# REPORT OF THE INQUIRY

# INTO THE TREATMENT AND CARE OF

# MR D ESKE

A report commissioned by

SOUTHAMPTON AND SOUTH WEST HAMPSHIRE
HEALTH AUTHORITY
and
HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES
in September 1997

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COMMISSIONED BY SOUTHAMPTON AND SOUTH WEST HAMPSHIRE HEALTH AUTHORITY AND HAMPSHIRE COUNTY COUNCIL SOCIAL SERVICES

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## II PREFACE

We were jointly commissioned in September 1997 by Southampton and South West Hampshire Health Authority and Hampshire County Council Social Services to undertake this Inquiry.

We now present our report, having followed the terms of reference and the procedure which was subsequently adopted and issued to all witnesses and their representatives.

GERALDINE JOHNS - GWEN OVSHINSKY - STEPHEN WOOD

## III ACKNOWLEDGEMENTS

D E and all of the witnesses of fact for their frankness and willingness to co-operate in a process which was personally demanding and at times stressful.

Jen Dibb-Fuller - Clerk to the Inquiry

Naomi Forrest - Stenographer

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## CHAPTER I

### 1.0 INTRODUCTION

In the Crown Court at Winchester on the 14th July 1997 DE was convicted of Manslaughter, by virtue of diminished responsibility, of his mother PE on the 29th November 1996. He was made subject to a Hospital Order under Section 37 of The Mental Health Act 1983 with a Restriction Order under Section 41 of that Act, to Ravenswood House.

### 1.1 INTERNAL INQUIRIES

Following the death of PE the agencies involved set up their own internal enquiries.

Amanda Johnstone for Southampton Community Health Services NHS Trust prepared a factual account of DE's contact with his GP and the CMHT between July 1995 and the 25th November 1996 which was concluded on the 3rd December 1996.

Ruth Dixon from Hampshire County Council Services Department prepared a report detailing the contact that both DE and his mother had with the CMHT and Social Services from 1990 to the date of the incident.

### 1.2 INDEPENDENT INQUIRIES

Ruth Webb, Divisional Officer (Operational Standards) Adult Care Division Wiltshire Social Services Department, also prepared a report in February 1997 at the request of Hampshire County Council Social Services Department regarding the circumstances of the homicide involving people in contact with the local Social Services Department. The reports were based on discussions with members of the CMHT, perusal of the CMHT files on both PE and DE. In the conclusion of her report Ms Webb made six recommendations which this Inquiry has noted.

Following the completion of the Court proceedings in July 1997 Hampshire County Council Social Services Department and Southampton and South West Hampshire Health Authority declared their intention to establish an Independent Inquiry as recommended in Health Service Guidelines HSG (94) 27. We were appointed by October of that year. Terms of reference were agreed and are reproduced at Appendix 1. We adopted the procedure as formally noted in the Sinclair Report. Witnesses were invited to provide statements in advance of

their interview. All witnesses were provided with a transcript of their evidence and invited to revise it in the light of any errors.

This report is based on their evidence and consideration of all the records, policies and other documentation made available to the Panel. We are not aware that any documents have been withheld from us.

We have also taken note of the earlier Inquiry by Matt Muijen into the circumstances surrounding the death of three men who had been known to the Waterside and Romsey Community Mental Health Team.

In addition the Panel visited the Totton area and viewed the base of the Community Mental Health Team at Anchor House.

## CHAPTER II

## THE LIFE OF DE

### 2.1 GENERAL ISSUES

As with previous Inquiries we found in order to consider the treatment and care of a person suffering from a mental illness it is necessary to review his personal history;

i. To become familiar with the individual and the background to the situation and circumstances;

ii. To identify any factors and events which may have affected his behaviour in the course of his illness;

iii. To clarify to what extent those factors and circumstances were taken into account by those responsible for providing care and treatment.

We have been able to gain information about his personal and family history not only from the official records but also from members of his family, neighbours and from DE himself.

We are grateful to all the family for their frankness. We also noted their concerns that they were not fully aware of the circumstances immediately leading up to the tragic death of PE and the difficulties which they had perceived in obtaining any information. We hope that the outcome of this Inquiry will provide some such information and allay some of their fears.

### 2.2 FAMILY STRUCTURE

The E family originated in Kent. PE was born in 1947. She married JE and they had two children. KE, the eldest child, was born in Dartford, Kent on the 20th July 1972 and DE was born on the 14th May 1975 also in Dartford.

The family moved from Kent to Totton in 1979.

It was noted that in 1983 concerns were expressed at DE's school about his behaviour and a referral to the Child Guidance Service was considered.

At age 11 DE received help from a Consultant Child Psychiatrist as a result of his non attendance at school, withdrawal and isolation.

Tragically DE's father died in December 1989. This undoubtedly caused many problems for the family not least in coming to terms with their grief. It has been suggested by many family members and is recorded in GP notes that DE had many unresolved issues with regard to his father's death. He had apparently not been aware of the nature or seriousness of his father's illness. As a result he had not visited him as often as he might in hospital and experienced considerable feelings of guilt.

DE was again referred by his GP to a Consultant Child Psychiatrist who was concerned that DE was sullen and had a careless attitude. He had no desire to return to school and was quite prepared to live at home without making any financial or other contribution to the home.

It was noted at that time that DE was not going out very much. He was not washing or looking after himself. He slept a lot and rarely attended school. In November 1990 it was noted that DE and his mother "rub along reasonably well but have never had a particularly close relationship ...". She found however at that time he was not profoundly depressed and that he had probably got himself "into a rut which was difficult to come out of". The Psychiatrist seemed to feel that home tutoring might give DE a chance to build a relationship with somebody.
The Child Psychiatrist's involvement with the family ceased in 1991.

We noted that the Educational Welfare Office records were destroyed three years after the last contact.

Members of DE's family commented that he had become more and more withdrawn after the death of his father.

DE was 14 years old when his father died. He had been truanting from school regularly and was spending less and less time with friends.

His father had been a musician and DE had shown musical talent. For a time he played the guitar in a band but gradually fell out with the other members and eventually left.

DE admitted to experimenting with illicit drugs during his teenage years but this again tailed off.

His family commented that after his father's death DE's behaviour worsened. He became reclusive only going out occasionally fishing. DE's mental health began to deteriorate following his father's death, and in retrospect it seems clear that he was developing insidiously a psychotic illness.

By 1994 KE had left home and DE and his mother remained. PE had commented to her family about concerns that he would shut himself away

and would not mix with others. She apparently was reluctant to share other concerns and in the family's view that was because she was in fact frightened of her son although this was not expressly stated by PE. It would appear that other members of the family, whilst concerned about his behaviour, were not frightened of him.

## CHAPTER III

## THE SERVICES BETWEEN 1994 - 1996

### 3.1 Southampton and South West Hampshire Health Authority

The Southampton and South West Hampshire Health Authority was responsible for purchasing health services during this time. The period was marked by considerable activity in strategic planning and commissioning, changes in service providers and boundary changes. The Health Authority's boundaries changed twice between 1994 & 1996.

By the year 1996/7 the Health Authority was responsible for commissioning health services for a population of over 500,000 people with a budget of over £300m.

In June 1994 a five year Joint Commissioning Strategy for mental health services was agreed between the Health Authority and Hampshire Social Services. One of the aims is to shift from a centralised hospital-based service to a locality based service, with in-patient care integrated into a comprehensive mental health service. The main focus is the establishment of Locality Mental Health Teams (LMHTs) in five localities covering the Health Authority area, and the development of support services (including day care, leisure and employment opportunities, benefits advice, supported housing) in each locality. The localities are shown in Appendix 3. One of the localities was Romsey Totton and Waterside which was where DE and his mother lived.

The Health Authority undertook a market testing exercise (a competitive tendering process) to select providers for the implementation of the strategy. The two providers selected in March 1995 were Salisbury Health Care Trust for the Western New Forest and Totton and Waterside localities, and Southampton Community Health Services Trust for the Southampton City and Eastleigh Southern Parishes locality. A joint action plan was developed for the transfer of the Totton & Waterside Community MH Service to the new health provider.

Hampshire Social Services and the Southampton and South West Hampshire Health Authority work jointly on mental health strategic planning and commissioning through a joint commissioning board set up in 1994 to take forward the Joint Mental Health Strategy.

## 3.2 The NHS Trust

During the period 1994 to 1996, the Southampton Community Health Services Trust provided general in-patient psychiatry services to the Totton area, and community mental health services. For the whole of its catchment area the Trust had 75 acute in-patient beds and 20 rehabilitation beds. These beds and the psychological therapies services were based at the Department of Psychiatry in the Royal South Hants Hospital in Southampton, approximately 7 miles from Totton. A Community Alcohol Team was established in April 1995 based at the Department of Psychiatry and a Drugs Advisory Service was based in Southampton. There was also a district Community Rehabilitation Team service.

In-patient beds were under pressure; a District Audit report in 1996 recorded a 112% occupancy rate and 48% of in-patients were formally detained under the Mental Health Act.

As noted above, following the development of their joint 5 year Mental Health Strategy in 1994, the Southampton and South West Hampshire Health Authority decided on a market testing exercise, regarding the future provision of certain components of the strategy and to decide on preferred providers. One of the key criteria was that locality mental health teams and acute in-patient services should ultimately be integrated and managed by a single provider. The decision taken by the Health Commission was that from 1 April 1997 Salisbury Health Care Trust, as the preferred provider for in-patient services for Totton and Waterside, would also provide the Locality Mental Health Team for that locality.

The General Manager for Mental Health and Learning Disability Services for Southampton Community Health Services Trust was Mr A. He was the line manager for Ms B, who was the West Locality General Manager for mental health and learning disabilities for the catchment area which included the Totton and Waterside CMHT, Ms B came into this post in April 1995. The Team Manager for the Totton & Waterside CMHT reported to her.

**Comment:**

**Several witnesses commented on the tensions between the purchasers and the Southampton Community Health Services Trust which were exacerbated by the market testing undertaken by the Health Authority and Social Services joint commissioning board and the subsequent decision to move the contract for one locality from this Trust to another. This undoubtedly had an unsettling effect on the CMHT and particularly on the NHS employees in late 1996, as the time for the change of employer on the 1 April 1997 approached.**

## 3.3 Social Services

Hampshire County Council, Social Services Department, provided social work services to the Totton and Waterside locality. The headquarters of the Social Services Department are in Winchester. Operational services are managed through local area offices.

The management of operational mental health services for Hythe/Romsey Social Services area which included Totton, in November 1996 was under the direction of the Team Manager, Ms C. She was based in the Romsey Social Services office but visited the CMHT base weekly on average, and was available by telephone for consultation. She was also responsible for managing the Romsey and District Adult and Disability Team for people with learning disability, physical disabilities and older people from 1991 until 1997. She was responsible for approved social work cover in office hours, and had delegated responsibility for the Hythe/Romsey Area Social Services mental health budget. She was the line manager to the social services staff in the Waterside and Romsey CMHT. Ms C also provided professional supervision to these staff jointly with the CMHT Team Manager. In November 1996 there were 4 social workers and 3 part-time support workers from social services working in the CMHT.

In response to the Muijen review (see 3.6 below) a protocol had been established in January 1996 for shared management arrangements between the social services team manager and the CMHT team manager who had day to day management responsibility for the team. This document sets out the agreement between Social Services and the Southampton Community Health Services Trust on the attachment of social services staff to the CMHT, and the joint and separate management responsibilities of the social services team manager and the CMHT team manager.

The Social Services Emergency Duty Service had separate line management arrangements. The Team Manager was Mr D. His line manager was the EDS Service Manager.

There were very limited social care facilities in the Totton and Waterside area: Social Services funded a local social club in Hythe (The Gatherings).

## 3.4 The Community Mental Health Team (CMHT)

The Romsey & Waterside Community Mental Health Team was established covering the Totton, Hythe and Romsey areas of South West Hampshire as a pilot project in 1989; it was the first CMHT to be set up in the Southampton Community Health Services NHS Trust catchment area. The CMHT was based at Anchor House, in Totton.

Changes to the catchment area meant that from April 1996 the CMHT covered Totton and Waterside only. In addition as a consequence of the decision by the

Southampton and South West Hampshire Health Authority to award the contract for in-patient services for this area to Salisbury Health Care Trust from 1 April 1997, it was also decided that this Trust would be the provider of the Locality Mental Health Team from that date. This decision inevitably caused uncertainty for the NHS Trust members of the CMHT whose employers and managers would be changing. We have been told that staff turnover increased in 1996 in the period leading up to the contract change.

There had been numerous changes in the CMHT Team Manager post from 1994 to 1996. An acting manager was seconded from the Department of Psychiatry to fill the vacant post in 1995. A new substantive CMHT manager was appointed in January 1996. She commenced maternity leave in August 1996. In her absence the deputy Team Manager, Mr R, took on the acting Team Manager responsibilities from August 1996. While he was on leave at the end of November 1996, a CPN in the team, Mr F, was 'acting up' as CMHT Team Manager. A clinical nurse specialist had been appointed as the deputy Team Manager in order to provide clinical supervision for the nursing staff. The CMHT Team Manager or Acting Manager provided line management for the nursing staff and day to day operational management for all staff including social services staff.

The CMHT was a joint agency and a multi-disciplinary team. The Romsey and Waterside CMHT staffing consisted of 4 CPNs, 2 OTs, 3 social workers (4 in November 1996) 1.5 Consultant Psychiatrists, and 2.5 support workers for a population of 119,000. This gives a gross staff ratio to population 1 to 9,154. The Romsey and Waterside CMHT in 1996 ranked lowest out of 12 CMHTs in Hampshire for staffing levels, according to an audit by Hampshire Social Services as part of their management response to the Muijen Report recommendations.

The CMHT experienced considerable discontinuity in the Consultant Psychiatrist complement to the Team through illness and difficulties in recruitment from 1994 onwards. Six locum Consultant Psychiatrists worked in the Team for varying periods; Dr G and Dr H provided most stability to the Team as they were locum Consultant Psychiatrists from August 1995 and April 1995 respectively and remained throughout 1996 (Dr H left on the 12th December 1996).

The CMHT had a detailed operational policy, jointly agreed between Health and Social Services. This was revised in December 1996 in the light of recommendations made by the Muijen Report (see section 3.6).

**Comment:**

**The Panel found in 1996 the CMHT was struggling with a number of demoralising and undermining factors: the events leading up to the independent review chaired by Dr Matt Muijen; the lack of continuity in CMHT Team Manager; the continuing difficulties in recruiting permanent Consultant Psychiatrists to the Team; and the low level of resourcing of the team for the demands made on it. In addition there appears to have been very few other local services for people with a mental health problem which might have augmented the service offered by the CMHT or provided an alternative service for those not eligible for the CMHT services.**

**Comment:**

**Although there was a clear operational policy in place and clear management and supervision agreements between Social Services and the Trusts, the Panel consider that the lack of continuity in the substantive CMHT Team Manager post may have undermined the effectiveness of the team, despite the best efforts of its members.**

**The lack of continuity in Consultant Psychiatrists in CMHT was regrettable. The CMHT had to cope with the loss of a long serving and highly esteemed Consultant Psychiatrist in 1996. The national difficulty in recruiting Consultant Psychiatrists was reflected locally and the team had repeatedly to develop effective working relationships with a large number of locum Psychiatrists. Fortunately Dr G and Dr H were able to provide continuity and stability to the team from 1995 onwards. Nevertheless the clinical leadership provided by Consultant Psychiatrists in a CMHT is inevitably compromised when there are frequent changes of locums.**

**The demands on the team in relation to its staffing meant that staff have described the situation to us as "fire fighting" rather than having sufficient time for fuller clinical discussions about cases.**

**Despite all this, many members of the CMHT described working relations in the team as good and considered that the team worked well together.**

### 3.5 Care Programme Approach

The CPA policy and procedures in Hampshire were initially those produced by the Wessex Regional Health Authority in collaboration with social services and all the district Health Authorities in Hampshire. Since 1993, this has been successively revised and bilateral agreements made between the relevant NHS Trust and Social Services. Between 1994 and 1996, the emphasis was on applying the CPA to in-patients, and there appears to have been only a gradual extension to all patients in the care of the specialist psychiatric services, as

required by Department of Health policy. The CPA in use by the Romsey and Waterside CMHT from 1994 - 1996 focused on particular categories of vulnerable patients rather than all the patients in their care. The CPA assessment documentation asks staff to indicate the reason for CPA: S117; in hospital 6 months or longer; vulnerable discharge; or vulnerable community.

Although the key quality standards for 1996/97 in the contract for the provision of mental health services between Southampton and South West Hampshire Health Authority and Southampton Community Health Services Trust, includes operation of the Care Programme Approach "in accordance with national requirements", the contract then goes on to state "inpatients and clients living in the community who are considered vulnerable will be assessed for a Care Programme." In fact, national requirements since 1991 had been that all patients accepted by the specialist psychiatric services should be included in the care programme approach. See Department of Health circular HC(90)23/LASSL(90)11.

So in line with the contract, though not with national requirements, the Romsey and Waterside CMHT Care Programme Approach documents in 1994-96 specifically refer to categories of vulnerable patients. However by April 1997 this had changed and the new service specification in the contract for the provision of locality based mental health services between Salisbury Health Care NHS Trust and the Health Authority and Social Services, makes it clear that the Care Programme Approach is to be applied to all patients in the care of Mental Health Services.

We noted that the Muijen Report in January 1996 (see section 3.6) included recommendations on: improved application of the CPA; to address identified problems of lack of co-ordination between services, lack of documentation to support the CPA process and inadequate written care plans.

**Comment:**

**Certainty as to when a client who is referred to a Mental Health Team becomes eligible for a CPA is particularly relevant for the care of DE and is referred to in Chapter IV.**

## 3.6 The Muijen Review

Southampton Community Health Services NHS Trust and Hampshire County Council Social Services set up an independent joint agency review into the suicide or accidental deaths of three people in June and July 1995 who had been receiving services from the Waterside and Romsey CMHT. As a result a number of recommendations were made and both the Trust and Social Services developed separate and inter agency action plans to address these recommendations.

Of the 26 key recommendations contained in the report the Panel found that 7 were common to this Inquiry. They are as follows:-

i. The joint commissioning agencies should review the current staff/population ratio of CMHT staff;

v. Engagement with services needs to be tailored to the individual client. Thus for clients who are reluctant to leave home, out patients' appointments may be ineffectual;

vii. Key workers are responsible for ensuring that proposed interventions, e.g. out patients' appointments, are organised and are for monitoring them;

xiv. Where there are a number of services or agencies involved in the care and treatment of an individual, consideration needs to be given as to which has the lead role in what circumstances;

xviii. The Care Programme Approach (CPA) and supervision register arrangements in relation to the CMHT must be reviewed;

xxiii. The clarification of responsibilities in regard to inter agency communication should be seen as priority by all relevant agencies;

xxv. Information systems need to be established to allow the discovery of existing and recent service links of people with mental health problems living in the community, while not ignoring confidentiality issues.

The other 19 recommendations had either been successfully addressed by the agencies or were not relevant to this Inquiry.

## CHAPTER IV

## THE TREATMENT AND CARE OF DE AND PE BETWEEN 1994 - 1996

### 4.1 PE - Contact with the General Medical and Psychiatric Services

PE's only contact with the specialist psychiatric services was in March 1994 when she visited her GP complaining of depressed mood. At the beginning of June she was referred to the local social services department, who in turn referred her on to the Community Mental Team at Anchor House, Totton, where she was assessed on 03 August 1994 by a Mental Health Social Worker, Ms I.

From the assessment it seems clear that PE referred to DE's own mental health problems and that DE intimidated her and physically assaulted her, causing bruising to her leg. It appears that DE was drinking excessively.

**Comment**

**The Panel noted that Ms I's assessment letter contained important information concerning DE's alleged violence towards his mother, which was apparently not available to workers in the same mental health team, who were subsequently involved with DE. If this information had been available then it is possible, although unlikely, that the outcome may have been different. The Panel recognised that while it may be customary to screen the old medical and psychiatric records of the client being referred, practice differs as to whether the records of close relatives living at the same address should also be screened. We recommend that senior management in both Health and Social Services should consider the adoption of a clearly stated joint policy.**

### 4.2 DE - Contact with General Medical and Psychiatric Services

DE had few medical or psychological problems until he was aged about ten, when he attended several appointments with a child and adolescent psychiatrist in connection with poor school attendance. These difficulties preceded the death of his father in 1989, when DE was 14 years of age. The Panel were not able to examine his medical records for the period between January 1990 and October 1994, which appear to be missing.

Between October 1994 and the end of October 1996, a period of 25 months, DE made at least 24 visits to his General Practitioner, an average of roughly once a month. Almost all of these were concerned with psychological difficulties and in particular, with depressed mood and social withdrawal.

On 4 June 1995 PE visited her General Practitioner, Dr J and expressed concern about her son's mental state. In fact one of Dr J's partners had already diagnosed depression on 14 February 1995, and at the time had prescribed an antidepressant drug which seemed to improve the situation, at least at first. As a result of PE's concern, Dr J made an appointment for him for 30 June 1995 and wrote to DE to ask him to attend. He failed to do so and Dr J sent a further letter which resulted in a long consultation on 07 July 1995. During the course of this, DE told Dr J that he feared that he might be suffering from schizophrenia, but the doctor could find no evidence of delusions or hallucinations and reassured his patient. Antidepressant tablets were continued, but by the next appointment on 19 July 1995 DE was still anxious and agitated and Dr J referred him for assessment by the Community Mental Health Team.

**Comment**

**The Panel were of the opinion that Dr J and his partners had acted appropriately and without undue delay in referring DE to the Community Mental Health Team.**

**Members of DE's family expressed the view to the Panel that in writing to DE, Dr J had compromised PE's confidentiality and that as a result DE became mistrustful and resentful of what he perceived to be his mother's interference. The Panel considered that Dr J had been faced with a straightforward choice between making contact with DE in the knowledge that he would conclude that his mother had expressed concern about him, or doing nothing at all. We considered that Dr J had made the right decision in difficult circumstances and had he chosen to do otherwise, the result would probably have been that DE would have stopped attending the surgery.**

Dr J's referral letter to the Community Mental Health Team was received on 25 July 1995 and the case was allocated to a community psychiatric nurse, Mr F. Mr F assessed DE on 02 August 1995 and recorded his impression of an "isolated, demotivated young man who seems to be becoming gradually more depressed". Mr F discussed his assessment with his colleagues at a later clinical meeting and it was suggested that DE would benefit from training in anxiety management and social skills and that he should be offered the opportunity to address issues surrounding his father's death. DE was given leaflets describing anxiety management but Mr F admits in his letter that he did not give a verbal explanation to go with the literature. He also noted that "appropriate resources are not easily available at present" for social skills training. Additionally an appointment was made for DE to see the locum Consultant Psychiatrist, Dr H, although it was not made clear why this was thought to be appropriate. Mr F wrote in these terms to Dr J on 21 August 1995.

**Comment**

**The Panel considered that there had been no undue delay in assessing DE following the receipt of the referral letter from Dr J. However, a delay of 19 days between the date of the assessment and a reply being sent to the GP does seem to be excessive and we recommend that a review of procedures in the Community Mental Health Team is carried out by managers.**

**Comment**

**The Panel considered that Mr F had carried out an adequate assessment of DE and had identified a number of problem areas. However, he did not explicitly record a care plan as required by the Care Programme Approach which had been agreed with DE. As a result of team discussion three separate interventions were recommended, namely, training in social skills, training in anxiety management and individual bereavement counselling, but no steps were taken to provide these treatments. The Panel considered this was an inadequate response, although it recognised that the appropriate resources might not have been available locally at that time. We considered that the GP would have been misled into believing these interventions were available and forthcoming.**

The Panel heard from several witnesses that the Community Mental Health Team did not consider that DE had been *accepted on to the Team's caseload*, but was rather in the process of being *assessed* to see if he should be. It was represented to us that the referral to Dr H was an element in the process of assessment, and not evidence of acceptance on to the Team's caseload. The Panel felt that, at the very least, such fine distinctions were open to varying interpretation and subsequent confusion.

**We recommend that the operation by the CMHT of the Care Programme Approach be reviewed and explicit guidance given as to when a client is accepted for the purposes of CPA during the process of referral, assessment and management by the CMHT.**

**Comment**

**The Panel considered that there was a lack of clarity in the operational policy of the Community Mental Health Team at the time as to when a referred client became eligible for the Care Programme Approach. The relevant Department of Health circular indicates that CPA should be applied to all clients accepted by the Specialist Mental Health Services.**

In parallel with his involvement with the Community Mental Health Team, DE continued to attend the Testvale Surgery at roughly monthly intervals throughout the rest of 1995 and until the end of November 1996.

**Comment**

**We considered that DE's general practitioners provided good continuity of care.**

DE did not attend his appointment with Dr H and the locum Consultant notified the GP and the CMHT of this fact in writing. No further action was taken to complete DE's assessment

**Comment**

**We heard from Dr H that in 1995 his out-patient clinic had a long backlog of assessments which had not been carried out because of inadequate consultant staffing and that this was one of the factors which caused him to leave Southampton soon after. He told us that the only way he could cope with the pressure of referrals to out-patients was to offer only one appointment to new patients, and if this was missed, the patient would have to be referred again and go to the bottom of the waiting list. We consider this undesirable and we recommend that the Health Authority, together with the Trusts review the level of medical staffing in psychiatry.**

**Comment**

**We did not consider that the CMHT had done enough to complete DE's assessment following the failed out-patient appointment and we recommend that managers review procedures to correct this.**

The final sequence of events leading to the death of PE began at about 6am on Wednesday 27th November, 1996 when she requested a visit from the GP on duty, Dr K. His notes record that DE was "acting strangely - unable to say what. He says he needs to get his head sorted out - needs a few years. Feels out of control - ? passivity feeling. No hallucinations. No delusions - but seems possibly psychotic. Declines any further consultation. Discussed with mother. Agreed I should arrange Community Psychiatric Nurse to visit today".

Dr K told the panel that he did not consider the situation so urgent that he might have called the duty psychiatric team there and then, but he definitely wished him to be visited later on the same day and recorded this plan in the patient's notes. He also told us that he did not feel that a visit from the locum Consultant Psychiatrist, Dr G was required in the first instance, but that if, after visiting DE, the CPN thought it advisable, Dr G's assessment might be the next stage.

Dr K told us he telephoned the Community Mental Health Team later that morning, although the precise time is not recorded, and discussed the case with the CPN on duty, Mrs L. In his evidence to the Panel he stated that he asked for

a visit to be made on the same day. However, Mrs L says in her testimony "Dr K did not indicate in any way that it was urgent or that he wanted it done that day".

**Comment**

**The panel were unable to reconcile the evidence of Dr K with that of Mrs L and concluded there had been a misunderstanding. Dr K had told PE that a visit would be arranged for the same day and the fact that it did not happen must have caused her considerable anxiety. We concluded that the confusion might have been avoided if the CMHT referral procedure and documentation had required the clear and explicit recording of the degree of urgency of response agreed by both the referrer and the duty officer. We found that the Notification Form then in use was badly designed for this purpose and had not been fully completed by Mrs L. We recommend that management review the procedure and recording of referrals to the CMHT to ensure that there can be no doubt as to the degree of urgency of response required from the team and that this is explicitly agreed with the referrer.**

Mrs L gave evidence that she discussed the referral with CPN Mr F who was acting up as CMHT Manager in the absence of Mr R. She considered the referral to be too urgent to await routine referral for allocation for assessment. She was aware that Mr F had assessed DE in August 1995 and because of this thought that it was likely that he would carry out the new assessment requested by Dr K. She testified that Mr F agreed to take action on the referral, saying "I will see to it, I will deal with it." She believed him to indicate that he would visit DE personally or ask someone else to do it. In the event no visit took place that day.

**Comment**

**There was no system in place to check that action had been taken in dealing with non routine referrals which could not wait for the next allocation meeting. This led to an undesirable delay in DE's assessment by the specialist mental health services. We recommend that all referrals received by the team are reviewed each day by the Team Manager to ensure that non-routine referrals are dealt with appropriately.**

PE again had to call out the duty doctor at a quarter-past midnight the next morning, Thursday 28th November, 1996 when DE had locked himself in his room and had threatened to take an overdose of antidepressants. The GP on duty was Dr J who told us he had not been aware of his colleague's visit less than twenty-four hours before, but that PE informed him about it and that she had been expecting a visit from the CMHT which had not materialised. Dr J was able to interview DE and did not think that he was immediately likely to harm himself,

still less anyone else, but that he was sufficiently disturbed to need assessment in hospital. However, DE would not agree to go into hospital and Dr J decided to make a recommendation for compulsory admission under section 2 of the Mental Health Act. He discussed this with PE and her daughter, KE, who was also present, and he told us that they were content for DE to remain at home until later that day when an assessment by a Consultant and an Approved Social Worker could be arranged.

**Comment:**

**We found that Dr J had assessed the situation correctly and had come to a sensible plan of action. He did consider calling out the Duty Consultant and ASW straight away, but after discussion with the family decided not to. We considered that this was a reasonable decision in the circumstances as DE was no longer saying that he wanted to harm himself, and PE did not express any fear for her safety.**

Later that morning, Dr J telephoned the locum Consultant Psychiatrist, Dr G at the Royal South Hants Hospital and discussed the case with him. Dr G had an out-patient clinic in the morning but was free after 3pm and he arranged to visit after that with Ms M, the ASW.

During the MHA assessment DE was at first unwilling to talk to Dr G and Ms M and he left the room but came back some moments later and they were able to talk for about an hour. DE was tense at first but became more co-operative later and seemed to welcome the opportunity to ventilate his feelings about his father's death. Dr G told us he suspected DE was suffering from a psychotic illness, perhaps schizophrenia, but he could not elicit any obvious signs or symptoms. He denied experiencing hallucinations or interference with his thoughts and did not express any delusional beliefs. Nevertheless he seemed guarded and suspicious although not threatening or intimidating. Once again he vigorously refused the offer of admission to hospital but agreed to take some medication. Both Dr G and Ms M stated that they had consulted PE in private and she made no mention of violence or threats directed towards her. They concluded that it would not be necessary to admit DE under the Mental Health Act, at least not that day. A care plan was agreed with the following elements: Dr G would telephone Dr J's surgery for a prescription which PE would pick up later that evening; DE would visit Ms M at Anchor House the following Monday, the 2nd of December 1996 for a further assessment. We were told that PE and DE were in agreement with this plan.

**Comment:**

**We considered that the joint assessment of the Psychiatrist and the ASW had been properly conducted and thorough and that PE had been given an opportunity to voice her concerns in private and outside DE's hearing. We could readily understand that she might have been unable to bring herself to disclose her anxiety about his behaviour through motives of loyalty to DE or perhaps even fear of further violence. The decision not to admit him under the Mental Health Act seemed to us to have been a reasonable one at the time, given the uncertainty as to the content of mental state, diagnosis, the role of alcohol and drugs and the apparent absence of risk of violence or self harm. DE has told us that he now feels that he should have been detained and that the professionals should have been able to see through his denial of symptoms, but we felt that all reasonable care had been taken to gain his confidence and that it would not have been possible to persuade him to reveal his delusional thoughts. DE also told us that at the time he believed that his thoughts were being broadcast and so capable of being read by all those around him and their questions were superfluous. From the evidence available to the professionals involved in the assessment we conclude that the statutory requirements for compulsory admission to Hospital under the Mental Health Act were not satisfied at that time, ie. that his mental disorder was not of a nature or degree which warranted his detention in a hospital for assessment for at least a limited period.**

At 4pm the next day, Friday 29th November, 1996, PE telephoned the CMHT at Anchor House and spoke to the duty officer, who was a social worker, Ms N. PE was crying and upset. She purported to want to inform Dr G that DE was unlikely to attend his appointment with Ms M, ASW, on Monday the 2nd December 1996. It was not clear how to contact him at the Department of Psychiatry because the secretaries in the department finished work at 4pm on a Friday. There was no clear way in which the CMHT staff or public could contact the duty Psychiatrist after that time.

PE told Ms N that DE had kicked her on the leg and smashed some framed photographs of her late husband that morning. She was clearly concerned about him and she did not think he would attend his appointment with Ms M on the following Monday. Ms N asked PE to hang on and went to discuss the case with a colleague, Mr P who was the duty ASW that day.

**Comment:**

**The Panel recommends there should be a reliable means of contacting the duty Psychiatrist during the whole of their period of duty and this should be disseminated to all relevant parts of the service.**

According to Ms N's evidence, she was aware of the case as she had had a brief discussion the day before with Ms M, and it seemed clear to her that the care plan was breaking down. As Ms M was on leave that Friday, she felt that it was important that the duty ASW should be informed in case a further Mental Health Act assessment was necessary. Mr P advised her to give PE the telephone number of the Emergency Duty Service, the out-of-hours team that was shortly to take over social services emergency duties for the weekend.

In his evidence Mr P emphasised that he did not consider that PE was requesting a further assessment from an ASW, but rather asking for the information that DE was not going to attend on Monday to be passed on to Dr G and Ms M. Despite the obviously distressed state of PE, Mr P did not consider that any immediate response was required other than to inform the night-duty team that they might receive further enquiries from PE.

**Comment:**

**We were told that the operational policies of the CMHT and EDS are that any ASW assessment originating in normal working hours, that is before 5pm from Monday to Thursday and before 4.30pm on Fridays should be undertaken by the duty ASW in the Community Mental Health Team. After these times, the ASW from EDS takes over. The call from PE was at 4pm on a Friday and therefore the responsibility of the CMHT. The Panel consider that Mr P should have given much greater weight to the fact that PE was in a distressed condition, that this was the third time in three days she had asked for help with DE and that, for the first time in recent months she had revealed that DE had acted violently towards her. This should have alerted him to the desirability of a further assessment.**

By the time Ms N returned to the phone, PE had rung off, so she returned the call and gave her the number of EDS. By this time PE seemed calmer. Ms N attempted unsuccessfully to telephone the EDS to put them on notice of a possible contact over the weekend. Ms N then sent an E Mail with this information. Acting on her own initiative Ms N then telephoned Dr J to inform him of the situation. His reaction was that the situation must have deteriorated and that a further assessment should take place without delay. By this time it was after 4.30pm. Ms N completed the E-mail to EDS now requesting an

assessment by an ASW. She also telephoned them and left a message on their answer-phone because their lines were engaged.

**Comment:**

**The protocol for requests for assessment to EDS requires that it be made from manager to manager. The Social Services Manager Ms C was based at the Romsey office. She was not contacted about this referral before 4.30pm and would not have been available after 4.30pm. Mr F who was acting up as CMHT Manager was aware of the situation, but did not give advice on a course of action to either Ms N or Mr P. Mr F did not have the authority to decide whether an MHA assessment should have been carried out by the ASW. We consider that a member of Social Services complement to the team should have the responsibility to decide when a MHA assessment should take place should the duty ASW be in doubt. We recommend that this be implemented.**

At the time the recording was left on the answer-phone, all three EDS workers were busy with other calls and it was not until 5.45pm that the ASW, Ms Q telephoned PE to make the arrangements. PE seemed reasonably calm and confirmed the events of earlier that day. She stated that she did not think that DE could be left at home until Monday and that she wanted something to be done immediately. DE then came on the phone and asked who it was. Ms Q explained and he told her that his mother was "winding him up and setting people on to him". Ms Q asked him if he would consider coming into hospital and he immediately became angry and abusive and then slammed down the phone.

Next Ms Q telephoned the GP's surgery and the Royal South Hants Hospital for the duty consultant psychiatrist and left messages for both. She also started to make arrangements for her own back-up and then telephoned PE again at 6.10pm. DE answered and refused to let her speak to his mother, saying they were in the middle of an argument. However Ms Q could hear nothing in the background and was suspicious. At 6.15pm she rang the police and asked them to attend immediately. At 6.45pm she was told that PE's body had been found at the house.

**Comment:**

**Despite the fact that the correct protocol had not been followed and that the assessment should have been the responsibility of the CMHT ASW, the EDS response was prompt and helpful, but still came too late. Given the length of time normally taken to assemble the personnel, documentation and information necessary for a Mental Health Act assessment it is unlikely**

**that an assessment could have been carried out which would have saved PE's life.**

## CHAPTER V

## RISK ASSESSMENT

Risk assessment is included in the training for an approved social worker. The ASWs who were involved in the care and treatment of DE were both relatively recently qualified and in the view of the Panel fully aware of the need to assess risk. Dr G who was involved in the Mental Health Act assessment with Ms M we accepted as being a very experienced Consultant Psychiatrist with a clear understanding of the need for risk assessment. Mrs L as the CPN who accepted the telephone referral on behalf of the CMHT from Dr K informed the Panel that she did not receive any risk assessment training during her short term contract with the CMHT but at her own personal expense had undergone training in that area.

It is a truism that risk assessment is only as good as the information on which it is based. Unfortunately the professionals involved in assessing any risk of harm by DE, either to himself or to others, had only limited information because his mother had not disclosed to Health or Social Services staff that in the weeks leading up to the Mental Health Act assessment DE had once come into her bedroom in the middle of the night and tried to strangle her, bruising her neck. She had told a friend but even with encouragement did not approach professionals. It was reported to us by several witnesses that DE was verbally abusive and threatening to his mother and that she felt intimidated by him: she however did not disclose this to her GP or to Dr G or Ms M during the Mental Health Act assessment.

DE had only disclosed his delusions to a friend a few days before his mother's death. None of the professionals involved in his care were aware of his abnormal beliefs.

Dr G and Ms M considered the atmosphere in the household and the relationship between DE and PE did not indicate that her personal safety was at risk, although neither made specific enquiry. The focus of the assessment had been on DE's risk of self-harm as reported by the GP rather than the risk to others.

**Comment:**

**The panel was satisfied that those involved in the need to assess the level of risk were sufficiently qualified to do so at that time although there was no evidence of either joint guidance or joint training on the assessment and management of risk. We recommend that detailed joint guidance on the assessment and management of risk is developed for the community mental health team and that a joint programme of training be instituted. From the evidence available to the professionals involved in the assessment we conclude that the statutory requirements for compulsory admission to Hospital under the Mental Health Act were not satisfied.**

## CHAPTER VI

## CONCLUSIONS AND RECOMMENDATIONS

## CONCLUSIONS

The Panel examined all the circumstances surrounding the treatment and care of DE by Mental Health Services and Social Services from 1994 until the death of his mother in November 1996.

We found that during that time he had been in regular contact with the GP service and had limited contact with the CMHT. We found that the treatment, care and supervision by the GPs was entirely suitable

However, during the same period the CMHT had been struggling with a number of demoralising and undermining factors: a high turnover of staff, no permanent Consultant Psychiatrist and lack of continuity in the substantive team manager post, and inadequate level of staffing. All of these the Panel felt would have undermined the effectiveness of the CMHT although members of staff described the working relations as good.

The Panel found that management practices of the Southampton Community Health Services Trust need to be improved to ensure that clients who are reluctant to attend out patient appointments do not fall through the net. As a result of DE's failure to attend an out patients' appointment with Dr H he was lost to the system because there was no CPA or follow up system in place.

There was no Care Programme Approach formulated for DE because he was not accepted by the team. The Panel felt that following DE's meeting with Mr F, CPN, an adequate assessment had been carried out but this was not recorded in a care plan agreed with DE and subsequent recommendation by the team of three separate interventions failed to materialise due to lack of resources locally. Consequently there was no delivery of care, acceptance by DE nor monitoring at that time.

In the three days leading up to PE's death an appropriate care plan had been formulated when Dr G and Ms M visited DE on the 28th November 1996 but tragically PE was killed before it could be implemented.

The Panel considered whether or not PE's needs as a carer were adequately taken into account. This was certainly considered by Dr G and Ms M at the time of the MHA assessment. From the information provided to them by both PE and DE we feel that her needs were adequately taken into consideration. However, we were not satisfied that

when she telephoned the CMHT on the afternoon of the 29th November 1996 sufficient weight was given to her request by the duty ASW. By contrast when Dr J was informed of her call at 4.35pm he immediately requested a MHA assessment.

The Panel noted that the ASWs involved Ms M and Mr P, had not long qualified. As a result they would have received fairly recent training in risk assessment. Dr G is a long standing and experienced Consultant Psychiatrist. Mrs L advised the Panel that she had not received any risk assessment training whilst in post although she personally had undergone training in that area. We found therefore that at that particular stage the staff involved with DE's care had sufficient awareness of risk assessment, although there was no detailed risk guidance or training for the team as a whole.

The collaboration and communication between the agencies i.e. Southampton Community Health Services Trust, Hampshire Social Services and the GP was good. Of concern to the Panel was the lack of clarification of responsibility for decision making within the Team, and lack of active management overview of referral processes, assessment and interventions with regard to clients referred to the CMHT.

It is unfortunate that PE did not communicate her entirely valid fears for her own safety to her GPs or the Community Mental Health Team in the three day period immediately leading up to her death. Her GP had contacted DE when she expressed concerns for his welfare. However, the extent of the threats, intimidation and violence to which she had been subjected were not communicated in full to the Community Mental Health Team and other professionals and this clearly affected the level of support offered to her. The Panel felt that when she telephoned on the 29th November 1996 in a distressed state the telephone call was not dealt with with all due care and consideration. The significance of the timing of the telephone call at 4pm on a Friday afternoon cannot be ignored and the adequacy of the support given to PE at that time by the Community Mental Health Team must be questioned.

It is unlikely that her life would have been saved if a different response had been given at that time.

The Panel noted that many of the Muijen review recommendations have been addressed. There were however still 7 recommendations which needed to be reviewed and practices improved.

## RECOMMENDATIONS:

***We recommend:-***

1. ***That senior management in both Health and Social Services should consider the adoption of a clearly stated joint policy concerning the screening of previous medical and psychiatric records of the client being referred and the records of close relatives living at the same address.***

2. ***That managers review follow up procedures for clients who fail to attend out patient appointments.***

3. ***That the operation by the CMHT of the Care Programme Approach be reviewed and explicit guidance given as to when a client is accepted for the purposes of CPA during the process of referral, assessment and management by the CMHT.***

4. ***That the Health Authority, together with the Trusts, review the level of medical staffing in psychiatry.***

5. ***That a review of procedures in the Community Mental Health Team is carried out by managers to ensure there is no excessive delay in notifying the client's GP of the outcome of any assessment by the Mental Health Team.***

6. ***That management review the procedure and recording of referrals to the CMHT to ensure that there can be no doubt as to the degree of urgency of response required from the team and that this is explicitly agreed with the referrer.***

7. ***That all referrals received by the CMHT are reviewed each day by the Team manager to ensure that non-routine referrals are dealt with appropriately.***

8. ***That there should be a reliable means of contacting the Duty Psychiatrist during the whole of their period of duty and this should be disseminated to all relevant parts of the service.***

9. ***That a member of the Social Services complement to the CMHT should have the responsibility to decide when a MHA assessment should take place, should the duty ASW be in doubt.***

10. *That team management arrangements within the joint agency CMHTs are reviewed.*

11. *That detailed joint guidance on the assessment and management of risk is developed for the CMHT together with the institution of a joint programme of training.*

12. *That recommendations in the Matt Muijen report points 5 I, V, VII, XIV, XVIII, XXIII and XXV be further considered by both agencies.*

## Bibliography


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| 1994 April | Southampton Community Health Services NHS Trust<br>Draft guidelines for reporting serious untoward incidents |
| 1994 June | Southampton and South West Hampshire Health Commission and Hampshire County Council, Social Services Department<br>Joint Purchasing Strategy for people with mental health problems |
| 1994 | Department of Health NHS Executive HSG(94)27<br>Guidance on the discharge of mentally disordered people and their continuing care in the community |
| 1994-1998 | Hampshire County Council, Social Services<br>Mental Health Training courses |
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| 1995/96 | Southampton and SW Hampshire Health Authority.<br>Annual Report 1995/6 |
| 1996 Jan | District Audit. Audit Mental Health Audit 1994/5 Southampton & SW Hampshire Health Authority |
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|---|---|
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| 1996 | Southampton and South West Hampshire Health Authority<br>Contract for Provision of Mental Health Services 1996/97 with Southampton Health Services Trust |
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| 1996 | Southampton and SW Hampshire Health Authority<br>Annual report of the Director of Public Health |
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| 1997 March | Salisbury Health Care Trust: draft operational policy for Locality Mental Health Team, Totton |
| 1997 July | Hampshire County Council Adults Services Sub Committee |

| | |
|---|---|
| | Update on the Management Response to the Joint Agency Review into the circumstances surrounding the deaths of GC, PJ & TA |
| 1997 Sept | Southampton & SW Hampshire Health Authority<br>Implementation Progress Report on Joint Commissioning Strategy for People with Mental Health Problems |
| 1997 Sept | Southampton Community Health Services NHS Trust<br>Suicide Data 1988 to 1997 |
| 1997 Oct | Southampton and South West Hampshire Health Authority<br>Autumn Review of Mental Health Services - draft summary report and briefing paper |
| 1997 Oct | Summary of the report of the Inquiry into the treatment and care of Ms B |
| 1997 Dec | Inquiry into the treatment and care of Damien Witt. |
| 1997 Dec | Southampton Community Health Services NHS Trust<br>Report from the Mental Health Act Panel |
| 1997/8 | Hampshire CMHT staffing levels |

## GLOSSARY

| | |
|---|---|
| ASW | Approved Social Worker |
| CMHT | Community Mental Health Team |
| CPA | Care Programme Approach |
| EDS | Emergency Duty Service |
| MHA | Mental Health Act |
| NHS | National Health Service |
| LMHT | Locality Mental Health Team |
| CPN | Community Psychiatric Nurse |

## APPENDICES

1. Terms of Reference for Inquiry
2. Procedure adopted by Inquiry
3. Map of the Health Authority localities
4. Recommendations of an independent review chaired by Dr Matt Muijen, MSC,MD,Phd, MRCPsych
5. Resources
6. Hampshire Social Services Structure November 1996
7. People involved in the Inquiry

**APPENDIX 1**

## SOUTHAMPTON AND SOUTH WEST HAMPSHIRE HEALTH AUTHORITY & HAMPSHIRE COUNTY COUNCIL

### Terms of Reference for Inquiry

1. To examine all circumstances surrounding the treatment and care of DE by the Mental Health Services and Social Services, from 1994 until the death of Mrs E. In particular:

   - the suitability of his treatment, care and supervision in respect of:
     - his assessed health and social care needs
     - the assessed risk of potential harm to himself or others
     - any previous psychiatric history, including drug and alcohol misuse;

   - the extent to which DE's care met statutory obligations; relevant guidance from the Department of Health (including the Care Programme Approach HC(90)23/LASSL(90)11), the Mental Health Act Code of Practice and local operational policies;

   - the extent to which his care was:
     - effectively delivered
     - accepted by DE
     - monitored;

   - to assess whether Mrs E's needs as a carer were adequately taken into account.

2. To consider the adequacy of the risk assessment training of all staff involved in DE's care.

3. To examine the adequacy of the collaboration and communication between the agencies (Southampton Community Health Services Trust, Hampshire Social Services and DE's General Practitioners), involved in the care of DE, or in the provision of services to him.

4. To consider the adequacy of the support given to Mrs E by the Community Mental Health Team and other professionals.

5. To prepare a report and make recommendations to Southampton and South West Hampshire Health Authority and Hampshire County Council.

**APPENDIX 2**

## PROCEDURE ADOPTED BY INQUIRY

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

   (a) of the terms of reference and the procedure adopted by the Inquiry;
   (b) of the areas and matters to be covered with them;
   (c) requesting them to provide written statements to form the basis of their evidence to the Inquiry;
   (d) that when they give oral evidence they may raise any matter they wish which they feel might be relevant to the Inquiry;
   (e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness;
   (f) that it is the witness who will be asked questions and who will be expected to answer;
   (g) that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact will be asked to affirm that their evidence is true.

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

4. Written representations may be invited from professional bodies and other interested parties regarding best practice for persons in similar circumstances to this case and as to any recommendations they may have for the future.

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

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

7. All sittings of the Inquiry will be held in private.

8. The Draft report will be made available to the Health Authority and Hampshire Social Services for any comments as to points of fact.

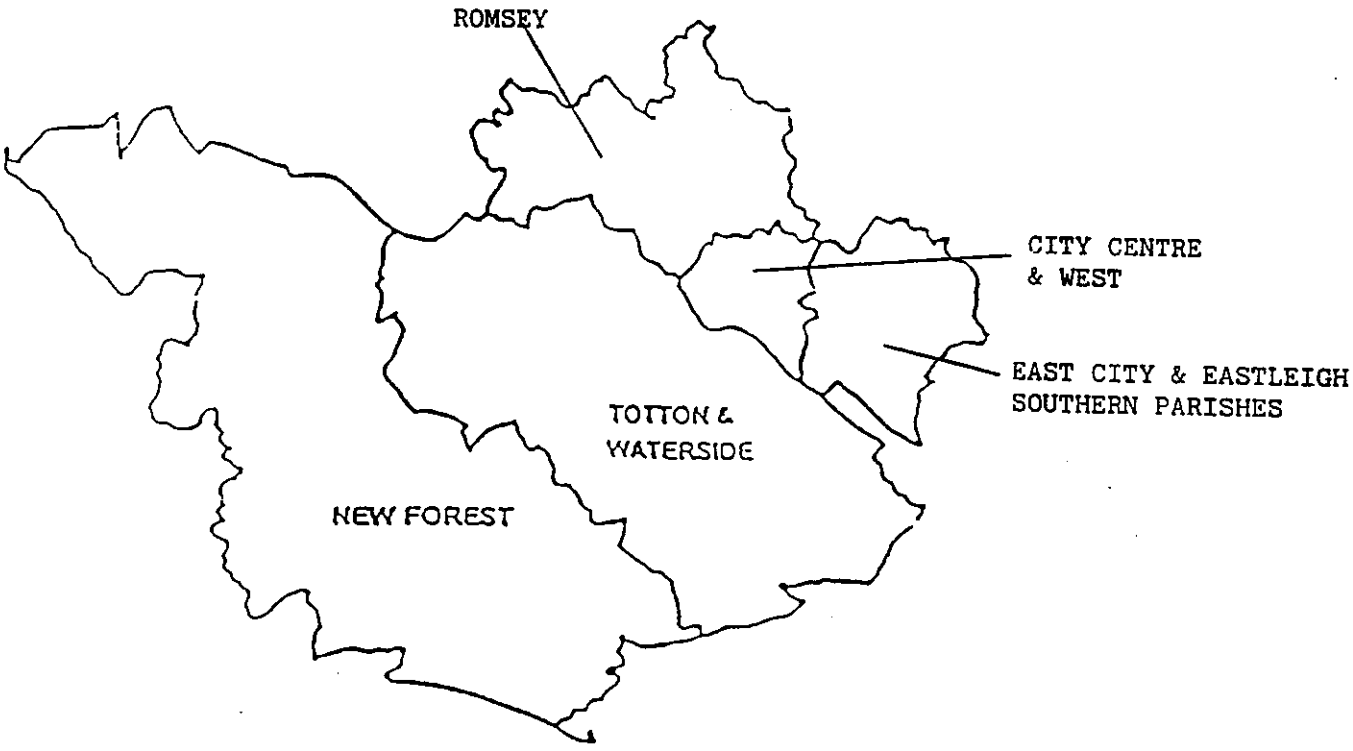
9. The findings of the Inquiry and any recommendations will be made public.

10. The evidence which is submitted to the inquiry either orally or in writing will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final Report.

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

APPENDIX 3

# MENTAL HEALTH LOCALITIES



**APPENDIX 4**

## SUMMARY OF KEY RECOMMENDATIONS: (MUIJEN REPORT 1996)

(i) The joint commissioning agencies should review the current staff/population ratio of CMHT staff.

(ii) Personality disorder in its own right should not be used as a criterion for acceptance or rejection from the team's services, but other indicators of severity and disability associated with mental health problems should be applied, including psychiatric history.

(iii) In allocating cases the team manager must have regard both to the complexity of the case and to the experience and skill of the worker.

(iv) Services need to recognise that patients may find multiple points of access confusing.

(v) Engagement with services needs to be tailored to the individual client. Thus for clients who are reluctant to leave home, out-patients' appointment may be ineffectual.

(vi) If closure of a case occurs, this must be handled with sensitivity and with due regard by the agency responsible to the possible outcome of such an action on the person.

(vii) Keyworkers are responsible for ensuring that proposed interventions, eg out-patient appointments, are organised and for monitoring them.

(viii) Consideration should be given to adequate staff protection and support when dealing with certain clients. The particular history of the client and experience/characteristics of professional personnel should always be taken into account.

(ix) Keyworkers must personally undertake an assessment and maintain appropriate direct contact with allocated clients.

(x) The care plan must specify who has medical responsibility. Where the GP has the responsibility he/she must be involved in all significant decisions affecting medical care. In such cases the opinion of the consultant psychiatrist can only be advisory.

(xi) GP participation in care planning should be sought wherever possible.

(xii) The prescribing practices of GPs for depression should be the subject of clinical audit leading to the establishments of protocols.

(xiii) The role of primary care prescribing in the treatment of complex mental health cases needs to be reviewed jointly between primary care and the specialist services.

(xiv) Where there are a number of services or agencies involved in the care and treatment of an individual, consideration needs to be given as to which has the lead role in what circumstances.

(xv) Where there are specialist social workers in the CMHT, all social services interventions for potential CMHT clients should be via that team rather than via the Social Services Area Centre.

(xvi) Where non-specialist (ie non mental health) agencies are the only link with a client, they should have agreed criteria with specialist agencies for referral and re-referral.

(xvii) Non mental health agencies should never be left without some degree of specialist backup, co-ordinated by a joint working plan, unless it is agreed as unnecessary.

(xviii) The Care Programme Approach (CPA) and supervision register arrangements in relation to the CMHT must be reviewed.

(xix) All information essential to effective care planning should be exchanged between the in-patient and community services in a timely fashion. This should be the subject of rigorous joint monitoring and audit by health and social services.

(xx) Where parallel processes occur (eg hospital and CMHT reviews) agencies need to inform each other prior to reviews taking place.

(xxi) The CMHT must be involved in, and agree to, the discharge planning.

(xxii) The police are asked to review their procedures for notifying the specialist agencies in the case of any concerns they may have about individual clients.

(xxiii) The clarification of responsibilities in regard to inter-agency communication should be seen as a priority by all relevant agencies.

(xxiv) Local managers must review mechanisms for resolving interagency policy disputes.

(xxv) Information systems need to be established to allow the discovery of existing and recent service links of people with mental health problems living in the community, while not ignoring confidentiality issues.

(xxvi) While health and social services have to play their part as the joint agencies responsible for care in the community, they can only operate in partnership with other agencies and those living in the community.

**APPENDIX 5**

## RESOURCES

The following sets out the resources available;

*Social Services*: In 1996/97 total expenditure on adult mental health for the population of 81,000 in the Totton and Waterside catchment area was £295k (net) for expenditure on social work staffing, residential care, day services, home support. The gross spend on mental health by Hampshire Social Service was 4.25% in 1997/98, increased from 3.11% in 1994. The range of spend by SSDs nationally on mental health is between 3% and 7%.

*Health Authority*: over 14% of the budget was spent on mental health (compared to 13-13.5% national average).

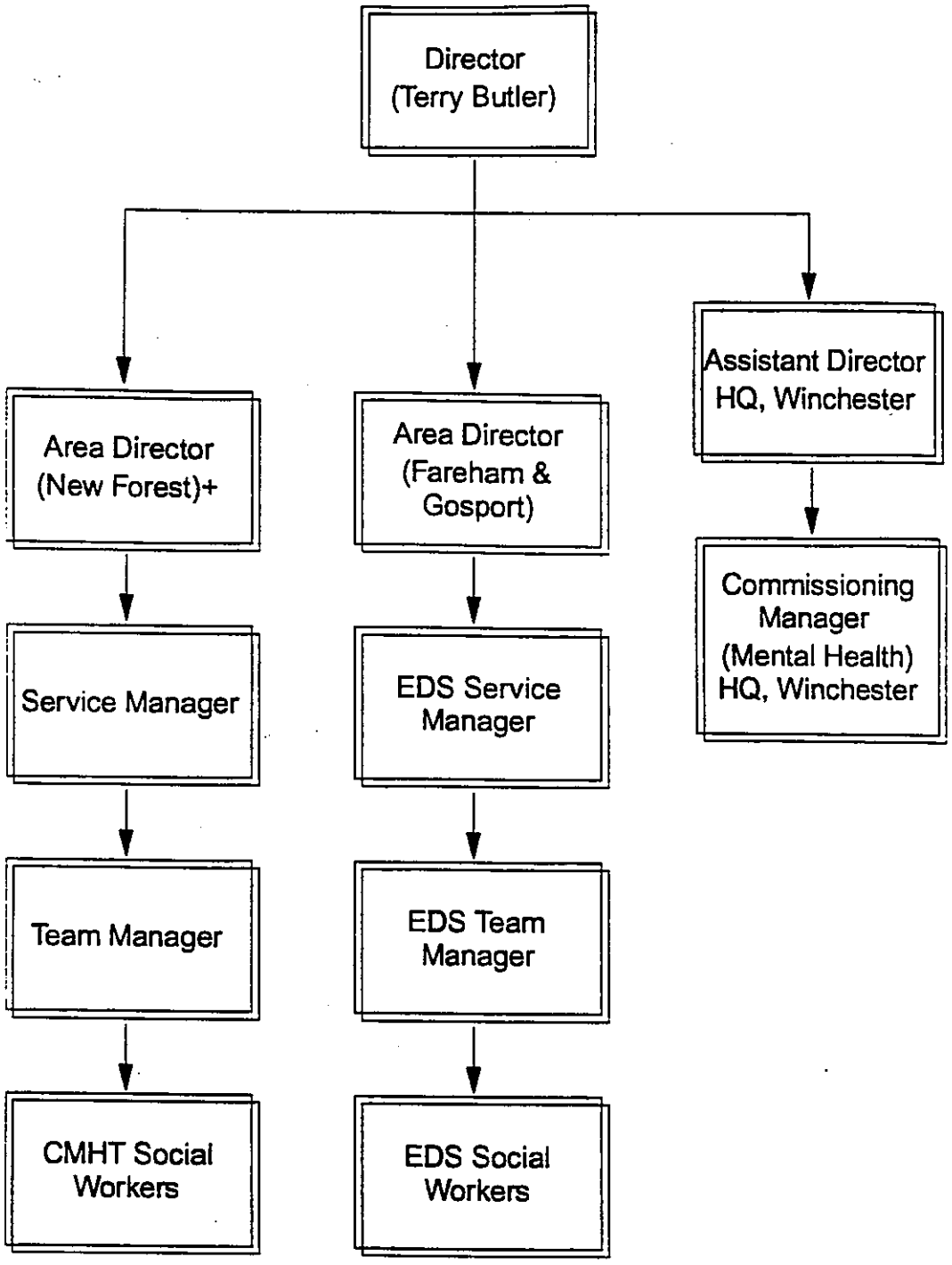
*EDS*: 50% of time is spend on ASW assessments; there has been a significant rise in the number of ASW assessments in Hampshire over recent years (in line with national trends) EDS had 11-15 ASWs to cover a population of 1.6m.

*ASWs*: The then Principal Adviser for Mental Health Services Hampshire Social Services (Andrew Newland) view was the authority was under resourced in ASWs and mental health specialist social workers; there were problems in recruitment of staff.

*Totton and Waterside CMHT*: this had the lowest staffing levels of all the CMHTs in existence in Hampshire in 1994-96. We note that for 1997/98 the position has improved with increased funding and this CMHT now ranks as second out of 11 CMHTs in Hampshire, having a staff complement of 5 CPNs, 2 OTs, 4 SWs, 1.2 consultants, 2 support workers and 3.9 psychology staff. This is a gross staff ration of 1:4475 population over a total population of 81,000.

This is markedly different from the gross staffing ratio of 1:9514 in the Romsey and Waterside CMHT in 1996.

## Relevant Part of Hampshire Social Services Structure Chart in November 1996




+ NB By this time the Hythe and Romsey Social Services Area Centre had been re-organised (as from August 1996) into a New Forest Area co-terminous with the New Forest District Council area (i.e. the west of the New Forest together with the area covered by Totton, Hythe and Waterside), and an Eastleigh and Romsey Area (taking in the part covered by Romsey).

**APPENDIX 7**

## PEOPLE INVOLVED IN THE INQUIRY

### PE (deceased) was the mother of Mr D Eske

### WITNESSES REFERRED TO IN THE TEXT

| Initials used in the text | | |
|---|---|---|
| Mr | A | General Manager, Mental Health & Learning Disabilities Service |
| Ms | B | West Locality General Manager for Mental Health & Learning Disabilities Service |
| Ms | C | Social Services Department Team Manager |
| Mr | D | Duty Manager, Emergency Duty Service |
| D | E | Son of PE |
| K | E | Daughter of PE |
| Mr | F | Community Psychiatric Nurse |
| Dr | G | Locum Consultant Psychiatrist |
| Dr | H | Locum Consultant Psychiatrist |
| Ms | I | Specialist Mental Health Social Worker |
| Dr | J | GP |
| Dr | K | GP |
| Mrs | L | Community Psychiatric Nurse |
| Ms | M | Approved Social Worker |
| Ms | N | Mental Health Social Worker |
| Mr | P | Approved Social Worker |
| Ms | Q | Social Worker for the Emergency Duty Service |
| Mr | R | Senior Community Psychiatric Nurse |

### OTHER WITNESSES

- Brother of PE
- Principal Adviser Mental Health, Hampshire Social Services
- Consultant Forensic Psychiatrist/Responsible Medical Officer to DE
- Sister of PE
- Neighbour and friend of PE
- Brother-in-law of PE
- Consultant in Public Health Medicine
- Friend/Partner of PE
- Sister-in-law of PE
- Partner of KE

In the view of Southampton and South West Hampshire Health Authority and Hampshire County Council Social Services none of the individuals involved in the care and treatment of DE or his family were found by the Inquiry to have acted improperly. The shortcomings which were identified relate to failures or lack of clarity of operational policy and procedures. Therefore, it would be inappropriate to include the names of staff in the published document.