Independent Inquiry into the care and treatment of Feza M.

Report of the Independent Inquiry Panel to
East London and The City Health Authority
and The London Borough of Hackney

September 1999

Independent Inquiry Panel Members:

Bridgit Dimond (Chair)	-	Emeritus Professor, University of Glamorgan
Dr Peter Carter	-	(then) Chief Executive, North West London Mental Health Trust
Dr Anthony Jolley	-	Consultant Psychiatrist, Riverside Mental Health Trust
Tim Watts	-	Assistant Director, Leicestershire County Council, Social Services Department

CONTENTS

APPENDICES

INTRODUCTION

1. At the Old Bailey on 12 October 1998 Feza M. pleaded guilty on the grounds of diminished responsibility to the manslaughter of Caroline C. on 16 September 1997. He was made subject to a hospital order under section 37 of the Mental Health Act 1983 with a restriction order under section 41 to remain at Rampton Hospital without limit of time.

2. The victim, Caroline C., had herself a background of serious mental illness and was described by her mother as "a very vulnerable person, very childlike in a woman's body – she trusted everybody and would give people her last penny". It was no coincidence that the victim of the homicide by Feza M. should herself have been mentally ill, since it could be seen that it was her vulnerability and lack of self-protection which led directly to the situation out of which the homicide arose.

3. Feza M. himself is a 36 year old divorced man of Turkish origin, coming from a professional family. He had been a client of mental health services at least since 1990 and from 1995 he had been under the care of the North West Locality Community Mental Health Team. His diagnosis was one of Paranoid Schizophrenia combined also with a history of abusing alcohol, marijuana and other illicit drugs. A brief table of key events up to the time of the homicide is attached at Appendix 'A'.

4. Following the homicide, the (then) Chairman of the City and Hackney Community Services NHS Trust (CHCST) Professor Murphy, in consultation with the East London and the City Health Authority (ELCHA) set up and chaired an inquiry (hereinafter called the "Murphy Inquiry") of a panel of independent professionals. This reported to the Trust and ELCHA on 24 June 1998 with major criticisms of the implementation of the Care Programme Approach, operational management systems, supervision arrangements, medical staffing and record keeping. It made ten significant recommendations for immediate implementation.

5. A decision to establish an Independent Inquiry was taken following the sentencing of Feza M. The terms of reference for the Inquiry are attached at Appendix B and details of the membership of the Panel and the conduct of the Inquiry are included at Appendix C. Not surprisingly many of our recommendations reiterate some of those of the Murphy Inquiry, but we were able to take a wider view incorporating both commissioner and provider perspectives and the role of all agencies involved in examining the care and treatment of Feza M.

6. The report is written in three parts. Part One provides a chronological summary of the care and treatment of Feza M. Part Two provides a summary of his family background and personal history based on information gathered both before and after the homicide and Part Three provides the Panel's identification of the main issues for the agencies involved, findings and recommendations.

PART ONE

CARE AND TREATMENT OF FEZA M.

CONTACT WITH MENTAL HEALTH SERVICES, 1988 TO 9.3.95

1988-31/10/91, At least one admission to Hackney Hospital, Outpatient follow-up, Discharged to GP on 27/9/91

7. Feza M. has reported that he first became unwell in 1988, at which time he came to believe that he was being followed. He speculated that this may have been due to his involvement with the Communist Party in Turkey, and thought that the CIA or MI5 may have been involved. At the time he was frightened that the people following him might do him harm or perhaps even kill him.

8. Feza M. has given varying accounts of his first contact with mental health services. By all accounts his first contact was prompted by a fear that his cigarettes were poisoned. He either attended a police station or was brought there by a policeman he approached in the street about his fears. According to Feza M. the police then called a psychiatrist who arranged his admission to Hackney Hospital under the Mental Health Act 1983. At various times Feza M. has stated that this first admission occurred in 1988, 1989 and 1990.

9. The earliest record available of Feza M.'s contact with mental health services consists of two entries in his GP notes, dated 9/3/90 and 10/3/90 indicating that he had been admitted to Hackney Hospital PICU (Psychiatric Intensive Care Unit) under Section 136 of the Mental Health Act 1983. His GP had subsequently undertaken a mental health assessment and signed a recommendation for his detention in hospital under Section 2 of the Mental Health Act 1983. The GP notes indicate that he had "some paranoid delusions" and felt that his "cigarettes" were "poisoned by wife and girlfriend".

10. There are no records available from Hackney Hospital regarding this admission. His GP records indicate however that he was prescribed Haloperidol 15mgs in the morning and 20mgs at night from the 6/7/90, suggesting a duration of admission of approximately 4 months, consistent with Feza M.'s own report of the duration of his first admission.

11. GP notes indicate that he attended the GP's surgery at monthly intervals to pick up prescriptions of Haloperidol 15mgs in the morning and 20mgs at night from 6/7/90 to 17/12/90. Thereafter he continued to attend his GP's surgery on a regular basis but it is not clear whether he continued to receive this medication.

12. There are no outpatient or community team records available of follow up by mental health services between Feza M.'s admission to Hackney Hospital in 1990 and his next hospital admission on 31/10/91, but copies of letters written by various doctors to Feza M.'s GP indicate that he attended for some outpatient clinic appointments during this time.

13. On 5/2/91 he was reviewed in the outpatient clinic at Homerton Hospital by Dr. VL, SHO to Professor Si, who wrote to the GP noting that Feza M. was "well, eating and sleeping normally and spending his spare time walking". Dr VL also noted that "His speech was almost monosyllabic" but found no evidence of psychosis and that "he accepts that he has been ill". He reduced Feza M.'s dosage of Haloperidol, at his request, to 10mg in the morning and 15mg at night and informed the GP that "As this was his first episode of paranoid psychosis, and as he has been on medication for 11 months, I feel it would be appropriate to gradually reduce his medication until he is drug free, and then review matters."

14. On 13/8/91 his GP noted that he was "not taking Haloperidol" and was concerned that he was preoccupied with the idea of having AIDS, despite negative HIV tests. The GP noted that he had not kept a psychiatric outpatient appointment arranged for May 1991.

15. By 21/8/91 the GP noted that he felt that "people were looking at him in the street", that he could hear "funny noises" in the house, that he was insomniac, anorexic and losing weight. The GP referred him to Professor Si's outpatient clinic for psychiatric assessment.

16. On 26/8/91 he was seen in the outpatient clinic at Homerton Hospital by Dr W, SHO to Professor Si. He informed Dr. W that he had stopped taking medication in March 1991 and felt he had become unwell again in June 1991.

17. Dr W noted that Feza M. was worried that he was HIV positive despite two negative HIV tests, and that he felt that he had clear signs of this including "fungus growing in his body". Feza M. felt he had contracted the disease either three years previously "when very promiscuous" or five months previously from a dentist whom he believed did not sterilise his instruments. Dr. W noted him to be normal in speech, mood and sleep pattern, "not suicidal", and to have "well encapsulated hypochondriacal delusions". She also found that "he had some insight into his illness and agreed to take medication". Dr. W prescribed Haloperidol 50mgs b.d. and arranged a further outpatient clinic appointment for 3/9/91, a week later.

COMMENT: 50mg b.d. is a very large dose of Haloperidol with which to initiate community treatment and is likely to be associated with significant adverse effects which may impair compliance.

It is noted however that Feza M. had been able to tolerate high doses of this drug during his previous admission and following his discharge.

18. On 3/9/91 he was seen in the outpatient clinic at Homerton Hospital by Dr. He, Locum Consultant Psychiatrist. Dr He noted that "he continues to be anxious and preoccupied by his psychotic symptoms", that his sleep was poor and concentration impaired, and that he "described his body as getting smaller" and was "preoccupied by a fungal infection of his testes". Dr. He thought him to have "essentially an affective disorder, but with hypochondriacal preoccupations". Dr He stopped Haloperidol, noting "He has had a trial of Haloperidol with little effect", and prescribed Dothiepin 50mg at night and Pimozide 2mg b.d., advising the GP that the former could be doubled if well tolerated. A further outpatient appointment was arranged with Dr W for 17/9/91, two weeks later.

19. Feza M. did not attend the outpatient appointment on 17/9/91 and did not attend a further appointment arranged for 24/9/91.

20. On 27/9/91 Dr. W wrote to the GP informing him of Feza M.'s non-attendance, noting "I feel the most likely reason for his poor attendance is that he does not believe he is suffering from a mental illness". No further appointment was arranged but Dr. W informed the GP that she "would be happy to see him again if the need arises". On the same day (27/9/91) Feza M. consulted his GP who noted that he was "was reluctant to continue with medication" and "hasn't kept Psych. OPA."

COMMENT: It is of concern that Feza M. was discharged from regular follow up by mental health services at a time when he appears to have had no insight. His non- attendance at the outpatient clinic in such circumstances should have prompted some attempt to assess his situation at home. The clinical records relating to Feza M.'s care during this period are unavailable, and it is not possible therefore to ascertain whether such an attempt was made.

21. On 17/10/91 he attended the GP surgery where it was noted that he was "not sleeping, getting drunk", admitted to being "slightly paranoid", was "aggressive and unpredictable", had "voluble speech" and was "rather menacing and frightening". It was noted that his wife was "very concerned and frightened for her own safety". At the time Feza M. refused to be assessed by mental health services and left the surgery.

22. On 31 October 1991 his wife attended the GP's surgery complaining that Feza M. had become violent. The GP arranged an urgent mental health assessment.

COMMENT: It is regrettable that all clinical notes of Feza M.'s care prior to his admission to Hackney Hospital on 31/10/91 were unavailable from local mental health services.

Clearly the absence of these records could potentially impair the ability of mental health staff to evaluate the risks posed to and from Feza M.; the main risk factor identifiable from the GP notes which is not documented in subsequent mental health service notes being that he required admission to a local secure facility (PICU, Hackney Hospital).

31/10/91-13/2/92, Admission to PICU and Strauss Ward, Hackney Hospital

23. On 31 October 1991 Feza M. was admitted to PICU at Hackney Hospital under the care of Professor Si. He was initially detained under Section 4, having been brought to the hospital by the police after an assessment by his GP and an Approved Social Worker. He was later detained under Section 2 of the Mental Health Act and transferred from the PICU to Strauss Ward on 29 November 1991, eventually being discharged from Strauss Ward on 13 February 1992.

24. On admission his wife reported that he had not been fully well since his discharge from Hackney Hospital the previous year but that he had been getting worse over the previous 4 weeks. He had been eating and sleeping poorly. He had been shouting at the television, abusing his wife and threatening to put her in an acid bath. He was also noted to display multiple hypochondriacal ideas.

25. He was treated initially with oral Haloperidol but towards the end of his admission was commenced on depot Haloperidol injections 200mgs IM 2 weekly in addition to continuing oral medication, Haloperidol 5mg in the morning and 10mg at night.

26. Following an initial period of trial leave he was discharged with plans that he attend the Junction Day Hospital, the outpatient clinic at Hackney Hospital and be seen by a Community Psychiatric Nurse who would also administer the depot injections.

27. The diagnosis made during this admission was of Schizophrenia and possible Pathological Jealousy.

13/2/92-9/3/95, Outpatient and CPN follow-up, Discharged to GP on 19/1/94

28. Feza M. saw Dr. D, SHO to Professor Si, on 10/3/92 at Homerton Hospital for initial review following his discharge from hospital. It was noted that he displayed no psychotic symptoms or mood disturbance, that he and his wife were getting on very well, that he had been attending the Junction Day Hospital and that he had been compliant with oral medication.

29. By the time of his next review in the outpatient clinic on 21/4/92 Dr D noted that, although he did not exhibit any psychotic phenomena, he did not seem as well as he had been. He had stopped taking depot Haloperidol, although he continued to take oral medication. He had also stopped attending the Junction Day Hospital.

30. His Community Psychiatric Nurse, wrote to Dr D on 15/5/92 confirming that he was refusing depot Haloperidol, although continuing to take oral medication. The CPN noted that he was "reasonably stable at the moment" and informed Dr D and Feza M.'s GP that she would not be visiting again unless requested to do so by Dr D or the GP.

31. On 14/8/92 Feza M. attended the GP surgery and was noted to be "well psychiatrically".

32. There are no further mental health service notes until 12/10/92, at which time it appears that Feza M.'s RMO had changed from Professor S to Dr T. Feza M. did not attend an appointment made for him with Dr T's SHO, Dr K, at St. Bartholomew's Hospital on 9/10/92. He was advised to contact the department to arrange another appointment.

33. Feza M. was next seen in clinic at St Bartholomew's Hospital on 3/12/92 by Dr G, SHO to Professor D. Again there appears to have been a change of RMO, and Dr. G noted that no previous clinical notes were available at the time. Feza M. reported sleep problems and housing difficulties but was noted not to be depressed or to display any psychotic symptoms. He said that he had been compliant with medication with Haloperidol 5mg in the morning and 10mg at night. Dr. G added Chlorpromazine 50mg at night to help with sleep, and arranged a further appointment for "6 weeks time".

COMMENT: The absence of clinical notes is of concern, particularly as this appears to have been Dr. G's first contact with Feza M..

34. Feza M. was reviewed by Professor D in outpatient clinic at St Bartholomew's Hospital in January 1993, at which time he had stopped taking all medication. In a letter to the GP dated 2/2/93 Professor D noted him to be "very stressed by housing problems and his problems at work" but that he "did not display any florid psychotic symptoms".

35. He was advised to re-commence medication (Haloperidol 5mg in the morning and 10mg at night) and agreed to do so. He did not however attend for follow up thereafter and on 19/1/94 was discharged back to the care of his GP by Dr Hu, SHO to Professor D.

36. On 10/1/95 his GP noted "Chronic Schizophrenia. Not seen at hospital for 1 year. Stable. On Haloperidol. He lives alone".

PERIOD OF CARE UNDER THE SOUTH EAST LOCALITY TEAM, MARCH 1995

9/3/95, Attendance at St Bartholomew's Hospital Alcohol Clinic, Referral to SE Locality Team

37. On 9/3/95 Feza M. attended the Alcohol Clinic at St. Bartholomew's Hospital a "self-referral". He was seen by Dr B who noted that he had a history of "chronic psychosis", was "smelling of alcohol" and "behaving like intoxicated". At the interview Feza M. said he was "fed up with the world", that "nobody likes me" and stated "I am masochist". His sleep and appetite were noted to be "irregular" and he admitted to hearing derogatory voices "on and off". Dr. B contacted the South East Locality team to inform them of Feza M.'s attendance and request follow-up by duty workers and arranged for him to attend the alcohol clinic the following week "for a proper assessment when sober".

12/3/95, Overdose, Accident and Emergency Department, Homerton Hospital

38. On 12/3/95 Feza M. took an overdose of Haloperidol in combination with alcohol. He was seen in the Accident and Emergency Department at Homerton Hospital. He was also assessed by the Liaison Psychiatric Nurse who thought that he had some paranoid symptoms but he absconded before he could be seen by the duty psychiatrist.

39. According to notes made in the subsequent assessment by Social Worker, ML on 23/3/95 Feza M. claimed that he had wanted to kill himself and had consumed about 5 to 6 pints of beer and taken 80mg of Haloperidol. Under the influence of the overdose he fell from his bed and injured his right arm, an occurrence which may have prompted his attendance at the Accident and Emergency Department. Subsequently Feza M. claimed that, under the influence of the overdose, he was assaulted and that some of his personal belongings were stolen by a stranger who had offered to help him walk home.

40. Following Feza M.'s premature departure from the Accident and Emergency Department he was referred to a Community Psychiatric Nurse who, according to a note made by Dr T on 10/4/95, attempted to visit him at home on the afternoon of 12/3/95 but found him not in.

20/3/95, Attendance at GP Surgery

41. Feza M. saw his GP on 20 March who noted that he "appears to be relapsing, disinhibited, needs Haloperidol 5mgs bd, no suicidal intent now".

21/3/95, Telephone contact with Alcohol Clinic, Threatening behaviour

42. On 21/3/95 Feza M. contacted the Alcohol Clinic requesting a further appointment. At the time Dr. B noted that during the previous week Feza M. had attended the clinic and "was physically threatening to one of the female nurses who had to lock herself in a room". Dr B noted that this incident had been discussed by Drs. Se and W, Consultant Psychiatrists, who felt he "should be assessed urgently at home by the locality team with a view to a possible sectioning and admission to a psychiatric ward". Dr. B contacted the SE Locality team who informed him that they had planned a visit that afternoon, but that Feza M. had cancelled this, saying that he had to attend a court case in connection with "some damage at his property". Dr B requested that a further assessment be made before his next attendance at the alcohol clinic "to rule out any potential risks" and was reassured that the team would attempt another visit the following morning.

21/3/95-23/3/95, Attempted home visits by SE Locality Team

43. From 21 to 23 March 1995 members of the South East Locality Team made 3 attempts to visit Feza M. at home but found him not in.

23/3/95, Attendance at Alcohol Clinic

44. On 23 March 1995 Feza M. was seen again in the alcohol clinic by Dr B. Dr B noted that he was "calmer today". Feza M. told him that he had tried to kill himself since his last visit to the Alcohol Clinic but that he "does not want to die any more". Dr B noted that he was experiencing auditory hallucinations of voices telling him that he should die and that "he feels that people are quite threatening and they might hurt him". Dr B felt that hospital admission was appropriate and noted "Dr. Se and Dr. W agree with it". Feza M. was also in agreement, Dr B noting that "He is willing to be admitted to a psychiatric ward as he understands that he needs treatment". The Bed Manager was contacted but no beds were available. Dr B then contacted the Grovelands Priory, a private psychiatric hospital, but no beds were available there either. Dr B informed the Duty Consultant , Dr. O'M, of the situation and contacted the SE Locality Team requesting an urgent assessment.

45. He also noted a medication dose of Haloperidol 10mg three times daily and Procyclidine 5mg three times daily. According to Dr B's notes Feza M. eventually left the clinic "(quite drowsy) after waiting two hours here".

COMMENT: It is of considerable concern that three doctors including two Consultant Psychiatrists were of the opinion that Feza M. required hospital admission and that no hospital bed, either in the NHS or the private sector, could be found for him.

24/3/95-27/3/95 Contact with SE Locality Mental Health Team

46. On 24/3/95 Feza M. was visited at home by TS, Psychiatric Nurse, and ML, ASW, from the SELMHT. Feza M.'s presenting concerns related to his overdose in February and the assault and robbery upon him which had taken place whilst he was under the influence of the overdose. Following this initial assessment it was agreed that Feza M. should be provided with a bus pass, that day care arrangements be looked into and that ML, would write to the DSS with a view to back dating his claim for sickness benefit. A further home visit for psychiatric assessment was arranged for 3 days later.

47. He was visited on 27/3/95 by Dr B, Psychiatrist and ML. At the time it was noted that he "speaks with a loud voice and uses foul language at times". He was hallucinated by voices saying "kill F" which he believed came from outer space. It was noted that "he was blaming the British Government for his psychological problems". He expressed a wish to go to the Connolly Ward, Hackney Hospital for a few days because "I need to get better before my daughter comes to the UK".

48. He did not want to be "locked up on the PICU ward". It was noted that he had been taking Haloperidol 5mgs tablets prescribed by his GP. Arrangements were made for him to see Dr B again on Connolly Ward on 7/4/95.

27/3/95, Arrest at DSS Office

49. Later on 27/3/95 Feza M. was arrested at a Department of Social Security Office and taken to Stoke Newington police station where he was interviewed by police in the company of an appropriate adult, BL, Social Worker. Feza M. had been seen in the Social Security office with a knife.

50. According to Feza M.'s account to the panel, he had taken to carrying a knife with him around this time to protect himself from being mugged after the incident in which he was assaulted and robbed following his overdose in February 1995.

51. According to Feza M. he had taken the knife out and was toying with it whilst sitting in the DSS office waiting for his number to be called. He denied any intention of threatening or harming others with the knife at the time. Following questioning he was released without charge and denied carrying the knife with him thereafter.

52. The only near contemporaneous record of the incident in the clinical notes is an entry by ML dated 28/3/95 of a telephone call from the Emergency Duty Team stating "T/C from EDT. Feza M. had gone to DSS with a knife. He was taken to Stoke Newington Police Station and interviewed in front of BL, Social Worker. He was released without any charge"

53. A much later record in a referral form for day care dated 22/6/95 prepared by AP, student nurse, states "Feza M. was involved in one incident where he became threatening towards DSS staff over benefits. This appears to have been an isolated incident caused by frustration and severe mental health difficulties at the time. No violence was used or physical harm caused".

COMMENT: It is regrettable that there is not a more detailed contemporaneous note of the circumstances of Feza M.'s arrest at the DSS office. This clearly limited the ability of the service to take appropriate account of the incident in future risk assessment.

27/3/95-10/4/95, Continuing Involvement of SE Locality Mental Health Team

54. Feza M. did not attend the appointment with Dr B on 7/4/95. He telephoned the SELMHT informing them that he would not do so because he had "other things to do" and said that he would contact his GP regularly as he had been doing. Feza M. also wrote to the mental health services saying that he did not wish to attend the appointment on April 7 and requested a visit to his home.

55. On 10/4/95 Dr T wrote to Feza M.'s GP informing him that a home visit would be arranged by the LMHT. Dr T noted in the letter that mental health services were aware that Feza M. had repeatedly presented to the Alcohol Clinic, "often with a somewhat threatening demeanour."

PERIOD OF CARE UNDER THE NORTH WEST LOCALITY TEAM (APRIL 1995 TO SEPTEMBER 1997)

31/3/95 Transfer of Feza M.'s care to NW Locality Mental Health Team.

56. Feza M.'s care was transferred to the NWLMHT to catchment area boundary changes. A letter to Feza M. was sent to this effect by the SELMHT .

13/4/95-22/5/95, Contact with NW Locality Team, Discharge to GP care on 21/4/95

57. On 13/4/95 Feza M. was visited at home by a CPN, and SB, Locum Social Worker, from the NWLMHT.

58. His main complaint at the time was of financial difficulties. He denied mental distress although was noted to be slightly agitated and slightly elated in mood. No overt signs of mental illness were detected. He agreed to accept help with benefits but was reluctant to accept any psychiatric support. He claimed to be compliant with oral Haloperidol medication prescribed by his GP. Following this assessment case closure was recommended, confirmed by Team Leader, ED, and the GP was duly informed by letter on 21/4/95. No psychiatric follow-up was arranged and he was therefore effectively discharged to the care of his GP.

COMMENT: Feza M.'s discharge to the care of the GP only weeks after an overdose and an episode of very threatening behaviour associated with psychosis and alcohol intoxication is clearly of concern. It is noted however that Feza M. was reluctant or unwilling to accept follow-up by mental health services at this time, and that the NWLMHT was not staffed to provide the level of "assertive outreach" which would be required to maintain contact in such circumstances.

59. On 10/5/95 ED received a call from PCOK, Support Worker at the Day-Mer Turkish Day Centre, expressing concern over Feza M.'s mental state. According to Mr PCOK, Feza M. was clearly not taking his medication, complaining to staff at the day centre that it made him feel too drowsy. Mr PCOK wondered whether he might be prescribed a less sedative anti-psychotic. ED noted that he would "arrange with Dr S re. domiciliary visit as soon as possible".

22/5/95-2/6/95, Admission to Hackney Hospital

60. On 22/5/95 Feza M. was admitted to Hackney Hospital under the care of Dr D, Consultant Psychiatrist, after having presented to Hackney Hospital Emergency Clinic. He had presented there, demanding a job in a verbally aggressive manner and swearing at other patients in the waiting room.

61. On admission his talk was noted to be loud and pressured. He was irritable and slightly grandiose. He appeared to be deluded in the belief that there was a computer system in the lights of the hospital and elsewhere, and that the CIA were trying to control his movements in some way. He also appeared to harbour some persecutory ideas regarding his wife, complaining that she had caused him to lose his job. He denied any thoughts, however, of harming his wife or others. He was noted to have little insight into his condition but was compliant with medication.

62. He absconded from the ward a week after his admission but was not discharged until 2/6/95. Dr J, SHO to Dr D, in his discharge summary of 22/6/95 said "I should be writing to his Locality team in order that they know of his situation".

COMMENT: It is of concern that the NWLMHT were not informed of Feza M.'s admission and departure from Hackney Hospital until what would appear to be at least 23 days after he had absconded.

30/5/95, Home visit by Dr. K and ED

63. On 30/5/95, following from the concerns expressed by Mr PCOK, ED and Dr K, Senior Registrar to Dr S, visited Feza M. at home. Mr I, Feza M.'s uncle, was also present and assisted with interpretation.

64. It transpired that, unknown to the NWLMHT, Feza M. had been admitted to the Homerton Hospital and had absconded some 3 days previously. At interview Feza M. admitted that he had kept a can of petrol in his flat for the past 2 months and more recently had been considering killing himself by either setting himself alight with petrol or stabbing himself with a needle in the throat. He complained that the television was giving him messages "to stay inside" so that he is "looked after". He was suspicious that the CIA was involved in this but did not know why. He also complained of hearing voices some time ago saying "burn the flat yourself" and "we kill you" which he suspected emanated from outer space. He admitted to drinking up to 10 pints of beer per day when he had money, about once a week, and to cannabis abuse.

65. It was thought that he required admission to hospital in view of the risk he posed both to himself and to others.

66. Although he was still nominally an inpatient at Hackney Hospital, no bed was available there (presumably his bed being occupied by another patient as a consequence of bed shortages) nor in a private sector hospital. The Dukes Priory Hospital in Chelmsford however agreed to accept him the following day. His uncle removed the petrol can and his medication was increased from Haloperidol 5mgs bd (the dose that Dr. K thought he had taken since 1992) to 10mgs bd.

COMMENT: Again it is of concern that, although Feza M. clearly posed risks to himself and others, no bed could be found for his admission to hospital until the following day.

31/5/95-23/6/95, Admission to Duke's Priory Hospital, Chelmsford

67. He was admitted to the Dukes Priory Hospital in Chelmsford on the following day (31/5/95) on an informal basis under the care of Dr J, Consultant Psychiatrist.

68. On admission his symptoms were as described by Dr K on the previous day. It was also noted that he was friendly and co-operative and not overtly depressed but reluctant to mix with other patients.

69. He was initially treated with oral Haloperidol 5mg b.d. and later depot Depixol in a dosage of 40mgs monthly was initiated. Within 10 days of admission his mental state had improved considerably, and he was no longer hallucinated or expressing persecutory ideas.

70. ED, CPN and Team Leader in the NWLMHT was contacted by ward staff and agreed to co-ordinate his transfer back into the community. On 16/6/95 a meeting took place at the Duke's Priory Hospital between JA, social worker, and AP, student nurse, from the NWLMHT , Dr. J and nursing staff at the Duke's Priory. JA undertook an assessment of Feza M.'s needs at the hospital prior to discharge and subsequently became his Key worker within the Care Programme Approach. AP became the Designated Contact Person (DCP) within the terms of the local CPA policy, responsible for most of the future contact with Feza M. under the supervision of the CPA Key Worker.

71. He was eventually discharged on 23/6/95 with plans that he be allocated a Community Psychiatric Nurse to monitor his mental state and administer depot medication, for a referral and assessment at the Lee House Day Centre, for possible referral to a MIND employment project, for possible referral to the Psychiatric Rehabilitation Association, for assistance in getting his flat back into order and for assistance with his request for a housing transfer.

23/6/95-3/9/96, Contact with the NW Locality Team, Case Closure on 6/10/95, Outpatient Attendance on 12/4/96

72. The NWLMHT arranged 16 contacts, 11 home visits and 5 office or depot clinic appointments, in the 9 month period between his discharge from the Duke's Priory Hospital and the 6/10/96. Contact was made on only 3 occasions, one attendance for depot clinic and 2 home visits by AP, Student Nurse. The team's involvement during this period was as follows:

10/7/95: Feza M. did not attend clinic for depot injection

10/7/95: Home visit by AP, Feza M. not in.

11/7/95: Home visit by AP. Feza M. not in.

12/7/95: Home visit by AP. Feza M. not in.

18/7/95: Attendance at clinic for depot injection.

19/7/95: Home visit by AP. Feza M. not in.

24/7/95: Home visit by AP who accompanied Feza M. to the Darnley Day Centre for assessment with a view to attendance there (Lee House, the day centre initially considered for Feza M., having a waiting list).

28/7/95: Home visit by AP. Feza M. not in.

1/8/95: Home visit by AP. Feza M. informed that he could attend Darnley Day Centre from 7/8/95. It was noted that he "appeared mentally stable", "no longer hears voices", "sometimes feels a 'bit down' but says he does not feel depressed". AP noted that she had applied for a bus pass for him.

7/8/95: Outpatient appointment with Dr K, Senior Registrar to Dr S. Feza M. did attend.

7/8/95: Feza M. did not attend the Darnley Day Centre as had been arranged.

10/8/95: Home visit by AP. Feza M. not in.

21/8/95: Feza M. did not attend clinic for depot injection. Letter sent.

23/8/95: Home visit by AP and HR, Care Worker, to introduce HR who would be taking over her role with Feza M.. Feza M. not in.

5/9/95: Telephone call to Feza M.'s uncle, His wife informed the team that she and her husband had tried to contact Feza M. and had been to visit him but that he was never at home and did not ring them.

6/9/95: Telephone call to Darnley Day Centre. Feza M. had not attended there since his initial visit.

6/9/95: Letter to GP informing him of the difficulty in maintaining contact.

11/9/95: letter to Dr S informing him of the difficulty in maintaining contact

22/9/95: Home visit by HR. Feza M. not in.

25/9/95: Telephone call to Mr I (Uncle) Message left asking him to contact HR.

29/9/95: Home visit by HR. Feza M. not in.

3/10/95: Telephone call to Mr I. Message left asking him to contact HR.

3/10/95: Telephone call to GP. GP "hasn't seen Feza M. in quite some time". He had an appointment on 15/9/95 at the GP surgery but did not attend.

3/10/95: Telephone call to Mr PCOK, Day-Mer Turkish and Kurdish Community Centre. Mr PCOK on leave. Message left.

?/10/95: Letter to Mr I returned to the team.

6/10/95: Telephone call to Mr I regarding Feza M.'s whereabouts. Mr I had spoken with Feza M. 2-3 weeks previously. HR noted from the conversation that "Apparently Feza M. is fine. Everything seems to be OK". After discussion with JA, the case was closed. HR noted that she had "asked F's uncle to ask Feza M. to contact us". Thereafter Feza M.'s care was dealt with by the team on a "duty" basis. No psychiatric follow-up was arranged.

COMMENT: The closure of Feza M.'s case at this point was perhaps premature. It is notable however that the team had made strenuous efforts to maintain contact with Feza M. and, prior to closure, had discussed the situation with his uncle, who had reassured the team of Feza M.'s current mental state. It is also clear that the team was insufficiently staffed at the time to provide an "assertive outreach" approach to follow-up for all of its patients who had a profile of needs similar to those of Feza M.. It is also notable that the team responded promptly to concerns about Feza M. raised by the housing department some 20 days after case closure, and that Feza M. maintained contact with the team after case closure and, indeed, resumed attendance for regular depot injections some 3 months later (see below).

73. On 26/10/95, shortly after Feza M.'s case was closed, JA received information from the London Borough of Hackney Housing Department that Feza M. had received a notice to quit his accommodation.

74. JA visited on 13/11/95 but Feza M. was not in.

75. A further visit was arranged for 27/11/95, during which Feza M. complained of noisy neighbours, problems with bills and benefits and made a request for a housing transfer to the Enfield area.

76. On 29/12/95 Feza M. attended the locality team office requesting an increase in his DLA benefit. He was again seen by JA who discussed the matter at length with him and informed him that he did not think that his needs would justify it.

77. On 15/1/96 Feza M. telephoned the locality team and spoke to HR, Care Worker. HR noted that he "sounded very irate and quite elated". He requested an immediate appointment and was invited to attend as soon as possible. He arrived shortly thereafter and was noted to be "panicky and nervous". He complained of noises and the people who lived above him. He complained of being "fed up with it all". His appetite and sleep pattern had been poor for the previous few days. He felt he was becoming ill and requested an injection. He was given Depixol 40mgs. HR noted that she would arrange an appointment for Feza M. to meet Dr S for medical review.

78. On the following day (16/11/95) the locality team received a call from the Social Services Department informing them that Feza M. had complained that his neighbours were perpetrating child abuse.

79. He accepted further monthly injections of Depixol 40mg im. on 12/2/96 and 11/3/96 and also attended the team office on 5/3/96 where it was noted that "everything is fine at the moment" but that he was requesting funds in order to take a holiday.

80. On 4/4/96 he attended the team office for a depot injection complaining of feeling stressed and tense, insomniac, unable to concentrate and of becoming socially isolated. It was noted that he was taking oral medication, Haloperidol 5mg three times daily. He requested an increase in depot medication. His usual dose of depot was given and arrangements were made for him to see Dr S at a community surgery on 12/4/96.

81. At the outpatient clinic appointment on 12/4/96 Dr S noted that, although Feza M. reported himself to be "ah, about 90%", towards the end of each month he became troubled by paranoid ideas and auditory hallucinations which were accompanied by agitation, sleep disturbance and loss of appetite. He felt that Feza M. was suffering from fluctuating paranoid symptoms which were kept in check by the depot neuroleptic medication which was "wearing off" towards the end of the injection period. Dr S increased his depot frequency from monthly to 3 weekly and did not arrange another outpatient appointment, informing the GP that he would be followed up by his CPA Keyworker, and copying his letter to JAr, CPN, as such.

COMMENT: Dr S appears to have believed that Feza M.'s Keyworker was JAr, CPN, although at this time Feza M.'s case had been closed to the team and he was being dealt with on a "duty" basis. This error probably arose out of JAr having seen Feza M. as a duty case. The error led to Feza M. receiving no planned follow-up to assess the efficacy and adverse effects of the change in treatment apart from his attendance at the depot clinic.

82. Thereafter Feza M. attended the locality team office for 3 weekly injections of Depixol 40mgs on 3/5/96, 24/5/96 and 17/6/96, after which his depot injections were administered at the John Scott Health Centre on 8/7/96 and 16/8/96.

83. On 2/9/96 he came to the locality team office requesting help with benefits as some of his money had been stopped. He was seen by HR who attempted to contact the DSS but was unable to do so. She informed Feza M. that she would pursue the matter. She also noted that Feza M.'s behaviour at the time suggested that he might be responding to voices but on more detailed questioning he denied any difficulties.

3/9/96-5/9/96, Admission to Tuke Ward, Homerton Hospital

84. On the following day (3/9/96) he presented to the Emergency Clinic at Homerton Hospital in a distressed state, complaining that he had been unable to sleep the previous night and was hearing voices. The voices had been telling him to kill himself and burn his flat. In view of this he was considered to be a risk to both himself and others due to the possibility of arson. A note made by Dr M, Senior Registrar in the Emergency Clinic, at the time stated "without knowing this man and without his old notes, he needs admission and review by his team"

COMMENT: The absence of clinical notes is of concern, and Dr. M clearly made a prudent decision in the circumstances.

85. Upon admission to Tuke Ward Feza M. was noted to appear clean and tidy but to smell unwashed. He was appropriate and courteous but reported feeling angry and a bit depressed.

86. A medical note on 3/9/96 states "says he has been abandoned and has not seen a psychiatrist or social worker for years (although was being seen by Dr S, Locality Team ASW and HR)". He was also noted to be suffering broken sleep but his appetite was good and he expressed no thoughts of self-harm.

87. Although Feza M. acknowledged having heard voices exhorting him to kill himself on the night before admission, the voices had stopped by the time he arrived on the ward and he appears to have experienced no further hallucinosis in the course of his admission. On the day following admission he reported feeling much better. By this time no psychotic phenomena were in evidence in his mental state and he denied thoughts of self-harm. He requested to sleep over night at home as he had been troubled by noise in the hospital dormitory from other patients.

88. He was allowed over night leave and returned the following day (5/9/96) at which time he was reviewed by Locum Consultant Psychiatrist, Dr W. Feza M. was interviewed with an interpreter and reported that he felt well and wanted to be discharged. He told Dr W that he no longer heard voices exhorting him to burn down his flat. A nursing note by AP, now working on the ward as a staff nurse, reports "depot needs to be increased as Feza M.'s mental state is reported to show signs of relapse when next depot is nearly due".

89. The discharge summary of the admission by Dr P, SHO to Dr S also notes that "it was explained to Feza M. that the reason he becomes "edgy" towards the time his depot is due, and whilst on this occasion he heard auditory hallucinations maybe because he is not getting his depot medication often enough and that his depot medication should really be increased to 40mgs every 2 weeks". Feza M. appears to have had some initial reservations about the increase in dose, complaining that the medication caused him to put on weight and made him impotent, but eventually agreed to the increase in dose.

90. He was discharged on 5/9/96 with the plan that his depot medication be increased to Depixol 40mgs 2 weekly, that an outpatient appointment with Dr S be made in 2 months time and that his Keyworker, JAr, CPN, be informed of the change in his depot dose. No formal CPA meeting was held prior to discharge. A nursing note by AP dated 5 September 1996 states "CPA not applicable as all community care services are in place already and F has no needs other than those already known."

91. A nursing note by AP on the day of his admission (3/9/96) states "JA, his Keyworker has been informed of his admission". A nursing note on 5/9/96 however states "has good rapport with his Community Keyworker, JAr". Dr P also appears to have believed that JAr was Feza M.'s Keyworker at this time, copying his discharge summary to her as such.

COMMENT: There was a failure of understanding on the part of staff on Tuke Ward of the Trust's CPA policy. Even, as may have been the case, that Feza M.'s needs were currently being met by what ward staff understood to be his plan of care, this did not obviate the need to review this plan and confirm the roles of participants in it prior to his discharge. That this was necessary is clearly indicated by the confusion which appears to have obtained regarding by whom Feza M. had been keyworked under the CPA prior to his admission. In fact Feza M. had no Keyworker at the time and was being dealt with on a "duty" basis by the NWLMHT.

It is also notable that, although a copy of the discharge summary was sent to JAr as Keyworker (and that in a letter to Feza M.'s GP copied to her by Dr S dated 12/4/96 she was also described as such), no action was taken to correct the error.

JAr told the Murphy Inquiry that she had informed ED, the team leader, that she was not the Keyworker when the discharge summary arrived but made no attempt to inform Dr S. ED also appears not to have done so.

5/11/96-22/8/97, Attendances at Depot Clinic, John Scott Health Centre

92. Following Feza M.'s discharge from Tuke Ward he had no further contact with members of the NWLMHT, apart from attendances for depot clinic injections at the John Scott Health Centre, until the 11/8/97, some 11 months later.

93. According to his depot therapy prescription chart he was prescribed Depixol 40mgs IM 3 weekly from the time of his discharge until 22/8/97 Between 6/9/96 and 22/8/97 he attended the depot clinic fairly regularly for injections, the injections being administered at a frequency greater than 3 weekly on only 2 occasions (on 1/8/97 instead of 27/7/97 and on 15/11/96 instead of 8/11/96).

COMMENT: It is not possible that the improvement in Feza M.'s mental state during the course of this brief admission was attributable to an increase in medication as he was given no additional medication during the course of the admission. The increased frequency of depot dose which was agreed following Feza M.'s admission to Tuke Ward does not appear to have been put into effect. There appears to have been a breakdown in communication between Tuke Ward and the NW Locality Team which led to the depot prescription card for his attendance at the John Scott Health Centre being left unaltered.

There also appears to have been a failure to arrange an outpatient appointment with Dr S in the outpatient clinic at Homerton Hospital 2 months after discharge, and it appears that he was not seen there until 11 months after discharge. The panel were unable to find any documentation of the outpatient appointment with Dr S in March 1997 referred to by the Murphy Inquiry.

If a Keyworker had been appointed to monitor Feza M.'s treatment after discharge from Tuke Ward, it is likely that these errors would have been detected and corrected at an early stage.

11/8/97, Attendance at NW Locality Team Office, Re-allocation of Keyworker

94. On 11/8/97 Feza M. attended the NWLMHT office. Fortuitously on that day he had again been allocated a Keyworker, SD, Community Psychiatric Nurse, who had recently joined the NWLMHT. He was seen by SD at the office and expressed a number of concerns including disturbance from upstairs neighbours, whom he accused of making noise all night and making it difficult for him to sleep, and rent arrears of approximately £500.00 which he claimed he had already made an arrangement to pay but about which he remained concerned. He also requested a short term loan of £20.00.

SD wrote to the Housing Department regarding Feza M.'s neighbours and rent arrears and advised him that the NWLMHT was no longer able to issue loans. Feza M. was advised to attend the DSS office regarding the possibility of extra money.

11/8/97, Attendance at Dr S's Outpatient Clinic, Homerton Hospital

95. On the same day (11/8/97) Feza M. attended an outpatient clinic appointment at Homerton Hospital with Dr S. At interview with Dr S he complained that "I need euthanasia". He reported that he could no longer tolerate poisoning by "them". It was noted that he was "desperate – can't cope", that he was being "harassed by a neighbour", that he was anxious about his physical health and preoccupied with thoughts of having BSE or HIV infection, and that he had "desperate, vague suicidal ideas" but there was "nil imminent" meaning that he had no intentions at the time of carrying these through. It was noted that he was drinking alcohol and consuming cannabis heavily. Dr S wrote to Feza M.'s GP following the appointment noting that he was "mildly psychotic at present, with bizarre, paranoid delusions. He is using alcohol and marijuana heavily". Dr S reassured Feza M. regarding his concerns about HIV and BSE infection, advised him to reduce his consumption of alcohol and cannabis and recommended an increase in his Depixol dosage to 40mgs fortnightly. Dr S contacted the NWLMHT and spoke to SD on 11/8/97, informing him of his plans to increase the depot dose and to advise SD to encourage Feza M. to reduce his alcohol and cannabis consumption. A CPA meeting to review Feza M.'s care was arranged for 29/8/97.

15/8/97, Home Visit by SD

96. On 15/8/97 SD visited Feza M. at home and noted him to be "deteriorating slightly". He was described as "agitated and a little hypo-manic". He complained that people were against him and putting "things" in his drink and cigarettes. He also complained of daily vomiting and sexual dysfunction including impotence and ejaculatory failure. SD noted that he had continued to drink alcohol heavily but reported that he had stopped smoking cannabis over the previous month. A friend who attended with Feza M. however was sceptical that he had stopped smoking cannabis and reported that Feza M. was spending 2 weeks of benefit money in the 2 days after its receipt. He also reported that people on his estate and at the Day-Mer Turkish Community Centre were ridiculing him to his face. SD discussed an increase in depot medication frequency with Feza M. and he was agreeable to this. SD also discussed supported accommodation and budgeting difficulties with Feza M. and he agreed to consider low support style accommodation and weekly payment of his benefits to assist in budgeting.

19/8/97, Home Visit by SD

97. On 19/8/97 SD again visited Feza M. at home. Although Feza M. was described as "behaviourally settled" he reported to SD he was "not at his best mentally". He reported that he had barely slept for the previous month. SD also noted that he expressed ideas of reference, believing that people on the television were talking to him personally, and that he was experiencing thought broadcast, believing that his eyes could communicate with other people and thereby others would know what he was thinking. Feza M. also reported hearing an unrecognisable Turkish voice telling him to do various things ranging from washing his hands to setting himself on fire.

98. He reported that he could only hear the voice when alone, un-distracted and when there was a background noise such as running water, fans or traffic. SD discussed medication, both oral and depot, with him. Feza M. expressed a view that he was not being given his full dose of Depixol at the depot clinic. He was willing to take a particular brand and dose of Haloperidol (Haldol 5mg tablets manufactured by Janssen) as he felt that these had helped him in the past. He was unwilling however to take a different brand or dose of Haloperidol. SD noted that "these issues to be discussed at his CPA meeting (on 29/8/97)", some 10 days later. He also noted that a further appointment for Feza M. was given for 21/8/97, but there is no note indicating that this occurred.

22/8/97, Attendance at Depot Clinic, John Scott Health Centre

99. On 22/8/97 Feza M. attended the depot clinic and was given Depixol 40mgs IM. This was some 3 weeks after his immediately previous injection, the clinic not yet having received a prescription to support the increase in his dosage of Depixol to 40mgs IM 2 weekly. He was noted again to appear "agitated and a little hypo-manic". Feza M. informed the nurse himself that his depot frequency had been increased to 40mgs 2 weekly and the CPN, who ran the clinic noted that he was "reassured" regarding this.

27/8/97, Attendance at GP surgery

100. Feza M. saw his GP on 27/8/97 to have a passport application signed. It was noted "seems a bit more agitated. Has dates for injections".

29/8/97, CPA Review Meeting cancelled

101. The CPA review meeting arranged for 29/8/97 did not occur. Feza M. did not attend and SD was on sick leave on the day in question.

1/9/97, Letter from SD to Dr S

102. On 1/9/97 SD wrote to Dr S outlining a number of problems that Feza M. was experiencing including his "continual agitation and degree of hypo-mania", continuing alcohol and cannabis abuse, poor self care and domestic hygiene, budgeting difficulties, poor appetite and sleep, vomiting and sexual dysfunction. SD also reported Feza M.'s beliefs that the television was speaking to and about him , that a substance was being put into his food and cigarettes to make him unwell, that other people were able to "read his mind and communicate with his eyes" and that he was hallucinated by an unidentifiable Turkish voice. Although SD wrote that "I do not believe F is an immediate risk to himself or others at the moment", he was concerned that Feza M. had not yet received the increase in depot medication which had been agreed during the visit to Dr S on 11/8/97 and felt that "in order to avoid a serious lapse into ill health, we must start looking at the situation". SD also wrote that he had discussed oral medication with Feza M. "on a temporary basis at least" but that Feza M. would only accept a particular brand of Haloperidol which was not that usually purchased by the Trust.

103. SD requested that Dr S see Feza M. in the outpatient clinic "where you could explore the oral meds issue and re-examine his mental state".

104. SD also informed Dr S that he had rearranged the CPA review meeting on Feza M. for 24/10/97, the earliest date available within the team diary for same.

5/9/97, Attendance at Depot Clinic, John Scott Health Centre

105 According to the depot clinic diary at the John Scott Health Centre, Feza M. attended for an injection at the John Scott Health Centre on 5/9/97, some 2 weeks after his immediately previous injection on 22/8/97. The depot therapy prescription chart relating to this administration of medication is unfortunately not within the notes. At interview with the panel Feza M. confirmed that he had attended for this injection.

COMMENT: Although Dr S advised SD that the frequency of Feza M.'s depot injections should be increased from 3 weekly to 2 weekly on 11/8/97, Feza M. did not receive the increase in dosage until 5/9/97, some 25 days later. This appears to have been due to a delay in the receipt of a prescription supporting the increase in dosage. This delay in altering Feza M.'s treatment is of concern. It is possible that a more rapid increase in medication may have had a positive effect on Feza M.'s condition at an earlier stage.

5/9/97, Home Visit by SD.

106. SD visited Feza M. at home on 5/9/97. Initially he felt that Feza M. may be improving as he stated that "he no longer heard voices and was generally feeling much better". During the course of the visit however Feza M. "picked up a broomstick began banging on the ceiling, complaining of all the noise his upstairs neighbours were making". When questioned about this by SD Feza M. "stated the people upstairs were sending the voices down to him, disturbing him all the time". Overall SD concluded that Feza M. "appears to be deteriorating in his mental state" and "appears more agitated than previously". He felt that Feza M. had "obviously lost a great deal of insight and his auditory hallucinations appear worse". SD noted that his depot medication had been increased to 2 weekly frequency "which may relieve his distress shortly". He arranged a further home visit to Feza M. on 9/9/97 and made a plan for Feza M. to have a medical review at Anita House, the locality team base. SD also noted that he would discontinue the complaint about noise that he had made on behalf of Feza M. to the Housing Department in view of his belief that Feza M.'s complaints about noise were related to hallucinatory experience.

9/9/97, Home Visit by SD

107. On 9/9/97 SD visited Feza M. at home. Music could be heard playing in the flat but Feza M. did not respond to knocks on the door and SD left after 20 minutes with a plan to visit again later in the week. At interview with the panel, Feza M. recalled this visit, reporting that he decided not to answer the door because he was smoking cannabis at the time. He did not see SD but believed him to be the person knocking at the door at the time as he had been expecting him.

10/9/97, Attempted Home Visit by SD

108. SD attempted to visit Feza M. again the following day (10/9/97). Again music could be heard in the flat but SD received no response to his knocks. Again Feza M. stated to the panel that he recalled this attempt to make contact but that again he did not answer the door because he was smoking cannabis. Following the aborted visit SD wrote that he would "call again tomorrow, if still no sign of Feza M., I will contact Halkevi to check if they have seen him. If not then I will discuss case with ASW (Approved Social Worker) and medical staff."

109. SD reported to the Murphy Inquiry that he believed he had called again later the same week with the same result, although this is not recorded in the locality team notes.

COMMENT: SD did not contact Dr S or discuss the difficulties he was experiencing in making contact with Feza M. in supervision. At this time his usual supervisor, ED, was on leave and there appears to have been a gap in his regular supervision. At this time SD did not regard Feza M. at significant risk of harming himself or others, and was initially disbelieving of the accusations against Feza M.

In assessing SD's work with Feza M. it is important to recall that he had been aware that Feza M.'s mental health was deteriorating and had tried to arrange a medical review at the beginning of September. In addition he had incomplete notes, no proper handover from a previous worker, and, at the time that he was having difficulty in contacting Feza M., no clear supervision arrangements.

Furthermore he had been given Feza M.'s case as one of six not regarded as "difficult" or "risky" as part of his induction into the team. He had been working as a CPN in the team only from August 1997. This panel therefore endorses the view of the Murphy Inquiry that "no blame whatever attaches to him for subsequent events".

THE DEATH OF CAROLINE C.

110. The panel visited Feza M. at Rampton Prison on 14/12/98. Prior to the interview we spoke with Dr Sa, Consultant Forensic Psychiatrist responsible for Feza M.'s care at the hospital. Dr Sa informed us that Feza M. was not currently displaying symptoms of psychotic illness. At interview, conducted with the assistance of a Turkish interpreter, Feza M. was fully co-operative, polite and deferential in manner. His speech appeared to be fully coherent. He was able to give a detailed account of the events of 16/9/97 which led to the death of CC. He recounted these events in a 'matter of fact' way, with no evidence of emotional distress. He showed no remorse for his actions while giving his account of these events or at any other time during the interview.

111. Feza M. has given sometimes conflicting accounts of the events of 16/9/97 to the various medical assessors (Dr S on 23/7/97, Dr J on 9/3/98, Dr L on 26/5/98, Dr de T on 6/10/97 and Dr. V on 14/10/97) who have interviewed him since his arrest. His account to the panel on 14/12/98 also conflicted in some respects with those given earlier.

112. By all accounts Feza M. had left his flat on the morning of the homicide with the intention of going to a Turkish Social Club. On the way he saw Ms C in the street. He had not met her before. She asked him if he "wanted business". He explained that he had no money but that he would be willing to pay her later. Ms C accepted this arrangement and she walked back to his flat with him. On arrival in the flat Ms C declined to have sexual intercourse with him. According to Feza M. she said she was tired and wanted to sleep first.

113. The explanation he gave to Dr V for the killing was "I brought her there for sex. She refused to give me sex and went to sleep. She was no good so I killed her."

114. By his account to the panel and other medical assessors, he accepted Ms C's wish to sleep and suggested that she go into the bedroom.

115. Soon after she had gone to sleep he became fearful that Ms C was not a prostitute, as she purported to be, but rather that she was working for, by different accounts, the police, MI5 or the CIA. He had already become suspicious of her when she agreed to accompany him despite having told her that he had no money to pay her. With this in mind he decided to go through her handbag. He found some paper in the handbag on which he said was written "he is a bad man, a very bad man". Feza M. said that he immediately knew that this related to him. At the same time he began to experience auditory hallucinations saying "If you don't kill her, she'll kill you" or "kill her, kill her,..." or "kill her or she kill you" or "The woman has come to kill you. Before she kills you, you will kill her first" according to various different accounts. The hallucinations were of a male voice unknown to him, speaking in Turkish, and sounded as if they were blasted at him by a megaphone.

He immediately went into the kitchen where he located a large kitchen knife. He took this to the bedroom and stabbed Ms C in the neck and abdomen with it. On realising that she was still alive he returned to the kitchen where he obtained a rolling pin which he then used to beat Ms C about the head. At this point he began to feel some remorse for what he had done. To the panel he said "I then felt sorry. I felt mercy for her and went to the bathroom". He then carried Ms C to the bathroom, placed her in the bath and attempted to revive her. He then heard another voice, that of his father, telling him to, by different accounts, change or remove his clothes. He then went to a neighbour and requested that an ambulance be called.

116. Ms C died later on 16/9/97, from multiple injuries, at the Homerton Hospital. There were at least 6 major wounds to the neck and both the heart and liver had been punctured. The Home Office pathologist stated that the area of injury to Ms C's forehead would suggest that a minimum of 15 blows had been used, and that this had caused injury to the brain.

117. It was considered that the stab wounds to the heart and liver would have been sufficient in their own right to cause Ms C's death.

EVENTS FOLLOWING THE HOMICIDE

16/9/97, Telephone call to NW Locality Mental Health Team from Stoke Newington Police Station informing the team of Feza M.'s arrest

118. On 16/9/97 SD received a telephone call from DI P of Stoke Newington Police Station informing him that Feza M. had been arrested at 11.20am on a charge of attempted murder and asking that an "appropriate adult" attend the police station to be present with Feza M. during a police interview.

119. SD interviewed Feza M. himself before the police interview. He noted that Feza M. appeared "calm and well composed", that he "displayed no agitation or motor restlessness", that he was "attentive with good eye contact" and that "his eyes were clear and responding normally, indicating no evidence of alcohol or drug consumption." He was "dressed in a paper forensic suit" and "had dried blood on his body and limbs". SD noted that Feza M.'s speech was "lucid and coherent." Feza M. "showed no exhibition of paranoid or delusional belief" and denied hallucinations. His account of the events of the day to SD, as recorded in SD's notes, was that "he had been out that morning to a café and on return to his locked flat heard moaning coming from the bedroom. On investigation he found the woman stabbed on his bed. He undressed to avoid getting blood on his clothes and carried the woman to the bath to clean her wounds. He placed her in the bath and ran the water. He redressed and went to his next door neighbours to ask them to call an ambulance". During the subsequent police interview SD noted that Feza M. "coped well". He denied that he had attacked the woman and stated "if I had done it, why would I have called the ambulance". SD noted however that Feza M. stated in the interview that the voice of his father had instructed him to remove his clothes. During the course of the interview Feza M. was informed of the woman's death and SD noted that he "appeared upset by this information".

120. SD returned to the police station the following day (17/9/97) to be present as an appropriate adult in a further police interview. He noted that Feza M. "appeared flatter in affect and his ability to concentrate had deteriorated slightly". The victim had been identified by the police as a known local prostitute. According to SD's notes Feza M. "admitted to looking for prostitutes in the past and had felt like killing them when they dismissed him". Nevertheless Feza M. maintained his innocence during the police interview. At the conclusion of the interview Feza M. was charged with murder and remanded to Pentonville Prison Hospital Wing to appear at Highbury Magistrates Court. Later in the day SD discussed Feza M.'s case with team leader, ED, and as no further intervention of the team was possible, his case was closed.

121. On 23/3/97 1997 Dr S visited Feza M. at Pentonville Prison. Dr S in his letter to Dr I, Chief Medical Officer, HMP Pentonville of 24/9/97 noted that "at the outset of the interview he denied any involvement in the murder of the woman found in his flat" but "as the interview progressed, he clearly became more relaxed and willing to talk more openly of his thought content eventually he said "I killed her, because she's killed me."

122. He then went on to give Dr S a detailed account of the events which surrounded the killing of CC. Dr S subsequently prepared a psychiatric report in which he described the circumstances of the killing, as recounted to him by Feza M., and made a recommendation that Feza M. have further assessment by a Consultant Forensic Psychiatrist. His involvement in the case then ceased.

PART TWO

FAMILY BACKGROUND AND PERSONAL HISTORY

FAMILY BACKGROUND AND PERSONAL HISTORY

123. Feza M. is a 36 year old divorced man of Turkish origin who at the time of the homicide was living alone in the London Borough of Hackney. He was born in Ankara, Turkey and had been resident in Britain since 1983. From at least 1990 he had suffered with a Paranoid Schizophrenic Illness which was complicated by abuse of alcohol, marijuana and other illicit drugs. The account below of his personal and family background has been derived principally from his own accounts, sometimes conflicting, as given to various doctors and nurses during the course of his treatment by local mental health services in Hackney, to medical assessors following his arrest on 16/9/97, and to the panel at interview at Rampton Hospital on 14/12/98. The panel was unable to obtain corroborative information from close friends or members of his family.

Family of origin

124. Feza M.'s father, aged in his sixties, is a retired surveyor or engineer. He and his father last met 5 years ago when Feza M. went to Turkey on holiday. He had never been close to his father and attributes this to repeated physical abuse that he had been subjected to by the father as a child. Frequent marital arguments, often involving violence towards his mother made him an unhappy child.

125. His father's violence often, but not invariably, occurred when he was drunk. Feza M. thinks his father suffered from a "paranoid illness" into which he had no insight. To his knowledge, his father had never consulted a psychiatrist or received psychiatric treatment.

126. His mother, aged 72 years is a retired bank officer. They have always been on close and friendly terms. He is in frequent contact with her by telephone and letter. His 13-year-old daughter lives with his mother.

127. He has no full siblings. His parents divorced when he was aged 5 years. His father re-married after the divorce and he has a half-brother, aged 30 years, who is now working as an obstetrician in Turkey. He has had occasional contact with his half-brother and they have a friendly relationship. There is no history of mental ill health in his family apart from the possible "paranoid illness" in his father. He also denies any family history of criminality.

Childhood, Adolescence, Education

128. Feza M. reported an unhappy childhood marred by frequent parental arguments involving violence. He was also the victim of violence from his father. Most of this occurred when his father was drinking but alcohol was not an invariable accompaniment.

At various times he has given accounts of being beaten by his father with a belt and with a wooden bat. He cannot recall an occasion however when the beating led him to require medical treatment.

129. After his parents divorced he lived initially with his paternal grandmother and then with his father and stepmother. From the age of 9 years he returned to live with his mother and paternal grandmother.

130. He never enjoyed school and attributes this to poor quality of teaching and harsh discipline. Nevertheless he had many friends at school and reported no difficulties with other children.

131. He truanted frequently, usually with groups of friends, from the age of 9. He and his friends would smoke cigarettes and play games. Occasionally he would truant from school for a whole week at a time. He left school at the age of 15 years without qualifications.

Occupation

132. After leaving school he continued to live at home. For 2 years he worked in a furniture shop. He then undertook a typing course. He has given varying accounts thereafter of working in a bank and as a Civil Servant. He denied any difficulties with his employers.

133. At the age of 20 years he undertook a 2-year period of National Service. This was for the most part in the Army, although towards the end of his service, he spent 45 days in the Navy. National service was a difficult time for him. The work was hard and the discipline harsh. He got on all right with some soldiers but not others. He was not involved in combat. He denies commission of any disciplinary offences.

134. During his period of National Service, at the age of 21 years, his family arranged a marriage to a British Citizen of Turkish Cypriot origin. After he completed national Service he and his wife lived at his mother's home. During this time he was unemployed and was principally occupied in attempting to obtain a visa which would enable him to travel with his wife to the United Kingdom and work here.

135. In 1983, at the age of 22 years he and his wife came to the United Kingdom and initially settled in the Palmers Green area. The couple had initially planned to find work in order to save money to start some kind of business enterprise. His first week of work was in a kebab shop but about a month after coming to Britain both he and his wife found work in textile factories. Over the following 8 years he worked in a number of textile factories. He was not dismissed from employment, but rather resigned from jobs periodically due to the very heavy nature of the work and limited remuneration.

He reported that he "relaxed and rested" between jobs and has given varying accounts of being unemployed for periods up to between 6 months and 2 to 3 years at a time. He stopped working in textile factories in 1991 after his second admission to hospital. Thereafter he was in receipt of state benefits including Disability Living Allowance.

136. Plans were made for him to attend mental health day services, after his 2nd discharge from hospital in 1992 (The Junction Day Hospital), and after his 4th discharge in 1995 (The Darnley Day Centre) but he appears not to have engaged with either.

137. When unemployed he would spend time drinking alcohol in public places or going to social clubs or Turkish community centres, in particular the Day-Mer Centre. While there he would play cards or pool. At times he has reported that he had plenty of friends although has admitted on others that he was isolated and largely friendless. Sometimes other people at the Day-Mer Centre made jokes at his expense about his psychiatric illness. He denied however being worried or offended by this. He noted that a support worker at the Day-Mer Centre, Mr. PCOK, had been very helpful to him.

Marital and Psychosexual History

138. Feza M.'s marriage was arranged by his family during the course of his period of National Service in Turkey and he and his wife had not had any substantial contact before the marriage. For about 6 months prior to their arrival in the United Kingdom in 1983 the couple lived with his mother. Both were unemployed at the time and the relationship between them was good. His mother and wife had never got on well and he suspected that his wife's desire to move to the United Kingdom was because she wanted to live away from her.

139. For the first years after their arrival in the United Kingdom the couple were happy together. During his periods of unemployment between jobs however his relationship with his wife would deteriorate.

140. In 1985 his wife gave birth to a daughter who is now 13 years old. Because they were not working it was decided that their daughter should be sent to Turkey to live with his mother. His wife did not like this arrangement but accepted it as a sensible course given their circumstances.

141. Serious problems in the marriage began to emerge from 1988, at which time he began to be psychiatrically unwell and also to drink alcohol heavily. The sexual relationship between the couple ended in 1989. Feza M. has given conflicting accounts of at whose instigation this occurred. The couple also began to argue and this led to him spending increasing amounts of time outside the home in public houses or Turkish social clubs.

He has given his variable accounts of violence within the marriage. At times he has denied any recollection of threats or violence towards his wife. At other times however he has admitted violence towards her. At interview with Dr. L, Consultant Psychiatrist, at Rampton Hospital on the 26/5/98 he admitted that when he returned home after attending public houses or social clubs that his wife would argue with him about the amounts of time he was spending away from the home. He admitted that he would sometimes beat her and that this would involve him punching her on the face 3 to 4 times. This would occur about once or twice a week.

142. In 1992 he went alone to Turkey to visit his mother and daughter. When he returned he found his wife had left the home and he has not seen her since. He believes she is still resident in the United Kingdom. He has stated that in 1993 his wife arranged for them to be divorced in Cyprus and that he arranged the same in Turkey.

143. When his marriage deteriorated, Feza M. began to see prostitutes. He has given conflicting accounts of when this began ranging from 1991 to 1995. From 1995 onwards he would approach prostitutes in the street in the Stoke Newington area and take them back to his flat. The frequency with which this occurred would vary according to how much money he had, but he reported it to have occurred, on average, about once per week in the two years before his arrest. Sometimes he saw the same woman on more than one occasion.

144. Dr S, in his report dated 24/9/97, based on an interview with Feza M. in Pentonville Prison on 23/9/97, after his arrest, noted "The patient was in the regular custom of soliciting the services of prostitutes in Stoke Newington Church Street, close to his home, from whom he enjoyed receiving physical beatings. 'I am a masochist'." During police interview on 17/9/95 he was asked whether he had talked to a friend about having 'rough sex' with women 'or anything like that' and responded "No I don't do things like that, (unclear), I'm a masochist". He is also reported to have said "I am masochist" during an attendance at the Alcohol Clinic at St Bartholomew's Hospital on 9/3/95 but there are no other references to masochistic sexual practice in his clinical notes. At subsequent interviews on 9/3/98 and 26/5/98 with Dr. J and L respectively, both Consultant Forensic Psychiatrists, Feza M. denied sadomasochistic interests. According to Dr J "He said that Dr S had got it wrong when he said in his report that the defendant was a masochist.....He denied any homosexual or paedophiliac interest and denied any interest in sexual activities involving violence, for example rape." Dr L stated "Feza M. said that he has only ever been interested in 'normal sex'. He denied any interest in sadomasochism, cross dressing and ever requesting that he be hit or whipped by a prostitute or even by his wife." He also reiterated this denial at interview with the panel at Rampton Hospital on 14/12/98.

145. At interview with Dr J on 9/3/98 he admitted to occasionally having had arguments with prostitutes prior to the homicide but denied violence. Dr J's report states "He said he sometimes had arguments with them in his flat when they asked for more money, but there was never any violence between them. On other occasions he had approached prostitutes in the street who would tell him to go away and this would make him feel rejected and in retaliation he would telephone the police and tell them that they were on the street. He said that this had happened about three times and the last time was approximately two weeks before the killing."

146. In the face of conflicting evidence the panel were unable to determine whether or not Feza M. had sadomasochistic sexual interests. We are unable to comment therefore on what, if any, role they may have played in the death of CC. We were assured however that this matter would be explored further in the course of his assessment at Rampton Hospital.

Forensic History

147. On 26/5/98 at Rampton Hospital Feza M. told Dr. L, Consultant Forensic Psychiatrist, that at the age of 19 years he had been arrested by the police. According to Dr L "He had apparently been distributing Communist political posters with a group of friends. He told me that he was not really interested in Communism but at the time he did oppose the regime in power in Turkey. He said that he spent 13 days in prison and that this had been an unpleasant experience. He said that Turkish prisons did not have any beds and unless you had your own money to buy food it was difficult to survive."

148. Apart from the above incident Feza M. has denied police contact in Turkey or that any convictions had been recorded against his name there. Prior to the homicide he had been arrested on one occasion by the police in Britain for possession of a knife, but, after questioning, was released without charge.

Alcohol and other drug use

149. Feza M. has given sometimes conflicting and occasionally implausible accounts of his use of alcohol and drugs to various psychiatrists since his arrest and to the panel at interview at Rampton Hospital on 14/12/98.

150. He began to drink alcohol at the age of 18. He first experienced unpleasant effects if he did not drink in 1983. These consisted of sweating and tremor in his hands first thing in the morning. He did not however begin to regard his alcohol use as a problem until 1989. From this time he has variably described his daily consumption as about 3-4 pints of beer during the week and 7-8 pints of beer on weekends, 5-6 pints per day and 10 pints per day. He reported that he could choose whether to drink or not. Occasionally he would experience unpleasant effects upon withdrawal from alcohol. There were also occasions when he was amnesic from drinking bouts. He started to vomit on a daily basis about a month before the homicide.

151. In 1994 he was advised by his GP to stop drinking. He was told that the alcohol would interact with his medication. Feza M. claimed that he became abstinent from alcohol for about 12 months after this, but resumed drinking thereafter because he was bored.

152. His abuse of marijuana began in 1995 or 1996. It was first given to him by a friend in a social club. Thereafter he used it consistently and frequently, usually on a daily basis, and on different occasions since his arrest claimed to have consumed 2g per day, 3g per day and 4g per day. Accounts that he has given of his expenditure on the drug in the fortnight before the homicide vary from £10 per day to £65 per day. He told Dr L on 26/5/98 at Rampton Hospital that marijuana would make him feel happy and relaxed, though he admitted that it exacerbated his feelings of persecution and auditory hallucinations. To the panel he reported that it made him feel "on top of the world".

153. Feza M. had disclosed his abuse of alcohol and marijuana to Dr S and SD in the month before the homicide, and indeed had been advised by Dr S to reduce his consumption of these drugs at an outpatient appointment on 11/8/97. There is no clinical record of his abuse of other drugs prior to the homicide. At interview at Rampton Hospital on 14/12/98 Feza M. told the panel that he had been asked on several occasions during his contacts with mental health services whether he had used other drugs. He said that he had always denied it.

154. At interview with Dr L on 26/5/98 he admitted to use of crack cocaine for the first time on the night prior to the homicide. At interview with the panel on 14/12/98, however, he admitted to having used crack cocaine on a weekly basis for some time before the homicide, and to spending about £90 per week on same. On 8/9/98 he told Dr Sen, Honorary Senior Registrar in Forensic Psychiatry, that he had been using 7g of cocaine per day at the time of the homicide. Referring to Feza M.'s use of crack cocaine on the night before the homicide, Dr L, in his report dated 27/5/98 stated "He said that he thought the cocaine had affected his mind, making him think very grandiose and religious thoughts. Feza M. thought that it had been a very pleasant experience and that apart from a very slight worsening of his paranoia and auditory hallucinations it had no other ill effects. He said that he did not feel substantially different after abusing the cocaine than he had done before." To the panel at interview on 14/12/98 however he reported that "It *(use of crack cocaine)* would make me feel bad". Despite this he told the panel that he had used the drug because of his curiosity about it.

155. Feza M. also told the panel that he had smoked heroin two days before his arrest, though at another point in the same interview he insisted that he had used the drug only once in 1997. He reported that "when you smoke heroin you don't want to know, you have an empty head."

156. Feza M. admitted both to Dr L and to the panel that, on the night before the homicide, he had been visited by a friend, a Mr MK, who had brought crack cocaine to his flat. He had smoked it in a pipe together with marijuana. He denied any drug use on the day of the homicide.

PART THREE

EVALUATION AND RECOMMENDATIONS

BACKGROUND CONTEXT

Hackney: A profile: its people and characteristics

157. The Community Care Plan 1996/97 described Hackney as having an estimated total population of 194,300 with a relatively young population compared with the rest of England and Wales. There is also a high turnover of population, which results in an unstable population and a lower level of social support. The population contains a wide range of black and minority ethnic communities. From census-based information available, just over one third of the population is estimated to be from black and minority ethnic groups, with the largest groups recorded as Black Caribbean and Black African. Turkish residents were not identified separately in the Census. However the Community Care Plan using information from pupils in Hackney schools estimated that about 9.5% of pupils in year six in Hackney in 1994 were Turkish Cypriot. Hackney also has a growing refugee problem, estimated in the same plan as about 20,000 which represents world wide situations of war and conflict. Many refugees had been the victims of torture which led directly to mental health problems.

158. The Panel were informed that there was a degree of tension sometimes within particular ethnic groups, for example between Kurdish and Turkish groups as much as between various Sri Lankan, Indian and other groups.

159. In terms of socio-economic factors, the Community Care Plan describes the following daunting picture: "All generally accepted measures of deprivation, such as the Jarman index, confirm the extent and depth of Hackney's multiple areas of need." In comparison with its neighbouring boroughs it had the most extensive deprivation, but Newham beat Hackney in being the most deprived borough overall. High levels of unemployment, especially long term unemployment, high numbers of lone parent households, overcrowding, higher numbers of adults with physical disabilities, high rates of people with learning disabilities provide considerable challenges to the statutory authorities.

160. The Community Care Plan 1996/7 also states that "It is well established that mental health problems are closely linked with deprivation factors such as unemployment and homelessness. Unemployment has been associated with higher than expected rates of depression, suicide and parasuicide. Hackney faces high levels of mental health problems and pressure on services. People from black and minority ethnic groups have particular mental health problems." The plan estimates that between 5,000-6,000 people are likely to have contacted the Mental Health Teams during 1995/6.

161. This analysis is supported by the Report of the District Audit for Adult Mental Health Services for the City and Hackney Community Services NHS Trust for 1995/6 (Summary Report, Action plan and Presentation, Andy Vowles, July 1996). It noted that: "60% of all referrals to the (locality mental health) teams came from the in-patient wards, well over the national average of 40% identified by District Audit. In addition, only 10% of referrals came from GPs, compared with a national average of almost 50%. This is likely to be due to the high level of need of most of the team's clients, many of whom are not registered with a GP, and the relatively weak primary care sector."

162. In addition the Community Care Plan of 1996/7 also states that misuse of alcohol and drugs is similarly linked with levels of socio-economic deprivation. Certain areas within Hackney, like many other inner city areas have a particular challenge in responding to increases in drug misuse and prostitution. As one of the witnesses informed the panel about one specific area in Hackney: "There is a big explosion in a prostitution and drug dealing racket which is going on. It is famous for its crime, its shootings, its stabbings and so on. Two of my patients have been murdered there since I began. There are shootings and drug-dealing protection rackets all the time."

The impact of reorganisations on services 1995-7

163. In addition to the levels of deprivation and social problems within Hackney, the panel also heard evidence of the impact of major re-organisations on the three agencies during the period in question.

164. The London Borough of Hackney Social Services Department underwent a major restructuring during 1996/7, and both the City of Hackney Community NHS Trust and the East London and the City Health Authority were established in 1995 with the East London FHSA integrated into the Health Authority one year later. It is clear these changes absorbed much management time. The Panel heard evidence that this impacted on making progress in inter-agency working and possibly hindered the development of more effective joint monitoring and evaluation of mental health service provision across the three agencies.

Establishment of integrated Adult Mental Health Services in April 1994

165. Prior to this period of change in 1993 Hackney Council, the Health Authority and the then City and East London Family Community Services Trust had embarked on a policy which was innovative, challenging and progressive: the integration of social services with health staff in community mental health teams under health service line management. It was a bold move, pre-empting the philosophy of the Green paper on mental health services (Developing Partnerships in Mental Health February 1997 HMSO) by several years. It was also an intrepid step in view of the political problems which confronted the London Borough of Hackney at that time, including a no redundancy policy which led to recycling of staff. It was made possible because of the vision and personal contact of the leading figures in the Social Services Department, Health Authority and Mental Health services at that time.

166. In evidence to the panel, Joyce Moseley, former Director of Social Services, described the synergy of energies which made possible the collaboration and co-operation between health and social services. Integrated mental health teams were seen as only the first stage of the process of collaboration because the plan included residential and day care services that were being run by social services and which also needed to be integrated. Joint commissioning ideas would come further along the line.

167. 4 teams were established, and later the report considers in more detail the operation of one team, the North West, which from 1995 provided services to Feza M. Originally, it was proposed overall management of the teams would be jointly shared at Senior level between the Social Services Department and the Trust. This arrangement was quickly replaced with an agreement the Trust would be responsible directly for the management of the teams. Joint reporting arrangements through the establishment of a joint management board were not achieved until 1996. What is clear from the evidence the panel heard is that for good reasons the teams were rushed into existence, that with very little time for preparation, there were substantial differences in culture between health and social services staff to overcome across the teams and there were shortcomings in the detailed planning. These included in summary:

- The lack of any formal written agreement between the Social Services Department and the Trust clearly stating respective responsibilities and joint reporting arrangements.
- A lack of clear Senior Social Services management accountability for the Service.
- Budgets were ad hoc based on historic spending patterns.
- Initially there was no direct management link between the teams and specific Wards.

Conclusion

168. ***In terms of the context in which the care and treatment of Feza M. is considered, it is important to acknowledge the challenges faced by services at that time. Later the report considers the management and resource issues raised in evidence from the Inquiry. We now return however to the care provided to Feza M. and in particular the application of the Care Programme Approach, key-working and assessment of risk in his case.***

CARE PROGRAMME APPROACH AND THE ROLE OF THE KEYWORKER IN RELATION TO FEZA M.

169. For those readers not familiar with the introduction or operation of the Care Programme Approach, the background and the summary of its implementation in Hackney is summarised in Appendix D, which includes an explanation of the tiered approach introduced and implemented in Hackney in August 1996.

170. As was the case in the Murphy Inquiry, there was almost universal agreement by team members and staff that gave evidence during the inquiry that Feza M. should have been subject to the CPA procedures of the Trust as soon as the tiered policy was introduced. There were differing views however as to whether he should have been allocated to CPA level 1 or 2. After reviewing the clinical notes the panel concluded that he should have been allocated to CPA level 2. This is supported by his diagnosis of paranoid schizophrenia, his history of self-harm and threatened harm to others, his social isolation and limited English skills, his history of neighbour disputes, rent arrears and benefit problems and a review of his history which shows a pattern of repeated relapses and/or re-admissions to hospital after discharge or default from regular follow-up by the mental health service.

171. The Trust's CPA Policy was not in operation throughout the period of Feza M.'s care, and the tiered approach was only in the early stages of introduction at the time of his 3 day admission to Tuke Ward in September 1996. This may explain the lack of understanding of the policy by ward staff which was so manifest during the brief course of this admission, and which led to Feza M.'s discharge without the appointment of a Keyworker to monitor and co-ordinate his care, without determination of his status within the CPA (Level 1, 2 or 3) and the absence of a formally recorded plan for his post discharge care. This error was further compounded by a failure of staff within the locality team to correct the understanding of Dr. S and the ward staff by informing them that Feza M. did not have a Keyworker and was being dealt with on a "duty" basis.

172. There was a lack of effective care planning and review, and the absence of a key worker to monitor Feza M.'s care in the period from the closure of his case to the NWLMHT on 6/10/95 until the resumption of key working on 11/8/97. The absence of these essential elements of the CPA, both before and after the Trust's introduction of a new CPA policy in 1996 led to delays in medical review and failure to detect incorrect medication and left SD without a proper handover and no clear plans from which to work. ***It is in this absence of a strategic approach to Feza M.'s care over an almost two year period prior to the homicide that the CPA practice of the team failed in this case.***

173. Feza M. could clearly be "elusive" and this was very evident at the time that his case was closed by the team in October 1995 and at several earlier points in the course of his illness when he was discharged to the care of his GP after defaulting on hospital appointments. At the time of case closure in October 1995, the team was not staffed at a level to enable it to provide an "assertive outreach" style of follow-up to all of its clients with a profile of needs similar to those of Feza M.. ***The panel accepts that the CPA is not a substitute for the resources required to maintain contact with patients who were as elusive as Feza M. was at times during the course of his illness. We nevertheless believe that there may be a value in continuing to provide some elements of keyworking in such circumstances, provided that the expectations of the role are commensurate with the level of resource provided.***

174. After case closure on 6/10/95, Feza M. experienced a minor relapse of illness which prompted him again to seek the assistance of the team. Paradoxically his face-to-face contacts with the team thereafter were more frequent than during the period in which he had a keyworker. Despite this re-engagement with the service his case continued to be held on a "duty" basis, with no care plan, no keyworker to monitor his care and no review process to determine the appropriate level of the CPA on which he should have been managed. ***In the panel's view, his re-engagement with the service from 15/01/96, should have prompted his re-allocation to a keyworker and his placement on level 2 of the Trust's CPA as soon as the tiered CPA policy was introduced.***

175. Some 36 days before the death of Caroline C. Feza M. did have a Keyworker, SD, although his status within the CPA (Level 1, 2 or 3) had not been fully clarified. During this time SD had made an assessment of his social and clinical needs, outlined an interim plan of action, was in contact with Dr S, the only other person in mental health services directly involved in his care at the time, by letter and telephone, and had arranged a CPA review meeting. In SD's practice the elements of the Trust's CPA policy were clearly being observed, although there is no formal CPA documentation to support this. ***Had the CPA review meeting scheduled for 29/8/97 taken place the panel were confident that appropriate documentation of the care plan made at the meeting would have occurred.***

176. It is clearly very unfortunate that the CPA review meeting planned for Feza M. on 29/8/97 was cancelled. This would have afforded an opportunity for further reflection on the case and may have provided SD with a clearer plan of action should Feza M. withdraw from contact as did occur. It is important to recognise, however, that formal CPA meetings - even in well resourced services - involve many busy professionals, take a considerable amount of notice to arrange and occur relatively infrequently. They have essentially a strategic function in the long term care of the mentally ill and cannot be seen as a substitute for timely communication and co-operation between appropriate professionals at a time of crisis.

177. Delays occurred in response to Feza M.'s deteriorating mental health in the period immediately preceding the homicide, in medical review and in his receipt of an increased dose of medication. These cannot be ascribed to failed observance of the CPA policy in the period immediately preceding the incident. Rather, they were attributable to a widespread perception of Feza M. as a "low risk" patient, to delays in communication of a change in medication between the Homerton Hospital Outpatient Clinic and the Locality team, and to difficulties in arranging timely medical review given Dr S's heavy workload. In this last connection it is of note that there was a universal recognition amongst team members of Dr S's dedication and hard work. Many team members, including SD, commented that he would always be willing to advise or undertake medical review at the request of team members if they felt that risk was such that his urgent intervention was necessary.

178. The panel is concerned that the Trust's CPA Policy allows for patients to receive ongoing care from professionals within its specialist mental health service without the appointment of a keyworker who has responsibility for monitoring mental health status, for ensuring needs are met and for liaising with relatives/carers as appropriate. The panel believe that the personal advocacy of a Keyworker should be an irreducible minimum provision for all patients subject to the CPA.

179. Local Health and Adult Community Services in Hackney have developed an enviable degree of integration within the LMHTs. ***The panel is concerned however that outpatient clinics with separate processes of referral and assessment continue to operate at a separate site from the Locality Teams and their CPA processes. The delays and errors in communication which occurred between these sites in the case of Feza M. indicate a need for closer integration of these services.***

RECOMMENDATION 1.

We recommend:

i) **ELCHA, The Trust and the London Borough of Hackney should jointly review the existing CPA policy to ensure Keyworker arrangements are in place for all patients subject to CPA.**

ii) **Standardisation of criteria for CPA level allocation should be considered across existing Trust and Social Services boundaries in East London to enable purchasers to make better informed decisions on resource allocation.**

(iii) **A formal system for reviewing cases on CPA levels 1-3 should be consistently implemented across all teams and regularly monitored.**

(iv) **CPA review meetings should not be seriously delayed to enable Consultant attendance.**

RISK ASSESSMENT

Application of Risk Assessment to Feza M.

180. Although the Locality team and various outpatient clinic doctors had had difficulty in maintaining contact with Feza M. earlier in the course of his illness, for the 20 months following the re-establishment of regular depot injections on 15/1/96, Feza M. had been very largely compliant with treatment, and had, indeed, attended the North-West Locality team base or Emergency Clinic on several occasions to seek a change in treatment or admission to hospital at times when he felt his situation to be deteriorating. He did not, as the Murphy Inquiry report remarked "conform to the classic 'difficult' patient, that is the alienated, uncooperative, non-compliant person who refuses depot and will not engage with services." On the contrary, by the accounts of all of the team members who were in contact with him during this time, he was a warm, polite and pleasant man.

181. In his evidence to both the Murphy Inquiry and the current inquiry SD reported that he could not believe that Feza M. could have committed the crime for which he had been arrested. He had been allocated Feza M. as one of "six easy cases" with which to cut his teeth as a CPN. His sentiments were echoed widely within the team.

182. Dr S spoke of "even the most experienced people in the world" being "lulled into what we might now, in retrospect, see as a false sense of security" by "someone who has retained interpersonal warmth". He also spoke of Feza M. as a person who "always returned to a high level of functioning" and "retained a lot of interpersonal warmth"... "when away from alcohol and marijuana".

183. There are numerous references in the notes to Feza M.'s alcohol problems and marijuana use. The association of the former with self-harm and violence is well known. The ability of the latter to precipitate relapse or exacerbation of schizophrenic symptoms is also well documented. Both problems are sadly relatively common, both in the general population and in the mentally ill. Dr S, who has a special interest in alcohol problems, in referring both to Feza M.'s attendance at the Alcohol Clinic and his subsequent contacts stated in his evidence to the inquiry "He (Feza M.) never fulfilled dependency criteria.

184. He was a chaotic problem drinker who exploited the anaesthetic properties of alcohol, like some people do. But he never actually moved into fully blown 'gasping for a drink' syndrome". In regard to Feza M.'s attitude to his drinking, Dr S stated "He was not seeking help. He never saw in those terms..... So I think it is best to say that his engagement was desultory at the best of times at the alcohol clinic." Regarding the problems of caring for patients with a "dual diagnosis" of schizophrenia and alcohol or drug misuse, Dr S's evidence also highlighted the potential problem of patients "falling between two stools" if services for the two problems are not integrated. In relation to Feza M. Dr S indicated this had not happened, as his alcohol problem was not serious enough. This assessment was corroborated by Dr.MH, his GP at the time of the homicide.

185. Clearly the team's perception of Feza M. was as a "low risk" patient, and the panel would agree that this would largely appear to have been the case on the basis of the personal experience of team members.

186. There is no evidence from Feza M.'s clinical notes that a systematic formulation of the risks he posed to himself and others was undertaken. A careful review of Feza M.'s clinical records, not all of which were available to the team, reveals the following entries relating to events which, in association with his history of alcohol and drug use, may have raised the team's perception of the risk which Feza M. posed to himself through self-harm or of harm to others:

11/8/97 **Homerton Hospital Outpatient Notes:** "I need euthanasia", "Feels can no longer tolerate poisoning by 'them'", "desperate, vague, suicidal ideas. Alcohol ++"

23/9/96 **Homerton Hospital Discharge Summary:** "He was considered to be a potential danger to himself and others as there is a possibility of arson".

22/6/95 **Hackney Hospital Discharge Summary:** "This man presented....in quite a verbally aggressive and threatening manner and swearing at patients in the waiting room"

30/5/95 **Locality Team Notes:** Voices saying "burn the flat yourself. We kill you". "Brought petrol into flat to do this!" Petrol removed from his flat by his uncle and admission to hospital the following day.

10/4/95 **Homerton Hospital Outpatient notes:** Letter copied to Locality team referring to overdose and expressing concern that "he was repeatedly presenting to the alcohol team often with a somewhat threatening demeanour".

28/3/95 **Locality Team Notes:** "T/C from EDT. Feza M. had gone to DSS with a knife".... "He was released without any charge"

23/3/95 **St Bartholomew's Hospital Alcohol Clinic Notes:** Letter to ward (uncertain if sent as no bed could be found for his admission) stating

he had been "threatening and abusive (a female nurse had to lock herself in a room), later took an OD (More than 100 tablets).

23/3/95 **St Bartholomew's Hospital Alcohol Clinic Notes:** Noted that he was experiencing auditory hallucinations of voices telling him that he should die and that "he feels that people are quite threatening and they might hurt him".

16/3/95 **Locality Notes:** History of being "1st" brought to A&E 8/3/90. Section 136 via Dalston police station.....presenting serious threat to family. Admitted PICU"

9/3/95 **St Bartholomew's Hospital Alcohol Clinic Notes**: Noted to say "I am masochist".

31/10/91 **Hackney Hospital Discharge Summary:** Noted to have been "shouting at the television, abusing his wife and threatening to put her in an acid bath"

31/10/91 **Admission to a local secure facility** (PICU, Hackney Hospital)

9/3/90 **Admission to a local secure facility** (PICU, Hackney Hospital)

187. In the panel's view the predominant and certainly the most immediate risk suggested by this review is not one of harm to others but one of self-harm.

188. In relation to the risk of harm to others, the most concerning of the above events are the threats towards his wife and the nurse in the Alcohol Clinic, his history of admissions to a local secure facility, his possession of petrol with thoughts of burning his flat and his arrest for possession of a knife. It is by no means clear however that Feza M. was intending threat or harm with the knife at the time of his arrest. The significance of his single statement "I am a masochist", unsupported elsewhere in the notes is unclear. That Feza M. had sexual relationships with prostitutes, or that he used drugs other than alcohol and marijuana was unknown to Dr S or the team until his arrest on 16/9/97.

189. Feza M. had 6 separate sets of clinical notes: old inpatient and outpatient notes from 1990-93, some of which appear to have been lost, Alcohol Clinic notes from St Bartholomew's Hospital, Locality Team notes, Homerton Hospital inpatient and outpatient records, Emergency Clinic notes and depot clinic records, all of which appear to have been stored in different places.

190. Although attempts had clearly been made to copy salient material from one site to another, this was, and could only, be partial. ***The team's ability to judge the risk posed by Feza M. was significantly compromised by lack of easy access to the full detail of past clinical records, and in particular to the records of his attendance at the Alcohol Clinic and the full Homerton Hospital Outpatient notes.***

191. None of the team knew about Feza M.'s arrest at the DSS office prior to the homicide, perhaps because the entry in the notes regarding it was so brief , without mention in typed correspondence, and because it does not clearly indicate whether or not Feza M. was intending threat or harm at the time.

192 It is not possible to say with certainty that if the team had undertaken the above review of events that there would have been any difference to Feza M.'s overall care. Many of the events are, according to evidence from many team members and other staff of the Trust, commonplace in the world of community mental health in Hackney. This panel however concurs with the view of the Murphy Inquiry that, if such a formal list had been made available to SD and the team, an urgent admission to hospital in late August 1997 may have been considered.

193. It is of considerable concern that, on two occasions prior to the death of CC, Feza M. was thought to require admission to hospital because of the risk he posed to others, but that no bed could be found for him. On one occasion he was sent home, and on the other his admission delayed until the following day. When asked about the effect of bed availability on the management of risk Dr S stated "There are two ways of answering that. One would be, well, if we need a patient to come in, we will always bring him in. We pay lip service to that, but the truth of the matter is that, for a variety of factors which I hope you will address this afternoon, there are few beds. Beds have always been scarce. At the time of the incident I was running a bed occupancy of about 120%, which is normal". Speaking of the effects of bed availability, he further said "....we have got into a culture where to not admit is seen as the norm. In other words, you have to be really unwell". A further indication of the problem of bed availability is given by a letter to J. Wilkinson, the Commissioning Manager for Mental Health, East London and the City Health Authority from a local GP, Dr Anthony Levy, dated 22/6/96 which states "Many patients are discharged on 'weekend leave' because of the pressure on beds. When they return on Monday they are told there is no bed and they are for practical purposes discharged. Patients find this rather upsetting as they were expecting to be readmitted".

194. Risk assessment can only be of value, and perceived to be so by those who undertake it, if resources are available to deal with the risks identified. ***The panel is concerned that limited bed availability may have led to a culture in which staff may have been attuned to tolerate a level of risk in the community which they would otherwise have responded to by arranging hospital admission. The panel accepts also that the level and range of community based resources will impact upon the need for acute psychiatric beds, but an appropriate balance between the two needs to be achieved to support the effective management of risk.***

Development of a formal risk assessment tool.

195. During the course of the Inquiry, the panel heard evidence of the work being undertaken within the Trust to develop a formal risk assessment tool. The first draft, drawn up by Dr. Louise Petterson., Clinical Director of Adult Mental Health from March 1997, had stimulated debate within the Trust, including consideration of the potential resource implications of implementing the comprehensive approach proposed. ELCHA was in the process of reviewing its original position that development of locally-based risk management procedures drawn up in conjunction with local agencies, were preferable to negotiating a uniform procedure across the Trust. Dr. Jacobson ELCHA's Director of Public Health told the panel that with the proposed creation of a single Mental Health Trust across East London, she favoured now a debate about implementing a unified risk assessment tool across the new Trust area.

196. The panel agrees there are considerable advantages to the central development of a risk assessment tool in consultation with other key agencies to be used across the authority as part of the Care Programme Approach and which meets the anticipated requirements of the National Service Framework (Mental Health). There would also appear to be considerable advantage in re-searching effective risk assessment tools used in conjunction with the CPA by other authorities.

RECOMMENDATION 2

We recommend:

(i) ELCHA, The Trust and the London Borough of Hackney should:

(a) In conjunction with other relevant authorities commission a review of the levels and balance of community based provision and availability of acute psychiatric beds to support the management of risk across East London.

(b) **Develop and introduce in conjunction with other key agencies a standardised form of clinical risk assessment across East London, which might include both a brief screening instrument as well as an approach to more comprehensive risk assessment.**

OPERATION AND MANAGEMENT OF N.W. LOCALITY TEAM.

197. The panel heard conflicting evidence on the operation of the NWLMHT. The Murphy inquiry made considerable criticisms of its functioning. These cannot be accepted in their entirety since the Murphy Inquiry did not take evidence from the former locality manager, nor was he given an opportunity to respond to the implied criticisms of him in their report. In addition, the Murphy Inquiry drew no distinction between the situation before and after June 1997. This panel did hear evidence which suggested there were aspects in the operation of the team prior to June 1997 which indicated a lack of effective leadership and management. Evidence however was given to this panel to indicate that, for a variety of reasons, the situation in the NW team deteriorated from the middle of 1997 and over the following nine months and is only just recovering.

198. MG, Operational Manager for the CPA, stated that he was not aware of any audit or documentation which stated that the NW Locality team was worse than other teams, other than the criticism of CPA allocations. The District Audit report had identified that in the NW there seemed to be a lower level of people on CPA. There was no attempt, however, to look into the functioning of individual teams. He said that the teams developed at different paces. It was generally accepted that the NWLMHT was slower in picking up, but there were claims that they had a catchment area with more seriously ill patients than other areas. No audits were undertaken of the functioning of each team in 1996. The priority was to get the framework for CPA and the integrated teams into place.

Allocation and the Role of the Duty Team

199. The purpose of the duty system as described by the Locality Manager R. McN. was "to carry out initial assessments of new referrals to obtain sufficient information to enable informed decisions on allocation and priority to be made by Team Leaders and the Locality Manager. The duty system also carried out short term work which could be opened and closed on duty relieving the pressure on allocation. The duty system also dealt with urgent work or necessary tasks under the direction of the Duty Team Leader if the allocated worker was not available".

200. Evidence from more than one team suggested it was inevitable that certain patients would be "held on duty" rather than allocated a key worker. Those assessed as Level 2 and 3 CPA would be allocated a key worker, but often patients on 'Level 1' would be held on duty. It was, in effect, a system of rationing allocation to ensure caseloads were manageable.

201. In the SW team patients were not held on duty for long periods. There was a pending system. After six weeks the case would come to the team leader for a decision. The team leader then had responsibility for deciding whether that person should be allocated to a key worker, or a decision made on whether ongoing support or disposal was needed. If, following the review, it was decided that there was no need for a key worker, then, if there were no on-going issue they would be closed to the system. They would come off level 1. A summary and a referral would go to the GP. If, however, the patient was still attending outpatients to see a consultant psychiatrist, they would be still on Level 1 and they may or may not have a key worker. RA from the SW team stated that he would be very concerned if a patient was held on duty for as long as six months or if many patients were being held on duty.

202. The process of 'holding on duty' in NWLMHT was, however, less tightly managed. There was, as in the case of Feza M., no clear system for reviewing cases held on duty.

Caseload Management

203. There was conflicting evidence as to how effectively caseloads were being managed in the NW Team. J. Wa, the new locality Manager appointed in June 1997 indicated to the panel she felt caseloads were not being managed properly and that there was a lack of prioritisation. She also found a lack of information on actual individual caseloads of individual members of staff and that information held on the Mental Health Link database system was inaccurate. She described the work she undertook with JA to rationalise caseloads and obtain the specific details of caseloads and CPA review dates, which could be updated monthly.

Closing Cases

204. Whist there was a procedure for Team Leaders to formally agree any case closure and signify this on the case file, this procedure was not followed on one of the occasions when Feza M.'s case was closed. The panel was informed by JA that in 1996-7 the procedure for agreeing and processing closure was inadequate. He indicated: "The system we had at that time did not involve a check on what CPA level the case to be closed was. Nor did it have a check to see the GP and any other interested party had been informed/consulted. We have revised this during 1998 to safeguard against this kind of system failure and now use forms which take proper account of these issues and are signed and dated by key workers and team leaders".

Role of Health Care Support Workers and Unqualified Staff within the Team.

205. Feza M. had been assigned within the CPA Policy operating at that time both a Care Co-ordinator (J.A., Social Worker), and a Designated Contact Person (A.P., Student Nurse) in June 1996, where the roles of both members of staff were clear with case responsibility remaining with the Care Co-ordinator. H.R. (Health Care Support Worker), subsequently took on the role of Designated Contact Person. Both AP and HR retained contact with the Care Co-ordinator and their own line manager in relation to their work with Feza M. However, HR indicated she saw herself as a key-worker with her own caseload at one stage of around 15 cases. She told the panel in an ideal situation she would case work with qualified staff. ***The panel considers there is a real risk with pressure of work that unqualified staff take on the role of key worker de facto without the necessary training, with qualified staff retaining only a nominal role. Strong caseload management and supervision are required to ensure this does not happen.***

Supervision of Staff

206. One of the cultural conflicts which became apparent when the integrated LMHTs were established were contrasts in procedures for supervision: ASWs as a profession had by custom and practice enjoyed a system of supervision, whereas supervision was not a regular practice for health service staff, except for those working in the field of psychotherapy. The teams had been established with a requirement that there would be one team leader with a social work background and one with a CPN background to ensure viable professional supervision arrangements could be established for both ASWs and CPNs. No jointly agreed policy on supervision existed between the Trust and Social Services, nor did the Trust with management responsibility for the teams have a policy of its own in place.

207. Supervision arrangements appear to have varied between teams, with practice left to the discretion of individual managers. There was conflicting evidence over the level and quality of supervision provided within the NW LMHT and there was also a lack of any documentation to support local practice.

Supervision Arrangements for SD, keyworker to Feza M.

208. SD was transferred on a temporary basis from Tuke Ward (where he was a staff nurse) to be a CPN in the NW LMHT. Because this was his first experience as a CPN, he was given a smaller caseload, of 6 apparently straightforward cases, a smaller number than was usual. When he first started as a CPN, his team leader was ED. ED provided regular supervision for SD.

209. SD described his supervision sessions as being diarised and planned in advance; they were held weekly.

210. In SD's words: "I was initially receiving supervision from ED in which we discussed the needs of the clients and work on what my kind of reaction would be. He would guide my practice from there." ED stated "I saw it very much as a support and development type supervision. SD had come to us from Tuke Ward. I was given the task of supervising him, which was fine. I thought he took to the work like a duck to water, really. In terms of the actual work, I thought that he worked very well and also managed Feza M. quite well."

211. ED went on to describe his supervision work with SD in the following words: "He focused very much on his own developmental need as a new member of staff and as a nurse in the community, but also focused on the actual contact with the patient, the practice aspect of things. We met on a regular basis. It was initially on a weekly basis because he was new to the team and I felt that he needed that kind of support. Then that tailed off as time went on and it became a little bit more ad hoc, partly because sometimes SD did not turn up for supervision because he was off sick or he was not present. Then it was difficult and we had problems arranging and rearranging supervision. So it did not run as smoothly as we started off, which was meant to be on a weekly basis."

212. The homicide occurred at a time when ED was on annual leave, prior to his eventual departure from the NW team. SD told the Panel that his supervision arrangements faltered after ED's departure.

Recording of Supervision

213. The supervision records allegedly kept by the two team leaders, ED and NE and the locality manager RMcN are missing and not available to the panel. NE gave evidence that he destroyed his own personal notes which he felt would not have been appropriate for anyone else to have seen.

214. However the absence of a policy covering what documentation should be kept and the lack of any systematic monitoring to check what was actually taking place and what was being recorded means that any such supervision records would probably have been fairly meagre.

215. HR who was supervised by ED referred to the records relating to the closure of Feza M.'s case: "The only place that (i.e. details of the case closure) might be would be in the supervision notes that myself and ED had. Anything that was discussed would have been noted and recorded."

216. The Feza M. case closures in 1995 are documented in the team notes by ED (May) and JA (Sept). Similarly NE indicated that key points and actions agreed in supervision would be confirmed by memo and placed on the case file.

217. However in relation to Feza M. no patient information resulting from the supervision sessions appeared to be filed in the notes. If Feza M. was discussed during supervision, as SD says he was, then no record to that effect was ever entered into his records.

Staffing

218. It is clear that by the middle of 1997 the team was going through a very difficult period. The loss of an Occupational Therapy post to the team and the need to re-allocate her caseload led to the position where according to the Team Leader N.E. there was for the first time a waiting list for allocation. Staff turnover had increased significantly during the second half of 1997, during which time both experienced Team Leaders left to work elsewhere. The panel were told that 18 people had left over the past 12 months during a period of low morale.

N.W. Locality Team Base – Anita House

219. The panel visited Anita House, formerly a clinic but now the base of the NWLMHT, saw the facilities available and discussed present and future arrangements with staff. The team base is in an accessible location but more space is required. The ground floor of Anita House has been identified for this purpose, but the funding not yet secured. At present a CPN has an office in a corner of the conference room, which is also used for all team meetings and the meetings of the Turkish support group run by MY. Accommodation is also required for the Doctors attached to the team, especially if outpatient clinics are to be re-sited to the locality team base. At present three interview rooms are used by the doctors for their clinics, for interviewing patients who 'drop-in' or for those who have planned appointments with other team members.
One of the rooms can also be used as a family meeting room but there is no space for a treatment room. CPA meetings are held at the base for those who are not inpatients.

220. Depot medication, however, is administered at the John Scott Health Centre (a large local health centre) and at Barton House since October 1998. Occasionally patients still come to Anita House for Depot medication, particularly if they have missed their appointment at the clinics. 20-30 patients come to Anita House on different days of the week to see different key workers. Visits without appointments result in a very fragmented service with depots being given by nurses who are not aware of who the key worker is. The usual procedure is for the CPN to take the depot records (not the clinical file) from Anita House to the clinic for the depot injection. If the patient fails to attend, a letter is sent, inviting the patient to come the following week. If the patient fails to attend this second appointment, the key worker is notified and if appropriate, a visit is arranged to the patient's home.

Integration between the ward and locality team at local level

221. Criticisms were made in Professor Murphy's report that there was poor communication between the NWLMHT and the ward. In response to this criticism, the locality manager from 1994-97 wrote to the Inquiry as follows: "When the NWLMT was established in May 1994 there was no dedicated ward for the locality, nor a consultant until the present consultant started in December 1994. Tuke Ward opened the following year. Good communication and liaison with the ward was achieved in the following ways. The Locality Manager met regularly with the Ward Manager, the Ward Manager or senior nursing staff attended the weekly locality meetings as described above, the Team Leaders attended the ward management meeting on Monday mornings, key workers attended ward rounds and details of admissions and discharges were routinely faxed to the locality team by the ward. In addition, from September 1996 I (the Locality Manager) chaired the weekly CPA planning meeting on the ward."

222. In September 1996, therefore, shortly after Feza M.'s discharge from the ward on 5/9/96 without a care plan or keyworker in place, arrangements for strengthening communication between the ward and locality team had been put in place.

223. In the subsequent reorganisation which took place in June 1997, locality managers became responsible for both ward and locality team in order to improve integration.

224. The panel visited Tuke ward at Homerton Hospital and spoke to the Specialist Services Manager and also to the ward manager, who had been appointed in June 1997. He said that there had been a 95% turnover of staff since the ward and community team were linked under the management of the locality manager. There were now clear strategies in place to strengthen ward and community links. These included: every Monday locality clinical meetings were held, chaired by the locality manager or ward manager attended by team leaders and the Consultant.

225. On Tuesday the ward manager went to Anita House for a clinical management meeting where patient issues were raised with the team and likely admissions discussed. This was chaired by the Consultant. On Wednesday and Thursdays, ward rounds were held and attended by the keyworkers. A CPA assessment was carried out on admission of a patient and the ward manager was of the view that no patient would leave Tuke ward without being assessed for CPA, though they would not always have a keyworker. A daily fax, introduced by the ward manager in 1998 between ward and Anita House gave information on ward activity: admissions, discharges, patients on leave and details of the staff on each shift.

226. One of the barriers to total integration in staffing between the wards and the community was the different gradings. The lowest grading in the community was G grade, but some staff nurses on the ward were on D grade. Thus although it was possible to arrange for secondments to the community, it was not easy to set up secondments from the community to the ward. The ward manager said it would be helpful if he had some E grade vacancies on the ward to use for community secondments.

Improvements subsequent to the Homicide

227. The panel's visit to Tuke Ward described above is indicative of what the Panel found generally during the evidence it received, that staff and management were taking a proactive approach in addressing identified issues, partly because of staffing changes and also because of the implementation of some of the recommendations of Professor Murphy's Inquiry. The following is a brief list of improvements planned or introduced by the Locality Team and drawn to the attention of the panel:

- Inclusion of depot administration in the Mental Health Link Database to notify the keyworker of all failures in attendance or compliance.
- Planned additional staff training in dealing with violence, aggression and risk assessment and improved staff induction arrangements.
- Introduction of Standards for the Management of Incoming Work (November 1998), including improved allocation and keyworking arrangements.
- Introduction of a new supervision system (including recording of supervision requirements).

Conclusions on the Operation and Management of the N.W. Locality Team

228. The North West Team has been through a long period of crisis. Arrangements for the allocation of work, caseload management, supervision, the procedures for holding cases on duty, closure of cases, all required review and improvement. Stronger and more effective leadership and management had been required at a time where the team was facing increasing demands. Nevertheless there was evidence of a strong commitment to service provision from individuals working within this difficult environment at the time and also evidence of recent improved morale and a determination to ensure that formal procedures are both put in place and monitored to develop the effective operation of the team.

229. Internal audit systems are now working and leading to improvements in the implementation of CPA, risk management and keyworker allocation, but further work is still required on establishing a safe system for patients who fail to attend depot clinics. In addition procedures are needed for dealing with patients who fail to respond to home visits.

RECOMMENDATION 3

We recommend:

(i) There should be a systematic process for the review of cases held on duty.

(ii) The operational policy of the locality teams should:

a) Specify the maximum duration of time that patients can be held in the duty system before allocation or case closure.

b) Ensure that full multidisciplinary consideration (including the responsible consultant psychiatrist) should occur before decisions to alter the CPA – care plan.

c) Ensure that default from attendance at clinics for the administration of depot neuroleptic injections is followed up in an assertive and timely manner.

d) Provide clear procedures for notifying team leaders of failed appointments and no response visits, particularly where there is concern about an individual's deteriorating mental health, and the procedure to be followed before forced entry to a patient's home is used, including how many unanswered calls should be allowed to take place before action is taken.

(iii) Allocation of cases should be matched with the skills and experience of staff.

(iv) Co-working arrangements with respect to the roles of the Health Care Support Workers and Keyworker be clarified and monitored through supervision.

(v) The introduction of improved arrangements for supervision and case load management within the team should be a priority and monitored.

(vi) The outpatient services for the NWLMHT, currently situated at Homerton Hospital should be more closely integrated with the Locality Team. This might include the development of a single route of referral for both services and a relocation of the outpatient clinic to the Locality Team Premises, (subject to expansion or relocation of premises).

(vii) The Trust should explore other options for further strengthening the integration of the locality team with Tuke Ward (for example through staff secondments across sites).

RECORDS AND RECORD KEEPING

230. It occasionally happens that the only time a multi-disciplinary team get to see the full picture of a patient's history and care and treatment is when there has been a tragic incident followed by an inquiry. Unfortunately the care and treatment of Feza M. is an example of such an occasion. We have already seen in the section on "Application of Risk Assessment to Feza M.," that he had 6 separate sets of clinical notes. The North West Locality Team's ability to judge the risk posed by Feza M. was significantly compromised by lack of easy access to the full detail of past clinical records across different sites. Witnesses to the Murphy Inquiry had expressed surprise when confronted with facts and records of Feza M.'s history of which they had no previous knowledge.

231. This section answers the following questions:

What records were in existence in relation to Feza M.?
What records were used by the NWLMHT?
What deficiencies existed in the record keeping system?
What improvements have been made since the incident in 1997?
What improvements are still necessary?

What records were in existence in relation to Feza M.?

232. The Inquiry chaired by Professor Murphy brought together the following sets of records:

Records of Feza M.'s care by the NWLMHT and SWLMHT.
Drug administration (Depot) records kept by the NWLMHT.
GP records.
Some of the records of the in-patient stay and OP clinic in Homerton (and previously Hackney) Hospitals; (records of an admission in 1990 and an admission in 1988, mentioned to the panel by Feza M. were not available).
Records of his OP clinic attendances at St Bartholomew's Hospital.

233. In addition the present inquiry obtained the records from Duke's Priory, a private hospital in Chelmsford to which Feza M. was admitted on 1 June 1995 to 23 June 1995, and the records kept on the Mental Health Link, a computer system used by the NWLMHT.

234. Mention has already been made of supervision records which could include patient information following discussions between the supervisor (usually the team leader) and the keyworker or support worker. However neither the Murphy Inquiry nor this Inquiry obtained sight of such records and there is no evidence that supervision notes were filed in Feza M.'s community records.

What records were used by the NWLMHT?

235. The NWLMHT practised a unified system of record keeping for patients referred to the team. Every practitioner who worked with the team kept their patient records in a central folder retained at Anita House, the team's HQ. Thus the record completed by the keyworker whether nurse, social worker or OT was kept in a central record. If the doctor saw the patient at Anita House these were also kept centrally. If the doctor saw the patient in Out-Patients or in a clinic held in a GP Practice, then he would ensure that a copy of the note that he made for the file held in that location was sent to the keyworker, NWLMHT to be kept in the central file.

236. In-patient records from Homerton Hospital were stored in the Out-patients Department (OPD) or Emergency crisis centre and were available to be accessed by any keyworker, but they were kept separate from the community team records. A diligent keyworker, with time available, could visit the OPD to read up on the patient's history, as far as it was contained in that set of records.

237. AP gave evidence that she worked from the discharge summary which had been prepared following Feza M.'s discharge from Duke's Priory in June 1995 but did not read through any earlier notes. She did not remember seeing records from the hospital when Feza M. was allocated to her. She thought that the team leader had done an assessment, and so had the key worker, JA.

238. HR was given the community records when the case was transferred to her from AP. She told the panel that she was passed the file that AP would have been working on i.e the LMHT file which was kept in the headquarters - this contained all the papers except those which were kept, following discharge, at the emergency clinic at the Homerton Hospital and at Hackney Hospital. She had been there to see the records of one patient, she could not recall visiting them to see Feza M.'s records. She had no access to his in-patient records.

239. There is no evidence that SD accessed the OPD records for Feza M..

What deficiencies existed in the record keeping system?

240. The main deficiencies were as follows:

a. An inadequate computer system.
b. Failure to link up the diverse records held across the district.
c. Depot records kept separate from the main community records.

An inadequate computer system.

241. The team leaders and locality manager who were in post before June 1997 gave to the panel a picture of an efficient central record system for patients allocated to the NWLMHT.

242. RMcN (Locality manager 1994-97) informed the panel that: "A central record was kept by admin. of all referrals made to NWLMHT since the Locality team opened in 1994. A central record was kept of all cases allocated and admin. staff had responsibility to ensure that the Mental Health Link was updated as cases were allocated. Individual caseload lists were held on computer by admin. and updated when cases were allocated or closed. A paper backup system was maintained and updated caseload lists were provided to the Manager and Team leaders at the beginning of each month."

243. He did not refer to the technical failures of the Mental Health Link, which from the evidence of managers and other professionals clearly existed. The Mental Health Link which had been in existence before the integrated teams were established appeared to be only intermittently functional. Intended to provide a data base for all patients receiving mental health services, on which each team member caring for the patient could add details of specific interventions, it was unreliable as a database to the extent that some staff did not bother to enter any record of their contact with patients.

244. The Panel was informed that on one occasion it was "down" for over 8 weeks. It was not therefore surprising that staff learnt not to rely upon or even use the Mental Health Link.

245. The inadequacies of the Mental Health Link system had repercussions on the overall management of patients and it appeared there was no clear database of patients, whether or not under CPA. There also appeared to be an absence of information relating to case loads of individual keyworkers; the allocation of patients; the numbers who were not allocated; the numbers who were being dealt with on duty; the numbers of patients who had not been seen within the past six months. Such basic information, which was necessary to ensure an effective case management system, ensure realistic work loads and check that patients were not falling through the net, could not be easily accessed.

246. J Wa, Locality Manager from June 1997 provided a copy of Feza M.'s record on the Mental Health Link but said: "It shows mostly the depots being done. The reason that I put that in there is that there may be a list on the Mental Health Link, which said that this is when he was given his depot, but I cannot be sure that he was not given his depot at other times that were not recorded on the Mental Health Link, which shows the unreliability of the information recorded or not recorded there."

247. J Wa also confirmed that out-patient clinic appointments, for example at hospital, also figured on the Mental Health Link, with the input of data by the receptionist at the out-patient clinic at Homerton. She stated that: "On the whole the Mental Health Link is very useful in that it congregates everything. If it was 100% accurate it would be wonderful but part of the problem is the system itself. It has not been consistent in its running. It is already out of date and needs to be looked at. But you could tap in somebody's name and find immediately when they were seen and by whom."

248. Evidence from the SWLMHT suggested that a more proactive management approach to ensuring data was entered correctly on the system, to include also records of depot medication, (made easier in this team's case by the location of the clinic at the Team's base), could make the existing link system, despite its inadequacies, more reliable and useful.

Failure to link up the diverse records held across the district.

249. J Wa described the different notes which existed in 1997: "The locality file, one on each patient; there would be depot notes, which may or may not be in the locality file, depending on where people have their depot, they could be kept in a file which would be taken to the clinic on a weekly basis..... If the GP was giving the depot then the GP would be generating the prescription himself. Records for depots at Anita House were kept in the lever arch file and would be taken up to Anita House. The notes of the hospital admission would be kept at the Homerton Hospital. We would get the discharge report/summary."

250. It would require diligence and time to access records which were not held centrally. If the patient was an in-patient when first assessed for CPA, then that assessment could be undertaken with the in-patient records to hand. However following discharge, the keyworker would not have easy access to those records. The Doctor on the other hand would see them whilst conducting an Outpatient clinic.

Depot records kept separate from the main community records.

251. The depot cards were kept separate in their own file. This was the procedure then and it still appears to be so. There are, of course, clear advantages in the depot records being kept separately, so that for every clinic, the CPN could gather up the prescriptions and have the necessary charts for the patients with appointments on that day. The weakness however occurs when there is a failure to attend.

252. JA told the panel in writing that: "Depot treatment cards were kept on the client files. There was no central record relating to depot clients. There was no system in place which would enable managers to get a feel for how effective the depot service actually was other than by relying on anecdotal evidence or by episodically ploughing through a large volume of records or possibly through some form of audit. I am not aware that any such audit took place."

253. Asked what would happen if Feza M. turned up at a clinic to have the depot and they have not got the file there, he told the panel that the depot card could be faxed and this did not present a problem. However they did not have a set procedure at that time if the patient failed to attend for a few depots. There was not an automatic system where every time a patient failed to attend a depot the key worker or someone who was responsible for the patient would be notified. He stated: "there was definitely a problem in terms of minimising the chances of missing information like that."

What awareness was there of the deficiencies in the record keeping system and what action, if any, was taken?

254. Many witnesses appeared to be aware of the deficiencies, particularly the failings of the Mental Health Link. There was also an understanding and recognition of the fragmented nature of the records held across different sites, particularly the separation of community teams, inpatient and outpatient records.

255. **The Inquiry cannot trace any significant action which was taken to improve the situation.** There appeared to be an inevitability about the problem: part of the context within which they had to work. On the one hand, resources were tight and there were not the funds available for any radical overhaul of the computer system, or of the integration of records kept at the hospital and those held in the community. On the other hand, there is no clear evidence that team members raised these issues with senior management as a matter of priority. Not till late 1997 were attempts made to improve the situation.

What improvements are still necessary?.

256. Both the Trust and ELCHA recognised the importance of developing a comprehensive electronic mental health record system particularly given the very mobile population in East London. Dr. Jacobson, Director of Public Health, told the panel that a bid through the Health Action Zone had been submitted to provide a system which would include primary care and Social Services and within which Mental Health would be a top priority. ***The proposed establishment of a single Mental Health Trust for East London provides an opportunity to review existing systems and prioritise the establishment of a Trust wide system, in collaboration with local authorities, which addresses the deficiencies identified in this report.***

257. In the meantime there is the urgent necessity, as several witnesses identified, of seeking improvements to the existing Mental Health Link pending the introduction in due course of a new system.

What improvements have been made since the incident in 1997?

258. As far as the panel can ascertain no major changes have taken place to remedy these apparent deficiencies in record keeping systems since 1997.

Conclusions on record keeping

259. ***There were major deficiencies which existed in the record keeping system in the LMHTs . These included an inadequate computer link system, separation of hospital records from community records, and a lack of awareness of other hospital records. In only exceptional situations was there access by keyworkers to hospital records.***

260. ***Middle and senior management were aware of these deficiencies but since the resolution of the problems was seen in terms of resources, no action was taken.***

261. ***Current plans include the securing of funds for a radical new IT system which includes health and social services records, (covering East London) and might eventually be linked into social security and police records, subject to safeguards on confidentiality.***

262. ***A realistic view suggests that the implementation of such a vision is several years, if not more, away. In the meantime, more mundane action is necessary to ensure that keyworkers have immediate access to all relevant information of the patient's history and risk factors. The immediate action should include ensuring that the Mental Health Link is reliable, since an unreliable computer system will lead to staff reluctance in recording information on the database and therefore dependence upon a manual (duplicate) system of record keeping, such a dual system being costly in time.***

RECOMMENDATION 4.

We recommend:

(i) **Steps should be taken immediately by the Trust to ensure the Mental Health Link system is made more reliable, including ensuring that all relevant data is entered on the system.**

(ii) **Priority should in the long term be given to the development and resourcing of a comprehensive unified electronic record system across NHS services in East London with a feasibility study undertaken on integrating NHS and social services notes.**

(iii) **Easy access should be provided for the keyworker to the full patient record, including hospital records, and any administrative resource implications arising from this should be considered.**

(iv) **Review of the feasibility of patient held records should be undertaken as part of any longer term strategy.**

SUBSTANCE ABUSE AND DUAL DIAGNOSIS

263. Evidence is given in Part 1 of this report on the Care and Treatment of Feza M., that as well as being seriously mentally ill, he had both an alcohol and drug problem.

264. The apparent scale of drug abuse in Hackney has been referred to earlier and presents a major challenge for all the agencies involved co-ordinated through the local Drug Action Team. In terms of dual diagnosis, ELCHA's Chief Executive, Peter Coe, estimated that at present about 50% to 60% of mental health inpatients (based on measures carried out within the Hackney Trust) are likely to have used illicit drugs at some stage. Dr. S, Feza M.'s consultant estimated that 25% to 30% of patients with a diagnosis of schizophrenia are regularly taking more alcohol and marijuana than Feza M. was, although as Dr. Jacobson, Director of Public Health for ELCHA indicated to the panel, it is extremely difficult to assess the level of dual diagnosis in relation to drug, alcohol and mental health problems, because of the difficulty in agreeing definitions.

265. What is clear from the literature is that whatever the actual scale of the problem, which undoubtedly in Hackney is substantial, the levels of risk of violence to self or others are significantly increased where dual diagnosis exists. This section explores briefly issues around the commissioning of services and the role of the respective agencies before presenting a summary of conclusions.

Commissioning of Services by ELCHA

266. A new Commissioning Strategy for Drug Misuse Services within ELCHA was prepared in February 1998. This aimed, among other objectives, at shifting resources and responsibility from secondary (specialist) drug services to primary care and community drug services. A report on the progress made towards implementing the strategy in July 1998 noted that "the specialist nursing posts for HIV and mental health formally based at the Healthy Options Team have moved to the Specialist Drug Service and recruitment of two Consultants with responsibility for Tower Hamlets and Newham should shortly be occurring. The Consultant who currently covers City and Hackney is remaining in post in a part time capacity."

267. It does not otherwise refer to the dual diagnosis issue discussed here. Peter Coe, Chief Executive of ELCHA and John Wilkinson, Mental Health Strategic Manager explained however to the panel that commissioning in relation to dual diagnosis was under review. The specification for the work included the issue of dual diagnosis and the interface between local drug and alcohol services and mental health services.

268. The Chief Executive explained: "We are expecting a set of recommendations around how we address what seems to be a growing level of co-morbidity across East London mental health services. We are starting just as one example by appointing in each locality (and funding is coming from the centre for this) somebody who will be training up the LMHT staff in managing people who have drug and alcohol difficulties. That is just a beginning."

269. They emphasised the importance of effective interagency working in this area involving health, police, probation, Social Services and the voluntary sector, for example in the development of court diversion and arrest referral schemes.

Contracting out of substance abuse services

270. Substance abuse services in East London, following a tendering process had been contracted out to the voluntary and private sector, with the Health component provided for East London by the neighbouring Tower Hamlets Trust. Dr. Jacobson told the panel the proposed creation of a single Mental Health Trust across East London provided the opportunity to consult on integrating drug and alcohol services much more closely with mental health services and acknowledged the current divide that existed. She also told the panel of ELCHA's plans to commission a consultant with direct responsibility for alcohol services who should be located, in ELCHA's view, within the proposed single Mental Health Trust.

271. In terms of current services she indicated the need for improved liaison and greater awareness of services existing within the voluntary sector and told the panel that there were for example good alcohol counselling services that mainly supported primary care and provided a community based detoxification programme.

The Trust's view of the substance abuse issue

272. The Chairman of the Trust, Professor Murphy, emphasised the importance of the dual diagnosis issue and the need for the work of the local Drug Action Team and Mental Health Services to be far more integrated. Dr. T., former Medical Director of the Trust told the Panel "We have been very angry about the way in which drug dependency services have been managed in this district for the last four years".

273. In particular he referred to the Trust's loss of its own drug dependency unit when Town Hamlets was given the contract on an East London basis and the failure of the Trust to win the contract to provide an alcohol service which had gone to the voluntary sector. He stated alcohol services are very limited.

274. One service that had been provided through the Trust was the alcohol clinic which Dr. S., Feza M.'s consultant, had run for two years up until 1996. There was no specific funding for the clinic, which was run voluntarily by staff, including nurse and social worker input. Dr. S told the panel that there had been good communication between his alcohol clinic and the LMHTs.

Social Services, Housing and Substance Abuse

275. Hackney Social Services Department runs a separate substance-misuse team. RH, former Mental Health Service Manager for the London Borough of Hackney told the panel she worked closely with the manager of that team and they were encouraging better links between the substance misuse and mental health teams aimed at improving expertise and co-ordination of services to people with a dual diagnosis. However, at the time of the homicide there was no specific strategy in relation to dual diagnosis. The Director of Commissioning for Customer and Advice Services, Mr. Latham, for the London Borough of Hackney Estate Management and Development Department informed the panel that dual diagnosis was becoming an increasing issue for the Estate Management and Development Department and good links had been established with the new Head of Strategy and Commissioning for Adult Community Services. He informed the panel of a small project team funded through Joint Finance and a grant for Estate Management both to provide support to people in their tenancies who had a combination of mental health and substance misuse problems and to ensure that referrals were made to the appropriate agencies for re-assessment where this proved necessary.

Conclusions on dual diagnosis and substance abuse.

276. Services for mentally ill people who abused substances were patchy, and within Hackney there was a lack of confidence from mental health clinicians in the ability of substance misuse services purchased through the voluntary and private sectors to provide appropriate services to people with severe mental health problems. The Alcohol Clinic in Hackney which Feza M. had attended, had been run on an adhoc basis and was not funded as part of ELCHA's commissioning strategy.

277. From the mental health perspective there are clear advantages in providing substance abuse services as part of mainstream mental health services. However there are also disadvantages, for example, from the perspective of services to young people and the potential impact on the role played by the voluntary/independent sector in the provision of community based substance abuse services.

278. The panel supports the plans to commission (before the year 2000) a consultant with direct responsibility for alcohol services who would be able to liaise at consultant level.

279. The panel believes that the establishment of a single mental health Trust for East London provides the opportunity to review existing service arrangements and provide a strategy for integrated service development.

RECOMMENDATION 5

We recommend:

(i) ELCHA, The Trust and the LBH should develop a risk policy which should be developed for those patients who suffer from mental illness and who engage in bouts of substance abuse.

(ii) Existing service arrangements for people with a clinical diagnosis of mental illness and substance abuse should be reviewed by the statutory agencies and Drug Action Team and consideration given to the development of an integrated service across East London.

(iii) The Trust and LBH should take steps to improve the links between existing substance abuse services and LMHTs.

GENERAL PRACTITIONER SERVICES

280. The panel was informed that GPs, though invited, did not attend CPA meetings. Feza M. had some contact with his GP who received discharge summaries from the hospital, but looked to the depot clinic and the OPD meetings with his psychiatrist for medical care of his mental health problems. Liaison was assisted by the fact that Dr S and Dr B held some of their clinics in GP surgeries, writing their notes in the GP records with a copy to the key workers.

281. The problems of ensuring better liaison with GPs and the LMHTs concerned ELCHA and the Trust. The Annual Public Health Report for 1996/7 showed the low level of referral from GPs to the Hackney locality teams, 10% compared with Newham where 55% were referred by GPs to Newham's CPNs.

282. The panel was informed that the NWLMHT was implementing a strategy to improve links with GPs through the use of liaison workers. A questionnaire to GPs provided useful information on how GPs perceived the existing service. In a report (which also included feedback from team members) dated October 1998 RS analysed the responses from GPs as follows:

- 69% of GPs agreed that there was poor liaison between the NWLMHT and GPs.
- The majority of GPs said that they were not clear about the roles and responsibilities of the NWLMHT staff.
- 80% of the GPs said they did not have enough time to deal with severely mentally ill people effectively.
- 68% saw a need for specialist training.

283. As a result of this investigation, six GP practices whose patients were the most frequent users of the community mental health services have been allocated members of the team for liaison.

Evidence from Feza M.'s G.P

319 The panel spoke to Dr MH, one of the partners in the GP Practice with which Feza M. was registered. Feza M. came within the category of patients for whom the GPs provided general medical services, but whose mental health care following an in-patient stay is provided through the LMHT under CPA arrangements. The keyworker would then hold responsibility for monitoring attendance at depot clinics. In some cases however, the GP holds responsibility for the patient's mental health care without recourse to specialist services and will provide a depot service. As far as Feza M. was concerned, the GP kept in touch with the locality mental health services: he was notified, for information, if Feza M. failed to attend for a depot, but was not expected to take a proactive role in following this up. It was always possible for the CPN or the patient himself to raise with the GP practice the possibility of receiving depot medication in the surgery. Feza M.'s psychiatric care remained the responsibility of the Consultant Psychiatrist.

285. One of the main criticisms about the specialist mental health service made by Dr. MH was the delay in obtaining hospital discharge summaries. The absence of a discharge summary meant that patients, discharged on new medication, come to the surgery and ask for a new prescription and the GP has no idea of what medication they are on. He had complained to the Medical Director of the Trust about six months previously about the need for an initial summary of the patient as soon after discharge as possible. He was not aware that the situation had improved.

Links between the LMHT team and the GP.

286. Dr MH stated that when he first joined the practice, there was a CPN who was based in the Health Centre. She moved on and was never replaced, due presumably to insufficient staff.

287. Recently a CPN had been linked with his practice and attended primary care meetings, but this too had come to an end. He regretted this. "It is very much a two-way process. (The contact) is very useful. If we have people who we think are deteriorating and need to be visited, then it is helpful to them and it is also helpful for them to tell us what is going on.... I think having somebody coming twice a month or once a month was useful. Also in terms of communication and knowing a face, and somebody you can contact who will then sort things out is very useful."

288. GPs were not on the Mental Health Link computer system. He thought it might be useful, but since there were very few seriously mentally ill patients, it might only be used once every year, and the trouble is that if it is being consulted very irregularly, then "you forget it is there."

Primary Care Groups

289. Dr MH saw the establishment of Primary Care Groups as providing a more GP based service. He thought that there would be more clinics within health centres, more outreach clinics and improved communication. For patients on levels 2 and 3 of the C.P.A. he saw the Consultant Psychiatrist remaining responsible for their mental health care. However for other patients with mental illness, he envisaged CPNs allocated to a cluster of GP practices from which depot clinics would also be run.

Conclusion

290. ***It is important that the new PCGs develop a strategy for involvement in the support and care of mentally ill patients in the community and involvement in the work of the LMHTs, ensuring continuity of care particularly for those who are less seriously mentally ill.***

291. ***Unless this co-operation develops and is appropriately resourced then there will continue to be difficulty in discharging patients from the case loads of the LMHTs.***

RECOMMENDATION 6

We recommend:

(i) **The linking of the LMHTs with a nominated liaison officer working with a group of GP practices should be further developed by the Trust.**

(ii) **The Trust should ensure that hospital discharge summaries should be supplied to GPs within one week by the hospital and copies provided at the same time to the LMHTs.**

(iii) **The PCGs should institute a strategy for a unified system of record keeping between LMHTs and Primary Care services. (Links to recommendation 4(ii).)**

ETHNIC AND CULTURAL ISSUES AND THE ROLE OF THE VOLUNTARY SECTOR

The challenge facing Hackney.

292. The ethnic diversity within Hackney is rich, diverse and constantly changing. Whilst this section will focus more specifically on issues relating to service provision for people from the Turkish speaking community, the Turkish speaking population represents, it is estimated, 8% of the Hackney population compared to 24% who are Black African or Black Caribbean. With East London being traditionally a first point of arrival for many refugees, the fluidity of the population is marked. Between July 1995 and June 1996 the City & Hackney area alone, based on the area of origin of GP registrations, received 5,474 new arrivals. (Source: Health in the East End, Annual Public Health Report 1998/9, ELCHA). The more recent influx of refugees from Albania and Kosovo will have placed further pressures on services responding to a changing refugee population.

293. In relation to the Turkish and Kurdish community itself, the panel was informed by a number of witnesses of the range of political groupings and factions within these communities and the impact this has on service provision, including the use of appropriate advocacy/interpreting services.

294. The challenge facing service commissioners and providers in developing culturally appropriate services is considerable therefore. In considering the performance of the respective agencies involved account has to be taken of the scale of the problem relating to available resources.

The role of Commissioners

295. The commissioning strategies of both ELCHA and the Adult Community Services demonstrate a strong commitment to providing and developing services appropriate to the local communities. Both draw attention to the important role played by local voluntary organisations and community groups in providing accessible and relevant services. Nette Carder, Director of Adult Community Services, LBH, emphasised the value of mental health service provision coming through community organisations in terms of non-stigmatisation and improved access. The local authority department has a history of funding voluntary organisations. (Funding for mental health voluntary projects in 1998/9 amounted to over £1.2 million : Source Community Care Plan – Update 1998/9.) She told the panel that with the establishment of a Strategy and Commissioning Team in the department in May 1998, a review of voluntary sector provision was being undertaken, with an emphasis on commissioning services in the future on the basis of prioritised need.

296. There was also a shift towards introducing clearer arrangements for contracting for services with voluntary organisations. It was acknowledged that organisations would require assistance in meeting the requirements of the new contracting framework.

297. ELCHA similarly has a positive history of commissioning services from black and ethnic minority voluntary organisations and groups. Its mental health strategy in 1996 incorporated the following Action Summary:

(1) Representation and consultation of Black and Ethnic Minority organisations in the commissioning process.

(2) Development of local targets for mental health which take into account the specific health care needs of Black and Minority Ethnic Communities.

(3) Requirement included in the contracting process for ethnic monitoring and for Anti-discrimination Policy to be implemented by providers.

(4) Funding of health promotion initiatives aimed at particular communities.

(5) Funding of Black and Minority Ethnic counselling and psychotherapeutic services.

(6) Imagination in commissioning services from Black and Minority Ethnic organisations.

(7) Requirement for use of secure in-patient facilities to be justified by formal Risk Assessment procedures.

(8) Consider recruitment of specialist(s) in Transcultural Psychiatry; establishment of specialised Community Team(s) and/or funding of specialist workers attached to particular communities within LMHTs.

(9) Encourage providers to work actively with local community groups to increase use by Black and Minority Ethnic populations.

(10) Training and Education programmes for all staff to incorporate anti-Racist training, and cultural sensitivity issues relevant to the professions skills and knowledge base.

(11) Sponsorship of local research.

298. ***This summary is endorsed by the panel as forming a positive basis for commissioning services in the field of race and mental health. It is clear from the evidence received by the panel (described later) that substantial work is still required to meet the objectives outlined in the Action Summary.***

299. A particular problem arose in 1997/8 when ELCHA, faced with a substantial budget deficit decided to introduce cuts in the region of £2million in voluntary sector provision which inevitably affected black and ethnic minority organisations.

300. Mr. Coe, Chief Executive of ELCHA explained the approach taken to achieve the cuts and the objective to protect Mental Health Services at a time when savings had to be made. Dr. T, Medical Director of the Trust at the time described the impact of the cuts from the clinicians' perspective as follows: "Because of the nature of our clientele we spend our time writing on behalf of such as the Vietnamese Mental Health Team, who are very good and on behalf of the North Muslim Association and other Turkish Associations. We desperately try and keep them going, because in the end where do these people go? In terms of day centres or continuing care for people who cannot speak English, there is no point in them going to the regular day hospitals. How do you provide support for them? You need to be able to speak their language and know their culture, so the best groups are the voluntary groups to be seen to be funded and supported."

301. Dr Jacobson, Director of Public Health, ELCHA, emphasised, that no reduction was made in any of the services for people with severe mental illness - either in the voluntary sector or elsewhere, but some reductions had to be made, for example in bilingual and advocacy services.

302. The panel received evidence from one organisation affected by the cuts, the Health Advocacy and Counselling Services for the Turkish and Kurdish Speaking Communities. Ms. N. Tas, a Turkish speaking Counsellor, described the work she undertook in the field of mental health and the impact of the withdrawal of funding. funding then secured through a charitable organisation, with temporary funding then re-instated by the Health Authority until 1999. The case for secure funding for this organisation based on the limited evidence received by the panel would seem a strong one. It is regrettable that the speed with which cuts had to be introduced meant that there was not time for consultation with partner agencies and the voluntary organisations themselves.

303. Systematic consultation with and the involvement of black and ethnic minority organisations over the way in which services are developed is of fundamental importance. There was evidence (in Hackney) of the involvement of such organisations through the joint planning process and some positive outcomes – for example the development of the Afro Caribbean mental health crisis centre project - The Nile Centre. However, the City and Hackney Community Services NHS Trust in a bid, supported by ELCHA and Social Services to the Department of Health for funding for an Assertive Outreach Team in 1998 acknowledges: "We require a more sophisticated means of involving the substantial ethnic minorities in Hackney in the shaping of services. Consultation with these groups needs further development by encouraging their involvement in shaping the strategic direction of the adult mental health services." The panel agrees this should be a priority.

Provider Services

304. At both strategic and operational levels within Social Services and the Trust, the panel received evidence of a strong commitment to develop culturally appropriate services. The stated objectives and policies of both organisations reflected this. The organisational difficulties in achieving policy objectives in this area were also acknowledged, including in particular achieving the recruitment of staff representative of the communities served. The Chief Executive of the Trust, Ms. Dongworth, described the work being undertaken with local education providers to address this issue.

Provision of Mental Health Services to the Turkish/Kurdish Community

305. Specialist mental health services geared specifically to the needs of people from the Turkish/Kurdish Community are limited. These include:

Health Advocacy and Counselling Services for Turkish and Kurdish speaking communities: This project received referrals from GP practices across Hackney and from Community Mental Health Teams. 206 referrals were received in 1996/97, and 90% of referrals were from refugees or asylum seekers.

Halkevi: A Community organisation for Turkish and Kurdish people (mental health project worker funded by Social Services) with a mental health remit, liaising with the four 4 LMHTs.

Shoreditch: A Social Services Day Centre with a Turkish counselling project attached.

306. In addition to specialist mental health provision, other generic services are provided through community organisations and groups funded in a variety of ways. One such organisation is Day-Mer, a Turkish and Kurdish Community Centre, a drop-in centre which Feza M. attended.

Cultural issues with regard to the Care and Treatment of Feza M.

The North West Locality Mental Health Team (NWLMHT)

307. The Murphy Inquiry stated that "on balance the panel do not think that the very different cultural background of Feza M. and his locality workers adversely affected his care." Like the Murphy Inquiry, the panel was impressed with the depth of knowledge and cultural awareness displayed by the staff involved. The team had made efforts to recruit Turkish speaking staff and the recruitment in 1995 of NE, from a Turkish background to the post of Team Leader proved an asset to the team. In this respect the failure to ensure his retention as a valued member of staff during the management difficulties in 1997 within the NWLMHT was highly unfortunate. Since his departure the Team has successfully recruited a Turkish Development Worker, MY, who has provided valued assistance.

Use of interpreters by the Team

308. The panel considered whether interpreting services had been appropriately used for Feza M. The team did have access to Turkish speaking interpreters and this service was sensibly used on several occasions when Feza M. was particularly unwell. The panel heard evidence from a number of witnesses about Feza M.'s understanding and use of English.

309. MY, who had personal contact with Feza M. told the panel: "Feza M. was the one that could speak English to doctors and when he was in the ward, during the ward rounds. He was the one who used to help other people. When I say 'help', if someone needs a cigarette he was the one that used to go and ask the nurses or the staff whatever the other people who only speak Turkish needed".

310. He indicated his view that Feza M. would want to use his English and not put an interpreter between himself and a doctor. JA, Social Worker and Feza M.'s keyworker at one stage indicated to the panel that he felt that Feza M.'s English was good enough without the need for an interpreter although he acknowledged he may have been mistaken. AP, Student Nurse, felt there was no problem in communicating in English.

311. When the panel spoke to Feza M. it was apparent that he had some ability in speaking English, but there was a danger of accepting his nods as understanding rather than politeness.

312. On balance the panel considers that interpreting services were used appropriately in relation to Feza M., taking into account Feza M.'s wishes and needs.

In-Patient Services

313. The panel visited Tuke Ward at Homerton Hospital, from where Feza M. had been discharged in September 1996. The Ward Manager explained that a major problem on his ward was the failure to date to recruit any Turkish speaking staff on the ward, whilst a significant number of inpatients coming through the ward had Turkish as their first language. The use of interpreters or the use of the language line service at Homerton Hospital (2,663 minutes or just over 44 hours of Turkish were provided between Feb 1996 to January 1997 – Source: Language Line Data: East London and The City Health Authority Annual Public Health Report 1998/9), are of course no substitute for directly employing Turkish speaking staff. Efforts in this respect need to be re-doubled.

Primary Care Services

314. The panel received evidence from Dr MH, the GP from the Somerford Grove Group Practice attended by Feza M., and were impressed that the GP fundholding practice had succeeded in purchasing and developing a practice based Turkish advocacy and interpreting service. He explained with 20% of the practice population being Turkish/Kurdish speaking, the service was essential. The role included ensuring patients gained appropriate access to health and other services, including benefits advice, joint visits with Health Visitors and ensuring that within the practice there was an awareness of differing cultural perceptions of illness. The Panel commends the practice's initiative in establishing and developing this service.

The Appropriateness of Day Services

315. Following the initial assessment of Feza M.'s needs in June 1995, and as part of the Care Plan, AP, Student Nurse, sought a Day Care place for Feza M. Although there was a waiting list at the Social Services Day Centre, Lee House, the offer of a place was forthcoming from the Darnley Road Day Centre (run by a voluntary organisation). Feza M. visited and a start date was

arranged. However, he never attended. On reflection AP told the panel, she felt this "was not an appropriate placement anyway". Without commenting on the specific day services on offer the panel agrees that traditional day services may often find it difficult to respond effectively to the particular needs of individuals from a diverse range of communities.

316. The current review of Social Services day service provision as described to the panel by SH, Service Manager for Adult Mental Health within the LBH, should enable the development of more individually based community support provision, seeking both to develop employment opportunities and to provide links into alternative community provision.

317. The panel would wish to support the approach being taken by the Social Services Department in the development of more individually based community support provision, seeking both to develop employment opportunities and provide links into alternative community provision.

The Role of Day-Mer Community Centre

318. As indicated earlier it was in fact the local Turkish and Kurdish Community Centre, Day-Mer, that Feza M. himself chose to attend. The co-ordinator of the Centre, Mr. PCOK, gave in his evidence (from his personal knowledge of Feza M.) a different perspective of Feza M.'s contact with the statutory services. He also indicated the way in which statutory services are perceived by the diverse refugee community. In relation to contact with statutory services he told the Panel: "Always it is a constant brick wall. That is the experience. I am sure for a lot of different reasons. There are many care issues in the refugee community that just never get addressed for these reasons. Not being able to receive a response is almost a natural thing so when somebody in the mental health thing says there is nothing else we can do, what else will you expect?"

319 He felt there was a lack of understanding of the problems of refugees, in particular a failure to differentiate between the needs of different refugee communities. He stated the Turkish Health Advocacy Project was one attempt to address this problem. In relation to appropriate mental health service provision he emphasised the importance of attracting more Turkish speaking staff.

Conclusions

320. ***The Panel found evidence of a strong commitment from both the Health Authority, Trust and Local Authority to develop culturally appropriate services for people from different ethnic minority communities. The scale of the challenge especially taking into account the refugee situation in Hackney is acknowledged as extreme given the limited resources available. Some good work has taken place in developing an approach to commissioning voluntary sector services and there was evidence of the involvement of voluntary organisations in joint planning arrangements. Progress across the locality teams has been achieved, and the NWLMHT's commitment and relative success in recruiting staff that reflect the diverse population served is noteworthy, although it remains difficult to attract Turkish speaking staff. There is a particular need to redouble efforts to employ Turkish speaking staff on Tuke Ward, Homerton Hospital.***

321. ***The Panel considers that within the resources and staff available, the services provided to Feza M. sought to take into account his cultural needs, although his level of engagement with services might have been very different had it, for example, been possible to appoint a Turkish-speaking key worker for him.***

322. ***The Panel found evidence of some excellent work and services within the voluntary sector, and whilst good links are being established between funded specialist voluntary sector mental health projects and LMHTs, the importance of other local generic community provision such as Day-Mer needs to be recognised and a more systematic approach to developing links between these resources and LMHTs established.***

323. ***From the evidence the panel received it is apparent that barriers and difficulties in communication do exist between the Turkish and Kurdish communities and the statutory services, despite some good work undertaken. These barriers remain significant in the field of adult mental health.***

RECOMMENDATION 7.

We recommend:

(i) ELCHA, the London Borough of Hackney and the City and Hackney Community Services Trust should in conjunction with black and ethnic minority voluntary organisations review existing consultation arrangements in order to achieve a more systematic approach to service planning and development.

(ii) **The Trust and Social Services Department should continue to give the highest priority to recruiting staff from the ethnic minority communities. In particular the Trust should urgently address the need to recruit Turkish speaking staff to Tuke Ward, Homerton Hospital and the NWLMHT**

(iii) **Both the Social Services Department and the Health Authority should review the current level of funding to voluntary organisations within the Turkish and Kurdish community, to consider whether there is a need to prioritise enhancement in the current level of investment.**

(iv) **Locality Teams should strengthen their links with locally based black and ethnic minority voluntary organisations in a more systematic way, recognising also the contribution of general community based provision such as Day-Mer. Wherever possible the approach of identifying a member of staff to make and sustain informal links should be adopted.**

HOUSING

Housing and Strategic Planning.

324. The panel heard evidence from a number of witnesses of the positive work undertaken in developing a strategic approach to housing provision in the field of mental health.

325. Joyce Moseley, former Director of Social Services for the London Borough of Hackney, was instrumental in setting up a Joint Planning Housing Group in 1994/5. The panel heard evidence of the work of this group from Mr. Latham, Chair of the Group and Director of Commissioning for Customer and Advice Services for the London Borough of Hackney Housing Department. The work of the Group is encapsulated in the Community Care Plan Update 1998/9 in a specific chapter on Housing and Homelessness. This provides evidence of a well thought through strategic approach to planning which recognises the important role housing plays in Community Care provision involving key stakeholders, including the local authority, Health Authority and Trust, housing associations and voluntary agencies.

326. Of particular relevance to this Inquiry is the research commissioned in 1997/8 by the Hackney Housing Forum into general housing needs in Hackney, the extent of supported housing provision, the level of demand for move-on to alternative accommodation, and projections of unmet need. The Community Care Plan indicates the research project is scheduled to report its findings in the Summer of 1999.

327. In relation to Feza M. the issue of the availability of supported accommodation never arose, although SD, his keyworker in August/September 1997 had begun to discuss with him whether some form of supported accommodation might be appropriate for him.

328. The panel would wish to emphasise the value and importance of the work currently being undertaken within Hackney to develop supported housing schemes, which must be able to respond to the differing needs of individuals with mental illness from across the diverse communities within Hackney.

329. During the work of the Inquiry, the District Auditor was, as part of a national study, undertaking an audit of the housing department's performance against the recommendations of the guide, "Making Partnerships Work in Community Care" produced by the Departments of Health and Environment, Transport and the Regions. This "workbook" provides an accessible guide for practitioners in housing, health and social services and places great importance on joint working and collaboration at the operational level. The Community Care Plan Update 1998/9 includes as a priority the need to devise a strategy for implementing the recommendations of this guide.

330. The panel would wish that both the findings of the District Auditor and this Inquiry report give added impetus and priority to the development and implementation of this strategy within adult mental health services.

The role of Housing in the Care of Feza M.

331. Unfortunately, the panel was unable to analyse in any detail the contribution made by the Housing Department to the care of Feza M. from the Housing perspective, nor the level of joint working achieved with the LMHT in his case. This was because the four Housing files relating to Feza M. (and covering the period 1994 onwards) were missing and could not be traced.

332. The Director of Estate Management and Development of Hackney, in a letter to the Chair of the Inquiry Panel of 13th January, 1999 stated: "It is unusual for all four files to be missing and no audit card to have been completed for the release of any of these files from the neighbourhood office. There has been a high turnover of staff and an entirely new management team in charge at Stoke Newington. We must conclude, therefore, that somehow the files have been collated and lost. Staff have been put on alert with respect to the importance of these four files but I regret to inform you that, despite our best efforts, they remain lost. I regret the loss of these documents to your enquiry and on behalf of the Estate Management and Development Service of London Borough of Hackney apologise for the significant inconvenience it will cause to you."

333. The panel suggests that in future greater care and attention should be paid to ensuring the safe tracking of records through the completion of audit cards. The panel did have access to the files available for the period up to 1994. These contained a clear indication of Feza M.'s history of severe mental illness, a change in his status in 1993 from married man with wife and child to single person and an emerging pattern of his failure to respond to letters and requests to contact the local housing office in response to his tenancy application. The final entry on the file dated 28th June, 1994, indicates that because of no contact, case has been closed and Void Task Force are requested to proceed with eviction. There is no record of contact with Social Services or with the Health Service at this point, although we can assume the request to proceed with eviction was never actioned.

334. Records from the NWLMHT from May 1995 onwards indicate only limited contact between the local Housing Neighbourhood Office and the LMHT. In July, 1995, AP, contacted the Neighbourhood Office seeking minor repairs to Feza M.'s flat. No response is included on the file. The next entry is in October 1995, when the Neighbourhood Office Rent Recovery Department contacted the NWLMHT, where a message was received by JA, stating that Feza M. may have been sent a 'Notice to Quit the Premises' due to non-payment of rent. This prompted a home visit from JA who subsequently helped Feza M. in December 1995 to complete a housing transfer request. The next recorded contact is not until August/September 1997, when SD, newly appointed keyworker, contacted the Neighbourhood Office regarding rent arrears and reported problems of noise from a neighbour to which a prompt response was received.

335. The limited case history available suggests no evidence of joint working or genuine collaboration between the local teams over Feza M.'s care.

The Relationship between Neighbourhood Housing Offices and Locality Mental Health Teams

336. Evidence from witnesses suggested that more widely there was substantial variation between and within offices in the levels of collaboration achieved. Too much depended on the response of individuals , the training they had received and their individual understanding of mental health issues.

337. In summary good practice and joint working between neighbourhood housing offices and the LMHTs, whilst developing, appears at best patchy. In contrast relationships on the ground between Housing Association providers and LMHTs were described as good.

Housing Issues and In-patient Care

338. The importance of identifying and referring on as appropriate housing and accommodation issues at the point of admission to hospital rather than discharge is rightly emphasised in the guidance "Making Partnerships Work in Community Care".

339. This was a theme picked up by the Mental Health Act Commissioners in their visit to Homerton Hospital on 19th March 1996, where they stressed the importance of provision of appropriate benefits advice, including housing benefit and drew attention to concerns expressed by patients over the accumulation of rent arrears.

340. The identification of the need for housing and benefits advice to patients as well as addressing accommodation issues following admission to hospital, all need to be considered within the framework of the Care Programme Approach and care planning process.

Conclusions on Housing

341. ***There was evidence of good collaboration and joint work at the strategic level through the work of the Joint Planning Housing Group, reflected in the Community Care Plan Update of 1998/9.***

342. ***At the operational level, however, joint working between the housing department and LMHTs is patchy at best and in the case of Feza M. was extremely limited.***

343. ***An analysis of the role of the Housing Department in the care of Feza M. was limited due to the fact four Housing files relating to his case had gone missing.***

344. ***The panel heard evidence suggesting a lack of understanding by some Housing Officers towards people with serious mental illness and poor communication between local neighbourhood housing officers and LMHss.***

345. ***There was no clear evidence of a written policy on the appropriate sharing of information between the agencies or joint approaches to risk assessment. However, there was evidence also of some good joint work based on individual initiative.***

346. **The effective development of a strategy as proposed in the Community Care Plan 1998/9 to implement the recommendations of DOH./DETR guide for practitioners in housing, health and Social Services "Making Partnerships Work in Community Care" would address the shortcomings identified and therefore should be given very high priority.**

RECOMMENDATION 8

We recommend:

(i) Priority should be given to the further development of supported housing initiatives for mentally ill people based on an analysis of the current research being undertaken on housing need.

(ii) High priority should be given to the development and implementation of a strategy within adult mental health services to respond to the recommendations of the Departments of Health and Environment, Transport and the Regions' guide for practitioners, "Making Partnerships in Community Care Work". Particular priority areas arising from the Inquiry include the need for:

- **A systematic approach to Joint Training of staff across Housing, Health and Social Services.**
- **Development of joint assessment procedures (including risk assessment) underpinned by an agreed interagency policy on the sharing of confidential information.**
- **Consultation with service users and carers over the development and implementation of the strategy.**

RESOURCES

348. It will already be evident that there was scope within the NWLMHT to deliver improved services within existing resources. The performance of management in this respect is dealt with in the following section. This section focuses therefore more specifically on the resource context within which agencies were operating, issues arising from ELCHA's requirement to make substantial savings in 1997 and specific shortfalls in resources identified by the Panel.

Overall Resource Position

349. The Panel was told that ELCHA was spending (in 1998/9) broadly 16.7% of its budget on mental health services against a national average of 10.8%.and 2% more than that indicated by the York Formula. The King's Fund report on London's Mental Health (1998), however, indicated an average spend on mental health for the deprived areas of inner London of 18.6%.

350. Dr. Jacobson, Director of Public Health told the panel that whilst the Health Authority had the third highest weighting for mental illness in the country, the level of funding was clearly not enough.

351. This was despite the fact that services were being targeted on people with severe mental illness and the community mental health teams were even then not able to ensure full coverage for this group. She believed there was a case for altering the resource allocation formula. Discussions with the Department of Health had led however to additional short term funding (from the Challenge Fund). The Government's announcement (White Paper: Modernising Mental Health Services: Safe, Sound and Supportive 1998), of an additional investment of £700 million over the next three years may provide both the Health Authority and the London Borough of Hackney with the opportunity to address particular shortfalls in resources and gaps in services.

Financial Cutbacks by ELCHA in 1997.

352. Not surprisingly, given the above, ELCHA took the position in 1997, when faced with the need to make substantial savings, that services to people with severe mental illness would be protected.

353. An officer of Trust, however, gave evidence to the panel that he was not aware mental health spending was to be ring-fenced and a saving of £200,000 on mental health services was implemented by the Trust with cuts in Occupational Therapy and Psychology Services. This led to the loss of an Occupational Therapy post to the NWLMHT in 1997, at a time when the team was facing considerable workload demands.

Medical Staffing

354. At the time of the homicide Dr S was the sole Consultant Psychiatrist for a socio-economically deprived and ethnically diverse inner London population of 53,000. There were only four Consultant Psychiatrists for a district population of approximately 200,000. Dr S was supported by only one Senior House Officer, a trainee usually in his first post, rotating on a 6 monthly basis. He was responsible for 21 acute inpatient beds, all of the patients on the caseload of the locality team, four GP liaison clinics, outpatient clinics at the Homerton Hospital and an Alcohol Clinic at St Bartholomew's Hospital. He provided the medical care for between 10 and 15 community patients who had been conditionally discharged from hospital under Section 37/41 of the Mental Health Act 1983. He also had both undergraduate and postgraduate teaching responsibilities.

355. As Dr S put it himself to the Murphy Inquiry "My workload is manifestly not sensible."

356. The panel endorses the Murphy Inquiry's finding of universal recognition within the locality team of Dr S's hard work and commitment to community based psychiatric practice. Limited medical resource was however an issue for the team.

357. In relation to the introduction of the CPA to clients of the team, RMcN, manager of the team some months before the homicide, stated to the panel that "one of the resource issues really was the availability of RMO time". When Feza M.'s CPA review meeting was cancelled on 29/8/97, no further CPA review could be scheduled in the team diary until 24/10/97, some 6 weeks later. Outpatient clinics at the Homerton Hospital were also heavily booked. At the same time many team members commented on Dr S's unfailing willingness to advise or undertake medical review if team members felt that his urgent intervention was necessary.

358. The Murphy inquiry noted that in the surrounding districts of Lambeth, Southwark and Lewisham, London Boroughs with similar socio-demographic characteristics, the number of psychiatrists with local catchment area responsibility was two to three times greater than in Hackney.

359. It also noted the recommendations of the General and Community Psychiatry Faculty of the Royal College of Psychiatrists regarding the appointment of Consultant Psychiatrists with community responsibilities. These recommend a maximum population of 25,000 per Consultant and recommend smaller populations in Trusts, such as The City and Hackney Community Trust, which have high levels of psychiatric morbidity or significant undergraduate teaching responsibilities.

360. ***This panel endorses the recommendation of the Murphy Inquiry that an urgent review of consultant psychiatric staffing for the locality teams be undertaken.***

361. In response to the Murphy Inquiry, the City and Hackney Community Trust has undertaken such a review and agreed to the appointment of one additional Consultant Psychiatrist for each of the four locality teams in its district. The panel applauds and fully supports this decision. The panel was concerned to learn that this is being funded from within the Trust's existing resources.

Beds and Community Based Services.

362. Evidence was given to the panel about the pressure on beds for acute psychiatric services. A letter from a GP to ELCHA dated 22 June 1996 described the workload of serious mental health problems within his practice: "Many patients are discharged on "weekend leave" because of the pressure on beds. When they return on Monday they are told that there is no bed and they are for practical purposes discharged. Patients find this rather upsetting as they were expecting to be re-admitted.

363. There is also no time to plan a post-discharge "package" (to use the current jargon) and we are left with essentially a dump without any information from the hospital or diagnosis, post-discharge care or prognosis, even medication."

364. The ward manager of Tuke ward told the panel on their visit to Tuke ward that there were 16 beds but 21 patients at that time, with many patients having to sleep out on other wards. It was a constant problem to find beds, but they no longer had to discharge over the weekends to create vacant beds. In Part 1 an account is given of delays in admitting Feza M. in 1995 because of pressure on beds.

365. Dr MH, his GP, told the panel that in the past patients had been transferred from Tuke Ward at Homerton to other wards, or to other hospitals. His partner, when working as an SHO at Homerton Hospital in 1997 had spent a lot of time just finding beds for patients. He gave evidence that the situation had improved. He said: "I have never had anybody turned away who I thought was really seriously ill. From that point of view I could not say that they have refused admission of somebody. I have never phoned up and they have said 'We are full, we won't see them, phone this hospital."

366. The pressure on beds for acute psychiatric services cannot be seen in isolation from the level of community based resources available. We have, for example already drawn attention to the lack of an assertive outreach service within the Hackney area.

367. As we have indicated, the proposed introduction of an East London Mental Health Trust provides a good opportunity for the respective agencies to jointly review the current balance of community based and inpatient services in the light of the forthcoming introduction of the National Service Framework (Mental Health). (Recommendation 2(i), Page 46).

Other Resource Issues

368. Reference has been made elsewhere within the report to other resource issues which require attention. For the sake of completeness these are briefly summarised here:

- Improvement required to the accommodation of NWLMHT (Paras. 219 to 220, Page 51)
- Short term improvements to the Mental Health Link System. (Recommendation 4(i), Page 60)
- Investment in a new electronic record system for East London (Recommendation 4(ii) , Page 60)

Conclusions on Resources

369. ***In overall terms, the evidence suggests it is questionable whether ELCHA, the Trust and the Local Authority have at present sufficient resources to provide an acceptable level of service for all people with serious mental illness.***

370. ***Although ELCHA stated that, at the time of financial restraint in 1997, it gave priority to mental health services, there appeared to be a different understanding by the Trust over the protection of mental health budgets for severely mentally ill patients . It is a matter of significant concern that there were such fundamental differences of understanding over the financial position between the Trust and the Health Authority.***

371. ***In terms of medical staffing, there is clear evidence that medical staffing for mental health services in Hackney was grossly below the recommended levels and the Trust, following the Murphy Inquiry, has taken action to rectify the situation.***

372. ***There is evidence that the situation has improved in relation to the availability of acute psychiatric beds. However, there are still occupancy levels of over 100% and patients such as Feza M. appeared to have a low priority in being admitted. The proposed introduction of a single Mental Health Trust across East London provides the opportunity for the respective agencies, to jointly review the balance of community based and inpatient provision against the requirements of the National Service Framework (Mental Health).***

RECOMMENDATION 9

We recommend:

(i) That the Government should give recognition to the special needs in respect of Mental Health services in Inner London in its current review of the formula for the allocation of resources to Health Authorities.

(ii) That ELCHA should review its expenditure on Mental Health services in the light of the current evidence on the levels of expenditure for deprived areas in Inner London.

(iii) The Department of Health, ELCHA and the London Borough of Hackney should consider allocating resources to the Trust to establish an assertive outreach service.

(v) The Joint Management Board should be involved in any decisions concerning potential increases or reductions in resources to ensure each agency's perspective is taken into account.

(vi) Resources should be identified to improve existing accommodation and facilities for the NWLMHT.

MANAGEMENT

373. We have already considered the local operation and management of the NWLMHT and acknowledged, in setting events in context, that there were originally shortcomings in the detailed planning of the establishment of integrated LMHTs, in part caused by the speed of implementation required at that time. In particular there was no written agreement between the Trust and Social Services spelling out the responsibilities of each agency. (Paragraph 167 refers).

374. This section considers the broader management issues raised in the course of this Inquiry and the response of Senior Management. We start with consideration of the information available to managers through relevant internal and external audits of mental health services, then consider senior management awareness of deficiencies in the NWLMHT and action taken, the position of Social Services, monitoring, induction and appraisal arrangements.

Internal and External Audit

375. The panel analysed relevant District Audit, Mental Health Act Commission, CPA Internal Audit reports, as well as the results of two previous independent inquiries commissioned by ELCHA and the relevant Local Authority. (The Woodley Report, September 1995 and the Grey Report, November 1995). Internal reports from serious incident inquiries were also considered. A summary of the review of this material is attached at Appendix (F) What is clear from this review is that there was significant and ample evidence that there were major problems in 1995 and 1996 in implementing the Care Programme Approach as well as in other areas, for example case management, assignment of key workers, allocation and record keeping, all of which are familiar themes raised again by this Inquiry.

376. The panel heard evidence of attempts to address these problems and of improvements. For example the Trust had introduced in 1996 a well structured programme for training in CPA, with the introduction of the new tiered CPA procedures.

377. However our findings in relation to the NWLMHT would suggest that whilst plans for improvements were made, they were not always consistently and fully implemented, nor were there adequate systems in place to monitor performance.

Senior Management awareness of deficiencies in the NWLMHT and action taken by Senior Management.

378. It was apparent both from informal communications and from the official reports of the internal audit in 1996 that there were problems with the running of the NWLMHT.

379. Specific defects related to the failure to ensure that all relevant patients had been assessed for CPA, had been allocated a key worker, that cases were allocated on a rational basis, that supervision was provided on a formal basis to key workers and support workers and that concerns were being dealt with appropriately. It must therefore be asked: did middle and senior management know of these defects and, if so, what action was taken to improve the situation?

380. Clear evidence was given to the panel that all levels within the Trust hierarchy were aware that the situation in the NW team was not satisfactory. In relation to the District Audit Report the auditors had a feed back session with the Director of Priority Services and the difference between the NWLMHT's performance and that of the other teams in the allocation of patients to CPA was apparent.

The Director of Priority Services

381. IK, the Director of Priority Services told the panel about the action which he personally took as a result of seeing the District Audit Report. He agreed the draft report with the auditors and agreed on the recommendations, time scales, levels of priority and responsibilities for implementing changes. He then sent it out to all relevant people, along with a covering note, picking out key points. Then there was a session where the report was actually presented not just to the locality managers but also to other managers involved from the local authority and to some GPs. He remembered that the locality managers attended but was unsure whether any team leaders from the NWLMHT attended. He believed management objectives, based on addressing the deficiencies identified, were clear, and he had set out in writing objectives for the General Manager.

382. District Audit were then asked to come back, and did so about 12 months later, to do a re-audit and see the progress. A further report was produced which highlighted that significant progress had been made, for example in case load management and the allocation between different levels of CPA.

383. The one deficiency they still highlighted was that people were still finding it difficult to discharge cases. The failure to discharge was not seen as a problem specific to the NW team. A problem which was more specific to the NW was the general take up which IK saw as about something like 80 per cent as opposed to 95 per cent for the other teams. IK informed the panel he was aware of other problems in the North West, not covered in the District Audit Report.

384. He was told of these other problems by the General Manager, although he was not himself his line manager; that was Dr Louise Petterson, (Clinical Director for adult mental health services.) IK explained the dual responsibility for adult mental health services: if the General Manager had a problem with a locality manager and was not quite sure what action to take, he would refer that problem to both IK and Dr Louise Petterson. Other people had expressed concerns about the locality management for the NW.

385. In IK's words: "What became clear over a period of time was that it was likely we needed a change and that the usual management processes, whether you call it supervision, appraisal, objectives, or targeting did not seem to be working."

386. Asked if a letter had been sent to the locality manager setting out clear objectives, he replied "I suspect not, no. I am sure verbally it was done one to one. I know it was."

387. He accepted that the informal communication did not have the desired effect. He was anxious not to be seen as scapegoating any individual and stated that he thought the post of locality manager a very difficult job, "a very difficult time, for everyone. I think there were problems that anyone would have faced in that position, never mind the individual that happens to be there. I think we need to say that."

388. He accepted however that weaknesses at a particular middle management level and the lack of systems could have actually impacted on patient care. "I do not think there were adequate supervision arrangements, or adequate appraisal. It was hit and miss. I think that has changed to some degree."

389. At that time, the Trust did not have those management systems in place. Since then systems have been improved. According to IK, deficiencies are now well documented and timescales given for dealing with them.

The General Manager and his managerial role.

390. From the perspective of JK, the General Manager, the stumbling block in making any significant improvements in the NWLMHT, was that the locality manager was by training a social worker.

391. JK accepted that he had the responsibility, if a locality manager was ineffective, of having the right and the power to discipline that individual. However when he tried to exercise this responsibility he said he was

confronted by the fact that there was considerable support from officers within the local authority for the NW Locality Manager. He felt officers from Social Services did not quite understand the complexities of managing the locality team and they felt that the Locality Manager had done all that was expected of him.

392. He was aware from the criticisms from the District Audit Report of the position in the North West Team and the apparent contrast with the performance of the other teams which seemed to be more effective. He was asked if that was not evidence on which he could actually have tried to sort out the situation in the North West. For the reasons stated above, he felt the situation was made more difficult for him.

393. Eventually he agreed with officers of the Local Authority that the locality manager would be seconded back to the local authority, and that SH, who was a well established locality manager in the South East, would take over and manage the North West.. "to see if we could get to the bottom of it." The locality manager went to the Local Authority for three months in the middle of 1996. After three months he returned to the locality. "He was an employee of the Trust and it was very much down to us."

394. JK was responsible to the Director of Priority Services, IK and to Dr Louise Petterson and shared his concerns. JK considered that the issue was too sensitive to go down the ordinary disciplinary route. He agreed that his concerns were never put in writing and in hindsight accepted that he should have addressed this formally.

395. Asked if the locality manager was himself aware that there were concerns about his performance as a locality manager, he replied that: "I do not think he was, actually. I had a number of conversations with him where he failed to see how other people were seeing him as a person and his performance."

396. JK admitted that nothing was put in writing about deficiencies in performance. The situation continued until they reorganised. The locality managers were to manage the wards, and were re-interviewed and a new appointment made to the post of N W locality manager/Tuke Ward. No exit interview was held since these were not carried out as a rule or policy.

397. The panel gave JK an opportunity to respond to the criticism implied in the Murphy Inquiry on his personal responsibility for the NW problems.

398. He explained that whilst at the end of the day he did feel responsible for the systems in the North West Team, and he should have "sorted it", in the context described, this had been difficult to achieve.

Response of the Locality Manager to these criticisms.

399. RMcN subsequently told the panel and put in writing his response to the criticisms made in the Murphy report about his management of the NWLMHT. It must be said in fairness to him, that the panel was given no evidence showing that particular deficiencies were drawn to his attention in writing.

Social Services and Management

400. The establishment of the LMHTs was based on the secondment of ASWs (social services staff) and the transfer of both funds and responsibility for direct operational and management control to the Trust.

401. The District Audit of adult mental health services in Hackney carried out in 1994/5 (Summary report and action plan author Simon Perkins) made the following comments in its detailed Report: "the mechanisms by which the Trust and Social Services monitor and manage the LMHT needs to be clarified. Although the teams are working well, it is not clear how action would be taken if performance fell."

402. The truth of these comments is clear from the history in 1996 and 1997.

403. RH, who had been appointed as Mental Health Services Manager for the LA told the Inquiry that: "It was a complicated management structure, as I am sure you appreciate, when you try to have a unified multi-disciplinary team. There are certain legal constraints on that and the Local Authority had to maintain both the actual employment of the approved social workers because of the way the Mental Health Act is framed, and also to have a direct professional line to support their ASW status and training. That was part of my role."

404. Asked to what extent would she be involved if team members working in a LMHT were concerned about administrative arrangements and apparent disorganisation in terms of the allocation of cases and so on, she replied: "I would expect to pick up things like that through the regular discussions with the ASWs. I set up a quarterly ASW support forum which was really intended to look at issues arising out of the operation of the Mental Health Act in the district."

405. She was asked if in those meetings the ASWs raised with her any issues about the functioning of the LMHTs. She stated that: "Not that I recall that required me to actually get involved in anything specific." This statement is supported by the evidence of NE who told the panel that he did not bring up any issues relating to the NWLMHT with RH. Had she been made aware of these problems she told the panel that she would have taken it up with the Trust.

406. Her point of contact within the Trust was the General Manager, JK and she had very regular meetings with him, attending the general adult steering group, which was a meeting of the psychiatrists, ward managers, and clinical director. She also had weekly meetings with the General Manager and the Locality Managers once the new locality managers were in post in August 1997. She felt it was a good working relationship and she was not aware of any substantial difficulties in the NWLMHT or in other teams.

Monitoring

407. The evidence suggests there was limited monitoring of performance within the LMHTs. JK explained the monthly reporting system for staffing, vacancies, absence, sickness, turnover, but it was not divided by each locality. Management of budgets was delegated to locality managers who received monthly financial reports covering the Social Services Care Management Budget and the expenditure on Trust and Social Services staff.

Whistle Blowing

408. The panel was informed of the open culture that existed within the Trust promoted by Professor Murphy. Staff were encouraged to raise any concerns they had with whoever they felt appropriate within the organisation, including raising concerns about Senior Managers. However, there appeared to be no formal procedure in place for expressing concerns.

Induction

409. The panel heard evidence that the induction of key new staff, SD and J.Wa Locality Manager appointed in June 1997 had serious shortcomings. The limited induction programme for J.Wa was particularly surprising given the concerns the Trust had at the time of her appointment over the team's performance. J.Wa told the panel she felt it would have been helpful to have had some objectives set at the start and that she felt the ground had not been prepared for a change in management. She also complained she had not received copies of current procedures and policies and had to ask for these from staff. Whilst the panel heard different perceptions of the level of induction provided to her (including details of the Trust's half day induction for all staff), a more systematic approach to Induction was required. During the course of the Inquiry, a new induction system was introduced within NWLMHT for staff within the team and Tuke Ward. It would be useful if this induction document could also include reference to the current policies being used by the team listing them and ensuring that staff are given personal copies of those policies relevant to their work.

Appraisal

410. Written evidence from the Chief Executive of the Trust Ms. Dongworth showed that a new appraisal policy for the Trust was initiated in January 1998.

The material provided as part of the Investors in People initiative included a Staff Development and Appraisal Procedure, Standards for Conduct and Appraisal and Development Reviews. In the staff guide for the Personal Development Review the system of appraisal is linked to the supervision process.

Role of the Joint Management Board

411. The Joint Management Board, not established until 1996, is the means through which reporting arrangements, joint policies and joint monitoring arrangements can be effectively established and reviewed. The Board is now chaired by Nette Carder, Director of Adult Community Services of the London Borough of Hackney and the panel was pleased to hear that work was progressing on drawing up a formal written agreement between health and social services defining and clarifying respective responsibilities and that it was also reviewing all the policies and procedures of the LMHTs.

Conclusions on management

412. ***From IK's evidence management was aware of deficiencies but the systems of appraisal, supervision and objective setting were not in place in a formal sense and as a consequence middle and senior management were ill equipped to deal formally with the problems which presented.***

413. ***The General Manager also gave evidence that he was aware of difficulties within the NWLMHT but felt unable for various reasons, including the fact that the locality manager was, by background, a social worker, to deal effectively with the situation.***

414. ***There is no evidence that there was any clear management response by the Trust in the form of a written statement of improvements needed, or any clearly set management objectives to remedy the deficiencies in the NWLMHT.***

415. ***The transfer of all Social Services operational control and responsibility to the Trust and the lack of clarity over their responsibility if problems occurred, meant that officers of the Local Authority did not see themselves as having any responsibility for any deficiencies in the running of the LMHTs. This lack of responsibility and lack of clarity over the involvement of Social Services management made for a very difficult situation when the Trust felt inhibited in using ordinary disciplinary proceedings against a social worker or someone with a social worker background.***

416. ***Apart from audit inquiries and returns to ELCHA there were no formal systems of monitoring the functioning of the locality teams. Budget information was provided by finance. When the system of locality management was put in place, there was not an overall project plan and success or failure depended largely on individuals. Therefore when***

things began to go wrong in one particular locality there were no monitoring mechanisms to pick this up at an early stage and to deal effectively with it.

417. *Formal procedures for whistle blowing appeared to be lacking. The panel heard from senior managers that there is, in the Trust, a culture of openness and frankness even if formal procedures for making grievances known were not present.*

418. *In spite of this openness, we found evidence that extremely able, competent and dedicated members of locality staff simply left the service when things started to go wrong. This is a matter of significant regret particularly when recognising that recruitment to Inner City areas is very difficult at the best of times. This Trust could ill afford to lose such highly competent staff and the evidence would suggest that had there been mechanisms in place to enable staff to raise their concerns effectively at a more senior level in the organisation, good staff may have been retained and some of the problems we heard of might have been resolved earlier. There was no policy in place for holding exit interviews.*

419. *Until recently arrangements for performance appraisal appeared to be ad hoc. In their absence, senior and middle management appeared to be unable to make significant steps in changing known defects. In recent months a formal appraisal system has been introduced.*

420. *The absence of formal procedures of induction, appraisal, supervision and objective setting meant that when problems occurred, senior and middle management were not able to take effective action to deal with these and remedy known defects. Middle and senior managers had ample evidence that improvements were required, but despite good will and conscientious aims did not have the management tools in place to take effective action.*

421. *The situation was made more exacting by the fact that although day to day operational management and control of the integrated mental health services lay with Trust managers, they were reluctant to discipline or take effective action against employees with a social services background. Ultimately change was only effected through a major reorganisation. There is no clear evidence that the problems perceived by Trust managers were at that time discussed with social services officers in any formal way.*

422. *The establishment of a formal agreement clarifying the respective responsibilities of the two agencies in providing an integrated mental health service as well as a clear and strengthened role for the Joint Management Board should place both agencies in a stronger position to address the management issues identified. It is acknowledged also that substantial progress has already been made in a number of areas.*

RECOMMENDATION 10

We recommend:

(i) Work on a formal agreement between Health and Social Services to cover the integrated mental health services should be concluded urgently.

(ii) The Trust and Social Services should review the terms of reference, composition and functioning of the Joint Strategic Board. This should include a joint responsibility to analyse and act upon internal and external audits of mental health services.

(iii) The Joint Management Board should conclude its review of all policies and procedures for LMHTs by October 1999.

(iv) There should be a comprehensive jointly agreed Trust and Social Services induction programme with senior managers of the Trust and Social Services contributing to this and that core procedures should form part of the induction. The existing system should be reviewed to check its adequacy and monitored to ensure compliance.

(v) Both a formalised system of performance appraisal and a jointly agreed policy on supervision should be introduced by the Joint Management Board throughout the integrated mental health services of the Trust and Social Services.

SUMMARY OF FINDINGS

423. We have found that there were clearly failings in the care and treatment of Feza M. but it is not possible to assert whether or not the homicide would have been prevented if these failings had not occurred. We have heard that on the one hand he did not present as an alienated, unco-operative or non-compliant person unwilling to engage with services, although at times he proved elusive. In comparison to many other patients on the caseload of the NWLMHT, he was not seen as someone presenting a high level of risk to himself or to others. In the context of many demands being made upon an extremely busy team, he was not seen therefore as high priority.

424. However, we have also seen that a systematic assessment of risk, taking into account all the information available from a dispersed and incomplete set of records, never took place and there were therefore some significant indicators of risk missed. The Care Programme Approach should have provided for him an effective system of care planning and review, but as we have seen, the CPA practice of the team failed in his case, in particular when he was

discharged from hospital in September 1996, without consideration of his status under CPA and without allocation of a keyworker. The panel takes the view that he should have been allocated to CPA level 2 at this time and a co-ordinated care plan introduced. We also express concerns about existing CPA arrangements for patients assessed as CPA level 1 under the Trust's existing CPA policy.

425. We have also considered operational and management issues within the NWLMHT affecting its performance, as well as resource issues, including the lack of capacity to provide an assertive outreach service where this is required.

426. We found that the links between the Locality Team and other agencies and services could be strengthened, in particular in relation to Primary Care, Housing and voluntary sector provision. Further work was required by the statutory agencies to improve services to the Turkish and Kurdish communities, particularly in relation to the recruitment of Turkish speaking staff across both hospital and community team sites.

427. In our final sections we have considered the broader resource and management issues arising from the Inquiry.

428. Throughout this Inquiry, we were impressed by the commitment of staff from all the agencies to learn lessons from the events described leading to such a tragic outcome. We were impressed also with the work already undertaken and the decision of the Trust to act quickly to address one key recommendation of the Murphy Inquiry to enhance medical staffing. Our recommendations are intended to focus on the key areas where action can be taken to improve performance and thereby reduce the likelihood of a recurrence of a similar nature:

- **Action to improve Care Programme Approach policy and practice.**
  (Recommendation 1, page 41)

- **Action to improve the assessment and management of risk in East London.**
  (Recommendation 2, page 46)

- **Action to improve the operation and management of N.W. Locality Team.**
  (Recommendation 3, page 54)

- **Action to improve record systems to facilitate good practice.**
  (Recommendation 4, page 60)

- **Action to improve services to people with a dual diagnosis of substance misuse and severe mental illness.**
  (Recommendation 5, page 64)

- **Action to improve links with Primary Care Services.**
  (Recommendation 6, page 67)

- **Action to improve services to people from Turkish or Kurdish Communities and to strengthen links with LMHTs and relevant local voluntary organisations.**
  (Recommendation 7, page 74)

- **Action to improve communication and joint working between LMHTs and the Housing Department.**
  (Recommendation 8, page 79)

- **Action to address resource issues arising from the Inquiry.**
  (Recommendation 9, page 83)

- **Action to improve management performance and clarify joint accountability for Hackney's integrated mental health services.**
  (Recommendation 10, page 92)

429. We now expect ELCHA, the London Borough of Hackney and the City and Hackney Community Services NHS Trust to carefully consider the findings and recommendations of our report and to agree an appropriate plan of action. As part of this, we would also ask them to examine our recommendations with other relevant agencies in East London and with Central Government, given, in particular, their relevance to the proposed establishment of a single Mental Health Trust for East London.

APPENDIX A

Chronology of main events in FEZA M.'s care and treatment

1988-27/9/91
At least one admission to Hackney Hospital, Outpatient follow-up.

27/9/91
Discharged to care of GP. Failure to attend clinic.

31/10/91-13/2/92
Admission to PICU and Strauss Ward, Hackney Hospital initially under Section 2 of the Mental Health Act. Violence towards his wife. Diagnosis: Schizophrenia and possible pathological jealousy

13/2/92-19/1/95
Outpatient and CPN follow-up, Attended Junction Day Hospital from hospital discharge until April 1995.

19/1/95
Discharged to care of GP. Failure to attend clinic and default on depot injections.

9/3/95
Attendance at St Bartholomew's Hospital Alcohol Clinic, Referral to SE Locality Team

12/3/95
Overdose, Accident and Emergency Department, Homerton Hospital

21/3/95
Telephone contact with Alcohol Clinic, Report of threatening behaviour to a female staff member.

21/3/95-23/3/95
Attempted home visits by SE Locality Team

23/3/95
Attendance at Alcohol Clinic. Was thought to require admission to an acute psychiatric bed but was sent home as no bed was available.

24/3/95-27/3/95
Two home visits by SE Locality Team.

27/3/95
Arrest at DSS Office. Possession of a knife and possible threatening behaviour. Interviewed by police with a social worker. Released without charge

31/3/95
Transfer of Feza. M's care to NWLMHT due to boundary changes.

13/4/95
Home visit by members of the NWLMHT

21/4/95
Case closed to North-West Locality Team. No psychiatric follow-up arranged.

22/5/95-2/6/95
Admission to Hackney Hospital after attendance at the Emergency Clinic. Absconded from hospital a week after admission.

30/5/95
Home visit by Dr. K and ED, North-West Locality Team. Admission to an acute psychiatric bed felt to be necessary but delayed until the following day as no bed immediately available.

31/5/95-23/6/95
Admission to Duke's Priory Hospital, Chelmsford. Diagnosis: Paranoid Schizophrenia. JA undertook needs assessment and made a plan of care prior to discharge

23/6/95-6/10/95
Keyworked by JA of North-West Locality Team. Failed attempts to engage Feza M. with Darnley Day Centre. Default from monthly depot injections. 16 planned face-to-face contacts with Feza. M, of which only 3 occurred, before case closure on 6/10/95.

6/10/95-15/1/95
Feza M. dealt with by the North-West Locality team on a "duty" basis regarding housing, money and benefit problems.

15/1/95
Feza. M telephoned North-West Locality team duty, distressed and requesting depot injection. Depot given.

15/1/95-4/4/96
Regular attendance at North-West Locality Team base for monthly depot injections. Still held as a "duty" case.

4/4/96
Attendance at North-West Locality team base for injection. Stressed, insomniac, becoming isolated. Requested increase in depot medication. Depot given and medical review arranged. Still held as a "duty" case.

12/4/96
Attendance at Dr MS's Outpatient Clinic, Homerton Hospital. Noted to be becoming psychotic just prior to depot injections. Depot frequency increased to 3 weekly. Dr MS under the impression that JA is Feza M.'s Keyworker.

3/5/96-16/8/96
Regular attendance at North-West Locality team base and from 8/7/96 the John Scott Health Centre for 3 weekly depot injections. Still held as a "duty case"

2/9/96
Attendance at North-West Locality Team base requesting help with benefits. Noted to behave as if hallucinated but denied symptoms.

3/9/96-5/9/96
Admission to Tuke Ward, Homerton Hospital after attendance at Emergency Clinic. Hearing voices telling him to kill himself and burn his flat. Diagnosis: Paranoid Psychotic Illness. Depot frequency increased to fortnightly. No formal CPA review meeting prior to discharge. Ward staff under the impression that JAr is Feza. M's Keyworker.

5/11/96-1/8/97
Attendance at Depot Clinic, John Scott Health Centre for depot injections which continue to be prescribed at 3 weekly frequency, the recommended increase in frequency in the discharge letter not having been implemented. Attended late for depot injections on only 2 occasions, on each no later than one week. Still held as a "duty case".

11/8/97
Attendance at NW Locality Team Office with complaints about neighbours, problems with rent arrears and request for a loan. Introduced to SD who had just been appointed as his Keyworker.

11/8/97
Attendance at Dr MS's Outpatient Clinic, Homerton Hospital. Noted to be "mildly psychotic at present with bizarre paranoid delusions". Also that "He is using alcohol and marijuana heavily". Increase in depot medication frequency to fortnightly recommended. Advice on alcohol and marijuana use.

15/8/97
Home Visit by SD who noted Feza. M to be "deteriorating slightly".... "agitated and a little hypomanic". Also that he felt that people were against him. Discussed medication, housing and budgeting problems.

19/8/97
Home Visit by SD. Feza. M not sleeping, hearing voices telling him to do things including "setting himself on fire" and expressing bizarre delusional beliefs. Medication discussed.

22/8/97
Attendance at Depot Clinic, John Scott Health Centre for depot injection. Feza. M was again noted to be "a little agitated and hypomanic". This attendance was three weeks after his previous one.

27/8/97
Attendance at GP surgery for passport application. Noted that he "seems a bit more agitated".

29/8/97
CPA Review Meeting cancelled. SD on sick leave and Feza. M did not attend.

1/9/97
Letter from SD to Dr MS expressing several concerns about Feza. M including "continual agitation and degree of hypomania", poor sleep and appetite, poor self care, continued alcohol use, auditory hallucinations and bizarre delusions. Requested prescription to support increase in depot medication frequency and medical review.

5/9/97
Attendance at Depot Clinic, John Scott Health Centre, for depot injection. This attendance was two weeks after the previous one.

5/9/97
Home visit by SD. Noted that Feza. M was more agitated and that his mental state had deteriorated, had "lost a great deal of insight into his illness" and that his "auditory hallucinations appear worse". Noted that he had received depot on 5/9/97 and that this "may relieve his distress shortly". Planned to review case on 9/9/97 and, if no improvement, request medical review. CPA review meeting re-arranged for 24/10/97.

9/9/97
Attempted home visit by SD. Music heard in flat but Feza. M did not answer the door.

10/9/97
Attempted home visit by SD. Music heard in flat but Feza. M did not answer the door.

16/9/97
Telephone call from Stoke-Newington Police informing the team of Feza. M's arrest and requesting that an appropriate adult attend the police station to enable Feza. M to be interviewed.

APPENDIX B

The Terms of Reference (taken from HSG (94) 27 - The discharge of mentally disordered people and their continuing care in the community.)

The panel was appointed in September 1998 to investigate:

1. The care the patient was receiving at the time of the incident.

2. The suitability of that care in view of the patient's history and assessed health and social care needs.

3. The extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.

4. The exercise of professional judgement

5. The adequacy of the care plan and its monitoring by the key worker.

APPENDIX C

Appointment and Conduct of Independent Inquiry

Following the sentencing of Feza M. the East London and The City Health Authority in conjunction with the London Borough of Hackney Adult Community Services, and with advice from the NHS Executive and the Social Services Inspectorate of the Department of Health, determined that in order for independence to be seen to exist, an independent panel should be established under the Chairmanship of Professor Bridgit Dimond. Her appointment was followed by the appointment of Dr Peter Carter, (then) Chief Executive of North West London Mental Health NHS Trust and a qualified nurse, Dr Anthony Jolley, a consultant psychiatrist at Riverside Mental Health NHS Trust and Tim Watts, Assistant Director of Leicestershire Social Services, responsible for adult mental health services and a trained social worker.

The Panel agreed the procedure shown in Appendix C(i). Witnesses were invited to provide statements in advance of their interviews and many took advantage of this opportunity. Those witnesses who had appeared before Professor Murphy's panel were invited to agree a record of their evidence to that panel. All witnesses were provided with transcripts of their evidence and asked to revise them if any errors had been made. This report is based upon the statements of those witnesses, previously agreed evidence given to Professor Murphy's panel, the evidence given to this Inquiry and the records, procedures, policies and other documentation made available to the Panel, by officers of ELCHA, CHCST, and the London Borough of Hackney Adult Community Services. In addition the Panel visited Anita House, (the HQ of the NW LMHT,) the John Scott Health Centre, and the block of flats in which Feza M. resided, the Day-mer Turkish and Kurdish Allied Community Services Centre, Homerton Hospital and Rampton Hospital.

Acknowledgements

The panel wishes to thank sincerely Alvean Brown and Hilary Scarnell for their excellent support to the Inquiry and Sue Holland and Elaine Garratt for their secretarial assistance and the following:

Health Authority officers
The Chairman of the Trust and its officers
Local Authority Social Services and Housing staff
All those who gave evidence, whether still employed by these organisations, retired or in new posts
Members of voluntary organisations, Day-Mer Turkish & Kurdish Day Centre, Turkish Advocacy Services
Mrs F

Procedure adopted by Inquiry

1. The Inquiry will be held in private.

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

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

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

- a of the terms of reference and the procedure to be adopted by the Inquiry
- b of the areas and matters to be covered with them
- c requesting them to provide written statements to form the basis of their evidence to the Inquiry
- d that when they give oral evidence they may raise any matter they wish and which they feel might be relevant to the Inquiry
- e that they may bring with them a friend or relative, a member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness.
- f it will be the witness who will be asked the questions and who will be expected to answer
- g Panel members cannot be cross examined
- h evidence of witnesses will be recorded and a copy sent to them afterwards for them to sign.

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

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

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

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

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

APPENDIX D

Care Programme Approach and Keyworking

Circular HC(90)11 required District Health Authorities to implement the care programme approach envisaged in HC(88)43 for people with a mental illness and asked social services to collaborate with health authorities in introducing this approach and, as resources allow, to continue to expand social care services to patients being treated in the community."

The Care Programme Approach envisaged that the following key elements would be included:

"i. Systematic arrangements for assessing the health care needs of patients who could potentially, be treated in the community, and for regularly reviewing the health care needs of those being treated in the community;

ii. systematic arrangements, agreed with appropriate social services authorities, for assessing and regularly reviewing what social care such patients need to give them the opportunity of benefiting from treatment in the community;

iii. effective systems for ensuring that agreed health and, where necessary, social care services are provided to those patients who can be treated in the community."

Local arrangements need to consider:

- inter-professional working;
- involving patients and carers;
- keeping in touch with patients and ensuring agreed services are provided;
- the role of key workers.

Paragraph 16 of the annex to HC(90)23

"A particular responsibility of the key worker is to maintain sufficient contact with the patient to advise professional colleagues of changes in circumstances which might require review and modification of the care programme."

Health authority commissioning requirements:

In its Mental Health Strategy 1996 ELCHA defined the CPA as:
"An 'essential glue' which brings together community services, inpatient care, voluntary and local authority services for those with the most complex problems. For those with less complex but still serious problems it guarantees a consistent point of contact and regular review from the specialist services."

The 1996 strategy saw the key features of the CPA as being:

- a guaranteed assessment;
- an appropriate care plan;
- an agreed review date;
- a named keyworker;
- services to support their assessed needs.

The service agreement of 1995/6 and 1996/7 between ELCHA and CHCST required the Trust to implement the CPA policy.

The service specification of 1995/6 stated that:

"The CPA should form the basis of effective and sensitive discharge planning for in-patients to ensure the appropriate provision of "packages of care" in the community and that patients are not kept in hospital beyond the point at which they need direct medical or nursing care."

"Discharge planning should begin on admission. Effective liaison with social services... is essential so that the requirements of the CPA and Community Care Assessment are co-ordinated for the benefit of the patient. All clients should have a key worker who knows and understands their role."

Objective 7 of the service specification 1995/6 set out the requirement that continuity of care is ensured by complete implementation of the CPA; 9 targets are set, including a summary of the care plan being given to the client, the review of plans at agreed intervals and correct documentation of care plans . The community key worker has responsibility for ensuring the delivery of and client review. Audit of the CPA check list and other quality measures defined how compliance with the standards was to be assessed.

The Service Specification drawn up by ELCHA for 1997-8 for adult mental health services required the provision of "An integrated, high standard, comprehensive and accessible adult mental health service which meets the requirements of the Mental Health Act 1983, the Mental Health Code of Practice (1993), the Patient's Charter (1995), the Care Programme Approach (HC(90)23/LASS(90)11), Supervision Registers (HSG(94)5), Supervised After-Care (HSG(94)27) and the Patient's Charter for Mental Health Services (1997). The service will be client-orientated and sensitive to the needs of individuals, the carers, and significant others, and responsive to mental health needs of the communities in the area served.

In defining aims and philosophy of the general requirements, the specification states that:

"1.16 Within the Care Programme Approach, priority should be given to meeting the needs of people with severe mental illness."

Severe mental illness is defined in 3.2:

"Severe mental illness implies that an individual's mental or emotional well-being is likely to deteriorate to the point where he or she needs a significant level of intervention or is at risk of committing criminal behaviour and/or serious self-harm. The person lacks an adequate support system to restore him/her to an acceptable level of functioning; or that a person has required extensive treatment and support for a period of three months or more in the past two years; or presents with the medically recognised signs of a severe mental illness; ...."

Trust and Local Authority Policies

Trust and Local Authority policies reflected the ELCHA service specification and MG, who was appointed in October 1994 as the Care Programme Operational Manager, had the responsibility of introducing the CPA across the community mental health teams.

History and Developments

District Audit in 1994/5 and 1995/6 reviewed the progress that was being made in the implementation of the CPA and noted that there were concerns about the allocation of patients within the CPA.

These were followed up by ELCHA in its monitoring role.

ELCHA carried out quarterly monitoring of CPA implementation from late 1995 in response to a requirement from the NHS Executive.

The Chief Executive of ELCHA wrote on 16 November 1995 to the Chief Executive (then MF) of CHCST expressing his concern that East London had achieved the lowest grading in the fulfilling of CPA and he had been asked by the Regional Health Authority to provide details of the intended action locally to comply with the requirement for 100% CPA and the date by which that could be achieved.

He wrote

"I feel that it is now more than appropriate that I add my personal emphasis to giving this top priority, not as a bureaucratic formality but rather because it can ensure that appropriate co-ordinated care for individuals with high care needs, and for those with less severe needs gives the assurance of easy access back into services through a named keyworker if their needs change".

The Director of Priority Services for CHCST, IK, wrote to the ELCHA Commissioning Manager on 20 November 1995 replying to a request for further information about the CPA policy.

In his reply he stated that systems for monitoring CPA were far from ideal at the moment and it was planned to record CPA activity on the information system, Mental Health Link, by the beginning of January 1996 at the latest." The information recorded will include details of the three stages of CPA: Assessment, Care Planning and Review and will record the actual care plan. The system will also register review dates and issue automatic reminders as well as flagging up when reviews are overdue. For an initial period of 12 months, this information will be recorded centrally. Thereafter it will be done at source, both on the wards and in the community."

On the allocation of a community keyworker, he noted:

"Priority is given currently to those suffering from serious and enduring forms of mental illness. Once again, improved information systems will make monitoring of keyworker allocation easier."

By the end of January 1996 it was the intention to review all existing clients in the community and enter them into the CPA process and regular reviews could be monitored through the Mental Health Link. He stated that

"This process will also highlight anyone who does not have a nominated community keyworker and/or adequate care plan."

He estimated that the LMHTs had 1140 clients on the case loads (NE = 311, SE = 211, SW = 299 and NW =319).

A meeting was held on 20 December 1995 between ELCHA and CHCST which among other items considered the CPA Monitoring (and merger with care management policies).

The ELCHA Commissioning Manager reported to the NHS Executive on 3 January 1996 that in respect of Hackney Community Trust:

"Verbally Hackney state that 95% of people leaving hospital have a keyworker and full CPA. The 5% should be covered by moving in April to a tiered approach to CPA with three bandings commensurate with need and levels of future inputs of community services. Data is becoming more streamlined and a full report will be made to us as purchasers on 15 January to see if the 95% figure can be improved upon within current policies.

Community Team Caseloads are not yet all under CPA but an action plan has been initiated which will allow for this to happen by the end of January.

Hackney are looking to have all clients covered by the CPA by the end of January."

An internal progress report on CPA for ELCHA, prepared in January 1996 noted that 100% CPA had not been achieved because of patients taking their own discharge or because of premature discharge because of pressure on beds.

In Hackney during December 1995, 48/65 patients were discharged on the CPA with both a care plan and a named key worker. By holding CPAs shortly after admission, it was hoped to improve on this figure so that by 31 January 1996 100% of patients would by on CPA.

Tiering CPA introduced in 1996

Initial implementation of the CPA did not have a tiered approach and it was found necessary to review the CPA policy to achieve a more effective implementation. CPA mark 2 was introduced in 1996. MG, CPA Manager and PA, (who in January 1996 was seconded from St Bartholomew's Hospital for 14 months as a joint team leader in the south west LMHT and with the brief of working on the CPA) undertook CPA training and the development of the CPA manual.

The change was explained to ELCHA by IK in a letter to ELCHA Commissioning Manager on 29 December 1995 as follows:

"We intend to introduce a tiered CPA along the lines we discussed, in 1996. The 100% coverage is based upon the following:

All patients coming into hospital and being referred to LMHTs are assessed for CPA and placed on it currently. By the end of January all existing clients on LMHTs caseloads will have been assessed, care plans written up on appropriate documentation and registered on CPA."

MG told the panel that CPA came into operation in early 1995 and in the following six months it became fairly obvious that it was not a workable way of operating the CPA; and they needed to look towards a tiered system where they could identify more clearly those with high care needs from those with less high care needs. The criteria were agreed in early 1996 and the tiered approach was implemented in August 1996. Alongside that tiered process, defined roles and responsibilities were implemented. A summary of the tiered approach is attached.

Key worker and changing key workers

Definitions of keyworker:

One of the requirements of the CPA process is that each patient referred to the specialist mental health services should be allocated a keyworker as a result of the implementation of the CPA procedure.

The Care Programme Approach Manual (issued by The City and Hackney Community Services NHS Trust and London Borough of Hackney and Corporation of London Social Services in 1996 when revisions to the CPA policy took place) modifies this by stating that all patients on level II and III should have a keyworker. The role of the keyworker and the keyworker requirements are defined in section 7.1 of the Manual.

This includes the duty to: "Co-ordinate, monitor and review the implementation of the care plan and the CPA planning process and overall responsibility for ensuring that an agreed package of care is delivered to the patient."

The Manual states that all keyworkers will require access to regular support and professional supervision.

Core responsibilities of the keyworker are set out as are the knowledge core skills for levels 2 and 3

Designated contact person (DCP)

In some cases it was recognised that it may be necessary for the keyworker to identify a separate person to fulfil the role of designated contact person (DCP), when high levels of interpersonal contact are considered to be appropriate to ensure the needs of the patient are met and monitored effectively. Such a role could be carried out by a Support Worker in a community team. Section 7.1 emphasises in bold that: "The identification of a separate Designated Contact Person does not in any way dilute the above cited responsibilities of the Keyworker." Another instruction in bold in the Manual (para. 7.2) states that "It is particularly important for Keyworkers and DCPs to establish at community reviews who should contact whom if there is crisis, relapse or breakdown."

The Manual also states that a keyworker has to possess a recognised professional qualification and have experience in providing care for patients with mental health needs e.g. RMN, CQSW and OT. (Para Q11)

It was also a requirement that keyworkers received supervision. This is not further defined in the manual.

APPENDIX E

Review of relevant Internal and External Audits of Mental Health Services

External Audit
District Audit

1. An Audit of adult mental health services in Hackney was carried out for the local authority under the aegis of the District Audit in 1994/5. The summary report and action plan (author Simon Perkins) concluded that overall Hackney compares well with other local authorities and several areas showed good practice including that of being jointly managed by local authority and NHS Trust, and effectively targeting resources on severely mentally ill people Four areas were identified for improvement:

    - an above average number of approved social workers, not all of whom work directly in mental health; this brings into question issues concerned with their role and supervision;
    - needs assessment work is limited though developing slowly;
    - the implementation of the Care Programme Approach varies between sectors;
    - evaluation and performance review of services is limited.

    The action plan included the need to clarify joint reporting arrangements for LMHTs and noted that the new post of Mental Health Services Manager to oversee strategic development and take the lead on the joint commissioning of services was being created for the LA. The report noted specifically the absence of clarity over how action would be taken if performance fell (see section 11 of this report management). It suggested that further operational procedures were needed within LMHTs to ensure that responsibilities were clear.

    The 1994/5 Report noted that "whilst the SW team has achieved near universal implementation of CPA, less than a quarter of NW clients have a CPA; this is now being addressed."

2. The Audit for Adult Mental Health Services for the City and Hackney Community Services NHS Trust for 1995/6 (Summary Report, Action Plan and Presentation Andy Vowles July 1996) concluded that "the Trust's revised CPA policy follows good practice in a number of areas.

The introduction of three distinct tiers will be particularly advantageous, as this will ensure effort is focused on those most in need, and will improve the information available to managers." It notes the considerable variation in CPA implementation between the four locality teams. "Completion of documentation is also good, though some key data such as review dates, is regularly missing."

Key recommendations of the audit report included:

Actively manage caseloads by:

- using the new CPAs to apply weightings to caseloads;
- ensuring managers have up to date information on caseloads.
- Review how effective teams are in discharging clients from the caseload, to prevent workloads becoming unmanageable;

Ensure that the computerised register:

- contains complete information;
- is accessible to field staff;
- prompts key review dates;

The Audit found that the NW and SE teams had significantly more clients in category C (the most severe patients) than the other two teams.

It required the Trust to address in particular, in respect of case management: "the appropriateness of support staff, some of whom are untrained, working almost exclusively with people with severe and enduring mental health problems" and "the dangers of some individuals "burning out" as a result of working primarily with clients who have an exceptionally high level of need."

The Report also noted that only one team had an accurate caseload database, which could be used to ensure appropriate and equitable allocation of new cases.

It noted the dangers taking place across all teams of stacking, i.e new cases being taken on and very few clients being discharged. The Report warned: "if this interpretation is correct, the teams will in the future face major problems, as the workload may become unmanageable. To prevent this from occurring, it is important that the teams ensure that clients are discharged from the caseload where possible. In the longer term, it may be necessary to develop strong local networks which may be called upon to provide support to some clients, enabling specialist staff to reduce their input."

Its review of CPA noted that review dates were set in only 40% of cases (1995/6) and there were limited records of whether services were being delivered in line with the care plan.

The action recommended on the CPA was that: (a) a computerised register be complete, accessible and prompt review dates and (b) compliance with the new policy should be monitored across the four teams.

3. The Summary Report (Barry Purewal) on the follow up to District Audit of the Adult Mental Health Services City and Hackney Community Services NHS Trust 1997/8 was published in September 1998. It concluded from its audit that whilst the Trust had worked hard on managing caseloads and had adopted a more consistent approach to applying weightings to cases, it had had little success in effectively discharging clients from its caseload, and the recommendation on a computerised register was "still ongoing."

"The Trust currently still employs a manual register system as a result of trial runs of a computerised system producing unforeseen problems and not being able to cope with the demands placed upon it."

The Report recommended that the Trust focus on:

- Establishing a close relationship with local services to enable staff to become more effective in discharging clients;
- maintaining workloads at a manageable level;
- ensuring that a computerised register system is in place as soon as possible.

Internal Audit

A City and Hackney Community Services NHS Trust internal audit of CPA was conducted by MG (CPA manager) and SL (Clinical audit facilitator) and published in June 1997. It concluded, noting the small sample size, that there is significant room for improvement with regard to the completion of care plan forms. Information which was not specifically requested on a form such as outcome of actions which should have been taken following a review, or patient specific signs of relapse, was not provided. Attendance at meetings is varied. None of the GPs invited to attend CPA Meetings actually did so.

Recommendations included modifications to the CPA form, more training and revisions to the audit process.

At the time of the panel hearings, MG told the panel that an internal audit of the functioning of the LMHTs and the allocation of CPA levels was being conducted but the results were not at the time available. A further audit, which had been delayed by the Ethics Committee, was to undertake user interviews, but this has been temporarily put aside.

The Trust is also a participant in the Inner Cities Group of inner city mental health Trusts who meet to compare services, delivery, access to services, carer and user involvement, waiting times and to develop bench marking.

Mental Health Act Commission (MHAC)

Feza M. was admitted under section 136 in 1990, and under section 4 Mental Health Act 1983 on 31 October 1991, though there are no section papers in the records to confirm the dates. The section 4 was converted to section 2 but he was never placed under section 3. He therefore did not come within the provisions of Section 117 which places upon health and social services a statutory duty to provide after care, nor would he therefore have come within the category of patients placed on the supervision register, nor did he legally come under the provisions of the Mental Health (Patients in the Community) Act 1995. It is unlikely, therefore, that he was ever seen by the Mental Health Act Commission and he was only within their sphere of concern when under section 2. The observations made in the MHAC post visit letters to Homerton are, however, relevant to CPA, (under which Feza M. should have come) and to other issues raised in this Report.

The MHAC Report following the visit on 27 June 1997 to Homerton Hospital noted that: "The documentation for the Care Programme Approach - forms and checklists - is clear and appears to be well used by staff. Commissioners had some concerns about whether key worker allocation always happens at the appropriate time and whether this is documented accurately."

The MHAC Report following the unannounced visit to City and Hackney Community Services NHS Trust 8 January 1998:

"Risk Assessment/Care Programme Approach:
Questions were raised as to when the assessment was first completed and where the forms were kept."

The Commissioners noted that on Bevan ward the requirements of the CPA were not taking place on the ward because patients were transferred to an open ward prior to discharge. "Commissioners pointed out to management that patients could be discharged from that open ward the day after the transfer, with no CPA/Section 117 and no risk assessment. One Patient's most recent CPA meeting was 18 months ago."

Commissioners were also told that some CPA takes place in the community. These patients' CPA records are therefore not on their ward files for reference within the hospital. On Brett and Tuke Wards, the key worker in the community keeps some documentation, even if the meetings take place on the ward.

"..... Management told Commissioners that a draft risk assessment policy is hoped to be in place within three months. They look forward to seeing a more coherent approach throughout the hospital at their next scheduled visit."

The MHAC Report following the visit to Homerton Hospital on 28, 29 May and 5 June 1998:

The Commissioners were told of bed occupancy levels running at around 100%, with leave beds being used taking the occupancy rate to 130%.

"Managers informed commissioners that the four locality consultants are working with catchment areas way in excess of national norms in an area with the highest psychiatric morbidity in the country. The caseloads of CPNs and social workers are described as excessively high."

Concerns about the high proportion of detained patients, around 50-60% of the patient population which created additional pressures on all staff were also notified to Commissioners. "In addition, a large number of Turkish patients with complex social needs in the area covered by the NW LMHT is putting additional pressures on the service."

Commissioners were also notified of the problems presented by those with concurrent mental health and drug abuse problems and the lack of specialist services.

"Information about the CPA indicated that it was rarely initiated until shortly before discharge. On Mermaid Ward, the record of a pre-discharge meeting stated that CPA was complete, but there was no evidence on the file that the documentation had in fact been completed. They reminded the Trust that CPA is a continuing obligation, which should be initiated soon after admission of the patient to hospital.

Commissioners accepted that the requirements of CPA were being addressed but that the recording left considerable room for improvement."

Reports from other internal serious incident inquiries.

1. A report into the suicide of E F on 23 September 1997 who was discharged from Homerton Hospital under CPA arranged by the SE locality team.

   The issues which arose included:

   - no locality representative at the CPA meeting;
   - no entry in the locality notes about the annual leave of the keyworker and any handover of the case;
   - failures to contact him and assumptions about where he was;
   - Records note that the patient was noted to be "anxious and on the verge of relapse" but no action noted;
   - repeated appointments arranged for a client with a history of not attending pre-arranged appointments;
   - need for a policy for handover arrangements covering leave etc;
   - need to clarify the responsibilities of the duty worker.

2. A report into the death of a patient S C discovered at home 7 October 1997 raised the following issues:

- transfer of responsibility between two locality teams: NW to the SW;
- many visits and letter eliciting no response between his move to a new home and therefore transfer to the SWLMHT (c. June/July 1997) and 7 October 1997 when police found the patient dead;
- joint visit of the two teams, but patient not in, and records simply transferred across;
- Turkish patient reluctant to have contact with Turkish Day Centres because they were too political for his liking;
- the key worker responsible left the team suddenly and no-one took responsibility for her case load;
- the Report recommends that where staff leave a LMHT suddenly, the team leader should take responsibility.

3. A report into the death of a patient, Mr C at home following inability of the meals on wheels person to contact the client on 11 November (the patient was found dead on 3 December 1997) raised issues for the NE locality team on:

- failure to record client contact and other communications;
- failure to check the accuracy of an alleged sighting;
- the need for a policy on when to obtain access to a patient's home;
- the need for a rationale to standardise CPA levels according to the Trust criteria;
- the need for mental health practitioners to give more weight to the concerns of external agencies.

4. A report on the death by jumping of Mr Ch. on 14 November 1997 advised that a full independent inquiry was "unnecessary as it would not add to our understanding or examination of the evidence." However it raised serious issues including:

- the absence of CPA for a person liable to self-harm;
- no planned follow up following discharge;
- the absence of any person responsible for keeping his care under observation;
- evidence of his refusal of a residential placement;
- the need for a policy on the management of patients who deliberately self-harm.
- The report also showed no involvement of social services in the internal inquiry.

Both the reports of Mr C and Mr Ch. illustrate the effects of unmet need in Hackney i.e. patients outside the CPA, for whom there is no regular contact with statutory services who are vulnerable to self-harm, but for whom no policies nor resources exist. These 2 reports highlighted the following issues:

- Need for policy on when to secure access;
- need for policy on self-harm as part of risk assessment policy;
- need for resources for the outreach service for difficult to access clients.

5. A Report on the death of B R 28 January 1998 found dead in his flat under the care of the NELMHT. This raised the following issues:

- failure to achieve contact with him between 12 January 1998 when he had asked for admission to Homerton Hospital and took up but then left the respite Centre (Nile).
- Not seen after that despite home visits.
- Forced entry with the Housing Department led to the discovery of his death on 28 January 1998, police having refused to force entry on 27 January 1998.

The Report recommends more effective joint working with Housing and Police.

Results of previous inquiries held into ELCHA and its providers:

Woodley Report September 1995

The Independent Inquiry investigated the homicide on 27 July 1994 by SL of BB, both men being mental health users. SL was under the care provided by Newham Social Services and City and East London Family and Community Health Services.
Its recommendations are relevant to the care of Feza M. in the following areas:

- Race and ethnicity: the report expressed concerns about the lack of response to the race and ethnicity dimensions of SL's health care.
- Pressures on services and resources:

Relevant recommendations to this inquiry include:

Housing:

1.6 That the housing agency must notify the service user's key worker/care manager of the name of the housing officer who will have most contact with the service user, and of the housing management support role they perform. Thereafter, the key worker/care manager must ensure that effective liaison is maintained with the housing officer.

Finance:

5.9 that the Government increase the level of funding to the Social Fund for community care grants in areas of high need for mental health service users.

Day care services:

5.12 That large institutional day centres should be reprovided in local areas.

5.13 That assessment of an individual's day care needs should form part of comprehensive assessment (through the care programme approach or care management) and individual care plans devised which tailor services to the needs of individuals. In consequence, the traditional method of referral by day centre application form should be reviewed.

S.117, Care Programme Approach and Care Management:

5.23 That social services and district health authorities promote the involvement of voluntary organisations run by black and other ethnic minority groups in aftercare planning for inpatients from these communities.

The Grey Report November 1995

This concerned KG who murdered his mother. He had been discharged from section 2 of the Mental Health and soon went missing from the hospital. After having been without any contact with mental health services for 30 days he murdered his mother.

Relevant recommendations for this inquiry include:

22. A link should be established between the patient and a member of the LMHT from the time of admission until the time a key workers is allocated if a key worker is considered necessary;

27. A case should never be closed and a patient discharged from mental health care in ignorance of the patient's present health and welfare;

28.

29. The (City and Hackney Community Services NHS Trust) should ensure that the CPA is fully implemented in line with national guidance, that its implementation is fully audited using available audit tools, and that staff are fully trained to ensure that both the spirit and the letter of the CPA are embraced and adopted.

29 All existing procedures should be reviewed in the light of the discussion and recommendations contained in this report. If there are no procedures in place for areas highlighted in this report, they should be devised and implemented.

APPENDIX F

List of Witnesses

Mrs. F.	-	Mother of victim
Mr. Feza M.	-	Subject of Inquiry

Witnesses of Fact

JA	-	Acting Locality Manager, formerly Social Worker
RH	-	Former Head of Mental Health Services, LBH
MY	-	Turkish Development Worker/Interpreter, NWLMHT
RA	-	RGN, SWLMHT
NE	-	Team Leader
SD	-	CPN (secondment)
Dr. S	-	Consultant Psychiatrist
PA	-	Team Leader
J Wa	-	Locality Manager
RMcN	-	Locality Manager
JK	-	General Manager
Dr. T	-	Consultant Psychiatrist/Medical Doctor
ED	-	Team Leader
IK	-	Director of Priority Services
AP	-	Keyworker
HR	-	Support worker/keyworker
MG	-	CPA Manager
Dr. MH	-	Feza M.'s GP
PCOK	-	Co-Ordinator, Day-Mer Turkish & Kurdish Day Centre

Witnesses of local knowledge (current or positions at time of incident)

Mr. P. Coe, Chief Executive ELCHA
Dr. B. Jacobson, Director of Public Health, ELCHA
Mr. J. Wilkinson, Mental Health Strategic Manager, ELCHA
Ms. N. Carder, Director of Adult Community Services LBH.
Ms. J. Mosely, Former Director of Social Services, LBH.
Mr. E. Roberts, Former Assistant Director of Social Services, LBH.
Mr. S. Latham, Estate Management & Development Department, LBH.
Ms. A. Dongworth, Chief Executive, City and Hackney Community Services NHS Trust.
Professor Murphy, Chairman, City and Hackney Community Services NHS Trust.
Dr. Louise Petterson - Clinical Director, Adult Mental Health
Ms. N. Tas, Turkish Health Advocacy Counsellor.

Written evidence included: policies and procedures of the Trust and Social Services, commissioning specifications, audit reports, MHAC visit reports, reports of serious incident inquiries.

Members of the panel visited Rampton Hospital, Anita House, (HQ of the NWLMHT), John Scott Health Centre and Day-Mer Turkish and Kurdish Community Solidarity Centre

APPENDIX G

Letter to witnesses

Committee of Inquiry into the care and treatment of Feza M.
Strictly personal and confidential
To ..

Dear

Request for evidence from Witnesses

The East London and The City Health Authority and the London Borough of Hackney Social Services authority has set up this Inquiry after discussion with the National Health Services Executive and Social Services Inspectorate. The members of the Inquiry Committee are myself as chairperson, Dr Anthony Jolley, Consultant Psychiatrist, Riverside Mental Health NHS Trust, Mr Peter Carter, Chief executive of North West London Mental Health NHS Trust and a registered nurse and Mr Tim Watts Assistant Director of Social Services Leicestershire Social Services Department.

Copies of the Terms of Reference set for the Inquiry and of the Procedure adopted by the Inquiry are attached for your information.

(We are aware that you gave evidence at the internal inquiry set up by the City and Hackney Community Services NHS Trust and have been given a transcript of that evidence). We consider (however) that there is (further) evidence on which you can assist this Independent Inquiry and would therefore request you to attend a Hearing on .... in order to provide oral evidence. If however this date is not possible please discuss with Hilary Scarnell or Alvean Brown, administrative support to the Inquiry, alternative dates to attend. Your reasonable travel expenses and subsistence costs arising from your attendance at the Inquiry will be reimbursed. The hearings will be held at the offices of East London and the City Health Authority at 81-91 Commercial Road London E1 1RD.

When giving this evidence you may be accompanied by a friend or relative, trade union representative, lawyer or member of a defence organisation, or anyone else with the exception of another Inquiry witness. However it is to you that questions will be directed and from whom replies will be sought. Your oral evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign and return.

In order to shorten time on oral evidence, and to help clarify issues before the Hearing, we would ask you to provide a written statement, to supplement the evidence you gave at the internal inquiry, covering the following topics:

(specific topics for individual witnesses)

Any other information within your knowledge which is relevant to the terms of reference of the Inquiry.

The consent of Feza M. to the disclosure of his records relating to his care and treatment is being sought. I shall notify you if there are any delays in securing this, which will necessitate a postponement of the date of interview.

I would like to thank you for your co-operation and assistance. If there is any matter in addition to the above on which I can give further explanation, please let me know.

I look forward to meeting you.

APPENDIX H

Dates of meetings

10 September 1998
16 October 1998
10 November 1998 interview
19 and 20 November 1998 interviews
25 and 26 November 1998 interviews
3 and 4 December 1998 interviews
14 December and 15 December 1998
26 January 1999
4 February 1999
23 March 1999
5 May 1999
15 July 1999

APPENDIX I

Abbreviations

ASW	Approved social worker
CHCST	City and Hackney Community Services NHS Trust
CPA	Care programme approach
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
DCP	Designated Contact Person
DGH	District General Hospital
DSS	Department of Social Security
ECR	Extra-Contractual Referral
EHR	Electronic Health Record
ELCHA	East London and The City Health Authority
FHSA	Family Health Services Authority
GP	General Practitioner
HCA	Health care assistant
LMHT	Locality Mental Health Team (NW, NE,SE, SW)
MDT	Multidisciplinary team
MHA	Mental Health Act
MHAC	Mental Health Act Commission
MSU	Medium secure unit
OT	Occupational therapist
OPD	Out-patient department
PCG	Primary Care Group
PICU	Psychiatric Intensive Care Unit
RMO	Responsible Medical Officer
SEN	State Enrolled Nurse
SHO	Senior House Officer
SMI	Serious Mental Illness
S/N	Staff nurse

APPENDIX J

Bibliography

Audit Commission Finding A Place: A review of Adult Mental Health Services in England HMSO November 1994

Blom-Cooper et al Report of Inquiry into Ashworth Hospital 1992

Blom-Cooper et al The Falling Shadow: One Patient's mental health care 1978-1993

Report on Inquiry into the incident at the Edith Morgan Centre Torbay on 1 September 1993 London Duckworth 1996

Blom-Cooper et al The Case of Jason Mitchell: Report of the Independent Panel of Inquiry Duckworth 1996

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

Department of Health The Health of the Nation: Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. February 1996 Department of Health.

Department of Health Joint health/social services circular. "Caring for People" The Care Programme Approach for people with a mental illness HC(90) 23 Department of Health 1990

Department of Health Code of Practice on the Mental Health Act 1983 second edition Department of Health and Welsh Office 1993

Green paper Developing Partnerships in Mental Health February 1997 HMSO

The Grey Report Independent Inquiry Report to East London and the City Health Authority November 1995

Holwill Derek et al The Mabota Report Redbridge and Waltham Health Authority September 1996

Home Office Circular No 66/90 Provision for Mentally Disordered Offenders 1990

Home Office Circular No 12/95 Mentally Disordered Offenders: Interagency working 1995

Jones Richard Mental Health Act Manual fourth edition Sweet and Maxwell London 1994

Lingham Richard et al Report of the Inquiry into the treatment and care of Raymond Sinclair West Kent Health Authority June 1996

King's Fund Report on London's Mental Health Eds Johnson et al Executive summary by David Coldberg King's Fund 1998

Mishcon Jane et al The Hampshire Report Redbridge and Waltham Health Authority May 1996

NHS Executive HSG(94)5 introduction of Supervision registers from mentally ill people from 1 April 1994.

NHS Executive HSG(94)27 Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community

Peay Jill Inquiries After Homicide Duckworth 1996

Reed Chair Department of Health and Home Office Review of health and social services for Mentally Disordered Offenders and others requiring similar services

Final summary report CM.2088 HMSO London 1992

Ritchie J, Dick D, Lingham R, The Report of the Inquiry into the care and treatment of Christopher Clunis HMSO 1994

Royal College of Psychiatrists Report of Confidential Inquiry into Homicides and Suicides by Mentally Ill People. 1996

The Sainsbury Report: Keys to Engagement: A review of care for people with severe mental illness who are hard to engage with services 1998

Sims A Chair Clinical Standards Advisory Group Report of the CSAG Committee on Schizophrenia Volume 1 HMSO 1995

Trotter Report of the 1997 Inquiry into the Trotter Affair, presented by JK Barratt January 1998 London Borough of Hackney

UKCC Position Statement on Clinical Supervision for nursing and health visiting UKCC 1996

White Paper The New NHS Modern Dependable The Stationery Officer 1997

White Paper Modernising Mental Health Services Safe, sound and supportive 1998

The Woodley Team Report of the Independent review Panel to east London and the City Health Authority and Newham Council September 1995

The Zito Trust Learning the Lessons second edition July 1996 Zito Trust

An Executive Summary of this report is also available.
If you would like a copy, please contact:

Ms Alvean Brown
Administrator
East London and the City Health Authority
Aneurin Bevan House
81-91 Commercial Road
Lodon E1 1RD

Telephone: 0171 655 6617