Summary of the report of the Inquiry into the treatment and care of Ms B

A report commissioned by Avon Health Authority 1996

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AVON HEALTH AUTHORITY

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Co-opted:

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We were commissioned in June 1996 by Avon Health Authority to undertake this Inquiry. We now present our report, having followed the Terms of Reference set out on page iv.

Acknowledgements

The Panel would like to record its thanks to:

Ms B.

The family and friends of Ms B, in particular her mother and her partner.

Richard Lingham for his assistance in advising on the procedure and joining the panel as a Social Services assessor.

Mike Vousden, Debi Basham-Jones, Denise Cuer and Kate Tregale for their invaluable assistance.

Harry Counsell and Co. and the transcribers, especially June Martin and Miriam Weisinger.

Those staff who worked at Southmead Hospital, Fromeside Clinic and with Social Services who gave full assistance to this Inquiry.

Preface by the Chairman

The news that a close member of your family is suffering from a severe mental illness must be devastating. The loss of another member of your family, within a year and a month, as a result of that illness is a tragedy and calamity almost impossible to contemplate. It was in the hope that other families would not be destroyed in the way that hers has been that Mrs B gave the Inquiry her total support. We are grateful for that assistance and the help we also received from other members of the family and friends and from Ms B herself.

Those who were involved in the care of Ms B, in both health and social services, without exception also co-operated fully with the investigation. In some areas we have found examples of high standards of practice. We have found care by individuals which reveals considerable dedication and concern. We have not hesitated to make commendations where they are due. We have also found shortcomings and have made clear recommendations to the relevant authorities for appropriate action to be taken. We cannot say that had these shortcomings not existed the tragedy would not have occurred. We can say that the implementation of the recommendations would achieve a higher standard of care for patients and support for staff and families who work and care in a very challenging and exacting environment.

Three lessons stand out:

- Staff who have concerns have a professional duty to follow these through until they are satisfied that the concerns have either been met or are unfounded.

- Formal systems and mechanisms have a significant part to play in inter-profes sional and inter-agency communication and good standards of risk assessment, man agement and monitoring.

- Every effort should be taken to prevent a woman being incarcerated on her own on an acute ward of men in a medium-secure unit.

Our Full Report was presented to the Avon Health Authority in June 1997. In view of the fact that it contained many highly personal and sensitive details concerning the patient and her family, the Health Authority asked the Inquiry Panel to produce a summary of the full report which could be made available to the public. This summary includes all the Conclusions and Recommendations of the Panel. It is this summary which is now enclosed.

Terms of Reference

1 To examine all the circumstances surrounding the treatment and care of Ms B by the mental health services, in particular:

i) the appropriateness of her treatment, care and supervision in respect of:

a) her assessed health and social care needs;
see Conclusions to Sections 5, 6, 9, and 14.

b) her assessed risk of potential harm to herself and others;
see Conclusions to Section 13.

c) any previous psychiatric history, including drug and alcohol abuse;
see Conclusions to Sections 4 and 15.

d) the number and nature of any previous court convictions;
there were none.

ii) the extent to which her care corresponded to statutory obligations; relevant guidance from the Department of Health (including the care programme ap proach HC(90)23/LASSL(90)11, supervision registers HSG(94)5 and the discharge guidance HSG(94)27); and local operational policies;
see Conclusions to Sections 10 and 11.

iii) the extent to which her prescribed care plans were:

a) effectively drawn up;
see Conclusions to Sections 13 and 14.

b) delivered;
see Conclusions to Sections 13 and 14;

c) complied with by Ms B;
see Conclusions to Sections 5 and 6.

iv) could the homicide have been avoided?
The Inquiry concludes that the homicide could probably not have been avoided.

2 To examine the appropriateness of the professional and in-service training of those involved in the care of Ms B, or in the provisions of services to her;
see Conclusions to Section 18.

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

i) the agencies involved in the care of Ms B or in the provision of services to her;
see Conclusions to Sections 9, 11 and 14.

ii) the statutory agencies and Ms B's family;
see Conclusions to Sections 5, 6, 9, 10 and 11.

4 To prepare a report and make recommendations to Avon Health Authority.

Contents

Section 1: The homicide and immediate sequence of events

1. At Bristol Crown Court on 24 May 1996, Ms B pleaded not guilty to murder, but guilty to the manslaughter of her father on the grounds of diminished responsibility on 30 August 1995. She was made subject to a hospital order under Section 37 of the Mental Health Act 1983 with a restriction order under Section 41 to remain at Broadmoor Hospital without limit of time.

2. She had been held as a detained patient at Southmead Hospital under Section 2 and Section 3 of the Mental Health Act 1983. On 17 January 1995 she was given Section 17 leave to stay at Fromeside Regional Secure Unit, and was transferred under Section 19 to the managers of that hospital on 9 March 1995. At the time of the homicide she was detained under Section 3 at the Fromeside Regional Secure Unit and had been granted Section 17 leave. Following the homicide she was arrested and detained in Weston-super- Mare Police Station. She appeared at Woodspring Magistrates Court on 1 September 1995 and was remanded in custody at Pucklechurch Remand Centre. She was transferred to Broadmoor Hospital from Pucklechurch Remand Centre under Section 48/9 of the Mental Health Act on 15 September 1995. On 15 November 1995 she was committed for trial in custody to Bristol Crown Court under Section 6(2) Magistrates' Courts Act 1980.

THE INTERNAL INQUIRY AND BRIEF SUMMARY

3. An internal investigation was set up by Frenchay Healthcare NHS Trust, in accordance with the guidance contained in HSG 94/27 paragraphs 33-36. The Inquiry Panel included a consultant psychiatrist, the organisation development manager of the Trust, the project manager and the quality assurance adviser. It was set up with the knowledge of social services but not their participation. In October 1995 the internal inquiry interviewed the responsible medical officer, the senior registrar, the head of specialty, the charge nurse, the keyworker, an enrolled nurse and a social worker. Their recommendations were set out in their report dated 14 November 1995. Both the transcripts of their evidence and their report were made available to the Independent Inquiry.

Section 2: Appointment of the Independent Inquiry

1. In May 1994 the Department of Health issued guidance on the discharge of mentally disordered people and their continuing care in the community in HSG(94)27, which included the requirement that there should be an independent inquiry after any incident of homicide committed by a patient of the specialist mental health services.

   Between October 1995 and February 1996 discussions were held between Avon Health Authority and the NHS Executive on the formal requirements and practical arrangements for an Independent Inquiry. On 11 March a meeting was held between Avon Health Authority, representatives of Frenchay NHS Trust and Avon Social Services to agree the principles and Terms of Reference for the Inquiry. These Terms of Reference are shown on page iv.

2. In June 1996 Avon Health Authority appointed Professor Bridgit Dimond as Chairman of the Independent Inquiry, and this was followed by the appointment of the other three members - Dr Paul Bowden, Consultant Forensic Psychiatrist at the Maudsley Hospital; Mr Roy Holden, retired Clerk to the Justices for Cheltenham and Vice-Chairman of Gloucestershire Community Health Council; and Mr David Sallah, former Senior Nurse Manager at the Reaside Clinic, Birmingham. Dr Michael Vousden, Corporate Services Manager at Avon Health Authority, was designated Clerk to the Inquiry. In September, Mr Richard Lingham, former Director of Social Services in Cornwall, was co-opted to provide specialist advice on Social Services issues.

3. The Panel agreed the procedure shown in Appendix A. Witnesses were invited to provide statements in advance of their interviews and most took advantage of this opportunity. All witnesses were provided with transcripts of their evidence and invited to revise them if any errors had been made. This report is based upon the statements of those witnesses, their evidence given to the Panel and the records, procedure, policies and other documentation made available to the Panel. In addition the Panel visited Clifton Ward in Southmead Hospital and Fromeside Clinic.

4. Two matters caused delays to the progress of the Inquiry: the issue of consent by Ms B to the release of her records and delays in arranging interviews with Social Services Officers.

CONCLUSIONS

5. Almost two months elapsed before consent to access the relevant records was obtained. Had Ms B not eventually agreed to the release of her records to the Inquiry, the investigation would have been severely delayed in view of the reluctance of those authorities holding the records to release them to the Inquiry on the grounds of the public interest. It must be emphasised that these authorities were acting in the interests of the confidentiality of the patient. In the absence of Ms B's consent it would have been necessary for the Inquiry to have sought an order from the court for access to the relevant records (see Section 22).

6. Some six weeks' delay in the Inquiry's work was caused by the accommodation of the wishes of officers of Bristol City Council that they should control any access by the Panel to witnesses who had been employees of the by then defunct Avon County Council. Initial delay also seems to have been caused by the difficulties of the transfer of information and responsibilities from the former Avon Social Services Department to the new unitary authorities established on 1 April 1996.

7. The Panel also found the repeated requests for information from Social Services that either had already been provided or could quite easily have been asked for earlier in the process of its work a frustrating and unnecessary cause of delay.

Section 3: Health and social services in Avon in 1994/95

1. In 1994 health services in the County of Avon, with the exception of Bath, were the responsibility of Bristol and District Health Authority. The Health Authority, with a resident population of 820,000, had been created on 1 October 1991 from the three former health authorities: Frenchay, Southmead, and Bristol & Weston. The District contained four district general hospitals - in central Bristol (Bristol Royal Infirmary); north-east Bristol (Frenchay Hospital); north-west Bristol (Southmead Hospital); and in the extreme south-west of the district, at Weston-super-Mare. The four acute and community Trusts created in 1991 and 1992 were based on these hospitals and their service hinterlands. Thus, hospital referral patterns and the deployment of community services from Trusts maintained catchment areas broadly similar those of the former health authorities.

2. All four Trusts provided a range of in-patient and community-based mental health care, with some services for residents on the District's eastern boundaries being provided by the Bath Mental Health Trust. A specialist learning difficulties Trust provided mental health care across the district for people with learning difficulties. Forensic mental health services for the district were provided from Frenchay's Blackberry Hill Hospital site, which included the Fromeside Clinic.

3. Frenchay Healthcare NHS Trust provided mental health services for the north-eastern part of Avon, as well as general forensic psychiatric services for the other three Avon Trusts. Fromeside Clinic is the Regional Secure Unit for the former counties of Avon, Gloucestershire and Somerset, providing a level of security intermediate to that of general psychiatric wards and that of the special hospitals, such as Broadmoor. The Clinic opened in October 1988 in a purpose-built unit providing facilities in two self-contained wards: Ward 1, with a high level of security, and Ward 2, with a less secure regime to aid patients in the transfer to open psychiatric wards or rehabilitation in the community. In addition to 30 medium-secure beds at the Fromeside Clinic, the Trust provided 10 open forensic beds and 5 forensic rehabilitation beds at Blackberry Hill Hospital, adjacent to the Clinic.

4. Until 1992, Southmead Health Services NHS Trust provided its general in-patient mental health services at Ham Green Hospital and, by contract with Frenchay, at Glenside Hospital. In December 1992 the Trust brought all these services together in a purpose-built mental health unit on its main site at Southmead Hospital. This consisted of three wards of 20 beds each. Each ward was associated with one of the three consultant-led community mental health teams that covered the three geographically-defined sectors of the Trust's service area. A fourth ward provided 12 rehabilitation beds for all three sectors and there was a day unit for longer-term care and rehabilitation elsewhere on the main Southmead site. Also located within each geographical sector was a day hospital, providing out-patient clinics and therapeutic day services. Clifton Ward, Marine Hill day hospital and the south-sector community team covered the southern sector, which included Portishead where Ms B lived.

5. In 1995 the operational division of the County of Avon Social Services Department was hierarchically organised under the Assistant Director (Operations). Beneath the Assistant Director were six Area General Managers, covering three central areas clustered around Bristol and three peripheral areas covering the remainder of the county. Each area was sub-divided into three service units, each covering a defined geographical area with teams for different aspects of services - such as child care, adult care and mental health. The managerial hierarchy thus progressed from

director to assistant director, area general managers, service managers and team managers.

6. On 31 March 1996 Avon County Council was dissolved and the services were transferred to four new bodies: Bristol City Council, North Somerset Council, South Gloucestershire Council, and Bath and North East Somerset Council.

7. Also on 31 March 1996, Bristol and District Health Authority was dissolved and its responsibilities assumed by the newly created Avon Health Authority. Any references in this report to "the Health Authority", "Avon Health Authority" or "the Purchaser" relating to periods before 31 March 1996, are to be construed as references to Bristol and District Health Authority.

Section 4: Background

CONCLUSIONS

1. Ms B's account of her early life has inconsistencies in that she gives conflicting accounts of the same events; it is also unreliable in that it is at variance with the consistent account provided by others. We can only conclude that her illness has caused her to distort her recollection of past events and feelings. There are dangers, therefore, in relying solely upon her account of the events which took place.

2. Her psychiatric illness developed over a few weeks and following contact with her GP she was assessed competently and referred to specialist psychiatric services speedily and efficiently.

Section 5: Ms B's care at Southmead

CONCLUSIONS

1. Irrespective of its effect on others, Ms B's psychosis induced great fear and distress in herself; the particular abnormal mental experiences which she suffered raised the issue of both persisting and serious risk to herself and others.

2. Ms B's initial assessment was accurate and efficient. The Consultant Psychiatrist was accessible and played a major role throughout Ms B's stay at Southmead.

3. However, the strategies employed at Southmead both to treat the mental disorder and to manage the risk were responsive rather than pro-active. Failure to impose a management plan is most evident in two areas. Firstly, pharmacological control of Ms B's psychosis by ensuring compliance and employing full dose ranges was not achieved. There was no consistency in giving depot neuroleptics and medication given for periods of leave was possibly not taken. It is appreciated that a balance has to be struck between compliance and compulsion of the patient in taking medication and the Inquiry would not criticise the attempt to secure her consent to the medication. However, there is no evidence of a clear treatment plan. Secondly, it is clear that for several months Ms B was not safely contained physically. Many risks were taken, without calculation. It is clear that Clifton Ward did not have the physical resources to contain a patient presenting these challenges, but the Regional Secure Unit would probably not have taken her at an earlier stage.

4. Ms B behaved repeatedly in a way which created a risk of serious harm both to herself and others. It was understandable that the ward team should attempt to secure a co-operative alliance with Ms B and her family and boyfriend. However, the family and boyfriend were asked to undertake responsibilities which were both beyond their abilities and a source of conflict for them.

Section 6: Ms B's care at Fromeside

CONCLUSIONS

Diagnosis

1. Ms B had a good pre-morbid personality.

2. Between May and August 1994 she developed paranoid ideas associated with considerable fear and apprehension. It is possible that these thoughts and feelings were preceded by a belief that she had been abused by her father.

3. When examined in late August 1994 she was agitated, preoccupied (on religious and moral themes) and restless. Her speech was garrulous, with long pauses. Her mood showed fear and suspicion, and her affect was perplexed. She held a variety of poorly systematised abnormal beliefs in relation to her environment (delusions of persecution) and believed that her life was at risk.

4. Over subsequent months her delusional beliefs became more systematised, and auditory hallucinations a more prominent feature of her mental state. Her mood remained abnormal with great anxiety and perplexity. She showed pronounced emotional incongruity. Behavioural disorders were present in the forms of speech stereotypy and dangerously impulsive behaviour.

5. When interviewed at Broadmoor Hospital in January 1997, Ms B continued to allege that her father abused her sexually, and she said that since mid-1994 she has never wavered in this belief. She has no memories of actual abuse and bases her conviction on two factors: her interpretation of other events as confirming her belief; a deep conviction that it must have taken place. She said that the effects of the abuse had been to make it difficult for her to make relationships and trust people, and to make her introverted, shy and withdrawn.

6. Ms B had been treated with Clozapine for the few months preceding the January interview, and she complained of typical side-effects. Her medical notes reveal that mostly she does not accept that she has been mentally ill, and whilst there was no evidence of new delusional ideas, she continues to believe in the truth and reality of the abnormal ideas and perceptions which she experienced prior to her admission to Southmead and subsequently. Her affect (being her emotional response to herself and her environment) was flat (lacking in depth and repertoire) and inappropriate (to context and circumstances).

7. The most likely diagnosis is of schizophrenia.

8. Etiological factors include: the family history of mental disorder, life stresses and, possibly, substance abuse.

Care at Fromeside

9. Following her admission, Ms B's medication dosage was increased over a period of six weeks before control of her psychosis was achieved.

10. Up until early June 1995 the clinical team were well aware of Ms B's dangerousness, the need for planned discharge and for accommodation somewhere other than at her parents' home. However, from July Ms B largely controlled her contact with staff at Fromeside and other mental health workers (see Sections 10 and 13).

11. Although substance abuse featured for a long time in Ms B's diagnostic formulation there was no drug screening at Fromeside (see Section 15).

12. There were conflicting assumptions about the role the different social workers were playing (see Section 9).

Section 7: The family

CONCLUSIONS

1. The development of severe mental illness in a young adult can have a devastating effect on parents, siblings and other close family members. It is often very difficult to understand the emotional experiences of the sufferer and to distinguish between what is real and true, and what is not. Suddenly finding a family member exhibiting grossly disordered thinking and behaviour, and detained with other similarly distressed individuals evokes a variety of conflicting responses: of wanting to wrest care and control from others, and not being able to manage; of taking sides in situations where there appears to be conflict.

2. In this case there was the additional allegation of sexual abuse which involved Police enquiries.

3. Unable to manage Ms B's escalating dangerousness, Southmead took the unusual step of transferring a young woman, with her first episode of psychosis, to the Regional Secure Unit where male patients were in the vast majority (see Section 17). There she continued to be very difficult to manage for some time.

4. Mr and Mrs B were very concerned and involved parents, but on many occasions relationships within the family attracted comment from psychiatric staff. Given the family's attitude to attempts at therapeutic intervention it would be difficult to have changed the frequent meetings into anything more structured and positive.

5. There appeared to be differences between the parents in their attitudes to the dangers presented by Ms B. Mrs B frequently expressed her fears and concerns to staff at both hospitals and this is recorded in the nursing records. Mr B appeared not to have any fears for his own safety and in contrast to his wife placed considerable pressure on staff to permit leave of absence for his daughter to come home.

Section 8: Allegations of abuse

CONCLUSIONS

1. Clearly the Inquiry cannot judge the veracity of Ms B's allegations, or choose between what is fact, false memory, memory distortion, memory falsification, or a product of a combination of these and other factors.

2. For the most part, Ms B's belief that the abuse was real caused her great suffering. Whatever the origin of her beliefs, they were sometimes associated with other material which was clearly part of her psychosis.

3. The abuse allegations were never understood psychologically, nor were they addressed in a therapeutic way when some control had been achieved over Ms B's psychosis.

4. From the onset of her illness Ms B was distressed by others' interpretation of her allegations of abuse as evidence of illness. Furthermore, she was more than aware that speaking of certain matters was likely to prolong her stay in hospital.

5. If Ms B's belief that she had been abused was a product of her psychosis, the fact that she persisted in the claim was never interpreted as evidence of continuing mental ill health. If, on the other hand, it was based on fact, there was a failure to develop an appropriate care plan at a time when she was considered to be in remission, yet was still referring to the abuse (see Section 13).

6. Mental health staff at Southmead Hospital implemented the policy for dealing with abuse allegations by ensuring a visit on several occasions by the Police Child Protection Unit. At Fromeside Clinic there was no clear policy for dealing with the allegations of abuse; there was no clear decision taken by the Multidisciplinary Team and no lead taken by the RMO. There were many privately held individual views but no concerted plan of action. When rehabilitation on Ward 2 was underway, no discussions with the parents took place and no care plan was initiated on the abuse issue.

Section 9: County of Avon Social Services department

CONCLUSIONS

1. Mrs W, although an experienced approved social worker, had no previous involvement with Fromeside or knowledge of the clinic's operational methods, but had worked with patients who had previously been in Fromeside. She was not aware of Mrs F's limited experience as a recently qualified worker. Mrs F's experience did not include Care Programme Approach methods and procedures of the kind with which Mrs W was familiar. Social Services had been concerned about gaps in the Section 117 procedures which should have operated at Fromeside. Ms L, who was also new to Fromeside and its methods of working, had been pressing for improvements in discharge planning and after-care since June 1995.

2. In the period before home leave commenced, the records kept by the two social workers show very little overlap. They do not appear to have routinely copied their notes to each other, although this could have illuminated their mutual understanding of Ms B's progress, her movements and the evolving intentions for her continuing care. Their sharing of information and views seems mainly to have been by word of mouth.

3. Mrs W's records include fewer details of family dynamics and of the parent's views and actions when Ms B was at Southmead and Fromeside than what Mrs F recorded her as saying.

   The care team meeting on 26 April 1995 appears to have been something of a turning point for both social workers. Mrs W had on 24 April expressed to Mrs F her feelings of caution regarding the pace of change in Ms B's treatment and care planning. This was relayed by Mrs F in her memo to Dr D.

   Mrs W was not invited to the care team meeting held on 26 April, neither was she included in the circulation list for the notes of that meeting. She did not take part in multidisciplinary discussions until the care planning meeting held on 11 July, which was attended by herself, but not Mrs F. By that time the pattern of overnight leave with the parents, which did not call for community involvement, had started on 23 June. The notes of the care planning meeting made no mention of leave.

4. By 15 May it was Mrs F who expressed reservations to Dr D and the OT regarding the continuing pace of change, but by mid-June she was clearly reassured by Ms B's progress. In August Mrs F passed on to the MDT the request of Ms B to increase work and overnight leave. The MDT decided to wait for Dr D's return from leave before agreeing to increase Ms B's leave and work days.

5. The expectation on 22 June was that the allocation of council housing for Ms B would take some time after Mrs W had helped her to contact the Housing Department. By 28 July Mrs F was surprised at the fact that the timescale had been truncated by Ms B and her boyfriend finding accommodation for themselves. The implications of this in terms of community support were not recognised by the social workers or the MDT.

6. On her return from leave on 14 August, Mrs W found that Ms B had secured her own accommodation and had started to live there. To this extent the tasks set for her at the case review on 11 July had been overtaken by events. When she subsequently spoke to Dr D on 25 August it appears that no additional tasks or concerns

were identified, but it is not clear whether Dr D was aware that the last time Mrs W had seen Ms B was 11 June and that she had had no contact with her and/or her parents since 28 July 1995.

7. The two social workers at Fromeside were at the time of writing their contributions to the Clinic's 1995/6 annual report clearly expressing concerns about the definition of their role within the Multidisciplinary Team, their linkages with the rest of the Social Services, their training needs and the importance of reviewing their work in a structured way. These concerns were restated in the clearest terms by their manager, Ms L, during 1996, and although they were discussed with her area manager, Mr G, we can find no evidence that these matters had been tackled by senior management in Avon Social Services. It should be noted that during 1995 and 1996, Social Services were caught up with planning and implementing the reorganisation in local government which took place in April 1996.

RECOMMENDATIONS (see also Section 11)

8. Bristol City Social Services Department should without delay review whether its operational policies for social workers at Fromeside Clinic do in fact facilitate their contribution to multidisciplinary team-work and provide clear communication routes to Social Services departments in Bristol and elsewhere in the region.

9. Those policies must clearly define the arrangements when Fromeside social workers are appointed as keyworkers and for the transfer of those responsibilities to social workers in the community, including social workers employed by other social services departments.

10. Social workers who are appointed as keyworkers should attend MDT meetings at Fromeside Clinic to receive appropriate information and briefing on the tasks involved in the community support/supervision of patients following discharge. That information should be incorporated in CPA/Section 117 discharge documentation and noted in MDT meeting minutes.

11. The establishment of social workers at Fromeside should be kept under review by Bristol City Social Services Department in discussion with Frenchay NHS Trust to define the number, skills, experience and continuing training needs for the clinic's social work staff. If there are resource issues which extend beyond the boundaries of Bristol City Social Services, they should be defined and discussed with the other Social Services departments in the South West.

Section 10: Monitoring of Section 17 of the Mental Health Act 1983

CONCLUSIONS

Southmead

1. There is evidence that the Responsible Medical Officer was too responsive to the father's and Ms B's own demands in permitting leave of absence. Leave of absence appeared to be granted on occasions when her mental state would appear to be a clear contraindication (for example, 14 October 1994 and 29 November 1994).

2. The guidance in the Code of Practice on the Mental Health Act 1983 on the documentation of leave of absence was not always followed.

3. There were repeated occasions when she went absent without leave and staff were unable to prevent her running away from the unit.

4. The physical facilities of Clifton Ward were not suitable for detaining a patient in the mental state shown by Ms B in November and December 1994. She was cared for on an open ward which had no secure area. The Code of Practice on the Mental Health Act envisages that in extreme circumstances an open ward could be locked at the discretion of the nurse in charge and subject to clear procedures (paragraph 18.25). The absence of secure facilities presented staff with considerable problems of containment. The evidence presented by Dr W was that the RSU would not have taken Ms B earlier. There is therefore a need for interim accommodation between an open ward and a regional secure unit.

5. Her unauthorised absences were sometimes colluded in by her father.

6. Her mother did express concern to the nursing staff of the dangers which Ms B presented, but these did not seem to be appreciated by her father who continued to press for leave for his daughter.

7. In the light of the extremely dangerous events which occurred during her stay at Southmead, it is fortuitous that a tragedy did not occur earlier (see Section 5 Conclusions).

Fromeside

8. Initially very tight control was exercised, then after the final leave form of 10 July 1995 it was with minimal restrictions. Although this was the responsibility of the RMO, withdrawal of Section 17 leave was in practice, dependent upon the keyworker in association with the MDT.

9. The first few forms circled community service involvement as being not required. This is also true for the last part of leave; it shows that no support was considered to be necessary in the community.

10. There was an absence of a systematic process of monitoring in place:

- There were no formal criteria which staff had to check out to monitor the leave.

- The RMO was prepared to leave the monitoring to the nursing staff who do not appear to have been given specific guidance.

- The RMO was aware that the team had to be intrusive in obtaining information from Ms B and that any monitoring had to be done in a very proactive way.

- Although there were two CPNs attached to the unit, there were no appointed keyworkers monitoring her in the community.

- There was no contact between ward staff or community staff with employers to ascertain how she was coping; although Dr D had left a message with the employers asking them to contact her if there were any problems.

- The only monitoring which took place was on the ward or in the OT department. The nursing staff drew attention to the fact that there was insufficient time for monitoring, but no action followed this concern.

- There was an assumption that if psychotic symptoms were beginning to present then they would be obvious at a superficial level.

- There was an assumption that the trained nurse would notice a change in mental state from a relatively superficial observation.

11. The RMO was aware of the pressure that Ms B was exerting to speed up her progress in terms of her own outcomes.

12. The MDT took some action to control the situation; thus they were not prepared to permit increased work and leave until the senior registrar returned from annual leave.

13. The failure to implement Section 117 arrangements and the Care Programme Approach (CPA) meant that monitoring at ward level would have a higher significance than would otherwise have been the case (see Section 11).

14. After 11 July and during August there was no recorded contact with the family, friends or employers, except with the social workers over housing.

15. The MDT was not well placed to monitor any subtle signs of relapse.

16. The reduction of medication in August occurred at a time when she was not being closely monitored.

RECOMMENDATIONS TO SOUTHMEAD NHS TRUST

17. There should be a review of the policy for granting Section 17 leave and a clearly defined procedure for dealing with patients who regularly abscond.

18. A strategy should be developed for caring for those patients who present challenging behaviour, so that the limits of the capabilities of containment and care within Clifton Ward are clearly defined. Consideration should be given to the introduction of secure facilities at Southmead Hospital.

19. The guidelines of the Code of Practice of the Mental Health Act 1983 in relation to the documentation of Section 17 leave should be properly implemented and regularly monitored.

RECOMMENDATIONS TO FRENCHAY NHS TRUST

20. A systematic procedure for undertaking monitoring whilst the patient is on Section 17 leave must be introduced.

21. Planned therapeutic interventions for patients who are more difficult to monitor, accompanied by the training of staff who are to undertake the monitoring, and audit to ensure that the monitoring is being correctly implemented should be introduced.

22. Section 117 procedure and CPA should be introduced before Section 17 leave begins. (The policy has now been implemented.) (See Section 11.)

Section 11: Section 117, the Care Programme Approach and Supervision Registers

CONCLUSIONS IN RELATION TO SECTION 117 PROVISIONS

1. There was a failure to follow the recommended procedure on introducing Section 117 planning when extended leave commenced. There is no evidence that Section 117 thinking was in place when Ms B was enjoying substantial extended leave.

2. As a result of this failure to implement Section 117, there was confusion about roles and responsibilities.

3. The interviews with Mrs W and with Mrs F showed that neither had taken on the full Section 117 care of Ms B.

4. Mr G, the Social Worker Manager of Mrs F's Team Manager, was of the view that Mrs W had been appointed as keyworker and that the Social Services Team at Southmead were undertaking community responsibilities in relation to Ms B's care. Mrs W's manager saw Mrs W as having only an observation role together with specifically agreed tasks until the Section 117 meeting had been held.

5. Members of the MDT made assumptions about the support that Ms B was receiving in the community which were not based on fact; for example, the RMO assumed that the Woodspring Social Worker was liaising with Ms B and the family when the family were refusing any contact until Ms B was discharged.

6. Mrs F assumed that a CPN was in contact with Ms B when none had been appointed; a confusion possibly caused by the fact that the named nurse or keyworker on the ward was a CPN prior to her work on the ward.

7. The Panel considered it would have been appropriate for the MDT to have recommended home visits by the social workers and this was not done.

8. The MDT failed to consider the appointment of a keyworker in the community for Ms B before extended leave commenced or at any point thereafter. There were two CPNs attached to Fromeside who would have been available to provide monitoring in the community at that time. No suggestion was made by the MDT that their services could be used.

9. There was an assumption that the Southmead Community Mental Health Team would be taking over responsibility for her, yet they had not been invited to become involved in her care: Ms B's named nurse at Southmead Hospital had ceased to attend meetings following her transfer to the management of Frenchay (Section 19 Mental Health Act 1983); no detailed involvement of Southmead was taking place; Mrs W did not attend the case conference on 11 July as a keyworker.

10. The original plans to discharge Ms B to Southmead were changed without the full implications of this being taken on board. Some of the Team were working until quite late on the assumption that she would be discharged through Southmead Hospital. The original decision changed without any explicit decision by the MDT. There was a wide variety of views as to the intended discharge plan. No clear planning was made or recorded. The changed situation of Ms B, being back in work and living in a flat, meant it was less appropriate for her to be discharged to Southmead Hospital, especially as the Mental Health Team based there had not

been involved in her care after March. It could be said that the Team 'were pushed into the discharge plan in a sense, but ... were happy to go along with it given the clinical presentation' (Dr T). It was clear that Ms B was doing the pushing.

11. The statutory requirements under Section 117 to plan after-care services in conjunction with the voluntary sector were not fulfilled.

12. All planning, thinking and the strategy to be adopted was suspended and awaited the meeting which was planned for 6 September 1995.

13. The Social Services were aware that there were failures in following Department of Health guidelines on Section 117. There is no clear evidence that this was drawn to the attention of senior management in Frenchay.

14. In failing to implement the guidance in the Code of Practice (on the holding of a Section 117 meeting before Section 17 leave starts), the MDT did not put themselves in the situation where any signs of continuing psychosis could have been observed. It cannot be said that had the guidance been implemented, the homicide would not have occurred.

CONCLUSIONS ON THE CARE PROGRAMME APPROACH

15. Avon Health Authority, as the Purchaser, required Frenchay Healthcare Trust, the Provider, to implement the Care Programme Approach.

16. Frenchay Healthcare Trust notified the Purchaser that the CPA was not fully implemented.

17. The RMO was of the view that the philosophy of the CPA had been in operation for many years in the clinic; all that was missing was the documentation. He saw the principal characteristics as being: 'that it is patient-centred, patient-needs-led and having identified individuals doing identified tasks with that patient during the course of their care in specialist services'.

18. Dr R also was of the view that the philosophy of the CPA had been in existence for a long time, all that was missing was the documentation.

19. There was little evidence that the principles set out by the RMO were in operation in Ms B's case:

- there was only superficial monitoring of her needs (including her behaviour and her mental state);
- there were no identified individuals monitoring her care in the community;
- there was no CPN appointed to monitor her;
- there was confusion over the roles being played by the social workers which formal implementation of CPA principles would have avoided.

20. The RMO failed to appreciate the assistance which the formal adoption (including the documentation) of the CPA principles would have provided for the MDT, including the social workers, whose professional roles are supported by a reliance on more formal mechanisms.

21. The fact that during the latter part of July and throughout August Ms B was effectively an out-patient spending more time off the ward than on the ward did not result in the bringing forward of the principles of the kind expected by the CPA. The Section 117 meeting was arranged for 6 September, the earliest date when all could have been together. In the light of the extended leave granted to Ms B after June, the July conference should have been organised as the Section 117 meeting.

22. Assumptions were made by doctors as to the role social workers were taking which were not based on fact.

23. Assumptions were made about the involvement of Southmead Mental Health Team which were not correct. The inexperience in working in Fromeside Clinic of the Woodspring Social Worker who was used to a formal CPA policy and its implementation, and her failure to understand that the formal CPA was not in being in Fromeside, led to her not realising that staff considered her to be the lead social worker monitoring Ms B in the community, because she was helping Ms B obtain accommodation.

24. The formal use of the CPA in July in the care of Ms B would have ensured clearer identification of responsibilities, clearer definition of the function of the Southmead as compared with the Fromeside staff, and would have identified gaps in Ms B's care.

25. Social Services were aware of the deficiencies in the implementation of the CPA but were unable to bring about changes at the clinic.

CONCLUSIONS ON SUPERVISION REGISTERS

26. Government guidance placed a duty on Purchasers to have in place contracts which required Providers to draw up and maintain Supervision Registers.

27. The Avon Health Authority service specification required Frenchay Healthcare Trust to keep and monitor the use of Supervision Registers.

28. Nursing staff told the Inquiry that a Supervision Register for Fromeside was not in use in 1995.

29. The Purchaser had been made aware that patients were not being placed on the Supervision Register.

30. A meeting of managers and clinicians from Frenchay's Mental Health Directorate with representatives of the Department of Health and the NHS Executive was held from which the NHS Executive were satisfied that the policy of Supervision Registers was in place, but the consultant psychiatrists at Frenchay Healthcare Trust were atypical in exercising their clinical judgement since no one was placed on the Register.

31. The RMO considered that the Supervision Registers were in place; individual consultants were assessing, but no one was on the Register. Both consultant psychiatrists interviewed were of the view that the guidance should be amended before the use of Supervision Registers by them personally was appropriate. They claimed to base this view on ethical and practical principles.

32. If the Care Programme Approach had been implemented once Ms B had commenced extended leave under Section 17, and the guidance on Supervision Regis-

ters had been implemented, then discussions would have taken place about her being placed on a Supervision Register well before 6 September 1995.

33. Dr T stated that this would have been the concern of Southmead, not Fromeside, if she was going back to be under the responsibility of their Community Mental Health Team. However, the use of a Supervision Register in relation to Ms B's care had not been discussed with the consultant psychiatrist at Southmead.

34. The 'there is a Register, but no one is on it' policy could only be confusing to staff.

35. The Department of Health, the Purchaser and senior management in Frenchay Healthcare Trust appeared to be incapable of taking effective action in this matter.

GENERAL CONCLUSIONS ON SECTION 117, CPA AND SUPERVISION REGISTERS

36. The senior medical management at the Fromeside Clinic appeared to take the view that with regard to specific government policy and national guidance they were either already doing what was appropriate in terms of patient care (CPA), or were using individual professional judgement, which in effect meant that guidance was not being implemented (Supervision Register).

37. They had not taken on board the effects of this attitude on the rest of the Multidisciplinary Team, particularly the Social Services Officers, whose work would have been facilitated by a more formal compliance with government guidance and the necessary documentation.

38. There was a consequential failure to train staff in the implementation of these policies and to introduce the necessary documentation.

39. The quality of care provided for Ms B in terms of monitoring, supervision, control, communication between professional staff and communication with family, friends and employers would have been enhanced at the time that she was enjoying extended leave, if government policies, and in particular the guidance in the Code of Practice on the Mental Health Act (Section 117), had been implemented in relation to her management.

RECOMMENDATIONS TO FRENCHAY NHS TRUST AND AVON HEALTH AUTHORITY

Section 117

40. The Section 17 policy has now been amended to ensure that Section 117 planning takes place before extended leave commences. There should be regular monitoring of the implementation and effectiveness of this policy.

41. Where the RMO decides that there should be direct discharge from the RSU into the community, this should be the result of clear explicit decision-making in conjunction with the MDT in accordance with the CPA guidance.

Care Programme Approach

42. Urgent steps should be taken to ensure the full implementation of the CPA in the Fromeside Clinic.

43. The Purchaser should ensure that government guidance is implemented.

44. A mechanism should exist to assist staff in bringing to the attention of senior management the implications for them if government guidance is not implemented.

Supervision Registers

45. The Department of Health's guidance on Supervision Registers should be implemented at the Fromeside Regional Secure Unit at least in respect of the mentally ill patients who meet the criteria. The issue as to whether the Supervision Register should include those suffering from a personality disorder should be resolved in discussions between the Department of Health, Avon Health Authority as the Purchaser and senior management at Frenchay Healthcare Trust and the Fromeside Clinic.

46. Avon Health Authority should ensure that policies are clearly implemented.

47. Patients should be assessed for supervision before extended leave starts.

Section 12: Criticisms by family and friends

1. During the hearing, criticisms were made to the Inquiry, both in writing and by word of mouth, by family and friends about the care Ms B had received in both Southmead and the Fromeside Regional Secure Unit. These were put before the relevant witnesses for their response.

CONCLUSIONS

Southmead

2. Criticisms were made by Mrs B at the time of Ms B's stay about her dangerousness and fears for the safety of the family. These criticisms were linked to the fact that Ms B had considerable absence both with and without leave.

   The Panel accept the validity of these criticisms and consider that inadequate precautions were taken to prevent Ms B absconding whilst under section.

3. Other criticisms related to the open regime of Clifton Ward and the ease of access for visitors. Criticism was also levelled at the inability to distinguish between staff and patients and the apparent ease with which illegal drugs could have been brought in. These criticisms are not accepted. It is probable that in being unable to distinguish between staff and patients, the complainant was unaware of the extent to which she was observed.

4. Criticisms were also levelled at the lack of information which was given to the family. These criticisms are not accepted:

   ■ The evidence from the records shows that immediately after her admission to Southmead, Ms B did not wish the hospital staff to make contact with her parents.

   ■ After this initial stage, it is evident from both the medical and nursing records and the evidence given by the staff that there was considerable contact between the Multidisciplinary Team and the family. It is clear that the main point of contact with the family was perceived as being the father and it is not clear how much information he passed on to the rest of the family.

   ■ The criticism that insufficient information was given about Ms B's diagnosis could be seen as an understandable caution of the medical staff in making a firm conclusion on a specific diagnosis and prognosis.

   ■ The fact that Ms B's partner did not have sufficient information is seen as a reflection of the fact that he was not perceived by the staff as having a significant role to play. This is understandable at that stage in the care of Ms B.

   ■ The trauma faced by a family following the diagnosis of mental illness in the family may lead them to expect more information in the initial stages than staff are able realistically to give; they are also likely to have an unrealistic view of the ability of the Multidisciplinary Team to identify diagnosis, risk and prognosis.

Fromeside

5. The main criticisms are centred on the failure to monitor Ms B's condition after the reduction in medication in late August. This is considered in detail in Sections 10, 11 and 13 of this report.

6. Criticisms were also made about the lack of information, relating to both her condition and the risk which she presented. These criticisms were partly made in the mistaken belief that paranoid psychosis and voices were of special significance.

7. There are problems relating to the disclosure of information:

   ■ The patient is entitled to have information about her condition kept confidential, unless she consents to its disclosure or unless there are legally recognised grounds which do not require the duty to be kept.

   ■ Mr B was probably the main link with ward staff and he may not have passed on to his wife or his daughter's partner the full details of what he was learning from the ward staff.

   ■ The significance of Ms B's partner as the main carer was not appreciated until late on.

8. Booklets were available and these were not specifically handed out to the family.

9. Criticisms were made by Ms B's employers that more information could have been given to assist them in her support.

RECOMMENDATION TO SOUTHMEAD AND FRENCHAY NHS TRUSTS

10. There is considerable advantage in giving information in booklet form to the relatives which explicitly recognises the early difficulties in diagnosis, prognosis and the assessment of risk and indicates where further information may be obtained. The information should make clear that the adult mentally competent patient has the right to refuse to give consent to disclosure, subject to any exceptions recognised in law.

Section 13: Risk assessment, management and monitoring

CONCLUSIONS

Southmead

1. All patients at Southmead considered unsuitable for the Regional Secure Unit were, as a matter of policy, managed on open wards irrespective of clinical need.

2. Until effective pharmacological control of Ms B's illness was achieved the decisions to both manage her on an open ward, without access to secure facilities, falling short of that available in a RSU, and to allow her extended periods of leave was a risky one which could not be accurately quantified because the information on which the decision was based was inherently unreliable.

3. It is appreciated that it was not possible to reach a collaborative working relationship with Ms B. A care plan could not be implemented because Ms B was neither a reasonable nor a dependable person.

Fromeside

4. The documentation shows a thorough process of identifying problems to be addressed in the early months of her stay and the care plans were reviewed at the requisite intervals.

5. It was often unclear who in the Multidisciplinary Team was to action plans which were developed to tackle identified needs.

6. Care plans were nursing-orientated. They were brought to the ward round weekly, but they were seen as nursing plans rather that the plans of the MDT.

7. There was little structured multidisciplinary risk assessment and management after May 1995.

8. The MDT was concerned that a reduction of leave could be seen as a backward step in her progress. However, it was aware of the importance of and the difficulties in monitoring Ms B and failed to ensure that appropriate action was taken.

9. On the morning of the 29 August 1995 there was a clear instruction at the handover that Ms B was to be spoken to (presumably for the purposes of assessment), but this was not undertaken.

A POSTSCRIPT ON RISK ASSESSMENT

10. In 1996 the Royal College of Psychiatrists issued a booklet, *Assessment and Clinical Management of Risk of Harm to Other People.* Part of that document is summarised here and its principles are applied to the written material concerning Ms B.

    ■ Risk cannot be eliminated and neither can outcomes be guaranteed; most assessments have a short-term applicability and need to be reviewed frequently; risk can be both general and specific; interventions may not have the effect they were intended to have, sometimes the reverse; information on which assessments are based should be validated; team assessments are better than

individual ones. Assessment of risk from the history: previous violence; poor socialisation; poor compliance or recent discontinuance of medication; substance abuse; identification of precipitant to relapse; recent severe stress, particularly loss.

- Assessment of risk from mental state: persecutory delusions; delusions of passivity (the mind or body being influenced by external forces); emotions related to delusions; specific threats. Management of risk: negotiate safety; implement care programme approach; use Mental Health Act; consider supervision register; provide information, support and help for carers; record assessment and management plan and inform others on a need to know basis.

CONCLUSIONS ON RISK MANAGEMENT GENERALLY

11. Ms B clearly presented a significant risk of serious harm to both herself and others (people known to her and those caring for her) between August 1994 and late March 1995.

12. In the history only her father's illness could be relevant as a loss factor.

13. The allegation of abuse could have been a persisting persecutory delusion, with an identified persecutor, and a significant emotional reaction to the belief.

14. Risk was not formally assessed. The CPA was applied in an unstructured and idiosyncratic way and the Supervision Register was not a real option.

15. The homicide was probably not predictable.

RECOMMENDATION TO FRENCHAY NHS TRUST

16. It is understood that Fromeside has now introduced a formal system for the assessment, management and monitoring of risk for all patients including those on Section 17 leave. It is recommended that this implementation and the effectiveness of this system should be regularly monitored.

Section 14: Multidisciplinary team working, the role of the keyworker and issues relating to management and policy making

CONCLUSIONS

Southmead

1. The Team worked together well. The Consultant was seen very much as the leader and there was openness between himself, his junior medical staff and the rest of the Multidisciplinary Team. However, two members of the Multidisciplinary Team felt that their observations and comments were not acted upon. Evidence given by the RMO was to the effect that he had taken into account these concerns.

2. The treatment plan did not reflect the dangers which Ms B was presenting.

3. We commend the dedication and persistence of the nursing staff in managing the very disturbed behaviour exhibited by Ms B in an environment which did not physically contain her (see Sections 5 and 19).

4. Support for staff who were handling this very challenging behaviour does not appear to have been provided in a systematic way at the time.

5. The Named Nurse is to be commended for the concern he showed for his patient and the extent to which he ensured that the attention of the Responsible Medical Officer was drawn to the dangers which his patient was presenting.

6. Documentation was clearly written and understandable, but there was no record of a multidisciplinary care plan. Only nursing care plans were in existence.

7. There was evidence of involvement of Ms B in the development of aspects of her care.

Fromeside

8. There was only one multidisciplinary team for the whole unit. The Fromeside Clinic did not operate on a dedicated individual clinical team basis. It is, however, considered that the clinic is too large a unit to enable a single multidisciplinary team to plan the care of each patient effectively.

9. It was found that some of the staff, who belonged to the MDT, had actually played very little part in the direct care of Ms B. Persons who had no personal professional contact with her during the last few months still considered that they were able to comment on her care and supervision. They did not, however, appear to take action appropriate to their concerns.

10. There was confusion about the role of keyworker, named nurse or primary nurse. There is a need in the light of the Care Programme Approach to redefine and clarify the role of these persons within the Multidisciplinary Team structure.

11. The three named nurses were conscientious in their care for Ms B. Their documentation reveals their analysis and updating of the care plans, regular contact and monitoring of her needs.

12. The transfer of Ms B from Ward 1 to Ward 2 was planned and implemented with considerable care.

13. The transfer from one named nurse (who was leaving the clinic) in July to a new named nurse was also thoughtfully and carefully planned.

14. There was, however, a failure by the Named Nurse and the Ward Manager to follow up concerns which they had properly documented and brought to the attention of the ward round and the doctors responsible. It is not sufficient to record concerns. Professional responsibilities require them to take these concerns forward until they are satisfied that the concerns are either adequately met or are unfounded.

15. Other members of the MDT also noted concerns but failed to fulfil their individual professional responsibilities in following them up.

16. Care planning, although discussed in team meetings, appeared to be based on nurse plans rather than true multidisciplinary planning.

17. Decision making within the Team in the latter stages was not clear.

18. A decision by the Fromeside Clinic MDT to take responsibility for Ms B's community placement was not clearly made, because the Section 117 meeting had not been held (see Sections 10 and 11).

19. A true unitary system of documentation was not in force. Some professional groups kept their own records. Social Services' records were kept separately. This resulted in poor interchange of information and impeded effective team working and appropriate care delivery.

20. Psychology had played a limited role given the complexity of Ms B's needs.

21. Community psychiatric nurses existed within the Fromeside Clinic but were not involved in the care of Ms B at a stage in her rehabilitation when such involvement would have been of considerable value.

22. No lead forensic psychiatrist was responsible for ensuring the effectiveness of the Fromeside Clinic and its future clinical development.

23. The RMO failed to appoint a substitute RMO during his leave. Decisions on Section 17 leave were left very much to the senior registrar as would be appropriate. Decisions on reduction of medication were also left to the senior registrar, in particular the reduction when the RMO was on leave during August.

RECOMMENDATIONS TO SOUTHMEAD AND FRENCHAY NHS TRUSTS

24. It is recommended that training should take place in multidisciplinary team working.

25. Such training should include the development of systems which enable staff to express their disagreements about the course of care delivery.

26. Unitary record keeping that is chronologically written by all professional groups will improve the quality of care for patients. We recommend that the Teams should develop a system of record keeping that is consistent with and will foster multidisciplinary working.

RECOMMENDATIONS TO FRENCHAY NHS TRUST

27. We recommend that a lead consultant psychiatrist is urgently identified to contribute to the multidisciplinary clinical and managerial development of the Fromeside Clinic.

28. We recommend that the current policy of a single multidisciplinary team for all patients should be reviewed.

29. We recommend that the role of keyworker, named nurse or primary nurse is defined, and their roles, training needs and responsibilities are clearly specified collaboratively with all members of the Multidisciplinary Team, and within the context of the Care Programme Approach.

30. We recommend that all policies are updated and a yearly review of all policies is undertaken by the Trust.

Section 15: Drug abuse

CONCLUSIONS

Southmead

1. Ms B admitted to a pre-admission history of drug-taking.

2. Early medical assessment took on board the possibility that she was suffering from drug-induced psychosis. This was never substantiated.

3. Routine screening was not undertaken which could have confirmed whether illicit drugs were contributing to her illness. Only one test is recorded as having been taken - on 15 November 1994 - and this was negative.

4. During the early part of her stay at Southmead she was given extensive leave and her Responsible Medical Officer failed to take into account the possibility that she continued to have access to illicit drugs.

5. A policy for personal searches came into existence in November 1995, but there is no evidence that a policy in relation to illicit drugs or personal searches existed at the time Ms B was on Clifton Ward.

6. Mrs B expressed her concern that her daughter was allowed to leave the ward unaccompanied as the parents were worried as to where she was going when she was away from the ward.

Fromeside

7. The multidisciplinary staff were aware of Ms B's history of drug abuse.

8. It was assumed that because she had been an in-patient for over four months prior to admission to Fromeside Clinic, she had ceased to be an illicit drug user. This assumption may have been unfounded because of the extensive leave which she received at Southmead.

9. She attended group sessions on substance abuse and appeared to realise the dangers of substance abuse.

10. Evidence was given that there was a policy in existence for testing for substance abuse, but there is no evidence that this policy was implemented in relation to the care of Ms B, since she was not perceived to be at risk.

RECOMMENDATIONS TO SOUTHMEAD AND FRENCHAY NHS TRUSTS

11. It is recommended that both acute mental health units should develop a multidisciplinary strategy on the use of illicit drugs. This strategy should include the development of clinical expertise and an understanding of the implications of illicit drugs. It should also provide training for staff in dealing effectively with the problems which illicit drugs present.

12. Care planning should take into account the possibility of illicit substance abuse.

Section 16: Violence and the prosecution of mentally disordered persons

CONCLUSIONS

1. Both at Southmead and Fromeside Ms B committed many serious attacks on staff and other people. The serious incidents on 22.12.94, 16.1.95 and 21.2.95 were reported to the Police. The Police decided not to prosecute. There is no evidence that the doctors responsible for Ms B put forward strongly the benefits of a prosecution in possibly leading to a restriction order. Doctors may feel that it is the Police and the CPS who finally take the decision in these matters, but if the indication is that a restriction order is necessary, the prosecuting authorities would take account of the views of medical staff. Similarly, when a judge decides on a restriction order the psychiatrist's report is of considerable influence.

2. While there are pressures to divert mentally disordered people from the criminal justice system, it seems right that the interests of the patient, staff and public are borne in mind. There is a lack of policy in these areas: what to do when an assault takes place; whether to consider the views or reliability of the complainant; the responsibilities of individual members of the MDT, which may be conflicting. There should be a clear view as to what should be done and by whom, with perhaps advice from the solicitors of the Trust. Where the victim is a member of staff, he or she should be supported by external agencies if prosecution is considered to be in the public interest.

RECOMMENDATIONS TO SOUTHMEAD AND FRENCHAY NHS TRUSTS

3. Counselling for the victims of assaults should be available from sources independent of the Unit (see also Section 18).

4. Where untoward incidents occur, decisions to be taken about contact with the Police should be governed by a clear policy. This should include guidance as to the person by whom such steps should be taken.

5. In arriving at the decisions to be taken in recommending a course of action, the interests of the patient, of staff and of the public should be borne in mind.

RECOMMENDATION TO NHS TRUSTS, THE POLICE AND THE CROWN PROSECUTION SERVICE

6. In serious incidents it should be a prime requisite to consider the advantages of giving a court the opportunity of making a hospital order coupled with a restriction order.

Section 17: Women in regional secure units

1. Following her transfer on 17 January 1995 to the Regional Secure Unit at Fromeside, Ms B was often the only female patient amongst 15 patients on the acute admission Ward 1. When she was later transferred to the rehabilitation Ward 2, the greatest number of women at the time she was there was three, but often with leave of absence, she was with only one or two other female patients out of a total of 15 patients. All those giving evidence to us about women in regional secure units agreed that the situation was far from satisfactory, but inevitable.

CONCLUSIONS

2. All witnesses who addressed the issue are in agreement that the situation relating to women in regional secure units is not ideal.

3. Staff at the clinic were well aware of the tensions and difficulties produced by the fact that Ms B was occasionally the only female patient on Ward 1.

4. The Multidisciplinary Team are to be commended on their sensitivity to the situation and the way in which they planned and implemented the care for Ms B in these difficult circumstances.

5. There is no doubt that even though Ms B herself, when interviewed at Broadmoor, dismissed any concerns about being the only female patient, there is evidence that the situation was clinically unsatisfactory and adversely affected her mental condition, and that she was herself not happy at the time.

6. On Ward 2 an area at the end of the ward was allocated for female patients. There did not appear to be a comparable area on Ward 1.

RECOMMENDATIONS TO AVON HEALTH AUTHORITY AND SOUTHMEAD AND FRENCHAY NHS TRUSTS

7. Urgent action should be taken by the Purchaser and the Providers in negotiating NHS agreements for the purchase of medium-secure facilities for acutely ill female patients to plan for the centralisation of such facilities in one regional secure unit, serving the South West and South Wales.

8. Continued training and staff development on gender issues in regional secure units is recommended.

Section 18: Training

CONCLUSIONS

Southmead

1. There was evidence that training was given to Southmead staff on a wide range of areas relevant to the work of a psychiatric unit. Training included the policies and implementation of the Care Programme Approach and the Supervision Register.

Fromeside

2. The impression gathered from evidence and from the manuals, policies and reports that the Inquiry has received is that the nursing staff had in general good opportunities to keep up-to-date with their changing duties, with the exception of the operation of the Care Programme Approach and Supervision Registers. There was regular training provided for in-patient named nurses through the trained staff study days which would help them in this role.

3. The importance of training cannot be underestimated in view of the remarks in the Fromeside ward manager's annual report for 1995-96:

> *"This year has proved to be the most turbulent yet and highlighted the exceptionally difficult nursing role within a medium-secure unit."*

RECOMMENDATIONS TO FRENCHAY NHS TRUST

1. That training should include programmes on the implementation of the Care Programme Approach and Supervision Registers.

2. All policies should be regularly reviewed (see Recommendations to Section 14). Training should then be set up for any new policies.

3. In view of the number of incidents of violence that have been revealed in the history of this patient's case, it is recommended that training be given in counselling, and de-briefing should be available to staff who have been victims of assault (see Section 16).

Section 19: Resources

CONCLUSIONS

Southmead

1. The environment within which Ms B was cared for at Southmead NHS Trust did not offer the best opportunities for her effective treatment and management.

2. Clifton Ward proved inadequate for the treatment of patients who are physically aggressive as well as being persistent absconders (see Section 10).

3. The Inquiry was concerned at the extent to which staff were expected to physically control the presence of Ms B in the absence of a locked-door policy.

4. The Inquiry received no evidence of inadequate staff resources in relation to the care which was provided to Ms B on Clifton Ward.

Fromeside

5. The environment on Ward 1 for a woman on her own with up to 14 male patients is not satisfactory and this is considered in Section 17.

6. We are concerned about the problems relating to recruitment and retention of clinical psychology staff within Fromeside Clinic. As a result of the failure to recruit clinical psychologists there was a low level of input by clinical psychology in the Multidisciplinary Team. If vacancies could be filled, clinical psychology could have provided a valuable contribution to her care during the later rehabilitation stages.

7. We were also concerned to hear of the problem in the recruitment and retention of nursing staff. We were informed that there is a freeze on posts in nursing because the Fromeside Clinic needs to support the redeployment policy of the Trust. We are concerned about this. Forensic psychiatry is delivered within a very stressful and demanding environment and applicants who are employed within it should have specifically applied for this sphere of work.

8. The Inquiry was given no evidence that the care of Ms B was adversely affected by shortages of nursing or other professional staff (apart from clinical psychology).

RECOMMENDATION TO SOUTHMEAD NHS TRUST

9. We recommend that Southmead NHS Trust, in association with Purchasers, urgently review the way the provision of service is presently configured; in particular the need for developing secure facilities to relieve the pressure that very disturbed patients could have on both patients and staff.

RECOMMENDATION TO FRENCHAY NHS TRUST

10. We recommend an external audit of the reasons for the difficulties in recruitment and retention of clinical psychology staff at Fromeside Clinic.

RECOMMENDATION TO SOUTHMEAD AND FRENCHAY NHS TRUSTS

11. We recommend that a suitable system of support is developed whereby staff who are coping with difficult patient behaviours can discuss their experiences in a supportive environment. We expect staff to be consulted throughout the development of this system.

Section 20: The voluntary sector

CONCLUSIONS

1. There is significant and varied voluntary support for mentally ill patients in the north Bristol area.

2. Leaflets were available about voluntary sector services at Fromeside Clinic and the Inquiry accepts the evidence of the doctors that information on the services available through the voluntary sector was given to the family.

3. However this information was not repeated at a time when Ms B started to enjoy extended leave.

4. There is a statutory duty for after-care planning under Section 117 to take place in conjunction with the voluntary sector. There is no evidence of any intention to involve the voluntary sector at the meeting planned for 6 September 1995.

RECOMENDATIONS TO FRENCHAY NHS TRUST

5. A clear strategy should exist for giving information to patients and their families about the voluntary services available. Where possible this should include information in leaflet form. Information should be given both at the onset of the mental illness or first admission to the unit and then repeated when rehabilitation commences.

6. The statutory duty under Section 117 requires health and social services to make after-care plans in conjunction with the voluntary sector. Arrangements for an after-care planning meeting should include, with the patient's consent, a representative of an appropriate voluntary organisation which should be invited to meet with the patient informally before the meeting.

Section 22: Lessons from the Inquiry

1. The debate on the value of Independent Inquiries following a homicide by a person suffering from mental disorder in the format recommended by the Department of Health is still ongoing and it appears incumbent on each Inquiry to add its comments and recommendations on the basis of the facts and experience which it has perceived and acquired. The advantages and disadvantages are explored in Jill Peay's edited book *Inquiries After Homicide* (Duckworth 1996).

2. It seems clear that an investigation of the circumstances which led to the death is essential: lessons need to be drawn; remedial action taken; such action implemented; all with the expectation that similar tragedies might thus be prevented.

   The relatives in particular were extremely supportive in our Inquiry and anxious to prevent similar tragedies. They wanted to be assured of the independence of any investigation. They were anxious that other families would not suffer in the way in which they had. Any alternative to the present system on holding inquiries needs to take account of the need of families for a full independent investigation.

   Members of mental health teams also suffer stress and distress as a result of the homicide and during the inquiry process, and the Inquiry gave them an opportunity to explain their views. Some of the staff we questioned had not had any opportunity for counselling, especially those who were not directly involved in the care of the patient at the time of the homicide.

   From all these perspectives: patients, family, staff and the public interest there needs to be some form of independent inquiry. Is the present procedure the most appropriate?

3. The existing guidelines inevitably result in considerable expenditure; a lengthy investigation which takes time given that most panel members are not free of other work; and considerable variations of practice between Inquiries.

   The existing guidelines may lead to an unjustifiably narrow focus for the Inquiry: the homicide may not be the only cause for concern and investigation.

4. Every Inquiry must be aware of the dangers of hindsight and of the fact that it is probably inconceivable that some adverse comment on care management could not be made, but that this would not necessarily be of causative significance.

5. Inquiry panels should not feel pressurised to meet a specific timetable, since, although organisations, staff and family are all anxious for a speedy report, it is essential for the Inquiry to obtain the full facts and to make a careful assessment of those facts.

6. Inquiries need to be aware of the varying motivation of witnesses in the evidence which is provided.

7. It is essential that there should be an early common understanding by the Panel of the issues and priorities involved in the case to be investigated. A checklist of all the available documentation which is likely to be relevant in addition to the patient health and social services records would be helpful and this should be provided as early as possible. Such a list would include reports of untoward incidents, complaints, Mental Health Act Commission reports of visits, Community Health Council reports, correspondence between Purchasers and Providers, etc. We were able to obtain such information, but it was often only after witnesses referred to such

incidents or information that we were then alerted to their existence.

8. If the present procedure is to remain, then it is essential that some reforms are made. These should include the following:

■ Legislation to permit access by the inquiry panels to medical and other records relating to the care of the patient. This access is required in the public interest.

■ Consideration should be given to a legal requirement that every employee or former employee who has evidence relevant to an issue before the inquiry to be required to give evidence.

■ There should be standard procedures for all Inquiries relating to the taking of evidence and whether or not it should be held in public or private.

a). This Panel took the decision to hold the Inquiry in private on the understanding that a report of conclusions and recommendations would be made public, and that an inquiry held in private would result in less stress, publicity and unjustified attention for the family and those professionals involved. However, this is not a view which has been taken in several other well-publicised Inquiries. Consistency is needed.

b). Some Inquiries take evidence on oath or by affirmation. This Inquiry took the view that this was unlikely to make any difference to the veracity of witnesses and it was also unlikely that sanctions would be used against those later found to be guilty of lying.

c). Some Inquiries employ counsel to represent the Inquiry in the examining of witnesses. We did not do this. It is not clear to what extent we were thereby disadvantaged.

9. What alternatives to the present procedure could be adopted? It may be possible to extend the jurisdiction of the Health Service Commissioner or the Mental Health Act Commission to cover the investigation of the circumstances relating to the homicide. The former has full-time investigation officers, the latter could have.

10. There is need for a follow-up mechanism to ensure that following the report, monitoring takes place to establish the extent to which the recommendations have been implemented.

CONCLUSIONS

11. Homicide by a mentally disordered person requires a form of independent investigation from varying perspectives: patient, family, staff and the public interest.

12. There is considerable lack of uniformity in how such inquiries are conducted.

RECOMMENDATION TO THE DEPARTMENT OF HEALTH

13. There should be a government review of the guidelines provided by NHS Executive HSG(94)27 on the holding of an independent inquiry following a homicide. This review should consider the desirability of ensuring that powers exist for any inquiry to obtain access to records in the public interest and also the desirability of ensuring that there are powers of subpoena.

Appendix A: Procedure adopted by the Inquiry

1. The Inquiry will be held in private.

2. The findings and any recommendations of the Inquiry will be made public.

3. The evidence which is made available to the Inquiry either orally or in writing will not be made public by the Inquiry, except as is disclosed within the report of the Inquiry.

4. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   a of the terms of reference and the procedure to be adopted by the Inquiry

   b of the areas and matters to be covered with them

   c requesting them to provide written statements to form the basis of their evidence to the Inquiry

   d that when they give oral evidence they may raise any matter they wish and which they feel might be relevant to the Inquiry

   e that they may bring with them a friend or relative, a member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accom pany them, with the exception of another Inquiry witness

   f it will be the witness who will be asked the questions and who will be expected to answer

   g Panel members cannot be cross examined

   h the evidence of witnesses will be recorded and a copy sent to them afterwards for them to sign.

5. Any points of potential criticism will be put to a witness of fact, either verbally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

6. Representation will be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances as the present Inquiry, and as to any recommendations they may have for the future.

7. Those professional bodies or interested parties may be asked to give oral evidence about their views and recommendations.

8. Anyone else who feels that they may have something to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

9. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the report and any recommendations will be based on those findings.

Appendix B: List of meetings

15 July 1996	First panel meeting (excluding Roy Holden)
2 August 1996	Visit to Broadmoor by Chairman and Dr Bowden
26 September 1996	Panel meeting
14, 15, 16, 17 and 18 October 1996	Hearings
16, 17 and 18 December 1996	Hearings (joined by Richard Lingham)
12 and 13 February 1997	
9 and 10 April 1997	
21 April 1997	
2 June 1997	
23 June 1997	

Appendix C: List of witnesses

(relationship or appointments at the time of the homicide)

Ms B

Family, friends and work colleagues:
Mother
Boyfriend
Brother
Uncle
Colleague at work
A friend
A family friend

Fromeside staff:
Dr T, Responsible Medical Officer (interviewed twice)
Dr D, Senior Registrar, Fromeside (interviewed twice)
Clinical Practice Development Co-ordinator (on secondment to Avon and Gloucester College of Health)
Clinical Psychologist
Ward Manager, Ward 2
Staff Nurse: Named Nurse (Keyworker), Ward 1
Staff Nurse: second Named Nurse (Keyworker), Ward 2
Former first Named Nurse Keyworker), Ward 2
Staff Nurse attacked by Ms B on Ward 1
State Enrolled Nurse
Nursing Assistant
Occupational Therapist
Art Therapist
Dr R, former Consultant Psychiatrist; Responsible Medical Officer covering for annual leave of Dr T.
SHO
Clinical Assistant

Southmead staff:
Dr W
SHO/Acting Registrar
Mental Health Services Manager
Staff Nurse
Staff Nurse: Named Nurse (Keyworker) Clifton Ward
Clinical Psychologist
Occupational Therapist

Social Services staff (then Avon County Council):
Mrs W, Woodspring Social Worker (North Somerset Team)
Mr R, Team Manager for Woodspring Social Worker
Mrs F, Fromeside-based Social Worker
Mr G, Service Manager for Bristol Central Social Services
Ms L, Team Manager, Fromeside Social Worker

Broadmoor Hospital:
RMO

General Practitioner

Voluntary agencies:

Ms AF (National Schizophrenia Fellowship)
Miss McM (SANE)

Others:

WDC Child Protection Unit
Mr TM (author of a report into security at Fromeside Clinic 1993)

In addition, written information was received from a friend of Ms B.

Appendix D: Events under the statutory provisions of the Mental Health Act 1983

1. Compulsory admissions to Southmead and transfer to Fromeside Clinic and renewal:

25.08.94	Section 2 admission to Southmead
21.09.94	Section 3 admission to Southmead
17.01.95	Section 17 leave to Fromeside Clinic
09.03.95	Section 19 transfer to Fromeside Clinic
13.03.95	Report under Section 20 for renewal of section 3 on 21.03.95.
21.09.95	Section 3 due to expire.

2. Appeals:

Southmead:	Managers' section 2 on 02.09.94 - detention continued
Southmead:	Mental Health Review Tribunal section 3, 10.01.95 - detention continued
Fromeside:	Managers' hearing, 21.03. 95 - detention continued
Fromeside:	Mental Health Review Tribunal hearing due to be heard in May 1995 but application withdrawn 25.05.95.

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Appendix G: Abbreviations

ASW ..... Approved social worker
CPA ..... Care programme approach
CPN ..... Community psychiatric nurse
CPU ..... Child protection unit
DGH ..... District general hospital
HCA ..... Health care assistant
MDT ..... Multidisciplinary team
MHA ..... Mental Health Act
MHRT ..... Mental Health Review Tribunal
NSF ..... National Schizophrenia Fellowship
OT ..... Occupational therapist
RMO ..... Responsible medical officer
RSU ..... Regional secure unit
SEN ..... State enrolled nurse
SHO ..... Senior house officer
S/N ..... Staff nurse
UBHT ..... United Bristol Healthcare Trust