner after that date.

At this stage, Knightstone Housing Association wrote to Lesley Moon, as they had a potential vacancy to fill at Cedar Court. They sought up-dated information and therefore requested completion, once more, of their two application forms, one by Robert Viner and the second by Lesley Moon. Julia Buckingham, the team leader, advised that he should not be made aware of the vacancy, so as not to raise his hopes, as he would have been in competition with several other prospective tenants.

On 16 January Robert Viner duly completed his form and Lesley Moon hers on 23 January. In the meantime, Muriel Viner, in conversation with Lesley Moon, had threatened to evict him if he did not move of his own volition. This conversation occurred, following the serious road traffic accident involving Deborah Greaves, which occasioned urgent visits to Birmingham by Muriel Viner to support her daughter and family.

February 1995

As Lesley Moon was going on a course, another CPN, Anita Paul, once more took over the case from 16 February. On her first visit she "encouraged him to think more seriously about moving away from Corfe Mullen".

March 1995

On 1 March Robert Viner had a further out-patient appointment with Dr Ford. He noted that "he is not keen at all to move from his mother's home, although clearly at some stage this will need to happen."

April 1995

Anita Paul's visit of 5 April highlights Muriel Viner's continued ambivalence about her son moving, due to her sense of responsibility competing with her desire for greater freedom and social outlets. This was particularly poignant following her daughter's accident. On 19 April short term accommodation planning, in relation to the gathering crisis at home, was to try to arrange for Robert Viner to be admitted to hospital, as an informal patient to give his mother some respite.

The responses of the housing agencies

4.2 Keith Mallett indicated to us that the preferred route into special needs housing to which the District Council has nomination rights would be via a referral to East Dorset Housing Association, which would then allocate an overall priority to the applicant and refer them on to the most appropriate housing association(s).

4.3 We note that Julia Buckingham of Knightstone Housing Association did not share the perceptions of Keith Mallett as to the appropriate procedure in the case of a self-referral. Knightstone Housing Association clearly accepted an application from Robert Viner and included him on their waiting list. However she was not aware of the procedure outlined by Keith Mallett, whereby such requests were referred back to East Dorset Housing Association for prioritisation. We were also informed that health and social services department had nomination rights for an agreed number of places.

4.4 We also became aware of some weaknesses in procedures and record-keeping during the process of hearing evidence. An example of this is the confusion which we found over the outcome of Robert Viner's nomination to Hanover Housing Association. We were told by Patrick Shelley that Robert Viner was on a list of persons considered for a vacancy at their Moorhills scheme, and it is clear that the Hanover Housing Association sought from Dr Ford, and were provided with, an assessment of Robert Viner's suitability for this accommodation. However, there is no record of what happened subsequently in this case. We cannot establish satisfactorily whether an offer was specifically made to Robert Viner, nor what his response was. There is no written record of any offer or response, although we were informed by Patrick Shelley that an ex-employee at Hanover Housing Association vaguely recalled the circumstances. It was suggested that Robert Viner never responded to this offer, but we can find no evidence that he ever received it.

The responses of the social services department

4.5 In 1991 Alwyne Cross undertook an assessment of Robert Viner, to consider his suitability for a tenancy with Hanover Housing Association. This assessment was limited in scope, and was initiated by a letter from Hanover Housing Association dated 2 August 1991. It was concluded by 16 September 1991, when Dr Ford wrote to Hanover Housing Association giving the result of this assessment and supporting the application. By this time, we were told, the tenancy which had been available for Robert Viner had been allocated to another tenant the day before. We do not know why this happened.

4.6 We wonder whether a more detailed assessment suggesting ways that Robert Viner could have been supported in this particular type of accommodation (other than by his mother) would have facilitated a more favourable consideration of him by the housing association. Also, if this application had been followed up either by Alwyne Cross or Dr Ford, then the unsuccessful outcome that we have already discussed could either have been prevented or challenged. Alwyne Cross accepted, in retrospect, that she could have followed up the case to its conclusion. If the Hanover Housing Association application had been pursued to its conclusion then perhaps the sense of intractability

that we discuss below would not have been so pervasive. Certainly Deborah Greaves told us that both her mother and brother thought there was no chance of obtaining any alternative accommodation.[1]

4.7 In July 1994, Lesley Moon decided to request input from the social services department in assisting with Robert Viner's accommodation. The referral was allocated to the rehabilitation team, which has a remit only to deal with the sheltered lodgings scheme. The initial interview with Robert Viner identified that he did not really want to move, and therefore because of the precise remit of the professionals within the rehabilitation team, an assessment was not completed and a decision was taken that no further action should follow.

4.8 Teresa Breckenridge dealt with Robert Viner's request in September 1994 for information on accessing housing association property. Her response dealt factually with the request for information. Robert Viner was given advice on the general approach to obtaining independent housing. However it appears that there were more effective ways in which a person with special needs could have been assisted in accessing a housing association tenancy (see below). We do not expect that Teresa Breckenridge would have known this and we recognize that she had already gone outside of her limited brief to assist Robert Viner.

Accessing a housing association tenancy

4.9 As indicated above, there was some uncertainty as to the best route to access such accommodation. It certainly did not work well for Robert Viner to make his own application, as the representative from East Dorset Housing Association, Irene Corrigan, indicated that he was not perceived to have a high priority. It appears that there have been a number of changes introduced by East Dorset Housing Association since Robert Viner's original application was made in 1990. Were they to receive such an application now, the East Dorset Housing Association would involve the social services department in an assessment of the client's need for housing and their capacity to cope with a tenancy. The East Dorset Housing Association's expectation would be that a social worker would coordinate such an assessment, incorporating the views of all the health staff involved. Under the CPA, however, the keyworker could be a health professional and so that person could perform the coordinating function.

4.10 Should there be an urgent need for a change of accommodation, as for instance in a situation of potential carer breakdown, we were assured by Irene Corrigan that the East Dorset Housing Association would be willing to give rapid consideration to such a request. She said that the East Dorset Housing Association has regular requests from both social workers and CPNs, and it is able to respond to them, without the necessity of obtaining a specific medical recommendation.

4.11 It would also seem that much time and effort was expended by various professionals in pursuing the option of a Knightstone Housing Association tenancy, which did not become available over the two years in which Robert Viner was on their waiting list. A more effective process would have been to have supported Robert Viner's original application to the East Dorset District Council (later the East Dorset Housing Association) and liaised with those agencies regarding Robert Viner's accommodation needs. They could, therefore, if appraised of the urgency of the situation, have ensured that he was nominated to any vacancy which arose, whether in the Knightstone Housing Association, or any less specialist accommodation. The latter, could have been made acceptable with the provision of a suitable package of care.

The responses of Dorset HealthCare NHS Trust

4.12 At various times the accommodation difficulties experienced by the Viners were known to the consultant psychiatrist, to the OTs and to the CPNs.

4.13 Dr Ford initiated the assessment by Alwyne Cross to assist with the Hanover Housing Association nomination. Augusta Wilson initiated the idea of applying to the Knightstone Housing Association. This application was supported by Augusta Wilson, but she indicated that the need was not immediate, or urgent, because he was content to live at home with his mother. As we have already pointed out above, this was not the most effective way to access housing association tenancies.

4.14 Consequently, although Robert Viner was placed on Knightstone Housing Association's waiting list, he was not considered as a priority. When the situation at home worsened, and Muriel Viner told Lesley Moon, in February 1994, that she could not cope with Robert Viner at home, Knightstone Housing Association indicated that Robert Viner was not likely to be offered accommodation in the near future, not least because very few vacancies occurred. In response, Lesley Moon contacted the social services department to identify what help could be given and the referral, as previously discussed, was allocated to the rehabilitation team.

4.15 It is clear, at this time, that Lesley Moon was increasingly aware of the need to find Robert Viner alternative accommodation, due to the stress experienced by Muriel Viner. She attempted to encourage and persuade him to find alternative accommodation, but her efforts were frustrated by Robert Viner's wish to remain at home. Another factor was the response of Gerry Stickley and Teresa Breckenridge of the rehabilitation team. Lesley Moon's expectation was that the social services department would be able to assist by conducting a full assessment of Robert Viner's accommodation needs. The professionals from the rehabilitation team thought that they were being asked to provide a specific service - that is accessing sheltered lodging. Subsequent telephone conversations between both parties did not rectify this misunderstanding.

Multi-agency responses

4.16 In July 1994 Lesley Moon requested assistance from the social services department. After the home visit Gerry Stickley informed Lesley Moon that Robert Viner had refused to consider sheltered lodgings. We note that a misunderstanding arose at this point because Lesley Moon assumed that Robert Viner had refused assistance in relation to any alternative accommodation[2]. In January 1995 Lesley Moon and Teresa Breckenridge discussed the case. They both concluded that there was nothing that could be done without Robert Viner's cooperation and assistance. In any event if he were rendered homeless, bed and breakfast or a hostel would be the only accommodation immediately available.

4.17 We consider that an alternative response could have been to create a comprehensive care plan with the following components:

- initiate work separately with Robert Viner and Muriel Viner to assist them both in the process of separation;
- prioritize and facilitate application for accommodation with an accompanying package of care;
- strategically plan for Robert Viner's responses to include negotiating with him;
- give consideration to the possibility of managing the case within a legal framework e.g. guardianship;
- provide support and assistance to Muriel Viner.

4.18 We believe that, in either 1994 or 1995, if the agencies involved had been brought together in a formal setting, it would have been possible to have formulated a targeted solution to both Robert Viner's and Muriel Viner's accommodation needs.

4.19 When Lesley Moon made her referral to the social services department, there was a limited exchange of information between the health and social services professionals and no apparent contact between the social services department and the housing agencies. We recognise the specific function of the rehabilitation team, but are concerned that a referral was not made to the mental health team either by the professionals from the rehabilitation team, or at the instigation of the keyworker, following advice to that effect from those workers. For the sake of clarity the keyworker would retain responsibility for making such a referral. The keyworker could expect to be given informed advice by professionals from the other service.

4.20 We are aware of the apparent intractability of the problems being faced by Robert and Muriel Viner - in particular the general conclusion that Robert Viner did not want to move. It is clear that Robert Viner did not want to move to sheltered lodgings. It is less clear as to whether he would have moved to other types of accommodation. There can be no definite conclusion on this point. Deborah Greaves agreed that her brother showed

a large degree of antipathy towards moving into independent accommodation.[3] We are aware of what Robert Viner said to Dr Ford and Lesley Moon in December 1994. However, he was also regarded as a man who could be negotiated with. Dr Dudding concluded that, with reference to Robert Viner's use of antibiotics, that he would "listen to us eventually"[4]. The plan evolved to deal with the events of April 1995 by Dr Ford and Anita Paul assumed he would alter his view. He was adamant about not wanting sheltered lodgings but he himself initiated contacts with a number of housing associations. Sadly his willingness to move was never tested.

4.21 In relation to the accommodation issue, we believe that the practical steps we have discussed above were not identified. Furthermore more proactive work with both Robert and Muriel Viner underpinned by these measures could have assisted the process. Moving out could have been made more attractive to him. For example a "package of care" could have been assembled and offered. General needs housing could have been made available relatively quickly supported by this type of care package if there was an urgent need, for instance by virtue of carer breakdown. If Robert Viner had then chosen not to move the question of using compulsory powers as part of his care and treatment plan could have been addressed.

Creating a "package of care"

4.22 Fundamental to achieving an appropriate move for Robert Viner would have been a full ranging assessment of his needs, preferably coordinated by a social worker/care manager. We consider that such a person would have been the best worker to undertake such an assessment in this instance, as not only do they have a knowledge of the full range of available residential resources, but also they have the capacity to purchase an appropriate package of care to augment the chosen option. We recognize that this assessment could have been undertaken by a CPN who could have liaised with a social worker/care manager in relation to the purchase of such a package. In the context of the working arrangements now established in Dorset, this would enable the worker to access the special needs housing data base and to refer the case to the Special Needs Operational Liaison Group, which could provide an effective way of prioritising need and identifying the most suitable option available.

4.23 With the introduction of the NHS and Community Care Act, money has been made available to the social worker/care manager to purchase, either from within the social services department's own resources, or from the independent sector, an individually designed package of care to meet assessed needs. This money does not represent an addition to existing resources. It is money which has been transferred from central government to enable local authorities to fund the care of individuals whose care would previously have been funded by social security. We also recognize that the ability of local authorities to make this type of arrangement will depend on the assessed needs of the individual and his/her carer, the priority which this attracts in relation to the needs of other people with a mental illness and their carers, and the overall level of funding which is available for community care services.

4.24 A care package in this instance could involve the employment of a specialist personal care worker, preferably a specialist in working with people with mental health problems, whose work would be prescribed and monitored by the social worker/care manager or by other professional staff, who may have that function as part of their brief. Specialist personal care workers can be employed to assist the client in a range of practical tasks:

- Budgeting, paying bills;
- Shopping;
- Food preparation;
- Cleaning;
- Laundry;
- Self care.

They do not only work during office hours, and so can be employed to support someone who finds weekends difficult to cope with. On occasions, they can be used to support someone in attending a particular resource, which they might otherwise not do.

4.25 Above all, the availability of a specialist personal care service enables a wider range of housing options to be considered, as appropriate support can be provided according to individual need. In particular this type of care package could support such a living arrangement in general needs housing. We understand that the social services department home care service would assist clients in undertaking this range of tasks. Although this is not a discrete personal care service working with people with mental health problems we were told that money from the MISG has been allocated and "ring-fenced" to provide home care for people from this group and their carers.

Conclusions and recommendations

Housing agencies record keeping and procedures

4.26 We were concerned at the apparent lack of understanding within the housing associations about the routes into special needs housing. As a consequence of these concerns, we believe it is necessary for the individual housing associations which deal with general and special needs housing for vulnerable client groups, to have a clearer appreciation of the role and function of the responsible housing authorities. This will involve the establishment of clear written procedures and appropriate training for staff involved.

4.27 We also consider that there is a lack of awareness of the routes which should be followed in dealing with housing applications by persons with mental health problems. This applies to both social services and health staff. This could be addressed by more formal guidelines and appropriate training.

4.28 Whilst we acknowledge that it may not be possible for all records to be retained, we recommend, in relation to special needs housing, that the housing agencies review their information and record-keeping systems wherever there is knowledge of mental health service involvement. This is to ensure that there is an adequate written record of transactions which take place. In a CPA case, the lead agency should be provided with copies of all relevant documents and also the length of time records are kept should be re-evaluated.

Co-ordination structures

4.29 We were informed by Keith Mallett of the new co-ordination structures which had been established in Dorset to facilitate exchange of information relating to special needs housing. These consist of housing liaison groups at operational, strategic and county level, which meet regularly to pool data about needs and availability of special needs accommodation. We were told that this structure could facilitate the resolution of individual cases, and enables a strategic view to be taken of provision across the county. We welcome this development as filling a substantial gap which existed previously, and recommend that the role and function of the groups be clearly specified, and that all relevant professionals be advised of their existence. The existence of such a structure at an earlier date may have had a significant effect on the outcome of the Viner case.

4.30 It was disappointing to learn that the operational groups are not well attended by health professionals, because of resourcing difficulties. Given that the keyworker role is often assumed by health professionals in relation to clients with mental health problems, we believe that this issue of attendance should be reviewed to ensure that there is an adequate input from the health services in this process.

Database

4.31 We were also informed by Keith Mallett that a special needs housing data base had been developed which pulled together all information on the supply of such accommodation in Dorset. This enables a strategic view to be taken of both existing and planned provision and we welcome this initiative. We strongly recommend that a high priority be given to the development and maintenance of the data base and that the information therein be made available to all relevant professionals who become involved in the housing field. The existence of the database should be publicised, particularly to health keyworkers. We hope that the data base will also facilitate regular reviews of provision in Dorset, to ensure that identified need is met. We were, in fact, heartened to learn that special needs housing for people with mental health problems has already been identified as the top priority for development and were pleased to hear of new resources being opened.

Interagency communication

4.32 We remain concerned at the imperfect communication between health and social services department professionals. For example a written referral by the keyworker should have clarified a full assessment of accommodation needs was required. In future we recommend that all referrals of this nature are confirmed in writing and a copy of any care plan is made available.

Linkages between the social services department teams

4.33 The responses of the social services department, when contacted by Lesley Moon, were concerned only with the narrow issue of sheltered lodgings. We recognise that the remit of the rehabilitation team is specific and that their response was conditioned by this fact. However, we believe that there were other elements of the social services department provision, such as the mental health team, which could have been brought into play to examine what other options were available for support to the Viners, and to facilitate a move by Robert Viner to some form of independent living. We would therefore recommend that the social services department examine the linkages within the service - in particular those between the rehabilitation and mental health teams - and provide guidance to staff on the need to take into account the potential for onward referral between the teams.

Training

4.34 We were struck by the multiplicity of views about how someone in Robert Viner's position should access accommodation, independent of his mother. Clearly, he struggled with this problem for several years, sometimes alone and at other times with the assistance of a variety of professionals.

4.35 We therefore recommend that all health professionals, who are going to have to undertake a key worker role under the CPA, are involved in joint multi-agency training with housing and social services staff. The purpose of the training would be to broaden the understanding of the function and role of these two agencies in the accommodation field and to further their understanding of the resources available. (It is suggested[5] that health authorities raise the profile of mental illness by providing training courses for housing officers on mental health. We recommend that housing officers also train health professionals on housing issues.)

Accessing housing associations

4.36 In the event that applications are received by other housing associations, in the future, from people with mental health problems, we recommend that a procedure be established whereby these are referred to the social services department or to the relevant CMHTs, and to the housing authority for assessment and prioritisation. In the context of the current arrangements in East Dorset, we would anticipate that the responsibilities of the housing authority, in this instance, would be delegated to the East Dorset Housing Association.

4.37 We understand that a number of local authorities are now considering the establishment of a common housing register for their area, thus obviating the need for individual housing associations to maintain their own waiting lists. Under this system all referrals would be prioritised by the housing authority and nominated to the most appropriate association. We believe that the adoption of such a system would bring significant benefits to the allocation system and could simplify the procedures surrounding access to housing. We recommend that consideration be given to adopting this system.

Personal Care Service

4.38 We have noted the allocation of the MISG to the home care budget to provide for the needs of people with a mental illness and their carers. A further advance may be the development of a discrete personal care service, whose sole focus would be on provision for this particular client group. A separate service philosophy, specification, and the recruitment of specialist experienced workers may significantly improve the potential for individuals with mental health problems to remain in the community. We therefore recommend that provision of such a discrete service be given consideration.

1. Transcript Greaves, page 17
2. Transcript Moon, page 12
3. Transcript Greaves, page 15
4. Transcript Dr Dudding, pages 4-5
5. Building Bridges, page 29

5. CARER SUPPORT

Introduction

5.1 An analysis of the support provided for Muriel Viner is inextricably linked with any analysis of the management of Robert Viner's accommodation. Therefore much of the factual information in both the accommodation chronology and the carer chronology is common to both areas. We have accordingly limited much of the chronological material in this section and reference may need to be made to the accommodation chapter for further material.

Chronology

1979 The first indication we had from professional sources that Muriel Viner was finding caring to be a strain was in a letter from the GP, Dr Mulholland, to the consultant psychiatrist, Dr Gumbrell. He indicated that Muriel Viner had threatened to sell up and move away, rendering Robert Viner homeless, unless he obtained effective medical treatment. In his letter to the GP, following his appointment with Robert Viner, Dr. Gumbrell made no mention of the stresses on the mother.

1981 Robert Viner was admitted to hospital in 1981, and one of the reasons stated for the admission was his mother's inability to cope with him. However at that time there was no assessment of the home situation. The only follow up was an outpatient appointment.

1984 Muriel Viner wrote to Dr. Gumbrell, seemingly concerned about her son's mental state and his discomfort over the visit of his sister and her husband, whom he apparently found "formidable". It would appear that a home visit was made by Dr. Gumbrell, but no detail of a meeting with Muriel Viner was included in the feedback letter to the GP.

1991 The first visit by the social services department to the Viner home was in September 1991, when Alwyne Cross received a referral from Dr. Ford to assess Robert Viner's suitability for independent living. Alwyne Cross made one visit to the family home in order to complete her assessment. She met with mother and son together and remembered that Muriel Viner had offered to assist her son with some of the domestic activities, had his housing application been successful. She said that, although her brief was very limited, were she to have identified any problems within the home, she would have considered keeping the case open. She told us " I did not feel any tensions in the home between Robert and his mother in their relationship."

July 1992

Dr Hutchinson, Muriel Viner's GP, recorded in her notes a meeting with her patient on 29 July. She recorded : "Stresses- 40 year old schizophrenic son lives with her." This was the first time, after being registered with her GP for 7 years, that Muriel Viner had referred to this fact. Dr Hutchinson told us that she regarded this as a major stress whereas Muriel Viner understated it "She did not make anything of it. She was very matter of fact and to her it was not a problem".[1] This was the only record in Dr Hutchinson's notes of Robert Viner being discussed.

November 1992

Augusta Wilson, an OT, was the next mental health professional to visit the family home. During the second of Augusta Wilson's visits, Muriel Viner "...became quite tearful saying how stressful it is living with Robert and how no-one seems to realise she lacks support". She again spoke of her concerns regarding her son's alcohol intake, which she had touched upon on the first visit. Augusta Wilson, as a result, noted that she would explore support agencies for Mrs Viner. After consultations in her office, she found out about a National Schizophrenia Fellowship support group and duly gave Muriel Viner information about this on her next visit to the home. She was apparently grateful, and said that she knew that it existed, but that it was a long way away and difficult to get to. In giving evidence, Augusta Wilson, said she was not aware of any means by which she could have accessed assistance for Muriel Viner to enable her to attend. She did however report details of her discussions to the CPN, Maria Caundle, whom she regarded as the keyworker for the case.

1993

Robert Viner told Augusta Wilson that he felt that his mother resented him living at home and him not being an "ideal man". There was no further reference to Muriel Viner by Augusta Wilson - she transferred the case to a colleague, Anne Staite, in the rehabilitation OT team very shortly afterwards.

Mention was made, in the CPN records, of Muriel Viner's anxieties regarding her son's refusal to try any of the day centres which had been suggested to him. Additionally she indicated how upset she was on her return from holiday in June to find the house in complete disarray.

A care plan dated 23 July 1993 indicated that part of the brief for the CPN was to provide " education/counselling/advice/ support to carer."

1994

Lesley Moon attempted to discuss how things were with Muriel Viner when she visited, and she usually commented about how much her son was drinking. It seems that he felt that alcohol helped to lessen the distressing effects of his symptoms. So much so that, when Lesley Moon visited on 16 February 1994, Muriel Viner broke down in tears, stating that she could no longer cope. Lesley Moon gave her support and attempted to seek a resolution by trying to speed up the process of accessing a vacancy for Robert Viner in one of the Knightstone Housing Association properties. She also made a referral in July to the social services department to assist Robert Viner with finding accommodation.

As we have discussed, the referral was allocated to the Rehabilitation Team. Their brief was specifically to assess Robert Viner's suitability for the sheltered lodgings scheme. The referral form stated that Muriel Viner was "finding it difficult to continue caring". However, once he said he had no interest in being considered for the scheme, the assessment was effectively concluded.

January 1995

Lesley Moon telephoned Teresa Breckenridge on 11 January. She informed her that Muriel Viner wanted her son to leave as he had alienated both family and friends by his difficult behaviour. However they concluded that, without Robert Viner's cooperation and agreement, nothing further could be done.

On 19 January Muriel Viner told Lesley Moon that, if Robert Viner did not move of his own volition, she would evict him. At this time it did not appear that Lesley Moon felt she had anything to offer in terms of respite to Muriel Viner, as she continued to try to expedite a vacancy at Knightstone Housing Association, which would not however have been readily available. Shortly afterwards she handed the case over to her colleague, Anita Paul.

Anita Paul continued encouraging Robert Viner to consider leaving home, counselling him about his alcohol consumption and offering support to Muriel Viner. Anita Paul told us that she talked to Muriel Viner about seeing a counsellor at the GP practice. However, this recommendation was not followed up, and no mention was made of it in her notes.

April 1995

On 5 April Anita Paul's notes record Muriel Viner as still feeling ambivalent about her son moving out. Anita Paul chatted with her about "her sense of responsibility .. and her needs."

When Anita Paul visited on 19 April, Muriel Viner was very brusque in her manner, which was quite out of character. She later explained, in a tearful and angry fashion, that her son had disrupted the family gathering and had embarrassed her by his behaviour. She remained angry and stressed throughout the interview, at one stage demonstrating to the CPN the extent of her son's alcohol abuse by showing her several empty spirit bottles, which had been removed from his room following the family visit. There was considerable expressed anger between mother and son, Muriel Viner stating that she was at the end of her tether and Robert Viner repeatedly stating that he had no wish to leave home. Anita Paul was very concerned and deduced that the present situation would need to change. Hence her decision to tell them that she would discuss the situation with Dr Ford.

A decision to offer informal admission to Robert Viner was made, based on the premise that Muriel Viner was in need of respite from her son. The plan was that, once he was in the hospital setting, the clinical team would be able to persuade him to accept some form of alternative living arrangement. Hence a bed in St. Ann's Hospital was requested for Robert Viner and Anita Paul phoned Muriel Viner to convey this information. She attempted to make an appointment to see Muriel Viner, but the latter sounded distressed and said that her son was listening to the conversation, and therefore suggested that she should ring back the next day. Anita Paul did so on the following two days, but by this time both mother and son were dead.

Muriel Viner's views

5.2 We heard many positive things said about Muriel Viner. A constant theme was that she did not complain about her situation. As referred to above, she only once mentioned to her GP about caring for her son. We heard evidence from several of her close friends. They told us that she only occasionally discussed with them the difficulties that she experienced at home.

5.3 Frank Pratt and his wife had been friends of hers for about five years, having met at the sequence dancing classes, which had become a major source of enjoyment for Muriel Viner. He explained how she seldom shared her worries, preferring to keep them to herself. They were aware of Robert Viner's antipathy towards any of his mother's friends visiting the home, and therefore accepted the fact that, when giving her a lift home, she had to be dropped off away from the house, and they would not be invited in.

5.4 On one occasion, however, Muriel Viner did open up to Frank Pratt. She spoke of her desire to develop a life of her own, but felt prevented from doing so because of her son's continued dependence on her. He queried whether she had discussed this with the workers who visited, but she said this was never possible, as her son was always either present or at least within earshot. Frank Pratt said that it definitely ought to be discussed, as, by law, there should be a care plan, and she, as the carer, should be involved in its formation. If she did not have time or space to discuss things during the visit, she should have telephoned them at the office. We are aware that offers were made for her to telephone workers, should she feel the need.

5.5 We discussed with Deborah and Colin Greaves the issue of professionals' support for Muriel Viner. We have included a summary of some of their evidence:

> ... she would have greatly benefited from somebody to talk to ... she would not have discussed the problems concerning her son with her GP ... she did feel the benefit of talking to the psychiatric nurse but she was not able to talk as freely as she would wish because of her son listening ... she would have needed more encouragement than the offer of a telephone call to discuss her problems ... no-one was really interested in what she had to say (in the context that the professionals' main interest was to care for her son) ... she did not feel she needed counselling and advice. (We assume the last remark made by Colin Greaves was a reference to formal counselling.)[2]

We were left with the impression that whilst grateful for, and uncritical about, the assistance that her son was receiving. Muriel Viner would have benefited from, and welcomed some, independent support of her own. We also recognise that she appreciated, and received benefit from, the support she received particularly from Lesley Moon.

5.6 A close friend, Eve Hamlin, gave us further insights into the difficulties faced by Muriel Viner. She described Muriel Viner as having a tremendous sense of humour and of fun. She never normally talked to people about her son, in fact most acquaintances did not realise that she had one. Eve Hamlin, knowing her friend so well, often guessed that something was wrong when they met. Muriel Viner would then admit that her son had been abusive or insulting to her, but she would try to laugh it off in his presence. Eve Hamlin was one of the few people who did in fact visit the home, but their communication was often inhibited. She described Robert Viner's behaviour as being a strain on Muriel Viner.

5.7 Frank Pratt described her as being as much a prisoner as was her son. Eve Hamlin described Muriel Viner as looking forward to the prospect of Robert Viner having his own accommodation.

AGENCY RESPONSE TO MURIEL VINER'S NEEDS

Dorset HealthCare NHS Trust

5.8 The programme for the development of carer support commenced prior to the death of Muriel Viner. Subsequent to her death, further consideration has been given to this issue, which is outlined later in this section.

5.9 In November 1992, Augusta Wilson identified the strained relationships between mother and son , and attempted to assist Muriel Viner by giving her information about the NSF carers' group. Colin Greaves told us that she went to one NSF meeting. "She said that Rob had given her the nth degree about You have been discussing me..I think she decided she would not go again."[3] However, Augusta Wilson told us that she did not know of any other help which she could have accessed for Muriel Viner, although she did report the discussions to Maria Caundle.

5.10 Maria Caundle's assessment in January 1993 did not include any appraisal of Muriel Viner's needs as a carer and she did not institute any significant action to provide help for Muriel Viner, other than that offered during her visits to assist Robert Viner.

5.11 When Lesley Moon took over the case in July 1993, the CPN check list of actions specifically recognized the need to provide 'counselling and support to the carer.' Support to Muriel Viner was undoubtedly given, but, because it was offered alongside that offered to Robert Viner, its benefit was necessarily limited. Lesley Moon was aware of Muriel Viner's problems, and attempted to provide advice and assistance. She also offered support to Muriel Viner by suggesting she telephone her, or offering to see her at the GP surgery or at Alderney Hospital. However, this was within the framework of her role as a CPN for Robert Viner, and did not involve other agencies, such as the social services department, until much later.

5.12 We were told that, by 1994, Muriel Viner was in tears during one of Lesley Moon's visits, and could no longer cope with the situation at home. Lesley Moon provided personal support to her over the next few months, and identified trying to persuade Robert Viner to find alternative accommodation as one solution to the difficulties in the Viner household. We have discussed her referral to the social services department elsewhere.

5.13 We do not wish to minimize Lesley Moon's efforts, which were both positive and constructive, but we remain concerned that she did not identify a potentially helpful form of support to Muriel Viner by involving the social services department in a more substantive form. It appears that Lesley Moon did not seem to question the response given by the social services department in 1994, and to press for a full assessment. On the occasion when the referral was made, she indicated the strains which were placed on Muriel Viner, but the case was allocated to the rehabilitation team and the opportunity to provide a more wide-ranging intervention, which would have looked more closely at the needs of Muriel Viner, was missed.

5.14 After the transfer of the case to Anita Paul at the beginning of 1995, the latter continued to provide some support to Muriel Viner, as well as maintaining pressure on Robert Viner to find alternative accommodation. She recognized the increasing strain on Muriel Viner and, by 19 April, was sufficiently concerned to consult Dr. Ford about the situation. They agreed to seek Robert Viner's informal admission to hospital in order to provide respite for Muriel Viner. Steps were taken to achieve this, but before arrangements had been finalised, the tragedy had occurred.

Dorset Social Services Department

5.15 It must be a matter for concern that Muriel Viner could have cared for her son in the community for a substantial number of years and yet have had no effective contact with the social services department which would have enabled her to have access to assistance in her own right. Furthermore this was during a period when her son enjoyed regular contacts with health professionals, and latterly some contact with the social services department. We wonder whether this situation partly arose due to a lack of training and awareness on the part of professionals involved as to their obligations to carers.

5.16 When Alwyne Cross carried out her independent living assessment in 1991, she did not detect any tension in the household although there had been some indications beforehand which might have been brought to her attention as part of the referral. This is a case where the needs of the family could have been considered under the Disabled Persons (Services, Consultation and Representation) Act 1986, and yet the case was closed after only one visit, with no follow up of the housing application.

5.17 In 1994, when the referral to the Rehabilitation Team took place, Gerry Stickley did not consider that he should seek to undertake, or arrange, a full care management assessment, even though the carer was said to be not coping. This was on the basis that this team has a specific remit, and the carer's needs fell outside of that remit. Hence the assessment was not even started, let alone completed. This information was conveyed to Lesley Moon, and the case was closed to the social services department, shortly afterwards.

5.18 Further contact was made with the social services department, however, by Robert Viner himself. He was seeking additional information on access to his own place, via housing associations or the council housing route. Although both Teresa Breckenridge and Gerry Stickley went outside of their tight brief in order to help Robert Viner at no time did they seek to ascertain Muriel Viner's views independently of her son, nor was an internal referral of the case to the Mental Health Team considered.

5.19 This team could have undertaken an assessment of the carer's needs. They could possibly have provided some counselling assistance to Muriel Viner, or indeed have undertaken some joint work with the CPN, in order to facilitate the process of encouraging Robert Viner to leave the family home. At the very least the existence of a worker for Muriel Viner could have provided her with support to enable her to continue in her caring role, and have reduced her levels of stress.

Developments in carer support

5.20 Following the tragic events of April 1995, there has been a review of the provision of carer support by both the Dorset HealthCare Trust and Dorset Social Services Department. This has introduced some welcome new developments and procedures which were outlined to us during the Inquiry. We were pleased to hear that good use is made of the MISG, £250,000 of which is being spent on the independent sector, partly for the development of carer initiatives, some of which are outlined below.

5.21 Dorset Social Services Department had already approved a policy for carers at Social Services Committee in September 1994, which was followed up in November by the issue of a district manager circular, which advised staff of the change in policy. An impetus for the development of this policy was the work of the Carers' Impact Project in Dorset, which had been advising on how support to carers could be integrated into the mainstream of the social services department's work. A set of principles outlined the need for recognition of the carers contribution, and for their involvement at all levels of planning services for their relative, taking into account their own need for help. Practical help, availability of respite care and emotional support were all cited as essential elements of a care plan for the carer.

5.22 A further report was presented to Social Services Committee in March 1995, entitled "Carers' Strategy", which was followed by a management circular in May, indicating that the formal strategy had now been adopted. Up to this time, it had been best practice that staff should undertake a carer's assessment as part of the care management process. This circular, however, confirmed the requirements that staff should record details of carers at the point of referral and, at the time of assessment and review, all carers should be given the opportunity to talk in confidence about their own needs. If appropriate, they should be offered a separate assessment, carried out away from the person for whom they provide the care.

5.23 On 12 September 1995, the Dorset HealthCare Trust issued an advisory letter to all CMHTs on the matter of carer support, requesting that special efforts be made to review the support given to all carers, especially if they are carrying the main responsibility of supporting a family member at home. The general manager of the mental health services requested that staff confirmed to her that this action had been implemented. Since November, all CMHTs have been asked to record all formal contacts that they have with carers, as a means of gathering information on the prevalence and whereabouts of carers.

5.24 Examples of developments in support of carers were cited - for instance many of the CMHTs have already identified groups of carers, who have been invited to open forums to discuss their needs. This has been facilitated by the group development worker from the NSF, who has been employed with the specific brief of developing both user and carer groups. This is a full time post and the worker will specifically target carer and service user developments in the Poole, Purbeck and Wimborne areas. We also noted that not only was there a shortage of carer groups generally, but particularly in the Wimborne/Corfe Mullen area. There is now an intention to set up groups to facilitate support, but also it is hoped that neighbouring carers may be put in touch with each other to offer friendship and support outside of the group situation.

5.25 A further initiative is the setting up of a Community Support Bureau based in Boscombe, one of its top priorities being to develop a user and carer advocacy scheme. They are hoping, from April 1996, to pilot an information/advice line for carers.

5.26 Another positive step is the Carers' Information Centre, based in St. Ann's Hospital, which was set up as a result of the "Think Carers" Conference held in November 1994. In the future, it is intended to develop a carers' handbook and possibly an educational video.

5.27 There have been some joint health and social services department CPA training days, where carer organisations and carers have had input to the courses. The fact that there is now agreement for social workers to be full members of the CMHTs will hopefully enhance the understanding of all staff of the legal requirements imposed on social services staff to assess the needs of carers, particularly when the Carers' (Recognition and Services) Act 1995 comes into force in April 1996.

Confidentiality

5.28 We were told that Muriel Viner, at one stage, approached a consultant psychiatrist who was treating Robert Viner and who apparently would not see her because of patient confidentiality. A refusal to see Muriel Viner is referred to in the Greaves evidence[4]. "She wanted the opportunity to discuss the problems with Rob's carers and Rob's psychiatrist". We believe that this was probably when Dr Gumbrell was treating Robert Viner. Muriel Viner certainly was aware of the constraints imposed by the need for confidentiality (letter Muriel Viner to Dr Gumbrell 3 September 1984 requesting an appointment for Robert "he knows I am writing to you") and appears to have felt inhibited in some way by these constraints.

5.29 The issue of seeing Muriel Viner on her own arose in our discussions with Dr. Ford. He indicated that he had never met her, but added that she had never asked to see him. This would demonstrate that her original request for a private consultation had occurred in the era of Dr. Gumbrell, but that the rejection referred to above was so firmly implanted in her mind, as to deter her from asking again. Dr. Ford stated that, in retrospect, he felt it would have been beneficial to have met with Muriel Viner.

Conclusions and recommendations

5.30 We detected no lack of concern by the individual workers involved. At various times both the OTs and the CPNs gave support to Muriel Viner and made attempts to resolve the difficulties facing her. However, our concern is with the organisational response to the distress sometimes articulated by Muriel Viner. We believe she demonstrated a need for more in-depth support than was provided. At no time prior to July 1994 was a conscious effort made to involve the social services department or to develop a more broadly-based support framework for the family. Despite the indications given by Muriel Viner, there was no effective focus on her needs and her problems. We accept that she did not formally request help. At times it was said she felt she did not need help. However we heard enough evidence to indicate she would probably have responded to professional input in her own right.

5.31 Robert Viner was not subject to formal CPA. However we were told that Robert Viner was in receipt of the essential elements of an effective care plan. We have discussed this evaluation in the Policy Issues chapter. We also do not consider that the care planning that took place adequately involved Muriel Viner. National guidance, current in 1994, clearly indicated that carers should be involved in the assessment process and offered help.[5]

5.32 We also have concerns about the approach taken in this case by the social services department. We recognise that, apart from brief episodes in 1991 and 1994 -5, the social services department had no contact with the Viners. This in itself is a matter of concern, highlighting limited communication between the agencies involved. However, there were two occasions on which social workers became involved, and in each instance, we believe their response could have been of greater assistance to Muriel Viner. In particular, when Lesley Moon referred Robert Viner's case to the social services department in 1994, she stressed the effects of the home situation on his mother as part of her reason for seeking alternative accommodation for him. As we have seen, the referral was allocated to the Rehabilitation Team, who because of their remit, twice took a decision to close the case within 6 months.

5.33 We are concerned that the social services professionals involved did not identify either the need for social work support or the statutory requirement for an assessment, leading to the provision of assistance for both the service user and carer, and therefore did not draw this option to the attention of Lesley Moon during their discussions on the case. We are aware that they may have assumed that there was an effective care plan in existence which obviated the necessity for a further assessment. We saw limited attempts to clarify this with the keyworker and in particular to identify the needs of the carer.

Recommendations

Carer support

5.34 We were heartened to note that significant improvements have been set in train with regard to carer support, particularly by imaginative use of the MISG. This has required a high level of co-operation between the Dorset Social Services Department, Dorset Health Commission and Dorset HealthCare NHS Trust, along with the voluntary sector agencies, and we recommend that the implementation of these developments be given high priority

Confidentiality Policy

5.35 "Building Bridges" refers to the need for an agreed policy on confidentiality issues[6]. We were given the impression that confidentiality could hinder or impede effective working with the carer[7]. There is therefore a need both for a confidentiality policy, which must address the carer's circumstances. This must also take into account the difficulties that may arise where the patient requests that information is not given to the carer. In those circumstances the policy could reflect the Mental Health (Patients in the Community) Act 1995, which outlines the circumstances where a patient's wish not to consult a nearest relative or carer can be overridden where the patient has "a propensity to violent or dangerous behaviour towards others".[8]

Local policy and guidance on CPA

5.36 We note that current guidance refers to carers' involvement as follows:

- they should be involved in planning care[9];
- care plans should be agreed with carers as far as possible[10];
- carers may need their own needs assessed[11].

We recommend that steps are taken to incorporate this guidance in current local practice and procedure.

1. Transcript Dr Hutchinson, page 9
2. Transcript Colin and Deborah Greaves, pages 26-28
3. Transcript Greaves, page 31
4. Transcript Greaves, pages 25-26
5. HC(90)23/LASSL(90)11
6. Building Bridges, page 94
7. Transcript Lesley Moon, page 5
8. Section 25E(7)(A) Mental Health (Patients in the Community) Act 1995
9. Building Bridges, page 10
10. Building Bridges, page 15
11. Building Bridges, page 38

6. LEGAL ISSUES

Introduction

6.1 The legislation most commonly used to assist in the care in the community of people with a mental disorder is the Mental Health Act 1983 and the NHS and Community Care Act 1990. The health and social services' management of Robert Viner's case took place outside of this legal framework.

6.2 The legislation most often used to assist carers includes the NHS and Community Care Act 1990 and the Disabled Persons (Services, Consultation and Representation Act) 1986. The assistance given to Muriel Viner by health and social services took place outside of this legal framework.

> "Service users and carers should be informed of the result of the assessment and of any services to be provided. In the case of carers, due regard should be had to confidentiality, particularly when the carer is not a close relative. Where care needs are relatively straightforward the most appropriate way of conveying decisions can best be determined by taking individual circumstances into account. A written statement will normally be needed if a continuing service is to be provided. Written statements should always be supplied on request.
>
> Most support for vulnerable people is provided by family, friends and neighbours. The assessment will need to take account of the support that is available from such carers. They should feel that overall provision of care is a shared responsibility between them and the statutory authorities and that the relationship between them is one of mutual support. The preferences of carers should be taken into account and their willingness to continue caring should not be assumed. Both service users and carers should therefore be consulted - separately, if either of them wishes - since their views may not coincide. The care plan should be the result of a constructive dialogue between service user, carer, social services staff and those of any other agency involved."
>
> **(LAC(92)12 Paragraphs 3.27 and 3.28)**

6.3 The specific areas of law which we identified as being relevant, were as follows:

- the application of the Mental Health Act 1983 and the Code of Practice with regard to possible hospital admission of Robert Viner;
- the application of guardianship under the Mental Health Act 1983 to the management of Robert Viner's case in the community; and
- the obligations, if any, of the social services department under the NHS and Community Care Act and how those obligations were acted on in managing Robert and Muriel Viner's case.

Compulsory admission

6.4 If Robert Viner were to have been compulsorily admitted and detained in hospital, it is probable that his detention would have taken place either under section 2 or section 3 of the Mental Health Act. (See appendix 4 for extracts from the Mental Health Act 1983 and Codes of Practice).

6.5 Robert Viner was an informal patient at the Herrison Hospital in both 1981 and 1982. Some five years later, Dr Gumbrell offered him the opportunity of a further inpatient admission. ("Please let me know if you feel a spell in the Forston Clinic might help now or in the future", Gumbrell letter to Robert Viner 15 May 1987.) From that time until 1995, we heard no evidence that consideration was given to treating Robert Viner as an in-patient in a psychiatric hospital, and therefore compulsory admission under the Mental Health Act had no relevance.

6.6 It was only during the events of 19 April 1995 that the possibility of a further in-patient admission was considered. However, Dr Ford did not consider that Robert Viner was "sectionable".[1]

6.7 Dr Ford now accepts that there were no legal reasons why the use of section 2 or 3 of the Mental Health Act 1983 could not have been considered. However, Dr Ford maintains, on the evidence which was available to him at the time, that arranging for an informal admission for Robert Viner was the most appropriate course of action. In support of this argument Dr Ford refers to Robert Viner's agreement to be admitted to hospital, as an informal patient, in the past; the fact that Robert Viner was in some respects a compliant patient, and that he had no history of violence. Dr Ford concluded it would only be after a refusal of informal admission by Robert Viner that he would have sought to set up a compulsory admission. Dr Ford, however, considered that no definite offer had been made and therefore a refusal of admission never took place. Furthermore, there was nothing to indicate, from the information that Dr Ford was given, that an urgent assessment was justified.

6.8 We wonder whether the communication between Anita Paul and Dr Ford was entirely clear. We have set down below an extract from the notes made by Anita Paul and a summary of some of her evidence:

- Robert Viner was left with the suggestion or impression that he should be removed or parted from his mother to give her a break;[2]
- Robert Viner was expressly refusing the suggestion that he be parted from his mother to give her a break;[3]
- Robert repeatedly stated that he did not wish to leave home;[4]
- Anita Paul hoped that she would be able to persuade Robert Viner to be admitted once a bed was made available.[5]

6.9 There may be an inconsistency in Dr Ford and Anita Paul's analysis of events in so far as both assumed that there would be co-operation by Robert Viner in agreeing to be admitted as an informal inpatient, whereas the management of Robert Viner's case in the community was latterly steadfastly predicated on the basis that he would not cooperate with any change in his circumstances. However, there may be a difference between a move to hospital for short-term respite and a fundamental move which Robert Viner was not prepared to undertake.

6.10 Dr Ford had both background knowledge of Robert Viner as his patient, and up-to-date information given to him by Anita Paul. Taking all this into account, Dr Ford decided that the circumstances were not sufficiently serious to warrant taking steps to arrange, either for an ASW assessment, or an immediate informal admission. If Anita Paul's assessment of Robert Viner's persuadability was correct, we understand why Dr Ford arrived at this conclusion.

Guardianship

6.11 Guardianship, under the Mental Health Act 1983 is nationally not widely used. Reasons advanced for its infrequent use are various, including the absence of a power to convey. In the absence of any extensive research into the area, no firm conclusions as to why it is so little used can be drawn.[6] During the time of the management of Robert Viner's case, Dorset Social Services Department had four people subject to guardianship orders.

6.12 Legally, Robert Viner could have satisfied the criteria for guardianship (See Appendix 4). In particular, when the case was referred to the social services department in 1994, a more comprehensive assessment than that which actually took place could have considered the use of guardianship as an adjunct to any care plan. The legal power to require residence at a particular place was relevant at that time.

6.13 At this initial stage we accept that it would have been unlikely for guardianship to have been implemented. For example, the professionals may well have decided that the use of guardianship was premature. They may have concluded that it was not possible to test whether Robert Viner would move from his mother's house, until alternative accommodation was satisfactorily identified and made available. The Code of Practice suggests that the guardianship patient should be willing to "work together" with the guardian and Robert Viner may not have been prepared to do this.[7]

6.14 However it is a fact that a legal power existed, which could have achieved some of the stated objects of the service providers, in the event of Robert Viner failing to comply with elements of a care plan. Although guardianship does not contain a power to convey, other legal powers could be used to achieve this objective (See Appendix 3).

6.15 There will continue to be a number of cases where the powers under the Mental Health (Patients in the Community Act) 1995 will not be available. This is because the Act requires a patient to have been liable to be detained in hospital for treatment. Therefore an appraisal of the use of guardianship - as part of a comprehensive care plan - must be considered in this type of case. Our concern is not so much that guardianship was not implemented but that it was not considered. This underlines to us a lack of planning at a stage where a comprehensive multi-agency assessment could have resulted in effective joint working.

NHS and Community Care Act

6.16 Under section 47 (1) of the 1990 Act:- "where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority:

(a) shall carry out an assessment of his needs for those services; and

(b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services."

6.17 There is, therefore, an obligation on local authorities to make a needs assessment of any person who appears to them to require community care services and to decide, in the light of that assessment, whether they should provide such services. No community care assessment was ever undertaken by the social services department on Robert Viner, nor were the needs of his mother identified or taken into account. The social services department involvement was limited, and was regarded as taking place within a particular context, that is the request for sheltered lodgings.

6.18 "Duplication of social care assessments, for CPA and care management can and should be avoided, and arrangements made for the same procedures to be initiated regardless of the route by which a patient first contacts the health or social services".[8] It must be correct that if all the essential elements of an effective care programme had been in place in July 1994, then a further needs assessment by social services would have been unnecessary. "Social Services Departments have duties under the NHS and Community Care Act 1990 to assess people's needs for community care services. Multi-disciplinary assessment under the Care Programme Approach, if properly implemented, will fulfil these duties."[9]

6.19 However it appears that all the elements of an effective care programme were not in place. In particular:

- no detailed needs assessment of both client and carer had been undertaken;

- there was no comprehensive care plan and no mechanism or arrangement for monitoring and reviewing the plan on a regular basis.

6.20 Dr Ford asserted, both in his written statement and in his evidence that a very comprehensive care plan was produced by Maria Caundle in January 1993. We have looked at this undated document, which is entitled "Referral for CPNs' assessment". We do not consider that it represents a comprehensive care plan. For example, it does not contain any detailed evaluation of an area of importance, that is an assessment of Muriel Viner's situation and an identification of her needs.

6.21 Specifically, Dr Ford requested, in a letter to Steve Brake, (CPN), that any assessment should include "your observations on the current state of his relationship with his mother and the neighbours".[10] The absence of this information in any detail may partly be explained by the fact that the format of the assessment form does not contain any specific reference to the carer or their needs. "Carers often provide the majority of care to mentally ill people. Their contribution to meeting users needs should be explicitly recognised in the care plan".[11]

6.22 The assessment which was conducted in 1993, was the most detailed one to be undertaken by the CPN service. As we have noted above, it did not represent a full appraisal of the social care needs of both Robert Viner and Muriel Viner. If this fact had been brought to the attention of the social services department in 1994 when they were asked to make their assessment, a full needs assessment could have been undertaken which may well have triggered a multi-agency response. We have discussed in other chapters the ways in which we believe this could have assisted both Robert and Muriel Viner.

Disabled Persons (Services Consultation and Representation) Act 1986

6.23 When undertaking an assessment of a mentally ill person there is an obligation imposed on a local authority to take into account the ability of a carer to continue to provide care to that person on a regular basis. The Act covers the needs of persons "who are suffering from a mental disorder within the meaning of the Mental Health Act 1983," and thus would cover the situation of Robert and Muriel Viner. The performance of this duty is not dependent upon the carer requesting the local authority to consider her situation, and the Act was in force during the time that Alwyne Cross conducted her assessment.

Conclusions and recommendations

Guardianship

6.24 Dr Ford stated that he only had limited experience of the use of guardianship and this no doubt mirrors the experience of all professionals who had dealings with Robert Viner's case.

6.25 We recommend that greater consideration of the use of guardianship be given to cases where "individuals with long term mental health problems being supported in the community are opposed to moving to alternative accommodation, but when it is clearly in best interest of ageing carers".[12] This will require comprehensive multi-agency training.

Multi-agency case management

6.26 We recommend that consideration is given to establishing protocols and procedures for screening all CPA cases. This is to ensure that the lead agency/authority in a CPA case can evaluate whether the statutory or other duties and obligations imposed on other agencies/authorities are being fulfilled. Similarly, if another agency/authority is asked to assist in a CPA case, that organisation can assess if the request is compatible with their own statutory or other duties.

Training

6.27 We recommend that multi-agency training is arranged to allow health professionals, who are likely to be keyworkers under the CPA, to understand the resources and legal obligations of social services departments and housing agencies. The legal obligations that are imposed on local authorities in relation to provision for carers should be a matter for particular attention.

1. Inquest transcript, page 29
2. Anita Paul transcript, page 15
3. Anita Paul transcript, page 24
4. Nurse's notes 19.4.95
5. Anita Paul transcript, page 30
6. Mental Health Act Guardianship: a Discussion Paper. DoH 1994
7. Code of Practice, paragraph 13.5.
8. Building Bridges, page 47
9. HSG(94)27
10. Letter Dr Ford to Steve Brake
11. Building Bridges, page 15
12. Internal inquiry, paragraph 9.1

7. POLICY ISSUES

Introduction

7.1 At a national level, over the last few years, there have been a number of key guidance documents in relation to the care of mentally ill people in the community. These include:

- The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services HC(90)23/LASSL(90)11;
- Guidance on the discharge of mentally disordered people and their continuing care in the community HSG(94)27/LASSL(94)4;
- Introduction of supervision registers for mentally ill people from 1 April 1994 HSG(94)5.

7.2 Also, during the course of the current inquiry process "Building Bridges" was published.

7.3 Relevant documents produced locally include:

- Dorset HealthCare NHS Trust and Dorset Social Services Joint Policy Procedural Guidelines for the Care Programme Approach;
- CMHT guidance.

Care Programme Approach

7.4 Health Authorities are required under Department of Health Circular HC(90)23/ LASSL(90)11 to implement the CPA for all persons with a mental illness referred to specialist psychiatric services. Although the responsibilities above are divided between the health and social services authorities, the advice from the Department of Health in 'Building Bridges' stresses the need for close co-ordination between the agencies in their implementation. Authorities are therefore recommended to make arrangements for multi-disciplinary assessment and working where this is appropriate. This advice has been current to the relevant agencies since the introduction of the CPA in 1991.

7.5 Dorset HealthCare Trust and the Dorset Social Services Department produced joint policy and procedural guidelines for the CPA in March 1993. These guidelines identified the eligible groups as 'all in-patients being considered for discharge, and all new patients accepted by the service being treated in the community'. This also incorporated advice about care management. These guidelines identify the contribution which CPA can make to the care of people with a mental illness, and include, within the definition, those groups to which full CPA must be applied:

- Patients already being treated in the community who are deemed vulnerable without a planned programme of care.

7.6 In defining the groups to whom care management should apply, the guidelines refer specifically to assessment of individuals 'during their period of hospitalisation'. However, they make specific reference to the situation where:

- The ability of the carer to continue to care is under threat of immediate breakdown.

7.7 This position conforms with the advice given by the Wessex Regional Health Authority in 1991, which specifically identified patients already being treated in the community, who are deemed vulnerable, as an eligible group.

7.8 The implications of the criteria initially adopted by Dorset HealthCare Trust were that there was potentially a group of mentally-ill people, living in the community, whose needs would not be identified and addressed by the implementation of the CPA. These were specifically those people with long-term illness, who were being treated in the community, but who were not defined by the professionals as vulnerable. The joint evaluation of the CPA in East Dorset, undertaken by Dorset Health Commission and Dorset Social Services Department in January 1995 refers to the fact that the "definition of vulnerable has been very difficult to outline and this has given rise to considerable inconsistency in practice".[1]

Management of Robert Viner's case

7.9 Robert Viner was not subject to the CPA. The CPA has now been extended in Dorset, and since December 1995 he would now be included within the CPA. However, we were told that the essential elements of an effective care programme were in place for Robert Viner. We have tested this assertion below.

7.10 The main elements to the CPA, as identified in government circular HC(90)23/LASSL(90)11 and summarised in "Building Bridges",[2] are as follows:

- systematic arrangements for assessing the health and social needs of people accepted by the specialist psychiatric services;

- the formulation of a care plan which addresses the identified health and social care needs;

- the appointment of a key worker to keep in close touch with the patient and monitor care;

- regular review, and if need be, agreed changes to the care plan.

7.11 Looking at these individual elements in turn, the most up-to-date documented assessment of Robert Viner's health and social needs was that undertaken by Maria Caundle in January 1993. Maria Caundle's plan is essentially a check list, which was not updated, and the action undertaken was apparently not monitored or reviewed. Latterly, Lesley Moon completed a care plan, which was updated by Anita Paul. However where these plans move from purely medical matters, e.g. the administration of medication, they represent a check list, rather than an appraisal of how to achieve the stated objectives.

7.12 Conversion of the assessment into a care plan may be reflected in the CPN notes. However the references to the essential items are brief.[3]

7.13 There were certainly medical, OT and CPN assessments. The social services department assessment was not completed because Robert Viner was not interested in the sheltered lodgings scheme. There was also correspondence between psychiatrists and the primary health care team. However, there was no comprehensive care plan which was regularly updated and reviewed. If there had been an updated review, discrepancies in the working of the care plan could have been identified. For example, Augusta Wilson's expectation that the rehabilitation OT service was going to continue to work with Robert Viner in the community, was not realised when the case was closed by Anne Staite.

7.14 Robert Viner's apparent key worker (although no person was ever formally identified as such) changed on a number of occasions. The first key worker was Dr Ford, who then referred the case to the OT, Augusta Wilson. Augusta Wilson saw Maria Caundle as the key worker, whereas Maria Caundle considered that Augusta Wilson was the primary worker. The key worker function then transferred to the CPN service. There were apparently multi disciplinary discussions within the health care team. These discussion, were not minuted, but we are assured that they took place.

7.15 One of the prime functions of the key worker is to co-ordinate services with other disciplines and other agencies. In this respect, the key worker function was not always successful. Dealing with Robert Viner's accommodation needs was a key element in the management of his case. We have therefore, taken as an example, the liaison by the key workers with other agencies when dealing with accommodation issues:

- in 1991 Robert Viner's case was referred to the social services department for assistance with finding alternative accommodation. As we discuss below, if Alwyne Cross or Dr Ford had followed up the Hanover Housing Association nomination then the outcome could have been identified and dealt with;

- if greater guidance and support had been given to Robert Viner in his initial application to the East Dorset Housing Association, and had this application been supported by a professional, then the application could have been more positively appraised;

- Lesley Moon believed that a full assessment for accommodation needs would be considered, whilst the social services department believed only a referral for sheltered lodgings had been received;

- For Robert Viner to be advised to apply, without professional support, to other housing associations was not helpful.

We have listed the housing associations that Robert Viner had contact with:

- East Dorset Housing Association - Applied to on his own initiative and without professional support (1990) - Renewed annually thereafter;
- Hanover Housing Association - Referred by EDHA and supported by Dr. Ford (1991);
- Knightstone Housing Association - Applied by self-referral and supported by Augusta Wilson (1993). Renewed annually thereafter with support;
- Raglan Housing Association - Applied by self-referral , following Augusta Wilson's suggestion (1993). Case notes indicate this application was rejected in January 1993;
- Cheshire Foundation Housing Association - Applied by self-referral on advice by Social Services (1994) - Form completed in November, was acknowledged but not actioned further;
- Bourne Housing Society - Applied by self-referral on advice from the social services department (1994) - Advised that their waiting list was closed. They advised him to contact relevant local authority;
- West Berkshire Housing Association - Applied by self-referral on advice from social services department (1994) - Advised that nominations will be supplied by local authority.

7.16 Key workers are defined in the Dorset HealthCare NHS Trust and Dorset Social Services Department document, as "named individuals identified to take the responsibility for ensuring that services to the patient are provided as agreed and the package monitored".[4] The key worker functions, as described by Lesley Moon and Anita Paul in the care plan attached to the CPN notes, were:

- observe Robert's mental health on each visit;
- observe the side effects of prescribed medication;
- administer depot therapy as prescribed;

Each of these tasks were performed adequately by the CPN key workers.

- liaise with mother each visit re situation plus support.

All professionals acknowledged that one of the lessons they have learned from this case is the need to pay more attention to carers. This is underlined both in "Building Bridges" and the "Health of the Nation".[5]

- liaise regularly with other agencies involved.

The key worker function in this respect was, as we have stated above, not always successful. If there had been more effective liaison between the key worker and other agencies, then we strongly believe that changes in Robert and Muriel Viner's accommodation arrangements could have been initiated.

7.17 Recommendations

- All referrals to the social services department should be in writing (this excludes referrals directly to the attached CMHT social worker);

- If a referral is made to a social worker within a CMHT then that person must have access to original referral documents and details of any subsequent assessments undertaken;

- Care plans must be made available to agencies and workers to whom a referral has been made for involvement in mental health care. At all times the referring agency must be mindful of the balance between respecting confidentiality and the importance of full information to enable effective intervention;

- If the social services department is asked to become involved in a specific piece of work by health professionals, the existing care plan must be made available, evaluated and understood. As nearly all clients will now be subject to CPA, this should be a simple enough process. The first step is for the written care plan to be considered. Further steps could include liaison with the key worker at an informal level, or in a more formal setting, appraisal at a case review;

- Consideration needs to be given to the agencies establishing a process for resolving any disagreement that may arise over the implementation of a care plan;

- In line with national guidance that requires the CPA to be applied to all mentally ill patients who are accepted by the specialist mental health services, we recommend that existing local joint policy/procedural guidelines on the CPA are reviewed, to identify the CPA tiers that will be operated locally and to define entry requirements to those tiers with as much precision as possible.

1. Dorset Health Commission/Dorset Social Services. An Evaluation of the Process and Practice related to Care Programme Approach, page 22

2. Page 14

3. Care plan, page 278

4. Page 115

5. Key Area Handbook Mental Illness, page 39

8. RISK ASSESSMENT AND MANAGEMENT

Introduction

8.1 One of the basic tasks of this inquiry is to understand why the homicide and suicide took place. Part of this process of explanation is focused on the concept of risk. The consideration of risk involves analysis of an uncommon event in a way which provides satisfactory answers to questions.

Why did Robert Viner kill Muriel Viner?

8.2 The death of Muriel Viner could have arisen directly from the nature of Robert Viner's illness. There was no real evidence to support this. Although his symptoms included delusions that others could read his thoughts or influence him by telepathy, he never said that Muriel Viner was a part of these experiences.

8.3 Another possibility would be that Robert Viner had become so ill that anyone in contact with him would have been at risk. Again, there is no supporting evidence. Neither Dr Ford nor Anita Paul saw a deterioration in his mental state over the last months. Deborah and Colin Greaves, who knew him well, were at the home for three days just before the tragedy. They thought he was his normal, slightly eccentric, self. A number of Robert Viner's letters, a diary and other documents were examined; they showed no change of style or content over a period of years.

8.4 The opposite view would be that Robert Viner's illness had absolutely nothing to do with the deaths. This supposition is hard to sustain. Had it not been for his illness, it is unlikely he would have gone to live in Corfe Mullen. Had he done so, and not been ill, he could have worked and had a social life of his own - the situation would have been quite different.

8.5 A more convincing explanation is that the eventual crisis arose from the psycho-social effects of Robert Viner's mental illness. For example, he was known to resent his financial dependence on Muriel Viner. Her income, although not large, exceeded his - partly because she had a war pension arising from her late husband's military service. He often commented, illogically, that this was unfair. He was known to say that she did not deserve this money when he had so little. He seemed to make no practical contribution to the running of the home. There was no indication that he helped with cleaning or decorating; he never entered the garden.

8.6 With the idea of encouraging independence, there were several initiatives for him to attend a day centre - none were taken up. His somewhat impractical solution was to find a remote cottage in Wales so that he could live a life of seclusion, untouched by stress. There were doubts over his ability, and motivation, to live any sort of independent existence away from the support of Muriel Viner. He told Dr Ford about his worry that Muriel Viner might move to Birmingham, the implication was that, even if he had somewhere of his own in Dorset, he would still need her. She indicated that if Robert Viner obtained his own accommodation, he would still be welcome for weekends.

8.7 Being so dependent on Muriel Viner did not make him grateful. There were many reports of Robert Viner's difficult attitude towards her - but none which even hinted that he was aware how much she gave up for him. He said to Dr Ford that she was domineering.

8.8 The result of Robert Viner's behaviour on Muriel Viner's life was restrictive. Visitors to the house must have felt discomfited by the way he disappeared to his room following their arrival. Robert Viner appeared to feel threatened by most social contact.

8.9 A key question is how such an unequal and strained relationship endured for so many years. The answer produced by family, friends and professionals alike was simple; the situation was so convenient to Robert Viner that he was disinclined to consider an alternative. This may not be the whole story; his mood was depressed and anxious, he feared and avoided social, let alone emotional, contact yet remained in a home where there was argument and conflict.

8.10 During his last three years, nurses, social workers and doctors all attempted to plan his departure. Muriel Viner, knowing Robert Viner best of all, had periods when she showed considerable stress, but never reached the point of effecting his departure. We can only assume that he must have felt unwelcome at times; psychologically he was already on the edge of being homeless.

8.11 There is no way of knowing what tipped the balance from an unsatisfactory situation into something unbearable. The relationship between Robert Viner and Muriel Viner would be unlikely to collapse so badly as to end in their deaths unless there was some new event or pressure. However, it may be that their relationship was already so fragile that crisis point was never far away.

8.12 It is possible, even likely, that there was an argument between Robert Viner and Muriel Viner on the evening of Wednesday, 19 April. We can only guess at the cause of the argument -it may have been to do with the plan for his admission to St Ann's Hospital. Having attacked his mother, Robert Viner knew that his actions would have very serious consequences for him. It is possible that this knowledge led him to take his own life.

Patterns of homicide

8.13 There were between 450 and 500 annual convictions for homicide in England and Wales over the last decade. In half the cases the victim was a family member or lover.[1] Matricide is a rare offence; there may be some association with mental disorder. Although the report concludes that there is a small, but significant, risk of violence by mentally ill people, there is no correspondingly significant increased risk of homicide by mentally ill people.

Risk assessment

8.14 Risk assessment is concerned with making a prediction. That is, making an estimate of the likelihood that a particular event will take place.

> The guidelines form a summary of good practice in the care of mentally disordered people in the community. The space given to patients who present special risks (paragraphs 23 to 32) is an indication of the importance of this aspect of care in the community. The beginning words of paragraph 23 - "Patients with longer term, more severe disabilities....." point to the need to consider the aspect of risk in patients such as Robert Viner, whose illness was both long-standing and marked by continuing symptoms.
>
> Paragraph 14 contains a discussion of the importance of co-ordination and the "systematic assessment of health and social care needs" which certainly applied to the case of Robert Viner.
>
> However, improving performance is as much a matter of selection and training of mental health professionals as following formal guidelines - which should be regarded as a starting point for the development of good practice.
>
> **Guidance on the discharge of mentally disordered people and their continuing care in the community (HSG(94)27)**

8.15 Risk management is about preventing an event actually happening. This principle has been applied in other areas of medicine. For example, in obstetrics, risk management analysis is used to determine the factors underlying maternal deaths and stillbirths. In the field of mental health, research into suicide has been a recurring topic since Emile Durkheim's publication of "Le Suicide" in 1897. The features of those individuals most at risk of suicide are now well established. Regrettably, prevention i.e. risk management, has proved difficult despite this knowledge.

8.16 The study of homicide, and violence generally, has produced some results - particularly in disproving fallacies. The notion of "dangerousness" as an inherent personality trait, present in some individuals and absent in others, is no longer thought of as a starting point for inquiry. The questions are now framed in a different way. For example, dangerous to whom? To special types of victim - such as children, one gender and not another, perhaps figures of authority? Is there a connection with the use of alcohol or drugs? Might there be warning signs, such as an increase in angry talk or changing mood?

8.17 The most central questions, and the most neglected, have to be put to the individual, however uncomfortable this may seem. Does he or she have violent thoughts? What form do these take?

8.18 Was Robert Viner questioned specifically about the existence of hostile feelings towards Muriel Viner? Mental health professionals in the past used to avoid asking their patients about suicidal thoughts. It was thought, and now seems unconvincing, that the merest question could provoke the act. It is now accepted that a majority of people who experience depression also have thoughts of harming themselves. Discussing such thoughts with a person who is adequately trained and has the means to make a useful response, is a step forward in treatment. The practice of risk assessment and management, though not completely developed, should be part of the range of skills necessary to the treatment of mental disorder.

8.19 In the context of risk assessment, the deaths of Robert and Muriel Viner were exceptional in several ways. Robert Viner had no record of violent behaviour and no history of offending of any sort. Although he was a heavy drinker, there is no evidence that he was intoxicated at the material time. There is no evidence that the killing was premeditated. It is also unusual to have such a number of reliable witnesses able to give an account of events in the months, days and even hours before the tragedy.

Conclusions and recommendations

Training

8.20 We noted the involvement of some staff in training in assessment of risk. However, we recommend that this training be extended to all the members of the CMHTs.

CPA assessments

8.21 Although the death of Muriel Viner was not a predictable event, the collapse of her ability to act as prime carer to Robert Viner could have been anticipated. Each time she talked about her difficulties (as far back as 1980 she told Dr Mulholland she would move away leaving Robert Viner homeless unless he received effective treatment) the assumption was generally that she would always recover her ability to cope. However, we acknowledge that when it became apparent on 19 April 1995 that more immediate respite was required for Muriel Viner, Dr Ford and Anita Paul planned to offer Robert Viner admission to hospital. At the age of seventy-six, with the extra stress of her daughter's near fatal accident and subsequent disability, some sort of crisis was probable.

8.22 We, therefore, recommend that any assessment under the CPA is organised, in future, to include a full appraisal of the situation and potential difficulties of the carer - especially when that person is elderly and the burden is unshared. The health and stability of the carer is just as important as the details of the patient's medication.

1. Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. RCP 1996

9. MULTI AGENCY WORKING

Introduction

9.1 Reviewing the care offered to Robert and Muriel Viner has been an analysis of parallel processes. We have heard from CPNs about how Robert Viner was referred to the service, the assessment of need that was carried out, and the ongoing care plan that was developed. We have seen how Robert Viner's care was passed from one CPN to another as necessitated by personnel changes within the service. We have also heard of the referral to, and assessment by, the OT service, and have learned of the work undertaken by one OT and the onward referral to another. Other agencies and disciplines have described their involvement with Robert and Muriel Viner in similar linear terms. It has been much more difficult to discern evidence of these individual strands of work being woven together to provide a comprehensive and effective care package. We do not believe that the responsibility for this deficiency lies solely with the individual professionals involved, although some measure of responsibility must lie there. It is, however, our opinion that structural flaws existed, and to some extent still exist, that mitigated against effective multi-agency working.

Service re-organisation

9.2 Prior to July 1994, CMHTs did not exist in East Dorset, even in name. In common with most of the rest of the country, community mental health services had developed from in-patient services, and were constructed around a consultant psychiatrist to whom was linked a CPN team. Other disciplines were accessed on an "as needed" basis. Steps had been taken to improve communication between the specialist mental health services and primary care, with the formal linking of CPNs with GP practices in July 1993.

9.3 We have been informed that Dorset Social Services Department have always recognised the importance of investment in mental health services as evidenced by the following:

- CMHTs (with social workers as integral members) were jointly established by health and social services in west and north Dorset in the early 1980's and have continued to operate as such since then;

- community mental handicap teams (now known as community learning disability teams) were also established on a similar basis throughout Dorset in the early 1980s and have also continued to operate as such;

- in 1988, the social services department invited the unit general manager of the East Dorset District Health Authority with responsibility for mental health services to establish CMHTs in East Dorset on a similar basis to that which had been established in West and North Dorset but this was declined on the basis that the health service was not yet ready to decentralise its community psychiatric services from St Ann's Hospital.

9.4 In July 1994 a reorganisation of the mental health services was embarked upon with a view to remedying some of the perceived shortcomings of the existing structures. Under the new arrangements, CMHTs, with responsibility for a given catchment area and linked with named GP practices, were established. These teams were made up of various health professionals. Social workers were not integral members of these teams and the mechanism for accessing social work was variously represented to us, demonstrating a lack of common understanding between health and social services agencies. Amongst the health members of the CHMTs, there was agreement that the teams existed and about the membership of the teams, and relationships between team members. There was, however, little evidence that the teams actually functioned as teams. This problem is not unique to Dorset. Multi-disciplinary working can be problematic, particularly where the team formation takes place in the context of professional rather than functional management.

Managing CMHTs

9.5 Historically, the health service has run on professional management lines - nurses managing nurses, doctors managing doctors, OTs managing OTs. The Griffiths' Report in 1983 introduced the concept of general or functional management, a concept that has been widely embraced and implemented to good effect throughout the health service. A functional management model for a CMHT would require the appointment of a manager, who could come from any professional background, and who would be responsible for ensuring the effective functioning of the team.

9.6 This is a model endorsed by the Sainsbury Centre for Mental Health in their report on the 1994 survey into CMHTs. It also reflects a growing trend in community mental health. The 1987-8 national survey of CHMTs undertaken by the Sainsbury Centre for Mental Health, found that only 10% of teams had a dedicated manager. When this survey was updated in 1994, this had risen to 74.5%.[1]

9.7 The report also discusses the many challenges faced by CMHTs in delivering effective mental health care within a multi-agency and multi-disciplinary context. It makes many recommendations that would not be at variance with the direction in which the Dorset teams are being developed. The report concludes by stating that what is required is '....stronger operational management at team level rather than reliance on the team as a whole to make important strategic and operational decisions.' This is a view that is reflected in current government guidance.

'Teams must be managed efficiently if the (community mental health) service is to be effective. Individual teams will need to decide how the management tasks, such as the regular assessment of needs and available resources, the prioritising of work, the assessment of staff performance, negotiating with senior management, publicising the service, and managing the budget, are carried out. The team may be non-hierarchical, or conversely led by a single individual; what is essential is that, once again, there is **clarity** about respective roles and lines of accountability. Making sure that the organisation structure is right is not an optional extra for teams, but an essential part of effective working. There is some evidence to suggest that 'fully managed' teams are likely to be more effective.'

(Building Bridges p 36)

CMHT Management in Dorset

9.8 The team structures that are emerging in East Dorset have not yet been fully developed. This is understandable in the context of the evolutionary process in which the service is engaged. We are also aware that the operational policy document for the CMHTs that was produced in November 1995 furthers the development and process. The social services department were not prepared to support these developments until agreement had been reached on various issues including policy, service priorities and management/professional supervision.

9.9 There is, however, one fundamental decision that must be made about the future of the Dorset teams. Currently, they are constituted as multi-disciplinary, multi-agency teams, but they are managed through uni-disciplinary and uni-agency lines. In such a setting, accountability becomes very hazy. Is a CPN in the multi-disciplinary team accountable to the team as a whole, or to a named individual within the team, or to the nurse manager, who may not be a member of the team? If the current uni-disciplinary or professional management structure is maintained, then attention must be given to the way that professional management systems link with the management of the team as a unit. Unless that is done, then the CMHTs will not exist in anything other than name, and the pattern of working in adjacent but not always connected parallel processes, that we have seen evidenced in the care of Robert Viner, will continue to be replicated.

9.10 An approach which is rapidly gaining national support, although not specifically prescribed, is to embrace fully multi-disciplinary and multi-agency management of the teams and to make joint (i.e. health and social services) appointments of team managers. Irrespective of their professional background these managers have responsibility for ensuring the effective functioning of the teams and all team members are managerially accountable to them. Such a development would need to be balanced by ensuring that all staff had access to appropriate professional, as opposed to managerial, support and supervision.

Management of Robert and Muriel Viner's case

9.11 Had a clearly managed CMHT been in place during the time of Robert and Muriel Viner's involvement with the mental health services, there is no guarantee that the outcome would have been different. An effective team manager, however, could have ensured that there were clear systems in place for identifying key workers, and for reviewing regularly all active cases in a fully multi-disciplinary setting. For Robert Viner, these aspects of the team functioned imperfectly. We have noted the confusion among the professionals as to who had key working responsibility. There was no process of formal review. The various professionals who were involved with Robert Viner did discuss his care and progress with each other, but this seems to have taken the form of unstructured and informal conversations, rather than any systematic attempt to establish treatment aims and to evaluate progress against these aims. We did not see the pooled knowledge and experience of the multi-disciplinary team being fully used.

9.12 We are aware that the absence of systematic and recorded planning and review is a common difficulty in relation to clients with long term mental health problems, particularly where there is not felt to be any significant change in their well-being. However, we consider that if the team had been operating in a way that demanded a regular and systematic review of all active cases, it is possible that Robert Viner's accommodation needs, and the relationship difficulties between him and his mother, might have been addressed more effectively. For example, such reviews, if conducted in a multi-disciplinary setting, with team members who clearly understood each other's roles, would have avoided the confusion that we saw about the 1994 referral to the Rehabilitation Team. In addition, six monthly recorded reviews with action plans would have revealed the lack of progress in resolving the accommodation issues and might have prompted a rethink about strategies, including joint working with Robert and Muriel Viner.

Conclusion and Recommendations

9.13 We believe that the professional work undertaken with Robert Viner was sometimes impeded by ineffective multi-disciplinary team working. One practical way of addressing this problem is through the development and strengthening of the CMHTs and we recommend that that full consideration be given to the promotion of inter-agency and inter-disciplinary relationships within the CMHTs. Current research indicates that these relationships can be managed most effectively by bringing the disciplines and the agencies together under one line of management. We acknowledge that a particular difficulty may be that a manager who is a health professional may not be familiar with the statutory duties and other obligations imposed on social services departments. If one line of management is not the option that is chosen by the health service in conjunction with the local social services departments, then we would urge that explicit systems are established to ensure that the teams can nonetheless function effectively as integrated units, and no longer operate as a loose collection of individuals whose prime identity lies elsewhere.

1. The Organisation and Operation of CMHTs in England - a national survey. The Sainsbury Centre for Mental Health 1994

10. SUPERVISION

Introduction

10.1 The structure of a team and its management arrangements have a direct bearing on the quality of care that a service can deliver. These are not, however, the only factors. Consideration must always be given to staff supervision, a pre-requisite for effective clinical work. Over recent years much has been written about the nature and function of supervision in clinical settings. Reference is made in the bibliography to relevant texts. In this chapter we have identified some features of effective supervision and we have then commented on the extent to which these were operating in Dorset.

Models of supervision

10.2 Hawkins and Shohet (1989) suggest: 'The supervisor has to integrate the role of educator with that of being the provider of support to the worker, and in most cases, managerial oversight of the supervisee's clients.[1] This can be expanded into a list of the functions of supervision which include the following:

- to maintain and develop therapeutic competence;
- to monitor the effectiveness of helping relationships;
- to oversee the quality and quantity of caseload/workload responsibilities;
- to assist with the effective management of time;
- to enable professional development, continuing education and training;
- to consider future career development;
- to ensure awareness and effective use of resources;
- to acknowledge effective and successful use of skills;
- to share and explore the emotional demands of other people's psychological difficulties;
- to deal with stress, prevent burnout and address the negative aspects of work;
- to offer support for personal needs and growth.

10.3 All of these aspects are important for mental health professionals. The idea that supervision is only required by the most junior staff cannot be maintained. For these functions to be achieved, the supervision process must be planned. If left to informal arrangements, attention to some of the aspects that we consider important will be given at the expense of others. We do not intend to set out a blue print for supervision; that is something that lies with the local service. We would stress, however, that a supervision policy is not a luxury, but is an essential component of a safe and effective mental health service.

Supervision in Dorset

10.4 We had the opportunity to discuss with a variety of professionals the supervision arrangements that related to them. The picture that emerged was varied, although most professionals acknowledged that they were in receipt of some form of regular supervision. Often, the focus was more managerial than clinical, but there was a general acceptance of the validity of supervision as a concept.

10.5 We were particularly concerned about some aspects of clinical supervision. While most staff said that they could easily identify someone with whom to discuss any client who was causing them concern, we obtained the impression that this would only occur if a problem arose. We had little doubt that there would be ready support in a crisis; we were less certain that there existed for any staff a system that ensured that each case, whilst it remained open, both the less demanding and the acute, would be reviewed, at specified intervals, with a clinical supervisor. We additionally note that any effective supervision system should review decisions about transfer and closure of cases.

10.6 We acknowledge that this is a common problem. When time for supervision is limited, it is natural for the cases to be prioritised before they are discussed in supervision. For example, those that come to the fore most frequently may be those that are viewed as problematic or challenging; or less frequently, those where the professional is proud of some achievement. People like Robert Viner, who did not present any acute problems, and who was not judged even to merit the CPA, would rarely be presented.

10.7 Within the social services department, supervision was provided to Teresa Breckenridge and Gerry Stickley. We heard no evidence that Robert Viner was ever the focus of any clinical supervision session, within the health setting, outside the OT service. There is no way of predicting that the outcome of Robert Viner's case would have been any different if it had been subject to careful scrutiny within a clinical supervision session. However, had Robert Viner's care been reviewed even six monthly in clinical supervision, the issues about his accommodation needs, his ambivalence about moving, the tension in his relationship with his mother and her support needs might all have been noted and explored. As a consequence the alternative strategies that we have identified elsewhere could have been discussed and implemented.

10.8 The absence of any systematic review of all active cases was one of our particular concerns about the nature of supervision within the health service. We were also concerned about the more general supervision arrangements. We heard a great deal about the value placed on peer supervision and its prevalence, particularly within the CPN service. When this was explored, however, it appeared to be little more than the support that was available from colleagues on an informal basis, following the professional experiencing a particular problem. We recognise that such support is vitally important for the well-being of professionals who have day to day contact with clients. However, we were concerned that there appeared to be some confusion between peer supervision and clinical supervision. If supervision is to be effective, it must be a formalised relationship, with a clear and mutually agreed contract. It must stimulate a reflection on practice, which at times can be extremely challenging.

Conclusion and Recommendations

10.9 We did not see any evidence that there were effective clinical supervision systems in place for any of the professionals, with the possible exception of Augusta Wilson, who were involved in the care of Robert Viner. We believe that, had such systems been in place, then alternative strategies for resolving the impasse in which Robert and Muriel Viner found themselves, and which was reflected in the position of the professionals concerned, might have been developed and implemented.

10.10 We, therefore, recommend that urgent attention be given to the development and implementation of a supervision policy for all mental health professionals, including doctors, of all grades. Such a policy must address:

- frequency of supervision;
- duration;
- confidentiality;
- recording;
- style;
- content;
- mutual expectations of supervision and supervisee;
- training for supervisers and supervisees;
- process for review of the supervision contract.

We further recommend that any such supervision policy must make explicit the mechanisms that will ensure that every current case managed by a professional is automatically reviewed within a specified period.

10.11 We have been informed that clinical supervision was identified as a priority for improvement before the tragedy and one of the consequences of this has been the establishment of a joint post with Bournemouth University. Two areas of relevance that the University post holder is working on include a risk assessment tool for the mental health service and the production of a clinical supervision model.

1. Supervision in the Helping Professions. Hawkins and Shohet

11. INTERNAL REVIEW

Introduction

11.1 The inquiry remit required us to consider the recommendations (entitled the "action plan") of the internal review. In addition we decided that we needed to consider some of the processes of the internal review and its conclusions.

Action Plan of the Internal Review

11.2 We welcome many of the proposals to introduce improvement to mental health practice, in particular:

- to extend CPA to all patients being supported in the community;
- to ensure that CMHTs monitor arrangements for the support of carers;
- to review the range and location of carer support groups;
- to train staff in risk assessment.

11.3 The proposals to develop dual diagnosis programmes for people with mental health problems who also misuse drugs/alcohol will also improve the treatment of these problems locally.

11.4 The concerns expressed by the internal review about the legal powers available to professionals to force Robert Viner to move into other accommodation echo the issues which we have identified in our own investigations. We believe that mechanisms do exist to effect such a move, e.g. by the use of guardianship, and more needs to be done to raise awareness of these procedures (Appendix 3).

11.5 In addition to the points identified in the action plan we consider that it is important that action is taken to address the problems of communication between the agencies involved in mental health work. Although this will be improved through the introduction of CMHTs, we would like to see steps taken to ensure greater operational liaison. This is linked to the need to provide joint training programmes for health and social services department staff on CPA/care management, and on multi-agency working. This should also specifically aim to increase awareness among health staff about resources available through the social services department.

11.6 We also believe that the legislative requirements concerning carer assessments should be brought to the attention of all professionals working in the mental health field. Information should also be provided to staff on accessing the various forms of accommodation which is available.

Critical Incident Policies and Procedures

11.7 The internal review took place within the wider context of the process of managing and reviewing critical incidents. We were shown the Dorset HealthCare Trust protocol for the reporting of critical incidents. Within the Trust, as far as we are aware, there is no other guidance in existence for the management of a major incident.

Membership of the Internal Review

11.8 The internal inquiry had the following members:

- Mr E Wood, non-executive director and chair;
- Miss L Boland, general manager mental health services;
- Dr M Ford, consultant psychiatrist;
- Mr D Ozanne, acting senior CPN;
- Ms L Moon, CPN;
- Ms A Paul, CPN;
- Mr D Hosie, team manager, social services department;
- Mr G Stickley, social worker;
- Dr G Dudding, GP.

11.9 The chairman of this review was a non-executive director of the Dorset HealthCare Trust and also a solicitor. All the other members of the review had some involvement with the Robert or Muriel Viner either as caseworkers or managers.

11.10 Roger Browning told us that consideration was given to excluding the professionals involved in the case from the internal review process. However it was subsequently decided that they should participate. The basis of this decision appeared to be that, an internal, but semi-independent, inquiry followed by an external inquiry would be confusing and would put staff under pressure. Therefore, as the function of the internal review was seen by the Dorset HealthCare Trust as supplementing the team audit, it was decided that the professionals should remain involved.

Function of the inquiry process

11.11 If an external inquiry has to take place, as currently envisaged by the NHS Executive,[1] then the internal review needs to be limited in scope and function. The function of this review is to rapidly identify any significant faults in both the care offered and services provided. Further it will allow management to give urgent consideration to any disciplinary or other measures that need to be taken. Because the process of inquiry is time consuming and expensive, the function of internal and external inquiry should not be replicated. With hindsight we wonder therefore whether the remit of the internal review was too broad.

11.12 Dr Ford's "inquiry weariness", also echoed by other professionals, ought to merit attention. Dr Ford identified a number of audit processes that he engaged in, which included a presentation to the clinical audit appeal review, a clinical team audit and a report to the National Audit Survey. "In some ways this is an overdose of inquiries and reports.. and to be honest I do think it is too many."[2] Internally the following steps were identified by Roger Browning[3] as taking place: internal management review, clinical team review/audit, peer review and full internal review.

11.13 The number of investigations that staff have to participate in following a serious incident, should be limited. We therefore propose the following:

- immediate investigation by a senior manager to compile sequence of events and to take any consequent urgent action required;

- internal review/audit. The function of this review is to identify faults, if any, in provision of service. Membership of the review should be from outside the immediate service;

- if the internal review "stands alone" i.e. is not followed by an external inquiry then its remit could be broadly defined and involve persons from other clinical units or outside the employment of the Trust altogether.

11.14 "Building Bridges" contains guidance in relation to the conduct of "formal" internal reviews.[4]

11.15 If, as we conclude, there is some virtue in limiting the review process then other audit meetings, such as formal peer review and clinical audit, could be subsumed in the internal review process - for example by the use of a psychiatrist from another Trust to advise the review panel.

Inquiry membership

11.16 We consider that the members of any internal review team should not have been involved in the case under investigation. However the precise composition of the team must partly depend on the scope of the internal investigation. If there is to be a full internal inquiry, then the use of persons who are not in the employ of the Trust - both professional and lay - could be considered.

Findings of the Internal Review

11.17 We found ourselves in disagreement with some of the conclusions of the review. Our disagreement is influenced by a number of factors including the following:

- we have had much more time and opportunity to consider the evidence than the internal review team;

- we believe that the internal review team focused unduly on risk assessment, rather than the effectiveness of the care delivered to Muriel and Robert Viner in its totality; and

- we consider that, as the membership of the internal review group included some of the key persons involved in the incident, this may have impeded the process of objective investigation and evaluation.

We have listed some of our areas of disagreement:

- **para 3.5** refers to "many attempts by...OT's and Social Services" to promote a programme of rehabilitation. In fact there were efforts (mainly by Augusta Wilson in 1992), and none at all by the social services department who had little contact, apart from Alwyne Cross's assessment in 1991, and the assessment for sheltered lodgings in 1994;

- **para 3.7** "There have been many attempts to try to get Mr Viner to move to sheltered accommodation/independent housing." There were some attempts, by CPN's and OT, but they often relied on Robert Viner taking the initiative. There was no social services department input in this area in 1991 and 1994.

- **para 3.9** "Robert Viner would need to be asked to come into hospital." It was not clear from the evidence we heard whether Robert Viner had already been asked that question.

- **para 3.11** "Mr Viner has received regular support in the community over the past 14 years, particularly over the past two/three years". The regularity of the support in fact varied. From October 1984 to August 1986 and from 1 October 1986 to 18 July 1988 Robert Viner had no contact with any professional from the mental health services.

- **para 5.6 and para 5.7** "There were concerted efforts to try and get Mr Viner to move to sheltered accommodation/independent housing..... from February 1994-March 1995." We did not see any evidence of a co-ordinated strategy. Lesley Moon made efforts to find a solution, but the social services department, because of the nature of the referral, were unable to help and closed the case twice in six months. Teresa Breckenridge assisted, with some effort from Robert Viner himself.

- **para 5.8** "Robert Viner declined all offers of assistance in finding supported housing with Social Services." He did refuse all offers of help with supported lodgings but not special needs housing or other housing association properties.

Conclusions and recommendations

11.18 In any work context we believe that it is difficult for personnel to appraise their own performance objectively. Staff were however asked to do this within the internal review. We consider that this fact impacted on their capacity to analyse the events in which they were involved and consequently affected the conclusions which they drew.

11.19 We do not consider that the Dorset HealthCare Trust document entitled "The reporting of critical incidents" offers adequate guidance for the management of a major incident. We are not aware that the Trust has any other protocols or procedures related to this important area. In particular there is no detailed procedure for serious incident inquiries. We understand that discussions are being held with the chairman of the clinical audit committee to review existing arrangements and it is planned to produce a new policy for consideration in April 1996.

11.20 We therefore recommend that:

- any staff, or their managers, involved in direct work with the client/s, whose case is being investigated, should not be members of the internal review team. The role of these key staff would be to prepare reports and attend to give evidence as necessary. This would also assist them in preparation for the external inquiry process;

- the Dorset HealthCare Trust establish serious incident policies and procedures, including details of the staff and personnel to be involved in any investigation and audit;

- Dorset HealthCare Trust employees involved in managing reviews/audits should not be from the particular branch of the service concerned;

- the definition and classification of serious incidents needs to be developed;[5]

- the processes of serious incident reviews/audits need to be re-evaluated to avoid a multiplicity of reviews.

1. HSG(94)2
2. Transcript Ford, page 38
3. Transcript Browning, pages 3-5
4. Building Bridges, pages 79-80
5. Building Bridges, pages 77-78

12. CONCLUSIONS

Robert Viner

12.1 We acknowledge that Robert Viner, suffering from a severe mental illness as he undoubtedly was, lived in the community from 1982 onwards without any recourse to inpatient hospital treatment. We accept that is partly due to the professional support which he received over those years. We saw many examples of diligent treatment and care. It may be doing the service providers in this case a great disservice to have this particular non-acute case subject to such detailed scrutiny. We accept that they must manage many acute and worrying cases entirely successfully in the community. We are aware that it is possible for professionals to put much effort into a client's case which will not guarantee results. Yet we identified at least two recent occasions when the interagency response that could have assisted Robert Viner failed.

12.2 We are aware that, since this tragedy occurred, all persons in Robert Viner's situation should now be subject to the CPA. Also rapid changes in service provision through the further development of the CMHTs have occurred since his death. These changes will hopefully go some way to preventing this sort of tragedy occurring again.

Muriel Viner

12.3 We have deliberately not referred to Muriel Viner in the preceding two paragraphs. She deserves to be accorded separate treatment. We consider her needs as a carer were never fully identified and were subsequently not responded to. She was a stoical individual of a generation who found it difficult to ask for, or indeed, seek, help. The developments in service provision and legal obligation over the last decade, designed to help carers, completely passed her by.

12.4 We recognise that, since her death, there have been steps taken by both the key agencies involved in this inquiry to remedy some of the deficits in service provision for carers. National policy, published since the deaths occurred, underscores the needs of the carers. The needs of the carers must be given a high priority in the context of management of cases in the community.

Resources

12.5 We recognize that high quality community mental health care makes heavy demands on care services and their resources. There are currently 4,300 people with mental health problems subject to the CPA and cared for by the Dorset HealthCare NHS Trust. We also recognize that in every case clinical judgement has to be exercised as to how resources may best be used to support individuals. Service provision cannot be divorced from resource availability.

12.6 In considering the effect of resource availability on the management of Robert and Muriel Viner's case we noted that there was no clear evidence that staffing levels negatively impacted on the effective care given to Robert Viner, except possibly within the OT service. The lack of provision of special needs housing, however, may have hampered a successful resolution to managing Robert Viner's case.

12.7 We also acknowledge that some of our recommendations have resource implications. For example, although it is clearly good practice for a consultant psychiatrist to personally meet the individual caring for his patient this practice will have some impact on clinical resources. If, however, our recommendations improve practice then we would expect there to be some conservation of resources, for example, by avoiding the duplication of professionals' work.

12.8 Generally, we identify a problem in resource allocation. Increasingly hard pressed professionals working in the mental health field are being required to target scarce resources on managing acute cases, in the community. As a result, it will be significant risk patients, or highly volatile individuals, who will be subject to the full CPA. It is these people who will be placed on supervision registers. It will be these people who may be the recipients of the new orders under the Mental Health (Patients in the Community) Act 1995. Until or unless, generally stable individuals like Robert Viner are accorded consistent and well-focused care, which can be adjusted at times of crisis, then this sort of tragedy will recur.

Communication

12.9 One of the themes which we encountered during our investigation was that there is no point in looking for things on paper when you ought to be looking at the quality of the real work that was actually carried out. We were also told that there was an effective care plan although not presented as such, "There was not one care plan and one set of people, but each profession had their care plan and that was shared. There was a care plan although that was not written on one piece of paper and called a care plan".[1] None of us are so naïve as to regard paper presentation as the test of an effective service. After all, written plans, protocols and procedures are simply devices to aid effective communication. What we did find was that the absence of clear documentation, in key areas, reflected a deficiency in communication between professional groups and individuals.

Key working

12.10 Although the keyworker is entrusted with the responsibility of co-ordinating and managing an individual's care in the community they will often be working alongside other professional colleagues. Therefore, as happened in this case, there must be not only an expectation that the keyworker is the responsible person but that the keyworker can expect to be given a wide range of advice when referring to another professional colleague for a specific service.

12.11 It was the keyworker's responsibility to negotiate the maze. We believe there were two substantial missed opportunities in this process of negotiation. The first was the assessment undertaken for Robert Viner's accommodation in 1991. The second was the key worker's referral to social services in 1994. If there had been an effective care plan prior to the 1994 referral, or if a plan had been developed as a result of that referral, the agencies could have worked more effectively together. Two key components of a comprehensive care plan would have been to identify both the needs of user and carer and then to outline a strategy to meet those needs.

Concluding comments

12.12 Do we need another detailed inquiry report to establish the fault lines in community care? Perhaps the strongest argument for this type of inquiry is to evaluate objectively the standard of service provision. In particular, such provision in relation to CPA needs to be monitored. We cannot say, much as we might wish to, that this was a good or effective example of multi-disciplinary working. Looking at outcomes alone, this is not an acceptable proposition. We hope that matters have changed sufficiently to make this sort of tragedy less likely to happen. The challenge is to make sure that this type of continuing care case is managed effectively in the community.

12.13 We recognise that the professionals involved in Robert Viner's and Muriel Viner's care worked with compassion and dedication. Nevertheless, we consider this case highlights the inadequacy of the limited implementation of the CPA which was adopted in Dorset during the period covered by our investigation. It also demonstrates some deficiencies in communication between both the professionals and the agencies involved. This contributed to a failure to fully identify the needs of either Robert Viner or Muriel Viner, and to provide a comprehensive care plan which would have addressed these needs. We do, however, accept that the final tragic outcome could not have been predicted.

1. Browning transcript, page 8