THE REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF SHAUN ANTHONY ARMSTRONG

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THE REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF SHAUN ANTHONY ARMSTRONG

Presented to
The Chief Executive of
The Tees District Health Authority

by:

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Mr A Brown
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(Independent Panel of Inquiry)

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INTRODUCTION

On the afternoon of Thursday 30th June 1994 Rose (Rosie) Frances Palmer aged almost four years left her home at 12 Henrietta Street, Hartlepool in the County of Cleveland to buy an ice cream. On the 3rd July 1994 her body was found by the Police in a plastic bag at the home of Shaun Anthony Armstrong who lived approximately fifty yards away.

Rosie had been raped, otherwise sexually abused and her body had been mutilated following her death. Armstrong was arrested and on the 22nd July 1995 at Leeds Crown Court he pleaded guilty to murder when he was sentenced to Life Imprisonment by Mr Justice Ognall. Armstrong is currently detained at Wakefield Prison.

In May 1995 the National Health Service Executive published a circular "Guidance on the discharge of mentally disordered people and their continuing care in the community (HSG(94)27)", paragraph 35 of which requires that "in cases of homicide it will always be necessary to hold an inquiry which is independent of the providers involved".

Armstrong had received Psychiatric Care in Hartlepool General Hospital during several admissions in 1992 and 1993 and accordingly Tees District Health Authority appointed the members of this Inquiry in August 1995 and commissioned the preparation of this Report pursuant to Paragraph 34 of the NHS Executive HSG (94) 27. The Terms of Reference were drawn up by the Health Authority and are set out in Appendix 1 to this Report.

Witnesses and Documentation

Invitations were sent to those witnesses initially identified as having pertinent evidence to give to the Inquiry with a request that they should each submit a written statement in advance of their attending before the Inquiry. We were delighted at the general willingness of the statutory agencies and individuals to co-operate with the Inquiry and without that co-operation the task of the Inquiry would have been very much harder. Unfortunately the response to the request for written statements was fairly sparse and in some instances the written statements were virtually useless. In the end only one potential witness refused to attend at all, and one other witness refused our request that she should return to clarify certain points made in her evidence which appeared at odds with evidence given by subsequent witnesses.

We also had a number of problems with regards to documentation. As will become apparent from the main body of this Report, Armstrong had contact over a long period of time with a large number of agencies and organisations and we required a great many documents to clarify statements made by Armstrong and others.

We were mindful of the fact that as an Inquiry we could *invite* a potential witness to attend before us to give evidence or *request* a party or organisation to produce documentation required by the Inquiry. On this occasion we were perhaps fortunate that the evidence of the witnesses who eventually refused to appear or re-appear before us did not affect our overall view of the case. Likewise with patience, and the persistence of our back-up Team, we were eventually able to obtain the documentation which we required, although not necessarily at the appropriate time.

However the position might have been different and the Inquiry felt that consideration should be given at the highest level to the possibility of giving Inquiries the power to subpoena witnesses and documents.

Evidence from witnesses was taken under affirmation and following the conclusion of the evidence a copy of the recorded evidence was submitted to each witness with an invitation to correct any apparent error or to make any additional comment which he/she might think appropriate. In addition where the Report was likely to be critical of an individual or organisation a copy of the Draft Report was forwarded to the individual or organisation to enable him/her/them to comment.

Many of the witnesses accepted our invitation that they should be accompanied by a friend, colleague or Solicitor and we would like to thank those who attended in that capacity and made it possible for the various witnesses to feel at ease and give their evidence to us.

Fact Fiction or Allegations

This was a particularly unpleasant murder, bearing in mind the age of the victim and sexual offences committed against her prior to her murder. Following the discovery of the body there was, perhaps understandably, blanket media coverage of the case both nationally and particularly locally. The local press contained numerous allegations about Armstrong's sexual deviancy all of which were alleged to have been widely known to the authorities prior to the murder and the clear implication was that such a deviant should not have been in the community and in a position to carry out such a heinous offence.

Considerable investigation into the background of this case was required and it rapidly became apparent that the case had been more complicated than had been demonstrated in the media, but that pertinent information was not as widely known or available as was suggested in the media.

We discovered, for example, that in his encounters with the various psychiatrists and other agencies, Armstrong, who has been an inveterate liar all his life, had made outrageous claims about his past history and these had been accepted without any enquiry and recorded as facts. Some relevant information about Armstrong's origins and sexual activities had been known to his GP and medical and nursing staff at the hospital but not to the Social Services Department. Other information about alleged

sexual abuse of various children with whom he had come into contact through his various marriages and relationships was available to the Police and Social Services Departments and Probation Service but not to the medical authorities. And finally some information was simply not available to any of the authorities prior to the murder.

We also discovered, somewhat paradoxically, that notwithstanding the manipulative, unpleasant and disturbing behaviour exhibited on occasions by Armstrong, the professionals with whom he had come into contact were almost without exception, absolutely amazed that it was Armstrong who had committed the offence.

The Inquiry did have a problem with regard to some factual evidence given by certain witnesses, particularly the Nursing Staff, some of whom were totally unable to recall Armstrong in any detail at all and others who remembered considerable information which was not apparently recorded at the time. We felt that, in view of other evidence given about Armstrong's behaviour it was unlikely that he made no impression at all upon nursing staff when on the ward. By the same token we felt that some of the evidence given to us had the benefit of hindsight helped by interpretation of the media coverage of the case. In the event we had to balance some of the evidence given to us and make a decision about its credibility.

Even now, with the benefit of hindsight and considerable assistance from the numerous witnesses who have appeared before us, it is impossible to state with complete confidence that we have elicited the truth about all of the allegations made against Armstrong or the time at which information about him became available.

We have set out hereafter a chronological history of Armstrong dealing with his personal life, criminal activities and his involvement with the Psychiatric services and other agencies throughout his life. We must emphasise however that this listing is based upon evidence gathered from all sources during the course of the Inquiry and does not necessarily represent the information which was either available to or known by the various agencies at the date of its occurrence. This will be explored in greater detail during the text of this Report.

Acknowledgements

The prodigious task of organising this Inquiry was undertaken by Mrs Avril Rhodes the Corporate Planning Manager at Tees Health. It involved the obtaining and collating of all documents, the sending of letters and documents to all witnesses, the timetable of hearings and witnesses, and ultimately the organisation of this Report and its publication.

Mrs Rhodes' handling of all matters relating to the Inquiry was magnificent and her good humour and calmness throughout the entire period of the Inquiry made the task of the whole Inquiry Team much smoother. Within Mrs Rhodes' Department several people assisted in the day to day administration of the Inquiry and we would like to single out Mrs Pauline Williams who not only sat in on all of the Inquiry hearings and typed many

of the witness statements but also accompanied us to Wakefield Prison to record the interview with Armstrong which could not have been a very pleasant experience for her. Again our very great thanks for her patience and help throughout.

Title

Finally we gave some consideration to the Title for this Report. We were urged by Armstrong's Solicitor to consider omitting Armstrong's name from the Title of this Report in order to avoid drawing further attention to the commission by Armstrong of this horrendous crime. We were unmoved by this plea and decided that Armstrong's name should be the only one that should appear in the Title.

CHAPTER 1

CHRONOLOGICAL HISTORY OF SHAUN ANTHONY ARMSTRONG

30.6.62

Shaun Anthony Armstrong was born at the Littlethorpe Maternity Hospital in Easington, County Durham, to Rachael Teal, who was then unmarried and aged eighteen years. His father was Joseph James Steel, his mother's own father. He was apparently a blue baby, being delivered by forceps and as a result of obstetrical problems his mother was unable to have any further children.

For the first three years of his life Shaun Armstrong was brought up by his maternal grandparents as his mother was either working or in and out of hospital with psychiatric problems from which she had apparently suffered from about the age of fourteen. When he was three years old his mother married George Armstrong who was then fifteen years older than herself and Shaun Armstrong was brought up believing that he was the son of George Armstrong.

Shaun Armstrong alleged that his stepfather showed little affection for him but when his mother and stepfather subsequently separated Shaun Armstrong stated that he really looked up to his stepfather and indeed visited him on a regular basis until October 1989 when all contact ceased following Shaun Armstrong's second marriage.

1969

As an only child Armstrong appears to have been somewhat isolated and lonely and developed a close relationship with a maternal cousin, Andrew Christopher Steel who was almost exactly the same age. Andrew was tragically killed in a road accident in 1969 when both children were aged seven years. This event had a profound effect on Armstrong and led to an immediate deterioration in his behaviour and in his own words "I became a bastard. I became hateful and got mad at everyone". He was apparently referred to a Child Psychologist and possibly a Psychiatrist but no further details of the referrals are available.

Approximately one month after Andrew Steel's death, when Armstrong was aged seven years and two months he was subjected to inappropriate sexual behaviour by his mother. This continued until he was thirteen years when it progressed to full sexual intercourse which took place on an intermittent basis until he was sixteen.

1969-1974

Approximately five months after Andrew Steel's death his mother and stepfather separated when his mother moved back to her parents home taking Armstrong with her. Although they were reconciled about a year later they finally separated in 1974 when Armstrong was twelve years old. His mother in fact finally left to live with Thomas William Matthews whom she subsequently married. However Mr Matthews was described as being excessively jealous and the marriage only lasted four years.

1973

Attended Easington Secondary Modern School. Described as being overweight and a loner, he made few friends as his mother insisted that he went straight home from school and he was not allowed to play with friends.

1976

Aged fourteen he attended the Nautical School at Campden Square, Seaham, where he stated that he did well academically passing five 'O' Levels and two CSE's in Seamanship and Navigation. During holidays he found occasional work in sawmills and as a delivery assistant for a TV retail company.

25.2.1978

Letter written by Dr MR Whalley, consultant Child Psychiatrist to Armstrong's GP refers to contact with Durham Joint Child Guidance Services having been referred on account of overt sexual advances made towards his mother. Letter stated that Armstrong came from a broken home and his mother was concerned as to whether the circumstances of his birth meant he had a permanent mental disability. Dr Whalley stated that he reassured the mother but did consider that Armstrong was a very disturbed boy. There was a suggestion that Armstrong required psychotherapy and Dr Whalley considered discussing this with an Educational Psychologist but there is no further documentation in the GP's Notes.

23.7.1978

Enlisted for Naval training at Plymouth aged sixteen.

2.8.1978

Appeared before Easington Juvenile Court when convicted of offences of dishonesty for which he was given a two year Supervision Order.

17.11.1978

Discharged from the Navy on the grounds that he was psychologically unfit. This was allegedly following stress due to the death of his girlfriend from cervical cancer at the age of seventeen years. This association was alleged to have lasted over two years.

13.3.1979

Easington Juvenile Court. Convicted of offences of Burglary and Theft and given two year Supervision Order.

1979 - 1985

After his discharge from the Navy, Armstrong returned to the North East where he obtained employment in the sawmills at Carrville and then in the Horden Colliery where he worked for five years until he was made redundant in April 1985. He then worked for a number of employers including a two year spell in London but did not work after 1992.

June 1981

Armstrong left home at eighteen to marry CBM who was born on the 30th December 1954 and who was therefore nearly eight years older than himself. CBM already had two children, a daughter (A) who was seven and a son who was four. After the marriage the family lived at Horden.

28.1.1982

Easington Magistrates Court. Convicted of two offences of Theft and given a 120 Hour Community Service Order.

1982

Armstrong's marriage to CBM broke down. According to his wife this was a result of (a) violence towards her, (b) her discovery of Armstrong having sexual intercourse with his natural mother and (c) sexual abuse by Armstrong of her daughter (A) which she did not disclose at that time. According to Armstrong the breakdown was due to his jealousy when he saw her talking to another man and read more into the situation than actually existed.

1982

First contact with Health Authorities. Took overdose of mother's Parnate and admitted to St. Hilda's Hospital, Hartlepool for two days. During admission he saw a Psychiatrist but on his discharge no follow up arrangements made except a referral to his GP.

18.8.1983

Easington Magistrates Court. Obtaining by deception. Fined £100.

17.11.1983

Easington Magistrates Court. Three offences of dishonesty. Sentenced to three months imprisonment suspended for two years.

18.5.1984

Divorce proceedings initiated by CBM. On receipt of Decree Nisi Armstrong inflicted cuts to both of his arms in an apparent attempt to kill himself and was admitted to St Hilda's Hospital, Hartlepool.

31.5.1984

Easington Magistrates Court. Four offences of dishonesty sentenced to three months imprisonment.

November 1984

Armstrong met EJA who was a friend of his mothers, seventeen years older than Armstrong and with alcohol problems. She was also a divorcee with four children and lived at Peterlee, Co. Durham.

4.12.1984

Easington Magistrates Court. One offence of Assault Occasioning Actual Bodily Harm (to his mother) and five offence of dishonesty. Community Service Order for 160 hours. Armstrong subsequently stated that the assault on his mother followed her disclosure to him of his true paternity, but some doubt exists about this statement in view of his subsequent statement that his mother only disclosed this information after she had been diagnosed as suffering from carcinoma in 1989.

1985

Referred by his GP to St Hilda's Hospital in Hartlepool because of depression. After treatment with antidepressants he was discharged with no Out-Patient follow up.

18.6.1985

Easington Magistrates Court. Two offences of dishonesty. Sentenced to three months imprisonment.

12.5.1986

Teesside Crown Court. Three offences of dishonesty. Sentenced to two years imprisonment.

25.3.1988

Teesside Crown Court. One Criminal Damage and four offences of Dishonesty. Sentenced to 21 months imprisonment.

September 1988

Released on Parole (to February 1989).

18.10.1988

Armstrong married EJA.

October 1989

Armstrong's mother diagnosed as suffering from malignant melanoma. Until then Armstrong had believed that George Armstrong was his father but his mother now disclosed for the first time that Armstrong was the product of an incestuous relationship with her own father which had occurred from when she was twelve to seventeen years old when she became pregnant with Armstrong.

28.2.1990

Armstrong's mother died and Armstrong declined to attend her funeral.

28.3.1990

Armstrong seen at Peterlee Health Centre at request of his GP by Dr F Gowans a Clinical Psychologist from Hartlepool. Armstrong stated that his natural father was his mother's father and that he (Armstrong) had been abused by his mother from the age of eight throughout his school years. He also stated that he had had a nervous breakdown in 1982, after he had left his first wife, when he had just laid in bed shaking and crying.

4.4.1990

Armstrong failed to attend follow up appointment with Dr Gowans, who simply notified the GP of this fact by letter, but gave no details of any assessment or of the information supplied by Armstrong.

28.6.1990

Peterlee Magistrates Court. Fined £50 for Public Order Act offence and £10 for Theft.

July 1991

Attending Alcoholics Anonymous.

13.8.1991

Peterlee Magistrates Court. Fined £100 for Theft.

March 1992

Armstrong assaulted by stepson KA (adult son of EAJ).

20.3.1992

First admission to Ward 15 of Hartlepool General Hospital following a telephone request from his GP Dr Pearson. At the time Armstrong was low and anxious stating that in the past he had self lacerated his arms, had overdosed on his mother's prescribed Parnate, and was afraid that he might harm himself again.

On this admission Armstrong made the following statements to his Consultant or to the Nursing Staff:-

(A) He had received a Dishonourable Discharge from the Navy for shooting a Chief Petty officer.

(B) He had found his wife in bed committing adultery and had thrown the man through a plate glass window. As a result he had been sentenced to two years imprisonment and had in fact served 14 months.

(C) He was constantly fighting with his stepson who was one of the children of his then current wife EJA, who was herself 17 years older than him.

(D) He was annoyed because his step daughter (B) was going out drinking almost daily leaving him to care for her two children aged three and two years respectively.

(E) He was separated from his wife.

(F) He agreed he had both a drink and drugs problem particularly with regard to the drug DF118.

(G) His mother had sexually abused him as a child.

(H) His mother, his current wife EJA and his stepdaughter (B) had all been patients on the Unit.

24.3.1992

His Consultant advised Armstrong that he could stay in hospital for a short while until his marital problems were resolved but that there was no medication which was appropriate for his treatment. He was advised that on discharge he should attend either the North East Council for Addictions or the Alcohol and Drugs Advisory Centre to discuss his drink and drugs dependency but failed to do so.

3.4.1992

Armstrong stated that he felt unable to return to live with his current wife EJA and was exploring the possibility of taking a bedsit in Hartlepool. EJA subsequently stated the marriage had broken up because of violence towards her by Armstrong, her discovery of Armstrong wearing women's clothing and the allegation that Armstrong had abused one of her daughters in 1986.

6.4.1992

Social Worker contacted with regard to Armstrong's housing problem. An interview was arranged for Armstrong to go and look at Benedict House at Park Road, Hartlepool but following a short leave from Hospital, Armstrong returned saying that he had seen his first wife CBM and she had agreed to Armstrong going to live with her in Plymouth. The matter had allegedly been discussed with EJA who was in agreement.

7.4.1992

Armstrong discharged from Hospital. Diagnosis of personality disorder. No follow up appointments were made as Armstrong's new address in Plymouth was not known.

29.11.1992

Armstrong's stepdaughter (B), then aged 22 years, alleged that she and her sister had been sexually abused as children by Armstrong who had subsequently abused her daughter (C) aged two years. As a result of those allegations EJA threw him out of her home.

29 & 30.11.1992

Joint interviews took place between the Police, Social Workers and the child (C) but as nothing conclusive emerged the Social Services Department made the decision that, as Armstrong was no longer residing at his wife's home and no contact was to be allowed between Armstrong and the child (C), there were no further protection issues in respect of the child.

29.11.1992

Armstrong's second admission to Ward 15, Hartlepool General Hospital. Armstrong stated that as a result of pressures in his social life for a period of two months he had slashed both of his forearms and taken an overdose of prescribed medication including Ferricolin Folic, Co-codamol, Tagamet and Temazepam.

30.11.1992

Armstrong seen by his Consultant who diagnosed "Personality problem with addiction problems".

1.12.1992

Armstrong asked to see a Social Worker as he was separated from his wife and homeless.

4.12.1992

Consultant mentioned discharge from Hospital whereupon Armstrong became very threatening and spoke of harming himself in order to stay in Hospital. He threatened to walk under a bus and also talked of nightmares about when he was in the Navy and had killed a man.

7.12.1992

Discharge from Hospital. Non-committal about where he was going and follow up therefore impossible because of lack of address.

11.1.1993

Consultant carried out Domiciliary Visit at Armstrong's Wingate home at his GP's request in relation to Armstrong's drinking problems. Subsequently wrote to Armstrong's GP describing him as suffering from Psychopathic Personality.

11.2.1993

Armstrong failed to attend Out Patient Clinic.

8.3.1993

Police interviewed Armstrong about allegations made on 29.11.1992 by his stepdaughter (B). Totally denied by Armstrong and in the absence of any further proof Police decided to take no further action.

12.3.1993

Admitted to Hartlepool General Hospital Ward 7 (General). Stated that he was of no fixed abode and had taken an overdose following the curtailment of a relationship.

He requested assistance with his housing problem and arrangements were made for him to go to Union House at Southgate. He was accompanied to Union House by a temporary Social Worker attached to the Community Mental Health Team at Hartlepool General Hospital but only stayed one night and left with no forwarding address.

5.5.1993

Admitted to Medical Ward 5 at Hartlepool General Hospital from his Wingate address after an overdose following an argument with his girlfriend CA. Stated that he would take another overdose if things did not work out between himself and CA.

6.5.1993

Armstrong discharged from Hospital with no forwarding address.

5.6.1993

Admitted to Medical Ward 5 in a deeply unconscious state following a serious overdose of at least 28 Noctec and 28 Temazepam which he had taken as a result of an argument with CA. During this admission he stated that his girlfriend had thrown him out without any clothes, he was homeless and needed help with accommodation. He also stated that he intended to kill his girlfriend and then himself.

Subsequently transferred to Ward 15 where he stated that his girlfriend was drinking heavily and she had attempted to set fire to the house on two occasions. He had submitted an application to the Homeless Department at the Civic Centre and expected to be rehoused within two weeks. He had been offered a place at Benedict House but had turned that down as being too rough. His Consultant was asked to write a supporting letter to the Housing Department when he would be allocated a house or flat almost straight away.

Armstrong established a relationship with AS who was also a patient on Ward 15 and this caused some concern to the staff. Armstrong was transferred to Ward 16 but the relationship continued.

15.6.1993

Consultant wrote to Homeless Section at Hartlepool Civic Centre supporting Armstrong's application for Council accommodation.

21.6.1993

Armstrong discharged. Stated that he would contact the Unit with a forwarding address.

22.7.1993

Peterlee Magistrates Court. Fined £60 for Theft.

12.8.1993

Attended Out-Patients Clinic. Had changed address twice and was then living at 32 Lancaster Road, Hartlepool.

August 1993

Armstrong moved to 51 Frederick Street, Hartlepool, an upstairs Council flat.

28.10.1993

Attending Out-Patients Clinic. Still associating with CA who was allegedly pregnant. Also still seeing AS.

Admitted to drinking two litres of cider per day and Consultant made note that admission to Hospital likely in the near future. Advised to contact Keith Appleby at the Alcohol and Drugs Advisory Centre but failed to do so.

3.2.1994

Attended Out-Patients Clinic. Marked improvement noted. Stated that he had a job and a BMW car, was not taking drugs or drinking and was coping well in his flat, all of which were untrue.

5.5.1994

Failed to keep Out-Patients appointment. New appointment notified for 3.11.1994.

30.6.94

Rosie Palmer murdered.

3.7.1994

Armstrong arrested.

27.7.1995

Armstrong pleaded Guilty at Leeds Crown Court to Murder and sentenced to Life imprisonment by Mr Justice Ognall.

CHAPTER 2

ROSE (ROSIE) FRANCES PALMER

Rosie's mother Beverley Frances Wendy Anne Palmer was born in Hartlepool in 1957. She married at nineteen but the marriage only lasted four years before ending in divorce. At twenty-two she commenced nurse training and on successful completion she moved to the Bristol area.

Here she met Martin Palmer and they married in 1989. Rosie was born on the 1st August 1990. In September 1990 Mrs Palmer was admitted to Barrow Psychiatric Unit in Bristol apparently suffering from post-natal depression. Shortly afterwards Mrs Palmer discharged herself against medical advice and returned to live in Hartlepool, taking Rosie with her.

Approximately eighteen months later she met John Thornton and they began to live together at a number of addresses and finally at 12 Henrietta Street Hartlepool with effect from September 1992. On 18th December 1993 their daughter Emmie Thornton was born.

Although Mr and Mrs Palmer did not live together again after Mrs Palmer's return to the North East in or about October 1990, Mr Palmer was determined to maintain contact with Rosie and continued, on a regular basis, to drive up to visit every few weeks. The last contact was just a month before Rosie's tragic death.

Evidence was given to the effect that Rosie had distinctive ginger hair and wore glasses. She had an engaging grin and was always full of life; she adored her little sister and enjoyed horse riding and swimming; she was described by the staff at the Salvation Army Hostel Nursery, where she had a one hundred percent attendance record as being a sensible mature little girl who did not wander, and a happy child with a sense of humour.

Number 12 Henrietta Street was situated on the Headland in Hartlepool just fifty yards away from the upstairs flat at 51 Frederick Street where Armstrong had lived since August 1993. The Headland was considered to be a very close-knit community where it was safe for children to play out in the streets.

Rosie had a number of friends in the area including the great granddaughter of the lady who lived below Armstrong and it was not uncommon for Rosie to play in the common yard at the rear of those premises.

An ice cream van would visit the area almost on a daily basis and about three times a week Rosie would ask her mother for money so that she could purchase a lollipop, when the van stopped about forty yards from her home and to the rear of Armstrong's home.

On the 30th June 1994 Rosie's stepfather John Thornton had collected her from the Nursery School and was looking after her until Mrs Palmer returned.

Rosie asked for, and received from her stepfather, enough money to buy a lollipop and ran out of her house to the ice cream van. Apparently she asked not for a lollipop but an ice cream and, although she did not have sufficient money, the ice cream man gave her the ice cream as she was a regular and popular customer.

When Rosie had not returned by 5.30pm her stepfather woke her mother who had by this time returned home and fallen asleep on the couch and a search was instigated locally. When no trace of Rosie was found the Police were informed at about 8.45pm.

Rosie was never seen alive again. Although her body was not in fact found by the Police until 3rd July 1994 it is now clear that Armstrong had committed the murder no later than 4.30pm on the 30th June 1994.

From all the Reports which we read and the evidence that we heard it is apparent that Rosie was an endearing cheerful little girl who brightened the lives of everyone with whom she came into contact. It is an absolute tragedy that such a young life should be taken, and in such a heinous manner, and we express our condolences and sympathy to the family of Rosie Palmer for the suffering which they must have endured.

CHAPTER 3

ARMSTRONG'S INVOLVEMENT WITH MENTAL HEALTH AND OTHER SERVICES

Armstrong was born, educated and lived most of his life at various addresses in the Easington, Horden and Peterlee areas of County Durham. It was only in 1993 that he had taken up permanent residence in Hartlepool in Cleveland County.

From about the age of seven years, when he was referred to a Child Psychologist, Armstrong had been in contact on many occasions with a number of organisations connected with Mental Health, Social Services and the Prison and Probation Services. These contacts had occurred both while he was living in County Durham and Cleveland and therefore separate Social Service Departments had been involved.

From 1982 Armstrong had been admitted to Hospital on several occasions but as the areas in County Durham in which Armstrong had resided were covered initially by the Hartlepool Health Authority and later by the Tees Health Authority all admissions had in fact been to Psychiatric Hospitals in Hartlepool. In 1982 and 1984 these admissions had been to St Hilda's Hospital and following the closure of that Unit all future admissions during 1992 and 1993 had been to the General Hospital at Hartlepool.

Because of the complex nature of this case and the varying degrees of involvement of different Agencies with Armstrong and his various families, particularly at the times of his later admissions to Hospital, we have found it more convenient to consider the terms of the Remit of this Inquiry by reference to the individual Specialities who have been involved with Armstrong. Comments on points of interest or concern have been made under those headings but the Inquiry's Conclusions and Recommendations are set out in Chapter 14 of this Report.

CHAPTER 4

HARTLEPOOL GENERAL HOSPITAL

(1) General

Hartlepool General Hospital is situated at the northern end of the town of Hartlepool in the County of Cleveland and during the relevant periods consisted of separate Medical and Psychiatric Units, both of which drew patients from the whole of the District of Hartlepool and an area around Easington which is actually situated in County Durham. The Psychiatric Unit comprised Ward 14, which had fifteen beds for Psychogeriatric Patients and Wards 15 and 16 each of which had twenty five beds for Psychiatric Patients. In addition Ward 15 had a further four beds for Patients who were undergoing a detoxification programme relating to drink or drugs.

Until 1993 the Hospital was a single directorate incorporating acute medical and surgical services, community services and mental health services. During 1992 the Hospital expressed an interest in becoming a third or fourth wave Combined Trust, but either regionally or nationally it had been indicated that Trust Status would only be granted if the Hospital separated its acute and mental health services.

Accordingly the services were separated into Community Mental Health Services, which ultimately became the Community and Mental Health Trust, and Medical and Surgical Services which ultimately became the Acute Hospital Trust. These acted in shadow form for one year until 1st April 1994 when they both achieved NHS Trust Status.

Originally the Psychiatric Unit had been concerned exclusively with mental health issues but with the advent of Trust Status and subsequently as a result of various staff changes within the Trust the following had been added to the services provided namely Community Services, Drug and Alcohol Dependancy and Learning Disabilities.

Until 1992 the General Manager of Hartlepool General Hospital was responsible to the Chief Executive of Hartlepool Health Authority, as a directly managed unit, and from April 1992 - 1993 to the Chief Executive of Tees Health Joint Administration (the executive serving the then four health authorities within Cleveland). On attaining Trust status in April 1993, the Hartlepool and Peterlee Hospital Trust became responsible for providing acute hospital care and Hartlepool Community Care NHS Trust for community and mental health services for the population of Hartlepool and South Easington. Tees District Health Authority and Durham Health Commission, the purchasers, are responsible for planning and buying the services required to meet the needs of

their respective populations.

By a coincidence both Trusts had expressed an interest in remerging into one Trust. Both Durham County and Tees Health Authorities as purchasers of services provided within the Hospital had been approached and had given their approval as had the Regional Health Authority. During the time of this inquiry approval to remerge was given and as from 1st April 1996 the combined trust is known as Hartlepool & East Durham NHS Trust.

(2) Hartlepool Community Care NHS Trust (Provider)

General

(A) We received evidence from the Chief Executive of the Trust and from the Business Managers for Mental Health and Community Services. We were advised that as a result of the considerable differences in the status of the Hospital outlined above coupled with various retirements and moves for career reasons there had been substantial changes at virtually every level of Senior Management within a short period of time. In addition there were a number of important new issues with regard to health and social care which were demanding a great deal of time and effort and in a number of instances jobs were being shared and many staff were taking on completely new responsibilities.

Details of the Hospital's actual involvement with Armstrong on his various admissions during 1992 and 1993 are dealt with elsewhere in this Report in the Chapters relating to Consultants and Nursing Staff. We propose therefore to deal at this stage with those general issues affecting the treatment of Psychiatric Patients within the Unit.

(B) Planning

The philosophy determined by Tees District Health Authority of the Mental Health Services throughout the relevant period has been to provide a locally accessible and integrated service based upon the assessed need of the individual in close collaboration with statutory, voluntary and independent agencies.

The planning for the provision of services to meet the above requirements involved consultations and negotiations between individuals from the Hospital Trust and their counterparts both at Tees Health and the Social Services Departments for the Counties of both Cleveland and Durham. So far as the Social Services were concerned this took place both on the Chief Executive/Director level, where general policy was discussed and agreed, and at operational level where the day to day management of care was settled. Within the Trust itself the business planning was done on a multi-disciplinary

basis involving Consultants, Medical Staff, Senior Nursing Staff and other Heads of Departments so that the views of all staff could be formally and properly involved. As a result of iterative discussion between the purchasers and providers on an in-year basis any changes to service delivery were incorporated into contracts for the provision of services for the following year.

The Inquiry heard that the Hospital had established regular monthly meetings between the Trust contracting team, the Tees Health contracting team and the staff of Social Services in order to address points of issue that had arisen during the month although there were in fact frequent contacts, often on a daily basis, between various members of the Teams. In addition there was a Quarterly Meeting between the Chief Executive and Directors of Social Services to address major problems or issues of policy.

The Inquiry was satisfied that on the issue of planning, capable staff were in place and adequate systems of communication had been established to address and resolve policy issues affecting patients care and treatment.

(C) Audit Reports

Prior to 1994 auditing of standards within the Hospital had been carried out on the premises on a regular basis by Tees Health using the Standard Audit System to establish whether certain established standards had been met, partially met or wholly unmet.

The Inquiry was concerned to note from the auditing reports that there were a number of issues which were consistently unmet or only partially met and it seemed initially that although the systems were in place to highlight shortcomings, no lessons were being learned or steps taken to put matters right.

However on closer examination we discovered that many of the issues were of a trivial nature and involved differing interpretations of the standards to be met. By way of an example, we were told that the Hospital consistently failed to meet the appropriate standard for patients satisfaction with the meals served to them. It transpired that some patients complained that the food was undercooked but others complained the same food was overcooked. Simply because there had been complaints the Hospital was adjudged to have failed to attain the appropriate standard.

We found that the system of monitoring and auditing standards had been inefficient and aimed more at showing that there was an auditing system rather than establishing proper levels of service and ensuring that they had been met. We were pleased to see that the Hospital had in fact recognised this failure itself and with effect from 1st April 1994 a quality department had been established and proper audits commenced in May 1994. A comprehensive analysis of the new system had not been possible at the time that the Inquiry was taking

evidence.

There were however two issues that had been highlighted by the old system of auditing which were relevant to Armstrong's case and to the remit of this Inquiry. The first related to the form used in the admission process in the Psychiatric Unit and which was based on the Roper-Logan-Tierney Model. This had been found to be unsatisfactory for psychiatric cases, although it might be adequate for use elsewhere in the Hospital, and had subsequently been replaced.

Secondly was the way in which entries were made on the nursing records and the information actually recorded both of which were found to be unacceptable. Steps had been taken to ensure there was a considerable improvement in this area and the situation was being further monitored.

In view of our comments later in this Report about the standards of the entries made in Armstrong's Notes we were pleased to note the above action.

(D) Recent Changes Affecting Hospital

Not only had there been substantial changes in the status of the Hospital and the personnel of Senior Management during the last four years but there had also been significant changes in psychiatric health care both in the Hospital and the community during the same period. In addition there had been important developments with regard to training within the Hospital. The combination of all of these changes within such a time scale had meant that all senior staff had been exceptionally busy coping with the changes and human resources had been stretched.

In addition to the normal provision of care, staff had to cope with great changes in the development of community mental health and the creation and implementation of a drug and alcohol dependency service.

The Inquiry noted that prior to 1991 Hartlepool Hospital did not have Training Status for either Doctors and Nurses and this would clearly have had an effect upon the calibre of the Medical and Nursing Staff who could be attracted to the Hospital. So far as nursing was concerned, operational policies and quality checklists had been introduced and improved with a view to attaining Training Status. In 1992 the Hospital had passed the English National Board for Nursing, Midwifery and Health Visiting Inspection and was accredited as a Training Hospital for Nurses.

More importantly, the Hospital had in 1993 been successfully audited by the Royal College of Psychiatry and accredited as a Training Hospital for Senior House Officers and General Practitioners, which should make it easier in the future to attract suitably qualified Medical staff to fill junior vacancies at the Hospital.

The Inquiry was also pleased to note a recent Mental Health Act Commission visit had encountered no major problems, and three Community Health Council visits had produced very favourable reports with no specific recommendations relating to care. There had recently been a pilot scheme in the Northern Region for the Clinical Standards Advisory Group and Hartlepool General Hospital had been placed second, out of eleven hospitals surveyed, for overall performance for both Purchaser and Provider.

(E) Consultants

National guidelines suggest that to provide a Psychiatric service for Hartlepool and the district of Easington the Hartlepool General Hospital should have an establishment of five Consultants one of whom should specialise in the care of elderly people. In 1992 and 1993 there were in fact only three Consultants in place, one of whom was a Locum Consultant who had been in that position for approximately eleven years. It was stressed that although the optimum number was five Consultants only three were funded at the time.

There had been difficulties for a considerable length of time in attracting Consultant Psychiatrists to Hartlepool and efforts had been made for a number of years to advertise and fill the third Consultant's position on a substantive basis. This was not because of complaints about the Locum Consultant, since no particular concern had been expressed about the operation of psychiatric services within the Hospital, but simply because of a wish to have three substantive Consultants and a belief that there were suitable candidates, as had subsequently proved to be the case.

(F) Nursing Staff

Although the Hospital had subsequently adopted the Named Nurse system where a particular nurse was allocated to a Patient on his admission, Team Nursing had in fact been the practice during 1992 and 1993 when Armstrong had been admitted to the Unit. Depending on the Ward or shift involved this had usually meant a team of approximately five or six nurses looking after about eight or nine patients.

Individual nurses made entries on the patients notes but there were regular meetings to discuss patients' progress and information would be passed on to other members of the team at those meetings or at the handover at the end of a shift.

As appears elsewhere in the Report there appears to be a singular lack of clarity about when significant changes in procedures came about since there appeared to be differing opinions in both staff and management with regard to the introduction of the Named Nurse approach.

The Management view was that the Budget for nursing was just adequate. There were occasions when due to holidays, courses and sickness, things were a little stretched but it was usually possible to cover such times by offering overtime to other staff or calling on the Nursing Bank. It was not felt that this had caused any problem in providing treatment for Patients, although like all Hospitals they would have welcomed the opportunity to have more staff available.

The Inquiry noted however that with no regular change in staff or the infusion of new ideas and methods, attitudes and procedures could become stale, and bad procedures difficult to identify and eradicate. It is considered essential that proper training and retraining should take place and that periodic monitoring of practices and procedures should continue.

Nursing at Hartlepool was now in the hands of the Business Manager who was the Budget Holder. Below the Business Manager were a number of G Grade Nurses who were the budget managers and who had the twenty four hour responsibility for nursing. At the time of Armstrong's admissions to Hospital in 1992 and 1993 the majority of nursing staff, rotated on a three shift system including nights.

It had been recognised (albeit belatedly) that this system was simply depleting the day shift of experienced staff and accordingly with effect from early in 1995, one G Grade and one F Grade nurse had been appointed to permanent nights and the remaining nurses of those grades were able to devote their skill and experience to the day shifts.

In view of our subsequent comments about the nursing staff involvement with Armstrong in 1992 and 1993 we were pleased to note this development.

(G) Community Mental Health Teams

Since the beginning of medical history the perceived approach to the treatment of those suffering from mental illness had been quite simple. The public had to be protected and the patients had to be locked away in an Institution with little or no contact with the outside world. The concept of Care in the Community had gradually gathered momentum over the last three decades. The idea that patients could be treated in the Community and might benefit from that was a whole new concept that had to be accepted not only by those caring for the Patients but also by their own families and the public at large.

Early forms of treatment in the community had usually consisted of the monitoring of a patients medication and some basic support by a Community Psychiatric Nurse following a patients discharge from Hospital. Community services had evolved to include a multi-disciplinary approach in order to provide all of the services which patients might require in the community. This clearly required considerable negotiations with other agencies who would be involved, especially the Social Services Department, and in Hartlepool this had been hampered to some extent by the long term sickness of the Social Work Team Manager. Although the Community Mental Health Teams had been formed in early 1994 they were still not fully operational at the time of this Inquiry.

There were two CMHT's for the town of Hartlepool (which had been divided into the Victoria Road GP practices in one Team and the rest of Hartlepool, including the Headland in the second Team) and one for those parts of County Durham whose residents were to be treated by the Hartlepool General Hospital. Each team consisted of approximately eight nurses who managed themselves but whose co-ordinator reported to the Business Manager at the Hospital, while the Social Workers involved would continue to have their own line management responsibility.

At the time of this Inquiry the Teams were still based within the Hospital but they were in the process of obtaining premises so they could move out into Community Mental Health Centres where, in addition to the Nurses themselves, there would be Psychiatrists with their secretaries, Psychologists (when available), Out-Patients Clinics and Day Services staff.

(H) Relations with Housing Department

With the advent of Care in the Community, the Hospital was, like other Agencies, developing a number of smaller units in the Community, and, as a result, it was frequently necessary for discussions to take place with housing authorities, housing associations and other agencies. These discussions could take place both at Chief Executive level where general planning policies could be involved or at housing officer level where individual cases could be discussed.

It was felt that in such cases information about the personal circumstances of a patient would be disclosed to the housing department if the Hospital felt that they needed to know this information. While the Inquiry felt that on occasion this might be helpful other evidence which we received made it clear that in fact this did not occur and the Housing Department, in particular, received no helpful information with regard to patients whom they were expected to house or rehouse.

(I) Accident and Emergency Notes

If a Patient was admitted to the Acute Hospital following a drug overdose it often happened that the Patient would be treated in a general Ward and discharged from that Ward back to his home. This occurred even when the Patient had already received treatment from a Psychiatrist in the Psychiatric Unit.

Although a member of the Mental Health Team could request a Patient's notes from the Acute Hospital, if he was aware of the admission, there was no system of automatic referral of a case to the Psychiatric Unit to see if there had been previous involvement. The matter had been exacerbated on the 1st April 1994 with the creation of the separate Trusts which had served to emphasise the dividing line between the two Units.

The Inquiry heard that notwithstanding the belief of the Medical Director of the Community Mental Health Trust it would be possible for a patient to have a number of admissions to the Acute Unit without his own RMO being aware of any of those admissions. This was clearly not in the patient's best interests and would have to be addressed.

(J) Internal Inquiry

Following the tragic incident the Hospital had, not unnaturally immediately instigated an internal inquiry to establish what, if anything, in the Hospitals handling of Armstrong's case had contributed to the tragedy and to see if they could do anything in the future to prevent a similar tragedy.

They had identified four areas of concern. Two related to out-patients appointments where patients failed to attend and arrangements had been made to improve and audit the system. However we discovered from other evidence that in practice no change had occurred and this would have to be investigated further.

Thirdly was the Hospital's procedure on referrals of patients with drink/drug dependency problems to the appropriate agency. Previously the onus had been placed upon the Patient to make all necessary arrangements to demonstrate his wish to have help but more positive action was now being taken by the Hospital to put the referral on a formal footing. The Inquiry was not entirely sure how the system was being monitored or what steps the Hospital was taking in the event of a Patient failing to attend one or more appointments with the Counsellors involved.

Fourthly the Hospital's criteria for a patient's admission to the Care Programme Approach had previously excluded patients suffering from personality problems. We heard that the medical staff were still discussing this matter in October 1994, three months after the tragedy but that they had been overtaken by events in

that the Hospital's current policy now included all patients accepted as suffering from mental health problems.

(3) Tees Health Authority (Purchaser)

(A) General

As indicated Tees Health Joint Administration came into existence in April 1993 as the joint executive working on behalf of Hartlepool Health Authority, North Tees Health Authority, South Tees Health Authority and Cleveland Family Health Services Authority. At that time planning negotiations that took place with regard to services within Cleveland were between Tees Health Joint Administration acting for four health authorities and one local authority.

As far as Tees Health Joint Administration was concerned this had initially caused some problems since staff who had previously been working in three separate Authorities were being pulled together under one administrative arm and it was necessary to mould the staff into one team. This was all the more difficult since the three Health authorities had all appeared to have been operating in different ways in that the level of care being purchased and the level of priorities was not necessarily the same. It had been necessary to establish basic standards to be adopted throughout the area covered by Tees Health Joint Administration.

From 1st April 1994 following the merger of the various District Health Authorities to form Tees District Health Authority negotiations had been on a one to one basis. However in 1996 the four towns within the County of Cleveland have demerged and each have their own Social Services Departments. As a result the original position prior to 1992 would be totally reversed and four Social Service Departments would be negotiating with one Health Authority.

The past five years had not only involved substantial changes relating to the constitution of the Health Authority but had also included a national increased awareness in mental health issues. This had included the implementation of Care in the Community, the Care Programme Approach, the retraction of long stay patients from Victorian-type Institutions and the development of smaller mental health units. All of this had impacted on Health Authorities not only with regard to the amount of time and effort that had to be expended in developing those issues but also with regard to the reallocation of finances to provide alternative facilities and the infrastructure to support them.

(B) Planning

From the early 1990's this had involved the formulation, in conjunction with other bodies including Social Services, of strategic policies to meet future needs. Initially, it was accepted, this had been on a fairly limited basis since the Health

Authorities were only just coming to terms in 1991/2 with the new concept of Purchaser/Provider so far as health services were concerned. However from 1992 more concentrated efforts had been made to establish better links and co-operation with and by other agencies and particularly Social Services.

By 1993/4 Tees Health felt that the Hospitals within their aegis had begun to follow through the procedures proposed with regard to the administration of services. They had now established Quality Managers and Quality Assistants whose prime focus was ensuring that services at least matched those standards set out in the Patients Charter.

The Tees Health Authority and County Durham Health Commission both negotiated separately with regard to the provision of services for their respective geographical areas but in the event of any major differences in the negotiated contracts ie with regard to different conditions relating to the Care Programme Approach, then there would be contact between the negotiators of both Health Authorities to resolve the issue.

(C) **Quality Control**

It was recognised that Tees District Health Authority were not responsible for monitoring clinical decisions and judgments made by Consultants or other Doctors working in the Hospital with regard to the nature of the illness suffered or the care and treatment to be given. The medical profession had its own regulatory framework for dealing with incorrect diagnoses and treatment.

In the event of a specific complaint, Public Health colleagues in the appropriate speciality could give advice, but no more, and the matter was better investigated by the regulatory body. If there were a number of complaints about general matters of competency or procedures then the matter would be reviewed by the Hospital's own audit of its professional standards or by Tees Health. It was stressed that there had been no complaints about the level or quality of mental health services provided at Hartlepool General Hospital in general or by any Doctor in particular.

Tees Health was more concerned with establishing the standards for the services which they required the Hospital to attain and then ensuring by regular monitoring that those standards were met. Initially this had been done by Tees District Health Authority physically visiting the Hospital and carrying out a regular audit using the Standard Audit System, but over a period of time the system was integrated within hospital procedures. Accordingly, the primary responsibility for monitoring had been passed back to the Hospital itself, but the type and quality of the Audit had to meet Tees District Health Authority requirements.

(D) Community Mental Health Teams

In spite of the issue of national guidelines with regard to the establishment of Community Health Teams and the wish of Tees Health that these should be established as soon as possible, this had not occurred as had been expected in 1993. The Community Psychiatric Nurses who had been in place for many years continued to provide the only real community mental health service and it was not until April 1994 that the first complete CMHTs involving Consultant Psychiatrists, Social Workers, Psychologists, CPNs and Occupational Therapists had been established.

However it was felt that there had been an ongoing problem with Social Services with regard to involvement in the CMHT and this had principally revolved around a local issue of accountability. In other parts of Cleveland County the Approved Social Worker was seen as being a full member of the CMHT but this did not seem to be the position at Hartlepool. There, the Approved Social Workers had other duties off site which meant that their degree of integration with the rest of the team was not total. Meetings were still taking place in September 1995, while this Inquiry was sitting, to address this issue.

(E) Care Programme Approach

Following the Government's proposals for the delivery of community care in "Caring for People" Cm 849 (1989) Hartlepool General Hospital had implemented its own basic CPA in 1991 before the formation of Tees Health.

At that time the criteria for being accepted for the CPA were:-

(I) that the patient had been the subject of a Section of the Mental Health Act 1983 or
(II) that the patient was being discharged from a long stay ward at Winterton Hospital or
(III) that the patient was likely to be vulnerable on discharge.

After 1993 various changes had taken place in the requirements of the Health Authority for inclusion in the criteria for the CPA and those now comprised the following:-

(I) a continuous period of in-patient care exceeding three months or
(II) three or more admissions to Hospital within a twelve month period or
(III) an enduring mental illness coupled with a history of non-compliance or
(IV) a known risk of harm to the patient or others.

These changes had two distinct advantages over the previous criteria. First the relevant admissions were to Hospital rather than purely to the Psychiatric Unit so that admissions to the Acute Unit following drugs overdoses or other incidents

of self harm would be included. Secondly the need to assess the Patient's vulnerability had been removed, but it was implicit that there would be a risk assessment in every case.

(F) **General Practitioners Attitude**

While great strides had been made in getting medical and nursing staff within the Hospital and Social Workers and others outside the Hospital who would be involved in CMHTs to accept the change in philosophy, concern was expressed that similar progress was not being made with General Practitioners.

It appeared that the GPs still perceived that it was the Consultant to whom a patient would be referred on every occasion, and not the whole of the Team. More would have to be done to educate GPs with regard to the rationale of the CMHT and the multi-disciplinary concept.

There had also been problems with sectorisation which had been introduced in 1995. Consultants were now linked to geographical areas which were based on a patients address rather than the location of the GP's surgery. GPs had become accustomed to referring patients to a Consultant of their choosing but this was no longer possible and while there were considerable advantages in the new system, the perceived difficulties were perhaps causing attitudinal problems and reducing the expected level of co-operation. Again more would need to be done to educate the GPs to the advantages of the new procedures.

(4) **Hartlepool Community Health Council**

The Community Health Council was an independent body with its members appointed partly by the County Authority and partly from other organisations such as Age Concern, MENCAP or the St John's Ambulance Brigade.

The Council operated as the Patient's Watchdog and had two principle functions namely a public function to ensure that proper health services were provided and a private function to investigate Patients' complaints.

The Council made visits to hospitals without warning or invitation, approximately ten times each year. These visits could be initiated because some areas of concern had been raised or simply because the Hospital had not been visited for some time. While no major problems had been discovered at Hartlepool General Hospital the Community Health Council considered that there were a number of current areas of concern or need for improvement as follows:-

(I) Nursing:

Staff Levels appeared to be at a bare minimum and doubt was expressed as to whether the Hospital would be able to cope if there was any sustained period of pressure upon staff.

(II) Psychologists:

Waiting lists for bereavement counselling in particular and other counselling in general were unacceptably long. There appeared to be a regional (if not a national) shortage of qualified Psychologists. This was likely to cause problems not only at the hospital but also within CMHTs established through the County.

(III) Consultant Psychiatrists:

Again waiting lists were unacceptably high and it was felt that insufficient Consultants and other qualified staff were in place for a town the size of Hartlepool.

(IV) Care in Community:

While the theory of Care in the Community was very good and its long term implementation essential, it was felt that too much emphasis was being placed on achieving a programme too quickly without appreciating the long term problems that might be involved. There was concern too that the appropriate infra-structure might not be in place in sufficient time to cope with the anticipated rise in the number of patients expected to be resettled in the Community.

(V) Self Audit:

The Council was not happy with the system of Self Audit which had been established in local Hospitals recently since this was open to abuse. The Inquiry felt however that the systems of monitoring introduced by Tees Health should go a long way to eradicate the possibility of abuse and with the continued visits by the Council this should ensure the maintenance of good standards within the Hospital.

CHAPTER 5

INVOLVEMENT WITH CLEVELAND SOCIAL SERVICES

General History

The town of Hartlepool formed part of Cleveland County and under the terms of the 1970 Social Services Act all social service provision for the town was made through Cleveland County Social Services Committee, there being no separate Social Services Committee for Hartlepool itself. Unfortunately the geographical boundary of Hartlepool District Council for which Cleveland is responsible was not exactly coterminous with the geographical boundary of Hartlepool District Council was not coterminous with the boundary of Hartlepool Mental Health and Community Trust area. The latter Authority included the Easington/Peterlee areas in County Durham and their providers were the County Durham Social Services Committee. The effect of this was that patients in Hartlepool General Hospital could be the responsibility of the Social Services Departments for either Cleveland or Durham County Councils depending on their address at the date of admission or referral.

A revised organisational structure was introduced on 1st September 1991 in order to allow Cleveland Social Services Department to comply with its obligations under the National Health Service and Community Care Act 1990 and the Children Act 1989 the Cleveland County Social Services Committee had provided its services through powers delegated to the Director of Social Services and Heads of Services to Service Managers.

For the District of Hartlepool, which covered a population of approximately 91,000 people, there was one Service Manager for Adult Services and one for Childrens and Families Services. On a pro rata basis per head of the population served, this was slightly less provision than for other Districts within the County, but this was not seen as having caused any problems in itself.

When dealing with Adult Services (which was the one relevant to the Inquiry) the Service Manager was responsible for the division of Elderly Services, Learning Disability Services, Physical Disability Services, Drugs and Alcohol Addiction, and Mental Health Services. This formal structure was introduced in 1991 to ensure that Mental Health, Learning Disabilities and Physical Disabilities, all of which had lacked some provision in the past, had dedicated specialist services allocated to them. The Service Manager in Hartlepool had responsibility for managing two social work adult teams, one Social Services Department Community Mental Health Team, two adult resource teams comprising of Home Care, day care services, and homes for older people and one resource team providing services to people with mental health problems and services to people with learning disabilities.

The third team was the Social Services Community Mental Health Team (SSCMHT) which was physically based in Hartlepool General Hospital some two or three minutes walk from Wards 15 and 16 which comprised the Psychiatric Unit at the Hospital. The SSCMHT had been introduced in September 1991 to define and describe a dedicated Social Work Service working in a multi-disciplinary team setting for people with mental health problems, and was responsible not just for working with individuals referred through the Hospital setting but also for picking up referrals which were referred directly through the formal Social Services Department of people within the Community of Hartlepool. Initially the SSCMHT had consisted of a Team Manager and a full complement of six Social Workers dealing with purely mental health matters although to start with there had only been five Social Workers in place.

It was felt that the SSCMHT could possibly have benefitted from having some additional workers since Hartlepool had one of the highest incidences of mental health problems in Cleveland and the concentration of these problems had an impact on the Team in that they sometimes had to be selective in the work that they undertook. However this had not always been a bad thing as it had concentrated the mind to essential requirements at the time. In any event it was contended that there had not been such a serious shortage of staff as to have caused a major problem and it had not affected this case.

In addition to mental health issues the Social Workers were often required to deal with queries about social services issues, community related issues and housing issues so that it was always necessary to have someone on duty at the Hospital to answer queries from patients or indeed from relatives.

Planning, Recruitment and Training

Since 1992 Cleveland County Council's investment in Mental Health Services had risen from approximately 2% of its total annual budget to approximately 3%, as a direct result of a conscious decision to invest in the development of mental health services, and it was generally felt that this had helped to develop a fairly broad-based system of day services for people with mental health problems.

In particular we were directed to the recent appointment in Hartlepool of an additional Approved Social Worker and two Mental Health Support Workers which had been a welcome and necessary addition to the SSCMHT and as a result the ratio of Social Workers per head of the population in Hartlepool compared more than favourably with any other areas within the County. In addition there had been an increase in the provision of day services available and Cleveland had brought forward specific home care teams which were dedicated to providing services to people with mental health problems. Contacts and contracts had been established with voluntary organisations such as Mental Health Matters (formerly the Northern Schizophrenia Foundation) and MIND.

The recruitment of new staff had necessitated ongoing training in order to equip them with the skills necessary to undertake their responsibilities and in addition there was refresher and top-up training for Approved Social Workers. A programme had been established to ensure that all staff working in mental health settings generally had regular updated training since this was recognised by Management as being essential. Specifically there had been considerable work done in relation to multi-agency training on both forensic social work activity and also in relation to the Care Programme Approach. In the cases of training for Approved Social Workers and for the Care Programme Approach this had involved risk assessment and child protection procedures.

Whilst the statutory responsibility for planning health services lay with Tees District Health Authority, that organisation worked in collaboration with Local Authorities. Since 1990 this has meant that the structures for joint planning had been dynamic rather than static entities. In past years Tees Health had been responsible for producing a policy document in relation to mental health matters and Cleveland Social Services had been invited to comment upon the policy document. Currently Tees Health and Cleveland Social Services were engaged in agreeing a strategy for mental health services in order to qualify for Mental Illness Specific Grants for 1995/96.

At a more local level Tees Health Authority continue to operate Joint Consultative Committees with Local Authorities and these are the vehicles by which Joint Finance is managed and planning of local matters takes place. At provider level, and particularly in terms of implementing the Care Programme Approach local discussions take place between operational managers in both health and in social services in relation to the production of operational policies for care programmes. Regular monthly reports with regard to the implementation of the Care Programme Approach are regularly monitored and discussed by the Director of Cleveland Social Services and the Chief Executive of Tees Health.

Community Mental Health Teams in Hartlepool

It was decided that there should be two multi-disciplinary CMHTs in Hartlepool and as there were six Social Workers this would involve three Social Workers in each Team. However if this was implemented it was considered that there might be a serious deficit of Social Work cover for a particular team due to holidays, courses and other events. It was therefore accepted that a nominated Social Worker would be attached to a Team for a period of six months. That individual would attend all meetings and then bring back the work for allocation among the Social Work Team. As a result the nominated or attached Social Worker would also have the responsibility for feeding back to the multi-disciplinary CMHT, and to the Responsible Medical Officer.

It was considered that a change in the lead Social Worker every six months might occasionally lead to a problem in the level of knowledge held by the relevant parties but past experience had shown that this system outweighed the drawbacks to the alternative system of simply having two Teams each containing three Social Workers.

Links with other Departments, Agencies etc

We were advised that there were regular Social Work Team Meetings to discuss both individual cases and problems, and general policy matters. It was the responsibility of the Social Work Team Manager to attend monthly meetings with other CMHT managers throughout the County and weekly meetings with Social Work Team managers in Hartlepool, and to report back to her own Team on developments or changes in policy.

Involvement with other issues was also quite extensive in that all Approved Social Workers and Managers were invited on a two monthly basis to fora where discussions would take place on many areas and developments within the field of Mental Health. Specialist speakers were often invited to attend.

There was also close contact with Hartlepool as a Community through the Day Centres, the Day Unit and the two development workers attached to the CMHT. In addition the majority of the Social Work Team were long established members of the Team and lived in Hartlepool.

Links with Consultants/Ward

There was no specific link between a Social Worker and a specific Consultant or Ward and the work was very much shared between the Social Work Team members. As indicated above, the absence of designated Social Workers on holiday, courses etc could produce problems and a decision had been made that a more comprehensive service could be given with having block cover. As a result Social Workers might attend meetings held by any Consultant Psychiatrist.

The meetings would almost always be chaired by the Consultant and there could be discussions about individual new cases, general types of work or the relevance of interaction by a Social Worker or CPN. The meetings would also give the Social Worker the opportunity to discuss any cases that the Social Worker was involved with, including clients in the community.

Most of this work was reactive to requests from the Ward or the Consultant for intervention by the Social Worker, but it was not uncommon for referrals to come from GPs and CPNs. Patients on occasion also asked to see a Social Worker. There was no automatic attendance by a Social Worker at a Ward Clinic or Round. Some years previously there had been an arrangement whereby Social Workers attended Consultants rounds or clinics but while one particular Consultant had been working at the Hartlepool General Hospital, Ward meetings had been cancelled so frequently that

the situation had evolved where Social Workers only attended meetings when invited to do so.

It was contended that whilst it was always possible to communicate with the Medical Staff at meetings problems occurred and still do occur, over communication. A Social Worker could be involved with a case and suddenly find that the Consultant had discharged the Patient without any reference whatever to the Social Work Team. It was felt that relationships between Social Workers and the Nursing Staff were good and the opportunity existed for any member of the Nursing Staff to make direct referrals (as opposed to those directed through the Consultant) to the Social Services office and they frequently did so. By the same token, Social Workers felt free to call into the wards on an informal basis to discuss cases with Staff or Patients.

Relationship with County Durham Social Workers

Hartlepool General Hospital's catchment area includes both parts of County Durham and the whole of Hartlepool Borough and the ownership of work is determined by where the person is residing. If a patient was admitted from Durham a Cleveland Social Worker might be involved superficially initially but the work would be handed on to Durham County as quickly as possible.

Only if there was a significant delay in response from Durham County or, very rarely, in an emergency would Cleveland's involvement be anything more than superficial. This had also improved considerably since the County Durham Office had been moved from Seaham to Peterlee and response times had been reduced. In the circumstances involvement with Durham County Social Workers was minimal.

Provision of Social Histories

For many years prior to 1992 the Social Services Department involvement with Hartlepool General Hospital was as a generic team, dealing with all of the social work problems at the Hospital at that time, although a fairly high proportion of the work was involved with the Psychiatric Unit in any event. Frequently a request was made for a full Social History which involved a great deal of time on the part of the Social Worker involved, particularly as it was not uncommon to receive requests for up to twelve Social Histories per week.

In the preparation of a full Social History the Social Worker would obviously see the Patient first and would then seek additional details from the Patient's family and other key individuals in order to clarify their social circumstances. If it became apparent that the Patient was involved with other Agencies and it was likely that they would have a valuable contribution to make, then, with the Patient's consent, the Social Worker would consult that other Agency. The most common one would be the Probation Service if the Patient had a criminal record and that had a bearing on the current case.

During the five years or so before 1992 when the CMHT was established there had been a marked decline in the number of requests for Social Histories and in view of the work that had often been entailed in their preparation the Social Workers had not been unhappy to have this burden removed.

One of the reasons advanced for this decline was that it was seen as good practice for some of the junior members of the Medical Team actually to get to know the patients and the nature of their problems and that this would be facilitated by themselves taking a fuller Social History rather than leaving it to the Social Worker.

We were not impressed by this suggestion which shows a lack of appreciation or understanding of the difference between a Social and a Medical history. The Social history is to provide information about the social context of the Patient and factors which might possibly affect subsequent treatment or care of the Patient. It was suggested that on occasions decisions were made (and no doubt properly) that other work had a greater priority than the preparation of Social Histories and the Consultants were notified accordingly. The impression was given to the Inquiry that while no policy decision had ever been made not to prepare Histories, sufficient difficulties were raised to make the Consultants consider that it was not worth asking for a Social History. We felt that the Social Workers had allowed a situation to develop where an obligation which they had considered fairly onerous had effectively been removed from their aegis and left inappropriately to others.

Contact with Shaun Anthony Armstrong

We were advised that Cleveland County Council Social Services Department had only been involved with Armstrong on the following occasions:

(1) 06.04.92 Armstrong had been admitted to Ward 15 on the 20th March 1992 from a Peterlee address which meant that he would normally be a Durham County case.

On the 6th April apparently as a result of a referral by staff from Ward 11 Armstrong contacted the Social Work Office in the Hospital. The Inquiry was at a loss to understand why the entry should be recorded as having emanated from staff in Ward 11, a general medical ward, since Armstrong had clearly been admitted to Ward 15, a Psychiatric Ward. Armstrong stated at that stage that his then wife, EJA would not allow him to return and he was therefore homeless until the 16th April at which date he had other accommodation available to him. He was seeking help in finding temporary accommodation until then. The Social Worker telephoned Union House and Benedict House, Hartlepool, two independent sector facilities to see if there were any vacancies and an appointment was made for Armstrong to look at Benedict House. The entries in the Medical Case File would suggest that

there was no formal contact between Armstrong and the Social Worker at this time and the matter was dealt with entirely on the phone. However, before any positive action could be taken by the Social Worker she was advised that Armstrong was returning to live with an ex-wife in Plymouth and he was discharged from Hospital on the 7th April.

As the referral had simply related to housing accommodation no assessment was undertaken and no further action was taken by Cleveland Social Services. As no ongoing action was required by Durham County, no information was passed on to their Social Services Department.

(2) 17.03.93

Armstrong was again admitted on the 12th March 1993 to Ward 7 (Medical) at Hartlepool General Hospital following an overdose of drink and drugs and stated that a relationship had broken up and he had no fixed abode.

On the 17th March he again requested assistance with regard to housing and was subsequently offered a place at Union House. On the 22nd March 1993 a temporary and unqualified Social Worker attached to the CMHT at Hartlepool saw Armstrong and after giving him advice and guidance with regard to his housing problem escorted Armstrong to Union House. A follow up visit after the weekend revealed that Armstrong had only stayed one night and had then left without a forwarding address. Again as the only issue had been a housing problem no assessment was undertaken and no further action was considered appropriate or possible.

(3) 05.05.93

Armstrong was admitted to Ward 5 (Medical) at Hartlepool General Hospital following an overdose. He visited the Social Services office in the Hospital saying that he had an accommodation problem.

The Social Worker formed the view that Armstrong was manipulative, not receptive to working with the Social Services Department and that he had a gross personality problem rather than a mental illness. Armstrong also indicated that he was likely to take another overdose if things did not work out.

Armstrong was discharged to no fixed abode on the 6th May 1993. The Social Services Department actually played no part in the rehousing of Armstrong and once again, as this had apparently only been an accommodation problem, no further action was deemed necessary and the file was closed.

The Inquiry was concerned to note that notwithstanding the fact that Armstrong had been in contact with the Social Workers at Hartlepool on three separate admissions within a period of fourteen months following threats of self harm on one occasion and overdoses of drugs on the two most recent occasions, that the Social Workers had continued to deal with the referrals simply as housing problems.

We felt that inadequate enquiries had been made at the initial point of contact to establish fully what the problem really was or to make enquiries of the nursing staff or medical staff to establish details of the recorded history of the Patient, particularly when the Social Worker had recorded the view that Armstrong had a gross personality problem.

It was emphasised to us time and again that so far as Social Services were concerned there had only been three admissions to Hartlepool General Hospital and all of these had been to general medical wards, although it is now accepted that one of those admissions had in fact been to a Psychiatric Ward. Because the referrals had all only involved a housing problem, Armstrong had never been treated by Social Services as a mental health Patient, had never become an ongoing case and had never required any follow up either under the CPA or otherwise. The position had changed somewhat with the development of the CPA but it was still maintained that if in the future a Patient on a general medical ward had similar problems with housing he would be dealt with in the same way.

It was impossible, with the current staffing, for Social Workers to see every patient who attended the Hospital. There was a degree of screening at the initial point of contact by the Nurse and/or the Doctor to see whether Social Work involvement was required. If it was, then the appropriate action would be taken.

Care Programme Approach

General Principles

In September 1990 the Department of Health published a circular HC(90)23/LASSL (90) which stated inter alia "by 1st April 1991 District Health Authorities must have drawn up and implemented, in consultation and agreement with Social Service Authorities, local care programme policies to apply to all in-patients considered for discharge, and all new patients accepted by the specialist psychiatric services they manage from that date. Where a District Health Authority purchases psychiatric services from a self-governing Trust or elsewhere, the contractual arrangements should require these organisations to have adopted the care programme approach".

The Care Programme Approach (CPA) is a system and process for providing services to people who have a mental health problem and have been accepted by the specialist mental health services. The CPA as outlined in the Department of Health Circular HC(90)23/LASSL(90) "required, inter alia, that if, after assessment, a patient referred

to psychiatric services can realistically be treated in the community the Health Authorities in conjunction with Social Service Departments have a duty to ensure that proper arrangements are then made, and continue to be made, for the continuing health and social care of the patient treated in the community".

The purpose of the CPA is to ensure the support of mentally ill people in the community thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention. It applies whether or not a patient has been compulsorily detained under a Section of the Mental Health Act 1983 but health and local authorities also have a statutory duty under Section 117 of that Act to provide aftercare services for patients who have been the subject of compulsory detention under a Section of that Act.

The essential elements of an effective care programme are systematic assessment of the patient's immediate and longer term requirements with regard to health and social care, an agreed and recorded care plan, the allocation of a key worker and a regular review of the patient's progress and continuing needs. All decisions and actions should be systematically recorded and all parties should be aware of all of the details of the care plan and accept them.

It was also essential that all parties should have access to information relating to any past violence or risk of violence on the part of the patient so as to be able to assess properly the possibility of risk to others. Parties should also be aware of what actions were necessary if the Patient failed to attend for treatment or to meet other requirements or commitments of the care programme.

In a number of cases where something has subsequently gone wrong poor co-ordination of services or communications between those involved has been a major factor. The CPA with its emphasis on systematic health and social care needs, requires close inter-disciplinary and inter-personal working, particularly at critical times such as when discharge from Hospital is being considered.

A proper assessment cannot be made in the absence of full information about a patient's background, present mental state and social functioning and also his or her past behaviour since "nothing predicts behaviour like behaviour" (Panel of Inquiry re Kim Kirkman). It is essential to take account of all relevant information whatever its source including the treatment team, the patient, relatives, the Police, Probation Officers, Social Workers and even concerns expressed by neighbours. Too often it has proved that information indicating an increased risk existed but had not been communicated and/or acted upon.

In assessing risk there were also other matters which could be taken into account such as statistical evidence that violence was involved much more frequently when drug or alcohol misuse co-existed with a major mental disorder.

Social Services Departments have duties under the NHS and Community Care Act 1990 to assess peoples needs for community care services and multi-disciplinary assessment under the CPA, if properly implemented, will fulfill those duties. It was therefore essential that Health Authorities and Social Service Departments ensured that the CPA and care management arrangements were properly co-ordinated.

The CPA and Cleveland Social Services

Following the issue of Health Circular HC(90)23/LASSL(90)11 the CMHT at Hartlepool immediately put in hand (and they were among the first in England to do so) a limited form of CPA with effect from early 1991. At that stage, although the circular suggested that the CPA should apply to any patient accepted into secondary psychiatric services this was clearly not possible with the limited staffing available and accordingly a decision was made at local level that the CPA would be targeted at the patients with the most severe mental health problems.

By 1993 a policy document had been drawn up between the operational or Provider staff in Social Services and the Provider staff in the Community Mental Health Unit in Hartlepool. Again, because of the limited staff available, it was recognised that not all patients could be covered and the policy document specified that so far as Hartlepool was concerned the CPA would be implemented only if the patient fell into one of the following categories:-

(I) a continuous period of in-patient care exceeding three months or
(II) three or more admissions to Hospital within a twelve month period or
(III) an enduring mental illness coupled with a history of non-compliance or
(IV) a known risk of harm to the patient or others.

Since the issue on 10th May 1994 of NHS Executive HSG(94)27 protocols had been developed at strategic planning levels between the Social Services Authorities and Tees Health. Concern had been expressed by a member of Social Services that in Cleveland County the CPA was "simply stuttering along". As a result it had been decided that there should be one specific person who was unambiguously responsible for driving through the implementation of the CPA throughout Cleveland County.

In November 1994 an existing operational Service Manager was assigned the lead responsibility for the implementation of the Care Programme Approach within Social Services. She undertook this responsibility in addition to her full-time duties. Together with a manager from Tees Health Authority they comprised a core group which reported on the implementation of the CPA to the Chief Executive of Tees Health and the Director of Cleveland Social Services Department.

Within Social Services the Service Manager brought together on a regular basis the Team Managers of the Social Services Department Community Mental Health teams to manage the implementation of CPA. Additionally, from January 1995 there was a

Mental Health Forum comprising key managers of Health and Social Services Departments. The aim was to establish a system whereby every patient (with no distinction between mental illness and psychopathic personality) who was admitted and received secondary psychiatric treatment would have his case discussed by an experienced multi-disciplinary team who would decide whether the patient needed to be included on the Supervision Register or required a partial or full CPA with a built-in system of monitoring.

By and large it was considered that things had improved, and were still improving, but the system was not perfect in that the CPA was still not in place for every patient. The principal difficulty had been one of culture.

When the idea of the CPA had first been promulgated it had been considered as something special that staff were being asked or instructed to add on to their treatment of psychiatric patients in appropriate cases.. What had to be got over and accepted by the staff was that the CPA was part of a philosophy of treatment and should be an integral part of normal psychiatric services rather than something special. This was being achieved slowly but it was taking, and would continue to take, considerable training and retraining before all psychiatric staff fully understood the philosophy and procedures.

The CPA, Cleveland Social Services and Armstrong

It was maintained on behalf of Cleveland Social Services that the CPA had not been implemented in respect of Armstrong and should not have been implemented on the basis of the amount and nature of the information available about Armstrong at that time because it was considered that Armstrong's problem had related simply to housing and no follow up had been required.

We found the statement that Armstrongs problems had related to housing too simplistic. We accepted that his immediate problem on each of three occasions when Cleveland Social Services were involved was perceived both by Armstrong and the Social Worker involved to be solely that of housing but in fact further enquiry would have revealed that there were considerably more problems which should have been investigated on a multi-disciplinary basis.

The fact that this did not happen suggests to us that there was poor communication between the agencies on the site. This is emphasised by the fact that when Armstrong was last admitted to Hartlepool General Hospital on 6th June 1993 no notification of that admission was given to Social Services even though housing was still an issue.

It was maintained that Cleveland Social Services Department would not have considered Armstrong for the CPA on any of the admissions of which Cleveland Social Services were aware in that he did not comply with the criteria that existed at that time at Hartlepool for inclusion.

We felt that in view of the history of his admissions and the apparent reason for them, namely breakdowns in relationships, homelessness, self harming, attempted suicide and admitted alcohol and drug dependency, Armstrong should have been accepted as falling within the category of likely to be vulnerable on discharge and consideration should have been given to the possibility of the CPA being applicable to him.

It was accepted on behalf of Social Services that on occasions they would be involved in making a decision on vulnerability but in the case of Armstrong since he was not accepted as a case by Social Services the decision as to vulnerability and therefore qualification for the CPA must on each occasion have been made by the Consultant Psychiatrist following observation from the Medical and Nursing Team. While we accepted that this in fact had happened, we felt that for reasons previously noted Social Services should have been involved.

It was suggested that as Armstrong had been admitted from addresses in County Durham he should in fact have been the responsibility of County Durham Social Services Department and this we accepted in part. The proper procedure for dealing with a patient from County Durham would be to refer him on to the Social Services Department in Durham. By accepting the referral in the first place, and taking action to resolve the problem, the Cleveland Social Services had accepted some responsibility either for dealing with the problem or for obtaining the appropriate information before passing the case on to Durham County Social Services.

It was also suggested that even if the present somewhat improved CPA arrangements had been in place in 1992 and 1993 it was likely that Armstrong would still not have been accepted under the CPA. It was stressed that the CPA involved a multi-disciplinary decision and the agreement and co-operation of the Patient. We accepted that the indications were that Armstrong had been a manipulative man who was unlikely to cooperate in anything unless it achieved his particular objective, but an opportunity had been lost to investigate matters fully and to decide whether the CPA was appropriate and if it was, how best it could be implemented.

Information and Confidentiality

Following the tragic death of Rosie Palmer there had been considerable public debate about whether Social Services in general, and Cleveland Social Services in particular, had known that Armstrong had previous allegations made against him of child abuse and if they had been aware, could they have shared the knowledge with a wider group such as the local community in the Headland?

It was stressed that Cleveland Social Services were not aware of previous allegations. Even if they had been, it was clear from the way the law is currently prescribed in guidance issued by the Department of Health and other agencies, not least the issues surrounding medical confidentiality, that such information could not be shared.

It became clear to Cleveland Social Services after Rosie Palmer's murder that

Armstrong had previously been involved in Child Protection investigations by Durham Social Services and Durham Police and that other information was known to the Durham Probation Services. If Armstrong's case had been taken up as being suitable for further investigation and action, the enquiries could and would have been addressed to the Agencies in County Durham, but no action had been considered appropriate.

If any of the referrals to Cleveland Social Services about Armstrong had related to concerns about a child then it would have been the policy to make enquiries of the appropriate Social Services Department and it was the expectation that they would supply information with regard to investigations that they had carried out against that man but which had not been substantiated. However it was pointed out that Government guidelines indicated that the only way in which this information which is regarded as confidential can be made available is if there is a perceived threat to a specific and named child. It was not possible, for instance, to go on a fishing trip for information by addressing a general enquiry to a Social Services Department about any investigations that they might have undertaken in respect of an individual.

While we accepted the need for confidentiality and the protection of individuals rights to some extent, we felt that, in many instances, the lives or safety of others was more important than a possible breach of confidentiality and that there should be a better system for the retrieval of information about alleged offenders.

CHAPTER 6

INVOLVEMENT WITH DURHAM COUNTY SOCIAL SERVICES

We were advised that Durham County Council Social Services Department had only been involved with Armstrong on the following occasions:-

Chronological Summary:

(1) 10.6.1992 Referral from Easington District Council relating to proposed adaptation of property.

(2) 29.11.1992 Referral from Peterlee Police initiating Child Protection investigation in respect of alleged abuse by Armstrong of his step-granddaughter (C).

(3) 9.3.1993 Referral from Peterlee Police in respect of (D) aged 11 years with whom Armstrong was then living.

(4) 15.3.1993 Referral from Ward 7 Hartlepool General Hospital on behalf of Armstrong about his home circumstances prior to discharge.

(5) 25.5.1993 Referral from school in respect of (D).

(6) 6.7.1994 Enquiry from local GP on availability of support to Armstrong's relatives in Easington area.

(7) 8.7.1994 Enquiry from Hartlepool Probation Service regarding past involvement.

We found the apparent lack of any contact prior to 1992 very surprising in view of the fact that we received evidence from other sources that while resident in County Durham,

(A) Armstrong had been convicted as a Juvenile of a number of offences.

(B) Armstrong had been involved at one stage with Durham Child Guidance relating to sexual problems.

(C) Both the Durham County Police and Probation Services were involved with Armstrong in 1988 when he was on Parole from Prison and there was question of Recall following an allegation of sexual abuse by Armstrong upon one of his step-daughters by his second marriage. We were assured that a careful check of records had been made and there was no documentary evidence of any other involvement.

(D) In 1991 Armstrong's second wife was arrested and the Police Child Protection Unit became involved because Armstrong was thought to have abused her two grandchildren. The matter was investigated by the Police and recorded with a view to referring it to Durham County Social Services Department although the latter has no record of such a reference.

Relevant Referrals and Action Taken

1. 29th November 1992

In 1978 Durham County Social Services had established an Emergency Duty Team of Social Workers to cover emergency problems which arose outside normal working hours. The Team consisted of five very experienced Social Workers who covered the whole of Durham County and who were based at Ferryhill which it had been decided was the geographically most appropriate site. Although the Team was generic in nature there were specialists in child protection and other fields.

The Team had a Team Manager who was based at Easington and who was employed during the "normal" working week. Since the Team principally worked outside those hours they were empowered to make their own decisions about action to be taken at the commencement of a case and details were relayed to the Team Manager the following working day, when the case would be allocated to an appropriate Social Worker in the District concerned.

At their offices at Ferryhill the Team had access at all times to the Children at Risk Register so that they could immediately check if the subject of a referral was already on that Register. However that Register was apparently only updated every three or four weeks and could on occasion be out of date.

At the present time the Team still has no immediate access to the computer which is operated by Durham County Social Services since the computer is unmanned after 5pm and at weekends. We felt that in an age of advanced technology it was incredible that this vital part of the Social Services operations had not been provided with some facility to access the computerised information during the Team's hours of operating.

A member of the Police Child and Family Protection Team at Peterlee Police Station had contacted the Social Services Department emergency Duty Team on the 29th November 1992 at Ferryhill and had initiated a Child Protection investigation following a Report by Armstrong's step-daughter (B) of Peterlee that Armstrong had sexually abused her daughter (C), (Armstrong's step-granddaughter) who was then aged two years ten months.

Among other information supplied by the Police to the Emergency Duty Team Social Worker was that Armstrong had had an incestuous relationship with his own mother and that Armstrong's stepdaughter (B) had alleged that both she and her younger sister had also been sexually abused by Armstrong when they had been aged about fifteen or sixteen years of age and living with their mother.

At the time there was no policy to contact all appropriate Agencies in relation to an allegation that had been received. It would be the policy to see the person or persons concerned and in the light of what was then learned make a decision on future requirements such as a Case Conference.

On receipt of a referral it was normal practice to check with the Police to see if the person concerned had a criminal record and in view of the urgency of the situation this was done by telephone. A reply was received to the effect that Armstrong had no relevant convictions. It was felt that a conviction for an offence against the person would or might be relevant but nothing was disclosed about Armstrong's conviction for Assault Occasioning Actual Bodily Harm to his mother on the 4th December 1984. At the same time it was also confirmed that the child was not on the Child Protection Register.

In conjunction with the Police at a Strategy Meeting a decision was made to interview Armstrong's step-grandaughter (C) at Grampian House and record the interview on video tape while the alleged abuse was still fresh in the child's mind. In fact two videoed interviews took place on the 29th and 30th November 1992 in the presence of a Social Worker and a Policewoman but the step-grandaughter (C) made no reference to any sexual abuse although she did indicate that she wanted to kill Armstrong because "he hits me".

On the 29th November 1992 Armstrong was admitted to the Psychiatric Unit at Hartlepool General Hospital and a decision was made not to interview him while he was receiving treatment in Hospital but that the Police would interview him on his discharge. Unfortunately neither the Police nor the Social Worker who were both aware of the allegations being made against Armstrong transmitted any of this information to Armstrong's Consultant who was under the impression that Armstrong's overdose had been taken as a result of relationship problems.

The reason given for this failure to transmit information was a possible breach of confidentiality.

We found this view extraordinary. In view of the nature of the allegations and Armstrong's admission to a Psychiatric Unit it should have been apparent to anyone involved in the case that the more information the Consultant had, the better able he would be to plan the patient's treatment and the greater the possibility of preventing future problems. Whether the disclosure of such information would have helped to prevent the ultimate tragedy which occurred

must forever remain a matter for speculation. What is clear though is that there was a breakdown of communication at a potentially crucial stage.

Had the Consultant received details of the allegations it might have resulted in a change of emphasis in his treatment plan. It might have helped him to make the link between Armstrong's admissions to Hospital and the allegations being made against him. It might also have helped him to make the connection when, in May 1993 one month before Armstrong's last admission, his step-daughter (B) made allegations against Armstrong when being treated by the same Consultant.

The Consultant would almost certainly have contacted the Specialist Child Agencies or referred Armstrong on to a Psychotherapist who could then have explored Armstrong's sexual problems more fully in the hope that by expressing his thoughts verbally he might be less likely to carry them out in practice.

As indicated above the preceding two paragraphs are pure speculation but they illustrate possible consequences and actions based on information supplied and demonstrate the importance of all relevant information being made available at all times to those in a position to use the information to its best advantage.

On the 30th November 1992 Armstrong's step-daughter (B) was seen again and was adamant that she would not allow her children including her daughter (C) to visit their maternal grandmother's house (where Armstrong had been living) ever again. It was intended that a further visit would be made to Armstrong's step-daughter (B) following Armstrong's discharge from Hospital, but at that stage it was decided by the Social Services Department Team Manager that no Case Conference would be necessary.

In December 1992 the position was checked with the Police who confirmed that they had not yet interviewed Armstrong but that it was believed that he had been discharged from Hospital and was living in Hartlepool but no effort was made to check Armstrong's address at that stage.

On 22nd March 1993 it was confirmed that Armstrong had made no contact with any member of the family since the investigation had begun in November 1992. The Police also stated that they had finally managed to trace Armstrong two weeks previously but that he had totally denied all allegations made against him.

We were advised that Social Workers often have to take at face value what they are told by parties involved in a case. In this situation they felt that the mother was sensible and had acted appropriately and in assessing the level of risk to the child it was not felt that she would wilfully allow Armstrong to come into contact with the child again. We were however concerned that no effort whatever was made to check the position for a period of very nearly four months.

In view of the lack of formal complaint from the child Armstrong's step-granddaughter (C) and the lack of any additional evidence the Police decided that they could not take the matter of the alleged abuse of that child any further. Similarly in the case of the allegations of abuse against Armstrong's step-daughter (B) and her sister the Police also decided to take no action.

The Child Protection investigation was then closed without a Case Conference being called although the Social Worker making the final entry in March 1993 on the Case Papers recorded that in her opinion "he (Armstrong) is likely to be a risk to any child he comes into contact with". This view was not transferred specifically to anyone else but presumably was seen by the Team Manager before the file was formally closed.

We were advised by the very experienced Social Worker dealing with this referral, and who recorded the above entry, that in her opinion the child had been abused and if what was being related about Armstrong's incestuous relationship with his mother was true then he was likely to have had a very damaged personality. The Social Worker was also aware of the fact that abusers often take overdoses or inflict self harm (both of which occurred in Armstrong's case) when they are being investigated and therefore felt that Armstrong was potentially a danger to others. The Inquiry could not understand how or why in those circumstances and armed with the available information, more efforts were not made to bring those feelings about the potential risk to the attention of others.

There were occasions (fortunately rarely) where a person was known to have been convicted of offences where the Department had approached other Agencies and indicated that the person was at large within the area and a potential danger to others. This was possible where the department was aware of the offenders haunts and methods of operating. Unfortunately, even if the risk had been appreciated, the case would still have caused problems because Armstrong's whereabouts were unknown. While accepting these problems the Inquiry felt that the principal error had been in the fact that the risk was either not sufficiently appreciated or, if it was, not enough was done to make others aware of the problem.

It was stressed to us time and again in this Inquiry that the Child Protection investigation, as its very name implies, is concerned with the safety and protection of the child; that it must satisfy itself as to whether a child is in fact at risk and if it is then a Case Conference must be established and all necessary steps taken to ensure the continued safety of the child. Case Conferences are not established to deal with potential abusers but children who are at risk.

On this referral it was stressed that the Department had been satisfied that the mother of the child would not allow the child to visit the maternal grandmother's home and that in any event the maternal grandmother had removed Armstrong

from her property and that neither of them was likely to permit any further contact between Armstrong and his step-granddaughter (C).

As a result it had been decided that in the view of the Social Services Department the child was no longer at risk and no Case Conference was necessary. Subsequent events had fortunately proved this decision to be correct.

It was accepted that there was a secondary issue relating to Armstrong himself and the possibility of him harming other children.

However this was an entirely different issue from that which the Social Services Department were investigating namely the risk to the particular child (C).

It was stated that there are a range of issues relating to offenders against children but there is no national clarity or imperative on particular agencies to take a particular course of action. The matter is relatively simple where the person is a Schedule 1 offender but Armstrong was not a Schedule 1 offender and therefore not registered with any of the agencies. In the absence of any National Guidelines the Durham County Social Services Department policy was to consider the need to register the child. The name of the alleged abuser would not be placed on the Child Protection Register.

The Area Child Protection Committee were currently exploring the feasibility of establishing a Register of Schedule 1 offenders to be held by the Probation Service *but even if this Register had been in place at the time Armstrong would not have been entered as he had never been convicted of a Schedule 1 offence.*

Similarly, as the law currently stands, there is no apparent way in which a statement such as that recorded by the Social Worker with regard to the potential risk that Armstrong posed to any child that he might come into contact with, could in fact be registered or recorded in a document or register to which access could be obtained by any agency in subsequent investigations.

Whilst the involvement of the same Social Worker in another case or attendances at Case Conferences might throw up the appropriate information this could clearly not be relied upon and in any event Armstrong himself had moved addresses on a number of occasions and had therefore been involved with different Social Services Departments.

Our attention was also drawn to the civil liberties aspect of the handling of delicate information. Within the Child Protection arena it was felt that Social Workers and others were already taking certain risks with regard to the giving and sharing of information and justified those risks by the nature of the work that they were doing and the protection of children. However there were risks involved particularly in the area of unsubstantiated allegations and these risks had to be weighed very carefully.

We were advised that a new computer system was being installed (but was not yet operational) which would have the facility to record the name of an alleged abuser and link this to other cases but in view of the civil rights issues referred to above further legal advice was being sought about the implications of introducing this system.

2 (A) **9th March 1993**

As a result of the Police interviewing him in respect of an unrelated matter Armstrong was eventually traced to Wingate, where he was then living with CA whom he had met whilst in Hartlepool General Hospital. The allegation of abuse of his step-granddaughter (C) was put to Armstrong but as indicated above this was completely denied and no further action was taken by the Police in connection with the original allegations although the Police did return the following day and remove Armstrong from CA's property as a result of a domestic dispute.

Concern was expressed because CA's son (D) aged eleven years was living at that address and in view of the previous investigation and the fact that CA was an alcohol abuser, it was felt that the matter should be investigated but the Social Worker reported no undue concerns about the care of the child. Indeed the School reported that the child was coping remarkably well and apparently unaffected by any problems at home.

2(B) **28th May 1993**

The Headteacher of CA's son (D) school expressed concern about the standard of care being afforded to (D) by his mother.

The above matters were investigated by the Social Worker dealing with the case but Armstrong was not in fact seen and the only involvement appears to have been a reference by CA that her most recent lodger (allegedly not Armstrong) had been violent towards her in the presence of her son.
Armstrong was stated to be no longer resident at CA's address and no further follow up was deemed necessary. However the Inquiry heard from other sources that when Armstrong was admitted to Hartlepool Hospital in both May and June 1993 it was from CA's address in Wingate and on each occasion she was named as his Next of Kin.

3. **15th March 1993**

A Staff Nurse from Ward 7 at the Hartlepool General Hospital contacted the Social Services Department saying that Armstrong whose address was then stated to be at Wingate, had been admitted to Hospital following an overdose, was refusing to discuss with anyone at the Hospital the nature of his problem but wished to speak to a Social Worker about "his home circumstances prior to his discharge".

The Durham County Social Services Department had adopted a specialist team approach with the Community Mental Health Team in the Easington locality based across two sites at Seaham and Peterlee. Within the Specialist Mental Health Team there was a specific Social Worker whose role included acting in a liaison capacity with the Psychiatric Unit at Hartlepool General Hospital. His duties would include, when requested, attendance at Ward rounds and Care Programme Approach meetings on those individuals referred to the Department.

On receipt of a referral the Duty Officer would check the computer index, which had been established by 1993, and which contained the names, addresses and status of all of the Department's clients. On this occasion the computer showed that nothing was known about Armstrong, presumably because his name was not recorded in relation to the Child Protection investigations.

The Social Worker contacted the Psychiatric Unit at Hartlepool but was advised that Armstrong had not been admitted to that Unit. After making further enquiries the Social Worker contacted Ward 7 (General Ward) at Hartlepool only to be advised that Armstrong had already been discharged to no fixed abode which effectively precluded any further involvement by the Social Worker concerned, and the file was closed on 1st April 1993.

Information Systems

In 1992 the Durham County Social Services Department operated separate information systems with regard to children who were in the looked after category and families or individuals in respect of whom there might have been a general inquiry. In addition there was an entirely separate Child Protection Register with the result that a request for information from any of the systems or registers would only disclose information pertinent to that system or register and there was no proper system of cross referencing information. In addition there was no Register of Schedule 1 offenders.

Unfortunately there will always be cases where particular individuals do not meet the criteria for entry in particular Registers or records but although this cannot always be overcome, since 1992 the Department has been working towards a more integrated client record system in the hope that past anomalies might be avoided. In addition there is a degree of dependency on links formed between the Department and other agencies or individuals which in the context of Case Conferences often provides

essential information not otherwise immediately available.

With hindsight it is clear that other important information about Armstrong was held by other individuals and agencies. If Case Conferences had been held (and we were told that there were cogent reasons why they were not) an invitation would have been sent to the GP and other appropriate agencies and individuals. Whether those other people would have attended or supplied any relevant information will never be known.

Again during the 1992/93 period there were problems with regard to the information available due to the fact that Armstrong lived at a number of different addresses and on his discharges from Hospital there was often a doubt as to where he was to live and what Department would in fact have responsibility for his case. A further problem was created by the fact that Easington residents could be involved with a number of different health service providers and during that period there were a number of significant changes in relation to the Trusts that operated in those areas.

In 1992 the Durham County Council Social Services Department was acting in Mental Health matters on a reactive basis to requests for help, information or involvement, and there was no routine attendance of specialist workers at ward rounds or clinics or attachments to particular wards or links with multi-disciplinary teams or consultants. Since then the Department has begun to develop a more integrated approach to looking at the needs of Easington and standardising operations for Easington as an area.

Hartlepool had already drawn up their protocol for the Care Planning Approach which was geared to their own centre of population and what was required was a more integrated approach to Easington as a locality. However this would depend upon an approach being made by the Psychiatric Unit at Hartlepool to which Durham Social Services Department would then respond.

When Armstrong was discharged from Hospital to live in the Hartlepool area, Durham County Social Services Department were not aware of the fact or indeed of his address. Even if they had been, they would not have been able to pass on information to Cleveland Social Services as they had no information to pass. Armstrong was not a Schedule 1 offender. There was no relevant child on the Child Protection Register. And finally such allegations as had been made against Armstrong had all to some extent been investigated and a decision taken that no further action was to be taken either by the Police or Social Services.

Registers

It was pointed out to the Inquiry on a number of occasions that there are serious civil liberty issues and limits to the extent to which information about alleged abusers or offenders can be recorded if the allegation has not been substantiated in a court of law. The law of Libel could preclude the recording of any unsubstantiated allegation or at best make the recorder consider carefully the degree of information which could be recorded.

Care should also be taken to ensure that undue reliance is not made on registers in relation to assessing the risk to a person whether it is a Register of Children at Risk or a Register of convicted offenders. The mere fact that someone is not on a register does not lessen the risk and there could be a danger of people checking a register and because a name was not there it might lessen their level of concern.

For a Schedule 1 offender there is a legal requirement upon a person being released from Prison to notify the authorities of the address to which they will be going. Unfortunately there is nothing in law to prevent them, the very next day, changing that address and there is no further legal requirement to notify an address. Clearly this is quite wrong and representations are already being made nationally to the Government urging that the Courts be given powers to impose a duty upon released Schedule 1 offenders to notify the authorities of all of their addresses for a given period after their release, possibly until the conviction is "spent". This might in fact be more effective than a Register, particularly if the Court was given sanctions for failure to notify.

Care Programme Approach

It was stressed that on none of his discharges had Armstrong ever been made the subject of a CPA and therefore Durham County Social Services Department had never been invited to take part in such a programme involving Armstrong.

Attendance at Ward Rounds/Clinics

We were advised that for many years Durham County Social Workers had attended the Ward rounds or clinics held by Consultants or other Doctors at Hartlepool General Hospital but that this had always been at the specific invitation of the Medical Team and that there was no policy for automatic attendance.

Although the Medical and Nursing Staff's perception of the current situation was that Social Workers now attended Ward Rounds as a matter of course, and while perhaps this occurred with Cleveland County Council Social Workers, there had definitely been no change in policy so far as Durham County was concerned since Social Workers still expected to receive an invitation before attending a Ward Round.

We felt that it was unacceptable that such differing perceptions of the situation should still exist even after difficulties have been highlighted by a case such as this.

CHAPTER 7

CONSULTANT PSYCHIATRISTS

(1) Dr Subhas Chandra Roy

Dr Roy had been employed as a Locum Consultant in the Northern Region for approximately eleven years, including the period December 1987 to late March 1994, at Hartlepool General Hospital. Although Dr Roy had the qualifications MBBS, MRCP(UK), MRCP(I) and DPM, he had not obtained the qualification MRC Psych. without which the Royal College of Psychiatry would be unlikely to recommend appointment to a Consultant post.

Armstrong was first admitted on 20th March 1992 to Hartlepool General Hospital under the care of Dr Roy. He told us that Armstrong was in fact already well known within the Psychiatric Unit prior to that as he used to drop in fairly regularly when his mother, Mrs Matthews, was attending the Day Unit and also visited his mother until 1990 when she was being nursed on the Ward during her terminal illness. The Inquiry felt that in these circumstances Armstrong should have been "well known" and was both surprised and concerned when subsequent questioning of relevant staff did not confirm this.

Admission on 20th March 1992

Armstrong was admitted informally to Ward 15 of the Psychiatric Unit at Hartlepool General Hospital following a telephone request from his GP. On his admission Armstrong gave a history of self-laceration of his arms and overdosing on his mother's prescribed Parnate and said that he was worried he may harm himself again. At the time he was living with his second wife at an address in Peterlee and stated that he was feeling depressed and unable to cope with the pressures of life.

There were allegedly several problems within the family including a hostile step-son, a wife who also had alcohol related problems, chronic anxiety, agoraphobia and dependency on tranquillisers, and step-children who took advantage of him by leaving him much of the domestic and family responsibilities with which he could not cope. These difficulties were causing him to be chronically depressed which, in turn, exacerbated his own drinking problems, which then made him even more depressed.

The Inquiry was struck by the paucity of the History of the Patient obtained by the admitting Doctor (since deceased) and subsequently by the Consultant. It is a fundamental principle in the field of Psychiatry that a full chronological history of the Patient's past physical and mental problems is taken at the point of admission to enable those caring for the Patient to be able to devise the most appropriate Care Plan for the Patient. It is equally important that the history should be accurate and updated whenever appropriate. As will become apparent later in this Report, there was a signal failure on several occasions to record a chronological history, obtain information which was available elsewhere or to verify the accuracy of significant details in Armstrong's history, all of which could possibly have led to a different approach to Armstrong's treatment.

As a result of the admitting Doctor's Notes, and in particular the references to depression, Dr Roy called for the Medical Notes (which were kept on the Ward) of Armstrong's mother, Mrs Matthews whom Dr Roy was aware had been treated on the Unit by one of his colleagues. Dr Roy wished to know whether Mrs Matthews had suffered from manic depression as this would have been significant in diagnosing Armstrong's own problems. The Notes however disclosed that Mrs Matthews had suffered from a chronic neurotic illness.

Having obtained Mrs Matthews' Notes, Dr Roy either failed to read the complete file or simply overlooked an important reference in those Notes to the fact that Armstrong was the product of incest between his mother and his maternal grandfather. Certainly this was never documented in Armstrong's own Notes, although the Consultant did record details of certain criminal convictions of Armstrong that had been referred to in Mrs Matthews' Medical Notes.

During the course of this admission Armstrong made a number of statements about his past history including the following:-

(A) that he had received a Dishonourable Discharge from the Navy for shooting a Chief Petty Officer

(B) that he had found his wife committing adultery and had thrown the male through a window. As a result of this assault he had received a two year prison sentence of which he had served 14 months.

(C) that his mother had sexually abused him as a child.

Each of these allegations was recorded as a fact and allegations (A) and (B) apparently demonstrated a potential propensity towards serious violence towards others. The Inquiry was very surprised to discover that at no stage had the Consultant, or indeed any of those caring for Armstrong, made any effort whatever to discover any further details about the alleged incidents and whether they had in fact happened.

The Inquiry was equally surprised that, in view of the general acceptance that those who have been abused often themselves become abusers, greater efforts were not made to investigate Armstrong's statement that he himself had been the subject of sexual abuse as a child from his own mother.

As the Inquiry discovered by obtaining a list of Armstrong's previous convictions and other enquiries, allegations (A) and (B) were in fact totally untrue and simply other examples of Armstrong's ability to lie or invent stories to make his own life appear more exciting. However, the concern of the Inquiry was not the validity or otherwise of the allegations but the fact that no effort whatever had been made to verify the accuracy of serious allegations. This was a serious omission as subsequent assessments were based on this initial history.

Armstrong also disclosed during the course of this admission that he had a drink and drugs problem (especially relating to DF118) and that his wife and his step-daughter had all been patients on the Ward which was to become relevant later. Subsequently he claimed to have had nightmares regarding the incident with the Chief Petty Officer referred to above.

On this admission (and indeed on subsequent admissions) Armstrong settled quickly on the Ward and clinically there was no evidence that he was suffering from a depressive illness since his symptoms of low mood etc. were thought to be reactive in nature due to his personal circumstances. Although a diagnosis of psychopathic personality disorder was made, the Inquiry was surprised to note that this diagnosis was not in fact recorded in the Nursing Notes. This might have caused considerable problems for those caring for Armstrong in the event of the absence elsewhere of the Consultant.

In view of the diagnosis Armstrong was told that there were no tablets which could be given to him to resolve his problems but that he could remain in Hospital for a short while until his marital problems had been resolved. In fact Armstrong's own perceived problem at this stage was simply his accommodation since his wife was unwilling to have him home.

Referral was made to the Social Services Department who suggested the possibility of either Union House at Southgate, Hartlepool or Benedict House, Park Road, Hartlepool and an appointment was made for him at Benedict House although Armstrong did not in fact attend. Instead Armstrong returned from a short period of leave indicating that he had met his first wife and she was agreeable to him going to live with her in Plymouth.

He was finally discharged on 7th April 1992 with the advice to continue Dihydrocodeine 30mgm b.d. and Cimetidine 400 mgm b.d. No follow up appointments were made in view of the fact that Armstrong was allegedly leaving the area.

While on the Ward the questions of Armstrong's admitted dependence on alcohol and drugs had been addressed and he had been counselled about the wisdom of coming off his sleeping tablets and also cutting down his alcohol consumption. He was also advised to see the NECA Counsellor after discharge, which he failed to do. On this occasion it might have proved difficult to follow up this aspect of Armstrong's after care but the Inquiry felt that the informal arrangement of simply advising a Patient to attend the Drug and Alcohol Advisory Service was very unsatisfactory and that much more positive action was necessary.

Following Armstrong's discharge the usual Discharge Letter was forwarded to his GP. The Inquiry was advised that generally Discharge Letters were written not by the Consultant but by Junior Doctors and often not checked or seen by the Consultant. On this occasion the letter was written by a Junior Doctor and contained no reference to the diagnosis and no reference to any of the significant disclosures made by Armstrong while being treated on the Ward. We found the failure to share such information with the Patients GP wholly unacceptable and undesirable in the interests of the patients best future treatment. We also felt that, while accepting the pressures under which Consultants often work, it is imperative that Consultants should monitor the detail and content of Discharge Letters to ensure the accuracy of recorded information so that the GP has the best information available to him.

Admission on 29th November 1992

Armstrong was admitted to the Psychiatric Unit from his second wife's home in Peterlee stating that he had pressures in his social life for over two months which had precipitated him into slashing both forearms on numerous occasions and taking several overdoses of prescribed medication. He was also getting into considerable debt and drinking excessively to cope with his problems. On this occasion he stated that he had taken: 8 Ferricolin Folic, 4 Co-codamol, 1 Tagamet, 4 x 20mg Temazepam and 6 DF118 prior to admission. He received detoxification to which he responded well.

He was seen by Dr Roy on the 30th November when a diagnosis of personality problem with addiction problems was made. Again, he settled quickly on the Ward with no evidence of a depressive illness and by the 1st December he was asking to see a Social Worker stating that he was separated from his second wife and was homeless. Again Armstrong perceived his major problem as that of being homeless.

On 4th December Dr Roy discussed with Armstrong the question of the latter's discharge from Hospital whereupon Armstrong became very threatening and talked of self harm in order to remain in Hospital and also threatened to walk under a bus. He also again complained of recurring nightmares relating to the incident when he was in the Navy, although on this occasion he referred to having killed a man. Again the Inquiry was amazed that no efforts were made to pursue the veracity of such a statement particularly since at this stage there was apparently nothing to indicate Armstrong's propensity for lying.

On 7th December 1992 Armstrong was discharged from Hospital but was noncommittal about where he was going to live and no follow up appointments were made for this reason. The Inquiry felt that as this was the second admission and discharge within a period of seven months more attention should have been given to the ongoing problem and more robust steps taken to ensure that Armstrong's whereabouts after discharge were known so that follow up appointments could have been made notwithstanding Armstrong's apparent reluctance to co-operate.

There is also no reference to further counselling relating to the alcohol or drug addiction or to reference on to NECA following discharge. Again, as this was a second admission within a short period with similar problems, we felt that a much more positive step should have been taken to address these problems.

Following Armstrong's discharge a Discharge Letter was written by the Consultant's Junior Doctor to Armstrong's GP on the 12th January 1993 which refers to a diagnosis of "Depressive illness, personality disorder". As indicated above, there was a difference between Armstrong's subjective complaints and his objective presentation on the Ward where no evidence of a depressive illness was found during this, or indeed the previous admission. The Discharge Letter to the GP was misleading and it would have been helpful if it had been seen by the Consultant to ensure the accuracy of its contents.

Domiciliary Visit on 11th January 1993

On the 30th December 1992 Armstrong once again changed his GP and was then registered by the Family Health Service with a Dr Sinha who was unhappy with the medication that Armstrong had been prescribed previously. At that time many GPs were unhappy to prescribe Benzodiazepines and Armstrong was put on to Heminevrin. Dr Sinha was aware that Armstrong was drinking excessively and taking Analgesics and was unhappy to prescribe the amount of sleeping tablets being requested by Armstrong. He therefore asked Dr Roy to do a domiciliary visit to see what different approach could be taken in his treatment, and he accompanied him.

By that time Armstrong was residing in Wingate with CA, who had previously been a patient of Dr Roy who was therefore aware of the fact that CA had her own relationship problems, and also a serious alcohol dependency problem. Armstrong was very upset because he was not getting the increased amounts of sleeping tablets and Dihydrocodeine tablets which previous practices had prescribed for him.

After a great deal of discussion between Armstrong, Dr Roy and Dr Sinha it was finally agreed that Armstrong would be given a detoxification regime at his home and on this basis Dr Sinha would be prepared to prescribe a tranquilliser. On that understanding Dr Sinha did in fact prescribe Heminevrin and the Temazepam which had previously been prescribed was continued. Armstrong was again advised to attend NECA.

We feel that this approach to Armstrong's alcohol problem was totally unrealistic. Dr Roy was aware that Armstrong had failed to accept his earlier advice to attend NECA, that Armstrong was living with a woman who had had longstanding alcohol problems of her own and finally that Armstrong had no real interest in or intention of stopping drinking so long as he could still obtain his prescription.

Following the domiciliary visit an Out-Patients Appointment was given to Armstrong for the 11th February 1993 which he failed to keep. No further action was taken which again demonstrated the shortcomings in the follow up procedures adopted at that time.

The Inquiry noted that although there was a letter written to the GP there were no available contemporaneous Medical Notes by Dr Roy of that consultation.

Admissions on 12th March and 5th May 1993

Armstrong was admitted on both the 12th March and 5th May 1993 to the General Ward at the Hartlepool General Hospital following overdoses on each occasion of prescribed medication. On each occasion Armstrong was detoxified and discharged within a few days.

Notwithstanding the fact that Armstrong had had two fairly recent admissions to the Psychiatric Unit and a very recent domiciliary visit from his RMO, we were amazed that there was no system of automatic reference or notification either at the point of admission or by way of a copy of the Discharge Letter, from the General Ward to the Psychiatric Unit that a particular patient who had taken an overdose had been admitted.

Indeed had it not been for the fact that a Social Worker wrote to Dr Roy after the second admission, Dr Roy would have been totally unaware that a psychiatric patient for whom he was the RMO had had two admissions to his Hospital suffering from overdoses.

Admission on 5th June 1993

Armstrong was admitted to Medical Ward 4 in a deeply unconscious state having allegedly taken an overdose of 28 Noctec and 28 Temazepam in front of his girlfriend CA who was wanting to throw him out of her home.

The following day it was intended to transfer Armstrong to Ward 15 or 16 but no bed was immediately available with the result that a decision was made to discharge him home. However, Armstrong became very upset and stated that he was in fact homeless and if he was discharged back to his girlfriend's home he would kill her first and then kill himself. As a result of these threats further consultations took place with Ward 15 and a bed was made available that day for Armstrong.

Shortly after his admission to Ward 15 Armstrong was seen by Dr Roy who noticed considerable bruising to his face caused by CA's ex-boyfriend. Armstrong stated that he was miserable at having been thrown out and felt rejected by his girlfriend who he said was drinking heavily and who had attempted on two occasions to set fire to the house.

As on previous admissions Armstrong quickly settled on the Ward and it was absolutely clear that Armstrong saw his only problem as being one of accommodation. By 8th June 1993 Armstrong stated that he expected to be allocated a home within two weeks as he had submitted an application to the Homeless Department at the Civic Centre in Hartlepool. A Housing Officer indicated that if a supporting letter was received from Armstrong's Consultant then Armstrong could be allocated a house or flat immediately.

On the 15th June 1993 Dr Roy wrote to the Homeless Section of the Civic Centre stating that Armstrong needed accommodation urgently and that the Medical Team were not doing anything particular for Armstrong within the Psychiatric Unit and were simply awaiting a place for Armstrong so that he could be discharged and any psychiatric care which he required could be given on an Out-Patient basis.

Within days of arriving on the Psychiatric Unit Armstrong had formed an association with AS who was a patient on the same Ward and the relationship was of such a nature that it was causing embarrassment to other patients and staff. It proved necessary to transfer Armstrong to Ward 16 on the 15th June 1993 in order to keep them apart.

The relationship was still in existence on the 21st June 1993 when Armstrong was discharged for the last time from Hartlepool General Hospital. Although he had applied to the Local Authority for Council accommodation he was in fact discharged to his cousin's home.

Following Armstrong's discharge Dr Roy himself wrote the Discharge Letter to Dr Sinha and indicated therein three problem areas namely, (1) psychopathic personality, (2) social problems and (3) alcohol abuse. An Out-Patient appointment was also made for the 12th August 1993.

Dr Roy advised us that in consultation with nursing staff he was satisfied that Armstrong did not satisfy the criteria for the CPA.

Out Patient Appointments

(1) 12th August 1993

Armstrong had changed his address twice and was then living at 32 Lancaster Road, Hartlepool. He stated that his alcohol consumption was very minimal, almost nil at times and he was quite successfully managing to keep his sleeping tablets down to 30 mgm at night and was only taking 4 tablets of Dihydrocodeine per day.

(2) 28th October 1993

Armstrong had by this time moved to his final address at 51 Frederick Street, Hartlepool, an upstairs Council flat, where the tragedy was later to occur. He alleged that he was still in contact with CA who was then expecting his baby and also in contact with AS.

Armstrong stated that he was very anxious and drinking at least two litres of cider each day as well as continuing to take his medication. Dr Roy formed the opinion the Armstrong might need to be admitted in the near future. He counselled Armstrong about his dependancy problems and suggested, once again, that Armstrong should contact Keith Appleby at NECA or the Alcohol and Drug Advisory Centre. Once again Armstrong failed to make any contact with any Agency and yet again no follow up action was taken.

(3) 3rd February 1994

Armstrong appeared in good spirits and for once did not complain of depression. He stated that he was not drinking or taking drugs and as he had obtained a part-time job in a Shoe Shop he was managing his life satisfactorily and had bought a second hand BMW car. He appeared to be functioning well and because he had been away from the unsatisfactory domestic circumstances there had been no further problem with his family. Dr Roy decided that there

had been a marked improvement in Armstrong and that if the improvement was maintained up to the next Out-Patient appointment he would consider discharging him from follow up clinics.

The Inquiry discovered when it interviewed Armstrong in Wakefield Prison on 15th November 1995 that he had not worked in a shoe shop and had not bought a car as he could not drive but had continued drinking and taking drugs. This was yet another example of Armstrong's inability to separate fantasy from reality.

Dr Roy left Hartlepool General Hospital in March 1994 and had no further contact with Armstrong.

(4) 5th May 1994

Armstrong failed to attend his Out-Patient appointment with Dr Lowery (Dr Roy's successor) and a further appointment for the 3rd November 1994 was sent to Armstrong. By that date Armstrong was in custody for the murder of Rosie Palmer and there was no further involvement between Armstrong and Hartlepool General Hospital or it's staff.

Information Available

As will be apparent elsewhere in this Report there were several allegations that Armstrong had sexually abused a number of children in different households with whom he had been connected, although no allegation was ever proved in Court or indeed corroborated by other parties. Dr Roy advised the Inquiry that had he been aware of these allegations, his treatment of Armstrong might have been very different, particularly with regard to further enquiries that he might have made but that he had no knowledge of any allegation or anything that might alert him to the type of offence ultimately perpetrated by Armstrong.

The Inquiry noted that a number of connections were not made and it is our opinion that there were contributing factors for this. First, the Medical Team already had within its grasp knowledge of a number of significant disclosures made by Armstrong at various stages of his treatment and no attempt whatever had been made to pursue any avenues of enquiry which would have tested the veracity of Armstrong's claims. We accepted that there was a further paradox in this situation in that even if the information had been checked properly it would in almost all instances be found to be inaccurate. However this could only have demonstrated to the Medical Team that Armstrong was a liar whose statements should be treated with caution.

Secondly confusion was created by the different familial names. His mother was called Mrs Matthews. Armstrong himself went under the names variously of Tony and Shaun and his step-daughter, who had made allegations of sexual abuse against her sister, herself and her own female child, also had a different

name. It was not realised that the man involved with all of the above was one and the same, namely Shaun Anthony Armstrong.

Thirdly there were significant age differences in the relationships. Armstrong's second wife was seventeen years older than Armstrong himself. When references were made to his step-grandchildren the image created was a much older man. When Dr Roy wrote on 21st May 1993 to Armstrong's step-daughter (B)'s GP stating inter alia ""there have also been other stresses in the last few months in that her little girl who is three years old was probably involved in a mild sex abuse type of situation by her own step-father" he did not realise that the stepfather being referred to was in fact Armstrong.

The cumulative result was that on 5th June 1993 when Armstrong was admitted to Hospital no connections were made.

Diagnosis, Treatment and Discharge

Diagnosis:

At an early stage in his treatment of Armstrong Dr Roy had formed the conclusion that Armstrong was not mentally ill but suffered from a personality disorder coupled with social problems and abuse of alcohol and prescribed medication. He was satisfied that Armstrong was not suffering from a manic depressive illness and such depression as might have existed was purely reactive to his personal problems at the time.

With the benefit of hindsight, including the murder itself and all of the evidence and allegations that had subsequently come to light, Dr Roy had no reason to change his diagnosis in any way at all. We were provided with a number of Psychiatric Reports prepared for the benefit of the Crown Court and we took note of the fact that all of the Reports contained a similar diagnosis of Personality Disorder.

Treatment:

In view of the fact that Armstrong had been deemed never to have suffered from a mental illness it had never been necessary or appropriate to treat him with psychotropic medication either within the Hospital setting or after his discharge.

Treatment had usually consisted of detoxification following his numerous overdoses and the provision of a bed for a short period while Armstrong's family problems or accommodation needs were being resolved.

Drug treatment had usually involved the continuation of tablets prescribed by his GP and on occasion there had been counselling about the level of his medication, the need to cut it down considerably and the advisability of getting further counselling form NECA or ADAC.

We saw no reason to question either the diagnosis or the actual treatment which Armstrong had received during his various admissions to Hartlepool General Hospital.

Discharge:

As indicated previously, it was Dr Roy's considered view that Armstrong did not comply with the criteria as they then existed for being accepted for the Care Programme Approach and as a result no Care Programme was ever drawn up. There was no psychotropic medication to administer or monitor. It was also considered that there was no requirement for a Community Psychiatric Nurse to see Armstrong at any stage after his discharges.

Since Treatment and medication for the personality disorder were inappropriate, what was left was to address Armstrong's other problems as and when they arose. The question of his homelessness which Armstrong appeared to consider to be his principle, if not his only, problem was usually resolved by Armstrong's own efforts although occasionally advice and help was available to him. Before Armstrong's discharge could be considered on each occasion clearly a decision had to be made as to vulnerability and the likelihood of risk to himself and others. We note that since the Care Programme Approach was not involved this must inevitably mean that Armstrong was not considered vulnerable or a risk to himself or others.

The Inquiry considered that Armstrong did satisfy some of the criteria for inclusion in the CPA. Dr Roy was aware of four of his five admissions inside a fourteen month period. During the course of those admissions it is recorded in his Notes that Armstrong when thwarted became very threatening and talked of self harm by cutting himself or taking overdoses. He also threatened to walk in front of a moving bus and finally threatened to kill his girlfriend and then himself.

While the Inquiry accepts that a number of these threats were a deliberate attempt to alter clinical decisions about his management, taken in conjunction with his previous behaviour, they could at least have suggested that he was a danger to himself. Any assessment of risk would have demonstrated this.

This then left the question of Armstrong's dependence on drink and drugs. We were advised that steps had been taken to counsel Armstrong on a number of occasions and to refer him to the appropriate Agencies who might be able to help him. As Armstrong did not really accept the nature or severity of his problems in that direction he showed little inclination to co-operate with the

suggested referrals. Whilst we do not think that this necessarily affected the final outcome of the case we would agree with the findings of the Hartlepool Community Care NHS Trust internal inquiry that where a referral is deemed necessary to a specialist agency this should be done formally rather than the onus being left with the Patient. We will return to this point in our Recommendations contained elsewhere in this Report.

(2) **Dr S Mahapatra**

Dr Mahapatra was first appointed a Consultant Psychiatrist at Hartlepool in 1978 and served as Clinical Director of the Hartlepool Mental Health Directorate between 1991 and 1993 before becoming the Medical Director of Hartlepool Mental Health Trust in April 1994. In that post he told us that he was in a purely administrative position and was responsible for management matters such as the staffing organisation but was not involved in any clinical supervision of the Consultants since clinical responsibility lay solely with the Consultant who was the Responsible Medical Officer dealing with a particular case. However if shortfalls in the management of a patient or patients came to his notice it would be his duty to raise it with the Chief Executive of the Trust to see if the problem could be rectified.

Originally it had been suggested during the 1980's that the population in the Hartlepool area warranted the appointment of five Consultants of whom one would be a specialist in Psychogeriatrics but this had never been achieved. The establishment at Hartlepool Hospital was in fact for three Consultant Psychiatrists but on occasions prior to 1991, when Dr Cooper joined the team, there had been periods when the Hospital had to manage with two Consultants due to difficulties in getting staff to come to Hartlepool.

These difficulties also applied with regard to the recruitment of SHOs and Clinical Assistants and had been exacerbated in 1984 when the Hospital lost its training accreditation from the Royal College of Psychiatry (although this has recently been reacquired).

Dr Mahapatra advised us that since the clinical directorate had been formed in 1990/91 there had been regular monthly multi-disciplinary meetings between the Director of Mental Health, Senior Nurses, CPNs and the Psychology Services. In addition there were regular meetings with the nursing staff at Ward Sister level when Sections would be reviewed and the nursing staff would play their part in the clinical review of cases and in any clinical audit. The Doctor told us that when decisions had to be made with regard to the involvement of CPNs, Social Workers or any other organisation then matters would be discussed within the multi-disciplinary team and a team decision made.

When a new patient was admitted we were told it was routine practice to ask the Social Worker to prepare a detailed Social History of the patient and the nursing

staff and medical staff would all attempt to produce a simple Social History of the Patients background.

Information would be gathered from the patient himself, from the GP, Community Nursing staff, from relatives and from any other Agency involved and, where relevant, from the case notes of other members of the patients family who had been treated on the unit. It was stressed that it was routine medical practice to get all necessary information before making a diagnosis and formulating a treatment plan. We found these statements, while representing the ideal situation somewhat idealised, and not in accordance with the evidence which we received about what actually happened on the ward and which is borne out by the Audit Reports.

Likewise we were advised that routinely staff on the Accident and Emergency Unit in the General Wards would inform the Psychiatrist or his staff of any admission of a patient following an overdose of medication. This clearly was not happening since Armstrong was admitted on two occasions to a General Ward without any notification being given to Armstrong's RMO.

Although apparently a request would be made routinely to the Social Worker to provide a Social History, the pressure of work was such that the Social Work Team Manager at the Hospital had indicated that she did not have sufficient staff to undertake this work. The Inquiry formed the opinion that routine Social Histories had not been obtained for some years.

Hartlepool had been one of the first hospitals to start implementing a Care Programme Approach as long ago as 1990/91. With the resources available it was clear that at that stage it would not be possible to initiate the Care Programme Approach in respect of every patient. Discussions took place between the Medical Staff, Social Services, Senior Nurses and Psychology Services and a decision made that to qualify for inclusion in the Care Programme Approach a patient would have to meet one of the following criteria:

(I) Patients who have been the subject of a Section under the Mental Health Act 1983 or

(II) Patients being discharged from a Long Stay Ward at Winterton Hospital or

(III) Patients who were likely to be vulnerable on discharge.

While those Patients in (I) and (II) above were easy to identify it would be a multi-disciplinary decision as to whether a patient would in fact be vulnerable following his discharge into the community.

Since the tragic incident, but not entirely because of it (since certain measures were already in motion in 1994) some positive steps had been taken to improve the situation as it existed in 1993/94.

The principle change involved the creation of a Hartlepool Community Mental Health Team with effect from May 1994. The Team comprised a Consultant, a Junior Doctor, Community Psychiatric Nurses and a Social Worker on rotation. All parties made a point of exchanging information about every patient who is admitted. While much of this had been in place previously the improved communications had led to more informed decisions being made in the management of Patients.

Secondly staffing levels in the Medical Team had improved in that there were now three consultants, two staff grade Doctors and two Senior House Officers which meant less pressure upon the Consultants. Efforts were being made to appoint a third staff grade Doctor and a fourth Consultant which would reduce the pressure still further.

Thirdly, additional posts had been created within the Hospital for Nursing Co-ordinators and Nurse Managers which should help to ensure nursing standards were improved and regularly monitored.

Fourthly, the Trust had appointed a G Grade Sister to the position of Care Programme Approach Manager and her sole responsibility was to monitor Care Programmes, their Register and the Assessment of Risk Registers on a regular basis.

While we were pleased to note that positive steps had already been taken to alleviate or remove some of the Psychiatric Units previous problems, we noted that in the most recent Audit Reports there were still consistently unmet targets in respect of:

(I) Collecting comprehensive patients histories,

(II) Patients records being updated by all appropriate staff and

(III) Care Plan being completed by all relevant professionals.

With regard to Armstrong's case Dr Mahapatra stated that he had never been his RMO, had not treated him clinically and that so far as he was aware had never met Armstrong. He had however treated his mother (Mrs Matthews) over a number of years and from his conversation with Mrs Matthews he gathered that she did not like her son who had been to prison on a number of occasions, including one incident of violence towards his mother. There had also been instances of violence within his marriages and relationships with other women.

He was also aware of the incestuous relationship that had taken place between Armstrong and his mother which was recorded in the Case Notes relating to Armstrong's first wife.

Dr Mahapatra stated that it was normal practice on the admission of a new patient for the Consultant to call for the Case Notes of any close relatives of the patient who were known to have received treatment in the unit since information contained in those Case Notes could be helpful in completing an assessment in respect of the Patient. If it was impossible for the Consultant to read the files because of pressure of work it would be normal to ask an SHO or Registrar to do the necessary research.

(3) **Dr MU Khan**

Dr Khan advised us that he had started at Hartlepool in Psychiatry in 1975. Initially he had been on the Rotation Scheme for approximately three and half years and after his return from Winterton Hospital to the Hartlepool General Hospital in 1978 he had registered for the Senior House Officer Course which he had completed in 1983.

He had then served as a Clinical Assistant to Dr MC Khan from 1983 to 1988 and to Dr Mahapatra from 1988 to 1993 when he had become a Registrar.

He told us that his involvement in treating Armstrong had been minimal and he was unable to remember any real details about the man. It was only as a result of reading the entries in Armstrong's Notes that he had personally made that he could recollect any detail at all.

He had been involved during Armstrong's first admission on Monday 6th and Tuesday 7th April 1992 and the entries simply related to the fact that on the Monday he had nowhere to go on his proposed discharge on the Wednesday, but by Tuesday he had arranged to go and stay with his ex-wife in Plymouth. Everyone was apparently agreeable to the discharge arrangements and a small amount of discharge medication was ordered. The Doctor had not seen Armstrong again until his photograph appeared on television following his arrest.

The Doctor told us that there was no automatic follow up to see if a Patient's view of the address to which he would go was simply aspirational or fact and, further, that no check was routinely made to see if he did go to that address.

Dr Khan advised us that it was normal practice for Consultants who were aware that relatives of a Patient had been treated on the Unit, to look at the Medical Notes to see if they had any relevance to the case of the Patient. Although Dr Khan, as Clinical Assistant to a Consultant, had treated Armstrong's mother, Mrs Matthews in the Day Hospital in about 1987 or 1988 and again in the main Hospital prior to her death in 1990 he had personally not called for her Notes and was unaware if the Consultant had done so.

Similarly, although he had treated Armstrong's wife and admitted his step-daughter (B), he was unaware until after the event of their connection with Armstrong and had not seen their Notes with the result that he was unaware of any entries in those Notes which might affect Armstrong.

We were told that so far as the Doctor was aware the relationship with Social Services was good and their response to problems appropriate. If the problem related to housing problems the Social Worker would sometimes go to see the Patient, or vice versa, but quite often would just ring up and suggest one or more possible addresses that the Patient might try and it was then up to the Consultant or the Nursing staff to pass on this information to the Patient.

Dr Khan told us that any referral to the Social Services could be by the Consultant, the Patient himself or by the Nursing Staff and there was no requirement upon the Nursing Staff to obtain the consent of the Consultant, or even to discuss it with the Consultant, before taking action. As will be seen later, this was not necessarily the view of all of the Nursing staff and the divergence of opinion gave us cause for concern.

The Doctor felt that in Hartlepool General Hospital the multi-disciplinary approach had been successful and that the Nursing Staff had met all expectations in their support of the Consultants and their staff.

CHAPTER 8

GENERAL PRACTITIONERS

During his adult life Armstrong frequently moved his address partly as a result of his employment and partly arising from his co-habitation with his two wives and other partners. As a result of those moves and also arising from difficulties which he incurred with certain GPs regarding his dependancy on drugs Armstrong was registered with a number of GPs. However the only two GPs who treated Armstrong during the years 1984 until 1994 which we considered to be the significant period in so far as it affect this Inquiry, were Doctor Gordon Pearson who treated him (with the exception of a two year gap when he was in prison) from 1984 until 1992 and Doctor James Gallagher who treated him more recently. Their involvement with Armstrong was as follows:-

(1) Dr Gordon Pearson

Dr Pearson had also treated Armstrong's mother Mrs Rachel Matthews, usually for a depressive illness, between 1982 and 1990 when she died of carcinoma. The Doctor was aware of an allegation made by a friend of Mrs Matthews, who was also a patient of the Doctor, to the effect that Armstrong had "on occasion, when drunk, forced his sexual advances upon his mother", but so far as he was aware this allegation had not been raised with the mother or corroborated by her. In view of the fact that it was an unsupported allegation, the Doctor had chosen not to disclose the information to the Consultant Psychiatrist at the time of Armstrong's admissions to Hospital in 1992 even though the Doctor accepted that he had no reason to disbelieve the person who had given him that information.

Mrs Matthews had advised the Doctor on a number of occasions that her son had stolen items from her, including a television and a video in order to sell them for money to satisfy his addiction for alcohol. She had also stated several times that she hated her son and would like to kill him but it had always seemed to the Doctor that she was protective towards her son and notwithstanding what she had said he had done to her she had made no effort to get him to leave her home when he was actually living with her.

During the years when Dr Pearson had treated Armstrong he had prescribed Temazepam on a regular basis. On occasion the Doctor had felt that Armstrong had received repeat prescriptions too often or had consumed his prescription too quickly, but continued to issue the prescriptions when required. He had also prescribed Dihydrocodeine for joint pains but in spite of a referral to a Specialist in Hartlepool General Hospital no major problem had been discovered and the prescription continued.

Armstrong's medical notes held by his GP contained a copy of a letter dated the 26th October 1989 by Dr Pearson's partner Dr Barley referring Armstrong to a Psychologist at Hartlepool General Hospital and saying that Armstrong had had a lot of problems in his youth. The letter also referred to (1) an occasion in 1977 when at the age of 15 years Armstrong had been seen by a psychiatrist because of psycho-sexual problems that he was having and (2) the fact that Armstrong tended to eat Temazepam like Smarties.

Although the notes contain a reference to the fact that Armstrong was seen by the Psychologist on the 28th March 1990 but failed to attend any further appointment, there is somewhat surprisingly, no record of the details of the assessment of Armstrong by the Psychologist. We find this extraordinary in view of the fact that Armstrong had disclosed to the Psychologist that he had been abused by his mother from the age of eight years.

It would therefore appear that the GP's Practice which was treating Armstrong had knowledge of the allegation of incest between Armstrong and his mother, a referral to a Psychiatrist in 1977 for psycho-sexual problems and a referral to a Psychologist in 1989/90 but none of this information was passed on to the Consultant treating Armstrong in 1992 or 1993.

It was emphasised however that at no time was the Doctor or his colleagues aware of the allegations about sexual abuse of any of the children with whom Armstrong had come in contact. The Doctor stressed that if he had been aware that Armstrong had a penchant for cross-dressing or was particularly attracted to young girls, he would have referred Armstrong to a Dr Weaving who specialised in those types of problems as the case might have required more thought and attention than the Doctor felt could be given to the case at Hartlepool. The Doctor had received no contact at any time from the Police or Social Workers with regard to any allegations and had never been requested to attend any Case Conference involving Armstrong or any of the families with which he had been connected.

The Doctor felt that he had no real problem with the general service provided by Hartlepool General Hospital although this had improved considerably since the arrival of Dr Cooper. Prior to that the Doctor felt that there was very little feedback from the Consultants relating to referrals made by the GPs and discharge letters tended to give very little, if any, information which was not already known to a referring GP.

However this particular problem would probably not have affected Armstrong's case greatly. The Doctor described Armstrong as a manipulative and untrustworthy character who simply wanted his own way, particularly with regard to medication. Provided he received his prescriptions Armstrong was happy to leave the practice in peace and did not appear to want help in any other way. His lack of co-operation was typified by his failure to keep appointments with the Psychologist, the Orthopaedic Department and General Surgery Departments.

In 1992 the Family Health Service had requested the return of Armstrong's notes and Doctor Pearson had no further contact with Armstrong.

(2) **Dr James Gallagher**

Armstrong had been allocated to Dr Gallagher's practice on 20th January 1994 by the Family Health Services Authority. No reasons are given for such allocations but it usually meant that other Doctors were unwilling to accept the patient on their lists.

The practice was aware of Armstrong's history of abusing medication. The position was monitored closely and while inhalers were prescribed approximately once a month, if Armstrong required tablets he was seen on each occasion by a Doctor in the Practice.

The Doctor formed the opinion that Armstrong was not mentally ill. Although Armstrong did mention panic attacks and was treated for them, the Doctor had no reason to believe that there were any deeper psychiatric problems.

In particular the Doctor stressed that he had no knowledge of the allegations concerning Mrs Matthews or any of the children whom Armstrong was alleged to have abused.

We noted however, that with careful scrutiny, the information relating to Armstrong's previous referrals, detailed above, were contained in Armstrong's notes and were therefore strictly available to the GP.

CHAPTER 9

NURSING INVOLVEMENT

As indicated previously, Armstrong had been treated as a Patient on three different Wards during his five voluntary admissions to the Hartlepool General Hospital in a fourteen month period between March 1992 and June 1993, and we took the opportunity of interviewing almost all of those Nurses who had made relevant entries in Armstrong's Nursing Notes during the various admissions. This involved seeing nearly twenty Nurses including G and F Grade Sisters, Charge Nurses, Staff Nurses, Auxiliary Nurses and even Student Nurses who had simply been on placement on one of the Wards when Armstrong was a Patient.

We received no complaint whatever from any quarter about the quality of treatment by the Nursing Staff, of Patients in general or Armstrong in particular.

We had however serious concerns about some of the Nursing Staff's individual interpretation of the procedures and practices in place at the time of Armstrong's various admissions and indeed of some of the procedures and practices themselves.

We found in certain respects that some staff members' memories were somewhat selective in what they recalled, and perhaps this was understandable given the nature of the Inquiry and the possible perception that the Inquiry was trying to apportion blame to those responsible for allowing the tragedy to happen, rather than to inquire into the circumstances leading up to the tragedy and see if measures can be taken to ensure that similar tragedies could not or should not occur in the future.

Even though they had made entries on Armstrong's Nursing Notes several of the Nursing Staff could not or chose not to recall any details relating to Armstrong and simply said that he had made no impression whatever on them. Certain witnesses gave evidence which the Inquiry felt obliged to reject as highly speculative and unsubstantiated. Those witnesses who said that they could recall Armstrong variously described him as (1) pleasant and sociable on the Ward, (2) helpful to others, (3) chatty, (4) mixing easily with others, (5) a charmer, (6) well spoken, (7) intelligent, (8) keen to organise or take part in quizzes, (9) tall with glasses, (10) pale complexion, (11) brown hair with a reddish tint, (12) wearing Cuban heels, (13) slimy and (14) a story teller who terrified one Nurse. We felt it hard to accept that a patient who had been remembered for the above attributes could have failed to create any impression whatever on others and this inevitably cast some doubt on the quality of the evidence of those witnesses.

We also found the Nursing Staffs' memories and interpretations of the practices adopted on the Ward as varied as their memory of Armstrong himself, and because of the way in which this could have affected or did in fact affect the care and treatment of Armstrong, this caused us great concern.

We propose therefore to set out as separate headings various procedures between admission and follow up after discharge where there appeared to be no clarity about the methods to be adopted, or where accepted practices were simply not followed.

Admission

On admission to Psychiatric Wards 15 or 16 of the Hartlepool General Hospital a Patient would be seen by an admitting Nurse and a Doctor or Consultant, one of whose first tasks would be to assess the risk which the patient posed either to himself or others and as a result to set the observation level required by the Patient. If the level of observation was general no record was made since this encompassed the majority of patients, but if the level was to be close observation (checking the Patient's whereabouts every ten minutes) or special observation (one to one observation on a 24 hours basis) a record of this would be made and the Staff notified accordingly.

The usual practice was for the qualified First Level Nurses or Enrolled Nurses to complete the admission papers (Roper-Logan-Tierney Model) but if Student Nurses were present on the Ward this task could, and in the case of admissions during the late shift usually would, be allocated to the Student Nurses, but under the supervision of First Level or Enrolled Nurses.

Since the importance of correctly recording information at the point of admission cannot be stressed highly enough as it can affect the whole course of the Patient's assessment and future treatment, we would have expected that considerable care would be taken to ensure that Student Nurses or indeed any Nurses with limited experience would be very carefully supervised and trained in this important function.

We found that this was not always the case and on Armstrong's final admission to Ward 15 on the 6th June 1993 a Student Nurse undertaking Registered General Nurse Training, was allowed on her second day to undertake the nursing admission without, in our opinion, proper instruction or supervision.

On admission the admitting Nurse would interview the Patient and ask him a series of questions the answers to which she would record on an admission assessment form based on the Roper Logan Tierney Model. While this form may be satisfactory for admission to general wards we found that it was not entirely suitable for admissions to the Psychiatric Unit. Certain questions had little or no relevance to psychiatric matters and even the layout of the form appeared inappropriate in that it allowed equal space for the recording of bodily functions such as elimination as it did to more germane subjects such as the awareness of the Patient and his/her family to the nature of the illness and the ability of the Patient to maintain his own safety or ability to carry out the planned treatment.

We also felt that the information actually recorded at this initial and important stage, was extremely sparse and often consisted of simplistic answers such as "Is aware" without any further explanation of the level of awareness or reasons for it.

We accepted that the admitting staff were usually dependant upon the information which the Patient was prepared to give about himself on admission and that by the very nature of the Unit itself and the mental condition of patients who were about to be admitted it might on occasions be difficult to get the required information immediately. As a result it might be necessary to get the information from other sources such as relatives, CPNs or Social Workers or to go back to the patient later and try to "flesh out" the original information. We found that although some staff had an awareness of this requirement it was not always carried out.

We were told by some staff that it was routine to ask the Patient about previous involvement with other Agencies and seek their permission to check with those Agencies for details of their involvement, but we found that this was not always done.

It was stressed to us that all significant actions or statements by a patient would be recorded as part of the continuing process of evaluating the Patient's mental condition since the relevance of statements or actions might not be apparent until later. We found that this was not the case. One of the Student Nurses stated that during the admission procedures Armstrong had stated to her that he had fought in the Falklands Campaign and during his exploits there he had cut off the penis of a dead soldier and also cut off the breasts of a dead woman but had made no entry in the Notes about these incidents. She did however report to the Team Leader that Armstrong had referred to "shocking things" but was told to ignore them as Armstrong was known to make things up. There is no evidence that he ever served in the Falklands.

Likewise we were informed that during at least one of Armstrong's admissions conversations were taking place among the staff on the Ward relating to an allegation that Armstrong had raped his mother but again, no record or enquiry was made relating to that matter.

We were advised that once the admission papers had been completed they would be checked by the Co-ordinator on that particular Ward but we found that this check appeared to be superficial and aimed at checking that all sections had been completed rather than the content, since once again no apparent effort was made to refer to other Agencies.

Subsequent Admissions

Staff advised us that when a Patient was admitted on a second or subsequent occasion a request would be made for the Patient's Medical and Nursing Notes to be sent from Medical Records and, while these would probably not be available immediately upon the Patient's subsequent admission, they would arrive shortly afterwards.

We were advised that the person in charge would examine the Patient's previous records in order to try and get a better understanding of the case and that each admission would be viewed as part of a continuing pattern rather than as a single entity.

We found this premise admirable in theory but were not satisfied that it in fact operated in this way since much of the information contained in Armstrong's records was either unknown to staff who subsequently treated him or was unchecked in any event.

Team Nursing

In March 1992 when Armstrong's admissions to the Psychiatric Unit commenced, Wards 15 and 16 operated a Team Nursing approach to the treatment of Patients. Initially there were three colour coded teams but subsequently this was reduced to two teams although no-one apparently knew when this occurred. Each team consisted of a Staff Nurse, an Enrolled Nurse and Nursing Assistants and there was a Sister on each Ward who co-ordinated the teams.

On admission a patient would be allocated to a particular team. There were no special criteria for the various teams but a Patient would normally be allocated to the team of which the admitting Nurse was a member, and would usually remain a member of that team for the duration of the admission. We were surprised that the Nursing Records did not contain any reference whatever to the identity of the team that had been treating him.

The usual practice was that to a large extent the Patient's treatment would be undertaken by a member of his own team and the Nursing Shift System was drawn up to try and ensure that there were members of all teams on duty at all times. However this was not always possible and if a member of the Patient's team was not available for any reason another member of staff would be allocated to deal with the particular problem. As a result most of the Nurses on the Ward would care for or have some knowledge of most of the Patients on the Ward which in any event only had a maximum of between 25 and 29 Patients at any one time. This in turn cast further doubt on several nurses contention that they were unable to recall any detail whatever about Armstrong.

Whilst any member of the nursing staff could in theory be expected to care for any Patient on the Ward at any time and make the appropriate entries on his Nursing Notes, the questions of the evaluation and assessment of the Patient's mental state and his continuing treatment remained the responsibility of the allocated team who stated that they adopted a holistic non-judgmental approach.

Those team members met once a week, not at a set time or on a set day, but usually at the weekend, to review all of the patients allocated to their team and to make any necessary decisions with regard to future treatment. If however a Patient's condition warranted it, a team meeting could be called urgently and would then consist of whoever was available.

It was stressed to us time and again that all decisions made by the team were <u>team</u> decisions and that no-one was really in charge of a team. We felt that to some extent this was perhaps a slightly misguided closing of professional ranks to protect each other

since the very composition of the teams involves differing levels of staff and therefore differing levels of responsibility. If on the other hand there was no guidance or leadership from the Senior members of the team then there should have been.

We were advised that Team Nursing had now been replaced by the Named Nurse System and while this had been operating for some time none of the nursing staff appeared able to tell us when this important change in procedures had taken place. Indeed at least one Nurse designated in the Notes as being Armstrong's Named Nurse on his last admission had no knowledge of her appointment and believed the Named Nurse approach had been introduced later.

Care Plan

On admission the allocated team, in conjunction with the Consultant, would prepare an appropriate Care Plan for the Patient and thereafter this would be regularly reassessed and reevaluated to see if it continued to be relevant and to meet the needs of the Patient.

We were concerned to note that at the times of Armstrong's admissions there was little involvement of Social Workers in the preparation of Care Plans.

Clinics/Ward Rounds

These were held once a week, usually in the Doctor's room since this was less formal than the Ward and the Patients were usually less inhibited if not surrounded by other patients. Initially it had been accepted that the Team Leaders would attend the Clinics but this had proved impractical due to shifts, holidays etc and the practice had grown up whereby whoever was in charge on that day would attend and take the appropriate Notes.

Involvement with Social Workers

Prior to 1993 the staff advised us that Social Workers only attended Clinics if specifically invited by the Consultant or Nursing Staff. Since the arrival of a new Consultant this practice had changed and now Cleveland Social Workers attended Clinics as a matter of course. This contrasted sharply with the Durham Social Services practice and caused us concern.

The Cleveland Social Services Department had an Office within the Hospital and the nursing staff felt that there was a good response from both Durham and Cleveland Social Workers. If a referral was to be made the Social Workers would ask for the Staff's assessment of the urgency of the situation and would respond appropriately - immediately if necessary.

However, we were concerned about the uncertainty in the staff's minds with regard to the responsibility for referring a patient to a Social Worker. Opinions included (1)

referrals being entirely Consultant led, (2) possible by Nurses but only with Consultant's permission, (3) made by Nurses but discussed at some stage with the Consultant and (4) possible by Nurses at any time. Such divergence of opinion was unsatisfactory and could lead to differing levels of treatment depending on which staff members were involved.

Involvement with Community Psychiatric Nurses

Again the opinions of the Nursing Staff were divided as to the responsibility for referrals to CPNs with the opinions falling more or less into the categories referred to in the preceding paragraph, although, interestingly, not necessarily with the same member of staff. Again we found this divergence of opinion unsatisfactory.

In Armstrong's case it was stated by the Nursing Staff, as indeed it had been by the Consultants, that Armstrong was never perceived to be suffering from a mental illness was not receiving any psychotropic medication and there appeared to be no other reason for the involvement of a CPN or likelihood of Armstrong's co-operation.

Involvement with NECA

If a Patient was considered to have an addiction problem with either alcohol or drugs he would be counselled on the Ward about his particular problem and advised to seek further help by making an appointment with a NECA Counsellor.

There was no direct involvement by the staff in making a referral to NECA or an appointment for the Patient, this being left entirely to the Patient to enable him to demonstrate his own motivation by taking action.

As indicated elsewhere in this Report we found this attitude less than robust and not necessarily in the best interests of the Patient. We felt that more action should have been taken to ensure that a referral took place.

Discharge

The discharge of a Patient from the Psychiatric Unit was usually planned well in advance by the multi-disciplinary team. If a Patient attempted to discharge himself against medical advice the staff would always ensure that a Doctor was consulted and obtain the Patient's signature to a Self Discharge Form.

It was felt by several of the staff that some of the Psychiatric Patients perhaps stayed too long in Hospital but these tended to be Patients who had accommodation problems on their discharge. There was a chronic shortage of suitable halfway housing for Patients on the road to recovery and this sometimes resulted in their having to stay in Hospital after they were perhaps ready for discharge rather than discharging them to unsuitable accommodation.

If the Patient required follow up after discharge and Out-Patients appointments were considered appropriate, a call would be made to the Out-Patient's Department, an appointment arranged, and a card handed to the Patient.

The Staff informed us that all Patients were asked for details of their addresses after discharge and that no Patient would be discharged to no fixed abode. However we found that in practice this was not always the case. On one occasion Armstrong was discharged with no address being known and on other occasions there was at least some doubt as to the address where he would be living.

If a Patient stated that he was to reside with a relative some check would be made to see that the Patient's statement about his residence was not simply aspirational. Again we found that this did not always happen in practice.

Care Programme Approach

As previously indicated in this Report, the CPA adopted at Hartlepool General Hospital at the time of Armstrong's discharge from the Psychiatric Units in 1992 and 1993 was that Patients were only considered for inclusion if (I) they had been the subject of a Section of the Mental Health Act 1983, (II) they were being discharged from a long stay in Winterton Hospital or (III) they were perceived to be vulnerable following discharge.

A diagnosis was made on Armstrong's various admission and discharges that he was suffering from a personality disorder, coupled with social and addiction problems and that he was not suffering from an enduring and treatable mental illness.

Armstrong's nursing teams, in conjunction with his Consultant, Dr Roy, clearly formed the opinion that Armstrong was not vulnerable in the community and that therefore the CPA was not applicable to him. It is our opinion that the Inquiry's views outlined about the CPA in the Chapter of this Report dealing with Dr Roy are equally applicable to the nursing staff involvement in the multi-disciplinary team decision.

Out-Patients Department

We were advised that the Out-Patients Department staff comprised a G Grade Sister, who also administered ECT and who had been the Senior Sister for the past fifteen years, a part time Staff Nurse who worked Mondays, Wednesdays and Fridays in order to cover the Clinics while the Senior Sister was administering ECT, and a full time State Enrolled Nurse.

There were three Consultants, all of whom held weekly Clinics and each Clinic comprised one Consultant and one Junior Doctor who each saw patients in separate rooms. Effectively the Receptionist allocated the Patients to either the Consultant or the Junior but in practice the Consultant would always see new Patients on their first appointment, usually saw them on the second appointment and only passed them on to the Junior Doctor when the Consultant considered that the Patient was progressing

well. Even then the Junior Doctor was not allowed to make any major decision affecting the patient without first discussing the matter with the Consultant, although he could discharge a Patient from further Out-Patients treatment.

There was normally no Nurse sitting in on an Out-Patient appointment, partly because the Consultants preferred appointments on a one to one basis as patients were then more likely to discuss delicate matters more openly, and partly because of staffing levels which made this generally impossible.

However, if a Patient requested nursing involvement this would usually be arranged. Similarly if a Patient was known or likely to be violent, or in the case of a female Patient, was known or likely to make allegations against the Consultant then arrangements would be made for the attendance of an appropriate Nurse.

The Sister in charge would also look at the Case Notes of any relative known to have had Psychiatric treatment within the Hospital but it was stressed in this case that although Mrs Rachel Matthews had been treated in the Unit and they were aware that she had a son, she always referred to him as Anthony or Tony and the Unit were unaware that his name was anything other than Matthews. When a Shaun Anthony Armstrong had an appointment more than two years after his mother's death no connection between the two could be or indeed was made.

The Department stated that it had excellent links with the Cleveland Social Services Departments both within the Hospital and locally and equally good links with the County Durham Social Services in respect of Patients from outside Cleveland. Referrals could be made without authority from a Consultant and it was felt that the staff only had to pick up the phone for a problem to be dealt with immediately.

The Department had very stringent procedures with regard to its appointment system, which were applied without fail and under the direct supervision of the Senior Sister. The Department's informal policy was to cross T's and dot I's and had been in place for over twenty years.

Certain Patients could be, and were, identified as a source of possible risk and their files were kept in a set of filing cabinets within the Unit. Principally these were Patients who fell into two groups. First were those Patients who were being treated with drugs such as Lithium or Clozaril where regular blood and other tests had to be taken to ensure the Patient's proper compliance with medication. Secondly were those Patients where it was known or believed that they could be a danger to themselves or others if they suffered a relapse.

These vulnerable Patients would, as a rule, have already been involved with a Community Psychiatric Nurse, Social Worker, Probation Officer or some other nominated Agency and if a Patient failed to comply with medication or some other requirement, appropriate action would be taken.

The records of ALL Patients who failed to attend the Out-Patients appointment were referred to the Sister in Charge for her assessment of what further action was to be taken.

If the Patient was a new referral from a GP, the Sister would check the referral letter to see if there was any indication of possible danger to the patient or others and if appropriate would refer the matter to the Consultant for advice. In any event a letter would be sent immediately to the GP.

If the Patient's appointment was simply for a routine review of his case the Sister would arrange for a further appointment to be sent to the Patient and, if he missed that second appointment, a letter would be sent to his GP at that stage.

Due to staff shortages an appointment to see a Doctor was usually for at least three and possibly as long as six monthly intervals. Patients were sometimes offered earlier appointments with a Junior Doctor but usually preferred to see the Consultant.

We were advised that Armstrong was offered, and kept, Out-Patients appointments with Dr Roy on 12th August 1993, 28th October 1993 and 3rd February 1994. On all occasions he had attended promptly, soberly and caused no problems. Indeed on the 3rd February 1994 considerable progress had apparently been made in that he alleged that he was not drinking, was coping well in his flat and had obtained employment.

A further appointment was issued for 5th May 1994 when the Consultant was going to consider the possibility of discharge if the earlier progress had been maintained. Armstrong failed to attend that appointment and, in line with the procedure outlined above, a further appointment was issued for the 3rd November 1994, by which date Armstrong was in custody.

Generally we were impressed by the arrangements within the Out-Patients Department and the tight and efficient control kept over this important aspect of nursing by the small number of staff in the Unit.

There was however one point which caused us some concern. We were advised that notwithstanding what we might have been told by others with regard to changes in the Trust's policy following the tragic incident involving Rosie Palmer, no change had in fact occurred with the Out-Patients Department appointment system despite the recommendation of the Internal Inquiry. The interval between Out-Patients appointments with Consultants, which had previously been at least three months, was still at least three months. No direction had been given to reduce the intervening period and with present staffing levels it was not clear how the interval could be reduced without affecting other areas of the Consultant's work.

CHAPTER 10

POLICE INVOLVEMENT

Although Armstrong had an extensive criminal record stretching back many years and had clearly been involved with the Police on many occasions we found that the involvement of the Police in matters relevant to this Inquiry was relatively minor.

In November 1991 Armstrong's then wife was arrested for an offence of altering a drug prescription and while in custody she alleged that her daughter (B) had accused Armstrong of abusing her and her sister. The Police Officer concerned with the case prepared a report outlining the allegations being made and passed the report into the usual channels to go to Durham County Council Social Services Department, who stated that they had never received that report. We were surprised that there had been no follow up after the submission of the report to see what action had been taken by Social Services.

In November 1992 when the investigations were taking place in connection with Armstrong's alleged abuse of his step-granddaughter (C), the Police Officer made the information available again to the Social Services at the Strategy Meeting but again, according to that Department they had no record of that referral from the Police although they did have records that the matter had been reported directly to them by Armstrong's step-daughter (B) at that stage.

Following the allegation on 29th November 1992 by (B) that Armstrong had sexually abused (C), a decision was made that the child who was only two and a half years old at the time, was too young to interview formally and arrangements were therefore made for a more informal interview to be videoed. This was repeated again on the 30th November 1992 but in neither interview had the child repeated anything of the nature of the allegation being made by her mother. The only comment she made with regard to Armstrong was that she wished to kill him as he had hit her.

A Strategy Meeting took place at which a joint decision was made by the Police and Social Services to the effect that no prosecution or legal proceedings in respect of the child could take place in the absence of any real evidence and no further enquiries were required since future contact between Armstrong and the child was to be prevented by the family and therefore there was no continuing risk to the child.

Although, fortunately, no further harm befell the child involved we were not happy that such a decision had been made before an interview had been possible with the alleged offender. We were even more unhappy that no effort had been made by anyone to check that there was in fact no further contact between Armstrong and the child in question.

We were also surprised that no real effort was made to interview Armstrong. The Police were aware that he had been admitted to the Psychiatric Unit at Hartlepool General Hospital but no enquiries appear to have been made of the Consultant to see whether Armstrong, who was not even the subject of a Section under the Mental Health Act 1983, was fit to be interviewed.

Indeed even if a conscious decision was made to leave the question of any interview until he was discharged, no arrangements whatever appear to have been made with the Hospital to notify the Police of his impending discharge. We feel that more strenuous efforts could, and should, have been made to ensure that Armstrong was interviewed at the earliest possible opportunity when his protestation of innocence may not have been so intense. It had only been possible by pure chance to speak to Armstrong on the 8th March 1993 when he was being interviewed for an unrelated matter and another Officer took the opportunity of questioning him about the allegation being made against him. He had been living locally during the intervening time and we felt that further enquiries could have resulted in Armstrong being interviewed somewhat sooner.

The following day the Police Officer concerned on 8th March 1993 reported to Durham Social Services Department that Armstrong was again living at an address in Wingate which included an eleven year old boy. In view of Armstrong's past history and the fact that the boy's mother was a known alcohol abuser there might be cause for concern with regard to the care being given to that child. This is detailed in the Chapter of this Report relating to Durham Social Services.

CHAPTER 11

INVOLVEMENT WITH DURHAM COUNTY PROBATION SERVICE

Armstrong had been involved with the Probation Service in County Durham since 1977 when at the age of fifteen years he had been referred to a Psychiatrist by a Case Conference following difficulties at school. He had further involvement at various stages during the next twelve years when subject to a Supervision Order, Community Service Order, various terms of imprisonment and finally during two periods of Parole following his release from Prison. The final contact had been in February 1989 when his second and last Parole ended.

By the same token his second wife EJA had also been the subject of three separate Probation Orders during the period 1984 to 1993 and for much of this time had been supervised by the same Probation Officer who dealt with Armstrong's case. This had clearly had advantages in that he was much more aware of the somewhat chaotic relationship which had existed in the Armstrong household and was better able to see the difficulties that had affected both Armstrong and his then Wife.

In November 1977 a Case Conference involving Armstrong took place at Aykley Heads Child Guidance Centre when it was agreed that Armstrong should attend Child Guidance. At a further Case Conference on 12th December 1977, the Doctor involved suggested that Armstrong was getting nothing from therapy because of his denial of any problem and attendance at the Clinic was probably counter-productive as Armstrong was simply using it as a method of avoiding attending school. A decision was accordingly made that clinical psychiatric appointments and psychiatric social work involvement would be deferred indefinitely and only resumed if requested by the Probation Officer.

We noted that the Probation Service file simply recorded that these Case Conferences had arisen as a result of alleged bad parenting and Armstrong's non-attendance at school. We were aware from other evidence given to us that the referral had in fact arisen as a result of overt sexual advances which Armstrong's mother alleged Armstrong had made to her and this is documented in a letter from the Doctor involved in the Case Conferences to Armstrong's GP. Clearly this sort of information ought to have been recorded in case of future relevance.

Although Probation Officers had been involved with both Armstrong and his second wife on a number of occasions subsequently, these had been in isolation and it was not felt that there was anything that might be in any way significant to this Inquiry until 1987.

In 1981 Armstrong then aged nineteen had married his first wife who already had two children including (A). Although Armstrong and his wife separated in 1984 it would appear that some contact was maintained between Armstrong and (A) since in 1987 when Armstrong was serving a two year prison sentence imposed on the 12th May 1986 at Teesside Crown Court (A), then aged thirteen, visited him on a number of occasions in Prison.

During one visit, and in the presence of Armstrong's second wife (although they were not married at that stage) (A) had sat upon Armstrong's knee and he had stroked her leg. The matter had been reported to the Probation Officer who had questioned Armstrong. He had denied any impropriety and said that he was simply attempting to wind up EJA. (A) continued to visit Armstrong for a number of months and EJA was suspicious that something was going on between them but following Armstrong's release from prison in July 1987 no further reference to the matter was ever made by any party.

On the 25th March 1988 Armstrong received a twenty one month prison sentence at Teesside Crown Court and on the 11th May 1988 he wrote to his Probation Officer asking him to visit the Prison as there was a matter which he wished to discuss and could not put down in a letter. When the Probation Officer visited Armstrong in Durham Prison Armstrong disclosed that he was worried that he might be prosecuted for an offence of incest with his mother. It transpired that Armstrong had disclosed the question of incest to his legal representative before he was sentenced and the incest had been referred to in the Plea in Mitigation, after which Armstrong's Barrister had implied that the Police might investigate the matter and prosecute.

Armstrong disclosed at that stage that the incest had taken place between 1979 when he was seventeen and 1983 when he was twenty one and covered part of the time when he had been married to his first wife. These dates were in marked contrast to information which he supplied on other occasions when he had suggested that the incest had taken place when he was very much younger.

During a subsequent visit by the Probation Officer to Armstrong, who had been transferred to Acklington Prison, the question of the incest was again discussed and both Armstrong and EJA said that they wanted some help in resolving the issue. In July 1988 Armstrong's mother Mrs Rachel Matthews contacted the Probation Officer and stated that she wished to see Armstrong and apologise for the incest for which she hinted, but did not openly admit, that she had been responsible. Approximately three months later the mother did visit Armstrong in Acklington Prison and it was believed that she had in fact apologised to him.

At the time the Probation Officer wondered whether there was any connection between the incestuous relationship and the binge drinking in which he seemed to indulge on occasions. It seemed to the Probation Officer that Armstrong appeared to suffer from attacks of great anxiety and was then prone to drink much more heavily than usual and to try to obtain as many tranquillisers, anti-depressants or any other type of medication that he could lay his hands on. However no investigation of this possibility was undertaken and no record made of the Probation Officers thoughts on the matter.

In September 1988 Armstrong was released on Parole (until February 1989) and returned to live with EJA and her family. They were married on the 18th October 1988.

It was explained that Parole was a form of License which is governed by close controls and is operated by the Home Office Parole Unit. The Probation Service had a structure for reporting to the Home Office any incident which might affect the former prisoner's right to remain on Parole. The Home Office would then adopt a policy of noting the incident and then awaiting the outcome of any investigation before making any decision with regard to the Parole.

In November 1988 during the course of a family row EJA's daughters then aged sixteen and seventeen years respectively alleged that Armstrong had indecently assaulted them some time previously. The allegation was reported to the Police at Peterlee who investigated the matter although subsequent enquiries failed to elicit any Police record of this investigation. The matter was also reported to the Probation Service and through them to the Home Office. The Police enquiry was still continuing in February 1989 when Armstrong's Parole terminated and the Probation Service's involvement also lapsed at that stage. In fact no charges were ever brought by the Police against Armstrong. Subsequent enquiries showed that the allegations had not been reported to Durham Social Services Department at that stage and as a consequence no Case Conference had been called or any child's name placed on the Children at Risk Register.

The Inquiry was concerned that there had apparently not been any referral of the matter to Social Services to enable them to make their own enquiries about the allegations and any possible future risk to either or both of the young ladies who had made the allegations. Even if the investigation had not resulted in positive action (as might have been the case since Armstrong totally denied the allegations) there would have been a record of the complaint and this might have caused subsequent allegations made against Armstrong to be looked at in a different light.

We were advised that it was the policy of the Probation Service that while they could only act on the basis of proved facts they would bring to the attention of the Police or Social Services those matters which they felt required investigation. This had clearly not been done so far as Social Services were concerned on this occasion. We felt that as the Probation Service regarded children's protection as one of their highest priorities, more should have been done to ensure that Social Services were aware of the situation.

Although technically Armstrong's personal involvement with the Probation Service ceased in February 1989 when his parole was completed the Probation Service continued to be involved with his wife who was given her third Probation Order in January 1992 and the Probation Officer was aware of the continuing problems within the Armstrong household. EJA's grown up children continued to resent Armstrong's presence in the house as they still maintained that he had offended against (B) and her sister. Indeed the son assaulted Armstrong on one occasion and shortly afterwards Armstrong was admitted to the Psychiatric Unit at Hartlepool.

On the 1st December 1992 EJA attended a regular appointment with her Probation Officer and during the course of that interview she disclosed that her granddaughter (C) then aged two years ten months had made an allegation two nights earlier at bath-time that Armstrong had asked her to "suck his tail" but that she had not done so as "it was naughty". The Probation Officer, in accordance with the stated policy, had on this occasion immediately telephoned the Social Services office in order to pass on this information for investigation but was advised that Social Services were already aware of the allegation and the child had already been interviewed by the Police and a Social Worker.

Apparently the Police had not been able to trace Armstrong at that stage to interview him and the Police investigation was still technically in progress in January 1993 when EJA's Probation Order finished, and with it the Probation Service's involvement with the Armstrong family until Armstrong's arrest in July 1994.

It was explained that if, as a result of the Social Services enquiries, it had been decided that a Case Conference was required, then all relevant parties, including the Probation Service, would have been invited to attend and contribute any relevant information or advice. On this occasion Social Services had decided that a Case Conference was not required and that it was not necessary to place the child's name on the Children at Risk Register.

It was stressed that there was a close informal working relationship at local level between Senior Probation Officers and Social Work Team Managers and they frequently passed on or exchanged information on an informal basis, on occasions without any record being made. We felt that while the exchange of information was essential there should have been a more structured method of ensuring that relevant information was shared on <u>all</u> occasions with the appropriate Agencies.

One of the points which came over to the Inquiry, not only with regard to the Probation Service's involvement with Armstrong, but also in connection with all of the other investigations, was that no Agency ever had all of the relevant information at the right time or looked at the totality of the case. Each incident was apparently investigated and dealt with on an isolated basis but no one was able to stand back from the case and recognise the continuing thread of aberrant behaviour running through Armstrong's case.

We were advised that there was still the continuing problem of confidentiality and the need to balance the individual's rights and the protection of others. However the Probation Service are now much more aware of the issues involved and Line Managers, who have the overall responsibility for making decisions in this connection, are extremely keen to ensure the continued safety of others, particularly children.

We were advised that the Probation Service's attitude to co-operation and the exchange of information had changed and improved in recent years. It had been realised that it was not possible to act in isolation and what was required was a full partnership approach with all relevant Agencies exchanging information and acting with a common purpose. While the Inquiry was pleased to note these statements it felt that there had been occasions when the Service could have been more active in this case in bringing matters to the attention of the relevant agencies.

CHAPTER 12

INVOLVEMENT WITH HOUSING DEPARTMENT

General

Among the many and varied complaints and comments that were made in the Press following this tragic incident were statements to the effect that Armstrong should never have been offered, or allowed to retain his then current accommodation at 51 Frederick Street, Hartlepool by the Local Authority having particular regard to his mental health problems and the fact that complaints about Armstrong had been made to the Authority by local residents.

We therefore received evidence verbally from the Chief Housing Officer and in writing from the Director of Housing and Environmental Health of the Hartlepool Borough Council with regard to their general policy relating to rehousing homeless people and how that policy had applied to Armstrong's case.

The Housing Department had a housing stock of approximately nine thousand dwellings of which approximately one thousand became free for re-letting each year. Those properties comprised roughly seven thousand family units and two thousand single flats or bedsit/flats.

The Headland, where number 51 Frederick Street was situated, was a very popular and stable community built to the North of the docks area in the ancient Borough of Hartlepool. The turnover in Council house tenants of this particular area tended to be lower on average than the rest of the Borough and a real community spirit seemed to exist in the area.

Within the Headland was an area including Frederick Street and Vane Street which contained approximately fifty flats and bedsits/flats for single persons which were small and because of their limited space and standards, somewhat less popular than some other properties. As a result of this the turnover in the tenants occupying these properties tended to be somewhat higher than for the rest of the Headland, although not significantly higher than for other areas of the Town in general.

There had been some concern expressed throughout the Town, but certainly not exclusively to the Headland, about the allocation of Council accommodation to criminals and others guilty of antisocial behaviour. However there was no history whatever of complaints about the allocation of Council accommodation to existing or former mental health patients. Such complaints would be recorded and, where possible, investigated to see if they had foundation but there were no such complaints recorded.

The procedure for applying for Council accommodation was that the applicant would complete an Application Form setting out details of his current circumstances including existing or future dependents and any special needs, particularly with regard to health, that might affect the type of property required. No distinction was made in the Application Form between mental health, physical health or other social/health problems but information was sought about any relevant involvement of a Health or Care Worker in case further enquiries needed to be made or information confirmed. An applicant would also be asked to indicate his preference for the location of his intended property from a list of approximately twenty areas throughout the Borough.

If the applicant was already homeless or likely to become homeless in the immediate future he would also be required to complete a further Homeless Form which the Local Authority then dealt with on an emergency basis. Frequently the Housing Department received letters from Doctors writing in support of housing applications and seeking to gain a measure of priority for their patient. In the cases of physical disability there was usually no difficulty in determining priorities but it was much more difficult to interpret mental health issues such as anxiety and depression, and this could result in further enquiries having to be made although they would not question a Consultant's opinion.

In the majority of cases which required further clarification, enquiries would normally be made of the health professional (usually a GP) who had provided the original information or the matter would be referred to the Community Health Physician who would arrive at his own decision with regard to the application.

Following receipt of an Application Form the details on the form would be checked within the Housing Department and arrangements made, usually by letter, for a Home Visit to interview the applicant and to check the existing accommodation. It was emphasised that when dealing with applications from homeless people, the time scale for further investigation and enquiries was, of necessity, generally much smaller.

In the case of homeless persons the Department had only to establish two pieces of information, namely the relative need of the applicant compared to others and any special need of that particular applicant with regard to the type of housing or location requested. If an application was then shown to have a priority need he would be housed.

Generally a single person would not be classed as in priority need unless he was considered to be "vulnerable" under the terms of Section 59(c) of the Housing Act 1985 ie a person who is vulnerable as a result of old age, mental illness or handicap, or physical disability or other special reason. Having established vulnerability and homelessness the Housing Department would then be under a statutory duty to provide suitable housing accommodation.

Armstrong's Applications

Armstrong's first application for Council accommodation was lodged with an out-office of the Housing Department on 26th January 1993 when he indicated that he was living in private accommodation at 168 Burbank Street, Hartlepool which was temporary accommodation and needed a place for himself. So far as special needs were concerned, Armstrong described himself as suffering from manic depression and having suicidal tendencies but it would appear that no further enquiries were made about these significant statements.

A letter was sent to Armstrong on 2nd February 1993 acknowledging his application and making an appointment for a member of the Housing Department to call on 10th February 1993 in order to check the details and process the application. When the Home Visit was made on 10th February no-one was in and it was presumed that a card was left at the property inviting Armstrong to make further contact with the Department, although the file did not in fact confirm this. The application was simply held in abeyance and no further follow up was undertaken by the Department.

Armstrong's second application was lodged on 6th May 1993 when he gave his address as a Hostel at 49 Park Road, Hartlepool and stated that he required two bedroomed accommodation for himself, fiancee CA and her son who were then living in Wingate, County Durham.

Again a letter was sent on the 18th May 1993 to say that a Home Visit was to be made but on this occasion the letter was returned by the Post Office marked "Gone Away" and again the application was simply held in abeyance. On the 9th June 1993 there was a note on the file to the effect that Armstrong was back on Ward 15 at the Hartlepool General Hospital.

We were surprised that no effort was made to follow up this application once Armstrong's new address was known bearing in mind his potential homelessness, the vulnerability inherent in his admission to a Psychiatric Unit and the fact that we were informed that other housing applications had been followed up in Hospital.

On the 15th June 1993 Dr Roy the Locum Consultant Psychiatrist at the Hospital wrote at Armstrong's request to the Housing Department in support of Armstrong's application for Council accommodation. The letter referred to considerable social problems, a recent rather serious overdose and a chronic dependency on sleeping tablets and stated that Armstrong urgently needed a place of his own where he could be treated as an out-patient.

Rehousing Armstrong

As indicated above, there was no system of checking statements made by Consultants which were always accepted at their face value. The details supplied in Dr Roy's letter of the 15th June 1993 clearly demonstrated Armstrong's vulnerability and this was accepted by the Housing Department as establishing Armstrong as a priority need for whom the Department then had the statutory duty to provide accommodation.

On his Application Form Armstrong had ticked ten out of a possible twenty locations throughout Hartlepool, including the Headland, and when the property became available Armstrong was offered and took the tenancy of 51 Frederick Street, Hartlepool which was a one bedroomed upstairs maisonette, on the 19th August 1993.

We noted that Armstrong's second application was for a two bedroomed property but that he was in fact allocated a one bedroomed maisonette. There was no reference on the file of any correspondence or change in the application to explain this fact and we felt that the recording of information within the Housing Department was somewhat inadequate.

With regard to the allocation of that particular property to Armstrong, the following points were specifically made to us:-

(1) the Housing Department were not aware of any of Armstrong's previous convictions since the Application does not request this information and there is no obligation upon an applicant to disclose previous convictions;

(2) no-one had made any complaint whatever about Armstrong either prior to his application or after the allocation of the property;

(3) the Consultant's letter had contained no reference to any likelihood of the commission of an offence or any history of violence or previous sexual offences;

(4) Armstrong's vulnerability had been established and as a result the Housing Department's statutory duty to rehouse had arisen.

Policy

We were advised that as a result of this case the Housing Department had recognised a need for a greater understanding of the issues arising from an individual who is diagnosed as having a mental illness. There was an awareness within management that Housing staff would need more detailed information in order to assess properly the implications of rehousing such an individual and that such information would have to come from Consultants or GPs. However, we were not advised of any positive steps that had been or were to be taken with regard to the processing of applications relating to those suffering from mental illness.

The Application Form still contained no enquiry about previous convictions as these were stated to be irrelevant to the assessment of housing need within the existing housing policy. The hypothetical situation was put of a man who had just been released from prison for the murder of his wife and three children applying for accommodation next door to a lady with three children. There was an expectation, (but no current framework was in place) that in such a situation there would be a round table discussion between the applicant, the Housing Officers and those providing social or medical care to discuss the needs of the applicant and the risk to the applicant and others. Unfortunately national guidelines are currently such that on occasion people will be inappropriately placed through no fault of the Housing Department.

CHAPTER 13

ARMSTRONG SINCE 3RD JULY 1994

Following his arrest on the 3rd July 1994 Armstrong was remanded in custody to Durham Prison until his eventual trial at Leeds Crown Court on the 27th July 1995. In the initial interviews with the Police Armstrong denied committing the murder and even suggested that someone else might have planted the child's body in his flat.

By the time of his trial it was clear that Armstrong had abandoned that line of defence and instead intended to plead not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. A number of eminent Psychiatrists had prepared Reports which tended to support the view of Armstrong's mental state.

It came therefore as some surprise when Armstrong, though his Counsel, Mr Gilbert Gray, QC, indicated to the Court that he wished to plead guilty to murder. Careful enquiries were made to establish that Armstrong clearly understood that the mandatory decision of the Court to a guilty plea would be one of Life Imprisonment and he was capable of making the decision to enter that plea. When these enquiries were completed the Court accepted the Guilty Plea to the charge of murder.

Mr Justice Ognall in passing sentence stated that Armstrong was a severely disordered personality but had been fully responsible for his actions at the time of the murder and accordingly sentenced him to Life Imprisonment. Armstrong was transferred to Wakefield Prison where he remains to this day.

We visited Armstrong on the 15th November 1995.

We found him to be without any apparent remorse whatever for his actions. He totally denied many recorded facts and attempted to blame others, who had been involved in his treatment and care, for having failed to prevent the tragedy.

He stated in particular that during the five weeks prior to his arrest for Rosie's murder he had phoned Hartlepool General Hospital on eleven occasions and visited the Hospital once in an effort to see a Psychiatrist or to be admitted. In addition he had tried to kill himself once by drowning and once by an overdose.

We could find no record whatever of the alleged contacts with the Hospital during that period and as we found Armstrong's version of the facts so unreliable and not in accordance with documented information, we were not minded to believe that these contacts had in fact taken place.

Armstrong told us that he had made a number of attempts upon his life since his transfer to Wakefield Prison. From the information that we had already received from other sources and from the evidence that we observed in Wakefield Prison we had no reason to suggest that the previous diagnosis of a personality disorder was incorrect.

CHAPTER 14

CONCLUSIONS AND RECOMMENDATIONS

GENERAL

The conclusion and recommendations that we have come to relate to the issues that we were asked to consider in the remit given to us by Tees District Health Authority (referred to in Appendix I of this report). A number relate to general comments we wish to make and others refer to a number of the terms of the remit. We propose, therefore, to set out our conclusions and recommendations in full and refer to individual paragraphs of the remit where appropriate in brackets.

The main question in our minds during this Inquiry was whether the murder of Rosie Palmer could have been prevented if Armstrong had been treated differently by the various Agencies and professionals with whom he was in contact.

Although we accept that there were some inadequacies in his care, it is our opinion that even if those inadequacies had not existed Armstrong's behaviour, and therefore the risk to others, could not have been predicted. There was little history of previous violent behaviour and he had no official record of sexual offences. Various allegations were made about his sexual involvement with children in households where he had lived but these were not substantiated on investigation by the Police and Social Services, and no further action was, or could have been, taken.

When the chronological history (para 2 of remit refers) is studied (and it must be emphasised again that all of this information was not available to any one Agency) it is clear that Armstrong's sexual development was influenced by unique factors.

He was both the product of an incestuous relationship and in turn had an incestuous relationship with his mother. The taboo areas of his sexual behaviour would inevitably have been distorted with cross-generational confusion and his normal human friendships and experiences of affection would readily have become sexualised. It is striking that his longstanding relationships were with significantly older women.

Even with this awareness of sources of distortion in his sexual development one could not conclude that he would have behaved in the violent and sexual manner described with Rosie Palmer.

The Inquiry noted that all of the Psychiatric Reports prepared for the Crown Court contained a diagnosis of Personality Disorder. We saw no reason to question this diagnosis.

In general we are satisfied that there had been compliance with statutory obligations and guidance from the Department of Health, but our concern was with regard to the

implementation of local policies particularly in respect of Care Programme Approach (para 4 of the remit refers)

The inadequacies in the care of Armstrong arose directly from shortcomings on clinical history taking and in poor communication. Each of those areas will be dealt with in turn and several recommendations arise logically from them.

1. Clinical History Taking (paragraph 1-8 of the remit refers)

Adequate assessment and treatment of a Patient depends on complete and accurate information. It is impossible to carry out a proper risk assessment, formulate a coherent and individual care plan and implement a course of treatment without a comprehensive clinical history which is considered to be the very crux of the art of medicine.

There was a paucity of medical and nursing information in the Case Records held on Armstrong at Hartlepool General Hospital. The initial Medical History was inadequate and was compounded by some statements which we have established were inaccurate.

Points of the History should have been followed up by more adequate medical, nursing and social work involvement. His treatment on subsequent admissions was further compromised by reliance on the initial inadequate clinical history.

Our recommendations in respect of clinical history taking therefore relate to (a) Medical, (b) Nursing and © Social Work History taking. It is however accepted that even if all recommendations had been in force at the time, one could not have concluded that this tragic incident would have been avoided.

(A) Medical History

Recommendation 1 - The Responsible Medical Officer must ensure that recorded Case Histories are both comprehensive and accurate and that Case Notes are regularly updated. Particular attention must be paid to the initial History and inadequacies rectified at the earliest opportunity.

(B) Nursing History

Recommendation 2 - Nurses must ensure that a comprehensive History is taken on admission and updated regularly and in our view the Roper-Logan-Tierney Model is not suitable for the recording of this information in Psychiatry.

Recommendation 3 - There must be adequate supervision of the History taking exercise and recording of information when it is undertaken by a Student Nurse.

(C) Social History

Recommendation 4 - The opportunity must exist at Hartlepool General Hospital for the Medical and Nursing History to be amplified by a Social Work History when considered appropriate.

2. **Communications** (Paragraphs 1-3 and 5-8 of Remit refer)

Whilst it did not strictly affect the case, there were incidents where communications were inadequate. The Community Mental Health Team where formal and informal communications are fostered was not functioning properly.

The lines of authority within the Ward structure were not clear, leading to inadequate communication between various members of the Nursing Staff.

Patients admitted to the Acute Wards following incidents of self harm or overdoses were not always notified to the In-Patient Psychiatric Unit or to the Responsible Medical Officer.

Discharge letters to General Practitioners contained inaccurate and inadequate information and were rarely monitored by the RMO.

Referrals to Drug Counselling and Alcohol Agencies were left to the Patients.

There was a failure to communicate with the Hospital (and particularly with the RMO) by external Agencies (Police and Social Services) involved with Armstrong.

There were also occasions when legally it was not possible to pass on information which might have been helpful.

(A) Community Mental Health Team

Recommendation 5 - Communications within a multi-disciplinary team are fostered when there is a constant membership. The Social Work membership of the Hartlepool Teams is not currently constituted like that and we recommend that their functioning is continually audited and altered in line with other Cleveland Community Mental Health Teams if considered necessary.

(B) Communications in Ward Setting

Recommendation 6 - The role and responsibilities of Nursing Staff at all levels should be clarified in order to facilitate improved communication.

(C) Intra-Hospital Communications

Recommendation 7 - Patients admitted to the Acute Unit with episodes of self harm should be automatically notified to the In-Patient Psychiatric Unit, the RMO (if applicable) and to the General Practitioner.

(D) Discharge Letters

Recommendation 8 - The Discharge Letters should contain the five key points outlined in "The Impact of a Hospital Audit on Psychiatrists' Letters to General Practitioners" namely (1) Diagnosis, (2) Treatment, (3) Follow up arrangements, (4) Prognosis and (5) a Concise explanation of the condition.

Recommendation 9 - There should be some system of monitoring Discharge Letters written by Junior Medical Staff.

(E) Issue of Self-referral to Drug Counselling and Alcohol Agencies

Recommendation 10 - More direct action should be taken to ensure that referrals to Drug and Alcohol Agencies are made and that the initiative is not left to the Patient alone. It is however, accepted that individual patient commitment and responsibility is equally important.

(F) External Agencies

Recommendation 11 - External Agencies (ie the Police, Social Services etc) should communicate with the RMO when they are investigating an In-Patient who is known to be under the RMO's care.

3. **Re-appointments on Failure to Attend** (Paragraphs 1 and 3-7 of Remit refer)

This was a matter of concern to the Trust's internal inquiry and changes were recommended. We were advised that no change had in fact occurred in the Out-Patients appointments system despite these recommendations. The routine interval of three to six months between appointments is not acceptable.

Recommendation 12 - The recommended actions of the Trust's internal inquiry, ie that Audit should occur and that reappointments should be within two months at the outside, ought to be implemented as soon as possible.

4. **Care Programme Approach/Risk Assessment** (Paragraphs 1-8 of Remit refer)

It was our view that Armstrong did satisfy the criteria of vulnerability, particularly the risk of self harm, and as a result should have been included in the Care Programme Approach. It is recorded in his notes that Armstrong, when thwarted, became very threatening, talked of self harm by cutting himself or taking overdoses, threatened to walk in front of a moving bus and on one occasion threatened to kill his girlfriend and then himself.

We noted however that a decision had been made during 1992 and 1993 that Armstrong did not comply with the then existing criteria and he was not registered for the programme. In our opinion, this judgement as to the suitability of his care is questionable, but it is a matter for speculation whether inclusion on the programme would have made any difference to the final outcome.

We note that the criteria for entry on to the Care Programme Approach have altered and the only recommendation that we feel it is now appropriate to make relates to training.

Recommendation 13 - That Managers of the appropriate Agencies ensure that all staff who are involved in the implementation of the Care Programme Approach are trained in risk assessment.

5. **Child Protection Registers** (Paragraph 8 of the Remit refers)

Current legislation precludes us from making any relevant recommendations in this area because unsubstantiated allegations cannot form the basis of public record.

6. **Audit of Services** (Paragraph 4 of Remit refers)

We noted that the Trust's Audit Reports stated that there were consistently unmet targets in respect of (I) collecting comprehensive Patient's Histories (II) Patients records being updated by all appropriate staff and (III) Care Plans being completed by all relevant professionals. These shortcomings are very relevant to some of the conclusions mentioned above.

Recommendation 14 - That the Health Authority and the Trust continue to monitor the quality of the service and ensure that corrective action takes place.

7. **Additional Recommendations**

In the conduct of this inquiry, we were mindful that as an inquiry potential witnesses could be invited to attend to give evidence and requests for the production of documentation required could be made, but that no mandatory power existed to subpoena witnesses or documentation. In the event it did not

make material difference to the conclusions and recommendations reached, but did affect the time taken to conduct the necessary investigation.

Recommendation 15 - Consideration should be given at the highest possible level to the possibility of giving inquiries the power to subpoena witnesses and documents.

APPENDIX 1

REMIT OF INQUIRY

1. To establish the care that Shaun Anthony Armstrong was receiving at the time of the incident including the history of his medication and compliance with regimes

2. To establish suitability of such care in view of patient's history and assessed health, social care needs, any previous psychiatric history or court convictions

3. To establish the adequacy of the assessment of the patient's risk to himself and others

4. To establish compliance or otherwise with statutory obligations, relevant guidance from the Department of Health and local Policies

5. To establish the exercise of professional judgement

6. To establish the adequacy of the care plan and Shaun Anthony Armstrong's compliance with it

7. To establish the adequacy of monitoring arrangements by key worker

8. To establish the adequacy of communication by Health staff and use of liaison arrangements between Health Agencies and between Health and other Agencies

9. To prepare a report and make recommendations to Tees District Health Authority

APPENDIX 2

LIST OF DOCUMENTS CONSIDERED BY THE PANEL OF INQUIRY

Published Reports of Other Inquiries

The Report of the Inquiry into the Care and Treatment of Christopher Clunis

Report of the Inquiry into the Circumstances leading to the death of Jonathan Newby

The Woodley Team Report re: Laudat

Professional Reports

Court Proceedings - Regina vs Sean Anthony Armstrong, 26th/27th July 1995

Tees Health Joint Administration - Terms & Conditions of Service, Applicable to Service Contract Agreements, placed on behalf of Hartlepool, North Tees and South Tees Health Authorities, 11th March 1994

Hartlepool Health Authority - Specification for Adult Mental Health Services 1994/95 with Hartlepool Community Care

Hartlepool Health Authority - Service Specification for Mental Health - 1993/94

Hartlepool Health Authority - Service Specification for Mental Health - 1992/93

Briefing Paper - Rose Frances Palmer - Cleveland Social Services

Durham County Council, Social Services Department - Statement to Panel of Inquiry, dated 31st August 1995

Psychiatric Report on Shaun Anthony Armstrong - Dr Naismith, dated 25th July 1995

Psychiatric Report on Shaun Anthony Armstrong - Dr Burton, dated 14th February 1995

Psychiatric Report on Shaun Anthony Armstrong - Dr Fraser, dated 29th June 1995

Hartlepool Community Care NHS Trust - Report of Internal Investigation, August 1994

Bulletin of The Royal College of Psychiatrists (October 1995) re: The Impact of Hospital Audit on Psychiatrists Letters to General Practitioners (Shah and Pullen)

Medical Notes

Case notes from Hartlepool relating to Shaun Anthony Armstrong, Elizabeth Armstrong and Rachel Matthews

Primary Care records held by GP relating to Shaun Armstrong

Royal Navy Medical records re: D172709W/1978 Shaun Anthony Armstrong

Department of Health Circulars

HSG(94)27 - Guidance on the discharge of mentally disordered people and their continuing care in the community

HSG(94)5 - Introduction of Supervision Registers for mentally ill people from 1st April 1994

HC(90)23/LASSL(90)11- The Care Programme Approach

HC(89)5 - Discharge of Patients from Hospital

EL(94)24 - Report of the Mental Health Nursing Review Team - working in partnership "a collaborative approach to care".

Press release announcing the Secretary of State's ten point plan

Letters and other Personal Communications

Fax - dated 8th September 1995 from JA Earl detailing dates of Armstrong's entry and discharge into the Navy and the reason for discharge (1 page only)

Department of Health Draft Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community and the response of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (extracts)

Letter from Mr B Stothart dated 30th October 1995

Letter from Mrs Mawson dated 5th September 1995

Letter from Mrs DA Hopkins undated but received on 18th September 1995

Letter from Ms SL Robinson undated but received 29th September 1995

Letter from Mrs M McKinney dated 15th September 1995 enclosing the current job description for the Business Manager/Community and Additional responsibilities as Acting Nurse advisor

Letter from Dr A Burleigh dated 13th September 1995

Letter from Dr P Sinha dated 25th August 1995

Letter from Mr FA Patterson, Director of Housing & Environmental Health, Hartlepool Borough Council, dated 31st August 1995

Letter from Dr MU Khan dated 8th September 1995

Letter from Ms Carole Ruddick, County Durham Health Commission regarding details of GP registration in Durham, dated 14th September 1995

Statement from WPC Crick, Durham Constabulary, dated 8th September 1995

Statement from Dr SC Roy, dated 31st August 1995

Letter and statement from Mr DT Allsopp, dated 25th August 1995

Letter from Dr Roy to Mr Rutland, Hartlepool Borough Council dated 15th June 1993

Letter from Dr AK Brown, Hartlepool Community Care NHS Trust, dated 30th June 1995

Letter from Mr D Behan, Director of Cleveland Social Services, dated 15th January 1996.

Press Release, Tees Health, dated 7th September 1995, announcing inquiry and follow up press reports dating from 8th September 1995

Press Release, Hartlepool Borough Council, dated 27th July 1995

Collection of general press cuttings relating to inquiry, including briefing notes for press conference

"Hello" magazine article dated 12th August 1995