Strengthening the Net

An Independent Inquiry into the Mental Health and Social Services care given to Mrs Anne Murrie

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CHAPTER ONE

SUMMARY OF FINDINGS AND RECOMMENDATIONS

THE INQUIRY

1 On the night of 25-26 February 1994, Mrs Murrie took the life of her daughter, Louise Murrie. In October 1994, Mrs Murrie was sent to Broadmoor Hospital where she was detained with the diagnosis of psychopathic disorder, following her conviction for manslaughter.

2 In May 1996, a Panel of Inquiry was convened by Berkshire Health Authority.

3 The remit and methodology of the inquiry is explained in the following chapter. For the purposes of this summary, the panel's main objective was to consider the quality of care and the range of interventions provided for Mrs Murrie during the period leading up to the tragic event of Louise's death. The period in question is from 1991 to the index event in 1994. Ultimately, the panel sought to find out whether the health, social and probation services involved in Mrs Murrie's care or in the care of her family could have responded more appropriately or differently to Mrs Murrie with the result that their interventions may have prevented the death of Louise.

4 The panel studied a number of management and forensic reports before convening a series of interviews with managers and staff in health authorities, trusts and social services agencies in the South Oxfordshire and West Berkshire area. The panel also interviewed a court welfare officer, and Mrs Murrie herself. The final interview was conducted in July 1997.

5 This is a summary of the main findings and recommendations following the Panel of Inquiry's investigation. The panel's account and interpretation of all the evidence taken during the process of its inquiry is reported in detail in subsequent chapters.

FINDINGS

6 The Panel of Inquiry finds that the healthcare professionals and social workers employed by the health and social services agencies in the West Berkshire and South Oxfordshire, were generally solicitous in the way they provided care for Mrs Murrie, particularly in the context of the generally insufficient resources that were available to them.

7 The panel believes that it is important to place the work of individuals involved in Mrs Murrie's care in the context of the state of strategy and organisation of the mental health services at the time. The quality and appropriateness of their interventions depended on the quality of:

- mental health strategy in place within the relevant health authorities, NHS trusts, social services and housing departments and non-statutory agencies;
- the way services were deployed and resourced to implement this strategy, including the number, allocation and availability of staff, and
- working practices within and between the relevant agencies.

Mental Health Strategy and Organisation of Services

8 As regards the first of these, the panel finds that there were a number of strategic issues which affected the way professionals and front-line workers delivered services at the time:

- The mental health services available to the population of West Berkshire in the period between 1992 and 1994 were clearly in a state of flux. Inpatient services at Fair Mile Hospital in

Wallingford, South Oxfordshire were used by the health authorities responsible for purchasing mental healthcare for the populations of West Berkshire and South Oxfordshire. This was the only inpatient service available and it was being run down as part of a long-term plan to reprovide both inpatient and other services in the community. The run-down occurred at a time when, from all accounts, the range of mental health services in the Berkshire Health Authority area was variable in distribution and quality.

- The Berkshire Social Services Department and the West Berkshire Priority Care Service NHS Trust had few community mental health services to rely on in the relevant area, except for those provided at the Coley Clinic and Bucknell House in Reading.
- These facilities were, in the panel's opinion, gravely under-resourced in terms of the range and availability of staff.
- The introduction of the purchaser-provider system within Berkshire Social Services Department during the period in question appears to the panel to be have been more a hindrance than a help, at least during the period immediately preceding this department's involvement with Mrs Murrie.
- The organisation of health and social services in the South Oxfordshire and West Berkshire areas was - and to a certain extent remains - unhelpfully complex. Patients such as Mrs Murrie, who lived in or near Reading, bordering South Oxfordshire, had continuity of professional mental healthcare under the aegis of Berkshire Health Authority via services delivered by the West Berkshire Priority Care Service NHS Trust. This is because the Trust's boundaries of care extended from West Berkshire into South Oxfordshire. However, the same clients were referred between Berkshire and Oxfordshire social services departments, depending on their home address in the 'borderland' area that then lay west and north of Reading. The evidence presented to the panel shows that discharge procedures involving a transfer of care from Fair Mile Hospital to the social services department in Berkshire were properly and thoroughly carried out. The panel also understands that Berkshire and Oxfordshire social services departments were well used to referring clients across their borders, one to the other. However, the panel believes that the lack of coterminous boundaries of care between health and social services, when coupled with a general inadequacy of mental health service resources within the community, made the organisation of the care provided for Mrs Murrie more complex than necessary, particularly in the first six months of 1993.
- The panel found no evidence of a formal joint commissioning strategy for mental health services in the community in operation between health and social services (although there were examples of ad hoc arrangements).

Implementing a Programme of Care

9 The Care Programme Approach (CPA) was required to be introduced nationally during 1991. However, typical of the national as much as local picture, the protocols of care and case management required by the CPA had only partially been established in Berkshire between 1992 and early 1994. Nevertheless, the panel assessed the programme of care provided for Mrs Murrie against the protocols of the Care Programme Approach (CPA) as identified in Department of Health guidance HSG (94) 27.

10 The panel was particularly keen to see how the care provided for Mrs Murrie met the requirements laid down in HSG (94) 27 to establish the following essential elements in any package of care:

- systematic assessment of health and social care needs bearing in mind immediate and long-term needs;

- a written care plan agreed between the patient, his or her professional staff or carers;
- the allocation of a key worker;
- regular review of patient's progress and their health and social needs; and
- satisfying all these conditions in the event of transfer before discharge is made.

11 In order to institute systematic assessment of health and social care needs, the CPA requires close inter-disciplinary and inter-personal working. The panel finds that, although there were instances of good communication and close inter-disciplinary working, it does find fault in the degree to which 'systematic' assessment of Mrs Murrie's health and social needs was generally in process. The panel believes that there was no embedded mechanism to ensure systematic assessment. Such a mechanism would have helped to formalise inter-agency communication and collaboration.

12 Similarly, while there was review of Mrs Murrie's case, there was no system in play to ensure regular or systematised review. The exchanges of information made between professionals about Mrs Murrie appear to be the result of professional discretion rather than of any protocols laid down by the CPA. However, while the panel firmly advocates the use of formal cross-agency reviews in any situation where an individual appears to be at risk or particularly vulnerable, the panel is equally aware that:

- protocols concerning the use of formal cross-agency risk assessment were only then emerging; and
- until the very last stages of the case, it is doubtful whether a formal cross-agency risk assessment would have been warranted.

13 As concerns discharge procedures, the panel finds that Mrs Murrie's discharge from Fair Mile Hospital on 1 March 1993 was faultless and is an example of good professional practice. NHS trust staff at Fair Mile Hospital and social services staff at Oxfordshire Social Services Department made separate referrals, both thorough. Berkshire Social Services Department responded quickly, ensuring that an initial assessment was carried out within a few days of receiving the referral. Furthermore, the same consultant psychiatrist, who was responsible for Mrs Murrie's care while in hospital, continued to see her periodically as an outpatient after her discharge.

14 A key worker was allocated in the person of a care manager/approved social worker in the Reading Mental Health Team based at the Coley Clinic.

15 The main shortfall in terms of complying with CPA requirements was the lack of a written care plan. In the panel's view, a written care plan is a most significant component of care in the community. It is a means of embedding systematic review, a means of recording and commenting on interventions and therefore a useful basis of progressive case communication and collaboration between health and social services. However, although the care plan was not a written one in this case, the key worker did organise and continue to be responsible for a programme of care for Mrs Murrie. This mostly involved meetings for Mrs Murrie with the community psychiatric nurse (CPN) at Bucknell House; it also involved occasional communication with Mrs Murrie herself and organising appointments with her consultant psychiatrist.

16 The panel finds that there was evidence of a lack of effective communication both between agencies involved with Mrs Murrie and within agencies themselves. As part of this observation, the panel found evidence of individuals working in relative isolation. In particular, the panel believes that the local authority adult mental health teams tended to operate at a remove from children and family teams within their own social services departments. In Mrs Murrie's case, those who tried to engage with her tended to do so solely on the basis of what they - and she - perceived to be her needs. With relatively few exceptions, no one was sufficiently concerned about how Mrs Murrie's behaviour - often markedly anti-social and sometimes irresponsible -

may have affected her daughter. However, the panel has the benefit of hindsight in judging that it may have been useful to involve members of the children and family team in order to treat Mrs Murrie more 'holistically' in terms of her needs and those of her family.

17 Again, with the benefit of hindsight, the panel considers that the lack of communication between the court welfare officer and the key worker or with other health or social services professionals - and vice versa - is evidence of an ineffective system of communications. This again signifies unnecessarily isolated working practices. The court welfare officer's telephone discussions with Mrs Murrie (who was then clearly highly distressed), some weeks after the cessation of her formal engagement with Louise and the family during the enforcement of the Family Assistance Order, were not communicated to the key worker. Nonetheless the key worker had, at this stage, been sufficiently concerned about what appeared to be Mrs Murrie's volatile state that he had arranged for Mrs Murrie to see her consultant psychiatrist. Had the court welfare officer also communicated her concern about Mrs Murrie, there would have been a greater sense of urgency to act and a formal cross-agency review may have been convened. However, at this very late stage in the events preceding Louise's death, the panel believes that such a review is unlikely to have come soon enough to have prevented this tragic outcome.

18 To be set against any criticism of the way Mrs Murrie's care appears to have been managed, the panel acknowledges that Mrs Murrie was consistently difficult to engage. All those who dealt with her, in all the agencies concerned, found it very difficult to develop a relationship with her. In the circumstances, much of the care that was provided, and much of the personal effort put in by a number of individuals, reflects well on these agencies. Mrs Murrie presented as a woman who was extremely self-obsessed, often exhibiting histrionic behaviour and generally unable to perceive the point of view of others. All those who tried to work with her believed her to be a generally good mother to Louise, for whom she professed great love and who became the increasing focus of her hopes. No one at any time perceived that Mrs Murrie would harm Louise.

19 The panel questions whether anyone, operating with or without substantial resources at their disposal, with or without an effective strategic plan for mental health services, with or without full compliance with the CPA, would have perceived the risk to Louise. In the panel's view the degree of Louise's vulnerability could not have been foreseen by the individuals and agencies involved in Mrs Murrie's care. There may, possibly, have been more likelihood of preventing this tragic outcome if there had been greater inter-agency communication and a more holistic approach taken to the care of Mrs Murrie. However, although the panel finds that systematised communication was lacking in some key aspects, its own view is that even the most ideal cohesion of services is unlikely to prevent the unforeseeable.

20 The Panel of Inquiry's view is that there are some hard lessons to be learnt from this case. The hardest of all is the possibility that this kind of tragedy could happen again. No amount of organisational efficiency, staff training or forward-planning can account totally for the actions of a volatile individual who is perceived as a moderate priority because of a known risk of self-harm. However, actions can be taken to assess and diminish the risk of harm. Also, the panel believes that there are lessons to be learned from this tragedy, not only within Berkshire and Oxfordshire but at national level too.

RECOMMENDATIONS

21 It is essential that Berkshire Health Authority, in concert with local authority services and provider organisations, continues to make the development of an effective mental health strategy a top priority. The strategy should enable the development of services that offer good access for general practitioners; a range of services to allow various types of treatment and support; and the ability to respond rapidly to crises. The strategy should also ensure adequate staff sources including the availability of skilled CPNs, consultant psychiatrists and psychologists, occupational therapists and trained care workers; and the availability of adequate community-focused mental health service facilities.

22 The strategic implementation plan should require:

- the full implementation and monitoring of the CPA;
- a systematically embedded means of communication and collaboration between statutory agencies;
- the means of ensuring effective communication and collaboration between those involved in packages of agreed care in the community and other direct contact agencies and institutions involved with the public, including emergency services, the judiciary and probation services, the police and schools;
- embedded mechanisms of cross-agency review and formal risk assessment for individuals deemed to be at risk, including assessments of family members, particularly children who may be vulnerable; and
- joint commissioning procedures to ensure seamless and appropriate delivery of agreed programmes of care.

23 All agencies concerned should note the impact that organisational change can have on the efficacy of services. Where change is necessary, agencies should seek to manage it with appropriate training and organisational development.

24 Berkshire Health Authority should continue with its plans to close Fair Mile Hospital in the near future while ensuring the effective reprovision of a sufficient range of services, including inpatient and outreach facilities, in the community before closing the hospital.

25 All statutory agencies in Oxfordshire and Berkshire should have their attention drawn to the role of the Court Welfare Service, and to the need to ensure effective communication and collaboration with this service, particularly in cases that concern children and families.

26 The Oxfordshire and Buckinghamshire Probation Service should review its policy and practices for communicating with other health, welfare and statutory agencies and ensure that there is systematic communication and collaboration with other agencies.

27 Health and local authorities should ensure that they adopt and follow the CPA not only to establish jointly agreed procedures for managing cases, but also to ensure that staff adhere to the use of written care plans.

28 Training should take place within health authorities, Primary Care Groups, NHS trusts, local authorities and probation services to encourage a holistic approach to the assessment of patients, particularly in cases where risk to children is suspected.

29 Social services departments and NHS trusts should pay heed to the use of multi-agency case review meetings as delineated in the CPA. In particular, the panel recommends that statutory agencies in Berkshire and Oxfordshire review their procedures for setting up formal, cross-agency case reviews.

30 Multi-agency risk assessment should be more formally established as a safeguard by the Family Proceedings Court. For example, the courts should require communication between relevant agencies in circumstances such as the discharge of a Family Assistance Order.

31 Area Child Protection Committees (ACPCs) should ensure that practitioners, working in child care teams and adult mental health teams, are made aware or are reminded of the importance of effective inter-agency communications; the relationship between mental ill health and child protection issues; and the emphasis that should be placed on risk assessment procedures.

32 Where children are implicated as being potentially vulnerable to significant risk or danger, the children and family sections of social services departments should always be advised and, if necessary, brought in to compliment those dealing with care packages for adults.

33 Many of these recommendations concern actions to break down the insularity of roles and approaches within and between agencies, and to ensure that there are effective systems for communication and collaboration within agencies. The panel suggests that the chief officers of the organisations concerned should establish a joint group to act on the recommendations in this report.

CHAPTER TWO

THE REMIT AND TERMS OF REFERENCE OF THE INQUIRY AND COMPOSITION OF THE REPORT

THE REMIT OF THE INQUIRY

34 Following the guidance offered in HSG (94) 27, and acting on the advice of the Department of Health, Berkshire Health Authority convened an inquiry in 1996. The remit reads as follows:

1 To examine the management reports and, if necessary, the circumstances surrounding the treatment and care of Mrs Anne Murrie by the mental health services, in particular:

- the quality and scope of her health, social care and risk assessments;
- the appropriateness of her treatment care and supervision in respect of:
- her assessed health and social care needs;
- her assessed risk of potential harm to herself and others;
- any previous psychiatric history, including drug and alcohol abuse; and
- the number and nature of any previous court convictions;
- the extent to which Mrs Murrie's care corresponded to statutory obligations, relevant guidance from the Department of Health (including the CPA Approach HC(90)23, Supervision Registers, HSG (94)5 and Discharge Guidance HSG(94)27, and local operational policies);
- the extent to which her prescribed care plans were:
  - effectively drawn up, delivered, and complied with by Mrs Murrie.

2 To examine the appropriateness of the professional and in-service training of those involved in the care of Mrs Murrie, or in the provision of services to her.

3 To examine the adequacy of the collaboration and communication between the agencies involved in the care of Mrs Murrie or in the provision of services to her; and between the statutory agencies and Mrs Murrie's family.

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

35 The authors of this report consider that it discharges the requirement under item 4 of the remit quoted above. Annexe A provides information about the framework of policy, guidance and statute relating to Mrs Murrie's care. The chapters that follow here cover items 1, 2 and 3 in depth.

METHODOLOGY

36 The inquiry was convened further to the guidance offered in HSG (94) 27, which is detailed in Annexe A. This guidance was published after the events leading to the death of Louise Murrie in February 1994. Nonetheless, the panel considers that the vast majority of the guidance in that document is relevant to this case. Furthermore, it is the panel's opinion that the guidance is endorsed by the sequence of events that took place in Berkshire between 1991 and 1994.

37 The Panel of Inquiry has explored the matters relating to the care of Mrs Anne Murrie required of it by the remit set by the Berkshire Health Authority. In order to complete its tasks (see Annexe B), the Panel has reviewed the documents (referred to in Annexe E) and taken evidence from selected individuals (listed in Annexe D).

38 The Panel of Inquiry interviewed witnesses, identified in Annexe D, during the period between 16 July 1996 and 25 July 1997. The panel wishes to stress that it did not take evidence under oath from these witnesses. The evidence given was recorded, and written summaries were signed off by the witnesses. This evidence has augmented the panel's understanding of the course of events, and the way that individuals responded to them. The panel has also made extensive use of the reports of the forensic psychiatrists and internal management reports prepared during 1994. Extracts from certain reports are printed in Annexe F, while all the documents considered by the panel are listed in Annexe E.

THE COMPOSITION OF THIS REPORT

39 Chapter Three is a summary of the events that led to the death of Louise Murrie to provide a context for the chapters that follow.

40 Chapter Four offers an account of the principal resources and agencies involved, including changes in boundaries affecting the provision of care, and a discussion of the panel's findings as regards the effects of organisational change on these agencies. This chapter then provides an account of the roles of each of the principal agencies involved in the commissioning or provision of Mrs Murrie's care.

41 Chapter Five provides a more detailed account of the events leading to the death of Louise Murrie. The weight of this material derives from evidence taken by the Panel of Inquiry, as well as from a synthesis of records set down in the four management and two forensic psychiatrists' reports (itemised in Annexe E). In this chapter, the panel strives to balance the need for transparency with the need to protect the confidentiality and privacy of the personal lives of Mr Murrie, Mrs Murrie and their children. Plainly, compilation of certain personal details has been unavoidable in making this report and in providing a coherent account to support observations relating to each of the issues in the remit. The Panel of Inquiry is aware that repetition of these items and their presentation in a public document are likely to cause further pain and anguish to a number of people, including extended family members, who have been deeply hurt already. Certainly, the wish of the panel is not to cause further distress and so, wherever possible, the revelation of details has been restricted to those that appear to be materially important, and which convey an accurate picture of the circumstances.

42 Chapter Six presents the conclusions of the Panel of Inquiry, and the lessons for the future. The conclusions relate, first, to the role of each of the agencies; second, to the evidence provided to the Panel of Inquiry in relation to the questions asked by the remit. In this chapter, the panel also comments on the effectiveness of the management inquiries as conducted by the responsible authorities.

43 Chapter Seven carries the panel's recommendations.

44 The Annexes contain selected material which provides an account of:

- the policy framework which gives generic background detail concerning the statutory duties of the health, social and probation services;
- membership of the panel and the rationale behind the panel's procedures and conduct;
- the organisations involved in the case;
- the individuals interviewed;
- the documentation considered;
- extracts supporting the Panel of Inquiry's conclusions taken from the management inquiries;
- a map of the Berkshire/Oxfordshire area showing the overlap of health authorities with county boundaries; and
- bibliography and references.

CHAPTER THREE

A SUMMARY OF EVENTS

45 In this section, the panel outlines the events that led up to the death of Louise Murrie, the nine year-old daughter of Anne Murrie, during the night of 25-26 February. This outline is developed stage-by-stage in the chapters that follow.

46 At the time of the incident, on 25-26 February 1994, Mrs Murrie was 37 years old. She had lived in the Reading area for much of her life and had evidently suffered recurrent episodes of turbulence. She took overdoses in her late adolescence and subsequently was episodically and recurrently a patient of Dr H Dickinson, a consultant psychiatrist of the Fair Mile Hospital, Wallingford. Dr Dickinson first saw her shortly after her second child, Lianne, died in 1981.

47 Mrs Murrie's mother died in 1989 and, with hindsight, the panel considers that this event has been highly significant in Mrs Murrie's life. In 1990, Mrs Murrie was admitted to Fair Mile Hospital on two occasions. Her marriage began to deteriorate in the late 1980s and the Panel of Inquiry believes that the family suffered considerable and growing troubles in the period before and during Mrs Murrie's further illness in 1991.

48 During the next year, the situation appears to the panel to have stabilised, but further familial relationship problems occurred in 1991 and early 1992. This resulted in Mr Murrie deciding to take divorce proceedings.

49 Through the remainder of 1992 there was a crescendo of events and deteriorating family relationships. In the late summer of that year, Mrs Murrie left home for several months. She returned to face police charges and a subsequent conviction for fraud or theft, as well as divorce and a Residence Order made in respect of Louise in favour of Mr Murrie. In December, she took an overdose and was admitted to Fair Mile Hospital in Dr Dickinson's care once more. Again, accounts suggest that the period of her admission was a turbulent time in her relationships. Despite the breakdown in family relationships, Mrs Murrie was determined to be discharged to the family home. In January 1993, the situation broke down, after an intervening admission to a general hospital in Reading, and Mrs Murrie was readmitted to Fair Mile Hospital within days.

50 Accounts suggest that, during this series of admissions, Mrs Murrie continued to contest the Residence Order in respect of Louise and, as a consequence of the matter being brought before the court once more, Mrs Dunn, a court welfare officer, was appointed, in January 1993, to prepare a report to advise the court. Her report was submitted in April 1993.

51 Mrs Murrie remained in hospital as an inpatient until March 1993. She was discharged, initially to temporary accommodation, before finding somewhere more satisfactory. The decree absolute in Mr and Mrs Murrie's divorce was made in March 1993.

52 While Mrs Murrie was an inpatient at Fair Mile Hospital, in the first quarter of 1993, responsibility for her healthcare fell to the West Berkshire District Health Authority. This statutory body exercised its responsibilities by purchasing the services provided by West Berkshire Priority Care Service NHS Trust, of which Dr Dickinson and the staff at Fair Mile Hospital are employees. The trust, which has changed little in its role in the intervening period, was - and continues to be - responsible for the management and delivery of mental health services from Fair Mile Hospital (despite the hospital's location in Oxfordshire). Readers are referred to Chapter Four which deals specifically with the role of organisations and the effects of organisational change on the care provided for Mrs Murrie.

53 The immediate social work service to residents of Fair Mile Hospital, in Oxfordshire, was, and is,

provided by the two social services departments (Oxfordshire and Berkshire), depending on each patient's home address. When Mrs Murrie was admitted, her home address was in Oxfordshire. On her discharge from Fair Mile, in March 1993, when Mrs Murrie was given temporary accommodation within the Berkshire county border, responsibility for the management of her aftercare in the community was transferred to the Berkshire Social Services Department. Mrs Murrie's specialist healthcare continued to be provided by West Berkshire Priority Care Service NHS Trust after her discharge from hospital and until February 1994.

54 Initially, Mrs Murrie failed to keep appointments with the CPN to whom she was referred although she did accept a further referral to the same CPN later in the year - a relationship that continued until Louise's death.

55 Mrs Dunn's involvement with the family was concurrent. As stated in paragraph 50, Mrs Dunn's involvement with the family centred on Mr and Mrs Murrie's disputes over the care of the children, in particular it concerned Mrs Murrie's contact with Louise. Following Mrs Dunn's advice to the court, the court made a Family Assistance Order for six months during which time Mrs Dunn's role in assisting the family was formalised. The Family Assistance Order expired in November 1993.

56 Though matters could not be described as resolved, it is the panel's opinion that the situation was more stable through the summer of 1993. There is evidence that Mrs Murrie remained extremely upset by her husband's rejection of her throughout this period.

57 The situation deteriorated rapidly from around December 1993 onwards, culminating in Louise's death in February 1994.

58 The increasingly worrying behaviour exhibited by Mrs Murrie at this critical period appears to have been provoked by her awareness that Mr Murrie had formed a new relationship. Evidence suggests that this aroused increasing passion, anger and hostility in Mrs Murrie. There is also some evidence that Mrs Murrie began to misuse benzodiazepines at around this time. During December, she cut through television and satellite cables at the home of the woman with whom her ex-husband had formed a relationship. Several weeks later, she damaged a car belonging to the woman. Charges relating to these offences were outstanding in February 1994.

59 Late in 1993, after Mrs Dunn's involvement with the family had formally ended, Mrs Murrie contacted Mrs Dunn once more and the latter became informally involved in advising her during the next two months.

60 During the early weeks of 1994, Mrs Murrie's carers became increasingly concerned. At the request of Mr Clarke, Mrs Murrie's care manager within the Berkshire social Services Department, she saw Dr Dickinson again in February and there were anxious communications about her. Exploration by the panel indicated that the professionals involved feared she might commit further aggressive acts, most probably directed at herself or, possibly, against her ex-husband or his friend. No one considered that the direct object of any assault might be Louise.

61 By mid-February, several people were considering actions to reduce Mrs Murrie's contact with her daughter, but events supervened.

62 According to arrangements previously negotiated, on 19 February Mr Murrie took Louise to stay with her mother for the weekend. But Mrs Murrie did not return the child to her father at the end of the agreed period. Instead, Mrs Murrie departed to Southend with Louise, took lodgings in a guesthouse and remained there until 26 February 1994.

63 While Mrs Murrie was away in Southend with Louise, Mr Murrie returned to court and gained a Prohibited Steps Order (an order available to the courts in section 8 of the Children Act 1989) in

respect of Louise. This could not be served upon Mrs Murrie, as no one knew where she was.

64 During the night of 25-26 February, Mrs Murrie took her daughter's life and reported attempts to commit suicide afterwards.

65 Upon Mrs Murrie's recovery from overdoses, taken on 25 and 26 February, she was remanded to HM Prison Holloway and afterwards to a medium secure unit in the NHS. Her trial and detention in Broadmoor Hospital followed.

CHAPTER FOUR

THE AGENCIES INVOLVED IN COMMISSIONING, PURCHASING AND DELIVERING CARE TO MRS ANNE MURRIE

INTRODUCTION

66 This chapter considers the roles and actions of the agencies involved in the care of Mrs Murrie. It begins with key strategic issues from an agency perspective and then considers a number of issues selected by the Panel of Inquiry. Not all the responsibilities of the agencies are reviewed, solely those considered by the panel to impact on its remit and findings.

KEY STRATEGIC ISSUES

67 In the course of the inquiry, the panel examined a number of policy, strategic, structural and tactical matters. These include organisational matters that had the potential to affect the quality of mental health services adversely in Reading and South Oxfordshire areas. These matters are principally:

- organisational changes in the commissioning, purchasing and providing agencies;
- the lack of coterminous boundaries of the main agencies;
- the need for the development of an effective mental health strategy in West Berkshire and the South Oxfordshire areas; and
- financial constraints affecting mental health strategy development.

68 General matters relating to boundaries, the development of mental health strategies and financial constraints affecting their development, are commented on in the sections that follow. Each of the agencies involved in the commissioning and provision of care is then introduced separately.

Lack of Coterminous Boundaries

69 On 1 January 1993, the East Berkshire District Health Authority and the West Berkshire District Health Authority were functionally amalgamated. They worked as a consortium until 30 September 1993, when they were formally merged into a single health authority, the Berkshire District Health Authority, covering the whole county from 1 October 1993. In April 1996, a further reorganisation resulted in the amalgamation of the Berkshire Family Health Services Authority and the Berkshire District Health Authority to form the Berkshire Health Authority. This is the body that inherited the responsibilities of all four of its predecessors and, consequently, set up the inquiry reported in this document.

70 Whereas the boundaries of the social services departments follow those of their parent local authorities, in some instances health authority boundaries overlap county boundaries. Until April 1994 (after the period which is critical to this inquiry), the responsibilities of the Berkshire District Health Authority (as it became formally in October 1993) overlapped South Oxfordshire and South Buckinghamshire. From a health service perspective, the Berkshire District Health Authority was responsible for healthcare in these overlap areas until April 1994 (after the death of Louise Murrie). Responsibility for them then passed to the Buckinghamshire and Oxfordshire Health Authorities. Since April 1994, the Oxfordshire and Buckinghamshire social services departments have worked with the health authorities appropriate to their county boundaries because the health and local authority boundaries became coterminous at this time.

71 Thus, in this case, a particular concern relates to what is described as the 'Reading overlap' area, before April 1994, between Berkshire and South Oxfordshire. (The map in Annexe G illustrates the overlap area during the critical period covered within this report.) In this area, the Berkshire District Health Authority was responsible for commissioning and purchasing healthcare at the time of greatest significance in this case. The West Berkshire Priority Service NHS Trust, which provides psychiatric services mainly in West Berkshire, was also commissioned by the South Oxfordshire District Health Authority to provide these services for part of the population of South Oxfordshire. By contrast, the geographical areas of responsibility of the social, education and probation services were based on local authority administrative boundaries.

72 Thus, in March 1993, when Mrs Murrie was discharged from Fair Mile Hospital and came to live in Reading, after moving from South Oxfordshire, she remained the responsibility of the same health authority (until April 1994), and the same health service providers. However, the responsibility for Mrs Murrie's social care was transferred from one social services department, Oxfordshire, to another, Berkshire.

73 The Panel of Inquiry was keen to determine whether or not this complex situation may have had a materially adverse effect on the range and quality of the care provided for Mrs Murrie.

74 It should be recognised by readers, that from April 1998, the situation has changed once again with the formation of six unitary local authorities in the place of the former Berkshire County Council and district authorities within its boundaries. In this report, recurrent reference will be made to Berkshire as a local authority because it was the agency responsible for social services provision for Mrs Murrie in the period between March 1993 and February 1994.

The Need for an Effective Mental Health Strategy for Berkshire

75 At the time that the panel took evidence during 1996-97, health authority staff were working with health service providers and local authority partners to consider ways of improving the mental health services in its administrative area. As part of this process, GPs were widely consulted. Feedback from GPs has helped to inform the authority's future strategy as well as to provide the panel with a source of front-line information about services in the area. (The views of GPs in the Reading locality of the Berkshire Integrated Purchasing Project [BIPP] are referred to in the Health Authority's Purchasing Plan for 1997-98.)

76 In particular, the panel heard of the past and present differences in the make-up and quality of services between the East and the West of Berkshire. At the time that the panel sat, the planning and provision of such services was a shared responsibility between the Berkshire Health Authority and the Berkshire Social Services Department.

77 From the research carried out by Berkshire Health Authority during 1996-97, the mental health services provided in West Berkshire were among those that GPs felt needed most improvement. In particular, they required better access, a better range of services, and an ability of the service to respond to crises, including sub-acute crises requiring intervention within one month. The panel assumes that a similar state of affairs pertained in 1993-94, when the events that are the subject of this inquiry took place, and noted that the Berkshire Health Authority's Purchasing Plan for 1997-98 contains references to the need for improvement in community mental health teams, and to the day services at Bucknell House, which Mrs Murrie had formerly attended on a number of occasions.

78 The lack of a mental health strategy in 1993-94 for West Berkshire, including the Reading overlap area, is an underlying theme in the panel's findings and is addressed specifically in the

conclusions. A related issue is the apparent lack, at the critical time, of any joint commissioning strategy established between health and social services. (There were examples of joint collaboration and joint working in the Reading area in 1994 but nothing that the panel considers as amounting to a properly thought-out strategy.) This is also referred to in the panel's conclusions in Chapter Six.

Financial Constraints Affecting Development

79 Strategies and services have to be funded and the panel is aware of the recent financial problems that Berkshire Health Authority has been encountering. Nevertheless, the panel was advised in 1998 by the Chief Executive of Berkshire Health Authority that, as of June 1998, actual and planned spending has been increased for services for people with severe mental ill health by £2m through Extra Contractual Referrals, and through a commitment to spend £1.3m to expand community services. The capital to relocate acute and rehabilitation services has been approved. The panel was further advised that more beds for severely ill female patients have been opened, that a pilot for the Assertive Care Team (ACT) started during 1998, and bids are currently in for a crisis response capability. The authority is looking at the synergy between health and social care services in seeking to use resources in a joint and more effective way, and was working to a balanced financial plan in 1997-98.

THE ROLE OF BERKSHIRE HEALTH AUTHORITY

80 The current Berkshire Health Authority's stated purpose is to secure the greatest possible improvement in the physical and mental health of the people of Berkshire through the resources available.

81 Berkshire Health Authority, in common with its predecessor District and Family Health Services Authorities, holds a wide range of duties and responsibilities for strategic commissioning and purchasing an extensive range of health services for its population. This includes responsibilities for all those individuals who suffer from a mental illness or disorder. In addition, it is responsible for co-operating, collaborating and, where appropriate, planning jointly with local authorities and others to provide an effective range of physical and mental health services.

82 In April 1996, Berkshire Health Authority assumed responsibility for its predecessors. In this case, the previous relevant health authorities were:

- the West Berkshire District Health Authority;
- the East Berkshire District Health Authority;
- the Berkshire District Health Authority; and
- the Berkshire Family Health Services Authority.

83 The Panel of Inquiry took evidence from the following staff of the present Berkshire Health Authority:

- Mr Richard Mills, Head of Strategy (including mental health strategy from December 1995);
- Mrs Margaret Crawford, who has had the management lead on mental health since April 1996; and
- Miss Anne Francis, Locality Manager for Reading and the officer responsible for CPA monitoring.

84 Previously Mr Mills had been Director of Purchasing and Mrs Crawford Assistant Director of Purchasing in Berkshire Health Authority. The Panel was able to explore a number of themes with these staff that include their perceptions of services in the past and much more detail about

future plans. In particular, two key themes or groups of issues appear to the panel to be pertinent to the inquiry:

- past and present hurdles and challenges in modernising traditional services to produce a safe and effective community-orientated mental health service in West Berkshire; and
- the strategy for mental health services in the future.

85 The panel has seen the Berkshire discussion document on Mental Health Strategy dated June 1997. This summarises:

- policy guidance;
- key partnerships in mental health;
- the mental health services in Berkshire;
- the proposed model of care; and
- implementation issues.

86 Given the existence of this public document, the panel will not go into greater descriptive detail, in this report, on the proposals for the future.

87 In late 1996, the panel was told that resource mapping suggested that Berkshire Health Authority was underspending on mental health compared to other health authorities, and that the situation in 1994 was, in all probability, similar or marginally worse. This was particularly the case in West Berkshire where the traditional emphasis has been almost entirely on institutional services.

88 Thus, the panel surmises that the situation in West Berkshire in the early 1990s was one of relative under-investment and that the community mental health service was then an inadequate base upon which to plan the closure of Fair Mile Hospital without further prior investment. Furthermore, GPs' accounts had suggested to the authority's staff that the GPs had viewed the services in East Berkshire as more extensive and of better quality than those in West Berkshire. In West Berkshire, referral processes were seen as unclear and the services as lacking flexibility. Plainly there had been a series of plans to close and reprovide Fair Mile Hospital but none of these had come to fruition. One of the key problems was how to replace Fair Mile Hospital adequately. Within this problem lay other practical issues, including finding adequate bases for community teams, getting staff to work together as teams, and a lack of enthusiasm among community staff to take on care management responsibilities in these circumstances. It was clear to the panel that the authority's staff saw these as the main reasons for the differential development of services in East and West Berkshire. However, the panel speculates that the differences between services in East and West Berkshire also derived from differing levels of strategic leadership in the agencies concerned.

89 Since taking evidence, the panel has been informed by officers of the health authority that these former problems have been recognised and are being tackled. The panel reports specifically on this in Chapter Six.

IMPLEMENTATION OF THE CARE PROGRAMME APPROACH

90 The staff of the health authority told the panel of their opinions as to how implementation of the CPA had progressed.

91 Apparently, in late 1994, the West Berkshire Priority Care Service NHS Trust had a member of staff in post with responsibility for setting up systems for the CPA. He left and was replaced. The opinion was that, in 1994, there were attempts to implement the CPA but that they were not progressing. The problems appeared to relate to the level of involvement of the health authority, the financial implications of the CPA and concerns about its intentions. Later, from 1995

onwards, there was more rapid and effective progress in implementing the CPA before the government intervened nationally in the summer of that year in order to ascertain why the CPA's implementation across the country was, at best, partial and then to improve it. Locally, in Berkshire, this was achieved by adopting a joint approach involving the health authority, the trust and the social services department.

92 When the health authority presented evidence to the panel, its staff reported greater satisfaction with the implementation of the CPA, though opinion suggests there was still some way to go in convincing some of the clinical staff about it.

93 From this evidence, the panel believes that the CPA had not, in any formal sense, been implemented in day-to-day practice in West Berkshire, during the period between 1992 and 1994.

THE ROLE OF WEST BERKSHIRE PRIORITY CARE SERVICE NHS TRUST

94 In the course of the inquiry, the panel interviewed a number of employees of this trust. They were Ms Helen Horton, Non-Executive Director; Ms Eileen Spiller, Director of Service Development; Mr Gary Nixon, Quality Manager; Dr Harry Dickinson, Consultant Psychiatrist; Shirley Goldin, Senior Nurse, Child Health; Rosemary Mann, School Nurse; and Mrs Marion Johnson, Community Psychiatric Nurse. The evidence of those who had direct contact with Mrs Murrie, during the process of her care, is reported in Chapter Five.

95 Currently, and at the time that most concerns the inquiry, the West Berkshire Priority Care Service NHS Trust is responsible for providing:

- mental health services;
- learning disability services;
- community hospitals and community services;
- health visitors; and
- school nurses.

96 The trust provides services in South Oxfordshire where it collaborates with the Oxfordshire Social Services Department. The major purchaser for mental health services in South Oxfordshire in 1993 was the South Oxfordshire Health Authority, and is now the Oxfordshire Health Authority. In addition, at the time of Mrs Murrie's care, the trust also provided services in West Berkshire to parts of Wiltshire and North and Mid Hampshire.

97 Although Fair Mile Hospital (see paragraph 104) is based in South Oxfordshire, only 10% of its income comes from its contract with the Oxfordshire Health Authority. The major contract is with the Berkshire Health Authority. At the time of Mrs Murrie's inpatient care there, and subsequent offence, the psychiatrists were based, and had their beds in Fair Mile Hospital but covered a wider geographical area. Dr Dickinson covered the Reading and Wokingham areas.

98 In early 1994, the CPA was introduced by the trust but was not immediately and universally applied within the trust's areas of responsibility. Nonetheless, at that time, the trust had employed (jointly with the Berkshire Social Services Department) a CPA worker to implement the programme and its requirements.

99 The members of the trust board and officers of the trust were very helpful in supplying information on the background to the events into which the inquiry was looking, and in talking the panel through the detail of their own management inquiry into the tragedy. They agreed that the CPA had not been effectively implemented at the time. They offered the opinion that although the CPA had not been applied to Mrs Murrie, it did not materially affect the case and its outcome. In

effect, they told the panel that, although the CPA was not in place, their own management inquiry led them to believe that staff had followed the spirit of it in planning care, team building, working together and communication - that is, the core intentions of the CPA and the requirements of good professional practice had been met.

100 Witnesses from the trust told the panel that there was, in 1996, a policy to develop community mental health teams, as finances permitted. The county of Oxfordshire had made a substantial investment, and was building joint teams. These witnesses considered that the local authority and the Oxfordshire Health Authority were working well together. Comparatively, their perception was that the purchasers from the statutory sectors of care for services in Reading did not work together as effectively, but they emphasised that this did not mean that they did not work well together.

101 Further, the witnesses told the panel that effective work was always easier if agency boundaries of responsibility are coterminous, but that they managed to cope with the different boundaries without undue difficulties. They felt that the ways in which relationships (both within the health and social services) had been changed, as a result of the different ways in which the purchaser-provider system had been implemented by the agencies involved, posed more problems (see paragraph 124).

102 In the Reading overlap area, staff of the trust worked with both the Oxfordshire child protection procedures (for residents of Oxfordshire), and those of the Berkshire Social Services Department (for residents of that county). The trust therefore operated two sets of child protection policies, but its representatives did not believe that this presented a problem. They had a senior nurse who led on child protection and who sat on both the Berkshire and Oxfordshire Child Protection Committees. In their opinion, staff were clear as to whether their cases were from Berkshire or Oxfordshire. They did not believe this had caused any practical problems.

103 The officers and staff seen by the panel also reported that, before 1993, the community and mental health services were in the same unit. Subsequently, separate units from within the same trust were set up to provide these services. The panel was told that in the community unit, a lot of effort went into familiarisation with child protection issues and health visitors, and school nurses had a high standard of training. There was not a similar level of training and competence in the adult psychiatric services because it was felt that those working in this section saw their jobs differently in effect, there was a significant cultural difference between the two units. More recently, the trust has improved the amount of training for mental health service staff and advice and support are now made available to them.

Fair Mile Hospital

104 The reprovision of Fair Mile Hospital is clearly seen as the factor that will help to unlock developments to the mental health services in the West of Berkshire. The panel visited Fair Mile Hospital to see the site of Mrs Murrie's psychiatric inpatient care before her offence. At the time of the visit, Fair Mile Hospital had approximately one-third of its former bed complement filled, and in spite of the efforts of the clinical and nursing staff, it presented an overall picture of decay. Panel members were struck by the almost classic picture the hospital presented of problems arising from the gradual running down of large psychiatric hospitals, if not carefully managed by provider trusts, health and local authorities. Certainly, the panel cannot envisage that, in 1994, it provided the essential clinical core and back-up for an effective community- and family-centred service, sited as it is some 15 or so miles from the main conurbation that it serves.

THE ROLE OF THE SOCIAL SERVICES DEPARTMENTS

The Berkshire Social Services Department

105 The panel interviewed various officers at the, then, Berkshire Social Services Department, including: Nick Georgiou, Senior Assistant Director; Margaret Sheather, Assistant Director (Care Management and Purchasing); Anne Emmons, Area Manager; Mike Hayward, Care Manager/Co-ordinator; and Tony Clarke, Social Worker/Care Manager.

106 At the time of the events concerning the inquiry, the Berkshire Social Services Department had developed a structure in which purchasing and providing functions were separated and managed in distinct divisions. Formerly, the structure of the services had been based on a geographical approach. Subsequently, this was melded with the purchaser-provider approach when community care responsibilities affecting the social services departments, consequent on the NHS and Community Care Act 1990, were introduced in 1993.

107 The panel understands that the purchasing function in the social services department was split into East and West divisions, each headed by an Assistant Director, Care Management and Purchasing. Each of the assistant directors was not only responsible for the day-to-day activities in their geographical regions but also carried responsibilities across the county for service developments in either childcare or mental health. Furthermore, a group of officers worked to each of the assistant directors to assist them in their development functions. The assistant directors reported to a senior assistant director, Mr Nick Georgiou, who in turn was accountable to the director, Mrs Parker.

108 Thus, Mrs Margaret Sheather, Assistant Director West, whose area included Reading, was not only responsible for assessment of need and for the range of social services purchasing activities in West Berkshire but she also carried a functional and staff responsibility for work with children and families, including child protection, across the whole county. Her opposite number in the East carried a similar geographical responsibility for East Berkshire along with the developmental role for adult and disability services, including those relating to mental health.

109 In turn, the purchaser streams comprised 16 locality teams, three of which were based in Reading. These teams performed the tasks of assessing individual need and arranged for the provision of appropriate services, as well as subsequent monitoring and review. Each was headed by a general manager responsible for senior care managers and care managers in the two main functional disciplines of children and families, and adults and disability (including, as presented here, the social services component of the mental health services).

110 The panel heard in evidence from Mrs Anne Emmons, locality manager in Reading, that, at the time of Louise's death, her role included responsibility for the social services contribution to the mental health services for the town as a whole. Within her team, Mr Mike Hayward, an experienced mental health worker, discharged the practical responsibility for the department's mental health service through his role of care manager co-ordinator. In turn, he was the line manager of Mr Clarke, who was the care manager for Mrs Murrie.

111 The panel was informed that these operational arrangements for mental health services in the county as a whole, and in Reading in particular, were determined by the fact that, for the social services department, mental health was considered to be a relatively specialised area of work, resourced by a small group of staff which, therefore, could not be readily split into a number of teams. In Reading, this led to a concentration of most of the available social services staff into the Reading Community Mental Health Team based at the Coley Clinic and Bucknell House. Both Mr Clarke and Mr Hayward were based at the Coley Clinic.

The Coley Clinic and Bucknell House

112 In terms of purchaser-provider responsibilities within this local authority, the Coley Clinic largely contained the purchasing arm of the social services department's mental health services, and Bucknell House (jointly administered by the NHS and the Berkshire Social Services Department) contained the treatment (provider) facilities.

113 Separately in Reading, was the Eldon Day Treatment Centre, a resource funded by the health service for acutely mentally ill people. This took referrals from GPs or consultant psychiatrists. The panel learned from the evidence submitted that, at the Eldon Day Treatment Centre, there was regular contact between the consultant psychiatrist and the CPN teams. There was no consultant either present or available on a regular basis to the staff working in the local authority's Reading Mental Health Team, based at Bucknell House and the Coley Clinic. The panel learned that if a consultant psychiatrist was required, a CMHT member could ask for a visit or an appointment by means of direct contact by letter or telephone.

114 Thus, the Coley Clinic and Bucknell House, which are separated by half a mile, were the resources of most of the community mental health service diagnostic, assessment, and treatment facilities provided both by the social services department and the NHS, for people in need of them in the Reading area. Also these facilities provided a base for part of the CPN team for Reading, as well as for the social services mental health staff. The NHS provided (and continues to provide) the team of CPNs and the West Berkshire Priority Care Service NHS Trust employs its staff.

115 In evidence to the panel, the Coley Clinic and Bucknell House were described as having 'a dense traffic' between them. However, exploration indicated to the panel that, at the time, the social services and CPN teams that shared the same buildings did not necessarily share coterminous operational areas.

116 At the time, there was at Bucknell House only an occupational therapist, a social worker and a community psychiatric nurse. Witnesses reported that some posts were funded jointly by the health and social services authorities. It appears to the panel that this approach to joint funding had more to do with ad hoc arrangement than deliberate strategy. In the opinion of the panel, despite co-location and a good deal of communication between the social work and nursing professions, it would have been inappropriate to describe the service as being based on a structure comprising multi-disciplinary teams which spanned health and social services sectors of care and responsibility. Neither could it be said that the range of therapeutic modalities and skills available within the community mental health service were comprehensive. They could not be, given the numbers and disciplines of staff available.

117 The panel heard from Mr Hayward that, in addition to the facilities contained in the Coley Clinic and Bucknell House, there was a drop-in centre run by MIND in the town centre which operated on three part-days a week. There was also a social services day centre, called the Trinity Day Centre, which ran for three days a week and focused on older individuals with long-term mental illness who were relatively stable.

116 The social services department operated a priority system to determine the need of individuals, and decided service provision on that basis. Mr Clarke advised the panel that he constantly had to balance existing high workloads and new referrals, and always had a waiting list.

The Effects of the Purchaser-Provider System

119 Mr Hayward and Mr Clarke informed the panel of what, in their opinion, were difficulties encountered in the Berkshire Social Services Department in 1991 as a result of its introduction of the purchaser-provider system. The department's original intention had been to sub-divide each locality's mental health workers into three groups, but there was concern that this would lead to too great a diminution of relatively thin resources. To counter this, the concept of the Lead Locality Manager had been developed.

120 The panel learned that industrial action had been contemplated but had not actually taken place some 18 months before Mrs Murrie's referral. Among other issues, there had been concern among mental health workers, such as Mr Clarke, about their losing the title of social worker and becoming care managers. The concern centred on the fact that the Mental Health Act 1983 refers specifically to the duties of 'Approved Social Workers'. In Berkshire, staff were concerned that care managers would, therefore, not be able to make assessments under the terms of the Act. This was resolved by individual workers such as Mr Clarke being able to use both titles - in effect, they became social workers/care managers.

121 Mr Clarke and Mr Hayward told the panel that the debate at the time had been very intense. Mr Clarke told the Panel of Inquiry that he had been trained to help people to improve their lives, and had acquired the skills to enable him to do this through his training and practical experience as a social worker. He felt that care management, in its simplest form, was concerned with assessment of need as a function separate to treatment. His view was that it was not easy to separate the two processes, when working with difficult and vulnerable people. If a social worker engaged with a client on assessment and, through that process, was given information by the client, then, in his view, that marked the beginning of the treatment process. He felt that the care management concept separated the functions of assessment from treatment, and that the latter became the concern of providers only. He felt that this was an artificial division in the field of mental health if too rigidly applied.

122 Mr Hayward offered the opinion that Berkshire's approach was 'a purist one'. Certainly, it had led to 'tension' at the time, partly because there were limited resources available in terms of manpower and provision and it was difficult to separate the two functions.

123 There is a related issue noted by the panel in the evidence from staff in the West Berkshire Priority Care Service NHS Trust: although geographically separate, the relationship between the Coley Clinic and Bucknell House had been very close before the introduction of the purchaser-provider system. Afterwards, staff in the trust rapidly became unclear as to whether those employed by the local authority agencies at Bucknell House were purchasers or providers, and this began to fragment relationships. Staff had to try to come to terms with new relationships. The community mental health teams had been working well, but began to feel that services were being fragmented.

124 The panel believes that a residue of these concerns about working procedures was still present when Mrs Murrie's referral was made to the Berkshire Social Services Department at the end of February 1993 prior to her last discharge from Fair Mile Hospital. There had been a history of fairly recent organisational turbulence in the Berkshire social services which had particularly affected staff in its mental health services and had certainly, in the case of Mr Clarke, produced some uncertainty about his role.

125 The panel is aware that concern about application of the purchaser-provider concept to social services and social work was by no means peculiar to Berkshire and it has some sympathy with the views offered to it on this matter. While the panel does not believe that the subsequent events could be attributed to this, it was suggested that the various changes in organisational structures

had adversely affected the quality of teamwork that had formerly existed between the staff based at the Coley Clinic and Bucknell House. In evidence, it was suggested to the panel that this was mainly the result of the way in which the purchaser-provider functions were introduced.

The Oxfordshire Social Services Department

126 The panel interviewed the following officers from Oxfordshire County Council Social Services Departments: Philip T Hodgson, Assistant Director, Children & Families; Paul O'Hare, Unit Manager, Community Mental Health Team, Thame; Peggy Holland, Social Worker, Community Mental Health Team; and Pauline Bennett, Support Worker, Community Mental Health Team.

127 Mrs Murrie and, for all practical purposes, her family, were regarded as active clients by the Oxfordshire Social Services Department from 18 December 1992, when Mr Murrie contacted the children and families team based at Henley, until 1 March 1993, when Mrs Murrie moved to Reading after her discharge from Fair Mile Hospital.

128 During the period 1993-1994, the Oxfordshire Social Services Department delivered services through five geographical divisions. The division in the south of the county contained Fair Mile Hospital within its boundaries.

129 At that time, the Oxfordshire Social Services Department had a series of local teams delivering services for client groups such as children and their families and elderly people. These were relatively numerous and served recognisable sub-divisional areas. For example, the social care for people referred to the mental health team based in Townlands Hospital, Henley, was provided by the social worker attached to that team. Organisationally, this set up was repeated throughout the South Oxfordshire and Vale areas - ie. social services staffs were based with colleagues from health services in community mental health teams. The social workers in these separate teams in South Oxfordshire and Vale District Council administrative areas linked into the social services management through a manager with overall responsibilities for these two parts of the county.

130 As this report has already indicated, Fair Mile Hospital dealt with patients from parts of the local authority administrative areas of both the Oxfordshire and Berkshire County Councils. The two social services departments had worked alongside each other, understood the boundary issues and the sectors covered by the psychiatrists, and no evidence was presented to the panel that suggested that relationships at an individual and professional level were other than good between practitioners from all authorities. The siting of Fair Mile Hospital near Wallingford means that the presence of social services staff from Oxfordshire is, of necessity, greater at the hospital than the presence of staff from Berkshire. However, the workers from both counties that were interviewed had clearly established protocols and understandings to cover cross-boundary movements of individuals - and there were many of these. The panel understands that neither local authority based its social workers at Fair Mile Hospital. Rather, these staff would visit the hospital from bases in the community.

131 The disposition of the children's services in both counties was different from the mental health services in terms of staff and local access points. Both county social services departments told the panel that practitioners in their children's social services might work with individuals who are receiving inpatient or outpatient psychiatric care and with their families as part of their child care remit.

132 The panel understands from the evidence that initial referrals and much of the work concerned with adults and their families, such as with Mrs Murrie, was seen predominantly as the province of the mental health teams, with other services being called in as and when necessary. The involvement of other services therefore depended on the knowledge and vigilance of the workers concerned. The reverse is also true in that, often, referrals would flow from children's services to

the mental health teams. Therefore, workers in both mental and child care services had to be knowledgeable of mental health matters in order to bring in appropriate services when necessary. In the panel's opinion, the way that adult mental health and children and families teams communicate and collaborate is a matter of key importance (see Conclusions, Chapter Six).

THE ROLE OF THE FORMER OXFORDSHIRE PROBATION SERVICE

133 Throughout the significant period in 1993 and 1994, Mrs Murrie was almost exclusively perceived as the concern of the psychiatric and mental health services for the purposes of assessment and service provision. The notable exception (as far as the assessment of Mrs Murrie's parenting was concerned) was the intervention provided by the Family Court Welfare Service through Mrs Dunn, a probation officer employed by the former Oxfordshire Probation Service, now known as the Oxfordshire and Buckinghamshire Probation Service. The details about the statutory role of the probation service in relation to private law matters are outlined in Annexe A.

134 During its evidence taking, the panel met with two staff of the probation service. Mrs Dunn's role is dealt with in some detail in Chapter Five. The other officer that the panel met was Mrs Linda Forrest, then a senior probation officer in Oxfordshire.

135 Mrs Forrest told the panel that she was formerly, in 1993-94, Mrs Dunn's line manager. Therefore, ordinarily, Mrs Forrest was the person to whom Mrs Dunn reported and the person to whom she turned for professional supervision.

136 However, at the time when the Murrie's family case was active, Mrs Forrest was absent on maternity leave. Thus, Mrs Forrest attended the hearing of the panel to support Mrs Dunn, provide contextual information on the probation service and to represent its interests and the conclusions that it drew during its own management inquiry. However, it was clear to the panel that, because of her extended absence, Mrs Forrest would not be able to provide any direct, personal evidence relating to her service's conduct of the case.

137 In the light of the management conclusions of the probation service in its own management inquiry (see Annexe F), the panel explored the internal management arrangements for Mrs Dunn in 1993-94. The panel was told that Mrs Forrest's post was a job-share and, although her colleague was still at work, that officer's medical condition resulted in both of them being substituted by a full-time appointee. This person was new to the service and was, in Mrs Forrest's statement, under stress for other reasons. She therefore concluded that, at the material time, Mrs Dunn received 'little or no support at all... ' Furthermore, Mrs Dunn had no room of her own in the offices of the probation service because they were being refurbished.

138 Mrs Forrest also stated that, 'Clients did contact the court welfare officer after cases closed and the officer would make a judgement. Court processes took weeks or months and they had to think about what was best for the child and sometimes they would reinvolve themselves voluntarily. It was quite common for the senior officer not to know about this straightaway; they normally only learned about reinvolvement when the officers found themselves overwhelmed with work and the senior then questioned this.'

139 In the panel's opinion, it is important to be aware of this context in order to understand how, in the course of events, Mrs Dunn's supervisor had not known that Mrs Dunn had become re-involved with the Murrie family after the Family Assistance Order ceased in November 1993. Mrs Forrest's statement also indicates her opinion of the level of supervision that Mrs Dunn received.

140 From the evidence given to the panel, there appear to have been several factors that explain why Mrs Dunn did not hold discussions with her supervisor or share her concerns with officers at the Berkshire Social Services Department. The panel returns to these in it's findings in Chapter Six.

CHAPTER FIVE

THE CARE COMMISSIONED AND PROVIDED FOR MRS ANNE MURRIE

INTRODUCTION

141 In this chapter, the panel provides its interpretation of the information presented in Chapter Four from the standpoint of its perception of the roles of the practitioners and managers most closely involved in the care of Mrs Murrie.

142 The panel has assembled a substantial version of events from the records of various reports by the responsible authorities (see Annexe D). This has been augmented by the information and opinion provided by the witnesses to the panel in the course of evidence taking.

143 The initial overview in this chapter places Mrs Murrie in the context of the care provided for her. This is followed by the panel's interpretation of the most critical issues affecting her care.

ANNE MURRIE AND THE CARE PROVIDED FOR HER

144 Anne Murrie is an only child. She was born on 6 July 1956 and is, therefore, 42 years old as this report is presented to the Berkshire Health Authority. At the time of the incident, on 25-26 February 1994, Mrs Murrie was aged 37 years.

145 Mrs Murrie's family of origin moved to the Reading area when she was eight and she lived in that area afterwards. She left school at 15 with no qualifications, worked in shops and, from 1971 onwards, worked as a clerk for the BBC Monitoring Service in Caversham.

146 Mrs Murrie's psychiatric history began when she took a series of overdoses in her teenage years (1974, 1975, and 1976). She was first seen by Dr Dickinson, a consultant based at Fair Mile Hospital in Wallingford in 1981, shortly after the death, at 11 months of age, of her second child, Lianne. The Panel of Inquiry was told that Lianne had neurofibromatosis and that, subsequently, it was considered that the neurofibromatous tumours in her brain had caused her death. Mrs Murrie was described to the Panel of Inquiry as having been depressed and suffering from mood swings following Lianne's death.

147 It appears that, in the late 1980s, Mrs Murrie's marriage to her husband, Mr Alan Murrie, began to deteriorate and there was a relationship between Mrs Murrie and another man in 1986. In 1991, Mrs Murrie entered a further relationship. Subsequently, her husband instigated divorce proceedings. In the autumn of 1992, Mrs Murrie left home for three months and worked in a hotel in Devon. The remainder of 1992 was marked, for Mrs Murrie, by a number of serious problems and rapidly deteriorating family relationships. She returned from her period away from the family home to face charges for a first criminal offence, that of theft and use of a building society pass book belonging to an employer for whom she had been cleaning. She also faced divorce and a Residence Order being made in respect of Louise in favour of Mr Murrie. In December 1992, Mrs Murrie took an overdose and was admitted to Fair Mile Hospital in Dr Dickinson's care. During her admission, family relationships continued to suffer and this was a very turbulent period. Nevertheless, Mrs Murrie was determined to be discharged to the family home in January 1993. But the situation at home soon broke down and Mrs Murrie was readmitted to Fair Mile Hospital within days, following an intervening turbulent admission to a general hospital in Reading.

148 Therefore, Mrs Murrie had several episodes of psychiatric care during the early 1990s, including

admissions to Fair Mile Hospital in 1990, 1992 and 1993. She was discharged from Fair Mile Hospital in March 1993 with further follow-up offered by the mental health service provided by the staff at Coley Clinic and Bucknell House. Her discharge on 1 March 1993 followed her last admission to one of the general psychiatric wards of Fair Mile Hospital and preceded the incident which led to this inquiry by more than 11 months.

149 As this report has already shown, two social services departments provide the social work service to Fair Mile Hospital, on the basis of the residential addresses of the clients. Mrs Murrie was admitted from an address in Oxfordshire but was discharged to an address in Berkshire. Thus, before her discharge, Mrs Peggy Holland, of the Oxford Social Services Department, wrote to the Berkshire Social Services Department in February 1993, advising the latter of Mrs Murrie's forthcoming discharge. Subsequently, Mr Tony Clarke of the Berkshire Social Services Department was identified as Mrs Murrie's care manager.

150 In his role as care manager, Mr Clarke was the key person responsible for assessing, organising and co-ordinating appropriate care for Mrs Murrie in the community. He referred her to the staff at Bucknell House. The staff at that facility agreed that Mrs Marion Johnson, a CPN, would see Mrs Murrie. Unfortunately, Mrs Murrie failed to attend three appointments which were arranged for her by Mrs Johnson in April 1993. Consequently, she was discharged once again. Nonetheless, Mr Clarke remained Mrs Murrie's care manager and he referred her once again to Bucknell House later in the year. This time, contacts between Mrs Murrie and Marion Johnson were more successful. The Panel of Inquiry was told that they began to meet regularly from November 1993.

151 After Mrs Murrie was discharged from Fair Mile Hospital in March 1993, she went to live in accommodation found for her by a voluntary sector organisation before obtaining her own accommodation: a room in a house in Caversham. Both her son, Stuart, and daughter, Louise, remained with their father. Mrs Murrie had unsuccessfully applied for a Residence Order for the children in February 1993 and in that same month her husband was granted an injunction restraining his wife from coming to his home (previously their matrimonial home). Thereafter, Louise Murrie became the subject of a Residence Order in favour of her father though Louise retained contact with Mrs Murrie. By this time, in 1993, the relationship between Mrs Murrie and her son, Stuart (who was 16 in July 1993) had deteriorated to the point that there was little contact between them. Nonetheless, she had frequent contact with Louise throughout 1993, seeing her two to three times a week and usually at weekends. Contact between them included overnight stays for Louise in her mother's accommodation. At times in 1993, when matters concerning the residence of the children were before the court, and into 1994, Mrs Dunn, the court welfare officer, saw various members of the family. In May 1993, the court made a Family Assistance Order in respect of both parents and Louise.

152 It would appear that, during the months from March 1993, when Mrs Murrie was discharged from Fair Mile Hospital, to December 1993, matters proceeded in a relatively stable, though probably unhappy and tense manner. Subsequently, judging from commentaries made by various informants to the Panel of Inquiry, Mrs Murrie's situation appears to have become progressively more problematic during the latter part of 1993. In December 1993, she discovered that her ex-husband had formed a relationship with another woman. She told informants that at that time she went to pieces, cried constantly and became less able to cope with ordinary events in life. Events and commentaries suggest that Mrs Murrie began to misuse drugs again at this point and that she became progressively more unhappy and resentful. During December, she cut through the television and satellite cables at the home of the woman with whom her ex-husband had formed a relationship. Several weeks later, she went again to the family home and damaged the woman's car.

153 It appears that Mrs Murrie's mental state deteriorated in the early weeks of 1994. In February, Mr

Clarke referred her again to Dr Dickinson and contacts between Mrs Dunn and members of the family continued. At this time, Mrs Murrie was described as being distressed, angry, resentful and extremely upset.

THE EVENTS LEADING TO THE DEATH OF LOUISE MURRIE

154 Mr Murrie brought Louise to visit her mother on 19 February 1994. Apparently, he then told her that he was intending to see a solicitor in order to reduce the weekend contact between Louise and her mother. It is reported that Mrs Murrie discussed with Louise the possibility of the two of them going away for a few days. The plans were for Louise to be collected by her father on the next day but, preventing this, Louise and her mother travelled by train to a guesthouse in Southend.

155 Mother and daughter stayed together in Southend for several days. Reports indicate that Mrs Murrie spent much of the night of Wednesday, 23 February writing letters. One was posted and several others were subsequently found in the lodging house. They contained elaborate instructions for the funerals of Mrs Murrie and Louise and the disposal of Mrs Murrie's property. The Panel of Inquiry did not see these letters.

156 Subsequently, Mrs Murrie has told others that, earlier in that week, she had talked with Louise about the idea of them dying together. Mrs Murrie reported to the panel that, by the Friday of that week, Louise had accepted this suggestion.

157 At bedtime that day, Mrs Murrie gave her daughter a number of sleeping tablets and then, sometime later, suffocated her with a pillow. Mrs Murrie has described to others trying to kill herself after suffocating Louise by putting cling film over her face and attempting to cut her wrists. She thought that at the time she took an overdose of temazepam and paracetamol. Nonetheless, she woke the next morning to find Louise dead in an adjacent bed.

158 Mrs Murrie asked a fellow guest to call the landlord. During that morning, she took an overdose of her antidepressant tablets and was admitted to Southend General Hospital on 26 February 1994. Mrs Murrie remained there until 1 March 1994.

159 Subsequently, she was remanded to HM Prison Holloway and then transferred to the Wallingford Clinic (a Medium Secure Unit) in the grounds of Fair Mile Hospital in Oxfordshire. The psychiatric evidence indicates that Mrs Murrie suffered an acute psychotic episode for about a week after being taken into custody.

160 Later that year, Mrs Murrie was tried. Subsequently, she was admitted to Broadmoor Hospital on 7 October 1994 from Chelmsford Crown Court under sections 37 and 41 of the Mental Health Act 1983. In other words, the Court made her the subject of a hospital order with restrictions in the legal category of psychopathic disorder, following her conviction for the manslaughter of her nine year-old daughter, Louise.

KEY EVENTS AND ISSUES IN THE CARE OF MRS MURRIE

The Referral of Mrs Murrie and the Murrie Family to the Oxfordshire Social Services Department

161 The first referral to the Oxfordshire Social Services Department occurred on 18 December 1992 when Mr Murrie contacted the children and families team based at Henley and asked for advice. He explained that his wife was suffering from depression and was then an inpatient at Fair Mile Hospital. He and his wife were in the process of divorce and he wanted legal advice in the context of the Children Act 1989. Advice was given and, as no other services were requested,

the matter was considered closed.

162 The next referral was received on 31 December 1992 from the nursing staff at Fair Mile Hospital. This regarded discharge arrangements for Mrs Murrie.

163 Subsequently, Mrs Murrie was discharged to the family home. The Thames Valley Police made the third referral to the children and families team of the Oxfordshire Social Services Department on 26 January 1993. This followed an incident on 20 January 1993, when Stuart Murrie, Mrs Murrie's son, had rung the police to say that Mrs Murrie was hitting Louise and himself. The police had attended the family home but had found the situation calm and the children uninjured. The situation was assessed as being an ongoing domestic dispute. Mr Murrie was sent for and he returned home. Shortly after the incident, Mrs Murrie was readmitted to Fair Mile Hospital.

164 The police were not concerned for the safety of the children but as, a matter of procedure, telephoned the children and families team on 26 January 1993 to pass on the information. Originally, it had been supposed that the information from the police was not recorded, and this was the subject of an adverse comment in the Child Protection Committee's report on Louise's death (a report prepared by the Oxfordshire Social Services Department). However, in preparing papers for this inquiry, the referral form was discovered by the staff of the Oxfordshire Social Services Department. If it had been correctly filed then it would have been logged onto the client index. There was no record of its existence on the child care file for this case, held by the Oxfordshire Social Services Department, which was entitled 'The Murrie Family'. The mental health file within this department was separately located and entitled 'Mrs Anne Murrie'.

165 The referral on 31 December 1992, when Mrs Murrie was an inpatient, resulted in Mrs Murrie's case being allocated to Mrs Peggy Holland, who was a social worker working within the community mental health service, based in Henley. At that time, this was a new service set up in 1992, not long before the events under investigation, and not long after Mrs Holland had been appointed to her post. Mrs Holland described the service as being an extremely new one in an area, which had very few psychiatric resources apart from those based at Fair Mile Hospital.

The Roles of Mrs Holland and Mrs Bennett

166 Mrs Holland is an experienced and trained social worker who had previously worked in childcare and mental health settings in a variety of agencies. Between 1975 and 1976, she had worked in Reading, presumably for the Berkshire Social Services Department, although Mrs Holland herself stated that it was for Reading Borough Council. Be that as it may, she had worked in a centre dealing with child abuse.

167 Mrs Pauline Bennett, a support worker who worked to Mrs Holland, was also based at the Oxfordshire Social Services Department's Henley office. She had been appointed shortly after Mrs Holland. Mrs Bennett was an untrained worker and this was her first post in a social services department. Before becoming a support worker, she had been involved in voluntary work.

168 Mrs Holland described how she worked in the 'overlap area' in South Oxfordshire (as previously described) covered by Berkshire District Health Authority and the Oxfordshire Social Services Department. She told the panel that she had found it hard to describe the experience of working in conjunction with a different NHS provider than many of her colleagues. She felt that this made the management of her service by the Oxfordshire Social Services Department 'very tenuous'.

169 Mrs Holland delegated a lot of the work with Mrs Murrie to Mrs Bennett who reported back to her. The panel did not have access to the case notes but was advised that they contained detailed notes and reports from Mrs Bennett, which she shared with Mrs Holland.

170 The panel was advised that there are numerous references to Mrs Murrie's impending divorce on the file, and that there was a reference to a contact between Mrs Holland and Mrs Dunn, the court welfare officer, made on 18 January 1993. However, Mrs Holland could not recall this contact taking place, although she knew of Mrs Dunn's involvement.

171 Mrs Holland's view was that, in 1992-93, Mrs Murrie was a woman in crisis. She was being prosecuted for two offences of fraud; she was in the middle of 'a messy divorce', although she clearly wanted to be back with her husband. According to Mrs Holland's evidence, Mrs Murrie had stood out in Mrs Holland's caseload because she had taken three overdoses within a very short space of time, and there were clear and continuing concerns about self-harm. The hospital staff saw the overdoses in the context of what they believed was Mrs Murrie's personality, and as a way of acting out against the situation in which she found herself. They did not believe that she was depressed at the time, and neither did Mrs Holland, although all acknowledged that Mrs Murrie had experienced depressive episodes in the past.

172 Mrs Holland believed that, by the time she and Mrs Bennett became involved in the case, Mrs Murrie was very angry. She had committed some criminal acts, she had overdosed, and she had gone to live temporarily in Ilfracombe, but Mr Murrie would not have her back.

173 Mrs Bennett recalled that Mrs Murrie told her that when she stole two cheques from a policeman whose house she had cleaned, and took some drugs, it had been as if someone else was doing it; she had detached herself from her behaviour.

174 Mrs Holland told the panel that it was her impression that Mrs Murrie desperately wanted to keep Louise, not as a means of getting back at her husband, but because she wanted to be with her. The impression she had was that it would be the last straw for Mrs Murrie if she lost Louise. She had been aware that the divorce was getting 'to a sticky stage' and, because of this, Mrs Holland had felt that it was best to work through Mrs Murrie's solicitor, Mr Kelly, and had telephoned him and spoken to him about Louise just before Mr Murrie obtained an injunction against Mrs Murrie in the Spring of 1993. Mrs Holland told the panel that she had not met the court welfare officer, Mrs Dunn, but she had known of her involvement and of the Residence Order. At the time, she was aware - from her professional experience - of the impact that mental disorder may have on children of affected adults and its possible links with child abuse.

175 Mrs Bennett told the panel that she had seen Mrs Murrie on three occasions. Her first involvement in the case had been on 22 January 1993 when staff at Fair Mile Hospital had phoned and asked her to tell Mrs Holland that Mrs Murrie had overdosed and had, once again, been admitted to the hospital. On 4 February 1993, at Mrs Holland's request, Mrs Bennett had accompanied Dr Dickinson on his ward round on Ridgeway Ward. At that time, it appears that Mrs Holland had already considered lack of housing as Mrs Murrie's prime presenting problem and had been working on it. Mrs Bennett recalled that Dr Dickinson was concerned that Mrs Murrie might be using the hospital for accommodation while her divorce and housing were being sorted out. He had requested Mrs Bennett to ask Mrs Holland whether Mrs Murrie might be eligible for resettlement. Subsequently, Mrs Bennett visited Mrs Murrie on the ward to help her to fill in application forms for REAP, a housing agency in the Reading area.

176 Mrs Bennett was also asked by Mrs Holland to ring Mrs Murrie's solicitor about conciliation services. Mrs Bennett recalled that Mrs Murrie had been concerned that she was losing Louise, and that Louise was beginning to reject her. Apparently, Mrs Murrie said to her then that Mr Murrie was trying to turn Louise against her. Mrs Murrie was angry and crying and wanted accommodation so that she would not lose Louise. She had singled Louise out as being of special importance to her. She told Mrs Bennett that she felt that Mr Murrie and Stuart were ganging up against her and that Louise was beginning to do the same.

177 Mrs Murrie had cried in front of Mrs Bennett, though not in front of Mrs Holland. Mrs Holland's view was that Mrs Murrie 'would smile sweetly and would not engage with any of the plans that were set up to help her'. There was concern that Mrs Murrie might kill herself.

178 Mrs Bennett told the panel that she felt sympathetic to Mrs Murrie because of what had happened to her, although she found her difficult to deal with because Mrs Murrie was very emotional. Mrs Bennett recalled that, although Mrs Murrie had said that everything was horrific, she had seemed to quite enjoy being at Fair Mile Hospital. She had appeared to enjoy helping people and being the centre of attention. Mrs Bennett told the panel that, 'she would appear to switch on the crying one minute, but the next minute she would seem quite happy.' Mrs Bennett told the panel that, at the time, she had accepted what Mrs Murrie told her as the truth. But, when Mrs Murrie blamed Mr Murrie, Mrs Bennett was not certain what to think; she just knew that there was a lot of tension between the couple.

179 Mrs Bennett told the panel that she had been concerned about Louise and had spoken to Mrs Judith Haskell in the children and families team about these concerns. Mrs Bennett said that she had been told that this team was unable to help. She had reported this to Mrs Holland.

180 Mrs Holland said that she had worked in the social services department's office in Henley before starting her current job and had a good relationship with the staff of the children and families team. She was aware from her own professional experience of the impact that poor parental mental health might have on child abuse. She had found it a little surprising that the Murrie family had had the response that they did, but was aware that there was a shift in policy at that time, and that less preventive work was being done.

181 Mr O'Hare, Mrs Holland's manager, told the panel that he believed that the children and families team had set a certain threshold over which referrals were seen as either potential child protection cases, or cases which required active intervention from the department. The referrals of the Murrie family to the children and families team had fallen below these thresholds.

182 Mrs Holland told the panel that she had been aware that there had been 'a dust up' between Mr and Mrs Murrie, but the police and the children and families' team had dealt with this. She had felt that this was appropriate. She had been aware that there were two children involved in this household, and Mrs Bennett had continued to remind her that she thought the children might be vulnerable, but she had mainly been concentrating on effecting Mrs Murrie's discharge. Mrs Holland told the panel that she was familiar with child protection procedures.

183 When the panel saw Mrs Murrie at Broadmoor Hospital on 27th January 1997, she expressed the view that, during the period before her discharge from Fair Mile in March 1993, she 'was doing it all by myself' and was aiming to get accommodation near Louise's school so that she could apply for custody of her. She felt that a lot of her attention was focused on her daughter because she did not have her living with her. Mrs Murrie said that she found her circumstances difficult because she had no money and no job. Her father had helped her a lot but she did not get much help from anybody with accommodation or employment, although she did not know what more might have been done. She believed that nobody was at fault for what subsequently happened.

184 Mrs Murrie was discharged from Fair Mile Hospital on 1 March 1993 to a guesthouse in Reading. Previously, on 22 February 1993, Mrs Holland had written to Mr Hayward at the Coley Clinic asking whether his team would accept the referral of Mrs Murrie for aftercare as she 'has moved from Oxfordshire into Reading and is expecting to be discharged imminently from Ridgeway Ward, Fair Mile Hospital under Dr Dickinson to her new flat'. A message was left for Dr Holcombe (Mrs Murrie's GP at the time) advising of Mrs Murrie's discharge on 1 March 1993. On 3 March 1993, a discharge letter was duly sent to the GP. A referral was also received by the staff at the

Coley Clinic from Ian Mundy, a charge nurse on Ridgeway Ward at Fair Mile Hospital for the involvement of the community services. Mrs Murrie was said to be under continuing stress with divorce proceedings and a pending court case for fraud.

185 Mrs Holland's letter is included in the list of numbered, written evidence provided for the Panel of Inquiry (Annexe E). The letter is, in the opinion of the panel, full and comprehensive. Mrs Holland concluded her letter by saying, 'I see Anne as continuing to need considerable support if she is to avoid further overdoses and re-admissions during this undoubtedly stressful time caused by the break-up of the family home and her anxieties around the other two impending court cases. However, Anne, it must be said, has not been an easy person to help or get close to. She has often changed her mind and attitudes and has put herself outside the remit of helping agencies."

186 After her discharge, Oxfordshire Social Services Department regarded Mrs Murrie's case as closed. The panel was told that decisions had already been taken, separately, to the effect that Mr Murrie's enquiry and Stuart's phone call to the police did not warrant opening a case and taking on a continuing commitment to Mr Murrie and his children, who still lived in Oxfordshire. Therefore, the case that was transferred to the Berkshire Social Services Department was solely that of Mrs Murrie. Nonetheless, the information that was provided as part of the referral did concern Mrs Murrie's domestic situation and the impact that this might have on her mental health.

187 Mrs Holland could not recall any contact with Mr Clarke following Mrs Murrie's discharge from Fair Mile Hospital. About a month after the case was closed, Mrs Bennett had suggested that they find out how Mrs Murrie had fared. Consequently, Mrs Holland had phoned Dr Holcombe, Mrs Murrie's GP, and had 'briefed her about the situation'. There was a further contact in July 1993, when Mrs Holland spoke to Mrs Newman a social worker at the Coley Clinic. The panel was told that the note on the file stated that Mrs Murrie was doing well, had recently moved to a flat in Reading, her daughter visited her at weekends, and the matrimonial home was up for sale.

188 Mrs Holland considered that Mrs Murrie was a difficult woman to work with; she often rejected advice and did the opposite. On reflection, Mrs Holland felt that, given the constraints on Mrs Bennett and herself, she was pleased with the work they had done with Mrs Murrie.

The Transfer of Mrs Murrie's Care from the Oxfordshire to the Berkshire Social Services Department

189 Thus, the referral made by the Oxfordshire Social Services Department was passed to the Reading Community Mental Health Team of Berkshire Social Services Department. Mrs Newman, at the Coley Clinic, was the member of staff in Berkshire who received it. Mrs Newman was a colleague of Mr Clarke's, and also a care manager. Both were accustomed to working together. A common thread running through the referral documents was the difficulty of engaging and working with Mrs Murrie. Therefore, after initial discussions, Mrs Newman and Mr Clarke decided to make a joint visit to see Mrs Murrie.

190 As to the referral documents themselves, Mr Clarke told the panel that the depth and clarity of the referral was, in his opinion, above average. He had received a three-page letter from Mrs Holland, and he had also received a two-page letter from the staff of Ridgeway Ward. In the latter, ward staff had expressed the opinion that Mrs Murrie needed active support in the community. Mr Clarke told the panel that he was aware that efforts had been made by the previous social worker, hospital chaplain, and nursing staff to find Mrs Murrie alternative accommodation. Mrs Holland's letter was more detailed and gave the chronological background.

191 When Mr Clarke and Mrs Newman made their initial visit, Mrs Newman realised that she knew

Mrs Murrie. They had previously been employed at the same place before Mrs Newman had become a social worker and before Mrs Murrie had married. Therefore, it was decided between them that Mr Clarke alone should be the care manager charged with the task of assessing Mrs Murrie's needs. He agreed to take responsibility for arranging and managing the social care resources that she required in a co-ordinated fashion with other provider agencies.

The Role of Mr Tony Clarke, Care Manager

192 Mr Clarke is an experienced and qualified social worker. At the time of receiving the referral of Mrs Murrie, he had been qualified for 10 years and, before undertaking the training for the Certificate of Qualification in Social Work (CQSW), he had worked for two and a half years as an unqualified social worker.

193 Mr Clarke told the panel that he constantly had to manage a high workload because of the level of demand in Reading. Habitually, he and his colleagues had waiting lists. In spite of this, Mrs Murrie had been assessed on 16 March 1993 because she was felt to be a vulnerable woman who was in need of support. According to Mr Clarke, she fell into a priority group of people who received early assessment.

194 Mr Clarke recalled that the referral letters were comprehensive. He recalled having information about Louise and about Mrs Murrie challenging the Court Order which gave Mr Murrie responsibility for the day-to-day care of Louise. He knew that the court welfare officer was preparing a report at this time. He told the panel that he considered that he had been given sufficient information about the case to enable him to work with Mrs Murrie.

195 Mr Clarke told the panel that his own assessment revealed that Mrs Murrie saw her own priority as wanting to sort out her contact with Louise. She had also wanted to clarify her financial situation via her solicitor.

196 Mr Clarke said that Mrs Murrie told him that she did not blame her husband for everything. Mr Clarke told the panel that he had tried to look at things from her point of view and she had seemed to him to be badly done by, as, in his opinion, are many women who undergo separation and divorce. He recalled that at the stage of assessment, he had felt positively about Mrs Murrie. He had tried 'to remain professional with Mrs Murrie, but that was difficult because this was not a technical job.' He felt that he normally saw a woman's point of view in this sort of situation and he knew that she felt discriminated against and that she was desperate to have the care of her child. Therefore, he believed he had to balance his difficulty in working with her with the need to remain empathetic towards her.

197 During the course of this assessment, Mrs Murrie mentioned to Mr Clarke that she had been helped by working with a small group when she was an inpatient at Fair Mile Hospital. Mr Clarke formed the view that she found group work helpful - a positive feature accentuated by her reluctance to accept professional views of her, or of her situation. He told the panel of his general opinion that clients could gain insights from other people who had suffered similar problems and that they could move out of the role of being the sick person by helping other people. Mr Clarke described this as 'the only spark of professional inspiration' which he had had while handling Mrs Murrie, whom he had found difficult to engage.

198 Mr Clarke said that he did not feel a professional responsibility towards Louise because someone else was caring for her. Mr Clarke told the panel that he was aware that a Court Order had defined Mrs Murrie's responsibilities for Louise. He said he was also aware that Mrs Murrie was pursuing the issues of care, residence and contact through her legal advisers. Mr Clarke gave the opinion that, had the contact arrangements been altered subsequently, he might have reviewed his position with respect to his professional responsibilities towards Louise.

199 Mr Clarke expressed the opinion that Mrs Murrie did not have much going for her except her relationship with her daughter. He told the panel that it was his opinion that she was a good mother. Further explanation revealed that this opinion was based on Mrs Murrie's professed love for her daughter. Mr Clarke told the panel that he never met Louise, nor had he spoken to Mrs Dunn, so he did not know her views about Mrs Murrie's relationship with Louise or Louise's state of mind. Nonetheless, he considered that Mrs Murrie had a good relationship with Louise, and that Louise meant a lot to her. He accepted that the importance that Mrs Murrie placed on the relationship was not the same as saying that the relationship between them was good. Mr Clarke viewed Mrs Murrie's relationship with Mr Murrie as not good and with her son, Stuart, as being poor.

200 In Mr Clarke's view, there was no formal written care plan as such; nor was there anything subsequently that could be so described. He told the panel that, at the initial stage, his aim was to get as much support for Mrs Murrie as could be offered using the few resources at his disposal.

201 The support that he had identified as appropriate was provided from Bucknell House where the staff ran groups. He had referred Mrs Murrie to a women's group. He told the panel that he became involved in providing practical help for Mrs Murrie because he did not see himself in a counselling role. One piece of practical help in which he recalled being involved was finding a bed settee for Louise to use when she stayed overnight with Mrs Murrie.

202 Mr Clarke told the panel that he had been well aware that Mrs Murrie had not attended appointments organised for her by the staff at Bucknell House. The CPN, Mrs Johnson, was not part of his team, but he had received feedback by telephone, personal conversation and by letter. Also, he had liaised with Mrs Murrie's GP and with Dr Dickinson when, during the crucial later stages, he (Mr Clarke) was involved in setting up appointments for Mrs Murrie.

203 Mr Clarke recounted to the panel his recollection of what, for him, was the seminal event in his relationship with Mrs Murrie. This occurred on 15 January 1994 during a period when Mrs Murrie's behaviour was escalating and becoming increasingly volatile.

204 In his evidence to the panel, Mr Clarke described what he saw as an important turning point when Mrs Murrie appeared to make some kind of connection for herself which he felt resulted from work going on at Bucknell House. At this point, Mrs Murrie's feelings of unresolved love for her husband became those of hatred and bitterness; to Mr Clarke there appeared to be a significant shift. He recalled that Mrs Murrie had said to him something to the effect of 'If it takes me for the rest of my life I shall get even with my husband'. He had responded by advising her not to do anything that would adversely affect her contact with her daughter. He took Mrs Murrie's threat to imply that she would harm Mr Murrie or his friend.

205 On 15 February, Mrs Murrie phoned Mr Clarke complaining that Dr Dickinson had not been helpful and that she felt like running off with Louise. Mrs Murrie told Mr Clarke that she would try to obtain revenge on her husband for the way he had treated her. On 17 February, Mr Clarke wrote to Dr Dickinson outlining the telephone conversation of 15 February, with a written copy to Dr Boon, the GP, and Marion Johnson, the CPN. At no time did he consider that Louise might be at risk. Rather, it appeared to Mr Clarke that Mrs Murrie enjoyed her contact with her daughter and she talked positively about her.

206 In his evidence, Mr Clarke told the panel that the possibility of a tragic outcome of the kind that took place in February 1994 had never entered his head. He had thought that Mrs Murrie's anger and hatred was directed towards her ex-husband and possibly her son with whom she had a difficult relationship, or perhaps towards her husband's new friend.

207 In Mr Clarke's opinion, Mrs Murrie had misused Louise on occasions by trying to use her as a means to get at her husband. He remembered some difficult conversations with Mrs Murrie when he had tried to point out that this was inappropriate. He told the panel that, in his experience, partners who were separating were often unable to separate their own conflict and the children's needs. He said that Mrs Murrie was worried that her ex-husband could enter into a new sexual relationship and that Louise would somehow witness this and that that would be horrendous for her. He had tried to put some boundaries around this by suggesting to Mrs Murrie that Mr Murrie would be able to protect Louise from this.

208 Mr Clarke told the panel that he had felt that Mrs Murrie was difficult to engage long before the disclosure of her feelings of hatred and her wish to avenge herself on Mr Murrie. His view was that she was doing some inappropriate things, for instance shoplifting and causing criminal damage and that the situation was getting worse rather than better. He told the panel that, at times, he had felt as if he was being ineffective.

The Role of Dr Harry Dickinson

209 Of all the workers seen by the panel, Dr Harry Dickinson, a consultant psychiatrist based at Fair Mile Hospital since 1979, had knowledge of and acquaintance with Mrs Murrie over the longest period of time. Since 1981, he had been the consultant to whom she was referred episodically.

210 During the period covered by this report, Dr Dickinson had been covering a much larger catchment area than the one for which he was responsible at the time of the sittings of the Panel of Inquiry. In 1992-94, his area straddled the two social services areas of Reading and Wokingham. In Wokingham, there was a well-established community mental health team (CMHT) with social workers, CPNs, and occupational therapists working in the same area. Dr Dickinson and his colleagues conducted clinics in that area and saw the professionals of the CMHT on a weekly basis. He told the panel that the service in Reading was much more dispersed in that members of the team were based in different places. There were aspects of joint working but, at that time, there was no regular consultant psychiatrist input. This could not have come from him at that time because he had been fully committed.

211 Dr Dickinson knew that, as early as 1974, when Mrs Murrie was only 18 years old, she had taken her first overdose and there were more overdoses during the next three years. She had then had a more settled period in her early-married life and after the birth of her first child, when there were no known overdoses or referrals to psychiatrists. But Dr Dickinson had no doubt that Lianne's death, in 1981, had a major impact on Mrs Murrie and, in his opinion, this might have been the life event that, combined with her personality, provoked the episodes of greater depression, anxiety and other relationship problems in more recent years.

212 In Dr Dickinson's opinion, following a miscarriage and then the birth of Louise, Mrs Murrie experienced a succession of relationship problems, affairs and problems with her immediate family. Apparently, Mrs Murrie had fallen out with her parents and, at one point, was not on speaking terms with them. There were increasing problems with her marriage and she behaved in a disordered way with increasing frequency. Dr Dickinson told the panel that he was sure that her problems were aggravated by her misuse of temazepam. Her problems included an affair in 1991 and the aftermath of that was increasing tension in her marriage.

213 According to the account that Mrs Murrie gave to Dr Dickinson, Mr Murrie and their son had made her life extremely unpleasant through 1992. This was after her second affair when her husband had decided to end the marriage. The divorce process had taken another year. In 1992, she went to Ilfracombe for several months when she had very little contact with her family. Mrs Murrie told Dr Dickinson that after returning to her family home, her husband and son had

subjected her to a lot of unpleasantness, and this culminated in her divorce. Her version of events was that her husband told her that he would not allow her to take any kind of responsible role within the family or the home and that he had undermined her. It seemed to Dr Dickinson as though her relationships had progressively fallen apart.

214 Once their marriage had broken down, Mr Murrie gained responsibility for determining the day-to-day care of their daughter. Mrs Murrie had impressed on Dr Dickinson that her overriding concern was to have custody of Louise and to be with her. In his opinion, she had idealised that relationship.

215 At the time, Dr Dickinson had stated in his reports that he felt that Mrs Murrie was a satisfactory mother to Louise and that she was capable of handling her and having custody of her at some stage. He had felt that she had a lot of positive qualities; he believed that she was capable of having custody of Louise and that she was capable of looking after her, in spite of the disordered behaviour that Mrs Murrie had exhibited in the past. He had stated this in reports to her solicitors or doctors, and he genuinely believed it. Dr Dickinson had met other members of Mrs Murrie's family earlier on; he had met her parents and her husband on a number of occasions. However, he had not met her children. Nonetheless, Dr Dickinson believed that Mrs Murrie was properly concerned about her daughter's welfare. In his experience, many self-centred people make adequate parents. He did not doubt that Mrs Murrie had sufficient awareness of her daughter's needs, from what she had said, for her to be able to take responsibility for her daughter's upbringing.

216 After her discharge from Fair Mile Hospital in March 1993, Dr Dickinson was clear that Mrs Murrie had an identified key worker who was Mr Clarke. Dr Dickinson understood that Mr Clarke's role was to monitor Mrs Murrie, maintain contact with her, assess her needs, and be responsible for purchasing care for her or referring her for any care that she needed. Also, he was aware that a CPN, Mrs Johnson, was providing supportive counselling to Mrs Murrie, while he, Dr Dickinson, was considered to be the backstop. Further, Dr Dickinson was aware that Mrs Johnson was responsible to a nurse manager who was also based within the CMHT.

217 Following her discharge from Fair Mile Hospital in March 1993, Dr Dickinson saw Mrs Murrie from time to time as an outpatient. He recalled seeing Mrs Murrie with Mr Clarke in November 1993 when he had been concerned about her impulse control because she had been shoplifting. He remembered that they had talked about the possibility of her seeing a clinical psychologist, but instead she was referred to Mrs Johnson. (Subsequently, the CPN, Mrs Johnson, indicated to the panel that the psychologist post at Bucknell House was vacant at the time.) Dr Dickinson did not know to what extent Mrs Johnson had addressed impulse control in her meetings with Mrs Murrie. However, he believed that she was dealing with Mrs Murrie's feelings of loss regarding her husband. Dr Dickinson had not met Mrs Johnson.

218 Dr Dickinson said that, when Mr Murrie formed a new relationship, Mrs Murrie had attacked the woman's property and had been faced with another court case. Afterwards, Mrs Murrie had wanted to see Dr Dickinson (this occurred on 14 February 1994) and had asked Mr Clarke if this could be arranged.

219 Dr Dickinson told the panel that his letter to Dr Boon (Mrs Murrie's GP), written following that appointment, stated that he had seen Mrs Murrie in his outpatient clinic on 14 February at the request of her social worker. He explained that Mrs Murrie had not had a recurrence of her depression, but had again got into trouble with the law; also that, shortly before Christmas, Mrs Murrie had learned, via her daughter, that her husband had formed a liaison with another woman. She became obsessed with wanting to know what the woman looked like. She had gone to the woman's house and cut the TV and satellite cables. He also explained that, on another occasion, Mrs Murrie had damaged the woman's car when it was parked outside her former matrimonial

home and that she was facing court proceedings about both these incidents. He advised that Mrs Murrie was clearly still hurt and angry about the break-up of her marriage and the fact that her husband had custody of their daughter. He explained that he was waiting for the solicitor to contact him for a report. He had outlined the medication, which Mrs Murrie was taking and recommended that this be continued. He had advised that Mrs Murrie was seeing Mrs Johnson, the CPN at Bucknell House, for weekly counselling and that he would review her condition himself when necessary.

220 When Dr Dickinson saw Mrs Murrie on 14 February, she told him that she was holding down several cleaning jobs. She was not depressed or weepy and she presented herself well. Typically, she had taken trouble with her appearance. She had come to see him alone and he recalled that one of the difficulties for him on that occasion was that she attempted to control the interview. During the appointment on 14 February 1994, Mrs Murrie gave him a long and rambling account of the offences as she perceived them. Dr Dickinson told the panel that one of his difficulties in working with Mrs Murrie was that she always came with her own, often undisclosed agenda. For example, he felt that she frequently wanted something from him, but she would not come out and say this openly. On this occasion, Dr Dickinson had felt that she wanted him to try to explain matters to the court on her behalf.

221 In particular, he felt that she was trying to control the interview in such a way that he would prepare a favourable report. Mrs Murrie appeared to him to want him to be on her side; to want him to protect her from the court and, thereby, to protect her from the consequences of what she had done. (Afterwards, Dr Dickinson had started the process of preparing a report but he did not finish or dispatch it because of subsequent events.) Dr Dickinson's impression was that, during the interview, on 14 February, Mrs Murrie appeared to him to be trying to influence what he would say in his report because (he speculated) she felt that, through her behaviour, she had scuppered her chances of getting custody of Louise.

222 Dr Dickinson told the panel that from what he had learned of what Mrs Murrie had said to one of the social workers on the day after he saw her in February 1994, she had left her appointment feeling that she had not gained his co-operation. He told the panel that it was a matter of grave regret to him that she had left feeling like that. From his perspective, he had felt that the encounter was friendly and supportive. At the time, he had thought that they had had a helpful discussion but, in retrospect, it seemed that he not given her what she had come for.

223 Dr Dickinson described Mrs Murrie to the panel as being quite a lonely person. He considered it significant that a number of her friends were also psychiatric patients. He knew that Louise's death had a devastating effect on a number of his patients and other people with whom Mrs Murrie was friendly. He had attempted to support these people. It was difficult to know what had been going on in her mind because others had told him that the people that she saw, and who were also patients of his, had felt that she appeared quite well in early 1994. For example, Dr Dickinson was aware that, on 30 January, she had been to the birthday party of one of his other patients. She had taken Louise with her and had seemed cheerful and quite well at the time. Mrs Murrie had told one of Dr Dickinson's patients, in February, that she was looking forward to her holiday. She said that she was planning to take Louise into the country at half-term and that her husband had given permission for this plan.

224 Dr Dickinson said that he could not remember who had told him about what had happened subsequently, but he had been shocked and appalled by the news. Before the event, Dr Dickinson had had no sense of any person being in any danger. Further, he had not felt that Mrs Murrie posed a danger to herself when he last saw her. Nonetheless, he had endeavoured to determine whether she had been responsible for her actions when she attacked her husband's friend's property. He had concluded that she had been responsible for this; moreover that there

had been an element of pre-meditation and revenge involved in her motivation. He expressed a caveat that he had found it difficult to come to a clear conclusion. However, he was certain of his opinion that the attack had not taken place because of a psychotic episode.

225 Inevitably, Dr Dickinson had been concerned that there might be a recurrence of this kind of violence and, therefore, he was concerned about the extent to which Mrs Murrie posed a risk to Mr Murrie's friend or her property. Mrs Murrie had attacked the woman's property on two occasions, once at her home and once at Mr Murrie's home. Dr Dickinson felt that Mrs Murrie was mentally responsible for her behaviour during those attacks, and he did not feel that there was anything he could do for her, apart from talking through the implications. Therefore, on 14 February 1994, he had asked Mrs Murrie whether she felt that there was a danger of any repetition and she had reassured him that there was not and that she felt her behaviour was under control. However, he had found the assessment of this risk very difficult.

226 Dr Dickinson's opinion was that Mrs Murrie was talking about revenge in the heat of the moment in her discussion with Mr Clarke in February 1994 and he had concluded that she would not necessarily do anything dangerous. In Dr Dickinson's experience of Mrs Murrie over the period of the previous two to three years, she had often said that she loathed her husband and wanted nothing more to do with him. At other times, she had said that she would happily go back to him. Dr Dickinson felt that this showed her fluctuating state of mind.

227 Dr Dickinson's clinical opinion then, in mid-February 1994, was that there was no reason for Mrs Murrie to go into hospital at that stage; he had not felt that she was acutely ill in any sense. Furthermore, Mrs Murrie was not asking for admission. He suspected that she felt that if she had asked for admission again that might have gone against her in her attempts to gain custody of Louise. He recalled that, at the time, he considered it appropriate to prepare a report that said he did not feel that she was psychiatrically ill.

228 According to Dr Dickinson, Mrs Murrie was impulsive and unpredictable in her behaviour. He told the panel that he was aware that, over the years, a number of people considered that they were being manipulated by her and, on the last occasion that Dr Dickinson had seen her, on 14 February 1994, he had felt strongly that she was trying to manipulate him. He expressed the view that, with the benefit of hindsight, it could be seen that what was happening in early 1994 was the culmination of a long process in which the quality of Mrs Murrie's life deteriorated.

229 Dr Dickinson told the panel that he believed that Mrs Murrie had only trusted him to a limited degree. He did not feel that they had a close, trusting relationship despite many contacts between them. He felt that her personality prevented this. However, he had not considered Mrs Murrie to be spinning out of control at that time; rather he had felt that the events reported at his interview in February 1994 were occurrences in a series of continuing incidents.

230 He recalled speculating at the time about what Mrs Murrie would do next. He considered her to be unpredictable and he knew that she was to appear in court again on 1 March 1994. In the event, this was the Monday after she killed Louise. Dr Dickinson had not anticipated that she would risk exhibiting any disorder of behaviour before the court case. He thought she would have been careful to make sure that the court case went as well as possible. At the time, he believed that she would try to keep her behaviour under control in order to give a good impression.

231 Again in retrospect, Dr Dickinson considered that he had underestimated Mrs Murrie's misuse of temazepam and the effect that it was having on her behaviour. His opinion was that Mrs Murrie had been misusing temazepam for a number of years and it had been of concern to her GP who had attempted to address the problem. Dr Dickinson told the panel that, in theoretical terms, the impact of this substance on her behaviour might have been to impair her judgement in that she might, at times, have been confused. Additionally, her mood would have been more volatile as

temazepam can have a disinhibiting effect. In his opinion, temazepam could still have these effects if misused over a long period of time. However, he did not think that Mrs Murrie's misuse of temazepam was likely to have had much of a bearing on her subsequent actions. In particular, in Dr Dickinson's opinion, the substance could not be held to account for her killing Louise.

232 With the benefit of hindsight, he wished that he had suggested that Mrs Murrie come into hospital when he saw her on 14 February although, clinically, he still could not recall any reason for so advising Mrs Murrie. Furthermore, he did not think that she would have agreed to it. In particular, he had found no psychiatric grounds for her admission, although he might possibly have offered to support her through the court case, which she was facing, if he had been aware of the level of her distress. She had, however, been through other court cases before without needing to come into hospital. Thus, this was not a course that he had seriously considered on 14 February 1994.

233 In response to specific questions, Dr Dickinson told the panel that he had corresponded regularly with Mrs Murrie's GP, Mr Clarke and Mrs Johnson. He had no contact with Mrs Dunn, the court welfare officer, and he had not known of her involvement at the time of the events in 1993 and 1994.

234 Retrospectively, after looking through the letters he had written to Mrs Murrie's GP over the years, Dr Dickinson told the panel that he had tended to emphasise those components of her state of mind which he felt were treatable. For example, he had focused on the fact that Mrs Murrie had suffered from agoraphobia, also her misuse of temazepam and, at one stage, her misuse of alcohol. Mrs Murrie had also taken several overdoses. He did not think that the panel would find the diagnosis of a personality disorder in any of the letters that he had written, not because this was inaccurate in his opinion, but because he thought that this 'label' would be unhelpful to Mrs Murrie's care.

235 Thus, Dr Dickinson told the panel that he thought that some professionals might have said that Mrs Murrie had a disordered personality of the psychopathic type. By preference, Dr Dickinson felt that she showed histrionic behaviour. Further, he considered that her personality was shallow and self-centred and she could only see a situation in terms of what others did to her. Also, he thought that Mrs Murrie could not see the full effects of her behaviour on other people and she could not perceive her own responsibility when matters went wrong. Dr Dickinson said that Mrs Murrie habitually blamed other people for predicaments for which she was responsible. In his experience, it was difficult to get close to her and relationships were always on her terms. She had a tendency to romanticise, and retreat into a fantasy world. He observed that she habitually put a lot of emphasis on appearances, particularly her own appearance.

236 He told the panel that, in his experience, if people are labelled as having a personality disorder, there is a danger of staff dismissing them and their problems because effective treatment is such an unknown quantity. Thus, he rarely described people as psychopathic, or as personality disordered. However, in retrospect, he considered that perhaps he should have emphasised Mrs Murrie's disordered personality, for there was no doubt that she had diverse problems that would support such a description.

237 Dr Dickinson had diagnosed Mrs Murrie as suffering episodically from depression and phobic anxiety. While he considered these to be accurate diagnoses, he had felt that other professionals would have responded differently to Mrs Murrie if he had also emphasised her co-existing personality disorder. He had not referred to a disordered personality in letters about her, because (as discussed above) he felt that it would be destructive to point out that aspect of her. He felt that he needed to continue to work with her to enable her to function. Nonetheless, there had been a lot of discussion about her personality in conversations. This had influenced the way in which staff tried to treat her.

238 Dr Dickinson told the panel that his habitual style was to stick with his patients. He did experience exasperation with Mrs Murrie at times but he and the rest of the team felt good will and concern for her. He felt that if she was going to be helped it would be by supportive counselling rather than by psychotherapy.

239 In his response to the panel's questions, Dr Dickinson agreed that Mrs Murrie's disordered personality was the reason for her being sent to Broadmoor rather than to prison, but he emphasised that personality disorder was not the focus of his treatment of Mrs Murrie.

240 Dr Dickinson told the panel that he did not know what could be done to protect the families of other, similar patients. He felt that Louise's death could not be foreseen from anything that Mrs Murrie had done before. Mrs Murrie had never voiced anything of that sort before to workers involved in her care. It was later reported to Dr Dickinson that she had said to someone else that, if she could not have Louise, her husband would not have her either, but this only came out after Louise's death. There were clearly issues of revenge in her mind, but that was several months before the event.

241 The Panel of Inquiry took the opportunity to enquire with Dr Dickinson about more general matters. In response, he told the panel that the Oxfordshire-Berkshire overlap area had not presented him with significant problems. He felt that communications were good and that discharges went smoothly. He recalled that staff had held a case conference before Mrs Murrie was discharged from hospital in March 1993, and Dr Holcombe, her GP, had attended. Later, Dr Boon had taken over from Dr Holcombe.

242 With regard to the Care Programme Approach, Dr Dickinson told the panel that, when staff at the trust that employed him had begun to implement the CPA, they started with patients who had been detained in hospital under section 3 of the Mental Health Act 1983, or who had been in hospital for more than six months. In effect, they had initiated action by considering patients who were deemed to be the most vulnerable. Mrs Murrie did not come into that category. However, in spite of this, they had held a case conference concerning her.

The Role of Dr Jean Boon, General Practitioner

243 When Mrs Murrie was discharged from Fair Mile Hospital in the spring of 1993, her previous GP, Dr Holcombe, was informed. Subsequently, Dr Jean Boon became Mrs Murrie's GP. Therefore, the Panel of Inquiry saw and took evidence from Dr Boon in order to understand her role and in order to seek any observations that she might make that could shed further light on the events and opinions about them.

244 Dr Boon became a partner in the practice in which Mrs Murrie was registered in October 1993. Therefore, this was the earliest time of her possible involvement with Mrs Murrie or with her family. Dr Boon told the panel that she had had no medical contact with the Murrie family as such, because the other family members lived at a distance from Mrs Murrie's address in Caversham and were, presumably, registered with a different practice. Also, at the time of her meeting with the panel, Dr Boon had to rely on her memory as she was no longer Mrs Murrie's GP and, therefore, was no longer the holder of Mrs Murrie's records.

245 Nonetheless, she recalled Mrs Murrie well and told the panel she had only known Mrs Murrie when matters for her were at their worst. She recalled Mrs Murrie as being excited and bitter about her ex-husband forming a relationship with another woman. This matter had formed the content of their discussions on the four or five occasions when Dr Boon had met Mrs Murrie, prior to the death of Louise.

246 Dr Boon recounted how Mrs Murrie had described to her the episodes when she had sneaked up on her husband's house. Apparently, Mrs Murrie had come to discuss this with Dr Boon because she (Mrs Murrie) felt that she could not handle the situation. However, there was never any mention, as far as Dr Boon could recall, of Mrs Murrie expressing an opinion that it was inappropriate for Louise to live in her husband's home.

247 Dr Boon also told the panel that one of her partners had previously been a member of the junior psychiatric staff in West Berkshire and that, in that capacity, she had known Mrs Murrie. Apparently, this doctor had commented to Dr Boon on how well Mrs Murrie had appeared to her to be compared to when she had seen her previously in hospital.

248 Turning to Louise, Dr Boon told the panel that she had never picked up that Mrs Murrie had felt anything other than love for her daughter. It had never crossed her mind that Louise was at risk. Nonetheless, she was aware of Mrs Murrie's overwhelming emotion of jealousy towards her ex-husband.

249 Dr Boon said that she would have expected Mr Murrie's new friend to be the subject of Mrs Murrie's jealousy but she would not have expected Mrs Murrie to express actual violence towards her. Nonetheless, Dr Boon had thought to herself that the main avenue of risk might be damage to the other woman's property. In this regard, Dr Boon recalled with some clarity Mrs Murrie's inability to see that she was doing anything wrong; Dr Boon also recalled the vociferous manner in which Mrs Murrie expressed her feelings. Dr Boon told the panel that she had not argued with Mrs Murrie but had endeavoured to point out to her the realities of the situation with regard to her husband.

250 Dr Boon told the panel that she had met Louise at one consultation when she had accompanied her mother. She recalled Louise sitting by her mother's side. From memory, Dr Boon recalled that this occurred during her second consultation with Mrs Murrie before Christmas 1993. Although Dr Boon had never met Louise on her own, she told the panel that Louise did not present to her as an unhappy child. Indeed, she was a chatty girl who was not overawed either by her mother or by being at the doctor's surgery. Mrs Murrie had seemed to Dr Boon to be happy to discuss personal matters in front of Louise and Dr Boon could recall that one of the issues that she discussed with Mrs Murrie was Mrs Murrie's concern about how much time each of her parents would spend with Louise over Christmas.

251 Although Dr Boon could not recall any suggestion of Louise being remarkably upset, she did tell the panel that she had speculated within herself about Louise's circumstances and the emotional situation to which she was being exposed. Dr Boon told the panel that she naturally experiences considerable empathy with children and that she felt concerned for Louise at being brought up in circumstances such as hers. Otherwise, she was not aware of any particular reasons for being concerned about Louise and confirmed that none of the professionals had approached her about Louise.

252 During the week when Mrs Murrie killed her daughter, Dr Boon was away from her practice on holiday but she recalled receiving a letter from Mr Clarke on her return. Dr Boon told the panel she was aware that Mrs Murrie was being seen on a weekly basis by a CPN and by a social worker and she recalled the worrying tone of Mr Clarke's letter to her. In retrospect, she had wondered whether there was anything further that she could have done to prevent the tragic events that unfolded in February 1994 but, on reflection, had concluded that there was nothing that she might otherwise have done.

253 Dr Boon considered that her own role with Mrs Murrie had not been a very considerable one because Mrs Murrie was being seen by a number of other health professionals. Therefore, as Mrs Murrie's situation began to become more difficult in the opening weeks of 1994, Dr Boon recalled receiving copies of the various letters about her from those involved in her care, but she did not feel that she should do anything more than was already being done by the other professionals.

The Role of Mrs Marion Johnson, Community Psychiatric Nurse

254 Mrs Marion Johnson was the last witness to be seen formally by the Panel of Inquiry. Formerly, Mrs Johnson was an employee of the West Berkshire Priority Care Service NHS Trust. She had been employed by the trust in November 1992 and went on maternity leave in August 1994 before resigning her post. Thus, Mrs Johnson was involved with the care of Mrs Murrie after her discharge from Fair Mile Hospital in 1993 and until around the time of the death of Louise.

255 Mrs Johnson is a community psychiatric nurse. She undertook her initial nurse training at St George's Hospital in Mid Staffordshire and worked there as an enrolled nurse for a number of years. She came to Berkshire in 1986 and qualified as an RMN in 1988. She worked on the acute wards at Fair Mile Hospital before being promoted to the post of deputy charge nurse at a day unit in Essex. Subsequently, she applied for the job of CPN at Bucknell House. Mrs Johnson told the panel that she has Diplomas in Psychotherapy, Hypnotherapy and Neuro-Linguistic Programming (NLP) techniques from St Anne's Hospital, London.

256 Initially, Mrs Johnson described to the panel the nature of the service at Bucknell House. She explained that at the time she worked there, the services at Bucknell House were run by the Berkshire Social Services Department. She recalled being the only member of NHS staff based there and that the other staff included an occupational therapist and a senior social worker employed by the local authority. Her NHS manager was based at the Coley Clinic. Mrs Johnson told the panel that there was another NHS post for a psychologist in the team at Bucknell House, but it was never filled during her time there.

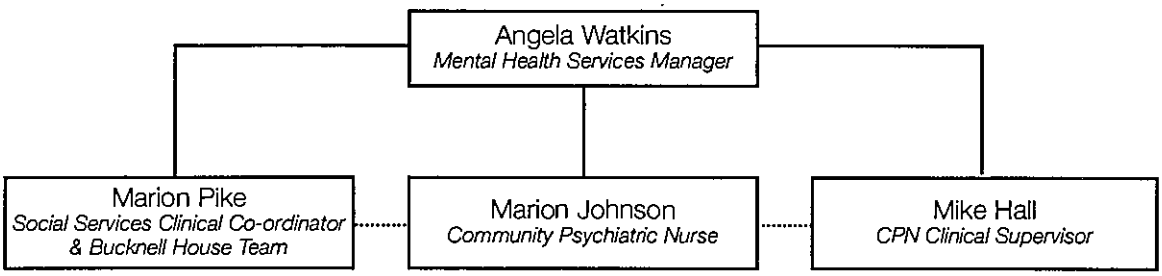
257 Mrs Johnson's tasks at Bucknell House were to provide the nursing input for a depot medication clinic and to conduct other nursing duties as a member of a multi-disciplinary team. She told the panel of the tensions that arose from her being the only NHS member of staff working in a team run by the social services department; she recalled that the professional basis for decision-making and actions were different between the two sectors of care. Indeed, she recalled that the work plans were based on social services practice and guidelines, and were quite different from the guidelines she was used to in her previous unit in Essex. Mrs Johnson told the panel that, during her time at Bucknell House, mechanisms for planning and management of care plans were absent, but she did make her own plans for her own clients.

258 Further exploration revealed that, in Mrs Johnson's opinion, there might have been a programming mechanism conducted by the social services department employees, but this did not operate from a NHS perspective. Thus, she felt out on a limb as the only NHS-employed person present in that team. In summary, she told the panel that she thought the team was professionally very good but functioned as a social services team into which she had to try to fit.

259 Nonetheless, Mrs Johnson recalled receiving weekly supervision of her work with her clients though she considered that there was a lack of day-to-day support from her colleagues, as well as the absence of a peer group that thought along the same lines as she did.

260 Mrs Johnson's account of her professional and managerial working relationships accord with that given to the panel by the senior staff of her employing trust. Her professional and managerial relationships are summarised in the diagram overleaf.

Professional Relationships for Marion Johnson, Community Psychiatric Nurse



——— *Line Management Professional Links*

..... *Mrs Johnson would also be involved in monthly meetings with the CPN team*

261 The management inquiry conducted by West Berkshire Priority Care Service NHS Trust also mentioned a number of shortcomings relating to Mrs Johnson's professional situation which gave rise to recommendations for the future (see Annexe F). These conclusions appear to the panel to fit with the information and opinion provided to this inquiry by Mrs Johnson.

262 In Mrs Johnson's view, there were three key people involved in Mrs Murrie's care from the mental health services. These were Dr Dickinson, the consultant psychiatrist; Mr Tony Clarke, the social worker; and herself, a CPN.

263 Mrs Johnson's first contact with Mrs Murrie was in autumn 1993, although she recalled that Mrs Murrie had been referred to the service at Bucknell House after her discharge from Fair Mile Hospital in March 1993. Mrs Johnson said that, at the time, Mrs Murrie was not living with her family, and that she (Mrs Johnson) had not met any other members of the family. Indeed, she told the panel that it was not usual for her to meet other members of her clients' families if they were referred to the unit, as was Mrs Murrie, for work on an individual basis.

264 Mrs Johnson recalled Mrs Murrie as being a pleasant person who talked a lot although, on reflection, Mrs Johnson considered that it had been difficult to get beneath what she took to be a superficial veneer. Mrs Johnson stated that although she had seen Mrs Murrie on about 10 occasions, she felt that she had only glimpses of the person she regarded as the real Mrs Murrie. Further, Mrs Murrie did not always turn up for her appointments.

265 Mrs Murrie had told Mrs Johnson about the early days of her marriage. Mrs Johnson also recalled Mrs Murrie talking a lot about Louise. She had told Mrs Johnson that having Louise had improved her marriage.

266 Mrs Johnson told the panel that she last saw Mrs Murrie about three weeks before Louise's death. She recalled her perception that although Mrs Murrie often said socially acceptable things to her, she did sometimes talk about how she felt about her husband and his new friend. Nonetheless, Mrs Johnson did not consider that Mrs Murrie was confiding in her in particular. Similarly, Mrs Johnson recalled Mrs Murrie's feelings that she would be able to get back together with her husband if it wasn't for the presence of his new friend, who stood in the way. Mrs Johnson felt that Mrs Murrie only partly believed that this was possible, while also recognising that such a development would be unlikely. However, Mrs Johnson could not recall Mrs Murrie saying anything that had given cause for alarm.

267 During the course of their meetings, Mrs Murrie had told Mrs Johnson about the damage that she had caused to Mr Murrie's friend's house and car. This gave Mrs Johnson glimpses into Mrs Murrie's tendency to get both angry and violent. Mrs Murrie would often burst into tears after speaking about these incidents. Mrs Johnson believed that Mrs Murrie could act impulsively, although she told the panel that it was also her opinion that sometimes what appeared to be impulsive acts were actually planned ones.

268 Towards the end of the panel's interview with Mrs Johnson, she was asked to speculate on service responses that might have changed the situation for Louise and the eventual outcome. In retrospect, Mrs Johnson conceded that it was possible that not enough was done to look into Louise's care. She expressed the view that when children are in a split family with problems of the kind faced by Mrs Murrie, the family unit of the service should be advised to look into the situation.

Information Provided about Louise at School and by the School Nursing Service

269 In the report on its management inquiry, the West Berkshire Priority Care Service NHS Trust concluded that: 'Louise Murrie had made a normal and unremarkable progress in pre-school years and was seen for routine screening by Rosemary Mann, Community School Nurse, following a school entrance medical in 1990.' Elsewhere, this report states: 'The Health Visitor was aware that Anne Murrie was receiving help from Psychiatric Services. However, it is not normal for Health Visitors or School Nurses to be told of the involvement of Psychiatric Services unless there is a specific reason.' The inquiry report also states, 'There were normal records kept by Health Visiting and Community School Nurse Services.'

270 In her report of April 1993, Mrs Dunn refers to her contacts with Louise's school. She concludes that 'Louise has already shown some signs of confusion and distress that are just under the surface... ' and 'She also soiled her underwear from time to time - a sure sign of insecurity... '

271 The panel has seen the brief report, written by Louise's class teacher in March 1993. This describes Louise's hard work and improvement in reading. She is portrayed as a loner but as having developed friendships with other girls in the class, and also as being settled and more integrated into the class. Her teacher reported that there had been tears and outbursts in a previous class. However, she reported that none of these episodes had occurred in her six months' knowledge of Louise.

272 The implication of these reports appears to the panel to be that Louise had shown signs of upset and strain in 1991-1992 and into 1993 but that these were abating during 1993.

273 The panel interviewed Mrs Rosemary Mann and her school nursing service professional supervisor, Mrs Shirley Goldin, Senior Nurse, Child Health.

274 Mrs Mann told the panel that she had had two contacts with Louise over the four years in which Louise was in a school served by Mrs Mann, and that the last time she saw Louise was in October 1992, when Louise was seen for routine screening of her vision. Mrs Mann also told the panel that she had good relationships with the teachers at Louise's school and, ordinarily, teachers conveyed any concerns about pupils to her. Frequently, there were discussions about the pupils between the teachers and Mrs Mann, but there were no contacts about Louise. Mrs Mann also offered 'drop in' sessions in her schools, but she had had no information about Louise from this source.

275 After Louise's death, Mrs Mann learned from one of the helpers at the after-school club held at the school, that Louise had told the helper that she was not happy being with her mother. Also, it became clear later that Louise's teacher had known, indirectly and by hearsay, of Mrs Murrie's more recent upsets and her attacks on Mr Murrie's friend's car. However, there appeared to be no information or concerns circulating within school at the significant time in 1993 and 1994, about Louise herself, or her own condition.

The Role of Mrs Loran Dunn, Court Welfare Officer

276 Mrs Dunn told the panel that she had been a family court welfare officer in Oxfordshire since 1992. Originally, she had trained as a probation officer. Since 1974, she has performed a variety of probation officer and childcare, hospital and psychiatric work roles. Mrs Dunn also has a mental health qualification. She has worked at Broadmoor Hospital for four and a half years in the past and, during this time, she undertook the training provided for Approved Social Workers.

277 Mrs Dunn told the panel that, in April 1993, she was ordered by the Reading County Court to prepare a welfare report in respect of Mrs Murrie's, later unsuccessful, application for a Residence Order relating to Louise.

278 Mrs Dunn said that, in April 1993, when she had written her report, Louise was adamant that she did not want to see her mother because she feared that her mother would get a Residence Order. Louise was relieved of that worry when her mother withdrew the application and she knew that she could live with her father. She was then more prepared to see her mother. Mrs Dunn's court report of 1993 had been written in the context of the events of 1992, when Mrs Murrie had been quite ill and had taken Louise away for several days on three occasions without permission. In that period, Mrs Murrie had also disappeared for about three months to Ilfracombe, when she had very little contact with her family. When she came back, she had demanded to return to the family home. According to Mrs Dunn, when Mrs Murrie had been hospitalised, Louise had said that she hated going to Fair Mile Hospital to see her mother. Mrs Dunn's understanding was that Louise was upset about her mother trying to get her to live with her, particularly as Mrs Murrie did not have a permanent home.

279 Mrs Dunn had written her report, detailing her advice to the court, during April 1993. The court's subsequent decision in May 1993 was to make a Family Assistance Order in respect of the Murrie family and this required Mrs Dunn to keep in touch with the family for six months. Mrs Dunn said she had not recommended a Family Assistance Order in her report, but had subsequently recommended it before the matter had come to court. In the event, the Family Assistance Order was agreed between the parties, in that Mrs Murrie withdrew her application for a Residence Order in respect of Louise, in return for the regularisation of contact with her, and the support and assistance of someone like Mrs Dunn.

280 Mrs Dunn told the panel that the Family Assistance Order placed obligations on her, and it also allowed her to remain a party to the proceedings. In general terms, she believed that this often took pressure off parents and, if a return to court was necessary during the period that the Order was in force, then it was someone neutral who was instigating the action. In this case, that had not been necessary because matters settled down and went well for the next six months. Mrs Dunn considered that, during that period (approximately April to November 1993), Mrs Murrie had achieved quite a lot. She was not on very much medication, and she seemed quite cheerful (although she did complain about Mr Murrie). She had found herself a room to live in and she had two part-time cleaning jobs. Although she spent a lot of time on her own, she was apparently not abusing medication, was not becoming depressed, or spending hours in bed. Furthermore, Louise seemed to be happy to be seeing her.

281 Mrs Dunn recalled for the panel that, after Mrs Murrie's discharge from Fair Mile Hospital in March 1993, she had been found a temporary room in Reading. Then she had found a room in Caversham that was close to the family home where Louise lived with her father. At that time, the divorce had already taken place and the decree absolute had been granted. In Mrs Dunn's view, Mrs Murrie had still not, at that stage, come to terms with the divorce and was feeling persecuted and resentful. Gradually, over the following months, she appeared to reconcile herself to the divorce. She also appeared to accept that it was not appropriate for her to demand to come back into the family home, and that these demands were not good for the children.

282 Mrs Dunn reported to the panel that she had talked these matters through with Mrs Murrie. In many of their conversations, Mrs Murrie returned to what appeared to Mrs Dunn to be a prevailing theme of complaining about Mr Murrie. Mrs Dunn's assessment at the time was of someone having a good moan. For example, Mrs Murrie had moaned about how nasty her husband had been in ejecting her from the family home and seeking a divorce. She complained that he was hard and unfeeling.

283 Mrs Dunn told the panel that, in preparing her report, she had had to get a lot of information from Mr Murrie, as it was clear to her that Mrs Murrie was 'in denial'. Mrs Dunn told the panel that she viewed Mr Murrie as a courteous, conscientious and slightly formal man who probably had a hard time coping with his wife. Her opinion was that Mr Murrie managed to get on with his life in spite of past tragedies.

284 Mrs Dunn thought that, at this time, Mrs Murrie had still hoped to be reconciled. Mr Murrie was sceptical about the state of Mrs Murrie's health, while Mrs Murrie was scornful about Mr Murrie while still professing to love him.

285 In summary, Mrs Dunn's view was that Mrs Murrie had had her ups and downs and a bad time in 1992, but seemed to have been coping reasonably well during the period when the Family Assistance Order was in force in 1993. The Order lapsed in November 1993.

286 During the period from the end of the Residence Order in November 1993 to Louise's death in February 1994, Mrs Dunn renewed contact with the family, partly at their request, but also because she recognised the need for assistance. It appears that Mrs Dunn's supervisor had not known that her involvement with the family had recommenced after the Order had ceased, and was under the impression that Mrs Dunn had withdrawn. Mrs Dunn told the panel that the focus of her work was the family and Louise, and not Mrs Murrie and her psychiatric condition. Mrs Dunn had become involved again because of the family.

287 Mrs Dunn explained to the panel how her renewed involvement in the case had begun. On 31 December 1993, Mrs Dunn was in her office and received a call from Mrs Murrie. She was very distressed. She told Mrs Dunn that Mr Murrie had found a new partner. In Mrs Dunn's opinion, Mrs Murrie was then pathologically jealous. The advent of Mr Murrie's new friend had brought back all Mrs Murrie's unresolved feelings about her divorce and her relationship with Mr Murrie. She felt that she had been shoved out of Mr Murrie's life and home, despite the fact that she still loved him, and that he had separated her from Louise.

288 During this conversation, Mrs Murrie related to Mrs Dunn how she had visited the family home shortly after Christmas and had seen Louise and talked with Stuart. Mr Murrie had later asked her to leave because he was taking his friend and Louise out to dinner. Mrs Murrie had told Mrs Dunn that she had successfully put pressure on Louise not to go, even though Louise wanted to do so. Mrs Dunn had told Mrs Murrie that this was inappropriate and confusing for Louise. She told the panel that she had been amazed that Mrs Murrie could have so blatantly displayed her jealousy to Louise, when she had already been divorced for a year. In spite of Mrs Dunn being so blunt, Mrs Murrie had continued to talk to her. Mrs Dunn thought that Mrs Murrie sounded

depressed and hopeless. Mrs Murrie had said that she was expecting to see Louise for the afternoon and take her to the cinema. Mrs Dunn had tried to cheer up Mrs Murrie and, by the end of the telephone call, she thought that Mrs Murrie sounded happier.

289 Mr Murrie contacted Mrs Dunn in January 1994. He told her that he had a new friend and that Mrs Murrie had slashed the tyres on her car. He asked Mrs Dunn to see Louise because he thought she was confused. Consequently, Mrs Dunn saw Louise who told her that her mother had asked her to ring her father's friend to ask her not to visit. Mrs Dunn had told Louise not to get involved; she had explained to her that her mummy was sad that her marriage was over and that her daddy had got a new friend. She had asked Louise if she was able to say no if her mum asked her to do anything like that again. Louise had agreed that she could. Louise had also told Mrs Dunn that her father's friend always visited after she had gone to bed, and that she wanted to get to know her because she thought that she might be quite nice. Mrs Dunn told the panel that this was very different to the usual situation because, in her experience, children were usually resistant to potential step-parents. She had told Mr Murrie this.

290 On 17 February 1994, Mrs Dunn received a further telephone call from Mrs Murrie who seemed to be in the depths of despair. At first, Mrs Murrie had been a little hostile and wanted to know why Mrs Dunn had seen Louise and why she had not told her afterwards. Mrs Dunn told Mrs Murrie the truth; that Louise had complained that her mother had tried to get her to be nasty to Mr Murrie's friend. Once the friend's name was mentioned, Mrs Murrie became extremely upset and Mrs Dunn could tell that she was crying, and sounded sleepy as though she had just been to bed, or had taken a substance which caused sleepiness. Mrs Murrie told her that Mr Murrie's relationship with his friend was 'cracking her up' and that she could not cope with it. Mrs Murrie said that she still loved Mr Murrie, and did not want Mr Murrie's friend to make a relationship with Louise. At that point, Mrs Murrie had not seen Louise for nearly three weeks.

291 Mrs Murrie also told Mrs Dunn, during this telephone conversation, that she had gone to her former matrimonial home on one evening (26 January 1994). Mr Murrie's friend's car was outside. Mrs Murrie said that she had looked through cracks in the curtains. She had become convinced that her husband was upstairs in her bed with his friend and she was worried that Louise would somehow find them together. On an impulse, she had slashed the car tyres and, coming away from the property, she had seen Stuart and there had been an altercation. In the meantime, the police had been called and she was apprehended.

292 Mrs Murrie told Mrs Dunn that, after this event, she had phoned Louise and told her that she thought it best not to see her for a while. Then, after a week, she had changed her mind and begged Louise to visit, but Louise had refused. Mrs Murrie reported to Mrs Dunn that she thought Louise was coming around to the idea of visiting, and that she would probably come and see her at the weekend, which she did.

293 It was a particularly intense telephone call. Mrs Dunn reported to the panel that she had rarely encountered someone more distraught. They talked about Mrs Murrie's anger and how it probably dated back to the loss of Lianne. Mrs Murrie was inconsolable about Mr Murrie's new relation with his friend. She said she was now happy for the family home to be sold, as in her mind it was sullied by the presence of Mr Murrie's friend. Mrs Dunn tried to direct Mrs Murrie's thoughts to the future; they spoke about how the financial settlement would have positive implications for Mrs Murrie in terms of independence and better accommodation. Mrs Dunn suggested that Mrs Murrie should explain to Louise that she had not been feeling well but now wanted their contact to get back to normal.

294 Mrs Dunn told the panel that, during the conversation, Mrs Murrie had also expressed anxiety about Stuart walking home late at night from the pub, in case he got mugged. Mrs Murrie had asked Mrs Dunn to mention this to Mr Murrie. At the end of the conversation, Mrs Dunn thought

that she sounded more hopeful. The conversation had taken place on a Thursday. As stated, Mrs Murrie was hoping to see Louise at the ensuing weekend (19-20 February) after a gap of three weeks.

295 Mrs Dunn told the panel that Mr Murrie had phoned her on the following Monday (21 February). He said to her that Louise had gone to visit her mother, who had now taken Louise away for a few days. Louise had telephoned him on the Saturday afternoon and asked if she could stay the night. Mr Murrie had been concerned but Louise had seemed all right so he had agreed to Louise's request.

296 During this conversation, Mrs Dunn told Mr Murrie of her conversation with Mrs Murrie on the previous Thursday. Mrs Dunn asked Mr Murrie if he had any plans to stop Mrs Murrie disappearing again with Louise. Mr Murrie said that he would be guided by the solicitor, but he wanted the question of contact looked at again as it was getting out of hand. Mr Murrie did not know where they had gone but this had occurred three times before in 1992, and she had always returned. Mrs Dunn and Mr Murrie assumed that Mrs Murrie would turn up with Louise, but in the meantime Mr Murrie was taking the matter back to court.

297 On, Wednesday 23 February, Mrs Dunn spoke to Mr Murrie who had gone to a Judge and been granted a Prohibited Steps Order (an Order under section 8 of the Children Act 1989), but this could not be served as no one knew where Mrs Murrie was. Mr Murrie said that he hoped to go back to court on the following Wednesday when it was hoped that Mrs Murrie would have reappeared. If this had been the case, Mrs Dunn would have attended the court in the context of Mr Murrie's application, and would have asked to become re-involved either by preparing a further report, or through another Family Assistance Order.

298 In summary, Mrs Dunn explained that, in her opinion, the critical period was between 31 December 1993 and the middle of February 1994. Mrs Dunn told the panel that at this time Mrs Murrie's mental state and its effect on Louise had concerned her. She had also been concerned by Mrs Murrie's emotional displays of jealousy and by her sudden disappearance with Louise.

299 During its meeting with Mrs Dunn and Mrs Forrest, the panel explored the very low level of contact between Mrs Dunn and other agencies. The panel was left with the impression that the probation service saw itself as occupying an exclusive position with regard to its relationships to the courts, to clients and to other services.

300 For example, the panel was told that, in the opinion of the staff interviewed, court welfare reports were always confidential; they were prepared for the courts and not released to anyone else. The parties concerned saw the reports - usually the parents and their solicitors who held copies; the parents did not get copies. The reports were for the judge in court and, once the relevant matters had been dealt with they stayed on the court files.

301 Also, Mrs Dunn told the panel that effectively there was a six-week period in late 1993 and early 1994 in which the case was technically closed, and before she had become drawn into it again. Towards the end of that time she had concluded that she should seek to become re-involved formally. With hindsight, she accepted that, at that time, she might have contacted the other professionals.

302 As recorded earlier, during those six weeks Mrs Dunn had felt that Mrs Murrie was becoming distraught. Therefore, with Mr Murrie taking the case back to court, Mrs Dunn had resolved to suggest to the Judge that her official involvement should be re-established. Mrs Dunn told the panel that, if she had been successful in so doing, she would have contacted the professionals in other agencies involved in Mrs Murrie's care. She explained that if there had been social services childcare involvement, she would automatically have contacted other professionals at an earlier

stage. Routine checks with the Child Protection Register, carried out during the preparation of the welfare report had not revealed any child protection involvement. If there had, at any time, been any risk indicators of child abuse, she would have acted immediately. Mrs Dunn said, however, that, at the material time, she was becoming increasingly concerned at the emotional impact on Louise of Mrs Murrie's response to Mr Murrie's new relationship.

303 Mrs Dunn told the panel that she contacted Mr Clarke after Louise's death. He had told her that Mrs Murrie had mentioned to him that she would take Louise away. Had they been in contact before, Mrs Dunn thought that she might have picked up the threat to take Louise away, but she did not think that this knowledge would have made a difference because Mrs Murrie was 'always threatening things and moaning about her husband'. Unless this threat had been made in a very forceful way, she might not have acted on it. Furthermore, it was known to Mrs Dunn, through reading the psychiatric reports, and through her discussions with both parents while preparing the welfare report, that Mrs Murrie had taken Louise away on three previous occasions in 1992 and she had always brought her back.

304 Thus, although Mrs Dunn had limited contact with the family during the January and February 1994 'crescendo' period, and at the point at which Mr Murrie had applied for a Prohibited Steps Order, she had been sufficiently alarmed to consider requesting the court to order her re-involvement in the case. Mrs Dunn felt that Mrs Murrie's distraught behaviour of 1992 might be repeating itself, and that the family, particularly Louise, should have help in coping with that. In her professional opinion, she felt that any contact that Mrs Murrie had with Louise should be carefully managed.

305 The panel questioned Mrs Dunn about the degree of her awareness of the other elements of care that Mrs Murrie was receiving and how this had affected her responses to Mrs Murrie's situation.

306 Mrs Dunn told the panel that, in her opinion, Mrs Murrie was a disturbed woman; sometimes more disturbed than others. Mrs Dunn believed that Mrs Murrie had a personality disorder but not to the extent of being psychopathic. Mrs Dunn confirmed to the panel that she was aware that Mrs Murrie was receiving psychiatric care during the period that she knew her, and had assumed that the feelings that Mrs Murrie had been expressing to her, of jealousy and of difficulty in coping with the fact that her husband had a new friend, were also being expressed to the other workers involved in her care. Her information was that Mrs Murrie saw her psychiatrist from time-to-time in the way that someone with a psychiatric history might do, and that she had a social worker.

307 Mrs Dunn reported that in one of her conversations with Mrs Murrie, the latter had asked if she would like to speak to her social worker, and had given her his name. Mrs Dunn did not know why Mrs Murrie had suggested this; it had seemed odd to her at the time. Mrs Dunn did not take up the suggestion and, at the time, did not know what good it could have done. In retrospect, she believed this suggestion could have been a cry for help; perhaps Mrs Murrie was indirectly asking the care workers to help her to pull herself together. At the time, Mrs Murrie came across to Mrs Dunn as needy, aggressive and distressed. She could not believe that Mrs Murrie was not projecting herself in a similar way to the professionals involved in Mrs Murrie's care. Mrs Dunn told the panel that Mrs Murrie would have poured out her feelings and her distress to those involved in her care.

308 From Mrs Dunn's understanding of what Mrs Murrie had told her, Mrs Murrie was always complaining about her husband; he had thrown her out; he was mean and vicious to her; he made cruel and sarcastic remarks and had turned the children against her. This picture did not fit with Mrs Dunn's view. Mrs Dunn viewed Mrs Murrie's comments in the context of someone that had a mental illness, and was dependent on temazepam, which she abused.

309 Mrs Dunn provided the panel with the following assessment of the character of Louise and of her relationships with her parents. She also provided a more detailed account of what she understood of Louise's own feelings, as they related to her family situation and, particularly, to her mother.

310 Mrs Dunn said that Louise was a vivacious, attractive and ordinary little girl. She was very nice, friendly and quite assertive. In Mrs Dunn's opinion, because of the discord between her parents, Louise had become a game player - playing one person off against another. She would play tricks such as telling her mother that Stuart had a ponytail.

311 Mrs Dunn said that, in her opinion, Louise's relationship with her father was stable and loving. She was an outgoing and mischievous little girl and they had a normal relationship. Her relationship with her mother was disturbed in the way you would expect it to be when a mother has had serious mental health problems. Sometimes, Louise had to do things that were inappropriate for her age, such as understanding strange matters that did not happen to other children. Thus, in Mrs Dunn's opinion, Louise would be involved in adult concerns and, even though Mrs Dunn met a lot of children who would be similarly involved, there was a depth to Louise's experience which Mrs Dunn believed was probably the result of the degree of Mrs Murrie's disturbance.

312 The panel asked Mrs Dunn whether she had felt that Louise might have been physically at risk as a result of her situation, particularly in the light of Mrs Dunn's appreciation of Mrs Murrie's distress.

313 Mrs Dunn explained to the panel that she had not been concerned that Louise was physically at risk because, whatever the parents said about each other, her practical care was good; she was clean, tidy, well-fed, and Mrs Dunn believed that Mrs Murrie had an awareness of the developmental needs of children. Mrs Murrie would constantly say things like, 'I love Louise; she is my life, I am always there for her'. Mrs Dunn recalled that Mrs Murrie occasionally made very aware and appropriate comments about child development. Mrs Dunn said that she had never had cause to doubt Mrs Murrie's love for Louise, even after the conversation on New Year's Eve 1993.

314 In particular, Mrs Dunn told the panel that she had not been concerned about physical danger to Louise. Through her experience of working in Broadmoor, she had known people who had killed through pathological jealousy and she knew that, statistically, it was very rare for a child to be killed. Usually, a new partner or ex-partner was the victim. It was inconceivable to her (Mrs Dunn) that Mrs Murrie would have harmed Louise. She considered that there was a huge gap between slashing tyres and making nuisance phone calls, and committing the homicide of the child whom Mrs Murrie professed to love so deeply. There was nothing, even during the distraught second telephone conversation, to indicate that Louise was in danger from Mrs Murrie.

CHAPTER SIX

CONCLUSIONS AND LESSONS FOR THE FUTURE

INTRODUCTION

315 The panel believes that the death of Louise Murrie should not be seen as an isolated event, although it was one that could not have been predicted. Rather, the sequence of events that unfolded can be seen, with the considerable benefit of hindsight, to progress inexorably over a period of time.

316 The question that arises in this case not only concerns the way in which each individual and agency acted in the conduct of their responsibilities to Mrs Murrie and her family. It also concerns whether they discharged their duties in a manner that enabled optimum professional skills to be brought to bear in a co-ordinated and programmed way, with the result that any of the risks, run by any of the parties, was reduced to a minimum.

317 Because it is easier to be wise with the benefit of hindsight, the panel has adopted two perspectives in its examination of the care offered to Mrs Murrie.

318 First, the panel has looked at the sequence of events, putting itself in the position of the professional parties and the managers of each of the agencies. In this respect, the panel wished to determine whether the behaviour of the managers and the professionals was, in the relevant circumstances, reasonable and of an acceptable standard. Inevitably, the panel's perspective as an inquiring body affects its chances of achieving this aim wholly: it knew of the tragic outcome of events from the outset and, unlike any single agency, professional or manager - has developed a view built on evidence from many sources. Therefore, to provide as clear an understanding of cause and effect as possible, the panel has tried to review the evidence available to it in a chronological sequence. The critically important part of this sequence runs from the discharge of Mrs Murrie from Fair Mile Hospital, in March 1993, through her aftercare in the community until the fatal event in February 1994.

319 Second, the panel has allowed itself the full privilege of the use of hindsight, the better to explore the cumulative effect of these events, and to draw any possible wider conclusions of local and national significance.

KEY STRATEGIC ISSUES

320 The panel believes that it is of signal importance to place the work of individuals involved in the care of Mrs Murrie in the context of the state of strategy and organisation of the mental health services at the time. The quality and appropriateness of interventions made by professionals and other front-line workers who are involved in mental healthcare in the community depend, to a significant extent, on the quality of:

- the mental health strategy in place within the relevant health authorities, NHS trusts, social services and housing departments and non-statutory agencies;
- the way services are deployed to implement this strategy, including the allocation and availability of staff and resources.
- the way in which services are organised and interact with each other.

Mental Health Strategy

321 The mental health services available to the population of West Berkshire between 1992 and 1994 were clearly in a state of flux. The run-down of services operating from Fair Mile Hospital happened at a time when there was, from all accounts, an inadequate range of mental health services in the community. Berkshire Health Authority recognises, from its reviews and consultations in 1996-97 and its current commitments to make improvements, that there is still not a satisfactory level of primary and secondary mental health services in the West of its area. The panel inevitably concludes that this was previously the case in the early 1990s, when the events of Mrs Murrie's case were unfolding. Certainly, there is no evidence of a sudden and catastrophic decline of services.

322 The opinion of the panel is that the state of mental health services during this period inevitably reflects a lack of strategic planning and resource allocation. This is both demonstrated and compounded by various factors (some but not all of which are, in the opinion of the panel, the result of the processes by which the NHS reforms were implemented):

- West Berkshire Priority Care Service NHS Trust relied on Fair Mile Hospital, then being run down, for virtually all its inpatient mental healthcare;
- lack of strategic planning coupled with financial constraints ensured that the West Berkshire Priority Care Service NHS Trust and the Oxfordshire and Berkshire Social Services Departments had few community mental health services to rely on in the relevant area except for those provided at the Coley Clinic and Bucknell House;
- the community facilities were gravely under-resourced both in terms of the actual staff and the availability of consultant psychiatrists;
- the introduction of the purchaser-provider system in the Berkshire Social Services Department served to confuse roles and operations of staff and agencies within the Coley Clinic and Bucknell House, as well as among key social workers;
- liaison between mental health and children/family service teams within both Berkshire and Oxfordshire social services departments was not effective;
- the complexity of systems that are required to deliver social services for children and families, and those with mental health problems were added to in this case by the introduction of the purchaser-provider concept, and other organisational changes arising from the introduction of Community Care in 1993 (this led, at least at operational level to complex and potentially vulnerable assessment and providing arrangements); and
- there was no formal joint commissioning strategy for mental health services in the community in operation between health and social services in the area (although there were examples of apparently ad hoc arrangements of joint funding).

323 Inevitably, the availability of a properly planned and adequately resourced range of accessible, responsive, good quality, community-based mental health services significantly affects the options available to clinicians and care workers who are charged with the care of individuals. The evidence suggests that key professionals from both the local authority and NHS in Reading, at the time relevant to this inquiry, were stretched even to provide a basic level of service. In the context of inadequate multi-agency strategy for mental health services in West Berkshire, these professionals appear, in some instances, to have performed their duties above the level of the resources available to them.

324 As a matter of general rather than particular note relating to this case, paucity of resources does not excuse poor professional or clinical care, but it does place very real constraints on the extent of the provision of care and the range of interventions and treatments that can be called upon. Ideally, the strategic and financial context of provision should support clients and their

practitioners, and those affected by clients in the community.

325 As concerns Fair Mile Hospital, which was the sole providing institution for Mrs Murrie's inpatient care during the period, the panel concludes that the sooner that properly planned and financed reprovision of services currently offered at the hospital, is brought into service, the better for all. Such a reprovision must surely include the establishment of good quality, community-orientated services comprising inpatient, an adequate range of other residential and day services of a variety of types and purposes, and properly resourced outpatient, community and home-based services.

326 Within local authorities, complex purchasing and operational arrangements of the kind established within Berkshire and Oxfordshire social services departments (detailed in Chapter Four) are not uncommon. Often, they have arisen from the need to maintain responsibility for both specialist and generic social services tasks. Nevertheless, services divided into geographical, specialist and generic categories may be vulnerable and may not be applied effectively. They rely on individuals, singly and severally, having clear perceptions about their roles and lines of accountability. This situation is more complicated when social services departments (and individual staff and workers within them) carry both the purchaser and provider roles, unlike in the structure in the NHS, in which these functions are located in separate organisations within the service. The panel returns to the purchaser-provider context of services in the next section.

327 Alongside organisational complexity, the panel also concludes that the community mental health teams provided by the Berkshire Social Services Department, particularly in the Reading area, and the West Berkshire Priority Care Service NHS Trust, had too little choice of resources to call upon. Added to this, the perception - held within both Berkshire and Oxfordshire social services departments - of the specialist nature of adult mental health services, led to such services working in relative isolation from other departmental teams, particularly those responsible for services for children and families.

328 Cumulatively, the evidence presented to the Panel of Inquiry suggests that the extent of the community mental health services provided for the area in which Mrs Murrie was resident, was inadequate in the range, volume and depth of its capacity and capabilities. At best, the mental health strategy propelling these services was elementary. The statutory authorities had not combined effectively to plan for and provide the environment, or components of services, in which to deliver the best care for individuals like Mrs Murrie.

329 Since the panel took its evidence, it has learned from officers in the Berkshire Health Authority that these former problems are being tackled. Berkshire Health Authority has stressed joint commissioning as a more appropriate vehicle for commissioning and monitoring mental health services. A steering group has been appointed to include the relevant trusts, the social services departments, community health councils, GPs and the health authority. The health authority has restructured its staff to work within six localities and mental health is now an agenda item in each. The core of the strategic plan remains unaltered, viz. closure of Fair Mile Hospital with replacement of its core acute services at Prospect Park Hospital; provision of a range of 24-hour nursed and residential placements in a variety of community settings; and development of community-based teams that include psychiatrists in each of the six localities.

THE EFFECTS OF ORGANISATIONAL CHANGE

Lack of Coterminous Boundaries

330 As detailed in Chapter Four, the panel was concerned about the possible impediments to Mrs Murrie's care caused by the structure of health and social services that pertained during the 1992 to 1994 period, particularly the lack of coterminous agency boundaries.

331 In the panel's view, the difficulties presented to front-line professionals and workers by the virtual absence of an effective mental health strategy in the area was compounded by the lack of coterminous boundaries. In the current system in England, mental healthcare should not be the sole responsibility of either health or local authority services. High quality mental health services have to be designed to engage the most appropriate and timely interventions from both these and other statutory agencies. They therefore require a high degree of co-ordination and collaboration in their planning and delivery between agencies and individuals. Matters such as inter-agency boundaries can often be crucial in determining the ease of access that individuals have to services, and the quality of the services that individuals receive.

332 However, as evidenced in the process of Mrs Murrie's last discharge from Fair Mile Hospital in March 1993, the panel is satisfied that the quality of her care was not affected by the Reading 'overlap' (as detailed in Chapter Four). In fact, Mrs Murrie's discharge at this time stands out as an example of good and effective communication between the relevant agencies.

The Introduction of the Purchaser-Provider System

333 The introduction of the purchaser-provider concept into the NHS posed significant organisational problems for local authority social services departments which had to co-operate and collaborate with the NHS in order, as in this case, to deliver effective mental health services and to discharge their child protection functions.

334 Retrospectively, the NHS and Community Care Act 1990 appears to have led to different approaches to commissioning, purchasing and providing within NHS and local authority services. In the NHS, commissioning and purchasing on the one hand, and providing elements on the other, became the responsibilities of the new health authorities and NHS trusts, respectively. For a considerable period of time in the 1990s, health authorities concentrated on purchasing and contracting for services, while developments of strategy and commissioning approaches tended to follow later and there remains much to be accomplished in these domains in many parts of the UK. In particular, public health concepts led the NHS, post-1991 (after the reforms were introduced), to develop approaches based on purchasing healthcare for populations. However, within local authorities, the accent of change brought about by the same Act focused on a general separation of purchasing from providing, based on the concept of purchasing packages of care for individuals rather than purchasing sectors of care for populations, as in the NHS. In response to policy-driven financial requirements on them, local authorities tended to contract an array of service-providing agencies to fulfil the needs of packages of care. Many of these service providers were required to be outside the statutory sector.

335 In this setting, some local authorities, such as Berkshire, decided to take an early and proactive initiative in introducing purchaser-provider concepts, while others, including Oxfordshire, followed a more evolutionary and pragmatic line. Whatever the merits of the two approaches, the combined effects of the introduction of the purchaser-provider concept into the NHS and the Berkshire Social Services Department involved a significant degree of organisational change. The panel wishes to place this is in perspective because the observations that follow may apply more widely and not merely to Berkshire.

336 Clearly, following the enactment of all elements of the NHS and Community Care Act 1990 (see Annexe A), in 1993, local authority social service departments assumed statutory duties as both purchasers and providers of social care. At the same time, there were transitional arrangements that required local authorities to purchase services from a range of external providers, thus producing a mixed economy of social services. Where mental health matters relating to individuals in the community are concerned, these major organisational changes have had a bearing on the deployment of available resources.

337 Berkshire Social Services Department was particularly affected, in the panel's view, by these organisational changes. For example, from Mr Clarke's evidence, it learned of his perception of the confusion caused by the way in which the purchaser-provider system was implemented in Berkshire. It appears that he and his colleagues had to be retitled, after some rather sharp exchanges, as care managers/social workers, in order for them to identify with and to fulfil their duties.

338 In the particular context of the Berkshire Social Services Department's Reading Mental Health Team, the purchaser-provider system appears to the panel to have been a rather artificial concept. The panel shares Mr Clarke's view that it made his role somewhat unclear, dividing what was previously seen as a homogeneous service. Certainly, the Panel of Inquiry has come to the opinion that the purchaser-provider system, in this situation, appears not to have added any extra value to the service. No extra resources were made available to Mr Clarke, who did not have a wide range of resources to deploy. If anything, the impact was to reduce his own role as a trained provider of care. Add to that his own uncertainty about his role, and the result appears to have been too narrow a response to Mrs Murrie's particular needs. Indeed, the panel formed the view that Mrs Murrie largely attempted to manage her own care.

THE ADOPTION OF THE CARE PROGRAMME APPROACH (CPA)

339 The Care Programme Approach (CPA) was required to be introduced in England during 1991. The underlying assumption of the Department of Health's original guidance (the substance of which is carried in detail in Annexe A) is that the CPA would be in operation during the period covered by this inquiry.

340 This said, the panel is well aware of the problems that there were in establishing the CPA, and its slow implementation. Nationally, general difficulties emerged in enacting and then making operational sense out of the different emphases of case management, care management and the CPA and co-ordinating these three overlapping processes. Therefore, in its conclusions, the panel has taken the national as well as the local framework of CPA implementation into account.

341 In the summer of 1995, the Department of Health conducted a major national review in order to drive the CPA forward. It is clear from this review that, throughout 1993 and 1994, the government-led CPA and, the panel assumes, the protocols of care and case management had only been partially established in Berkshire, as elsewhere.

342 To place this finding in context, it is helpful to highlight the essential elements of an effective care programme within the CPA, according to HSG (94) 27. They are:

- systematic assessment of health and social care needs (including accommodation), bearing in mind both immediate and long-term requirements;
- a care plan agreed between the relevant professional staff, the patient, and his or her carers, and recorded in writing;
- the allocation of a key worker whose job (with multi-disciplinary managerial and professional support) is:
  - to keep close contact with the patient,
  - to check that the agreed programme of care is delivered,
  - to take immediate action if it is not;
- regular review of the patient's progress and of his or her health and social care needs; and
- before discharge of the patient it is essential that those taking the decisions are satisfied that all these conditions are fulfilled.

Systematic Assessment

343 In order to institute systematic assessment of health and social care needs, the CPA requires close inter-disciplinary and inter-personal working. As concerns Mrs Murrie's discharge from Fair Mile Hospital to Berkshire Social Services Department, there is clear evidence of effective action of this kind. However, the panel, with the undoubted benefit of hindsight in this particular case, can find fault in the degree to which 'systematic' assessment of Mrs Murrie's health and social needs was generally in process. It is clear from the evidence that effective assessments were made by staff within all the statutory services as part of the process of their engagement with Mrs Murrie. It is not evident that these assessments were made 'systematically'. There was little example of an embedded mechanism in Mrs Murrie's case; a mechanism that would have helped to formalise inter-agency communication and collaboration.

Regular Review

344 There was 'review' of Mrs Murrie's case, even if there was no system in play to ensure 'regular and/or systematised review'. But, where exchanges of information took place, they were the result of discretionary decisions by professionals and did not appear to be guided by protocols laid down in the CPA. There is no evidence that a formal, multi-disciplinary and properly communicated risk assessment, as might now be conducted in services of the highest quality, was carried out except at the point of Mrs Murrie's discharge from Fair Mile. However, the panel is aware that protocols of this sort were only then emerging. Moreover, after Mrs Murrie's discharge, in March 1993, it is doubtful whether a formal cross-agency risk assessment would have been warranted until the very last stages of the case. The panel returns to the factor of cross-agency review later.

Discharge

345 As to ensuring that all these CPA conditions were fulfilled before discharge, it is the panel's opinion that the process of Mrs Murrie's discharge from Fair Mile Hospital, on 1 March 1993, could not be faulted. The referral information given to Berkshire Social Services Department was comprehensive. The staff of the Ridgeway Ward and Mrs Holland of the Oxfordshire Social Services Department made separate referrals to the Berkshire Social Services Department. The response was quick, and the initial assessment took place within a few days of the referral being received. Dr Dickinson communicated about Mrs Murrie's situation to her GP. Therefore, the Panel of Inquiry believes that Mrs Murrie's discharge from Fair Mile Hospital is an example of good professional practice and, as such, must be seen to comply with the spirit of the requirements of the CPA, despite there being no formal care plan recorded in writing or monitored by explicit cross-agency review meetings.

Key Worker

346 Also complying with the requirements of the CPA, following Mrs Murrie's discharge from Fair Mile Hospital, a key worker in Berkshire Social Services Department was appointed. The panel broadly believes that he fulfilled all three parts of his remit as a key worker, specified in the guidance quoted above.

Written Care Plan

347 Therefore, the main shortfall in compliance with the CPA in this case is the lack of an effective written care plan shared by the agencies. The absence of a written care plan raises critical considerations about the actual management of Mrs Murrie's care.

348 In order to embed the process of assessment and review 'systematically', a written care plan - agreed and acted upon by health, social services and other relevant services - is a most useful component of 'care in the community' and 'community care'. Even if a written care plan was not required by government policy, good professional practice demanded that there should be one.

349 Although Mrs Murrie proved to be very difficult to work with as a client of both health and social services, her case did not present as a high priority to any of those involved in her care at the time of her discharge. A written care plan would have no doubt reflected this. It would nevertheless have supported the process of systematising assessments made about Mrs Murrie later and would have provided a basis for recording interventions and agency responses.

350 As highlighted already but detailed more specifically below, in the conduct of Mrs Murrie's care, there are examples in the evidence of good, non-systematic communication and collaboration between agencies, and between individuals within agencies. There are also examples of agencies and their sub-departments working in relative isolation. There are examples of individuals and agencies sometimes lacking sufficient information to ascertain a complete picture to make an assessment of Mrs Murrie's needs or those of her family. Therefore, the lack of a written care plan, lodged with a key worker in the community and understood by all concerned with her, is by no means the only missing link in Mrs Murrie's care. It is one of a number of indications that show that the system of 'care in the community' in place at that time was not effective.

The Management of Mrs Murrie's Care in this Context

351 There are observations that the panel wishes to set against this outline. While the panel concludes that there was no written care plan for Mrs Murrie and no embedded system of assessment that united the various agencies, it is evident that reasonable attempts were made by the individual agencies to work with Mrs Murrie. There is a general consensus from the evidence that, following her discharge from Fair Mile Hospital, Mrs Murrie's care was perceived as a moderate priority. Mr Clarke made initial attempts to ensure care through his referral to Mrs Johnson at Bucknell House. Mrs Murrie withdrew from any initial engagement in this programme. Later, Mr Clarke made a second referral concerning Mrs Murrie, again to Mrs Johnson and, the panel gains the impression that a more sustained relationship then developed between Mrs Murrie and the CPN.

352 It is clear to the panel that Mrs Murrie posed problems for all the professionals who had to deal with her. In some settings, she might have been seen as someone suffering from a personality disorder and therefore as, arguably by some although not all professionals, as beyond treatments that are readily effective and of proven benefit. In this instance, the professionals involved in her care afforded her moderate or higher priority and continued their involvement with her.

353 The panel believes that Mrs Murrie, although difficult to engage, did not present with an exceptional set of management problems that would mark her apart from many people who present to the mental health services. However, the panel does consider that management of her case, as part of the system of 'care in the community', seemed to lack a sense of direction, while the resources deployed appeared to lack substance.

354 Nevertheless, the panel notes that there is a difference between problems affecting the system of available care and the performance of individuals in the conduct of Mrs Murrie's care. Therefore, it has considered the roles played by the key professionals engaged in the conduct of Mrs Murrie's care.

355 The panel was impressed with the long-term commitment shown to Mrs Murrie by Dr Harry Dickinson, one of the consultant psychiatrists employed by the West Berkshire Priority Care Service NHS Trust. There is little doubt in the minds of the panel members that it was very

difficult for Dr Dickinson both to assess Mrs Murrie's needs and to establish an appropriate therapeutic alliance with her.

356 Following her committal for trial in 1994, both the expert witnesses ascribed to Mrs Murrie a diagnosis of psychopathy within the meaning of the Mental Health Act 1983. In his evidence to the panel, Dr Dickinson agreed with the thrust of these diagnoses but indicated that he had refrained from becoming engaged in a debate about diagnostic matters for fear that this might in some way limit or prejudice the care offered to Mrs Murrie. The Panel of Inquiry understands the sentiments that he expressed, which point to another more general issue relating to the position of personality disorder as a diagnostic category and the role of the health service in its treatment. The panel considers that Dr Dickinson's intentions reflected his general commitment to Mrs Murrie as a client. His recurrent efforts to help her must be seen in the context of her own frequently perplexing and frustrating responses.

357 Similarly, the panel considers that Dr Boon, Mrs Murrie's GP, showed a good grasp of matters. In many respects, her role was peripheral to the main thread of events. Nonetheless, she had been kept informed by letters from Dr Dickinson and others of the progress of events, and recalled for the panel a key meeting with Mrs Murrie when she had also met Louise. There is some evidence, arising from Dr Boon's own account that she had considered the pressure on Louise and had taken note of her presentation. What is of key significance in this case is that Dr Boon was one of the very few professionals who had met both Mrs Murrie and her daughter, Louise.

358 The other person who had met both mother and daughter was Mrs Dunn of the Oxfordshire and Buckinghamshire Probation Service. The panel considers Mrs Dunn to be a highly experienced, widely qualified worker with relevant knowledge. She maintained contact with the family almost to the point of Louise's death in February 1994 and was particularly helpful in setting out the events from her initial involvement in 1993 to Louise's death. She was therefore able to give the panel an account that ran closer to the last days of Louise's life than any other witness. During the latter part of 1993 and early 1994, it was Mrs Dunn who had had the greatest experience and knowledge of prevailing Murrie family dynamics, and of the wishes of Louise and her mother. The panel believes that her assessment of the family's circumstances was most competent. In particular, she appeared to have a good understanding of Mrs Murrie's individual problems and their potential impact on Louise.

359 During the period when the Family Assistance Order was in force, Mrs Dunn had a statutory duty to look after the best interests of the children in the Murrie family. The family clearly saw her as a key figure, and renewed contact after the Order had ceased. It is apparent to the panel that Mrs Dunn's reinvolvement with the family in late 1993 and early 1994 was motivated by her anxieties, by the pattern of relationships within the family, and by her concern to provide a monitoring role. Indeed, the panel formed the impression that Mrs Dunn had continued her work with Mrs Murrie and Louise beyond the expectations of her department. This part of Mrs Dunn's account exemplifies a particular tension that exists in many agencies that contribute to mental healthcare: that of establishing the limitation of individual roles given contemporary pressures upon them.

360 However, and of particular note, it was extremely unfortunate that Mrs Dunn did not communicate her mounting concerns about Louise's welfare, toward the latter part of her contact with Mrs Murrie, to staff in the local authority. It appears to the panel that the reasons underlying this include:

Mrs Dunn's perception, as that of her managers, of the separate and distinct role she had as an officer of the court; her own judgement of the circumstances; and the limitations in her supervision at the time. In its management inquiry, the probation service concluded that, 'Communication should have been made with social services' and 'The voluntary contact sustained with Mrs Murrie after the order expired should have been discussed with the

supervisor.' The panel shares that conclusion.

361 In the panel's view, the interests of children should have primacy. In this circumstance, the panel's opinion is that Mrs Dunn would not have contravened her role as an officer of the court by sharing her concerns with the appropriate local authority's children and families service. Also, the panel considers that it would have been possible to seek the court's permission to share this information, if Mrs Dunn had been in doubt.

362 The Panel of Inquiry is keen to record that, despite the various organisational changes discussed here, the management of Mrs Murrie's care within the Berkshire Social Services Department's Reading Mental Health Team seemed sufficiently competent to the panel. Contacts were maintained with the general practitioner and the consultant psychiatrist, and there was liaison with Mrs Johnson, the CPN at Bucknell House, who was providing the therapy commissioned by Mr Clarke. When Mr Clarke took some leave during the period immediately prior to Louise's death, he made certain that Mrs Murrie was aware of this and that there were back-up arrangements in place. Similarly, once Mrs Murrie told him of her feelings of hatred and wish for revenge against Mr Murrie, he acted promptly in writing to Dr Dickinson and arranging an outpatient appointment with the consultant.

363 As measured against the approach laid down in the CPA, but also taking account that the CPA was not fully implemented, the Panel of Inquiry finds that there were two main problems which combined to make the care purchased and provided for Mrs Murrie less than ideal, and which led to a relatively insular approach to her care within the agencies concerned:

- insufficient resources were available to individuals and teams within agencies; and
- there was no embedded, systematic approach or mechanism to ensure that cross-agency communications between certain agencies were easy and customary.

THE INDIVIDUAL VERSUS THE FAMILY

364 The panel has already stated that it is impressed by the conduct of Mrs Murrie's discharge from Fair Mile Hospital in March 1993.

365 However, in spite of abundant information about the turmoil in the family (the significance that Mrs Murrie, on her own admission, placed on Louise; the fact that she was contesting Mr Murrie having legally-defined responsibility for determining where Louise lived; the self-referrals that the family had itself made and Mrs Bennett's concern about Louise), both social service departments focused on Mrs Murrie alone as the recipient of their services. The evidence of both Mrs Holland (Oxfordshire Social Services Department) and Mr Clarke (Berkshire Social Services Department) clearly shows that both these social workers reacted to Mrs Murrie's circumstances to a large extent according to her own account of herself and her requirements. Their interventions were thus limited by considerations about Mrs Murrie's apparent needs as an individual. For example, Mr Clarke's decision to refer Mrs Murrie to a woman's group, under the aegis of the CPN at Bucknell House, was one born of his preclusive concern for Mrs Murrie as an individual.

366 It seems to the panel that there was a failure to recognise that, for Mrs Murrie to be dealt with effectively, she had to be seen within the context of her family. To accomplish this, time would have had to be spent with other members of Mrs Murrie's family to obtain a complete picture. The departments concerned might have engaged their own services for children and families - if appropriate liaison mechanisms had been established and responses of the various sub-departments to each other had been sufficiently sensitive.

367 Both the social services departments' mental health teams claimed they did liaise with their opposite numbers in the children and families teams but, in the circumstances, these services

appear to the panel to have operated separately. For example, there were two record systems in the Oxfordshire Social Services Department; one for clients of the family and children team, the other for the mental health team. The agencies involved appeared to place a reliance on professionals sharing buildings as a means of achieving co-ordination, rather than on adopting effective systems of co-ordinating programmes of care or comprehensive record systems.

368 Both local authorities operated systems to prioritise the allocation of their services, but the local authorities' mental health and children's services operated on separate criteria. In Oxfordshire, the emphasis of the social services' mental health team was on ensuring a prompt and effective discharge from Fair Mile Hospital. Mrs Bennett's praiseworthy approach for advice and assistance, to the children and families team within her department, was unproductive. In Berkshire, there was again a recognition of the importance of the family situation and its impact on the behaviour of Mrs Murrie, but dealing with that seemed to be viewed as someone else's responsibility.

369 Both local authority mental health teams were aware of the involvement of Mrs Dunn, and why she was involved, but the evidence suggests that neither set of staff attempted to contact her. It appears to the panel those workers' settings and roles seemed to lead to circumscribed views of how to deal with Mrs Murrie. For example, it was only Mrs Bennett, the newly appointed social work assistant to Mrs Holland, who perceived the importance of Louise to Mrs Murrie, before her discharge from Fair Mile Hospital in 1993, and who tried to bring her concerns about Louise to the attention of colleagues in the children and families team.

370 In this case, the panel does not believe that an alternative course, that would have involved treating Mrs Murrie and her family within a familial context, would in itself have prevented her from committing her offence and, thereby, have prevented the death of Louise. But the panel does believe that by adopting an individual rather than familial approach this inhibited the assessment and communication of the risks which Mrs Murrie posed in the period leading up to Louise's death.

371 Again these findings point to the problem of relative insularity in approach to the care provided for Mrs Murrie and her family. They highlight the need for agencies to be aware of the overlapping risk factors within families and the multiplicity of pathways into agency contact that family members may take. They also lead the panel to explore the potential value of the role played by child protection procedures in this case.

CHILD PROTECTION PROCEDURES

372 The Panel of Inquiry was keen to learn whether there was any evidence to suggest that individuals or agencies concerned in the care of Mrs Murrie would have had reason to institute child protection procedures on behalf of Louise.

373 As a point of principle, the panel endorses the view put forward in a recent paper by Anthony Harbour in Advances in Psychiatric Treatment (Annexe H) that consideration for the safety and well-being of children should be a fundamental part of any risk assessment. Mr Harbour quotes from Oates (1997): 'Adult psychiatrists should be aware that the majority of their patients are parents, many of them caring for young children. They have a duty of care to consider the well-being of these children... ' Mr Harbour also outlines the proposition, supported by the panel, that, 'not only is it lawful to breach confidence in the context of child protection, but in fact there is a positive obligation to do so'.

374 Assessments of the risks of dangerous behaviour had been made in the weeks before Louise's death, though it is clear that the direction in which such behaviour would be expressed was not predicted. In the latter stages of Mrs Murrie's care, there was certainly increasing concern about

her state among the professionals involved - including Dr Dickinson, Mrs Johnson, Mr Clarke and Mrs Dunn. Specifically, there was more awareness about Mrs Murrie's feelings of anger and resentment; her attacks on property, and her particular preoccupation with Louise. However, the available information was not consolidated into a corporate view and shared by all the agencies and their staff.

375 Most of the professionals who were closely involved at that point had assessed that there were increasing risks, evidenced by Mrs Murrie's apparent state of mind. Dr Dickinson considered that Mrs Murrie did not show the signs of depression or great clinical risk when he last saw her in February 1994. However, he told the panel that he considered the risks were either a repetition of violence against property or of aggression or violence towards Mr Murrie or his friend. But, above all, he considered that the main risk was that Mrs Murrie would take a further overdose. It would appear that Mr Clarke had come to a similar opinion. In this same period, it is apparent from what Mrs Dunn told the panel that she too was concerned about the developing situation. Mrs Dunn was concerned about Mrs Murrie's level of distress and about its emotional impact on Louise. But the panel spoke to no one who considered that Louise herself was physically at risk.

376 It is fair to say that very few of the professional staff had met both Louise and her mother and it would appear that there was little direct assessment of Louise's mental state made by individuals centrally involved with Mrs Murrie. Of those centrally involved, only Mrs Dunn had done this. During the course of the inquiry, the panel took evidence from the nurse for Louise's school and Dr Boon, both of whom were on the periphery of Mrs Murrie's care. Their evidence concerning Louise's condition suggests that she was coping reasonably well, given her circumstances.

377 However, it appears that few, if any, impressions of Louise's well-being or personality were known to the staff of the Berkshire Social Services Department, or to the staff of the mental health services provided by West Berkshire Priority Care Service NHS Trust, when they made their assessment of the situation overall. Thus, the key staff involved with Mrs Murrie made their assessments of her, and of any risks, without a direct examination of Louise and her brother and without knowledge of the opinions of Louise, formed by those that had met her.

378 Any physical danger to Louise prior to her mother taking her to Southend in February 1994 was not perceived or predicted. Earlier in this report, the panel has presented the escalating level of Mrs Murrie's distress, described by all those involved in Mrs Murrie's psychiatric and community care at the time, during the six-week period at the beginning of 1994. The panel believes that it is unlikely that these concerns could have been translated into direct intervention, which would have definitely protected Louise. A properly organised structure of care planning and systematic communication, combined with good fortune, might have increased the likelihood of protecting Louise, but the panel would prefer to take a realistic view. For example, Mrs Dunn reported, shortly before the index event, that she was sufficiently concerned about Louise's emotional vulnerability, to make the decision to intervene when her father took the issue back to the Family Court. However, in common with the other professionals involved in this case, at no point did Mrs Dunn anticipate the possibility of physical harm being done to Louise, and in the circumstances she had no legal power to make a referral back to the court. In the experience of the panel only in quite exceptional circumstances of immediate risk would a court have been able to intervene sufficiently rapidly.

379 As regards the specific issues relating to child protection procedures, the panel's own findings are in line with those of the management and expert witness inquiries that the panel was asked to consider as part of this inquiry (see paragraphs 386 to 394). The panel agrees that neither of the local authorities was presented with evidence indicating a need for activating child protection procedures. Nonetheless, the panel believes that the case could have been made at several points for active involvement of the children and families teams.

380 This case stresses the importance of having good channels of communication between agencies involved in caring for individuals and for those involved in caring for families.

GAPS IN COMMUNICATIONS

381 The panel finds that communication between agencies was far from ideal in a number of situations. Where communication appears, with the benefit of hindsight, to have been inadequate at the level of individual responsibility, the panel concludes that the reasons for this are mostly traced to the way in which individuals and agencies perceived their roles and functions, and to the way in which the latter were organised and resourced. Thus, individuals themselves reacted to circumstances according to their brief and to their particular understanding of Mrs Murrie's circumstances. Therefore, to a significant extent, poor communication in this case owed to factors beyond individual control. This finding can be illustrated by certain key events.

382 The panel believes that there were shortcomings in Mrs Dunn's communication with other agencies, as there were shortcomings in their communication with her. Similarly, there seems to have been a lack of communication within the probation service itself. Mrs Dunn suggested to the panel that her role as court welfare officer is an independent one, reporting to the court, and that hers was a role not widely understood by other agencies. That is clearly so, and there are also legal boundaries and limits concerning what can be divulged when a case is under consideration by the courts. (Nonetheless, as noted in paragraph 361, it is possible to share information with appropriate agencies, with permission from the court.) Furthermore, at the time, in late 1993 and early 1994, Mrs Dunn was not then working officially on behalf of the court.

383 In any situation, contact with other agencies and workers is not precluded by the courts, and is usually welcomed by them if the outcome is to provide fuller information. The panel would have expected that the satisfactory discharge of the Family Assistance Order would have involved communication with other agencies involved in Mrs Murrie's care.

384 It should be clear that mental health services and child protection services in general are multi-agency in nature. The systems for providing care in circumstances of risk require inter-agency, cross-disciplinary approaches.

385 Thus, more systematic and established methods of communication and collaboration and the consequent sharing of information between agencies and workers, may possibly have led to a more co-ordinated framework for dealing with the last weekend and the events immediately leading up to it. It seems to the panel that the professionals' and agencies' perceptions of their roles occasionally became constraints against communication and co-ordination. While these professionals were aware of the presence of others, in the panel's view, they operated in relative isolation.

THE MANAGEMENT AND EXPERT WITNESS INQUIRIES

386 Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue arises that is likely to be a matter of major public concern, Part 8 of Working Together (see Annexe H) requires an individual review by each agency involved, and a corporate review by the Area Child Protection Committee (ACPC). Detailed guidance is provided on the timing of these reviews, which should be completed within one month of the incident occurring. The time scales are widely regarded as unrealistic, particularly where a death has occurred, as in this case, and a decision on prosecution has to be made.

387 The Panel of Inquiry was asked to consider the management inquiries that were undertaken by the responsible authorities soon after Louise's death in 1994.

388 The view of the panel is that, for the most part, the Oxfordshire Social Services Department, which acted as the key agency in compiling a review for its Area Child Protection Committee (ACPC), endeavoured to bring together various management inquiries. These included the inquiries carried out by Oxfordshire's own social services and education departments, the Berkshire Social Services Department, the West Berkshire Priority Care Service NHS Trust, the Oxfordshire and Buckinghamshire Probation Service and the Thames Valley Police. (Relevant extracts from their findings, conclusions and recommendations are shown in Annexe F.) The Panel of Inquiry finds that, overall, the circumstances were looked into thoroughly by each of the organisations.

389 For the most part, the panel agrees with the conclusions that were drawn in the individual inquiries, but with the caveats that certain inquiries seemed to be deficient in two related respects: they concentrate on the niceties of procedure within their departments with the result that they tended to offer too narrow a focus; and they appear, possibly as a result of the tight time scales imposed by the Part 8 review process, to draw conclusions that are based on restricted evidence.

390 As regards the latter, in its review, the Berkshire Social Services Department concludes that 'the child protection procedures were not the appropriate framework for Berkshire's involvement in the case'. The ACPC Review conducted by the Oxfordshire County Council reiterates this conclusion. The review states that 'there was no information contained in any of the management reviews that should have triggered child protection procedures'. The opinion of the panel is also that child protection procedures were not the appropriate framework for professional intervention though the panel suspects that it has arrived at this conclusion by a different route.

391 Berkshire Social Services Department's and the ACPC Review findings may be accurate. However, the point of significance here is that the Panel of Inquiry appears to have available to it rather more evidence concerning Louise, and assessments made of her, than may have been available to either the Berkshire or Oxfordshire social services departments. This raises two issues.

392 First, as has been indicated in previous sections, none of the staff of the Oxfordshire Social Services Department, the Berkshire Social Services Department, or the mental health service provided by the West Berkshire Priority Care Service NHS Trust, appear to have had any direct contact with Louise. Therefore, the records held by these agencies are unlikely to have contained direct evidence of Louise' personal condition. In the absence of an assessment, or of information exchanged about Louise at the time of the events, it is difficult to see the basis for their conclusion that child protection procedures were not warranted.

393 Second, the panel regrets that the Berkshire management inquiry did not appear to address the broader issue of the appropriateness or otherwise of not involving its services for children and families. The panel believes that a case could have been made, at several points in the sequence of events, for the Berkshire children and families service to have been more fully engaged in the conduct of the case as it unfolded.

394 A qualification must also be made about clerical practices within Oxfordshire Social Services Department. This relates to one of the observations made in the ACPC review and it's accompanying recommendations (see Annexe F). In that document one of the review's findings is that Oxfordshire Social Services Department had not recorded the telephone referral from Thames Valley Police on 26 January 1993. In fact, in the course of preparing to give evidence to this Panel of Inquiry in 1997, staff of Oxfordshire Social Services Department located the lost written record of the report made by telephone by the Thames Valley Police. Thus, the error was not one of failure to record telephone calls but one of failing to file the written record.

LESSONS FOR THE FUTURE

395 In this chapter so far, the panel has presented its conclusions about matters of importance to public interest in respect of the care offered to Mrs Murrie. The panel has also endeavoured to assess whether the death of Louise was preventable. Yet it is apparent that the matters considered by the Panel of Inquiry have a far broader significance. The panel would wish to draw general matters to the attention of other agencies commissioning and providing mental health services, to ensure continuing evolution of mental healthcare of increasing quality.

396 There were a number of factors in play, ranging from the strategic through to the day-to-day operational, during 1993 and 1994. Predominantly, this inquiry draws attention to the importance of effective care programming within agencies, across disciplines, across agencies and between sectors of care. Once again, effective and systematic co-ordination and collaboration emerges as a key issue in promoting services of high quality.

397 The inadequate mental health strategy that pertained in West Berkshire during the period covered by this inquiry, and resulting inadequacy in mental services in the region, serve as warnings. Furthermore, this analysis of events in West Berkshire indicates how unresolved strategic matters can percolate down to staff involved on operational and in day-to-day practice. The confusion of roles between care manager and social worker experienced by Mr Clarke, generated in him some uncertainty. Although this is not seen as having contributed to any failure of care of Mrs Murrie, it is nonetheless a feature which, in other circumstances, might intrude into the care of individuals.

398 Thus, there are potent reminders - in this case for senior managers of health and local authorities, and trusts - of the importance of strategic clarity and proper communication between those responsible for strategy and those responsible for the direct delivery of services. Therefore, communications should not be left to 'osmotic' processes, while tensions among front-line workers about their roles should be understood and managed. Senior managers should be reminded that strategic shortfalls translate into service quality. They can and do affect the day-to-day operation of services through their impact on front-line staff as well as through scarcity of resource.

399 The panel has already said much about the importance of enhanced liaison between services offered to adults and those services offered to their children. Practitioners are increasingly aware of the mental health risks to children of mentally disordered adults and vice versa. The panel believes that what is required is services that are based not so much on the identification of individuals as patients, but more upon an understanding of families on a holistic basis. Plainly, achievement of services of this kind depends on resources and also demands a commitment to the training of professionals. This also has resource implications at a time when services are already stretched.

400 Finally, there is the vexed matter of an approach to people with personality disorders, as concerns conceptual understanding, diagnosis, intervention, and the roles of the NHS and other statutory services.

401 It is plain that there are very many people in society who are in difficulties as a result of attributes of their personality. In this case, Dr Dickinson put his finger on a key issue relating to stigma and its impact on mental health systems. Recent policy focus, giving priority to services for people with a serious mental illness, has for the most part been welcomed. Certainly, it has produced greater clarity within the specialist mental health services.

402 The overall impact of stigma cannot be denied but it would appear that, whatever the philosophical position on the notion of personality disorder as a concept, diagnosis of this

spectrum of disability brings with it greater stigma than most other mental disorders. Intervention with, and treatment of, people who are said to have personality disorders are particularly difficult. Presently, there are few effective treatments that are readily applied to people who fall into this wide category. This may, in itself, induce a sense of frustration and impotence in professionals who attend people with these problems.

403 The panel believes that there is now a requirement for a policy lead concerning services for individuals who are considered to have disordered personalities. This needs to be translated into clear strategies at national and local level. Integral to such a strategy, there should be more emphasis on research into personality disorder, and into the treatment that develops from research. Therefore, the Panel of Inquiry recommends that the lead policy and its related strategies should be evolutionary in concept, allowing service practice to be directed and styled according to an evidence-base developed by research.

CHAPTER SEVEN

RECOMMENDATIONS

INTRODUCTION

404 In this chapter, the panel summarises the recommendations drawn from the conclusions made in the last chapter. Some of the recommendations are specific to organisations mentioned in this report, but all of them point to lessons that ought to apply widely, encompassing a variety of organisations working in health, community care and related areas.

405 Nearly all of the lessons are unexceptional, in the sense that most managers and practitioners would see them as central to good planning, administration and practice. Regrettably, many of them, particularly those to do with communication, collaboration and joint working, underline and repeat lessons from many other child care and mental health inquiries.

406 The panel hopes that this familiar, if depressing, reiteration may produce a determination in those who read this report to improve such matters in the future.

ESTABLISHING AN EFFECTIVE MENTAL HEALTH STRATEGY

407 It is essential that Berkshire Health Authority, in concert with the local authority services and provider organisations, continue to make the development of an effective mental health strategy a top priority.

408 A model strategy should:

- be based on multi-agency, multi-disciplinary agreements, that have been overtly negotiated, as concerns a realistic vision for the future;
- provide agencies with a clear notion of the purposes of services;
- provide all agencies with clear direction about the part played by key services for mental health in the area;
- define the client groups across and within agencies;
- outline the key roles of each agency;
- provide a clear direction and framework for service development;
- express and propel strategic leadership; and
- be taken through the processes of service redesign into local implementation.

409 In particular, the strategy should enable the development and provision of services that offer:

- good access to services for GPs and other referring agencies;
- a sufficiently wide range of services to allow for a significant variety of modalities of treatment and support; and
- rapid response to crises, including response mechanisms for sub-acute crises enabling intervention within a stipulated time, preferably no more than one month.

410 The strategy should ensure that there are:

- adequate staff resources, particularly in terms of the availability of skilled community psychiatric nurses and consultant psychiatrists, supported by access to consultant psychologists (for example by a properly resourced psychology service at Bucknell House), occupational therapists and other trained care workers;

- adequate community-focused mental health service facilities, including inpatient and other residential services, as well as sufficient day patient and outpatient services, group and individual counselling and treatment;
- appropriate in-service training for professional staff of all disciplines, supported by additional training and monitoring to ensure that there is a full understanding of the procedures implicit in the CPA;
- additional training to ensure that there is mutual understanding of the roles of adult mental health services and services for children and families; that these staff develop an understanding of personal, emotional, social and psychological development from birth to older age; and
- training to ensure that all professionals involved in mental healthcare in the community are knowledgeable about child protection procedures.

411 The strategic implementation plan should require:

- joint commissioning and purchasing procedures to ensure seamless and appropriate delivery of agreed programmes of care between statutory agencies;
- a systematically embedded means of communication and collaboration between statutory agencies;
- the means of ensuring effective communication and collaboration between those involved in planning and delivering packages of agreed care in the community and other direct contact agencies and institutions involved with the public, including emergency services, housing services, the judiciary and probation services, the police and schools, and the agencies in the non-statutory sector;
- embedded mechanisms of cross-agency review and formal risk assessment for individuals deemed to be at risk, including assessments of family members, particularly children, who may be vulnerable; and
- the full implementation and monitoring of the CPA (see below).

412 All agencies concerned should note the impact that organisational change can have on the efficacy of services. Where change is necessary, agencies should seek to manage it with appropriate training and organisational development.

413 As part of the required mental health strategy, Berkshire Health Authority should make its plans clear for closing Fair Mile Hospital in the near future, while ensuring the effective reprovision of a sufficient range of services in the community before closing the hospital. These should include various types of community-based geographically dispersed, inpatient and other residential services.

IMPLEMENTING THE CARE PROGRAMME APPROACH

414 The local authorities and health authorities concerned should ensure that they adopt and follow the CPA not only to establish jointly agreed procedures for the management of those cases that are subject to this approach, but also to ensure that appropriate staff within the departments concerned subscribe to a written care plan for individuals which is understood and agreed by all agencies. This is good professional practice and should become standard practice.

415 The written care plan should be prepared to enable:

- continuity of information about the way that resources are used;
- inputs from the various agencies concerned in particular programmes of care;
- information about assessments and the need for reassessment; and

- a vehicle for communicating care needs on a multi-agency basis.

416 A number of specific recommendations that follow reinforce Department of Health guidance, laid out in HSG (94) 27 (Annexe A), concerning the effective implementation of the CPA.

EFFECTIVE COMMUNICATION, COLLABORATION, AND JOINT WORKING

417 Following the publication of this report, all agencies concerned should review, and where necessary establish systems for ensuring that their protocols and procedures for child care and mental health work are consistent and positively require and encourage joint working, collaboration and communication. These reviews should encompass the constituent parts of organisations as well as the whole.

418 All the agencies concerned should review their clerical, administrative, and recording procedures to ensure that each agency has unified records on service users and patients, and that referrals are appropriately recorded and correctly filed.

419 All the agencies concerned should ensure that, within each agency, there exists a consistent approach to the criteria used to determine access to the various services provided and the means of assessment employed for this purpose.

420 Agencies should also encourage a more holistic approach to the assessment of individuals and their families, rather than one that focuses in a partial way, on individuals.

421 All agencies concerned should ensure that there is clear guidance and training about the routes and interfaces between services that are primarily for children and their families, and those that are primarily for individuals who have mental disorders. Agencies should also ensure that this guidance and training positively emphasises collaboration, joint working, and a holistic approach to work with individual adults, children and their families.

422 Specific recommendations that follow in this chapter also involve inter-agency and cross-agency communication and collaboration.

Communications Concerning Probation Services and Other Statutory Services

423 All statutory agencies in Oxfordshire and Berkshire should have their attention drawn to the role of the Court Welfare Services, and to the need to ensure effective communication and collaboration with those services, particularly in cases that concern children and families.

424 The Oxfordshire and Buckinghamshire Probation Service should review its policy and practices for communicating with other health, welfare and statutory agencies to ensure that there is systematic and effective communication and collaboration with other agencies, particularly where the interests and safety of children are concerned.

425 The Oxfordshire and Buckinghamshire Probation Service should ensure that obstacles to appropriate joint working and communication between itself and other agencies do not result from over-emphasising the statutory nature of the relationship of the court welfare officer to the court.

426 The Oxfordshire and Buckinghamshire Probation Service should review its line management systems to ensure that court welfare officers are effectively supervised and that their workloads are regularly and closely monitored. The service should maintain a policy of easy access to

managerial and other forms of support, ensuring a two-way flow of communications between management and front-line workers.

427 The Oxfordshire and Buckinghamshire Probation Service should ensure that its procedures, as regards the duties of court welfare officers to the court, encourage these officers to communicate, when appropriate, with practitioners in other agencies involved in child care.

428 Nationally, there may be a need, at the highest levels, to review and clarify policy relating to the role of the Court Welfare Services. While the panel accepts the special position of these services vis a vis the courts, it believes there is a need to strengthen and develop strategies to enable these services to communicate appropriately with other statutory agencies.

Risk Assessment and Case Reviews

429 Training should take place within health authorities, NHS trusts, local authorities and probation services (as well as in other statutory and non-statutory agencies involved in services for children and adults) to encourage a holistic approach to the assessment of clients and patients. This is particularly important in cases where risk to children is suspected, or presents as a possibility. The needs of the family are as much a part of the assessment and treatment as the needs of the individual.

430 Risk assessment is particularly important in circumstances in which agency workers become aware that a client shows a deteriorating and potentially dangerous pattern of behaviour. The statutory agencies involved should establish mechanisms for setting up risk assessment procedures expediently and for communicating findings quickly; also for ensuring that practitioners in the agencies concerned understand these procedures. The definition of protocols for assessing risk is a matter for professional advice in the local context.

431 The panel recommends that multi-agency risk assessment and attendant communication is more formally established as a safeguard by the Family Courts. For example, there should be communication between relevant agencies in circumstances such as the discharge of a Family Assistance Order, where family members are known to be under the care of mental health services. In such circumstances, court decisions and their implications (assessed by the court welfare officer) should be communicated to the local statutory services involved in a given individual's programme of care.

432 Social services departments and NHS trusts should pay heed to the use of multi-agency case review meetings as delineated in the CPA. These may be particularly appropriate in cases where the individual's problems relate to serious family issues, and also in situations where the lack of response from individuals, or the difficulty of establishing relationships with them (notably the case with Mrs Murrie) lead to sporadic interventions that do not allow the caring services to build a full picture of the client's progress. In such circumstances, there has to be an advantage in convening a multi-agency care-planning meeting. Not only do workers and carers from all agencies have the chance to exchange information, voice concerns and discuss the progress of a care plan, but such a meeting also provides as full as possible a picture of a client's health and social care needs.

433 In particular, the panel recommends that statutory agencies in Berkshire and Oxfordshire review their procedures for setting up formal, cross-agency case reviews. Such procedures should be made known to all workers involved in care in the community. The procedures should be planned and agreed jointly by the health authorities and the social services departments as part of their mental health strategies. In tandem, there should be guidance for all statutory workers about formal cross-agency reviews. This would clarify such issues as the appropriate context for setting them up, and who has responsibility for convening them.

Child Protection Procedures

434 To ensure effective multi-agency communications, Area Child Protection Committees (ACPCs) should ensure that practitioners working in child care teams are made aware or are reminded of:

- the importance of effective communications between agencies and between practitioners;
- the potential relationship between mental ill health and child protection issues;
- the consequent need for communication and collaboration between mental health services for adults and child protection services; and
- the emphasis that should be placed on effective risk assessment procedures.

435 There is strong evidence to suggest that mental ill health in parents, guardians and even close members of the family can have adverse effects on children. Therefore, ACPCs should review their multi-agency child protection procedures to ensure that they contain appropriate advice and guidance about the potential vulnerability to risk or danger to children arising from the mental ill health of one or both of the parents or immediate carers. In all such cases, proper risk assessments should be undertaken.

436 In some cases, children should be assessed by the children and families' teams the better to consider their health and social welfare needs and possible protection. Where children are implicated as being potentially vulnerable to significant risk or danger, the children and families sections of social services departments should be advised and, if necessary, brought in to compliment those dealing with care packages for adults. The panel considers that it is for the responsible authorities to define the meaning of the word 'significant risk' in the local context.

THE NEED FOR CORPORATE ACTION

437 Many of the panel's recommendations concern actions to break down insularity of roles and approaches within and between agencies, and the need to ensure that there are effective systems and procedures for communication and collaboration between agencies. This recommendation is applied by the panel at all levels, from the strategic to the day-to-day operational and must engage commissioning by health authorities, primary care groups and local authorities as well as service delivery by providers. For this reason, the panel hopes that the report will be acted on in a corporate manner. The panel suggests that the chief officers of the organisations concerned should establish a joint group to take action in response to the findings and recommendations made in this report.

438 Other important aspects covered in the recommendations concern organisational effectiveness and strategic planning of mental health services. The panel notes an increase in the rate of organisational change since this report was commissioned. This can have a considerable deleterious effect on service stability, the ability to plan effectively, and the morale of professionals, unless the change is positively and effectively managed. For example, Berkshire Social Services Department has now been split into six units as a result of local government reorganisation.

439 A further round of NHS reforms and changes is also underway and, while there is always a need for development and improvement - and much that concerns both health and social care does need to be improved - such constant changes can have unintended adverse effects on consumers and on staff.

440 As this report has attempted to make clear, the Panel of Inquiry believes that organisational changes and the transitional phases of policy introduction did not best serve the interests of effective planning or delivery of services in West Berkshire. The panel sounds the general

warning, wishing it to be heeded corporately, that the management of change must take account of the need to protect and strengthen mechanisms of collaboration and communication between agencies.

441 Finally, the panel proposes that, subject to the agreement of the Berkshire Health Authority, it follows up this report 12 months after the date of publication to monitor the progress that has been made in implementing its recommendations.

ANNEXE A

THE POLICY FRAMEWORK

MENTAL HEALTH POLICY

The Care Programme Approach

1 The basic principles covering the discharge and continuing care of all adult mentally ill people are embodied in the CPA, which authorities in England were required to introduce in 1991 (Health Circular (90) 23/ Local Authority Social Services Letter (90) 11). Much of what follows in this Annex is reproduced, with the panel's additions and amendments, from HSG (94) 27 which sets out the intentions of the CPA. The CPA is a key policy, central to this inquiry into the care purchased for and delivered to Mrs Anne Murrie.

2 As a summary note, the CPA, and the processes of care management and case management should be complimentary to one another in the care of individual patients. Health authorities, NHS trusts and social services departments all have responsibilities under the current policy framework for the discharge and continuing care of all adult mentally ill people. For this reason, this inquiry has addressed not only discharge of the responsibilities of the key health provider agencies, but also the strategic commissioning, purchasing and quality review responsibilities of the relevant health authority (and primary care groups), and the roles and discharge of responsibilities of the two social services departments that were involved in the care of Mrs Murrie.

3 The CPA applies whether or not a patient has been detained under the Mental Health Act 1983. But health and local authorities also have a statutory duty, under section 117 of that Act, to provide aftercare services for patients (in all categories of mental disorder) who have been detained in hospital under sections 3, 37 (whether or not with restrictions under section 41), 47 or 48 of the Act. The policy in England is that, to fulfil this duty, authorities should ensure that the CPA is fully implemented for mentally ill patients who have been detained, and that its principles are applied so far as they are relevant to the aftercare of other patients. Authorities should have proper mechanisms to monitor the application of the CPA as a whole and should report regularly on progress to authority members.

4 The purpose of the CPA is to ensure the support of mentally ill adults in the community. This minimises the possibility of their losing contact with services and maximises the effect of any therapeutic intervention. It also applies to all adult mentally ill people who have been accepted for treatment by specialist psychiatric services and subsequently discharged; including those released from prison.

5 The essential elements of an effective care programme are:

- *systematic assessment* of health and social care needs (including accommodation), bearing in mind both immediate and long-term requirements;
- a *care plan* agreed between the relevant professional staff, the patient, and his or her carers, and recorded in writing;
- the allocation of a *key worker* whose job (with multi-disciplinary managerial and professional support) is:
  - to keep *close contact* with the patient;
  - to check that the agreed *programme of care* is delivered; and
  - to take *immediate* action if it is not.
- *regular review* of the patient's progress and of his or her health and social care needs; and

- *before discharge* of the patient it is essential that those taking the decisions are satisfied that all these conditions are fulfilled.

6 It is essential for the success of a continuing care plan that decisions and actions are systematically recorded and that there is a clear and agreed structure of communication between members of the care team. The patient and others involved (including, as necessary, the carer, health and social services staff, and the patient's general practitioner) should be aware of the contents of the plan and should have a common understanding of:

- its first review date;
- information relating to any past violence or assessed risk of violence on the part of the patient;
- the name of the key worker (prominently identified in clinical notes, computer records and the care plan);
- how the key worker or other service providers can be contacted if problems arise; and
- what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

7 The CPA lays great emphasis on ensuring continuity of care for patients in the community:

'Every reasonable effort should be made to make contact with the patient and where appropriate with his/her carers, to find out what is happening, to seek to sustain the therapeutic relationship. Often patients may wish to withdraw from part of a care programme and the programme should be sufficiently flexible to accept such a partial rather than a complete withdrawal.' (HSG (94) 27)

8 Any such change to the care programme should as far as practical be agreed with all those involved.

9 When a patient moves from one area to another it is essential to maintain continuity of care. The patient remains the responsibility of the original team until a hand-over has taken place and has been recorded in writing. If there is any doubt about where responsibility lies for purchasing aftercare services for a discharged patient, reference may be made to the Department of Health's guidance booklet on *Establishing District of Residence* published in 1993 and, where appropriate, Local Authority Circular (93) 7 on *Ordinary Residence* and a care assessment.

10 In a number of cases where something has subsequently gone wrong, poor co-ordination of services or communication between those involved has been a major factor. For example, one inquiry report noted that:

'It was not that there was wilfulness in the lack of co-ordination, but that information that one practitioner had might not reach another practitioner in the same or a different discipline.' (HSG (94) 27)

11 The CPA, with its emphasis on systematic assessment of health and social care needs, requires close inter-disciplinary and inter-personal working, particularly at a critical time such as when considering discharge from hospital. The aim should be to ensure that timely and co-ordinated responses could be made to individual needs. The inter-agency arrangements necessary to ensure continuity of care and to prevent people *'falling through the net'* (eg, contact points, knowledge of each other's roles, contingency arrangements, needs assessments) should be clear and easily understood by all parties. They should include the police, courts and probation service so far as they are involved in the management of people with a mental disorder and so far as this is compatible with obligations on confidentiality.

12 There must also be effective links between local agencies and supra-district services such as special hospitals and medium secure units, as well as prisons. Agencies then know which patients they have eventual responsibility for and can work jointly with the discharge unit to develop effective arrangements for continuing care.

Supervised Discharge

13 In 1993, the then Secretary of State's proposals on supervised discharge were announced as part of a ten-point plan. In 1995, Royal Assent was given to the Mental Health (Patients in the Community) Act 1995. This established a legal power so that patients who are deemed to be in need have their care supervised after discharge from hospital by named individuals. This power applies to non-restricted patients who have been detained in hospital under the Mental Health Act 1983 and who would present a serious risk to their own health or safety, or the safety of other people, unless their aftercare is supervised.

14 The intention is that discharge under the powers given by the 1995 Act should establish a level of supervision which reflects the principles of the CPA as well as including some of the key features of Mental Health Act guardianship.

15 At the time of Mrs Murrie's last discharge from hospital in March 1993, this power was not available and the concept of supervised discharge had not been developed. Moreover, Mrs Murrie had not been the subject of detention in hospital under powers given by the Mental Health Act 1983. Therefore, the powers offered by the Mental Health (Patients in the Community) Act 1995 were neither applicable nor available to her.

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community

16 In 1994, the NHS Executive issued guidance as part of the Secretary of State's ten-point plan announced in August 1993. The guidance was framed in HSG (94) 27, which set out good practice to be followed for all patients who are discharged following referral to the specialist mental health services. It is based on the application of the CPA, with particular emphasis on the need for risk assessment prior to discharge.

17 Although HSG (94) 27 was issued after the event that had brought about this inquiry, paragraphs from that document have been used here to describe the CPA as they aptly summarise the policy which had been developed in the years preceding publication of that HSG and that were enshrined within the original intention of the CPA promulgated in 1990.

18 Furthermore, as this inquiry report has indicated, general matters that have been brought to light by the case of Mrs Murrie, support the guidance contained in HSG (94) 27. In some instances, the Panel of Inquiry believes that the guidance (which was offered subsequently) was enacted in the management of Mrs Murrie's case. Nonetheless, as reported in the conclusions and recommendations of this document, the panel considers that there were aspects of the care of Mrs Murrie that were not ideal. In effect, this report has suggested additions to the guidance offered in HSG (94) 27. Therefore, the Panel of Inquiry considers that it is relevant to quote from this guidance.

19 HSG (94) 27 reiterates key messages concerning the CPA and sought to ensure:

- that psychiatric patients are discharged only when and if they are ready to leave hospital;
- that any risk to the public or to patients themselves is minimal and is managed effectively; and
- that when patients are discharged they get the support and supervision they need from their responsible agencies.

20 HSG (94) 27 offers guidance on patients who present special risks (summarised in the section below) and also guidance on procedures if things go wrong.

Patients who Present Special Risks

21 HSG (94) 27 advises that patients with longer-term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour need special consideration both at the time of discharge and during follow-up in the community. No discharge decision should be agreed unless those taking the clinical decisions are satisfied that the patient's behaviour or disorder can be controlled without serious risk to the patient or to other people. In each case, it must be demonstrable that decisions have been taken after full and proper consideration of any evidence about the risk the patient presents.

22 The guidance also concerns actions to be taken before discharge. It states that there must be a careful assessment by both the multi-disciplinary teams responsible for a patient in hospital and by those who will be taking responsibility for his or her care in the community. Both parties must agree the findings of a risk assessment, the content of a care plan, and who will deliver it. In accordance with good practice in the delivery of the CPA generally, there must be a contemporaneous note of the outcome of any risk assessment and of any management action deemed necessary and taken.

23 Although the progress of many mentally disordered people after discharge from hospital can be monitored adequately by attendance at an outpatient clinic to see a psychiatrist and/or by visits by a community mental health nurse, monitoring progress is more difficult for those patients presenting a complex range of needs. They are likely to need regular and, at times, possibly urgent multi-disciplinary re-assessments by the community-based team. Which members of the team need to come together for a particular case will be a matter of judgement, but at least the consultant, the nurse, social worker or care manager - and always the key worker - should be involved. The patient's general practitioner should be informed in all cases, even if it is not practical to involve him or her in the immediate consideration.

24 Where an urgent problem arises, one responsible person (preferably the key worker or another professional in consultation with the key worker) should take the necessary immediate action, followed by a wider consultation as soon as possible.

25 The guidance then recognises that a number of cases demonstrate how difficult it can be in the present state of knowledge to make accurate judgements about future risks. It offers guidance about assessing potentially violent patients and indicates various ways of reducing uncertainty, predominantly by making sure relevant information is available and by conducting a full assessment of risk.

26 The guidance states that the following have been shown to play a part in arriving at a decision about risk:

- the past history of the patient;
- self-reporting by the patient at interview;
- observation of the behaviour and mental state of the patient;
- discrepancies between what is reported and what is observed;
- psychological and, if appropriate, physiological tests;
- statistics derived from studies of related cases;
- prediction indicators derived from research;
- defining situations and circumstances known to present increased risk; and
- seeking expert help.

27 HSG (94) 27 also offers brief advice about assessing the risk of suicide and highlights the guidance offered by the NHS Health Advisory Service on suicide prevention (Suicide Prevention: The Challenge Confronted, NHS Health Advisory Service HMSO. 1994).

28 As the next section will show, HSG (94) 27 has a particular relevance to this inquiry because it was convened under the auspices of the guidance contained in that document.

If Things Go Wrong

29 HSG (94) 27 urges that if a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved but also, in serious cases, to learn lessons for the future.

30 In this event, action by local managers must include an immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the CPA. Where court proceedings in relation to the incident have started or are thought likely to be required, legal advice should be sought to ensure the investigation does not prejudice those proceedings. In particular:

- if the victim was a child ie, is under 18 years of age, the report of the investigation should be forwarded to the area child protection committee within one month of the incident; and
- incidents involving a death should be reported to the Confidential Inquiry into Homicides and Suicides by Mentally ill People.

31 The guidelines also advise that, after completing any legal proceedings, it may be necessary to hold an independent inquiry. Where homicide is concerned, the guidelines state that it is always necessary to hold an inquiry that is independent of the providers involved. The only exception is where a child is a victim and the report of the area child protection committee is considered fully to cover the remit of an independent inquiry.

32 HSG (94) 27 indicates the nature and content of the remit of the independent inquiry that should be conducted. The remit of this report includes those items recommended in the guidance.

Other Statutory Duties of Health and Local Authorities

33 Health and local authorities have a statutory duty under section 117 of the Mental Health Act 1983. This duty is to provide aftercare services for patients (in all categories of mental disorder) who have been detained in hospital under sections 3, 37 (whether or not with restrictions under section 41), 47 or 48 of the Act.

34 Local authority social service departments have duties under the NHS and Community Care Act 1990 to assess people's needs for 'community care' services. Multi-disciplinary assessments under the CPA, if carried out properly (as outlined above), fulfil these duties. Health authorities and local authority social services departments need to ensure that the CPA and care management arrangements are properly co-ordinated. Detailed arrangements depend on the type of care management system that the social services department has implemented but, in all cases, a key worker should be allocated as required under the CPA.

POLICY ON SERVICES FOR CHILDREN

The Children Act 1989 and 'Working Together'

35 Every local authority in England and Wales also has a wide range of duties and responsibilities under the Children Act 1989. Predominantly, these are to identify children in need within the

authority's area, to provide appropriate services and to protect the welfare of such children. Where a local authority believes a child within its area is likely to suffer significant harm, but lives or proposes to live in the area of another local authority, it must inform the other local authority (Children Act, s.2, para.4). The local authority is bound by statutory requirements to investigate reports of children at risk and to take the appropriate action to protect the child and promote his or her welfare.

36 Guidance contained in Working Together under the Children Act 1989 is very clear about collective responsibility and collaborative procedures:

'It is essential that whenever one agency becomes concerned that a child may be at risk they share the information with other agencies. Other agencies may have information, which will clarify a situation, and therefore WORKING TOGETHER for the protection of children is crucial. Agencies are not only carrying out their own functions but are also making, individually and collectively, a vital contribution to advising and assisting the local authority in the discharge of its child protection and child care duties... primary responsibility of the agencies is the need for inter-agency co-operation in the planning of and providing services for a child or family. The duty of the local and health authorities to co-operate in the exercise of their respective function is set out in section 22 of the National Health Service Act 1977... Inter-disciplinary and inter-agency work is an essential process in the professional task of attempting to protect children from abuse by their parents or other carers. Staffs from all agencies have a duty to work on the quality of relationships between agencies, endeavouring to create a climate of trust and co-operation that will be the cornerstone of multi-disciplinary work. If co-operation between agencies is to be effective, it must be underlined by the shared understanding not only of the respective responsibilities of every agent but also by a shared understanding of the handling of an individual case." (Oxfordshire Child Protection Committee Procedures 1996)

PROBATION AND COURT WELFARE SERVICES IN PRIVATE LAW MATTERS

37 As readers will be aware from Chapters 4 and 5, applications concerning Louise's residence and contact arrangements, made to the courts by her parents, resulted in the appointment of a court welfare officer who played a significant role in assessing Louise's needs and the family circumstances. Also, at one point, the court made a Family Assistance Order under powers contained in the Children Act 1989. This section provides some specific information concerning the law, policy and practice relating to the role of the probation and court welfare services in private law.

38 In private law matters, the courts may direct the social services or the probation services, or other appropriate bodies, such as the NSPCC, to report to them on matters concerning a child's welfare. This may occur, for example, where there is a dispute between the parties about the residence of a child, contact or parental responsibility.

39 The Family Court Welfare Service (The Probation Service) undertakes all of it's inquiry work under Section 7 of The Children Act 1989 and reports to courts on such matters relating to the welfare of the child(ren) as required by the court

On receipt of a report from the Family Court Welfare Service prepared under Section 7 of The Children Act 1989 the court may consider it appropriate for a Care or Supervision Order to be made and for it to direct the appropriate Local Authority to undertake an investigation of the child's circumstances under Section 37 of The Children Act 1989.

40 A report provided to the court by a Family Court Welfare Officer under Section 7 of The Children Act 1989 should address:

- the issues specified by the court
- sufficient information to enable the court to have regard to the matters set out in Section 1 (iii) of The Children Act 1989, namely:
  - the ascertainable wishes and feelings of the child taking into account the child's age and understanding
  - the child's physical, emotional and educational needs
  - the likely effect on the child of any change in circumstances
  - the child's age, sex, background and relevant characteristics
  - any harm the child has suffered or is at risk of suffering
  - how capable each of the parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting the child's needs
  - the range of powers available to the court under the act

41 In 'exceptional circumstances' (ie, not routinely), a court may make a Family Assistance Order, for six months or a shorter period, under s.16 of the Children Act 1989. This requires a person, usually a probation officer or social worker, to advise, assist, and (as appropriate) befriend any named person who may include:

- any parent or guardian;
- any person with whom the child is living or in whose favour a contact order is in force with respect to the child; and
- the child.

42 Before including a Family Assistance Order in the options to be considered by the court, the worker must:

- identify clear plans for the work to be undertaken;
- state how it will be achieved;
- discuss the plan with the parties and obtain their consent; and
- take into account the child's wishes, although the child's consent is not required.

43 Family Court Welfare National Standards define the primary objective of all Family Court work as:

'To help the courts in their task of serving the needs of children whose parents are involved in separation or divorce or whose families are involved in dispute in private law.'

44 The document goes on to say:

'The purpose of a welfare report is to provide the court with information about matters relating to the welfare of the child which will enable the court to make decisions that are in the child's best interest. Where, in the course of preparing a report, the Court Welfare Officer identifies opportunities for helping the parties to reach agreement, these should be pursued in line with the general principle of promoting parental responsibility but it is not the role of the Court Welfare Officer to set out to resolve disputes when preparing a welfare report.'

45 The court's instructions and any orders that may be made normally limit the roles of court welfare officers, and the extent to which they continue to have contact with families. Nonetheless, contact with the named person may continue after cases are closed. In practice, the judgement as to whether this is appropriate is often left to the individual officer within the usual remit for accountability. In some contested cases, court processes can be prolonged and sometimes further involvement is required in order to safeguard the interests of the child or children involved.

ANNEXE B

MEMBERSHIP, PROCEDURES AND CONDUCT OF THE PANEL OF INQUIRY

1 The Panel of Inquiry was constituted by Berkshire Health Authority and consisted of the following:

Professor Richard Williams - Chairman

Professor Williams is a Consultant Child and Adolescent Psychiatrist. He was also Director of the NHS Health Advisory Service between 1992 and 1996 and thereby gained wide and in-depth experience of mental health services throughout England and Wales. At the time when the Panel of Inquiry sat, he had the additional appointments of Senior Fellow at the Health Services Management Centre in the University of Birmingham and Vice Chairman of the Mental Health Act Commission. Now, he is Professor of Mental Health Strategy in the University of Glamorgan and a Consultant Child and Adolescent Psychiatrist in the Gwent Community Health NHS Trust.

Mr Michael Hennessey

Mr Hennessey was the Director of Social Services for Shropshire County Council from 1985 to 1998. He has worked at a senior level in social services since 1972 and has had extensive experience of social care provision since 1963. He also has substantial experience of working with the National Health Service at regional, local and, on occasions, national level. Mr Hennessey is an associate member of the Association of Directors of Social Services, and is an independent lay member of the Parole Board.

2 Two observers to the Panel of Inquiry were also appointed. Berkshire Health Authority appointed Mrs Catherine Green, one of its non-executive directors. The Regional Office for Oxford and Anglia of the NHS Executive appointed Mr Carl Petrokofsky to act as an observer. In the event, Mr Petrokofsky was taken ill during the time that the Panel of Inquiry sat and was consequently unable to participate on more than one occasion. The remaining members of the panel took advice and agreed that, because its proceedings and evidence taking were advancing, it would be inappropriate to seek a replacement for Mr Petrokofsky.

THE PROCEDURES ADOPTED BY THE PANEL OF INQUIRY

3 The proposed panel met first on Monday 20 May 1996 to consider its remit and to discuss its methodology. On 28 May 1996, Berkshire Health Authority confirmed the composition of the panel for this inquiry and, subsequently, confirmed the remit for the inquiry.

4 A second meeting took place on 4 June 1996 to discuss these matters further and to confirm methods of working.

5 The attention of the panel was drawn to the documents listed in Annexe E. The panel considered each of these documents and reviewed the conduct of previous inquiries before deciding on the procedures to adopt for this one.

6 The underlying intention has been to conduct a formal inquiry to deal effectively with each of the items in the remit, but to do this in a way that would have minimal unwarranted effects on individual witnesses or organisations. At the same time, the panel has been concerned not to sacrifice clarity and objectivity, and determined to consider all the issues openly and fairly. Adopting this approach gave the Panel of Inquiry a substantial task.

7 The panel began by considering the written evidence (the documents listed in Annexe E). From this, the panel constructed a list of the agencies and individuals that it wished to examine orally in order to explore issues arising from its scrutiny of the documents and in order to fill gaps of information and opinion. This list was enlarged as the inquiry proceeded and as the panel became more familiar with the events, the issues and the people involved.

8 At the outset, it was therefore agreed that each of the witnesses called to give oral evidence to the panel should be advised about the constitution and remit of the Panel of Inquiry before attendance, whenever possible. It was also agreed that witnesses could bring a supporter at their own instigation.

9 Throughout the conduct of the inquiry, three officers of the Berkshire Health Authority supported the panel and, between them, provided the secretariat. They are Dr Jeremy Cobb, Inquiry Co-ordinator; Mrs Sharon Billinghurst, Assistant to Dr Cobb; and Carol Pendel, Assistant to Dr Cobb. Dr Cobb, effectively the secretary to the inquiry, provided a personal means of contact with each of the witnesses. The secretary's position has now been transferred to Mrs Lynda Winchcombe who took on this role in December 1998. It was agreed that Mrs Billinghurst would keep a record of the proceedings of the inquiry. Where this involved taking oral evidence from witnesses, her records were afterwards distributed to the witnesses for factual correction and confirmation before they were considered as authoritative transcripts of the oral evidence.

10 At the conclusion of its formal proceedings, the Panel of Inquiry mention a number of occasions to consider the evidence and then drafted its report. At its initial meetings, the panel resolved to adopt a procedure whereby key agencies and individuals would have a further opportunity to comment on aspects of the panel's findings, particularly if they were to criticise or adversely comment on their roles and behaviours. Therefore, the panel agreed that, on completion of an advanced version of its final report and before its confirmation, parts of it might be distributed in draft form to certain of the agencies and witnesses involved in order to:

- give key agencies and key persons an opportunity to correct matters of fact relating to their positions; and
- enable certain agencies and individuals to be aware of observations and /or opinions about their roles and conduct that the panel might make in its final published report.

11 Necessarily, the processes adopted in this approach, particularly during the report preparation stage, have each taken time to complete adequately.

12 At no point were solicitors or other legally qualified persons involved directly in the evidence-taking proceedings. The panel determined that witnesses would be free to seek legal support during their oral examination if they so determined. In the event, none of the witnesses chose this course. The panel did itself seek legal advice at intervals either through face-to-face meetings or indirectly through the secretary to the inquiry. This usually concerned gaining opinion on issues relating to the procedures to be adopted and the resolution of one particular procedural problem when it arose. The panel has also sought legal advice, at intervals, as the drafting of the report progressed.

THE CONDUCT OF THE PANEL OF INQUIRY

13 The procedures described in the previous section were adopted throughout the inquiry. In the event, the inquiry involved three main phases.

Phase One

14 During phase one, the Panel of Inquiry determined the methodology for conducting the inquiry

and, in particular, the procedure to be followed with respect to taking and confirming oral evidence. The members of the Panel of Inquiry also considered a number of documents supplied to them. These included the written reports of the management inquiries conducted by:

- The West Berkshire Priority Care Service NHS Trust;
- The Berkshire Social Services Department; and
- The Area Child Protection Committee (ACPC) report of the Oxfordshire Social Services Department.

15 After considering the documents, the panel determined a preliminary list of witnesses from whom to request oral evidence and any supporting written documentation. Subsequently, this list was confirmed and supported by the opinions formed from evidence offered to the Panel of Inquiry and by the documentation reviewed. The major documents considered are listed in Annexe E. Also, during phase one, the Panel of Inquiry considered a variety of issues related to theory and good practice and a number of previous reports. Those found most useful by the members of the Panel of Inquiry are listed in Annexe H.

Phase Two

16 During phase two, the Panel of Inquiry met witnesses to take oral evidence. A summary of the witnesses interviewed is provided in Annexe D.

17 Most of these sessions took place at premises provided by the Berkshire Health Authority. Also, the Panel of Inquiry met Mrs Anne Murrie at Broadmoor Hospital. During that visit, the panel members had an opportunity to meet Dr Andrew Johns, who was the consultant responsible for her care there at the time of that visit.

18 In addition, the members of the Panel of Inquiry made a visit to Fair Mile Hospital to view the premises to which Mrs Murrie had been admitted, hold discussions with the hospital managers and nursing staff, and met Dr Dickinson once again.

19 The panel offered the opportunity of an interview to Mr Murrie and to Stuart, the son of Mr and Mrs Murrie, on several occasions. In the event, neither person took up this offer and, after further consideration, the panel resolved not to press matters with them further in order not to add to the distress that members of Louise's family must, inevitably, have suffered.

Phase Three

20 After completing phase two, the members of the Panel of Inquiry reviewed the evidence provided to them, discussed and agreed their conclusions and recommendations for the future and prepared this report. Inevitably, this phase required much detailed consideration in formulating the observations and advice of the panel and in drafting this report.

ANNEXE C

A LIST OF THE ORGANISATIONS INVOLVED

The Health Authority
Berkshire Health Authority
57- 59 Bath Road, Reading, Berks.

Berkshire Health Authority is the agency that commissions and purchases mental healthcare from the West Berkshire Priority Care Service NHS Trust. This authority was established on 1 April 1996 by the formal merger of Berkshire District Health Authority and the Berkshire Family Health Services Authority. Previously, on 1 October 1993, the East and West Berkshire District Health Authorities were merged to form the Berkshire District Health Authority.

THE HEALTH SERVICE PROVIDER

West Berkshire Priority Care Service NHS Trust
Prospect Park Hospital, Tilehurst, Reading, Berks.

The West Berkshire Priority Care Service NHS Trust, which runs the NHS contribution to mental health in the community in Berkshire (including Fair Mile Hospital) is the trust that was responsible for Mrs Murrie's mental healthcare during the period of time that the inquiry has considered.

THE SOCIAL SERVICES DEPARTMENTS

1 Berkshire Social Services Department
Shire Hall, Shinfield Park, Reading, Berks.

In February 1993, prior to her discharge from Fair Mile Hospital in March 1998, Mrs Murrie was referred to the Berkshire Social Services Department because she was moving to Reading. The letter of referral went to the Coley Clinic, Reading, where she was allocated a social worker/care manager.

2 Oxfordshire Social Services Department (Children and Families Team) Calthorpe House, Calthorpe Street, Banbury, Oxon.

Reference was made to this children and families team, provided by Oxfordshire Social Services Department in December 1992 because it covers the South Oxfordshire area (the overlap area) in which the local authority for Oxfordshire and the Berkshire District Health Authority (now Berkshire Health Authority) had responsibilities. Members of one of it's mental health teams provided services for Mrs Murrie while she was an inpatient at Fair Mile Hospital in December 1992, and January and February 1993.

THE JUSTICE AND COURT SERVICES

1 **Oxfordshire Probation Service**
1st Floor, 2 Cambridge Terrace, Oxford, Oxon OX1 1TP

The Oxfordshire Probation Service, now the Oxfordshire and Buckinghamshire Probation Service, was (and under its new title remains) the employer of the court welfare officer who was responsible for the preparation of a report concerning Mrs Murrie's application for a Residence Order in February 1993.

2 **Reading County Court**
Friars Walk, Reading, Berks.

Mrs Murrie was first at the County Court in Reading in September 1992 in connection with her marriage and for subsequent legal action. It was to this court that the welfare officer from the Oxfordshire Probation Service submitted her report.

ANNEXE D

INDIVIDUALS WHO PRESENTED ORAL EVIDENCE TO THE INQUIRY

Date Seen	*Name of Witness*	*Job Title*
16 July 1996	Eileen Spiller	Director of Service Development West Berkshire Priority Care Service NHS Trust
	Helen Horton	Non-Executive Director, West Berkshire Priority Care Service NHS Trust
	Gary Nixon	Quality Manager, West Berkshire Priority Care Service NHS Trust
9 September 1996	Margaret Sheather	Assistant Director (Care Management and Purchasing), Berkshire Social Services Department
	Nick Georgiou	Senior Assistant Director, Berkshire Social Services Department
	Anne Emmons	Area Manager, Berkshire Social Services Department
10 September 1996	Tony Clarke	Social Worker/Care Manager, Berkshire Social Services Department
	Mike Hayward	Senior Care Manager, Berkshire Social Services Department
	Rosemary Mann	School Nurse, Caversham Area West Berkshire Priority Care Service NHS Trust
10 September 1996	Shirley Goldin	Senior Nurse Child Health, West Berkshire Priority Care Service NHS Trust
	Loran Dunn	Court Welfare Officer, Oxfordshire and Buckinghamshire Probation Service
	Linda Forrest	Senior Probation Officer, Oxfordshire Family Court Service Oxfordshire and Buckinghamshire Probation Service
	Philip T Hodgson	Assistant Director, Children & Families, Oxfordshire County Council Social Services Department

Date Seen	*Name of Witness*	*Job Title*
	Paul O'Hare	Unit Manager, Community Mental Health Team, Thame Oxfordshire County Council Social Services Department
24 October 1996	Dr Rob Ferris	Consultant Forensic Psychiatrist, Fair Mile Hospital, West Berkshire Priority Care Service NHS Trust
	Dr Harry Dickinson	Consultant Psychiatrist, Fair Mile Hospital, West Berkshire Priority Care Service NHS Trust
1 November 1996	Peggy Holland	Oxfordshire Community Mental Health Team, Oxfordshire County Council Social Services Department
1 November 1996	Pauline Bennett	Oxfordshire Community Mental Health Team, Oxfordshire County Council Social Services Department
	Paul O'Hare	Unit Manager, Community Mental Health Team, Thame, Oxfordshire County Council Social Services Department
2 December 1996	Richard Mills	Head of Strategy, Berkshire Health Authority
	Margaret Crawford	Management Lead on Mental Illness, Berkshire Health Authority
	Annie Francis	CPA Monitoring, Berkshire Health Authority
27 January 1997	Anne Murrie	
12 February 1997	Dr Jean Evelyn Boon	General Practitioner, Caversham
25 July 1997	Marion Johnson	Formerly CPN, Bucknell House, West Berkshire Priority Care Services NHS Trust

ANNEXE E

A LIST OF THE DOCUMENTS CONSIDERED

No.	*Document*	*Date*
1	Letter from Peggy Holland, Senior Practitioner, Community Mental Health Team, Townlands Hospital, Henley on Thames, to Mike Hayward, Coley Clinic	22 February 1993
2	Oxfordshire and Buckinghamshire Probation Service Court Welfare Officer's Report	21 April 1993
3	West Berkshire Priority Care Service NHS Trust, Fair Mile Hospital Care Programme Approach Documents	26 April 1993
4	Letter from Mr Clarke, Social Worker/Care Manager, Coley Clinic to Dr Dickinson, Fair Mile Hospital	17 February 1994
5	Joint Mental Health Service contact details from Marion Johnson, Community Psychiatric Nurse	18 February 1994
6	Royal County of Berkshire Report of a Management Review of the Involvement of Berkshire County Council Social Services Department with Mrs Anne Murrie	11 April 1994
7	West Berkshire Priority Care Service NHS Trust Management Inquiry Report	12 May 1994
8	Psychiatric report of Dr Susan Iles, Consultant Forensic Psychiatrist, Broadmoor Hospital	17 August 1994
9	Psychiatric report of Dr Rob Ferris, Consultant Forensic Psychiatrist, Fair Mile Hospital	7 September 1994
10	The ACPC multi-agency child protection training report	September 1994 - August 1995
11	Oxfordshire County Council Part 8 Review - Louise Murrie	20 October 1995
12	Oxfordshire County Council Social Services Department Structure Charts of Oxfordshire Social Services Department prior to and from 1 May 1995.	7 October 1996
13	Psychiatric Report to the Mental Health Review Tribunal by Dr Andrew Johns - RMO Harrogate Ward at Broadmoor Hospital	28 October 1996

No.	Document	Date
14	Psychiatric Report (in process of preparation by Dr Dickinson as at 25 February 1994), Fair Mile Hospital, West Berkshire Priority Care Service NHS Trust,	29 October 1996
15	Report of events from Mrs Murrie	27 January 1997
16	Resource Assumptions for Mental Health Services for Berkshire Health Authority 4 March 1997 Resource Assumptions for Mental Health Services for Berkshire Health Authority	4 March 1997

ANNEXE F

EXTRACTS FROM THE MANAGEMENT INQUIRIES

1 *Extracts from a case review compiled by Oxfordshire County Council (Autumn 1995)*

(Paragraph numbering has been altered to make the extract clear.)

Thames Valley Police
Management Conclusion

At no time did police dealings with Mrs Murrie give cause for concern for the safety of the children and in particular Louise. The referral to Social Services on 20 January 1993 was made to accord with procedures and not with any expectation that further action was warranted.

Oxfordshire Education Department
Summary

Louise Murrie's progress at school was in line with that expected of a girl of her age and aptitude. Louise did not present as having any special needs therefore no referrals were made to psychological services or education social work services.

There were no issues, which could, even with hindsight, have prompted any child protection concerns.

Oxfordshire Social Services Department
Management Conclusion

The evidence from the file indicates the case was one of marital disharmony where one partner suffered mental health problems.

There is no trace on social services file of a telephone referral made by Thames Valley Police on 26 January 1993.

Oxfordshire Probation Service
Management Conclusions

On reading the case file, observations were made by the Family Court Welfare Officer about Mrs Murrie's state of mind and behaviour. Communication should have been made with Social Services. The voluntary contact sustained with Mrs Murrie after the Order expired should have been discussed with the supervisor as to its validity and relevance.

Oxfordshire Probation Service is currently in the process of revising its internal child protection procedures.

Practice Issues Identified from Management Reports

Oxfordshire Social Services had not recorded the telephone referral from Thames Valley Police on 26th January 1993.

Recommendation

All telephone calls between agencies must be recorded.

The Divorce Court Welfare Officer did not report concerns about Mrs Murrie's behaviour to social services.

Recommendation

This must be done in future.

NB: Oxfordshire Probation Department has revised its child protection procedures. They are emphasising the importance of inter-agency communication in childcare cases.

Berkshire Social Services Department intends to review the awareness of Mental Health Teams of child protection procedures and will ensure an appropriate level of knowledge is maintained.

Recommendation

Oxfordshire ACPC similarly ensures that Mental Health Teams are aware of child protection via ACPC representatives and the NSPCC inter-agency training project.

The case review identified problems in obtaining a management report on the GP records. This is an area that requires further clarification by the Department of Health.

Case Review Conclusions

- There was no information contained in any of the management reviews that should have triggered child protection procedures.
- Child protection procedures were not appropriate in this case.
- Agencies reported learning points outside of child protection policies and procedures.
- Even with the benefit of hindsight, child protection procedures were not the appropriate framework for any agency involvement in this case.
- Therefore this tragic event could not have been predicted or prevented.

The Case Review Committee would also wish to raise with the Department of Health the problem of conducting a Case Review when Criminal Proceedings are pending.

This report may become disclosed material for the Criminal trial. The ACPC would wish for guidance on this aspect of conducting and reporting on a Case Review.

2 *EXTRACT FROM THE INTERNAL MANAGEMENT INQUIRY REPORT CONDUCTED BY WEST BERKSHIRE PRIORITY CARE SERVICE NHS TRUST*

(Paragraph numbering has been altered to make the extract clear.)

Summary of Findings

1 At the time of Anne Murrie's discharge in 1993, all normal procedures were adopted regarding referrals to Community Services. There was a clear, comprehensive and up-to-date report summarising the background and psychiatric assessment on the medical notes.

2 Normal expectations regarding the passage of information were fulfilled and there were no barriers to normal communication.

3 Recent changes to Health and Social Services Care Delivery have precipitated the separation of function and information between Social Services and Health.

4 Due to the separation of purchaser and provider functions within Social Services, Coley Clinic and Bucknell House now function as separate teams.

5 The Community Psychiatric Nursing Post at Bucknell House is affected as in 4 above and also the lack of a regular Consultant Psychiatric presence. Additionally, communication between Consultant Psychiatrists and Community Psychiatric Nurses is sometimes impeded by:

a) Geography

b) Mismatching of Community Services and Consultant Teams

c) Community Psychiatric Nurses having competing workload pressures from Consultant Psychiatrists and General Practitioners

6 Social Services Care Managers can refer to Trust Staff. However, it is not clear whether the expectations from the Trust Staff [sic] to:

a) Provide specific care requested by Care Managers who have assessed the patient and their needs.

b) Participate in the assessment to identify what is the appropriate care. If this is the case, then it is implicit that multi-disciplinary teams meet to assess, formulate and evaluate individual plans of care.

7 The Health Visitor was aware that Anne Murrie was receiving help from Psychiatric Services. However, it is not normal for Health Visitors or School Nurses to be told of the involvement of Psychiatric Services unless there is a specific reason.

8 There were normal records kept by Health Visiting and Community School Nurse services.

9 If all of the information regarding Mrs Murrie's circumstances were available to all Trust staff, it may have made things clearer, but not necessarily changed the way in which the case was handled.

10 It was fortuitous that the School Nurse was aware of the importance of, and encouraged the use of, counselling, which was beneficial to the adjustment of the school staff.

11 In the process of the Inquiry, many records, which provided a mass of detailed information, were received. It was not always clear how important some of this information was, and that some information was not recorded or communicated verbally.

Recommendations

12 The role and responsibility of each member within Joint Mental Health Teams should be viewed in the light of recent changes in Health and Social Services. Any review should address:

a) The expected links and relationships within the Joint Teams and other professionals within West Berkshire Priority Care Service NHS Trust, particularly in relationship to initial assessment of availability of information and mechanisms to continue to discuss client care.

b) How and what information is recorded and where it is kept. Additionally, if joint records are generated, then it is the responsibility of both Agencies for security and ongoing access is clearly understood.

c) How appropriate support and supervision can be given to all workers.

13 The mechanisms for delivering Community Psychiatric Nursing input to Bucknell House should be reviewed. Change may be necessary in order to ensure its continued delivery by reducing the isolation for a single worker.

14 A Consultant Psychiatric presence within the Coley Team should be negotiated.

15 Some thought should be given to the principles adopted in the recording of information so that the right information is recorded consistently in an understandable way.

16 Protocols should be developed to clarify when Trust staff, working in separate service, are told of other Trust staff involved in care in the patient's household.

17 It should be ensured that Community School Nurses are made aware of the beneficial practices of encouraging school communities to access counselling following tragedy within this setting.

18 The Trust should review how such incidents could be dealt with to ensure a more controlled and measured approach is agreed for the future. It may be of help to assist key staff in developing expertise to deal with incidents, which can occur within the Mental Health arena.

19 It will be necessary for the Trust to develop procedures for addressing the issue of professional competence when such incidents occur.

20 This report should be made available to all agencies involved in investigating this incident and a meeting with such agencies should be encouraged.

Conclusions

21 The Trust's systems and procedures in place were adequate to ensure appropriate communication and that these procedures/systems were followed.

22 All Trust staff who were interviewed and involved in the case of Anne or Louise Murrie acted professionally and in the interest of the patient/client.

23 If the recommendations made in this report were in place at the time preceding the incident it would not have changed the way in which the patient was dealt with or treated.

24 There are some improvements that can be made within the Trust and externally with other Agencies and these will need to be addressed in the near future.

25 This management Inquiry cannot reflect the wider organisation of care for those concerned and will need to be viewed in conjunction with Social and Educational Services reports.

3 *EXTRACT FROM THE REPORT OF A MANAGEMENT REVIEW OF THE INVOLVEMENT OF BERKSHIRE COUNTY COUNCIL'S SOCIAL SERVICES DEPARTMENT*

Management Conclusions from the Review

This paragraph addresses itself to the Child Protection Procedures.

The Child Protection Procedures were not the appropriate framework for Berkshire's involvement in this case. The referral was for mental health after care support and this was the focus of the work throughout. There was no concern expressed for Louise's care by her mother at the time of referral, and her contact with Louise continued throughout the period, without any such concerns being raised by her father or by other agencies.

Mrs Murrie's behaviour had been typified over a considerable period by harm to herself, not to others. More recently, her anger was directed against her husband's girlfriend. The most definite statement she made at any stage about Louise was in her phone conversation with Tony Clark on 15 February when she said she felt like running off with Louise. Even with hindsight this raises more thoughts about the potential emotional and psychological damage to Louise of such a course of action than it does of a threat of physical harm. The Child Protection Procedures would

not appropriately have been used.

The chronology given above (not quoted here) is a full account of Berkshire's actions in this case.

The decisions and actions of staff in the mental health team were in line with policy and procedure within the SSD. The relevant policies and procedures relate to the Department's expectations in assessment and care management, and these were followed. The detailed examination of the case for the purposes of this report has highlighted some areas where the management of the case could have been clearer and the role of the Mental Health Team with Mrs Murrie more tightly defined. However, there is no evidence that improvements in these matters would have had any influence on the final tragic events in this case.

The response within Caversham Locality was not in line with Departmental expectations and procedures, nor with the Locality's own expectations of their duty system. Had the matter been referred on to the Coley Clinic on 21 February rather than 24, Tony Clark could have shared his views with the police earlier. Again, however, it does not seem evident that this would have altered the overall train of events. Nevertheless it was a significant failure of practice.

Numerous attempts were made to provide Mrs Murrie with the services available to meet the needs she agreed she had. By February this year she was finally engaged in some counselling within which she seemed able to address her angry and confused feelings about her situation. The outcome had she been able to respond earlier to offers of help can only be a matter of speculation.

In response to this review three actions have been identified.

i Despite their limited relevance in this instance, to review the awareness in Mental Health Teams of the Child Protection Procedures and ensure an appropriate level of knowledge is maintained.

ii To take up with the staff concerned the detailed matters of case management identified in the course of the review.

iii The failure of the duty response in Caversham Locality has already been taken up with the Locality Manager and further discussion will take place to ensure that the system in that Locality has been tightened up and that no similar problems exist in other localities.

ANNEXE G

MAP OF GEOGRAPHICAL AREA, SHOWING BOUNDARIES COVERED BY HEALTH AND SOCIAL SERVICES

Key:

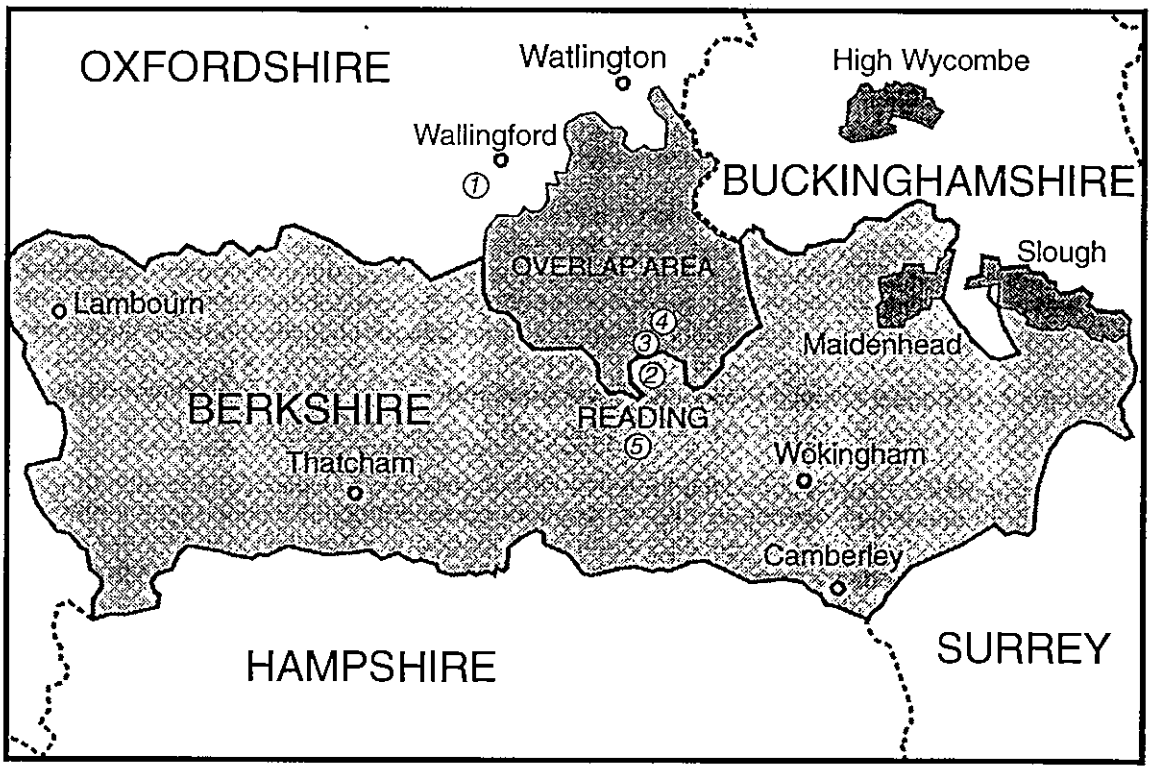
1 Fair Mile Hospital

2 Mrs. Murrie's home

3 The Murrie family home

4 Louise's school

5 The Coley Clinic - Berkshire Social Services Department



ANNEXE H

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