Report of the Inquiry

into the circumstances leading to the death of

Jonathan Newby

(a volunteer worker)

on 9th October 1993

in Oxford

July 1995

Report of the Inquiry

into the circumstances leading to the death of

Jonathan Newby

(a volunteer worker)

on 9th October 1993

in Oxford

Committee Members:
Nicola Davies QC (Chairman)
Richard Lingham
Clifford Prior
Professor Andrew Sims

July 1995

Contents

Introduction

On 9 October 1993 Jonathan Newby, a twenty-two year old graduate, working as a volunteer for the Oxford Cyrenians at Jacqui Porter House in Rectory Road, Oxford, was stabbed in the heart by John Rous, a resident in the house. Jonathan Newby died as a result of this injury.

John Rous suffers from a severe and enduring mental illness, schizophrenia. He has a concomitant severe disorder of personality. On 17 June 1994 at Oxford Crown Court he pleaded guilty to the manslaughter of Jonathan Newby. John Rous was ordered to be detained at Her Majesty's Pleasure, a hospital order together with a restriction order with no time limits was made. John Rous is now detained at Broadmoor Hospital.

In May 1994 the National Health Service Executive issued a circular: *"Guidance on the discharge of mentally disordered people and their continuing care in the community (HSG(94)27)."* Paragraph 35 of the Guidance stipulated that: *"In cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".*

At the time of Jonathan Newby's death, the mental health services in Oxfordshire were managed by the Oxfordshire Health Authority. The NHS Executive required the Oxfordshire Health Authority to set up and fund an independent inquiry into the circumstances leading to the death of Jonathan Newby, working in close liaison with Oxfordshire Social Services Department and the Oxfordshire Mental Healthcare NHS Trust (which had come into being on 1 April 1994). The Terms of Reference were drawn up by the Health Authority in liaison with the NHS Executive, they are set out in Appendix 1.

I was invited to become Chairman of the Committee of Inquiry in July 1994. My fellow members of the Committee were appointed by late September.

Preparation

The first task, having sought the consent of John Rous via his solicitors to the use of his medical and other records, was to obtain documentary evidence from a large number of organisations. John Rous had been in the care of practically every statutory and voluntary organisation in Oxfordshire and elsewhere. The Health Authority wrote an initial letter to all these organisations in August, and from September onwards shoals of documents began to arrive, to be catalogued, paginated, summarised and sent to each Committee member.

Public or Private Hearing

The Committee met for the first time on 11 November 1994. The most important issue to be resolved was the nature of the hearing, public or private. As Leading and Junior Counsel I have appeared in a number of inquiries, public and private; I am firmly of the view that no one rule can be made as to whether any inquiry should be in private or in public. I was conscious of the fact that the Committee would be inquiring into a death and into the care of a person who is mentally ill. For many witnesses questions would be asked upon matters which were delicate, difficult and which could be distressing to recall. Our primary task was to ascertain the facts. I believed that the additional pressure which can be created by the presence of press and public would assist no one in the giving of evidence and in our task to ascertain the facts. I therefore recommended to my colleagues on the Committee that the hearings should be in private, they accepted the recommendation.

There was no question but that the entirety of our report should be published. In compiling the report we were conscious of our duty to present all the relevant evidence; on occasion we have done so by reproducing extracts from the transcripts of evidence of individual witnesses. We have done so because we believe the transcripts reflect what people were thinking and doing in a way which our comments upon the evidence could not.

Counsel to the Inquiry

I decided that a Counsel to the Inquiry should be appointed. I thought it important that an independent advocate should ask the first line of questions of all witnesses. The appointment would also allow members of the Committee to listen to the evidence before asking any questions which they thought to be relevant. Alasdair Brough was appointed as Counsel to the Inquiry. His task was considerable, he met it with skill and diligence. The appointment of an able counsel considerably eased my own task. Alasdair Brough produced the detailed chronology which accompanied the letters to all potential witnesses. The chronology and the list of "Dramatis Personae" which appears in this report were also compiled by Alasdair Brough.

Witnesses

Following the meeting of the members of the Committee, Alasdair Brough and I met and worked our way through the many files of documents in order to identify potential witnesses and the evidence which I believed to be relevant to our Inquiry.

Letters were drafted and sent to such witnesses. In every letter I identified the various "head" of evidence upon which I thought each witness could assist the Inquiry. Witnesses were invited to submit written statements by way of response. Each witness

was invited to attend the Inquiry and give oral evidence. All were informed that they could bring a friend, relative, trade union representative or lawyer to the hearing. Expert witnesses on topics such as health care of the mentally ill in the community, registration and training were invited to produce written reports and give oral evidence.

Sixty witnesses were invited to give evidence, two came forward of their own accord. Eight persons either did not respond or declined to provide a written statement. Fifty-four written statements were received, forty-five people gave oral evidence. By the close of the Inquiry the documentary evidence including transcripts of oral evidence ran to some 7,000 pages.

The form of the hearings

The written statement provided by each witness formed the basis of his or her evidence to the Inquiry. Counsel to the Inquiry led with the questions based upon the written statements and any relevant information contained in documents. Questions would then follow from members of the Committee. The members of the Committee with the knowledge and experience relevant to any particular witness's evidence would lead on behalf of the Committee. At the end of our questions I invited all witnesses to give such further evidence as they deemed appropriate.

There were occasions when a member of the Committee would ask a question during the course of Alasdair Brough's questions. We attempted to keep such interventions to a minimum. I hoped that witnesses would be able to speak with a degree of freedom, unencumbered by too rigid a procedure or too daunting an environment. Those who were asked the questions will be better able than I to say whether I succeeded in this endeavour.

I have expressed the view that the most difficult question which I initially addressed was that of a public or private hearing. I am in no doubt that the private hearing did assist the process. I believe people spoke with an ease and frankness which may not easily be replicated in a public forum. Each witness knew that his or her evidence was being transcribed, all were sent copies of their transcripts to be corrected, amended and returned. Notwithstanding this fact I was encouraged by the response of all but two or three witnesses who gave evidence to the forum of this Inquiry.

Representation

In the order of 80% of witnesses chose to be accompanied. Some brought a friend, colleague or partner, others were accompanied by one or more solicitors.

I would like to thank all who came, whether to provide moral support or professional

assistance. Solicitors who accompanied individual doctors or past and present members of the Oxford Cyrenians carried out their respective roles with professionalism which was not intrusive but properly took account of their respective client's interests.

Co-operation of all parties

From the outset of this Inquiry I was heartened by the response of the statutory and voluntary agencies to our investigation. Documents were produced, letters responded to, written statements provided, people attended to give evidence. We had no power to compel attendance, individuals could have refused, fortunately few did.

From my own professional experience, I know of the disruption and uncertainty created by an Inquiry. The task of trawling through documents and preparing written statements is time-consuming. The giving of evidence is welcomed by few. At its lowest to have one's actions scrutinised by third parties is an uncomfortable experience. With these matters in mind I wish to express my gratitude to all those who did co-operate, voluntarily and fully. Had we not received this degree of co-operation we could not have conducted such a detailed Inquiry.

Draft Report

Upon completion of the draft of our report, chapters in the report which contained criticisms of any witness were sent to the relevant party. I decided that each chapter in its entirety should be sent so that the individual witness could see the proposed criticism in its proper context. Written responses were invited, they were sent, considered by us and amendments to our draft, if deemed appropriate, were made.

Acknowledgements

The task of organising this Inquiry was undertaken by Miss Janet Jeffs, Legal Services Manager at the Oxford Radcliffe Hospital NHS Trust. It was enormous. It involved the obtaining and collating of all documents, the sending of letters and relevant documents to all witnesses, the timetabling of hearings and witnesses, the organisation of the report and its publication.

Miss Jeffs's handling of this task was a model of skill and efficiency. The many responsibilities which she carried out with good humour and remarkable calmness considerably eased my own load. Our thanks to Miss Jeffs is without limit.

Within Miss Jeffs's Department several people assisted in the organisation of the Inquiry and I should like to record our thanks to Sarah Chung who typed the many pages of this report, and to Carole Purnell, who catalogued and indexed many of the documents.

Throughout our hearings the evidence was transcribed by Juline Trussler and Miriam Weisinger of Harry Counsell & Co. They worked long hours and speedily produced accurate transcripts.

Oxfordshire Health Authority were required to set up this Inquiry. Michael Taylor, the Chief Executive, could not have done more to ensure that the Inquiry was provided with all necessary accommodation, facilities and staffing to ensure as efficient and effective a process as possible.

My thanks to my fellow members of the Committee - Richard Lingham, a member of the Mental Health Act Commission, Clifford Prior, Grants and Projects Director of the Mental Health Foundation, Professor Andrew Sims, Professor of Psychiatry at the University of Leeds. Mine was the good fortune to sit and deliberate with colleagues of such calibre. Each brought to this Inquiry his particular knowledge and experience. I gratefully accepted all contributions and was frequently fascinated by the skill of questions being asked. This report represents the work of all members of this Committee. My colleagues gave unstintingly of their time to discuss, write and amend various chapters or parts of chapters. For their help, guidance and support I can only say thank you.

Mrs Jane Newby

I would like to record our thanks to Jonathan's mother, Mrs Jane Newby, for the assistance which she gave to this Inquiry. Her written and oral evidence was clear, cogent and admirable for the restraint which it demonstrated. We would wish to express our respect and admiration for the dignity and courage which were the hallmarks of her appearance before our Inquiry.

The life that was lost was that of Jonathan Newby. We considered that the only name which could appear in the title to this report should be his.

Nicola Davies QC
Chairman
June 1995

Dramatis Personae

Dr Peter Agulnik MB BS DPM FRCPsych	Consultant Psychiatrist Littlemore Hospital Oxford Assumed clinical responsibility for John Rous. November 1974. Consultant in charge of John Rous's psychiatric care from 1978 to 1993.
Ms Kay Asprey	Co-ordinator, Oxford MIND, The Mill, Jeune Street, Oxford from 1988 to date.
Mr David Belton	Former Director, Cherwell Housing Trust. Member of Oxford Cyrenians Council of Management.
Mr Jeremy Booker	Volunteer, Oxford Cyrenians from March 1992 to March 1993. Project Worker Oxford Cyrenians from March 1993 to March 1994.
Mr Robert Brown	Senior Homelessness Officer (1992) Oxford City Council Housing Department
Miss Evelyn Bryant	Probation Officer, Oxfordshire Probation Service from 1970 to date.
Ms Jean Carr	Divisional Director of Social Services, Oxfordshire County Council
Miss Susan Carruthers	Resident of Jacqui Porter House from August 1992 to October 1993.
Mrs Judith Chandler	Principal Inspector, Independent Inspection Unit, Oxfordshire County Council Social Services Department
Mr Ron Church	Inspector, Independent Inspection Unit, Oxfordshire County Council, Social Services Department from October 1992 to April 1994
Mr Brian Coombs BEM	Formerly Civilian Control Room Operator, Oxford Control Room, Thames Valley Police
Mr Roger Corbett	Volunteer Oxford Cyrenians from March 1993 to November 1993. Project Worker Cyrox House from November 1993 to June 1994. Project Leader Cyrox House from June 1994 to date.
Ms Trish Davies *(Expert Witness)*	Head of Inspection Hertfordshire County Council Social Services Department.
Mr John Ewens	Special Needs Co-ordinator, Cherwell Housing Trust.
Ms Kathryn Grant	Volunteer, Oxford Cyrenians from July 1992 to March 1993. Project Worker, Oxford Cyrenians from March 1992 to April 1994.
Mr John Michael Hall	Founder/Director of Oxford Cyrenians to December 1994.

Ms Lynne Hay	Homelessness Officer - 1992 Oxfordshire City Council Housing Department.
Ms Debbie Hill	Homelessness Officer - 1992 Oxfordshire City Council Housing Department
Ms Sue Jeffs	Housing Manager/Deputy Director, Cherwell Housing Trust
Dame Penelope Jessel	Member, Oxford Cyrenians Council of Management. Chairman, Oxford Cyrenians Council of Management from 1992 to January 1994.
Ms Lajla Johansson	Volunteer, Oxford Cyrenians from July 1985 to December 1986. Group Homes Manager, Oxford Cyrenians from September 1991 to February 1994
Mr Steve Kilsby	District Housing Manager Oxford City Council Housing Department
Ms Glynis Lapage	Financial Administrator, Oxford Cyrenians from September 1990 to May 1993. Acting Director, Oxford Cyrenians from May 1993 to March 1994. Now Assistant Director (Operations), Oxford Cyrenians.
Dr Alyson Lee	General Practitioner, East Oxford Health Centre, from April 1989.
Mrs Elizabeth Leyland	Member, Oxford Cyrenians Council of Management from 1991 to January 1994. Chairman, Oxford Cyrenians Council of Management from January 1994 to date.
Dr B M Mandelbrote MA Msc FRCPP FRCPsych	Honorary Consultant Psychiatrist, Oxfordshire Health Authority (now retired). Consultant in charge of John Rous's psychiatric care from 11 June 1968 to January 1978.
Mr David Marsh	Volunteer, Oxford Cyrenians from 1983 to 1984. Deputy Community Leader, Group Homes, from 1987 to 1991. Project Leader, Area Team Manager for East Oxford Group Homes from October 1991 to March 1993.
Dr Max Marshall MPCPsych	Research Fellow, Oxford University Department of Psychiatry.
Mr Andrew McCulloch	Assistant Secretary, Mental Health and Community Care Division, NHS Executive.
Mr Jon McLeavy	Former resettlement officer, Oxford Cyrenians. Co-ordinator, Elmore Community Support Team from Sept 1988 to date.
Mr Joseph McGowan	Volunteer, Oxford Cyrenians 1981. Team Leader, Simon House from 1982 to 1985. Manager, External Houses from 1985 to 1987 and 1989 to 1993.
Supt David McWhirter	Control Rooms Department, Thames Valley Police.

Mrs Verena Mitchell	Principal Inspector, Independent Inspection Unit, Oxfordshire County Council Social Services Department from 1986 to December 1992.
Ms Audrey Moore	Cleaner, Oxford Cyrenians 1990. Team Leader, Simon House 1990. Temporary Project Manager, Jacqui Porter House from March 1993. Manager, Unregistered Group Homes from October 1994 to date.
Dr Roger Morgan	Formerly Deputy Director of Social Services, Oxfordshire County Council. Now Chief Inspector, Independent Inspection Unit, Oxfordshire County Council Social Services Department.
Mrs Jane Newby	Mother of Jonathan Newby.
Mr Andrew Newland BSc(Soc) (Expert Witness)	Principal Adviser, Mental Health, Hampshire County Council Social Services Department
Mr Stuart Nicholls	Volunteer, Oxford Cyrenians from February 1993 to October 1993. Project worker, Oxford Cyrenians from October 1993 to Sept 1994. Senior Referral Worker, Simon House/Policy Co-ordinator from Sept 1994 - to date.
Dr Michael Orr	Unit General Manager, Mental Health Unit, Oxfordshire Health Authority, from 1986 to 1994. Now Chief Executive, Oxfordshire Mental Healthcare NHS Trust
Mr Peter Owen Evans	Volunteer, Oxford Cyrenians from December 1986 to 1990.
Mrs Elizabeth Parker NHS Executive.	Principal, Mental Health and Community Care Division,
Mr Richard Peacock	Director of Housing and Revenues Oxford City Council
Mr John Paul Rous	Resident of Jacqui Porter House from August 1992 - October 1993.
Ms Grace Scrimgeour	Group Homes Co-ordinator, Oxford Cyrenians from 19 April 1993 to 17 May 1994.
Mr Tony Smith (Expert Witness)	Officer, Local Government Management Board.
Ms Angela Stannard	Community Support Worker, Elmore Community Support Team from 1989 to date.
Dr Richard Stevens MA BM Bch DRCOG MRCGP	General Practitioner, East Oxford Health Centre. John Rous's General Practitioner from 1985 to 1993 (with small gap in 1989).

Dr Amanda Taylor	Honorary Senior Registrar, Broadmoor Hospital 1994.
Mr Chris Taylor	Volunteer, Oxford Cyrenians from March 1993 to November 1993.
Dr Phil Timms (Expert Witness)	Senior Lecturer in Community Psychiatry Guy's and St. Thomas's UMDS. Honorary Consultant Psychiatrist Mental Health Team for Single Homeless People Lewisham and Guy's Mental Health Trust
Ms Una Vickers	Development Officer, Oxford Cyrenians from 1990 to date.
Mr John Walker	Director of Environmental Services, Oxfordshire County Council.
Mr Ian White	Director of Social Services, Oxfordshire County Council.
Mr Bob Willsmore	Temporary Director/Director Oxford Cyrenians from 1994 to date.

Chronology of John Paul Rous's Mental Health

Background

John Paul Rous was born on 15.6.46, and was ultimately fostered with Mr and Mrs. Townsend of Bampton, Oxon. He has a brother, a half-brother and 2 foster siblings.

He was educated at primary school (5-11 years) then at a secondary modern school (11-15 years) in Bampton.

On leaving school he worked, aged:

- $15^1/_2$-17 years at a Blanket Factory, Witney.
- 17 years - Army Catering Corps.
- 17 years - Many short-time jobs in Watford staying with a friend.
- 18 years - Laundry work 5 months at home, then wandered around the country.
- 19 years - 3 months as a flyman at the London Palladium.
- 21-22 years - returned to Blanket Factory.

Criminal/Psychiatric History

18.12.64	Witney Magistrates Court. Theft. Probation 3 years.
29.01.65	Marylebone Magistrates Court. Theft.
05.04.65	Edinburgh Sheriff's Court. Theft. 30 days Young Offenders.
17.06.65 - 22.09.65	St Francis Hospital, SE22. Status: Section 25. Dazed and depressed and in a dreamlike state. Claimed to be amnesic for 4 years.
22.09.65	Transferred to West Park Hospital under the care of Dr Cochene.
22.09.65 - 10.12.65	West Park Hospital. Diagnosis: A Drimanyl addict.
08.10.65	Witney Magistrates Court. Theft x 2. Probation 3 years condition of psychiatric treatment. Diagnosed a Drimanyl addict. Claimed he had started to take it to relieve depression.

10.12.65	Discharged from hospital.
03.01.66 - 05.03.66	West Park Hospital. Drug addiction. Admitted feeling depressed. Treated with Nortriptyline 25mg qds and Sodium Amytal. Psychology report states: "Of average ability but wide variation in test scores. Affectless and disinterested but co-operative. No abnormal cognitive function or psychotic symptoms".
23.04.66	Charged with Theft. Remanded in custody at Lewes Prison.
03.05.66	Chichester Magistrates Court. Theft x 3. Probation order 3 years condition of residence at West Park Hospital 12 months. Transferred to West Park Hospital.
03.05.66 - 12.08.66	West Park Hospital. Diagnosis: Drug Addiction.
12.08.66	Discharged himself from hospital. Throughout admission he was receiving Amitriptyline and Stelazine but was continuing to misuse drugs. He was given the diagnosis of simple schizophrenia.
02.12.66	Witney Magistrates Court. Theft. Borstal. Released 13.2.68.
13.02.68	Custodial sentence following his breach of probation order.
11.04.68	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Immature personality and drug dependency. Status: Informal initially.
17.04.68 and 19.04.68	Two admissions to general hospital following overdose of Mandrax and lavatory cleaner.
28.05.68	Oxford City Magistrates Court. Possession dangerous drugs. Probation Order 2 years. Condition of residence at Littlemore Hospital 12 months. Court report by Dr Mandelbrote. "No evidence of mental disorder but long-standing problems in personality development at times associated with depression and extreme dependency." Suggested an admission to hospital.
08.06.68	Left voluntarily.

18.09.68	Swindon Magistrates Court. Possession of amphetamines. Fined £150.
05.10.68	St George's Casualty Department London. Claimed to be an amphetamine addict and taking Methadone.
14.10.68 - no date of discharge	Tooting Bec Hospital. Status: Informal Diagnosis: Drug addiction. Admitted that he was requesting help with his drug misuse. Described regular use of amphetamines, heroin, cocaine, cannabis and Methadone. Psychology reports say that the patient was not floridly psychotic at this time and has a fair ability to assess reality. However thought that there is an underlying thought disturbance "besides over-inclusive thinking and autism much unsystematised delusional material is present. Religiosity, aggression and sexuality are all prominent in these incipient delusions." There was also ample evidence of severe depression.
07.11.68	Bullingdon Magistrates Court. Possession of cannabis. 6 months imprisonment suspended 3 years.
18.07.69	Oxford City Magistrates Court. Theft. Possession of cannabis. 9 months imprisonment.
08.12.69	Gloucester Quarter Sessions Handling. Hospital Order
11.12.69 - 20.11.70	Tooting Bec Hospital. Diagnosis Schizophrenia. Status: Section 60/65 Transferred from HMP Winchester. Section 60 Order was discharged in November 1970 because he was no longer felt to be a risk to himself or others according to the Home Office.
04.01.71	Highgate Magistrates Court. Theft x 2. 12 months imprisonment.
16.01.72	Readmitted. Tooting Bec Hospital. Diagnosis: Hebephrenic Schizophrenia. Status: Informal.

11.02.72	Transferred to Littlemore Hospital.
11.02.72 - 20.04.72	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia. Status: Informal Admitted to hospital because he was distressed and tearful, thought- disordered and expressing paranoid delusions. Treated with Haloperidol.
13.03.72	Attacked another patient.
04.05.72 - 05.05.72	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia. Status: Informal. Admitted to Hospital having been found confused on the motorway. Started on Modecate and transferred to day patient attendance. During his time as a day patient he had caused damage at the Phoenix Unit, Littlemore Hospital following a refusal to admit him to hospital.
06.07.72	Bullingdon Magistrates Court. Criminal damage. Probation order 2 years. Condition of attendance at Littlemore Hospital for treatment.
1972	Continued as a day patient at Littlemore Hospital throughout 1972 living in Rutland House, a staffed hostel in Oxford. Overdose 50 - Mogadon
23.06.73	Left Rutland House.
05.11.73	Seen by Dr Mandelbrote at HMP Oxford. Remanded in custody for Theft. Diagnosis: Schizophrenia and drug abuse. Suggested treatment as part of the probation order.
30.11.73	Oxford City Magistrates Court. Possession controlled drugs. Conditional Discharge. 2 years.

14.12.73 - 07.01.74	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia. Status: Informal.
04.07.74	Oxford City Magistrates Court. Attempting to obtain drugs. Probation order 2 years.
02.08.74 - 19.09.74	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia Status: Informal.
24.10.74	HMP Oxford. Seen by Dr Mandelbrote in HMP Oxford. Expressing paranoid delusional ideas that he was a scape-goat and that shopkeepers were his enemies. Recommended a Section 60.
22.11.74	Oxford Crown Court. Burglary x 2. Hospital order.
22.11.74 - 15.07.75	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia Status: Section 60 of the Mental Health Act 1953. Became a day patient at Littlemore Hospital attending daily.
10.09.75 - 17.12.75	Tooting Bec Hospital. Consultant: Dr Bewley. Diagnosis: Schizophrenia.
15.09.75 - 17.12.75	Littlemore Hospital. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia. Status: S.60 expired - agreed not to renew. Continued to attend hospital three days a week and continued on depot medication and using illicit drugs.
29.01.76 - 02.02.76	Clifton Hospital, Yorks. Consultant: Dr Seymour-Shove. Status: Informal.

29.01.76 - 02.02.76 *(continued)*	Agitated, hallucinating and paranoid ideas. Sent back to live in Oxford.
	Admitted back as a day patient at Mayo Unit.
30.04.76	Charged with Possession of Amphetamines.
	Continuing as a day patient at Littlemore Hospital. On Depixol, Chlorpromazine and benzhexol. Thought to be making progress.
24.05.76	Oxford City Magistrates Court. Possession of controlled drug. Conditional discharge 1 year.
02.09.76	Dr Mandelbrote. S.60 Order recommended.
22.10.76	Oxford Crown Court. Burglary. Deception. Hospital order.
22.10.76 - Feb 1977	Littlemore Hospital. Status: Section 60 of the Mental Health Act 1953. Consultant: Dr Mandelbrote. Diagnosis: Schizophrenia.
17.12.76	Oxford City Magistrates Court. Theft. Fine £20. Mr Rous was admitted to hospital following conviction for Burglary.
	Thought to have psychotic illness of serious personality problems. Had regular thoughts of suicide.
	Dr Agulnik recommended altering S.60 Order, to allow release into community.
February 1977	Discharged from hospital, with day patient follow up - lived at 102 Marlborough Road.
18.03.77	Oxford City Magistrates Court. Forgery. Theft. Fine £25.
21.07.77	Dr Agulnik recommended that S.60 should continue. Care transferred to Dr Agulnik.
December 1977	Attacked a member of nursing staff, while a day patient at Littlemore Hospital. No evidence of psychotic symptoms at this time.
29.12.77	Transferred to out-patient care.

1978	Seeing Dr Agulnik regularly as an out-patient. Receiving Depixol depot injections and Artane (benzhexol).
05.01.78	German Hospital, London E8. Consultant: Dr Silverstone Status: Section 136 of Mental Health Act 1958.
	Admitted to hospital one night having been brought to hospital under Section 136. Thought to be suicidal.
	Discharged into police custody.
20.03.78	Court report by Dr Agulnik. No psychiatric recommendation made.
21.03.78	Oxford City Magistrates Court. Theft. Conditional discharge.
27.07.78	Report for Court by Dr Agulnik for a charge of Theft. Offered to supervise him as a condition of probation order. Diagnosis remained schizophrenia with personality disorder.
03.08.78	Oxford City Magistrates. Theft. Attempted Deception. Burglary. Community Service.
31.08.78	Oxford City Magistrates. Burglary/Theft. 6 months imprisonment.
16.12.78	Returned to live in Oxford. Outpatient follow-up with Dr Agulnik. Depixol 20mg 3 weekly. Living at Church Army Hostel.
1979	Continuing as psychiatric outpatient under the care of Dr Agulnik.
22.04.79	Knightsbridge Crown Court. Theft. 9 months imprisonment suspended 2 years.
06.07.79	Oxford City Magistrates Court. TWOC. Conditional discharge.
27.09.79	Oxford Crown Court. Theft. 70 days imprisonment.
07.06.80	Court report by Dr Mandelbrote. Diagnosis: Schizophrenia. 6 month history of misusing prescribed drugs

25.07.80	Oxford Crown Court. Theft x 3. 18 months imprisonment. Released 11.6.81.
	Continued to receive Depixol injections regularly.
26.07.81	Moved into Richmond Fellowship hostel. Continued to see Dr Agulnik in outpatients and receiving injections from Community Psychiatric Nurse.
08.10.81	Oxford City Magistrates Court. Theft. Conditional discharge 12 months.
08.02.82	6 months report Richmond Fellowship hostel to Social Security Dept.
	"Takes placement seriously. His long standing tendency to abuse his medication is still an issue. During most of his stay he has given responsibility for supervising his medication to the staff. Spends less time with former associates. Employment holds fear. Well aware how fragile he is."
01.05.82	Left Rutland Fellowship.
04.06.82	Report to the Court by Dr Agulnik suggesting that he continues to be seen as an outpatient on a regular basis.
14.06.82	Oxford City Magistrates Court. Theft x 3. Probation 6 months.
02.11.82	Oxford City Magistrates Court. Theft. Probation 1 year.
16.12.82	Oxford City Magistrates Court. Theft. Probation 18 months.
10.09.83	Oxford City Magistrates Court. Burglary. Community Service Order.
September 1983	Expressing paranoid ideas. Given Chlorpromazine in addition to depot under the supervision of Dr Agulnik.
1984	Living at bail hostel. Church Army;
24.09.84	Salvation Army; Church Army
21.08.84	Woodstock Magistrates Court. Deception. Community Service Order.

07.02.85	Overdose of Artane and amphetamines. Admitted.
	John Radcliffe Hospital, Oxford. Discharged following day. Status: Informal.
	No evidence of psychotic symptoms or suicidal ideas.
13.08.85	In a letter from Dr Agulnik to John Rous's Solicitor, Dr Agulnik wrote: "he suffers a chronic schizophrenic disorder associated with a disturbance of personality. In recent years he has shown much better social integration than previously. Although he is prone to impulsive acts of theft which tend to reverse the general progress he appears to be making. He has been considerably helped by his attendance at the Mill Day Centre, run by Oxford Mental Health Association."
09.09.85	Oxford City Magistrates Court. Theft. Community Service Order.
07.06.86	Overdose of Artane and Temazepam. Denied suicidal intent.
18.06.86 - July 1986	Warneford Hospital, Oxford. Consultant: Dr Keith Hawton. Diagnosis: Schizophrenia
	Admitted because he had become acutely disturbed. Expressing paranoid delusions about being castrated. Some degree of elevation of mood and pressure of speech. Marked loosening of association. Treated with Chlorpromazine.
July 1986	Discharged himself in July 1986. To 123 Magdalen Road.
	Suggested increasing his Depixol injections to fortnightly. Continued with an evening dose of Chlorpromazine.
	Continued to be followed up by Dr Agulnik
1986 - 1993	Continuing regular outpatient appointments with Dr Agulnik on a regular three monthly basis.
15.12.86	Abingdon Magistrates Court. Shoplifting. Conditional discharge.

08.08.88	Tenancy at 50 Riverside Court commenced. During this time John Rous was issued with a number of written warnings concerning his behaviour
04.05.89	Referred to Elmore Community Support Team by Dr. Agulnik "Angela Stannard to take on"
20.10.89	Oxford City Magistrates Court. Burglary. Theft. Conditional Discharge.
1990	Letter from General Practitioner, Dr Richard Stevens, stating that he had problems with an increased alcohol intake. Drinking on a daily basis. Also commented on him abusing Artane.
1991	Oxford Family Health Service Authority informed all general practitioners that Mr Rous should not be prescribed any drugs other than those by his General Practitioner due to his continuing abuse of benzhexol.
18.06.91	Report to Housing (Management) Sub Committee recommending eviction following meeting Dr Agulnik Ms Stannard Mr Kilsby
22.07.91	Moved to 333 Cowley Road but thereafter moves between : Night shelter Church Housing until
December 1991	Admitted to John Radcliffe Hospital. Discharged after 2 days. Admission for agitation. Had been taking amphetamines. No evidence of psychosis. Discharged after 2 days.
20.02.92	Oxford City Magistrates Court. Theft. Conditional Discharge.
07.03.92	Admission to John Radcliffe Hospital
11.03.92	Meeting between Ms Hill and Ms Stannard, John Rous completed an application to Oxford City Council for accommodation. Given temporary accommodation at 141 Iffley Road.

01.04.92	At a Meeting between Ms Hill and Ms Stannard, Miss Hill stressed the need for "Strong support package"
May 1992	John Radcliffe Hospital. Discharged after 2 days.
	Admitted for 2 days following injecting himself with amphetamines. Problems continued to be those of substance abuse, schizophrenia, and long term accommodation problems. No evidence of on-going psychosis.
24.05.92	Referral to John Radcliffe Hospital following overdose.
28.05.92	Oxford City Council list of nominations for Jacqui Porter House.
June 1992	Outpatient appointment with Dr Agulnik. Thought to be moderately depressed. Started on Lofepramine 70mg daily. Continuing with Depixol on a 3 weekly basis.
01.06.92	Confession at St Aldates Police Station re: Burglary committed circa April 1992 at 11 St Mary's Road
03.06.92	Referred to Jacqui Porter House by Ms Lynn Hay/Robert Brown.
	"B&B considered not suitable".
03.07.92	Interviewed by Dave Marsh.
06.07.92	Notice of acceptance at Jacqui Porter House.
30.07.92	Information provided by Angela Stannard to David Marsh re: John Rous.
04.08.92	Arrives Jacqui Porter House
09.10.93	Stabbing of Jonathan Newby.
June 1994	At Crown Court admitted manslaughter on grounds of diminished responsibility. Sentenced to be detained during Her Majesty's Pleasure. Section 37 Hospital Order, with Section 41 Restriction Order made with no time limits. Now at Broadmoor Hospital.

Chapter One

Jonathan Newby

1.1 Jonathan Newby was 22 when he died on 9 October 1993. He was the third son of Mrs Jane Newby, he had two older brothers and a younger sister and brother. Jonathan went to school in Devizes and then attended Leicester Polytechnic where in 1992 he obtained a 2:1 degree in the History of Art and Design. He specialised in film studies and eventually hoped to work in this field. Following graduation he decided to defer post-graduate study electing to 'make his contribution' by working as a volunteer. He wrote to Homes for Homeless People who put him in touch with the Oxford Cyrenians. Jonathan began working for the Cyrenians as a volunteer in April 1993.

1.2 Jonathan Newby moved into Cyrenian owned accommodation in Stratford Street, Oxford. Five volunteers lived in this house, four of whom became good friends including Jonathan, Camilla Aagesen and Roger Corbett. Roger Corbett told the inquiry that Jonathan was a very lively, charming and funny young man. Mrs Newby described her son as a very cheerful person with a great sense of fun, a love of life and a sense of humour, a giver not a taker. Jonathan worked in a number of different hostels but by October 1993 he was working in Jacqui Porter House. The group of volunteers in Stratford Street would share their experiences of working for the Cyrenians, often in a light-hearted manner.

1.3 Jonathan enjoyed his work with the Cyrenians and had applied for and been granted promotion to project worker, an appointment he did not live to fulfil.

1.4 Mrs Newby said that between late August and early October Jonathan returned to his home in Devizes for three weekend visits. His mother believed that he was finding Jacqui Porter House difficult. Roger Corbett told the inquiry of discussions which took place in the house in Stratford Street. Within the group of friends there had been concerns for the safety of those working in Jacqui Porter House. The concern stemmed from two sources, Camilla had been threatened with a knife by one of the residents at Jacqui Porter House and additionally each individual worker had a sense of insecurity arising from the fact that the residents were severely mentally ill and therefore more difficult to understand and identify with than the residents of Simon House.

1.5 In the days prior to 9 October 1993 Jonathan had been telling his friends of the 'turmoil' existing in Jacqui Porter House. The cause of this turmoil was a female resident B who was very unwell. B's behaviour was affecting the other residents, it was also affecting Jonathan and Camilla who were on edge and quite nervous about the situation. In a letter Jonathan wrote of how B had threatened to gouge out his eyes with a key and how B hit him in the groin with a bag of frozen peas.

1.6 Jonathan Newby was to undertake the 24 hour shift at Jacqui Porter House on Saturday 9 October 1993. The shift began at 5.00 pm on Saturday and ended at 5.00 pm on Sunday. Between the hours of 7.00 pm and 9.00 am Jonathan was to be the only worker on duty.

1.7 The tragic events of the evening of 9 Oetober 1993 are set out in Chapter 4. They resulted in the death of a bright and popular young man who died when attempting to deal with a problem with which he, alone and untrained, should never have been confronted.

Chapter Two

John Rous

2.1 John Rous is now aged 49. He was born in Oxford. John Rous has never known his natural father, he was abandoned by his mother when about three years old and thereafter was cared for by foster parents. He left school at the age of fifteen, joined the Army when he was seventeen but was medically discharged after three months. Following this discharge John Rous travelled the country moving from job to job. It was during this period that he began abusing drugs. At the age of seventeen he commenced with amphetamines and subsequently moved to abuse of barbiturates, heroin, other narcotic drugs, cannabis and hallucinogenic drugs.

2.2 His first admission to a psychiatric hospital appears to have been in 1965 to St Francis Hospital, Haywards Heath, for an amphetamine psychosis, when a diagnosis of personality disorder was made. In April 1968 John Rous was admitted to Littlemore Hospital, Oxford, for amphetamine abuse and was placed under the care of Dr B M Mandelbrote, a Consultant Psychiatrist.

2.3 In December 1969 for offences of handling stolen drugs and possession of amphetamines an order was made pursuant to Sections 60 and 65 of the Mental Health Act 1969 which led to the detention of John Rous at Tooting Bec Hospital.

1970 - 1980

2.4 In November 1970 the Section 60 order was discharged. In 1972 John Rous was readmitted informally to Tooting Bec Hospital with a diagnosis of schizophrenia. Later in that year he was readmitted to Littlemore Hospital where a diagnosis of schizophrenia was also made. From May 1972 Mr Rous attended Littlemore Hospital as a day patient. On 3 November 1972 John Rous was accepted at Rutland House, a Richmond Fellowship hostel in Oxford where he stayed until June 1973.

2.5 An admission to Littlemore Hospital in 1974 pursuant to Section 60 of the Mental Health Act 1959 led to the placement of John Rous in the Mayo Unit, a rehabilitation unit with strong links with the Oxford Group Homes organisation. By August 1975 John Rous had transferred to Stapleton House, a half-way house

then belonging to the hospital. Two aggressive episodes were noted at that time: in April 1975 John Rous picked up a cup and threw it with the apparent aim of hitting another patient; an incident is noted in August 1975 when John Rous was upset by living conditions at Stapleton House. Throughout this time John Rous was receiving long-acting neuroleptic medication.

2.6 In December 1975 Mr Rous was discharged to a room in East Oxford while continuing a day-time link with the Mayo Unit, the mode of management at the time being to try to resettle Mr Rous in the community in lodgings with daily attendance at the hospital. 1976 saw the making of another Section 60 order and re-admission to Littlemore Hospital.

2.7 In November 1976 John Rous struck two nurses on the ward for the elderly where he was working. In March 1977 he punched a patient on the nose. On 16 December 1977 John Rous attacked the Nursing Officer at the Mayo Unit, a serious attack which included punching and kicking. As a consequence of this John Rous was not permitted to attend the hospital as a day patient and Dr Peter Agulnik, who had taken over consultant care of Mr Rous, arranged for him to be seen as an out-patient at Littlemore Hospital.

2.8 In 1978 Mr Rous initially lived in lodgings in South Oxford, he then received a six month period of imprisonment and upon his release moved into the Church Army Hostel in Oxford. In 1979 further criminal offences occurred which led to a period of imprisonment and on his discharge John Rous lived in digs in Cowley. By this time Dr Agulnik had requested that John Rous's general medical practitioner take over the prescribing of medication.

1980 - 1990

2.9 In June 1981 John Rous resumed his out-patient contact with Dr Agulnik and in July 1981 he once again took up residence in the Richmond Fellowship hostel, Rutland House. In May 1982 John Rous was given notice to leave Rutland House which he did and lived for a period in a squat. He remained as an out-patient of Dr Agulnik's until October 1982.

2.10 Between 1982 and 1985 John Rous received medication from his general medical practitioner and maintained regular links with his probation officer, Miss Evelyn Bryant. He successfully completed a number of community service projects including working at a home for the elderly. He lived for a period of time at a bail hostel, he then returned to the Church Army Hostel but after a few weeks decided to move to the Night Shelter at Oxford. By 1985 John Rous had

begun attending the Mill Day Centre run by Oxford MIND. His attendance at Dr Agulnik's clinic was spasmodic and in December 1985 John Rous dropped out of regular follow-up. In June 1985 John Rous registered with Dr Richard Stevens at the East Oxford Health Centre and regularly attended the health centre to receive medication.

2.11 In June 1986 John Rous was admitted to the John Radcliffe Hospital with an overdose. Two weeks later his general practitioner referred him to the Warneford Hospital for assessment because he had become acutely more psychotic. Between 1985 and 1986 John Rous had resumed living in lodging houses and was refusing consideration of a bed and breakfast arrangement or a group home.

2.12 John Rous's attendance as an out-patient to see Dr Agulnik became increasingly inconsistent and in January 1988 Dr Agulnik contacted the Mill and asked the organiser to contact him if there were concerns about John Rous as there appeared little point in sending Mr Rous further out-patient appointments. John Rous was seen by Dr Agulnik in December 1988 when his psychosis seemed well controlled. By December 1988 John Rous had taken up a tenancy at Riverside Court where he remained until July 1991. Riverside Court is an Oxford City Council development comprising units for single people.

2.13 On 4 May 1989 John Rous was referred by Dr Agulnik to the Elmore Community Support Team. This team had been set up to provide assistance and support to the 'difficult to place' people in the community. Following acceptance by the Elmore Community Support team John Rous's attendance upon Dr Agulnik improved and he was seen at approximately six-weekly intervals.

1990 - 1992

2.14 During 1990 John Rous was experiencing difficulties at Riverside Court which included money worries and involvement with drug taking friends who, he claimed, were exploiting him. In February 1990 Dr Alyson Lee, a doctor at the East Oxford Health Centre, wrote to Dr Agulnik expressing her concern about John Rous who was then visiting the surgery every two weeks and, it was believed, had increased his drinking.

2.15 On 18 June 1991 the Housing Sub-Committee of Oxford City Council decided to commence possession proceedings against John Rous but he moved out of Riverside Court and into a lodging house before they were in fact commenced.

In November 1991 following a disturbance at the lodgings John Rous moved back to the night shelter. An attempt to provide accommodation at the English Churches Housing Hostel met with limited success and following the discovery of syringes in his room the hostel refused further residence. On Christmas Day 1991 John Rous moved back to the Night Shelter.

2.16 On 24 January 1992 John Rous was referred to the Warneford Hospital by his general practitioner because of concern that he was becoming more depressed and claimed to be suicidal. Following consultation it was decided not to admit John Rous to hospital. By March 1992 Angela Stannard of the Elmore Community Support Team had found John Rous a room in Cronin's Lodging House in East Oxford which was not satisfactory but probably the best that could then be found.

2.17 Mrs Stannard continued her efforts to find alternative accommodation which resulted in the placement of John Rous in Jacqui Porter House, a hostel for twelve people run by the Oxford Cyrenians. John Rous took up residence on 1 August 1992. During 1992 John Rous continued to attend for out-patient psychiatric appointments although during the second half of 1992 Dr Agulnik was absent from work due to ill health and Mr Rous was seen by another doctor.

1993

2.18 1993 saw no real change in the pattern of John Rous's life. He remained at Jacqui Porter House but on various occasions expressed a wish to leave. He was irritated by the restrictiveness of the house rules, by the low amount of spending money which was available to him, and he appears not to have formed any friendships with other residents. John Rous was the 'odd man out' amongst this group as he felt himself to be inferior, socially and educationally, to the majority of the other residents who he believed were in a better financial position than himself.

2.19 A description of the residents of Jacqui Porter House and John Rous's reaction to them was given to the inquiry by Audrey Moore who became the manager of the house in 1993:

"The residents were extremely articulate and bright individuals academically. They did have their illnesses but they were very bright people. Being a very working class person I found it a very middle class house. John Rous would have been isolated from the fact of his past, his perception of things, and his intellect as an outsider in the house, because they were not street people; they were people who had actually been through degrees who had had breakdowns,

people who had actually just been doing a doctorate and just been diagnosed schizophrenic, very bright people and a lot of them had come from very middle class backgrounds, and there was no common denominator for John Rous to react to. So the dynamics of the house was sometimes John Rous would be isolated because of where he came from."

2.20 Within the house John Rous was liked by some residents but not all. He was generally perceived as the jester. His expression of speech, and gestures were extravagant to the point of flamboyance. He was a rather loud, colourful character who could become excited and this would be demonstrated both verbally and in large physical gestures.

2.21 Throughout 1993 Mr Rous attended The Mill .Day Centre, and he also commenced a newspaper round. Out-patient appointments with Dr Agulnik recommenced on 15 February 1993.

2.22 If there was any change in John Rous's life in 1993 it was in the person of a girlfriend known to John Rous as Jessie. We were told that Jessie was the first real girlfriend known to John Rous. She became pregnant and John Rous believed that he was the father of her child.

2.23 By October 1993 John Rous had established a pattern in his life which, on the face of it, was known to those with whom he had contact, namely staff at Jacqui Porter House; staff at the Mill; Angela Stannard. He carried out his newspaper round, visited the Mill from Monday to Thursday, spent time with Jessie, went to his local pub, the Elm Tree, when money permitted and where, on occasion, he would read the poetry which he had written.

2.24 It became clear to the Inquiry that on the part of these people, and also the staff of Jacqui Porter House, there was limited knowledge of that aspect of John Rous's life which resulted from and was still associated with his years 'on the street'; in particular the misuse of alcohol and drugs, the friends and acquaintances from those years, the extent to which they represented a 'fall back' when the newer and more alien environment of Jacqui Porter House became too much.

2.25 John Rous had had a street life of some twenty years when he took up residence in Jacqui Porter House. Audrey Moore in acknowledging this part of John Rous's life said that with it she associated drink, drugs, violence and theft. She said that she was not totally aware of the extent to which these elements and his

friends from those days played a part in his life but it would be naive to think they did not. Mrs Moore's limited knowledge of the situation was shared by others. We believe that one reason for this was that John Rous deliberately kept this area of his life separate from his perceived daily existence. Significantly it was a friend from these years who gave evidence of events during the day of 9 October 1993, evidence which appears to be unknown to other witnesses.

2.26 In September 1993 John Rous went on holiday to Yorkshire which had been organised by The Mill. For a couple of months prior to the holiday staff at the Mill had noticed that his consumption of alcohol had increased. The Mill required all who were going on the holiday to take £60 spending money, and John Rous obtained a loan in this sum from Angela Stannard. John Rous enjoyed his holiday. He is reported as having drunk quite a lot. John Rous told us that he had enjoyed visiting the local pub, talking to and entertaining the locals. During the holiday it would appear that he ran out of money because he obtained a further loan from MIND of £20. Upon his return to Oxford John Rous attempted to negotiate repayment of the £20 loan by instalments. This was refused and John Rous paid back the £20 but was not pleased to have to do so (see also para. 12.7).

2.27 In the weeks prior to 9 October 1993 no one perceived any deterioration in John Rous's mental or physical state. John Rous was due to see Dr Agulnik for an out-patient appointment on 5 October 1993 but this was postponed by Dr Agulnik because of professional commitments. The news that the visit had been postponed did not please John Rous who indicated that he wanted to see Dr Agulnik. The events of the week prior to 9 October 1993 are set out in Chapter 3. During that week a female resident in Jacqui Porter House known as B was causing major disturbance to the smooth running of the house by reason of the deterioration in her own mental state. It is clear that B's behaviour was causing distress to John Rous. The evidence which we received regarding 9 October 1993 is to be found in Chapter 4.

Meeting with John Rous

2.28 On 19 December 1994 the Committee of Inquiry visited Broadmoor Hospital and met John Rous in the company of his solicitor for some two hours. John Rous was expansive in speech and readily answered questions from the Committee. On that day he exhibited clear psychotic symptoms.

2.29 One point struck us: John Rous expressed no remorse for the killing of Jonathan Newby, and we have found no evidence that he has genuinely felt such remorse.

2.30 Having met with John Rous we have no difficulty accepting the evidence of witnesses who spoke of his extravagance of speech and gesture and of how he would become verbally and physically excited. We found his account of events to be egotistical, we could easily understand how he would attempt to manipulate individuals and situations to achieve his desired goal.

Violence

2.31 During the course of the Inquiry one point was made forcibly by all witnesses who knew John Rous, be they friends, support workers, carers or doctors. It was their initial astonishment and disbelief at the news that John Rous had committed an act of such violence as to result in a death. A picture emerged of a man who could be verbally threatening but no witness - male, female, young or older in years - suggested that he or she had ever felt physically threatened by John Rous. His criminal convictions do not disclose a tendency to violence. Only one of the incidents of aggression recorded in the medical notes was regarded as being particularly serious and this occurred in 1977.

2.32 On the evidence available to us we conclude that the killing of Jonathan Newby was an act of horrific violence, it was also an act wholly out of character for John Rous and of a nature unforeseen by all who knew him.

Chapter Three

The events of 2 to 8 October 1993

3.1 We have decided to recite at some length the events of and the evidence relating to Jacqui Porter House, its residents and staff during the days prior to Jonathan Newby's death. We do so because it is clear that a crisis had arisen in the house caused by the deterioration in the mental state of a female resident, who will be referred to as B. We are in no doubt that this crisis had a direct causal effect upon the mental state of John Rous.

3.2 By 1 October Audrey Moore had returned to work following a holiday. On her return Mrs Moore found that resident B was causing concern. A summary of the weekly meeting of the 29 September 1993 of the staff at Jacqui Porter House held in order to discuss residents contains this entry in respect of B:-
"Continues to be very paranoid, especially about her room and its effect on her physical and mental health. Has therefore been very disruptive about the house and is deterring some residents from using communal areas as much as they may otherwise do. Having said that often seems better where there are people about in the lounge."

3.3 In the days which followed the behaviour of B did not improve. It was the subject of discussion between those who worked at Jacqui Porter House and amongst volunteers who shared accommodation, albeit working in different teams. It was from the volunteers that Lajla Johansson, the Group Homes Manager for four of the Cyrenians' hostels, learned of the problem, as a result of which she decided to visit Jacqui Porter House on the afternoon of Tuesday 5 October 1993.

3.4 Ms Johansson told the Inquiry that this was an unusual step as by then the hostels run by the Cyrenians had been divided into North and East sectors. Ms Johansson was the project manager for the North team and Mrs Moore was the temporary project manager for the East team. Ms Johansson said that she thought she was perceived by Audrey Moore and other workers in the East team to be intruding in the running of Jacqui Porter House when she had no right so to do. Mrs Moore denies that such a view was held.

3.5 When Lajla Johansson arrived she found Audrey Moore, Stuart Nicholls, Ken

McBride and a couple of volunteers sitting in the office discussing resident B who was causing problems. To Ms Johansson's surprise they asked her for her opinion upon the problem. Ms Johansson was told that resident B was very disruptive, she would go around the building and scream and disturb people at night, she was worried about electrical goods in her bedroom, she claimed to be hearing voices. Ms Johansson was told by one of the staff present that other residents were very upset and had said they would leave if the staff did not sort out resident B. Having been given this information Ms Johansson said that in her opinion B needed psychiatric help. Ms Johansson was asked of the reaction of members of staff to her advice, her evidence was as follows:-

"I just could not believe that they had not even considered it. They were more worried about her not wanting to return to Jacqui Porter House and worried that she was not going to like them afterwards if they did get her into hospital. They said that she was not willing to go in. And then they said they were going to get her a room on the Cowley Road and tell her that she would have to move there if she would not go into hospital, which was completely outrageous. It was her psychiatric problem that needed dealing with, not actually her accommodation. They just did not seem to understand what was going on, and considering that B had got quite a long history of these sorts of episodes and they had seen that before, I was surprised that they did not actually just get on to her GP and psychiatrist or the CPN and get somebody out to assess her."

Q: *"Did you get the impression that they had considered that as an option and dismissed it?"*

A: *"No, I do not think so, because Audrey Moore actually told me that B had taken herself to see her GP and the GP had been concerned about B and felt that she needed psychiatric help, and that was why I was really surprised that Audrey Moore had not actually taken the next step and contacted the psychiatrist or contacted the Ashhurst Clinic where B was well known."*

Q: *"You say that you pointed out to the staff that not only did you have responsibility towards B but also to the rest of the house. What reaction did that statement, that it was to be seen in a context rather than the individual, what reaction did that get from Audrey Moore and the other members of staff present?"*

A: *"I sort of got the impression that they were just concerned with this one problem and they were not actually considering the house as a whole. I was quite keen, particularly because of the statement that the other residents were going to walk out of the House because they had not done*

anything with B. I also used that as a statement to kind of make them feel a bit better about it because, you know, getting B into hospital if that is what they needed to do, because they seemed to be really worried that she was not going to like them afterwards."

3.6 Ms Johansson told the inquiry that her advice to the group was to contact B's general practitioner, thereafter contact the Ashhurst Clinic to inform them of the problems as this would be the place to which B would be sent, to explain the situation to the on-duty psychiatrist, allow the GP to contact the psychiatrist and social worker and arrange a time to meet at Jacqui Porter House. She said that having given the advice she believed it would be followed. We believe that, had her advice been followed, B would have been rapidly admitted to hospital. Mrs Moore did not recall Ms Johansson attending any meeting.

3.7 A hand-written note of the weekly staff meeting held at Jacqui Porter House on Wednesday 6 October attended by all the workers including Audrey Moore contains this entry in respect of B, it being the first matter to be discussed.
"B had been told that she is affecting other residents with her paranoia. Audrey advised her to seek private accommodation in an attempt to get her to admit her illness which has badly affected the house. B could possibly be sectionable at some point though this should only be a final solution. Keep pushing B till she admits her illness. B should hopefully admit herself otherwise sectioning on Friday is an option. B would refuse to see Trevor Lowe (CPN) or admit herself to Ashhurst before, maybe has been looking to Dr Lloyd for some support. If B is sectioned it would not only be disruptive to the house it would be unlikely that she would ever return to JPH, if we can avoid it we must. B has got to be sorted before the weekend. Firm but kind with B. Support for other residents."

3.8 In considering the evidence which Lajla Johansson gave to the inquiry we were conscious of the fact that she had not considered Audrey Moore to be an appropriate person to be appointed manager of Jacqui Porter House. Following Audrey Moore's appointment there appears to have been no real meeting of minds between the two women. With this note of caution it is not without significance that Ms Johansson's evidence of the meeting in which she became involved at Jacqui Porter House and the note of the staff meeting on 6 October mirror each other in the detail of the response of the staff at Jacqui Porter House to the problems created by B.

3.9 A second written document relating to the meeting of 6 October 1993 was to be found in the files disclosed by the Cyrenians. It was a typed document headed

'Jacqui Porter House Summary - 6 October 1993.' Audrey Moore informed us that this was the typed account of the meeting. The typed document was dated 10 February 1994. It differed in some detail from the hand-written account of the meeting. Nowhere in the typed document was there an entry dealing specifically with B. In this document, however, was an entry for John Rous which read: *"He has been ill with flu. He was annoyed with his psychiatric doctor cancelling their appointment again. Angela Stannard (Social Worker) visited him on Monday. He has been reciting poems, laughing and joking. He mentioned to Ken and other members of staff that B was upsetting the other residents in the house and it was creating a bad atmosphere and the residents were getting fed up with it. Ken told him that the members of staff were aware of B's behaviour etc. Also mentioned how irritating B is when she is up and down the stairs at night."*

3.10 We asked Mrs Moore if she could explain the discrepancy between the handwritten and typed account of the same meeting. She could provide no real explanation. The reason for the date of 10 February 1994 on the typed document was a backlog of typing, an explanation we accepted.

3.11 Having looked at all the notes provided by the Cyrenians it is a matter of regret to record that we were not surprised to find such disparity between two documented accounts of the same meeting. The documentation relating to the day to day running of the house, the condition and progress of the residents lacked both form and detail and could not serve as a reliable source of information for those responsible for the ongoing care of any resident.

3.12 In her evidence Audrey Moore said that she spent Wednesday, Thursday and Friday with B, firstly 'coaxing' her to try and take control of herself. On the Wednesday morning Mrs Moore was trying to get B to say that she needed help, she told us that she was putting the onus on B to realise that she was ill. Mrs Moore said that she did not know the title of B's psychiatric illness but that B was obviously getting quite mentally ill, the paranoia was increasing.

3.13 On the afternoon of Wednesday Mrs Moore spoke to B's general practitioner about her medication but not about compulsory admission to hospital. Mrs Moore wanted B to go into hospital of her own accord, she told us with frankness and fairness that she was spending a great deal of time with B and the rest of the staff were dealing with the other residents. Mrs Moore also left a message with Trevor Lowe, B's CPN, expressing her concerns and asking him to contact her, which he did on Thursday.

3.14 By Friday B would not accept that she required professional help. Audrey Moore told the Inquiry that on that morning she gave B a letter saying that if she did not seek professional help she would be evicted.

3.15 On Friday afternoon Trevor Lowe visited B and spent considerable time with her, following which B disappeared from Jacqui Porter House. Following B's disappearance Mrs Moore said that she and/or Trevor Lowe contacted the Ashhurst Clinic and B's general practitioner, the aim being that in the event that B returned and there was a problem these people could be contacted immediately. This evidence is corroborated in the daily record which states:- *"If there are problems with resident 2 over the weekend contact Dr Lloyd. If not contact the Ashhurst duty officer."*

3.16 Mrs Moore went on to state that she and Trevor Lowe had a plan to obtain the admission to hospital of B on the following Monday. The reasons given for not admitting B during the weekend were:

i) the difficulty of getting all the professionals necessary to effect a compulsory admission to hospital;

ii) the fact that B left the house, returned briefly and left again,

iii) the effect which compulsory admission of B would have upon the other Residents in the house.

3.17 Mrs Moore said that once Trevor Lowe was involved her role in "supportive housing had to stop because this was beyond my control". She told us it was Mr Lowe who knew all the relevant procedures. We understood her to be saying that her responsibility for effecting the admission of B to hospital had either ended or was now shared with Trevor Lowe.

3.18 The evidence for the day of Friday 8 October is based primarily on accounts given by Audrey Moore in an initial written statement, her oral evidence to the Inquiry and a subsequent written statement. We have attempted to relate the events as we understand them to have taken place, but our difficulty has been the inconsistencies which are contained in the three accounts. We are satisfied that at no time has Mrs Moore attempted to mislead the Inquiry: rather her difficulties of recollection are due to the passage of time and the distress which she has suffered arising from Jonathan Newby's death.

3.19 B did return to the house that night and her behaviour still gave cause for concern. A note records that she was running up and down the stairs in the early hours of the morning.

3.20 Given the evidence which we received from Mrs Moore as to the events leading up to the evening of Friday 8 October we asked her about staff cover for the weekend:-

"Q: Did it not concern you that over the weekend there would be one volunteer worker on duty having to deal like that?

A: It was not one volunteer: there were two during the day.

Q: What about the night?

A: At night time there was one volunteer. It did concern me and that is why I was in contact.

Q: Were you not sufficiently concerned to put someone else on duty in the night?

A: There was an open discussion with the whole team about that, and they felt basically that the staff would be more intimidating by having extra staff.....

Q: Who were the others?

A: The volunteers and the project workers.

Q: Did you consider that the volunteers and the project workers had sufficient knowledge, experience and training to be able to make a decision of that sort?

A: With the knowledge that there was a back up team.

Q: What was the back up team?

A: Dr Lloyd and the Ashhurst. I felt confident that if they thought that there was a problem they would contact these people, or the on call person.

Q: But the problem could arise quickly and help might be needed quickly - yes?

A: If help is needed quickly in the sense of ... in what degree of help?

Q: Physical help apart from anything else.

A: Physical help. Well, the on call person lived only just up the road, and so he would have been there. I would have been down there.

Q: So I am going to ask the question again: did you think it safe to allow one volunteer with only some months' experience to be on duty alone on Saturday night with a person who in your opinion should be sectioned?

A: At the time. At the time yes."

3.21 The result of this decision was that the normal weekend rota was maintained, the on call person on the Saturday evening being Julian Garren, with Audrey Moore providing on call support if required.

Staffing on 9 October 1993

3.22 On duty during the day of 9 October were Neilia Davies, a volunteer who had worked from 5.00pm on Friday to 4.30pm on Saturday, and Kristina Jensen, a volunteer who worked from 9.00am to 7.00pm. Jonathan Newby commenced his period of 24 hour cover at 5pm.

Conclusions

3.23 We believe that the manner in which the developing crisis was handled reflects the inability of those working in Jacqui Porter House properly to recognise and effectively to manage the problems of the severely mentally ill. It is our opinion that B required compulsory admission to hospital from no later than Tuesday 5 October. The note of 29 September demonstrates that her mental state was poor. In the days which followed no effective steps were taken to arrange her admission to hospital. We are not satisfied that those working in Jacqui Porter House knew the steps to be taken to initiate a compulsory admission to hospital.

3.24 We do not doubt that those in Jacqui Porter House, in particular Audrey Moore, genuinely believed they were acting in the best interests of B. That they manifestly were not stems from the absence of appropriate training, qualifications and experience in the care of the severely mentally ill, the expressed view that more staff would be seen as "intimidating" by residents, possibly the philosophy engendered by the Cyrenians to manage any problem themselves, the absence of any senior person within the Cyrenians with the requisite knowledge and training to whom Audrey Moore could have turned for advice.

3.25 The result of the staff's failure promptly and effectively to deal with B meant that the interests of other residents were subsumed to those of B. The effect of her behaviour upon them was not properly or fully considered, the support and care which they should have received during this period was not provided.

3.26 The decision to maintain existing, solitary staffing levels during a weekend:

a) which followed a disruptive and distressing week for the severely mentally ill residents;
b) which covered a period when up to eight residents would be in the home,
c) when one of those residents (B) was sufficiently ill to warrant compulsory admission to hospital; and
d) which resulted in an untrained volunteer being in sole charge of such a home;

is a decision which we find reprehensible.

3.27 In criticising the care of B we are conscious of the fact that Audrey Moore did not seek the position of project manager. She was appointed to it by the Director, Michael Hall, who was firm in the conviction that she was the appropriate person for the task. Audrey Moore had not received such training and experience as would have enabled her to appreciate that the task of managing Jacqui Porter House was way beyond such ability and skill as she possessed. She had no real insight into the difficulties of caring for up to twelve severely mentally ill residents. The Oxford Cyrenians should never have appointed to this position a person who lacked the appropriate training, experience and resultant skill. That they did reflects the inadequacy of the recruitment and training procedures which existed within the organisation.

Chapter Four

The events of 9 October 1993

4.1 The staff at Jacqui Porter House operated a system of loans to residents whereby a loan of up to £6 per week could be made to residents. A written IOU would be made out. The monies would be repaid at the end of the week. By the morning of Saturday 9 October 1993 John Rous had received two loans, £6 and £4. During the course of the day John Rous pestered the workers on duty, namely, Kristina Jensen and Neilia Davies, claiming he had been given only £1.50 of the second loan of £4. Inquiries confirmed that the full amount had been given. To the annoyance of John Rous no further money was given.

4.2 We asked John Rous about the day of 9 October. There was nothing unusual in his description of the morning and afternoon. Summarising his account he had an uneventful time in and around Jacqui Porter House and he drank two cans of lager.

4.3 We received a very different account of the late morning and early afternoon of 9 October from a witness who gave evidence. The witness was a friend from the street life of John Rous. With the support of Mrs Kay Asprey of MIND to whom we are indebted, he felt able to come to the inquiry and tell us how John Rous had spent the late morning and early afternoon of 9 October 1993. This witness has suffered a breakdown, he is in receipt of medication and on the day of Jonathan Newby's death was living in bed and breakfast accommodation for the homeless in Oxford. This witness asked for anonymity. One of the reasons given was his own safety. In our opinion his reasons for so requesting were valid and reasonable, and accordingly we have acceded to his request.

4.4 The information which this witness gave appears not to be known to any other person who gave evidence, there is no reference to it in any of the documents. Notwithstanding these facts, having heard this witness and assessed the credibility of the evidence, we believe it represents the events as they did occur.

4.5 We were told that during the course of the week preceding 9 October John Rous had visited this witness at his bed and breakfast accommodation every day save for one. It was said that this was unusual. John Rous told the witness that his reason for the many visits was to get away from Jacqui Porter House. On a visit in that week and again on 9 October John Rous had allegedly told the witness

that he wanted to be put in hospital in a lock up ward; the reason being that a woman, a fellow resident in Jacqui Porter House, was behaving in a disturbed way and it was getting to him. He said that the woman was throwing things and shouting and it was getting on his nerves. John Rous also told the witness that he had asked the psychiatrist to put him in hospital but the psychiatrist had refused. John Rous did not see a psychiatrist in the weeks immediately preceding 9 October 1993. We have been unable to find any evidence to support this alleged request.

4.6 On 9 October 1993 John Rous arrived at the bed and breakfast accommodation during the late morning and stayed for approximately three hours. The witness told us that upon arrival John Rous was upset. The causes of his distress were several: his lack of money; the actions of a man (one of the street people of Oxford) who was taking money from people who were mentally ill; and in particular the events in Jacqui Porter House, namely the actions of the female fellow resident.

4.7 The witness told the Committee at this particular time he (the witness) was on a 'drink bender' which, on occasion, had involved John Rous. On this particular Saturday John Rous brought with him a two litre bottle of cider and a can of Tennants strong lager. The witness also provided alcohol. In total four people were present in his room and together they proceeded to consume about four litres of cider and four cans of Tennants. John Rous was drinking 'snakebites', a mixture of cider and lager in equal parts. In addition to alcohol about an eighth of an ounce of cannabis was smoked. The cannabis was in the form of joints which were shared between the four people present, each taking his or her turn. The witness told us that he believed John Rous left between two and three o'clock in the afternoon. The witness described John Rous as being high and merry, and said he intended to return later in the day with another bottle. He did not return.

4.8 At about 5.00 pm Kristina Jensen gave John Rous his medication, and she went off duty at 7.00 pm. Jonathan Newby came on duty at 5.00 pm. Six residents were in the house that evening, two were to return later. Roger Corbett, a fellow volunteer and friend of Jonathan Newby's, called at Jacqui Porter House between 6.30 pm and 7.30 pm. He asked Jonathan how he was getting on and he replied "not very well". Roger Corbett wished Jonathan luck and left. Jonathan Newby was in the communal lounge watching television with another resident when John Rous came in and told Jonathan Newby that he wanted his money. Jonathan Newby and John Rous went downstairs. There are no

witnesses to this incident but Jonathan Newby made a note of it in John Rous's notes, which is transcribed below:-

"John also asked me for an IOU tonight and became extremely threatening when I refused to give it to him. He called 999 and told the police he was going to kill me. He also told me to my face he'd cut my throat if I didn't give him the money. He went into his room to get a knife so I locked myself in the office and he proceeded to attempt to kick the door in. At this point I was more concerned with my own safety and told him I'd give him an IOU if he'd sign a piece of paper explaining his reasons for needing it on a Saturday. He complied with this and has said he's going to the night shelter tonight. His behaviour was extremely intimidating and completely out of order. Jon."

The note is in handwriting unusual for Jonathan Newby and indicated that he was under considerable stress.

4.9 It is clear that John Rous did dial 999. His call was taken by the British Telecom operator who connected him to the police at the Oxford Control Room at 7.32 pm. We produce a transcript of the telephone call to the Oxford Control Room provided by Thames Valley Police:-

"Control Room Operator identified as Mr Brian Coombs = BC
Male caller remained unidentified = M

Person speaking	Text
'999' BT operator:	*Connecting you to pay phone 0865 200527.*
BC:	*Thank you - Police emergency.*
M:	*Yeah, it is yeah I'm ringing at 41 and 42 Rectory Road, are you with me?*
BC:	*I'm sorry you're ringing from .....*
M:	*Yeah that's where I'm ringing from*
BC:	*41/42 Rectory Road.*
M:	*Yeah that's where I live.*
BC:	*And what's the problem there?*
M	*The problem is I fucking got a loan off the people who run the place and they've ripped me off for three quid and I'm in a fucking bad mood and if I don't get that fucking money in the next half an hour I'm gonna take his liver out.*
BC:	*Hmm - Sir that sounds quite desperate I do wish you'd stop swearing.*
M:	*Yeah, I fucking, I deserve to fucking swear John Major says .....*"

Following this telephone call Mr Coombs, the telephone operator, took no action. (A complete transcript of the call is set out in Chapter 15.)

4.10 At some time between 7.30 pm and 7.48 pm Audrey Moore telephoned Jonathan Newby to inquire about events in Jacqui Porter House. Jonathan Newby told her that everything was fine and the house was stable. We have not been able to ascertain if this telephone call was made before or after the first incident involving John Rous.

4.11 Having received the additional money from Jonathan Newby, John Rous went to the Elm-Tree public house where he drank about one and a half pints of lager. He told us that it was in the pub that he decided to kill a person. He identified three people he could have killed and told us he decided to kill Jonathan Newby because he was young, not very physically strong, and John Rous did not think that Jonathan Newby would be able to stop him from doing something he felt compelled to do. At no time did John Rous say that he disliked Jonathan Newby or that he felt any antagonism towards him which prompted his actions.

4.12 From those who knew Jonathan Newby there was no suggestion of any animosity between himself and John Rous - rather the reverse. We gained the impression that Jonathan Newby liked John Rous and on occasion found him entertaining. Mrs Jane Newby informed the Inquiry that Jonathan was frightened of John Rous.

4.13 It would appear that Jonathan Newby returned to the communal lounge and began watching the television programme 'Casualty'. Two residents were also in the room, the time would be after 8.00 pm. John Rous returned to Jacqui Porter House from the pub and went to the communal lounge. He told Jonathan Newby that he was going to rip his liver out. Jonathan responded by inviting John Rous to go downstairs with him to talk. Jonathan left the room first, after he did so John Rous opened his jacket whereupon both residents saw that he had a kitchen knife tucked into the top of his trousers. One of the residents shouted to Jonathan "John's got a knife" - we do not know if her call was heard.

4.14 There are no witnesses to the killing of Jonathan Newby. It would appear that Jonathan Newby went into the office in Jacqui Porter House and John Rous joined him. It was in the office that John Rous used the knife to stab Jonathan Newby, and the knife penetrated Jonathan's left chest wall and heart. Two doctors who happened to be passing by attempted to resuscitate Jonathan Newby without suecess.

4.15 Police records show that at 8.21 pm a 999 call was put out to the police, at 8.23 pm the call was routed to the radio operator, at 8.33 pm the first police vehicles arrived at the scene. First aid was given to Jonathan Newby but to no avail. John Rous was arrested, taken to St Aldates Police Station and subsequently charged with murder.

Chapter Five

Mental State Of John Rous Immediately Preceding The Homicide

5.1 There seem to have been four major influences upon the mental state of John Rous in the weeks preceding and on the day 9 October 1993, on which the homicide took place. These were:

1. the severity, chronicity and current activity of his severe mental illness (schizophrenia),
2. personality disorder and the way it affected his relationships and behaviour,
3. drugs and alcohol misuse, and
4. predisposing social circumstances.

It is probable that all four of these factors contributed to the homicide; its timing, site and victim.

5.2 *Schizophrenic Illness*

a) Evidence for positive symptoms of schizophrenia

Positive symptoms of schizophrenia include delusions, hallucinations and thought disorder.

i) His depot injection was given two-weekly in 1993 and due on 8 October, however this had been delayed until 11 October. We have heard from various witnesses that immediately preceding his depot injection he was over-active, restless and excitable.

ii) In the report of Dr A Taylor, Senior Registrar, Broadmoor Hospital, John Rous described a delusion in which he claimed he had believed whilst at Jacqui Porter House that the staff, both project workers and volunteers, of Jacqui Porter House were "ex-Broadmoor inmates".

iii) There were positive symptoms present at our interview of John Rous in December 1994.

b) Evidence against positive symptoms of schizophrenia

i) We have had no comment on a recent increase in delusions just before the event either from staff of Jacqui Porter House or The Mill or from fellow residents of Jacqui Porter House or friends and acquaintances outside.

ii) Specifically no one reported the delusions concerning staff being ex-Broadmoor on either direct or indirect enquiry.

iii) The astonishment of all those recently involved with John Rous would suggest that there was no deterioration in his mental state immediately preceding the homicide. These witnesses included Dr Stevens, Mrs Stannard, the staff of Jacqui Porter House and The Mill, Dr Agulnik and others.

iv) It appeared that the schizophrenic symptomatology had been reasonably well-controlled although without the removal of positive symptoms altogether over many years.

v) According to Jeremy Booker and others there was no deterioration in John Rous's mental state during September, either before or after his holiday.

5.3. *Severe Personality Disorder*

i) Diagnosis of personality disorder was made when John Rous was first admitted to psychiatric hospital at the age of 19 and preceded diagnosis of schizophrenia.

ii) The development of personality disorder has been associated aetiologically with an insecure, unhappy and extremely deprived upbringing.

iii) The type of personality disorder was *dysocial* (the International Classification of Diseases, 10th revision term for asocial, antisocial or psychopathic personality disorder), it was prominent and pervasive and its manifestation can be seen throughout his adult life. It resulted in suffering of a psychological nature both to himself and to other people.

iv) Arising from his dysocial personality disorder was unacceptable behaviour, especially drug and alcohol abuse and repeated petty crime. It also resulted in a pattern of poor inter-personal relationships.

v) It has been considered a greater bar to effective rehabilitation than active schizophrenic symptoms.

vi) Characteristic of dysocial personality disorder is lack of a feeling to appreciate how one's unpleasant behaviour affects the emotional state of other people. There is total lack of sympathy and remorse.

5.4 *Drugs and alcohol abuse*

i) There was a past history of abuse of benzhexol (a prescribed drug also known as Artane), alcohol, amphetamines and cannabis.

ii) Evidence from the witness who spent some hours with John Rous on 9 October would suggest that more than 10 units of alcohol were consumed on the afternoon of 9 October in cider and strong lager by Mr Rous; that four people shared 5 joints of cannabis and John Rous took no less than anyone else, and that John Rous also took Artane on that occasion.

iii) This witness also described John Rous taking alcohol and cannabis in considerable quantities on 8 October and on previous occasions.

iv) We have heard that later on the afternoon of 9 October John Rous consumed 2 cans of strong lager bought from a pub. This probably represented a further 3 units. During his visit to a pub that evening he probably consumed another unit.

v) It seems likely that during the day of 9 October before 8 pm John Rous had consumed at least 14 units of alcohol, quite a considerable amount of cannabis and an unknown additional number of benzhexol tablets.

vi) The residents of Jacqui Porter House who were present in the evening of 9 October commented on John Rous's extreme irritability and argumentativeness and also that he was drunk, angry and excited.

vii) A syringe needle was found in John Rous's room after the incident. We have no knowledge of whether other drugs were being injected and when, but we do know that he had in the past injected amphetamine.

5.5 *Predisposing social circumstances*

i) For several weeks preceding 9 October, and certainly for the two weeks after John Rous returned from holiday, Resident B was in a highly disturbed and unstable mental state. This was described by Jeremy Booker as "incredibly disruptive". This affected all the residents of Jacqui Porter House, but especially John Rous, as it seems that B particularly picked upon him and their rooms were close together. The staff had failed to arrange for the admission to hospital of B and her noisiness and unpredictable behaviour was the reason he gave for going out so often to his friend in Iffley Road

where he consumed alcohol and drugs.

ii) Jessie, his current girlfriend, caused him some concern but this appears to have been helpful rather than detrimental to his mental state and abuse of drugs and alcohol.

iii) John Rous's previous girlfriend had also reappeared in the last few weeks and she seems to have been a disturbing influence and she was abusing drugs to a major extent.

iv) John Rous described money troubles during early October. This was a chronic situation that had been exacerbated by his spending money whilst on holiday. The last straw seems to have been the £2.50 he could not extract from Jonathan Newby on the evening of 9 October.

v) Earlier in that final week John Rous had suffered from influenza and this is frequently followed by marked irritability.

vi) In his normal mental state John Rous was not predisposed to violent behaviour. However, on the evening of 9 October he was not in a normal mental state.

vii) Jacqui Porter House appears to have been a very close, perhaps almost claustrophobic community; many staff have described it as potentially explosive at that time. There was a feeling of tension and high pressure and this was exacerbated by B's acute psychiatric disorder. It is known that sufferers from schizophrenia are adversely affected by such domestic situation of "high expressed emotion".

viii) There is evidence that John Rous felt himself to be the odd-man-out at Jacqui Porter House. He often spoke of this and regarded himself as socially, intellectually and educationally inferior to most of the other residents who, he believed, had private means. Sometimes this resulted in his being morose and in isolating himself, at other times he would play the fool to get attention. He talked about leaving Jacqui Porter House.

ix) There was no history of a bad relationship between John Rous and Jonathan Newby.

5.6 ***Opinion***

All these four factors probably contributed to John Rous's mental state and

consequent violent behaviour. However, the evidence is rather against an exacerbation of his schizophrenic illness. This illness would in part account for his long history of maladaptive behaviour and his consequent need to be living in Jacqui Porter House, but did not seem to have contributed to the immediate circumstances. There was ample evidence of long-term personality disorder and this was probably an important factor in his developing a habit of drug and alcohol misuse. A very high dose of alcohol consumed on 9 October and a considerable amount of cannabis could of itself account for an unpredictable, irritable, excitable and potentially extremely violent mental state. When one takes into account the coming together of many deleterious social circumstances, especially those inside Jacqui Porter House, there is adequate evidence to explain his abnormal mental state in the hour or two preceding the homicide and also how he could be impulsively violent to the extent of stabbing Jonathan Newby.

Chapter Six

Homelessness and severe mental illness

6.1 John Rous presented a severe challenge to those providing care. He was homeless, he had a severe and enduring mental illness and a concomitant severe disorder of the personality. The problem which John Rous presented is not uncommon.

6.2 There is considerable evidence that there is a much higher prevalence of severe mental illness among homeless people compared with the general population. [1]Kavanagh et al suggest that 11% of all people with schizophrenia are homeless or living in hostels, lodging houses, or night shelters, a proportion almost matching the 15% in hospital and the 15% in specialist accommodation. Other research indicates that the prevalence of mental health problems and mental illness may be over 10 times greater among homeless people than among the general population; a 1994 survey by the Royal College of General Practitioners gave a figure of 25 to 50 times higher prevalence.

6.3 Studies in night shelters, daycentres and soup runs for single homeless people confirm this picture. Around one third to a half of people surveyed in these settings have mental health problems, and estimates of the proportion who have at some point lived in a psychiatric hospital vary from 10% to 20%. Although there is anecdotal evidence that the proportion with mental illness has increased, the problem is not new: figures only slightly lower were being quoted as long ago as 1981.

6.4 The overwhelming majority of homeless mentally ill people are not former long stay psychiatric hospital patients. In the London Homeless Mentally Ill Initiative study, less than 2% of those in touch with the specialist mental health teams had been in psychiatric hospital for more than one year, whereas 68% had spent an average of less than 3 months as an in patient at any one time. The typical picture was one of multiple short term admissions to psychiatric hospitals, and of a "revolving door" population rather than the traditional long stay.

6.5 Another frequent feature among homeless mentally ill people is the combination of a range of problems and needs. Alcohol or drug misuse may be combined

with a mental illness. Many people have diagnoses of personality disorders alongside speeific mental illnesses. Histories of involvement with the criminal justice system, often for multiple petty offences, are also common. This combination of problems often results in exclusion from service provision, with many health agencies excluding those with serious substance abuse problems, and many projects set up to tackle substance abuse excluding people with mental illness. Any record of violence adds to the exclusion from care. While such restrictions on client group may make perfect sense for each agency considered individually, the overall result is that some of the most vulnerable individuals at the highest risk receive the least service from formal care agencies, relying instead on night shelters and other projects for the homeless which are more tolerant of challenging behaviour.

6.6 Homelessness and mental illness are linked in both directions. Homelessness can cause great stress which can exacerbate some forms of mental illness and trigger illness in vulnerable people. It also means that it is much harder for the individual to gain access to care and for care providers to deliver a good quality service. Mental illness can lead to a breakdown in family relationships, time spent in hospital making it difficult to maintain a tenancy or hold down a job, loss of income to pay for housing costs, hostility from neighbours and landlords, and generally reduce the ability of the mentally ill person to cope with the problems of everyday life. Many mentally ill homeless people have had long term accommodation and lost it as a direct or indirect result of their illness; perhaps a quarter have lost a council or housing association tenancy. As access to housing of all types has become more difficult for people on low incomes, the opportunities to get back into ordinary accommodation have reduced. In this context, the large numbers of people with mental illness in hostels for the homeless is entirely predictable. Across the country, agencies set up to provide for homeless people, mainly charitable and voluntary sector, have become almost by default major providers for people with mental illness. Some have recognised the increasing needs, and sought to make effective links with psychiatric and social work agencies. However, this has rarely been an easy task: homeless people have often received low priority for services from statutory care agencies.

6.7 Even with good intentions, the task is difficult: homeless people may have multiple problems and some may have a deep mistrust of psychiatrists and other formal carers. Good outcomes are reliant upon the co-operation of several agencies at the same time. The homeless mentally ill initiative in London, with its specialist clinical teams and specialist rehabilitation hostels, has considerable

success. It has demonstrated clearly that tackling the housing and care problems at the same time is far more effective than tackling one or other alone. It has also emphasised the value of professional mental health staff in this work, both in the direct provision of care and as trainers and advisers to generic hostel staff. However, it is a costly service which required central government pump priming to get off the ground, has suffered from a lack of access to permanent supported housing and continuing care, and is currently restricted to London.

Oxford

6.8 Against this national picture, the situation in Oxford presents a pattern which is familiar yet more exaggerated. There is a particularly high number of homeless people, including single homeless people in night shelters and lodging houses. Included among them are a high and increasing number of people with mental illness. There have been fewer than average statutory services for such people, allowing the burden to fall even more heavily on voluntary agencies for the homeless. Oxford has had an unusually sharp divide between statutory services in the group homes for people with mental illness whose behaviour is acceptable to the homes, and voluntary services in hostels and daycentres for another 150 or so homeless people with mental illness.

Priorities for action

6.9 The inadequacy of arrangements in Oxford for homeless people with severe mental illness is not unique, but merely towards one extreme of a national pattern. A national programme is required to tackle this problem. The Inquiry was reassured to hear that this is an area which is receiving priority attention from the Department of Health. Our recommendations are as follows:

6.10 Health authorities, social service departments and housing authorities should consider establishing a specialist outreach and care team for homeless people with severe mental illness.

6.11 Authorities should view the quality and quantity of accommodation available in their area for homeless people with severe mental illness against an assessment of needs, and should plan the development of new accommodation and care services to fill any gaps.

6.12 Health authorities should offer to appoint a qualified mental health professional as a sessional consultant or adviser to residential care homes and hostels which house significant proportions of people with severe mental illness.

6.13 The Department of Health should review responsibilities and service provision for people with multiple problems of mental illness, personality disorder, and substance abuse, and require health and social services authorities to make adequate provision.

6.14 Health authorities should ensure that they purchase sufficient high care accommodation to meet needs in their areas, including the needs of those people who are currently housed in hostels where the staffing numbers and skills cannot adequate care. (This is a current Department of Health priority, but one where they are having difficulty convincing health authorities at local level.)

References

1. Kavanagh S, Opit L, Knapp M, and Beecham J (1994) People with schizophrenia: resource consequences of changing the balance of care, in Knapp (1994) The economic evaluation of mental health service, Avebury.
2. Craig T, Bayliss E, Klein O, Manning P, Reader L (1995) The Homeless Mentally Ill Initiative: an evaluation of four clinical teams, Department of Health (Currently in press, and due to be published by the end of June)
3. Anderson, Kemp and Quilgars (1993) Single Homeless People, Department of Environment
4. CHAR survey of 145 people begging in central London, 1994
5. Duncan, Downey, Finch (1981) A home of their own, Department of Environment
6. Duncan & Downey (1985) Settling Down, Department of Environment
7. Keating F et al (1992) Homelessness and Mental Health Initiative: One Year On, Research and Development in Psychiatry (now the Sainsbury Centre for Mental Health)

Chapter Seven

Health Care for the Mentally Ill in the Community in Oxfordshire

The Hospital and Community based services

7.1 During the 1980's and until 1 April 1994 hospital care for the mentally ill in Oxfordshire was provided at the Littlemore Hospital, the Warneford Hospital, the Elms Clinic at Banbury, the Barnes Unit attached to the Accident and Emergency Department at the John Radcliffe Hospital and the Park Hospital for Children. These hospitals were managed by the Oxfordshire Health Authority which was also responsible for the provision of community services. Within the Health Authority were various Units, one such being the Oxfordshire Health Authority Mental Health Unit which managed the mental health services provided in the hospitals and in the community. On 1 April 1994 the Oxfordshire Mental Healthcare NHS Trust was formed and this is now responsible for the management of hospital and community-based services.

7.2 In 1986 Dr Michael Orr, a Consultant Psychiatrist, took up the post of Unit General Manager of the Mental Health Unit. He held the position on a part-time basis combining it with clinical duties. On the formation of the Trust Dr Orr became the Chief Executive and he continues to combine this role with his clinical duties. Dr Orr gave evidence to the Inquiry and provided a number of documents which detail the progress towards and implementation of the Care Programme Approach in Oxfordshire.

7.3 Within Oxford there exists the Group Homes Organisation of the League of Friends of Littlemore, Warneford and Park Hospitals (Oxford Group Homes). In the 1970's and 1980's the Health Authority was carrying out a process of relocation of long-term-hospitalised patients to local homes and hostels in conjunction with the Oxford Group Homes. The aim of the Group Homes is to provide good standard homes for residents, a large proportion of whom are mentally ill. The task of providing accommodation for this group of people fell to the Group Homes, the Cyrenians, English Church Housing and other charitable and voluntary organisations in the absence of any similar provision by Oxfordshire Social Services.

7.4 Dr Orr told the Inquiry that in the mid 80's the Health Authority did not have an infrastructure in place in the community that would allow implementation of an

effective care programme. In 1986 there were just six qualified community psychiatric nurses across all care groups for the whole of the county. This evidence mirrors that of other witnesses who specifically commended the efforts of Dr Peter Agulnik for his outreach work. In 1986 the Oxfordshire Health Authority agreed a ten year strategy for Mental Health Services and a capital investment programme. By 1990 the Health Authority was working with Social Services towards a joint strategy for mental health. Dr Orr said that within Oxfordshire was "a sad history of poor co-operation between health authority and social services which dated back to well before I became general manager in 1986". He went on to say that this was compounded by a poor record of investment by Oxfordshire County Council in mental health services ("second from the bottom in terms of investment in mental health services nationally"). Mr Ian White, the present Director of Social Services, also spoke of this history of poor co-operation and of more recent efforts, beginning with the appointment of Ms Jean Carr as Divisional Director to improve working relations and effect a joint strategy for mental health services.

7.5 Perhaps the prevailing situation in the 1980's between the two statutory agencies could be summed up by this passage from the evidence of Dr Orr:
"There always seemed to be financial constraints on both authorities that appeared to shift the focus of planning more to what we could pass on to whom rather than how we can build services jointly".
Given the absence of an effective working relationship and a low priority given to funding it is hardly surprising that voluntary agencies within Oxford took on the role of providing accommodation and care for the mentally ill.

Dr Peter Agulnik

7.6 It appears that Dr Agulnik had known and treated John Rous from 1974, when Dr Agulnik was working as clinical assistant with Dr Mandelbrote, Consultant Psychiatrist. Dr Agulnik assumed consultant responsibility for John Rous in 1978.

7.7 Dr Agulnik knew of the aggressive outbursts by Mr Rous in the 1970s including the serious episode in December 1977, directed at the Unit Nursing Officer. A change in John Rous's management was instituted by Dr Agulnik in direct response to this violence. From that date Dr Agulnik avoided in-patient or day-patient treatment at Littlemore Hospital and treated John Rous as an out-patient. Subsequently, he received his depot injections from his general practitioner.

7.8 Dr Agulnik was treating John Rous for a schizophrenic illness. He was fully

aware that Mr Rous abused the anti-Parkinsonian drug benzhexol. He was conscious over the years that prescribing involved a balance between: the severity of schizophrenic symptoms which were at least partially alleviated by neuroleptic medication; this medication was given by injection in depot form every few weeks, and there was some deterioration in mental state towards the end of the interval between injections; if the dose of neuroleptic drug was too high Mr Rous would default on his treatment, and he was entitled to do this as he was not subject to the Mental Health Act; high enough dose of neuroleptic required treatment of side effects with an anti-Parkinsonian drug, and benzhexol was effective; Mr Rous was abusing benzhexol for its psychological side effects and was both obtaining tablets by illicit means and on occasions selling them.

7.9 There were many periods over the years when appointments were missed and Dr Agulnik inevitably lost contact with Mr Rous. At no time after 1978 was Mr Rous subject to the Mental Health Act and there were no grounds for this having been implemented. Dr Agulnik consistently gave advice concerning John Rous when requested and maintained contact with agencies directly responsible for John Rous, eg. Probation Service, General Practitioner.

7.10 As part of his responsibilities for rehabilitation psychiatry, Dr Agulnik was active in the establishment of the Elmore Community Support team. He understood that Angela Stannard, the Support worker from the Elmore Community team, was acting as key worker both before and after Mr Rous become a resident at Jacqui Porter House.

7.11 In the early 1990's John Rous had intended to reduce his dose of Flupenthixol following an increasing dose in response to a return of psychotic symptoms. Dr Agulnik was actively involved with the general practitioner (Dr Lee) in readjusting the dose and continued to see John Rous at approximately 6-weekly intervals.

7.12 In mid 1990 to 1992, Dr Agulnik was aware that John Rous was injecting himself intravenously. He also considered there to be depressive symptomatology and prescribed the antidepressant drug Lofepramine. In July 1992 John Rous's social circumstances had improved in that he had been offered a place at Jacqui Porter House and his mental state was also improved so Dr Agulnik reduced Flupenthixol from 2 to 3-weekly injections. Dr Agulnik last saw John Rous on July 12 1993 when he considered him more stable both in his social state at Jacqui Porter House and in his mental state. He considered that it would be sufficient to see him every two months. He was due to have seen John

Rous on 5 October but postponed this because of an unexpected professional commitment.

Comment

7.13 With John Rous's frequently fluctuating course, six-weekly visits to out-patients reduced to two-monthly seems appropriate. Cancelling the appointment of October 5 appears in retrospect unfortunate but there was no alternative and there was no perceived visit at the time. Had it taken place it is unlikely that any change in John Rous's treatment would have been instituted.

7.14 Medication was always a balancing act between psychotic symptoms requiring neuroleptic treatment, the unpleasant side effects of neuroleptic drugs such as Flupenthixol, the need for an anti-Parkinsonian drug such as benzhexol to treat the side effects and John Rous's abuse of benzhexol. In retrospect the balance appeared to have been about right and there is no evidence that an exacerbation of psychotic symptoms contributed to the homicide.

7.15 Dr Agulnik provided a consistently high level of care for John Rous, he was clearly concerned for his welfare and had established a good working relationship. He believed Angela Stannard to be carrying out the role of key worker and that residence at Jacqui Porter House had resulted in greater stability and a social improvement for John Rous. He had no grounds to visit Jacqui Porter House and could not reasonably do so without invitation. Because Angela Stannard came to out-patient appointments with John Rous, Dr Agulnik had not met the staff of Jacqui Porter House and was not aware of their lack of mental health expertise.

Dr Richard Stevens - The East Oxford Health Centre

7.16 Dr Stevens was the general practitioner responsible for John Rous from 6 June 1985 until April 1989 and from 17 July 1989 until October 1993. John Rous received his two or three-weekly depot injection from the practice nurses and would make an appointment so to do. He also received prescriptions for benzhexol from Dr Stevens. Dr Stevens was fully aware of the abuse of benzhexol and at one time circulated general practitioner colleagues with a warning concerning John Rous's attempts to acquire tablets by deception.

7.17 Dr Agulnik prescribed the dose of neuroleptic and recommended frequency but Dr Stevens was responsible for administering this and following up missed injections. This he did assiduously. The precise day on which John Rous received his injection was negotiated by him with the practice nurse and an

appointment was made. This arrangement was acceptable as John Rous was a voluntary patient.

7.18 Dr Stevens was aware of the abuse of benzhexol. He had taken precautions by advising his general practitioner colleagues. He had considered other forms of medication and also stopping anti-Parkinsonian medication altogether but on balance he believed that regular prescription of benzhexol was the best way of maintaining control. Over the years he had established a good relationship with John Rous and this was shown by the length of registration of John Rous with that general practice.

Dr Alyson Lee

7.19 Dr Alyson Lee worked as general practice locum with Dr Stevens in April 1989 and became a partner in the practice in May 1989. She saw John Rous on many occasions from 1989 until February 1993 which was the last occasion on which she saw him. She was fully involved and agreed with the course of management undertaken by Dr Agulnik and Dr Stevens. She had no involvement with John Rous in the months immediately prior to the homicide.

Care Programme Approach

7.20 Dr Orr told us that by October 1994 the Care Programme Approach had been fully implemented in Oxford In explaining why it took so long to implement the CPA Dr Orr said that the infrastructure was not in place to support the CPA. From 1990 onwards, alone and with Social Services, considerable work was done to implement procedures for discharges from hospital, care management and Section 117 arrangements. As a considerable amount of work to relocate long stay patients from hospital into the community had already been achieved, largely in partnership with Oxford Group Homes, further wards were not being closed so resources associated with in-patient care could not be moved into the community. The aim was to build on existing good practice, increase the infrastructure and arrive at a point when it was felt that the Trust could confidently implement the CPA.

Conclusion

7.21 We accept that from 1990 onwards real efforts were made to effect a joint strategy and eventually implement the CPA. It is a matter of concern that during the 1980's financial constraints and the absence of any real joint working between health and social services resulted in too few persons with appropriate health care qualifications working in the community.

7.22 It is clear that Health and Social Services are now committed to continued investment in mental health services and to achieving an agreed joint strategy. It would be realistic to assume that there is a need for the voluntary agencies associated with mental health services in Oxfordshire to maintain a significant role in the provision of accommodation and care.

7.23 When CPA was introduced, it was unclear to many hospitals/mental health services throughout the country whether it should cover anyone other than those under Section of the Mental Health Act; or patients being newly discharged from hospital. Even if the Care Programme Approach had been introduced in Oxfordshire by 1 April 1991, it seems unlikely that John Rous would have been subject to CPA, because:

1. He had been discharged from hospital for many years.
2. He was not subject to any section of the Mental Health Act 1983.

Chapter Eight

Oxfordshire County Council Social Services Department- Community Services for People with Mental Illness

8.1 During the 1970's and 1980's the role of the Social Services Department in the care of mentally ill people in the community in Oxford was notable for its virtual absence. One of the strongest impressions with which we were left at the close of evidence was the dearth of any interest or involvement by Social Services until the 1990's.

8.2 Witnesses who have been working with clients in the community in Oxford in the 1980's, be it in health or with voluntary agencies, were at one in their low or non-existent expectation of any support, assistance or input from the Social Services Department. Mr Ian White, the present Director of Social Services quite properly made no real attempt to defend the pre-1990's lamentable state of affairs and accepted that the funding of such care was one of the lowest priorities. He did point out that help could not be given to people in the community if Social Services were unaware of their existence. We are bound to say that those who were caring for the mentally ill in the community appeared to have learnt by experience and as a result made no real effort to involve Social Services believing it to be of little use.

8.3 With the exceptions of the brief attentions received from Approved Social Workers in June 1992, John Rous was never a client of services in the community provided by Oxfordshire County Council Social Services Department.

8.4 This reflects the fact that his care was primarily in the hands of the health services and voluntary agencies. It also reflects the reality that the Social Services Department provided no services to mentally ill people in the community in the Oxford locality until 1991, with the sole exception of hospital-based Social Workers in the psychiatric teams at Littlemore and Warneford. Most of the department's complement of Approved Social Workers under the Mental Health Act actually worked in community teams for elderly and disabled people and undertook mental health work only on statutory duties. Social Services provided no hostel or day care services for mentally ill clients, and its contribution in this field amounted to grant aid to voluntary agencies. Until the

establishment of the Elmore Community Support Team these grants were not tied to contracts which specified targets in terms of the quantity and quality of service to be provided and neither were liaison, co-ordination or review procedures defined. In her evidence, Ms Jean Carr, the department's Divisional Director for Oxford City since 1990, contrasted this sharply with the record for services to clients with learning disabilities and their families. From her account it appeared that the department's commitment to those services had monopolised the allocation from budgets for mentally disordered people, including Joint Funding resources provided by the health service since 1978.

8.5 The pattern began to change after 1991, notably when Social Services established a care management team for people with mental illnesses, and began to promote small local day centres. John Rous was not involved as a client of these services, having already established his links with the services of voluntary agencies.

8.6 It is perhaps not surprising that a service containing almost no resources, and little in the way of operational strategies or targets, should have been the subject of little or no significant planning activity. Indeed, if the department had set its overriding priorities on the development of services caring for clients with learning disabilities, it would be pointless to spend time on planning services for mental illness which would then remain as thin as the paper they were written on. However, in many other parts of the country the process of planning, especially under the Joint Consultative Process. relating to the use of Joint Finance, has since the late 1970's promoted the development of shared operational policies by health, social services and voluntary agencies.

8.7 In Oxfordshire such a framework for joint operation seemed almost totally absent. A number of witnesses have described the separateness of health services provision for mentally ill people, not only from Social Services, but from housing and voluntary agencies. It is significant that those witnesses commended the outreach work of Dr Agulnik and his hospital team as an exception to this general pattern. We could, however, identify no social work component within his hospital team's outreach to Elmore, to the Cyrenians, or to John Rous himself, and thereby no linkage to social services.

Care Programme Approach (CPA)

8.8 We were particularly surprised to find that, although Department of Health circular HC(90)23 had specified an expectation that health and social services should by April 1991 have set in place procedures for the Care Programme

Approach, there had been no activity to this end in Oxfordshire until late in 1993. The CPA was not in fact set in place until 1st October 1994, and then simultaneously with the introduction of Supervision Registers, which had been directed as a national requirement in the early part of that year.

8.9 It is of course a mistake to assume that paper policies and procedural notes will provide a safety net, especially for someone like John Rous, who had been an informal recipient of community services for many years. He was also a free spirit, going his own way and largely using health services on his own terms. At times he manipulated and exploited health services to support his fondness for Artane (benzhexol).

8.10 Nevertheless it has to be said that a locality whose population of mentally ill people was served only minimally by Social Services, and where their co-ordination with health services was unplanned, might well be the last to detect and respond to signs of disorder or distress from individual patients. It was particularly notable that only two of all the people in the staff of Cyrenians in October 1993 referred to the possibility of consulting an Approved Social Worker regarding B and John Rous, whilst four of them considered speaking to a CPN. None of them knew that the established route in a psychiatric emergency was to consult the GP, who would refer to a Section 12 approved doctor and ask Social Services to provide an Approved Social Worker for an assessment.

8.11 We consider that this gap in awareness cannot solely be regarded as the fault of the Cyrenians or of the Elmore Team members' advice to the staff of Jacqui Porter House. Health and Social Services staff should have advised the Cyrenians and other voluntary agencies of psychiatric emergency call out procedures. This would especially be needed for a newly registered house accommodating people with current, often long-standing mental disorders who were well known to psychiatric services. It would have been of general importance to workers in any of Oxford's voluntary agencies who provided care to the substantial number of people in the city with histories of mental illness, drug and alcohol abuse. Mr Ian White, Director of Social Services, estimated that at any time this group would number around 150 people.

8.12 In her evidence, Ms Carr told us that her department's Care Management Team had been established in 1991 as a community team for Oxford, staffed by Social Workers specialising in the care of mentally ill people and in support to their families. The improvement of liaison with health service staff was set as a high priority, and also with primary health services, housing and voluntary agencies.

We have found no trace of or reference to that Team's involvement in John Rous's care or with Jacqui Porter House.

Operational Liaison

8.13 Ms Carr acknowledged that liaison between Social Services and Oxford Cyrenians had been less than satisfactory in the 1980's. Following her appointment in 1990 she had discussed this with Michael Hall, but continued to find that referrals of clients from the Cyrenians were often made at crisis point, when options for action had become unnecessarily narrowed. Cyrenians staff could then become frustrated by social service workers' inability to propose an acceptable course of action, or the fact that the client's situation had so deteriorated that referral on to health service care had become the only option.

8.14 Ms Carr told us very clearly that she had found it difficult to build a bridge between Social Services and the Cyrenians. Michael Hall had for example never attended meetings of the steering group of voluntary agencies established by Social Services to identify the needs of homeless people and the shortfall of local services, in preparation for the NHS and Community Care Act.

8.15 The relationship with Social Services was by April 1993 under distinct pressure as a result of the NHS Community Care Act's implications and uncertain consequences for the Cyrenians. From then on funding to each new resident in each of the Cyrenians' premises registered as a care home would be dependent on Social Services workers' assessment of needs, instead of provided automatically through Social Security allowances.

8.16 Thus the agency with whom Cyrenians had had a quite distant relationship was now the agency to fund them.

8.17 From 1992 onwards there were in fact three lines of contact between Oxfordshire Social Services and Oxford Cyrenians:

i) With the Department's Commissioning Unit, led by Mr Nick Welch, which was determining the type, amount and price of services to be purchased from Cyrenians for Social Services clients.

ii) With the Department's operational staff, working under Ms Jean Carr, particularly Care Managers who would be responsible for assessment of future residents, the determination and review of individual placements.

iii) With the Department's registration and inspection team, under the leadership of Dr Roger Morgan.

8.18 Michael Hall in turn acknowledged that relationships between the Cyrenians and Social Services had often been poor, and at the time of introducing the NHS and Community Care Act, were typified by mistrust and uncertainty, frequently for long periods of time. He made a notable exception from the time of his appointment in 1992 of Mr Ron Church, who was the Social Services Inspector most closely involved in Cyrenian registered homes. He was always obliging and accessible to Cyrenians staff and had worked closely with Glynis Lapage in defining standards for the homes. It was Mr Church who in the Summer of 1993 had met Mrs Lapage and other managers to define how the evidently growing cash flow crisis was to be managed, in particular its impact on staffing levels in each home.

Conclusion

8.19 The evidence given by Mr Ian White and Dr Michael Orr was remarkably similar in its account of the lack in activity on the part of both statutory agencies in the 1980's. We are satisfied that real efforts are now being made, and we can only hope that the impetus of the last years continues.

Chapter Nine

Oxfordshire Social Services Independent Inspection Unit Registration of Jacqui Porter House (41/42 Rectory Road) pursuant to the Registered Homes Act 1984 - Staffing levels at Jacqui Porter House

9.1. Oxford Cyrenians sought to register a number of group homes and hostels under the Registered Homes Act in 1991, and in doing so were part of a widespread trend. After several years of restrictions on board and lodging benefits for residents of non-registered hostels, and their replacement with housing benefit in 1989, the benefits available to support registration were seen as a solution to funding difficulties, and the Inquiry heard evidence that registration was primarily driven by financial motives in the case of the Cyrenians.

9.2 The work of registration and inspection units was mainly concerned with homes for the elderly. The Inquiry heard expert evidence that homes for people with mental illness, drug and alcohol problems formed a small part of their workload. Projects for homeless people with such problems would be even less familiar to inspectors. There is little doubt that the level of expertise concerning such projects among inspectors would be lower as a result.

9.3 Most local and national guidance and procedures also concentrated on homes for the elderly. However, specific guidance on standards for homes for people with mental health needs was published by the Social Services Inspectorate in early 1993, and copies were circulated to every registration and inspection unit. We note that this guidance includes no specific requirements for numbers of staff on duty at any one time in homes for people with mental health needs.

9.4 The application for registration of 41/42 Rectory Road under the Registered Homes Act 1984 was made by Michael Hall on behalf of Oxford Cyrenians Ltd. He was the sole signatory to the application form dated 2 September 1991. It specified that fourteen bed spaces would be provided and that residents would fall within the following standard categories: old age; mental disorders, other than past or present mental handicap; alcohol dependence, past or present; drug dependence past or present. The date for establishing the home was to be April 1992.

9.5 Section 1 of the statutory application form identified that the applicant had been employed or had an interest in other residential homes ie, Simon House, 170 Walton Street, 26 London Place, Cyrox Houses (Oxford Cyrenian Community Group Homes); 195 Iffley Road (Treasurer, Stonham Housing, Oxford Branch). The applicant would thus have been familiar with the requirements laid down in the publication "Oxfordshire County Council Social Services Guidance for Registration - A Handbook for Proprietors and Managers of Residential Care Homes in Oxfordshire", which had been issued in January 1990 and was provided to all applicants for registration under the Act. As the Cyrenians were an existing registered proprietor, certain sections of the form did not have to be completed.

9.6 The handbook specified the procedure to be followed by applicants for registration, and outlined the authority's requirements with regard to the duties, experience and qualifications of proprietors and managers; the standard of premises and facilities; the number of staff to cover the day and night care needs of residents. The guidance was largely based on the standards specified in the booklet "Home Life". This had been published nationally in 1984 and endorsed by the Department of Health as a guide to good practice, and as official national guidance to Local Authorities under Section 7 of the Local Authority Social Services Act 1970.

9.7. All other sections of the form were completed in full with the exception of Section 2 relating to staffing, which requested details of the numbers, positions and qualifications of resident and non-resident staff, full and part-time. The only category completed was that for full-time non-residential staff, as follows:-

Position held	Qualifications	Weekly Hrs	No of males	No of females	Total
Project workers (see Appendix III)		50	4		200

9.8 We have been unable to ascertain what Appendix III definitely was, neither could witnesses now explain its significance. There were, however, two documents marked Appendix III published in July 1991, one of which was the Cyrenians' provisional job description for a Project Leader at Jacqui Porter House and the other was headed Oxford Cyrenian Community House Volunteer Job Description.

9.9 The Inquiry found that this serious gap in the documentation supporting the application set a pattern which persisted up to the time of Jonathan Newby's

death and was the subject of fundamental differences of understanding and of evidence submitted to the Inquiry by witnesses from the Cyrenians and those from Social Services. We searched for evidence that the actual staffing rotas for Jacqui Porter House had been checked by Registration Officers or subsequently examined by Inspectors once the home was operational. The only documented evidence was that the Registration Officer had circled the word "Yes" against the item "Staff Duty Rota" on the checklist of documents provided prior to recommending registration.

9.10. In a letter dated 30 August 1991 from Una Vickers, the Cyrenians' Development Worker, addressed to Mrs Verena Mitchell, Principal Inspector, Oxfordshire Social Services, she stated:

"Re: Application for Registration of Oxford Cyrenian Community Houses

I am writing further to our recent discussions on the Registration of our Community Houses.

I have pleasure in enclosing Applications for Registration, duly completed, on all our properties. I have not enclosed a full set of plans for Jacqui Porter House or 34 St Michael's Street. If you would like a copy of the full set of either project, please let me know, and I will contact the relevant architects. However, 39 Rectory Road which is part of the Jacqui Porter House project in association with Cherwell Housing Association and Oxford City Council, is due to open in the next two months. The refurbishment on 34 St Michael's Street will be completed by the 4th January 1992.

We are in the process of restructuring our staffing levels, and I have attached to this letter a copy of the new staffing structure which we are in the process of implementing. We are discussing with Oxford City Council and the Cherwell Housing Association the Eligibility Criteria for Jacqui Porter House and I have also included a draft copy of this criteria which is self-explanatory.

I have also included a copy of Licence Agreements which we ask our residents to sign, on moving to our Community Houses from Simon House.

I hope the enclosed is of some assistance to you in being able to register our houses under Part I of the 1984 Registration Act, and I look forward to meeting with you again soon to discuss this and any other information you may need.
Yours sincerely, ..."

Although this letter pre-dates the application signed by Michael Hall on 2 October 1991, it seems clear that the application in respect of Jacqui Porter

House was to be processed as one of a complete batch submitted by the Cyrenians to the registration authority.

9.11 Mrs Verena Mitchell confirmed to us that she had been the Registration Officer responsible for processing the application for Jacqui Porter House, and that the progress of the application was charted on a set of standard forms which were then in use by Oxfordshire registration staff. These provided a complete schedule of all of the items to be checked and cleared in the process of completing a registration and required the registering officer to mark significant dates.

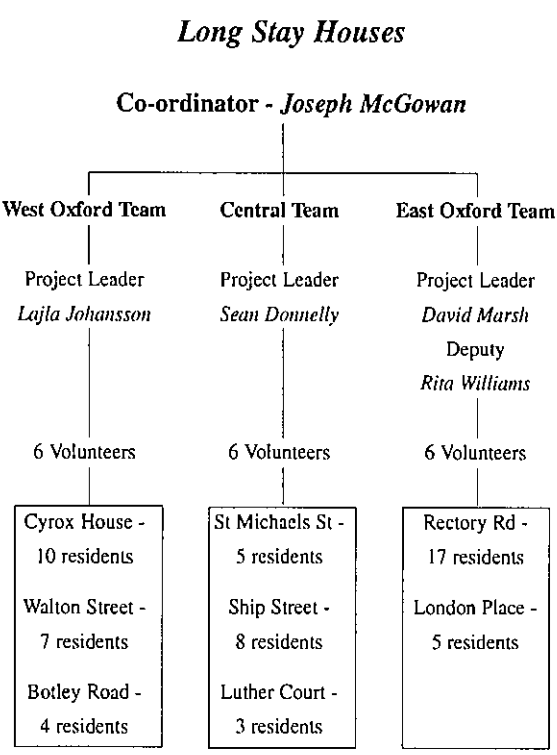
9.12. Several sections of the form which related to the background of the proprietors were deemed unnecessary, in view of the Cyrenians' existing status as a proprietor of registered homes. The form does, however, record the nomination of Mr J McGowan as Manager for whom a reference was provided by Mr J M Hall on 10 December 1991. Planning Consent was received on 27 November 1991, the Building Control Officer's report and the Fire Officer's report on 4 June 1992, the Environmental Health Officer's report on 29 May 1992. We have seen copies of all these documents, from the original files now held by Oxfordshire County Council Social Services Independent Inspection Unit.

9.13. The final check list is headed 'Documents Provided'. The "yes" item is circled for the following:- Detailed plans; Brochure; Contracts of Residence; Staff Duty Rota; Job Description. Only the item "Health and Safety at Work Policy Document" is marked "N/A". All of the items marked "yes" were available to us, with the significant exception of the Staff Duty Rotas. This is a matter of the greatest concern to us and has been pursued with all the related witnesses, including Mrs Mitchell, but to no effect. This issue assumed even more importance in view of our doubts as to whether the Inspectors who visited in December 1992, March 1993 and for the Annual Inspection in July 1993 did in fact examine staff rotas once the house was operational.

9.14 Mrs Mitchell as Principal Officer was able on 29 July 1992 to recommend that 41/42 Rectory Road should be registered, with the sole reservation that residents should be ambulant and that if they became immobile they should be transferred to appropriate accommodation. This recommendation was endorsed by Dr Roger Morgan, Chief Inspector, Oxfordshire County Council Social Services Department, on 30 July 1992 and approved by the Director of Social Services, Mr I A White, but his signature was undated.

9.15 The only documents detailing staffing structures which have been provided for the Inquiry which have a bearing on the registration and subsequent inspection of Jacqui Porter House are:

a) the "Revised Staffing Structures" referred to in Una Vickers's letter of 30 August 1991, which was drawn thus:



b) A staffing structure sent by Joseph McGowan, Group Homes Co-ordinator, to Verena Mitchell with his letter dated 14th February 1992. It relates to 39 Rectory Road, not 41/42 Rectory Road, but does describe the situations applying to the Cyrenians registered homes then and for the future in these terms:

"Please find attached the staffing structure for 4a & 16 Cyrox, and 39, Rectory Road, Jacqui Porter House.

The grid shows that we will have 24 hr. Cover on each project. This system will be applied to all registered projects in the future.

I hope this meets with your requirements. If there are any queries with this staffing structure please do not hesitate to contact me.

Yours sincerely, ..."

The grid dated 13 February 1992 and its explanatory note was as follows:

"Staffing - Jacqui Porter House, 39 Rectory Road

	MON	TUE	WED	THUR	FRI	SAT	SUN
Care Worker a	9am- 5.30pm	9am- 5.30pm	9am- 5.30pm	9am- 5.30pm	9am- 5.30pm		
Care Worker b	3pm-	9am. 3pm-	9am		3pm. 3pm	3pm	3pm- *9am Mon
Care Worker c			3pm	9am. 3pm	9am	3pm	3pm

The above table shows the format for staff cover for 39, Rectory Road. In addition there will be a deputy project manager working at the project from 9.00 am - 5.30 pm Mon- Fri, as well as other senior staff available during the day.

Outside normal working hours, including public holidays, there will be one senior member of staff on call.

Care workers b & c would alternate shifts weekly ie, from the above table Care workers b having finished 9.00 am Mon would come back on 3.00 pm Wed."*

9.16 Mrs Mitchell assured us that the staffing levels implicit from such a structure and grid could not possibly satisfy the requirements laid down in paragraph 3, on page 4.2 of the Authority's Handbook, which states that for a registered home with 9 - 16 residents there should have been:-

"in addition to the Proprietor/Manager,

a) Day care staff. There must be at least two members of care staff on duty throughout the day with an additional member of care staff on duty for the more active parts of the day."

b) Night care staff. One member of staff is required to be awake and one on duty plus one member of staff asleep on call in the home."

Paragraph 3 also states: "NB It is imperative that at no time will there be less than 2 members of care staff on duty".

9.17 Mrs Mitchell acknowledged that this apparently categorical advice might have been rendered somewhat equivocal by a table drawn from staffing proposals described in Annexe 5 in Home Life, which was located on an adjoining page in the Handbook. This table was headed "minimum day care staffing hours (per week) in private and voluntary homes". It indicated that a registered home for twelve mentally ill residents would require 96 hours in addition to the Proprietor's or Manager's hours. She acknowledged that this would have been insufficient to provide two people on duty from 7.00am to 10.00pm seven days per week. Mrs Mitchell initially stated that the proposals from Una Vickers and Joseph McGowan could not possibly have been accepted, and was sure that the standards laid down by the Handbook had been restated, in particular the requirement for 2 members of staff to be on duty. She acknowledged however that there was no correspondence on this important subject, neither was there any note in the registration check list. She acknowledged that her written recording had at times been deficient, but was categorically certain that the matter had been made known verbally to the applicants.

9.18. The registration forms asked whether a brochure had been provided for the registered care home, setting out its facilities. Verena Mitchell told us that the Cyrenians did not provide brochures as such, but did produce documents describing the role of each house. When her attention was drawn to an example in the Cyrenians files she agreed that this was the sort of document. Page 4 of this example stated that only one person would sleep in overnight, with another person on call for a group of 2 or 3 homes.

9.19 Verena Mitchell explained that this was agreed when Cyrox was registered - the first of the Cyrenians' group homes to be registered under the Registered Homes Act 1984. A letter from the Cyrenians confirming this arrangement was on the Inspection Unit files when she had checked them. The arrangement was solely intended to cover nights, from perhaps 10 or 11 pm onwards. It did not cover evenings, nor weekend daytimes.

9.20 Nonetheless it constituted an agreed variation from the standard requirements which she explained would have gone higher than her for approval. No specific forms were used at the time to document variations, but it would have been normal for the Chief Inspector to agree them. The Cyrenians could have interpreted this variation to apply to all their group homes, and nothing in later papers provided by the Cyrenians in respect of other homes indicated any variation in these staffing levels.

9.21 Mrs Mitchell retired from Oxfordshire Social Services at the end of 1992. Prior to her retirement Mr Ron Church had become responsible for the official inspection of Jacqui Porter House and other Cyrenian registered homes. Mr Church told the Inquiry that a minimum of two inspections per year were expected under the Registered Homes Act 1984. Although not required by the regulations, it was an additional practice of the Inspection Unit to inspect registered homes three months after registration and after the appointment of a new manager. Dr Roger Morgan provided us with a blank copy of the form which would be completed at such an inspection. The form specifically requires details of staff numbers, staff training and induction. Mrs Mitchell stated that it was standard practice to document all inspections.

9.22 In December 1992 Mr Ron Church carried out an unannounced inspection, four months after the registration of Jacqui Porter House. Mr Church appears not to have completed a form for this inspection. None has been found on the files and all witnesses from the inspection unit were questioned as to its existence. It does not appear that as a result of this inspection Mr Church raised any concerns regarding staffing levels at the home with any member of the Cyrenians staff.

9.23 With regard to staffing levels, Mr Church's written submission to the Inquiry states:-

"I can recall discussions with the senior managers of the Cyrenians about the use of volunteers as members of staff. Most of these discussions related to Simon House. It was always made very clear that the Inspection Unit would never accept volunteers being on duty without paid project workers on the same shift. It needs to be stated however that most of these discussions related to Simon House and night cover."

He further adds: *"I was aware that the Oxford Cyrenians were having difficulties in maintaining staffing levels because of financial restrictions. I attended a meeting at Simon House, called by the Cyrenians, to examine staffing issues because of their financial difficulties. The record of this meeting is on the file held by the Oxford Inspection Unit. Similarly the minutes supplied by the Cyrenians are on the same file. It was agreed at this meeting that the Cyrenians would complete a thorough review of all staffing requirements and submit their proposals to Dr Roger Morgan and myself on the 12th October 1993. This meeting was later postponed because of the sick leave of their director Mr Hall. It was subsequently cancelled because of the death of Mr Newby."*

9.24. On 2 March 1993 Mrs Judith Chandler, another Principal Inspector, visited

Jacqui Porter House. Mrs Chandler told the Inquiry that this was a familiarisation visit and was not an inspection.

9.25 The formal Annual Inspection was conducted by Mr Church on 14 July 1993, and the Authority's standard report document was completed and signed by him on 2 August 1993. Section 7 of the report covers staffing. It records as follows:-

71. Excluding the owners of the home, please give details of staffing:

	Numbers	Total hours per week	Home life recommendations
Day Care Staff	4	188	N/A
Night Care Staff	2	112	Normally 2 Project Workers and two volunteers on duty at any time.
Domestic Staff	-	-	
Cook	-	-	
Others	-	-	

NB: PLEASE ATTACH COPY OF CURRENT DUTY ROTA

72. Night Staff

a) No of Staff on waking duty each night.	-
b) No of Staff "on call" on the premises each night.	1

73. No of staff vacancies — 1

74. a) No of staff who have left since last Annual Inspection — N/A

b) Reasons for leaving

N/A

Mr Church acknowledged to the Inquiry that the totals of 188 day care hours and 112 night care hours could not have provided sufficient staffing to fulfil the additional note "Normally two project workers and two volunteers on duty at a time".

It is acknowledged that using the calculation assumptions of Home Life, these figures are sufficient to provide two members of staff during the waking day plus one at night.

We were unable to establish whether staff rotas had been seen by Mr Church and discussed with Cyrenians staff as a basis for the figures returned in Section 7 of the Inspection report form, which carried the instruction: "NB: PLEASE ATTACH COPY OF CURRENT DUTY ROTA".

9.26 Mr Church's report was concluded with the following comments:
"This was the first Annual Inspection at the newly refurbished Jacqui Porter House. As would be normally expected there are a few recommendations which are designed to ensure that the systems operating in this unit comply with the expectations of the Registering Authority.

The House offers a high standard of accommodation supported by an enthusiastic and committed staff team which consist of a mixture of full time employees and volunteers.

At the end of this, their first year, there is already evidence that the developing programme and the standards of service and accommodation are having a direct and valued effect on the residents' lifestyles.

During the Inspection I was able to have discussions with some of the residents, including a person who will be the first to leave to supported independent accommodation via a twelve month programme at Jacqui Porter House. All of the residents spoke highly of both the service, the commitment of staff and the standards of accommodation. All felt that this service appropriately met their needs and, because these needs were empathised, with their being able to make progress of a very positive nature."

9.27. It would appear that during the course of the inspection on 14 July 1993 Mr Church requested a copy of the draft brochure of Jacqui Porter House. By a letter dated 15 July 1993 Grace Scrimgeour, the Group Homes Co-ordinator for the Oxford Cyrenians, sent a copy to Mr Church. Of significance is the information on page 2 of the brochure under the title "Staffing and Support" which states:-
"Jacqui Porter House is staffed by a combination of paid staff and full-time trained volunteers, who provide 24-hour cover. There are generally 3 staff members available during the day and one at night. Staffing levels at the weekends are lower but a senior member of staff is always on call."
This document was in the file provided to the Inquiry by the Independent Inspection Unit.

9.28. A further Independent Inspection Unit document, the Annual Summary of Inspection visits to Private, Voluntary and Local Authority Homes, was signed by Ron Church as Inspector and J A Chandler as Principal Inspector on 5 August 1993. The conclusions contained in it were based on the Annual Inspection of 14 July 1993 and the Financial Inspection of 15 July 1993 and referred to the

unannounced introductory visit made by Mr Church in December 1992. **Section 9** of that report referred to staffing in the following terms:

"a) In relation to minimum standards in Oxfordshire County Council Guidelines

At the time of the Inspection there were no minimum standards set for staffing levels in this type of establishment.

The normal staffing levels during waking day are two paid Project Workers and two volunteers on duty at any time. These appeared to be an appropriate staffing level for the client group.

b) Inspector's Appraisal

The staffing group present as a committed, enthusiastic and professional team [whether volunteers or paid].

Discussions with the residents demonstrate that the end of the first year the staff team has become established and they both have empathy with residents' needs and a developing ability to meet their needs in an appropriate way."

9.29 In the course of taking evidence from Mrs Glynis Lapage of the Oxford Cyrenians, an apparent hiatus was disclosed in respect of the communication of information contained in both of these reports. Section 104 of the report and the final page of the Summary indicates that they were sent to the Proprietor for signature on 16 August 1993. The note to the Proprietor on the final pages of the report requests the Proprietor to sign a box to show agreement or disagreement with the report by 13 September 1993. In the latter months of 1993 Mrs Lapage was the Acting Director of the Oxford Cyrenians. She told us that she had not seen the report until it was produced by Social Services representatives to a meeting at Jacqui Porter House on Sunday 10 October 1993, which was attended by representatives of all the agencies involved. Judith Chandler stated that she believed Ron Church had been asked by Dr Morgan to go to Jacqui Porter House on the Sunday after the homicide. Inspectors would normally visit a home after notification under Regulation 14 of a significant incident at the home.

9.30 Mrs Lapage informed us that at the meeting she signed but did not date the report, at the suggestion of those present. The report was taken away by inspection officers. Subsequently the later date of 25 October was inserted in the report.

9.31 It was important for the Inquiry to establish who may have recovered the original

copy of the Report and Summary which had been sent to the Cyrenians on 16 August 1993. Such reports are routinely sent by the Inspection Unit to the registered Manager of a home at the address of the home. It seems clear that they had gone to Miss Grace Scrimgeour who had been named on the first page of the report as Manager of Jacqui Porter House at the time of the Inspection in July. Her written reply to our further enquiry on this point states *"the Annual Summary did not have a section for my signature and in fact was not returned to the Inspection Unit for some time, as I did not have an appointment to discuss it with Glynis Lapage when it was received. However, as I did not realise the point of confusion between the shifts that we operated and the Waking Day until after the investigations into staffing following Jonathan Newby's death, I would probably have signed it had I been required to immediately following the Inspection".*

9.32. With this qualification, relating to the Summary, all of the witnesses from the Cyrenians, be they past or present employees or volunteers, have affirmed to the Inquiry that the statements on staffing contained in the Report could not have been based on an examination of staff duty rotas at Jacqui Porter House, neither did they reflect established staffing practices throughout the Cyrenians organisation's registered residential homes at that time. We were impressed by the consistency of this evidence as it was given both by witnesses who were hostile to and supportive of the organisation.

9.33. All of the witnesses from Social Services, however, restate that the norms for staffing levels were understood to be these laid down in the authority's handbook. Mrs Verena Mitchell acknowledged that the apparently categorical advice which is contained in the statement *"NB. It is imperative that at no time will there be less than 2 members of care staff on duty", could be undermined by the table of staffing hours on the following page. She also emphasised that the handbook's advice amounted in the last analysis only to guidance. Mr Church said the same in his verbal evidence and his summary dated 5 August 1993 stated: "At the time of inspection there were no minimum standards set for this type of establishment".*

9.34 Roger Morgan's report to Ian White dated 3 February 1994 on the incident reviewed the staffing arrangements at Jacqui Porter House and the other Cyrenians group homes. From the summary of recommendations it is clear that in at least four homes, there were times when only one person was on duty. The Chief Inspector's report accepts this, requiring only that the one person should be at least at care assistant level. (Relevant homes are 39 Stockmore Street, 39

Botley Road, 31 Luther Court, 39 Rectory Road; some of these were registered under the small homes regulations.) We have noted that Dr Morgan's report mentions that the Cyrenians signed the inspection report as accurate on 25 October 1993, and it makes no mention of the circumstances in which it was signed which would have been known to Ron Church.

9.35 It has been put to us by a number of witnesses from Oxfordshire Social Services that the primary responsibility for providing competent staff in sufficient numbers and at all times lies with the proprietor or manager of a residential home. Furthermore, if there had been any confusion or uncertainty about staffing requirements or the interpretation of the clearly stated standard guidance in the Handbook for Proprietors and Managers, that it was incumbent upon the proprietor and manager themselves to seek to clarify that confusion in order to meet their legal duty of care.

9.36 These views, however, do not fit a situation in which a proprietor and manager believe that their existing practices, which they have not concealed, are known to and accepted by the responsible staff of the Registration Authority. Proprietors and managers may reasonably assume that Registration and Inspection Officers will bring to their attention any evident deficiency in relation to the standards required by the Registration Authority and that the Authority's officers will make sufficient enquiries including the examination of documentation in the course of registering an inspection the premises concerned.

9.37 We regret to say than no evidence other than verbal assurances and tick lists have been presented to the Inquiry by the Inspection Unit including its present and former staff members. We fail to see how it could be other than their prime responsibility to ensure that proprietors and mangers have understood the Registration Authority's requirements, by checking the source documents for the premises in question. It was self-evident to the Inquiry that the Registration Authority's check lists for registration and inspection expected just this. In particular Section 7 of the Inspection report carried the specific instruction: *"NB: PLEASE ATTACH A COPY OF THE CURRENT DUTY ROTA"*. We have received no evidence and been provided with no document which demonstrates that this instruction was ever fulfilled.

9.38 We conclude that the Registration and Inspection staff, in failing to fulfil their Authority's laid down procedures, did not detect the deficiencies of staffing at Jacqui Porter House in relation to the guidance which the Authority's staff had given to the proprietors and managers. We consider that the proprietors and

managers acted in good faith in continuing long established staffing arrangements and that they could have reasonably expected guidance to the contrary from the Registration and Inspection officers if they had detected those deficiencies.

9.39 There were a number of outstanding issues which we would have wished to pursue with Mr Ron Church. Mr Church gave limited evidence on 27 January 1995 and was granted an adjournment in order to provide adequate time to read relevant documents and to consider obtaining legal representation. Mr Church subsequently wrote and stated that as he could not afford legal representation he would not return to give evidence. In the initial letter sent to all prospective witnesses inviting them to attend to give evidence to the Inquiry they were informed that they could be accompanied by, amongst others, a lawyer.

9.40 Conclusions

1. The advice on staffing, derived from Home Life guidance, contained in the authority's handbook at the time of registration of Jacqui Porter House, was equivocal and may have been dangerously misleading.

2. We have been unable to find evidence that the staffing structure and draft rota presented by the Cyrenians at the time of Registration were rejected by the Registration Officer on behalf of the authority.

3. Subsequent visits and other contacts by Inspectors, and the Annual Inspection in July 1993 failed to hring to light that the staffing levels of Jacqui Porter House did not fulfil the Handbook's advised standards and were not as described in the Inspection Officer's report, which he stated reflected the information provided to him by the management staff of the home during the annual inspection visit.

4. The Inspector's report did not identify that:

   i) salaried staff at Jacqui Porter House were working to the hours between 9.00am and 5.30 pm or 7.30 pm from Monday to Friday and at other times were on call from home by telephone;

   ii) workers on duty at all other times, ie each evening, throughout every weekend and on Bank holidays, were all volunteers, usually working single handed.

5. We find it impossible to accept that the Inspectors did not know that this form of staffing had been general throughout the Cyrenians organisation for several years and that it did not change if Cyrenians houses became registered as Residential Care Homes.

6. If Inspectors were unaware of this basic fact it reflects very adversely on their diligence and/or competence.

7. We find it unsatisfactory that the Report and Summary of the Annual Inspection of 5 July 1993, which were sent to Miss Scrimgeour on 16 August 1993 were unknown to Mrs Lapage, until they were presented to her on 10 October 1993, in the aftermath of Jonathan Newby's death.

8. We conclude that she was given improper advice in being asked to sign it then, and that she was most unwise to have done so without checking its conclusions with great thoroughness, since it constituted the only written evidence that the Cyrenians organisation had been given specific expectations for staffing by the Registration Authority other than the general advice contained in the Handbook.

Chapter Ten

The Oxford Cyrenians

10.1 The Oxford Cyrenians were formed in 1967 by a group of university and townspeople who were concerned to provide accommodation and support for destitute, single, vulnerable and homeless people in Oxford. It was then known as the Simon Community and began in a derelict railway shed called Simon House. In 1968 Michael Hall began working as a volunteer at Simon House.

10.2 The Oxford Cyrenians Limited were incorporated as a company limited by a guarantee and registered as a charity in September 1970. In 1972 Michael Hall took over the running of Simon House and thus the Oxford Cyrenians. He worked full-time but covenanted his wages back to the organisation. Simon House developed from a night shelter to a 24-hour shelter. Michael Hall lived and worked in Simon House. He was assisted by volunteers.

10.3 In the early 1970's a steering committee of Oxford people was established to take managerial responsibility for the organisation. The steering committee became the Council of Management, elected members of the Council of Management are directors of the company.

10.4 In 1974 Michael Hall began a project to obtain funding to build a new Simon House. The new Simon House opened in March 1981. The house is owned by Cherwell Housing Trust on land leased from Oxford City Council. Simon House became the headquarters of the Oxford Cyrenians. It was also the reception and assessment centre for other Cyrenians hostels with the exception of Jacqui Porter House.

10.5 By 1981 Michael Hall was the Director of the Oxford Cyrenians. He was the driving force behind the organisation, and to many he was the organisation. The majority of people who worked with him were volunteers, those who sat on the Council of Management were supportive of him, and did not scrutinise or question his decisions.

10.6 Michael Hall's desire to provide a "panorama of homes each catering for a different category of the homeless" resulted in the opening of many homes. Between 1981 and 1992 the number of properties run by the Cyrenians increased

hugely. In 1984 the Registered Homes Act came into force and brought with it a means of funding homes pursuant to the Act. Simon House was registered in 1987. Funding pressures increased during the late 1980's as other sources of income were capped or cut. Finally the Council of Management took the decision to seek registration of all the larger group homes in 1992. The smaller homes were registered after the Act was amended to cover schemes with fewer than 4 beds, in 1993.

10.7 We list the various properties managed by the Oxford Cyrenians, when the home was opened, the number of persons for whom accommodation was provided and the date upon which any home was registered pursuant to the Registered Homes Act 1984.

Name of House/Address, date when opened:	No of Persons:	Date of registration:
Cyrox, 1972	10	27 February 1992
Simon House, 1981	64	19 February 1987
London Place, 1983	6	-
Botley Road, 1989	3	7 June 1993
Luther Court, 1989	3	7 June 1993
St Michael's Street, March 1990	5	3 August 1992
Stockmore Street, 1991	3	7 June 1993
2 houses Rectory Rd, 27 July 1992	12	1 August 1992
1 house Rectory Rd, 27 Sept 1992	5	1 April 1992
1 flat Rectory Road, 26 April 1993		7 June 1993
170 Walton Street, 1994	7	-

10.8 Michael Hall was described by many witnesses as a charismatic figure and they also commented that he was a skilled manipulator of people and meetings. It was clear that he would confront statutory agencies, individuals within them and any other organisation if he believed they could provide the assistance he required in order to open hostels or provide care for the individually homeless. It has to be remembered that Michael Hall's efforts were being made in the 1980's when Social Services were providing no real support, and the assistance provided by the Health Authority was limited. Michael Hall did single out Dr Peter Agulnik as a doctor who tried at no little cost to himself to help.

10.9 Perhaps because of his own experience of the statutory agencies and also because he took a pride in sorting matters out himself, the ethos which Michael Hall created amongst volunteers and workers within the Cyrenians was one of

managing any problem caused by a resident within the organisation, seeking outside assistance only rarely and often at a late stage. Such an ethos carries with it problems; it can become dangerous if those attempting to deal with the problem do not have the requisite training, qualifications and experience. The various hostels and homes were staffed by paid workers and "volunteers". Michael Hall does not accept that such an ethos was engendered by him, we believe it was. We do record that Audrey Moore in her oral evidence told us of efforts she made to involve other agencies. Her account of her efforts was corroborated by other witnesses.

Volunteers

10.10 Oxford Cyrenians recruited volunteers from three sources:

a) **Homes for Homeless People (formerly National Cyrenians).**
An application form, two written references and a medical certificate were required. We were told that each candidate would be interviewed at the Oxford Cyrenians. We are not convinced that this practice was strictly adhered to and query whether in fact every volunteer coming through this system received a formal interview at the Oxford Cyrenians.

b) **Community Service Volunteers.**
Interview prior to employment and access to references was not permitted to the receiving voluntary agency by this volunteer organisation. A written evaluation of the applicant was prepared by a CSV worker and a member of the Cyrenians could speak to this person. The volunteer would work for a trial period at the Oxford Cyrenians.

c) **Personal Applications**

10.11 We consider that the use of the word *volunteer* is inappropriate and proved a misleading and potentially dangerous misnomer. Volunteers were remunerated with their board and a small amount considered to be pocket money. In fact volunteers worked very long hours including a disproportionate amount of weekend and night cover. Their work was equivalent to that of a care assistant. Such a term would better describe their work and the expectations of management. In 1993 there was high unemployment both of graduates and other young people completing initial training. Many of the volunteers saw this work as a way into Social Work.

Recruitment

10.12 The philosophy created by Michael Hall was to recruit from within the organisation. Some external advertising took place, no formal methods of recruitment or interviews existed. The wages paid were low and may have

militated against attracting individuals who worked outside the Cyrenians. Significantly, the majority of the witnesses we saw who had been or were still employed by the Oxford Cyrenians had worked their way up within the organisation, many having begun as volunteers.

10.13 Project workers, the lowest level in the Cyrenians' employment structure, were virtually always promoted volunteers. Volunteers knew that if their work was appreciated there was likelihood of being promoted after about nine months to project worker at a salary of about £10,000 per annum. There was therefore a strong incentive for volunteers to fit in with the system, not protest too loudly and work for promotion to project worker which was seen as a useful stepping stone to further progress in Social Work and allied professions.

10.14 Within this system was something of the ethos of the school of "hard knocks", that is project workers and those more senior in the Cyrenians had been through the volunteer stage themselves and thought that it was quite appropriate for those joining the Cyrenians to demonstrate their enthusiasm for the work in the same way. We record that the Cyrenians do not accept that such an ethos was fostered.

Staffing System

10.15 Save for Simon House the system which operated throughout the Oxford Cyrenian homes and hostels was that the paid workers together with the volunteers would work the daytime hours between 9.00 am and 5.30 pm or 7.30 pm. If evening or weekend cover was required at any of the properties it would be provided by a sole volunteer with a more senior worker on call. Such a system totally ignores the fact that many of the residents will be out during the day but in during the evening. It assumes that residents are able to cope for themselves and that only a caretaking role is needed overnight. In this model it would be during office hours that staff would be needed to contact statutory agencies and try to sort out their rehousing and other needs; this is clearly inadequate for a registered care home. It also assumes that a volunteer will have the training necessary to manage a home and its residents alone. We are firmly of the view that the training provided by the Oxford Cyrenians to both volunteers and workers fell far short of any such standard.

Training

10.16 Within the Oxford Cyrenians no formal systems of training existed. In his written statement David Marsh described training in this way:-

"In the group homes volunteer and paid staff were supervised every 4 to 6 weeks by their line manager, Lajla Johansson or myself and sometimes by Joseph

McGowan. Training was mostly in-house and on-going; introduction to particular ways of working in the houses, dealing with situations that arose and the basic philosophy of the houses and how they were run. This was done individually with staff and often as a part of the weekly team meetings that took place. The above backed up through the Oxford Co-operative Training Scheme and day courses for voluntary sector staff; these courses dealt with areas such as basic counselling, alcohol and drug abuse, coping with violence etc. Staff also attended the food hygiene courses set up and run by the Environmental Health Department in Oxford."

10.17 There was a perception amongst the volunteers, although it was denied by the paid staff, that the external day courses were made available to paid staff and not the volunteers. No system appeared to exist to ensure that all volunteers and paid staff regularly attended day courses.

10.18 Joseph McGowan had obtained a Certificate in Social Services, and with that exception no one in the organisation had received recognised training in the care of the mentally ill. The training and supervision received by volunteers was entirely dependent upon the time, skill, experience and knowledge of the line manager, who more often than not had been recruited from ranks of the volunteers. Further, no formal system of staff appraisal existed.

Violence

10.19 Within the Oxford Cyrenians no written policy existed regarding the handling of and recording of incidents of violence. We were told that a violent incident would result in eviction. We received conflicting evidence as to how frequently this sanction was used. We are in no doubt that staff were expected to deal with incidents of violence and that an ethos of coping with and minimising such occurrences had developed. We are satisfied that no accurate record of such incidents was kept.

1992

10.20 The development of Jacqui Porter House is described in Chapter 14. It opened on 1 August 1992. It represented a departure from existing Cyrenian hostels in that the Cyrenians had no rights of nomination, and very limited grounds upon which to refuse admission, and residents would not have spent time in Simon House to allow assessment of their needs and problems. It differed from the other homes in that all its residents were severely mentally ill and were younger. One witness likened walking into Jacqui Porter House to walking into an acute psychiatric ward, "Everything was quite volatile, very much on the surface".

Notwithstanding this fact nothing was done to provide different levels of staffing, nor to ensure that those who worked there were trained in the care of the severely mentally ill. These differences seem neither to have been intended nor foreseen by the Cyrenians and were the result of the conflicting demands of funders. Jacqui Porter House was actually registered for a range of needs, of which mental illness was only one, yet all residents had current severe mental illness.

10.21 In August 1992 Michael Hall was still the Director of the Oxford Cyrenians. He was experiencing a number of personal difficulties. In or about April 1993 he began a period of compassionate/sick leave. He did not return to work for the Cyrenians.

10.22 Joseph McGowan was the Group Homes Co-ordinator. Mr McGowan had been a resident of the Cyrenians. Mr McGowan had begun working for the Cyrenians as a volunteer in 1981, he became team leader at Simon House and in 1985 was promoted to the position of manager of the external houses. In 1987 the Oxford Cyrenians seconded Mr McGowan to a Social Work course, and he obtained the Certificate in Social Services in 1989. By 1990\1991 Mr McGowan told the Inquiry that he was concerned about the manner in which the Oxford Cyrenians had changed, in particular how monies were being utilised on administration as opposed to employing skilled staff to work in homes. He raised these concerns with Michael Hall, the only result being a deterioration in the relationship between the two men. Michael Hall denied that any concerns were raised by Mr McGowan.

10.23 David Marsh was the project leader and became the manager of Jacqui Porter House. He had worked for the Cyrenians as a volunteer between 1983 and 1984. From 1987 to 1991 he was Deputy Community Leader, Group Homes. In October 1991 he became a project leader, later manager for the Jacqui Porter House and when the homes run by the Cyrenians were divided into North and East sectors, manager of the East team.

10.24 By August 1992 Joseph McGowan and David Marsh told the Inquiry that they had serious coneerns about the Oxford Cyrenians. Both felt it had lost direction, lost its philosophy of caring for single homeless people. They were concerned that Simon House and Jacqui Porter House were dealing with a different client group, the emphasis of the clients being upon mental illness as opposed to homelessness and that there were insufficient staff and in particular insufficiently trained staff to cover these hostels.

10.25 We gained the clear impression that both these men but, in particular, Joseph McGowan felt that their concerns were not being heeded. Michael Hall was not responding. The Council of Management did not question decisions and thus Michael Hall was neither accountable nor answerable to it. Michael Hall made difficult any access by Joseph McGowan and other staff to the Council of Management. In short Michael Hall ran the Oxford Cyrenians as he chose, unencumbered by any supervision or restraint by the Council of Management. We believe it likely that the poor relations between Michael Hall and Joseph McGowan contributed to the Cyrenians' failure to identify and resolve the problems of the different and much more demanding client group in Jacqui Porter House.

1993

10.26 About January 1993 Joseph McGowan left the Oxford Cyrenians. He told us that his reason for leaving was because his concerns were not being met. He felt that better staffing, people who were skilled and qualified to deal with the new type of resident were required. Another reason given for leaving was that the ethos and working structures were too much dominated by Michael Hall and his circle of confidantes. This evidence as to stated reasons for leaving is not accepted by the Cyrenians.

10.27 The departure of Joseph McGowan affected David Marsh who believed he had lost a source of support and supervision. On 12 March 1993 David Marsh left the Oxford Cyrenians. Grace Scrimgeour was appointed Group Homes Co-ordinator with effect from 19 April 1993. She held the post until 17 May 1994 when her employment was terminated by the Oxford Cyrenians. When she took up the post Michael Hall had commenced his period of compassionate leave. In her written statement Ms Scrimgeour stated:- "..... due to problems in the senior management I received an incomplete induction into the systems of the organisation and little or no support and supervision." It would appear that Michael Hall's period of compassionate/sick leave commenced a matter of days following Grace Scrimgeour's appointment. As Group Homes Co-ordinator Grace Scrimgeour had responsibility for the management of six registered care homes, two unregistered care homes and two unregistered group homes. Prior to working for the Cyrenians Ms Scrimgeour had worked as a housing manager at a resettlement agency. She possessed no social work nor mental health qualifications. We have been informed that Michael Hall did not commence his compassionate leave until July. Whatever the form of the arrangement we are satisfied that from April he was notable for his absence.

Glynis Lapage was working for the Oxford Cyrenians as Financial Administrator when in April or May 1993 she was asked to take on the role of Deputy Director. In July 1993 Dame Penelope Jessel asked Mrs Lapage to take on the role of Acting Director from 5 July 1993 to 3 October 1994 whilst Michael Hall was on extended sick leave.

10.28 Following David Marsh's resignation Lajla Johansson was asked by Michael Hall to manage Jacqui Porter House. Lajla Johansson had worked as a volunteer at the Oxford Cyrenians from July 1985 to December 1986. She thereafter worked at Littlemore Hospital on the Phoenix Unit as a nursing assistant for two years, at the Oxford night shelter as a night care worker, for Cherwell Housing Trust as a housing assistant and at English Churches Housing Association. Between September 1991 and February 1994 she worked for the Oxford Cyrenians as a Group Homes Manager responsible for Cyrox House, 170 Walton Street, 39 Botley Road and 34 St Michael Street. Ms Johansson refused the position of manager as she did not believe she had the necessary skills, experience and qualifications for the job. In evidence Ms Johansson said that these should be provided for by a social worker with a lot of mental health experience or by a psychiatric nurse.

10.29 Michael Hall denies any suggestion that he asked Lajla Johansson to manage Jacqui Porter House.

10.30 The post of project manager of Jacqui Porter House was offered by Michael Hall to Audrey Moore, a team leader at Simon House. Mrs Moore accepted the appointment. Audrey Moore began working for the Oxford Cyrenians as a cleaner in Simon House in 1990. After some three months Mrs Moore became a care worker and after approximately seven months she became a team leader at Simon House, a position she held for a year. In 1992 Mrs Moore obtained a City and Guilds qualification in care and management and subsequently attended courses dealing with the mentally ill, the elderly and working in a hostel environment.

10.31 It was in March 1993 that Mrs Moore took up the appointment of temporary project manager of the East team. From 31 October 1994 Mrs Moore has been the manager in charge of the now unregistered group homes. In her written statement to the Inquiry Mrs Moore stated that: *"My general life experience of being a mother, cleaner, care worker and Simon House Team Leader provided me with a great deal of varied experience with which to conduct my role as Project Manager, and thereon as Group Homes Manager/Assistant."* We are of

the view that Audrey Moore's qualifications, experience and resultant skill were less than equal to the task of managing a home containing 10 or 11 severely mentally ill residents, directing and supervising staff, the majority of whom were untrained.

10.32 On dates which have not been clarified Lajla Johansson told the Inquiry that she informed Grace Scrimgeour and Glynis Lapage of her concerns regarding Audrey Moore's ability to run Jacqui Porter House. Ms Johansson did not believe that Mrs Moore had the experience and skill to carry out the task, she was concerned that staff were not receiving sufficient supervision and direction from Mrs Moore, that project workers were playing too great a role and undertaking tasks which were those of Mrs Moore. Ms Lapage refuses any suggestion that she was approached by Ms Johansson. Staff who worked with Audrey Moore spoke highly of the support which she gave to them.

10.33 Audrey Moore told the Inquiry that she perceived Jacqui Porter House as providing supportive housing, allowing residents to develop personal skills which would lead them towards independent living. Given the illness of the residents we consider that the care which they required went far beyond that of supportive housing.

10.34 Audrey Moore was having to carry out a job in the absence of an effective superior or line manager who would be able to provide supervision or advice. Grace Scrimgeour was by experience an administrator. It was the evidence of a number of witnesses that whatever Grace Scrimgeour's defined duties she played no real role in the running of the various homes. Her involvement in the homes and the support which she was able to give to the senior staff contrasted sharply with that previously provided by Joseph McGowan.

10.35 Glynis Lapage made it clear to the Inquiry that her role in the Oxford Cyrenians prior to July 1993 had been financial together with an element of administration. She played no part in care management. We accept this evidence.

10.36 Ms Lapage told us that by June 1993 Michael Hall was into a "burn out" situation. Stress occasioned by the suicide of a close friend had been exacerbated by an accumulation of domestic crises. It was in July that his leave was formalised and Ms Lapage took over. Prior to leave being formalised Michael Hall was taking extended absences, locking himself away in his office, arriving at the organisation and without consultation varying instructions previously given by existing staff. His behaviour was creating considerable

difficulties for senior staff attempting to run the organisation in his absence.

10.37 The departure of Michael Hall allowed others to explore the administrative chaos which he had left. By September 1993 the Council of Management had become aware that a review of the Cyrenians' financial and management practice was required. Glynis Lapage commenced such a review.

The Council of Management

10.38 We took evidence from Dame Penelope Jessel, Mrs Elizabeth Leyland and Mr David Belton. Dame Penelope and Mrs Leyland have been and remain members of the Council. Mr Belton sat on the Council, initially representing Cherwell Housing Trust and thereafter in his own right. Dame Penelope accepted that during the 1980's the Council never questioned the decisions of Michael Hall. They relied upon him to inform them of what was going on. He was their sole channel of communication. Attempts to invite other senior staff within the organisation to attend meetings met with outright hostility from Michael Hall and the Council did not pursue the matter. Papers for meetings would arrive late with little time to digest their contents.

10.39 No one on the Council of Management had any real idea of what was going on in the organisation. By 1991 David Belton had concerns about the running of the organisation. In January 1992 he wrote to the Committee of Management, and we produce that report as Appendix 2.

10.40 As a result of the report the Financial and General Purposes Committee was set up and began for the first time to explore financial and administrative issues. The concerns of Mr Belton were met with hostility from Michael Hall and some of the members of the Council. It was only following the departure of Michael Hall that the full extent of the disorder created by him was discovered.

10.41 Following the departure of Joseph McGowan and David Marsh a meeting took place in April 1993 between the two men and Dame Penelope, Mrs Leyland and Mr David Belton. Joseph McGowan and David Marsh expressed in forceful terms their criticisms of Michael Hall, the problems that were present, the risks being created at Jacqui Porter House. Neither Dame Penelope nor Mrs Leyland gave their criticisms the attention which they warranted, they failed to take any steps to act upon them. Save for one or two visits neither Dame Penelope nor Mrs Leyland had spent any time in Jacqui Porter House.

10.42 The Residential Care Homes Regulations 1984 {SI 1984 No 1345} place certain

duties on the proprietors or "persons in control" of registered care homes. Regulation 19 says that:

> *19 (1) Where the person in control of the home is not also the manager of the home he shall at least once in every month visit the home or arrange for another person to visit the home on his behalf and to report in writing to him on the conduct of the home.*
>
> *(2) Where the person in control of the home is a company, society, association or other body or firm, the directors or other persons responsible for the management of the body of the partners of the firm shall arrange for one or more of their number to visit the home at least once in every month and to report in writing to them on the conduct of the home.*

10.43 These regulations are clearly set out in the Oxfordshire Guidance for Registration. In the case of Jacqui Porter House, the Cyrenians were the registered person in control and these duties fell on their Council of Management. There was confusion among the members about this: Dame Penelope Jessel as acting chairman had believed that Cherwell were the proprietors, but others knew that the Cyrenians were registered in this role. Una Vickers undertook the inspection role and reported on a verbal rather than written basis to the Finance and General Purposes Committee. Given her role in the organisation it is not surprising that her reports concentrated on bricks and mortar problems. The Cyrenians committee were insufficiently aware of the duties imposed on them by the registration to realise that this was an inadequate arrangement.

2 to 9 October 1993

10.44 In Chapters 3 and 4 we have set out the events in Jacqui Porter House during this time. We do not intend to repeat this evidence nor our observations.

Conclusions

10.45 We believe that by 1992 the Oxford Cyrenians organisation had grown out of all proportion to that originally envisaged and had done so very quickly. The growth did not coincide with the development of appropriate systems for:

i) recruitment of staff;
ii) supervision of staff;
iii) training of staff;
iv) appraisal of staff;

v) the provision of appropriately trained and qualified staff in sufficient numbers to care for a changing client group;

vi) organised care management procedures of care plans, the appointment of a key worker;

vii) general administration

10.46 By 1990 Michael Hall was attempting to carry out duties which had grown with the organisation. The size and scope of the duties were beyond the performance of any one person. Michael Hall insisted upon retaining them for himself and effectively excluded the involvement of senior staff in the organisation. The Council of Management should not have allowed Michael Hall to continue his role, a fact which they now accept.

10.47 The Council of Management failed to ensure that the Director developed these systems, and they also failed in their own duties to:

- require adequate management information and reporting on the key aspects of the operation, including housing management, care services, staffing and complaints, in addition to development and finance;
- establish a proper management structure including a senior management team who should have had access to the Council and been required to report to it;
- clarify their own roles and duties as committee members of a charity;
- consider the membership, skills and experience necessary for the Committee and check that they covered the required ground;
- train and brief themselves about their own duties and to keep up to date with expectations and issues in the areas of the charity's activity;
- establish a complaints procedure and ensure that there were appropriate routes for staff to report abuses and serious concerns;
- take external, independent and professional advice from time to time

Post October 1993

10.48 Following the death of Jonathan Newby the Social Services Department requested and funded a review of the "operation, service delivery and management of the Oxford Cyrenians". It was carried out by Julia Unwin and Clare Tickell. In March 1994 an interim report was presented to the Council of Management. Following the interim report Mr Bob Willsmore was appointed Temporary Director with effect from April 1994. Mr Willsmore had been a Divisional Director of Social Services in Oxfordshire. In December 1994 the appointment was made permanent: it is a part time appointment.

10.49 In May 1994 the final report by Unwin and Tickell was produced. The Oxford Cyrenians implemented various steps to investigate and implement the recommendations in the report. We reproduce the written appendix (Appendix 3) presented to the Inquiry by the Cyrenians to demonstrate the steps taken. We would stress that, although a copy of the Unwin\Tickell report was produced to this Inquiry, we conducted our inquiry de novo and include the recommendations only to show the subsequent efforts made by the Cyrenians.

10.50 We are in no doubt that since October 1993 the Oxford Cyrenians have made considerable efforts to identify and remedy defects in their systems and organisation. We cite examples of some actions taken:

1. Deregistration of six properties, closure of five;
2. Improved staff selection, external recruitment;
3. Improved staff training and a written induction programme which we found comprehensive and appropriate;
4. Development and implementation of 16 new policies including violence and complaints policies;
5. Volunteers work as additional helpers, never alone;
6. Increased rota cover;
7. An enlarged Council of Management to include those with relevant professional experience and expertise;
8. The Financial and General Purposes committee meets approximately monthly and examines policy documents, proposed developments, personnel issues, financial matters and progress of projects;
9. Strengthened links with statutory care agencies;
10. A strategy review group consisting of all levels of staff and chaired by the Vice Chairman of the organisation to review all aspects of practice and policy.

Staffing

10.51 The inquiry was told that over the last twelve to fifteen months a major overhaul of staffing structures at all levels has taken place. At Appendix 4 we reproduce the new staffing structure. We express the hope that those who hold the positions set out have now received the appropriate training for the task.

Jacqui Porter House

10.52 In October 1993 the Council of Management decided not to admit any further residents to the house. In March 1994 the Social Services Department served a Section 20 notice upon Jacqui Porter House requiring it to comply with the staffing levels of the Registered Homes Act. The requirements of the notice

were met and discussions ensued between Bob Willsmore and Oxfordshire Social Services Department, and Oxford City Housing Department as to the future viability of the house. On 30 September 1994 Jacqui Porter House closed. It is to reopen with a new remit and under a different managing agency.

Final Observation

10.53 In this chapter we have criticised many aspects of the system and practices prevailing in the Oxford Cyrenians prior to October 1993. We consider it appropriate so to do. We would wish to place in context our criticisms: The Oxford Cyrenians were able to grow because the provision of accommodation, care and support for the homeless mentally ill in Oxford by the two statutory agencies was absent. Even in 1992 and 1993 when Jacqui Porter House was operating, statutory care professionals were ignorant of the level and nature of care provided at the home: we do not criticise the Cyrenians for this omission.

Chapter Eleven

Elmore Community Support Team

11.1. The Elmore Committee's research findings were presented in a Report which was first published in 1987. The aim of the initial project was to demonstrate a new way of providing care in the community by setting up a flexible team of peripatetic workers who would be in contact with 'difficult to place' (DTP) people where they were and, by drawing in other relevant agencies, would provide support appropriate to the clients' needs.

11.2 The original proposal was that support for the DTP depended on bringing together the many agencies and services concerned with the clients. It became apparent, however, that since the research was undertaken an intricate network of inter-agency panels had been developed in the city. There was, in addition, an excellent primary health care clinic for patients with no fixed address through which they could be referred to the appropriate health services; there was also increased direct support from the Mental Health Services.

11.3 As a result of these developments the existing agencies were able to contain the DTP in the short term, but there were limited resources for continuing support for these in hostels or for clients with long-lasting disabilities.

11.4 In May 1988 the Committee received a grant from the then Department of Health and Social Security to set up a pilot project.

11.5 The Elmore Community Support Team became fully operative in January 1989 with Department of Health funding until April 1990. Thereafter, evaluation having proved positive, the scheme has been supported by grants from Oxfordshire Social Services and Oxford City Council, help with premises from the Probation Service, the secondment of the Team's CPN member from the NHS Trust, and a second member of staff from the Probation Service.

11.6 The Team consists of:

- a co-ordinator BA (Hons) trained counsellor;
- 3 support workers: 1 community psychiatric nurse,
  1 social worker,
  1 BA (Hons) trained counsellor;

- 2 part-time secretaries;
- 1 research worker, funded by the Mental Health Foundation to undertake research into the needs of mentally disordered offenders.

Shortly after the Team became operative in January 1989 the Social Services Department appointed a money management project worker for eighteen months and placed them to work in close co-operation with the Elmore Community Support Team.

11.7 The objectives of the Elmore Community Support Team as defined in its handbook were as follows. (They were modified slightly in the light of experience, and a Mission Statement and new Aims & Objectives were adopted in 1994 and are attached as Appendix 5 to this Report.)

1. *"To create a flexible and highly responsive team for those (DTP) individuals who have slipped through the existing provision and need guiding back to it.*
2. *To offer community support to those individuals identified by agencies as being at risk of becoming DTP, who, with appropriate support, could be helped to stay in a stable position within the network of existing provision.*
3. *To identify suitable accommodation in the community with the co-operation of the housing agencies.*
4. *To provide follow-on support to individuals and agencies. Having placed an individual within the existing network of provision, close liaison with the agencies concerned and continuing involvement with the agency workers and the client would be required to promote the individual's chances of stability.*
5. *To offer support to DTP clients who appear before the courts where they pose difficult sentencing problems because of the lack of suitable disposals.*
6. *To offer the resources of the Team for education and training about the DTP and the ECST to workers, volunteers and agencies.*
7. *To promote network liaison at a high level. Existing inter-agency co-operation is already a feature of provision. This will be encouraged and strengthened, and extended to include discussion at all levels.*
8. *To evaluate progress and achievement in these objectives, and gather further information about the factors leading individuals to become DTP and about effective methods of intervention and prevention."*

11.8 The overall responsibility for management of the Team lies with the Elmore Committee. In order to ensure inter-agency co-operation at a high level, the Committee has been extended to include representatives from senior management of Mental Health Services, Social Services, the Housing Department, Thames Valley Police and the voluntary sector. The Probation Service has been represented by the Chief Probation Officer. The Committee is concerned with broad policy issues and has taken responsibility for investigating the future funding of the project. The Inquiry received written and verbal evidence from Ms Jean Carr, Divisional Director of Social Services, and Dr Michael Orr, then Unit General Manager of Littlemore Hospital (now Chief Executive of the Oxfordshire Mental Healthcare NHS Trust), who are members of the Elmore Committee, both of whom testified to the focal role of the Elmore Team in the care of people in Oxford who suffer from mental illness and are difficult to place, or to support via conventional Health and Social Services.

11.9 The original working party has been designated the Management Sub-Committee and has been charged with responsibility for the day-to-day management of the Team. The membership of the Sub-Committee has been extended to include a representative of the following: Social Services, Probation Service, a local Housing Trust, two consultant psychiatrists and a former JP. The sub-committee meets monthly and reports to the Elmore Committee which meets three times a year, and refers all policy recommendations for approval. The Team co-ordinator attends meetings of both the Elmore Committee and the management sub-committee to which he is immediately responsible for the development of the project and the operation of the Team. He has full operational responsibility for the project and communicates agreed policy decisions to all members of the Team. The membership of the Management sub-Committee is as follows:-

Dr David Millard, Oxfordshire Mental Healthcare NHS Trust - *Consultant Psychiatrist (Chair)*
Miss Pat Goodwin - *Former Senior Probation Officer*
Mrs Dorothy Wilson - *Former Team Manager, Social Services*
Mrs Caroline Roaf - *Special Needs Teacher, former JP*
Miss Annabel Wilkes, Cherwell Housing Trust - *Housing Manager*
Mrs Kath Morris, Oxfordshire Probation Service - *Senior Probation Officer (Joined 1994)*
Mr Tim Skinner, Oxfordshire Social Services (Joined 1993) - *Team Manager, Social Services*
Dr Peter Agulnik, Oxfordshire Mental Healthcare NHS Trust - *Consultant Psychiatrist*

11.10 Liaison with other agencies takes place in three ways: at policy level, the Elmore Committee and the co-ordinator will liaise with the senior management teams of statutory and voluntary agencies in order to co-ordinate and develop provision; at the day-to-day level, the sub-committee includes representatives from the statutory and voluntary agencies; in undertaking client work, Team workers will liaise with individual agencies in the identification, referral and support of DTP individuals. Referrals can come from individual agencies, the inter-agency referral group and the network meeting. In addition, DTP persons identified by the Team will be accepted onto the Team's case load as appropriate.

11.11 In January 1989 the following guidelines were sent out to all agencies which might be concerned with referring individuals to the Team:

"'Difficult to place' refers to the difficulties that agencies have with some clients who do not clearly fall within the responsibilities of a single agency, it does not simply refer either to difficult clients or those who are difficult to house."

"Clients should display multiple problems rather than single intractable problems; combinations of some or all of the following are likely; homelessness, general health, alcohol/drug use, lack of social skills, offending, mental disorder."

"The client is likely to display bizarre or disordered behaviour."

"Referring agencies should be clear about any other existing responsibility for the client, so as to avoid duplication of support services."

"Referrals can be made by letter, by telephone or by direct contact with a team member, no referral form is required. As much relevant detail as possible should be available at this point to enable the team to make an assignment."

"The team will either offer an immediate interview or refer the case on to its weekly team meeting, dependent on the urgency of the case and on existing workloads."

11.12 We interviewed Jon McLeavy, Co-ordinator of the Team since its inception in 1988, and Angela Stannard who joined the team in October 1988.

11.13 Mr McLeavy had previously worked as the resettlement worker for the Oxford Cyrenians for five years, thereafter as the Co-ordinator of the Luther Street Centre for $2^1/_2$ years. He possessed no formal qualifications in mental health but had completed local training in counselling and originally graduated in Politics and English.

11.14 Mrs Stannard qualified as a state registered nurse in the 1970s and after a break to bring up her children took up voluntary work at The Mill centre, as a result of which she was encouraged to train as a generic social worker at Oxford Polytechnic where she qualified in the summer of 1988.

11.15 The Elmore team members had decided to work in a manner which Mr McLeavy describes as "de-roled". We understand this to mean that each member handled referrals on the same terms rather than according to his or her original professional discipline, but that members shared each other's knowledge and experience if the needs of the clients would be better served.

11.16 Each worker received fortnightly individual supervision from the Team Leader, when cases are discussed in detail. Notes on these reviews have been held on a staff supervision file rather than in clients' case notes, in view of the agency's policy of client access to records. We have examined the supervision notes relating to Mrs Stannard and found that at the outset they took the form of a list of client's names and a brief note of present circumstances or activities. These notes however petered out from July 1991 onwards. During 1992 there were almost no summaries at all either for clients or in relation to Mrs Stannard's personal progress. The monthly supervision summaries for 1993 amount to lists of names of clients with just a brief note, often of two or three words, alongside some of them. John Rous's name appears in February, May, June, July, August and November but not in March, April, September or October. The only notes alongside his name are *'HIV prevention'*, May *'Rob to visit for a chat'*, and November *'well dealt with'*.

11.17 The team meets as a group each week to determine case allocations and deal with other immediate commitments. Another meeting is held fortnightly to discuss workload, liaison issues, team needs and domestic matters, during which workers take it in turns to present for discussion individual cases presenting problems or needing joint consideration.

11.18 John Rous was referred to the Elmore Team by Dr Agulnik on 4 May 1989. Dr Agulnik had been influential in the setting up of the team and continues to act as a member of the Management Sub-Committee. His advice to individual Team members has been on a case by case basis. In her written statement Mrs Stannard noted: *"John was then living in a Council flat at 50 Riverside Court. He had an unwelcome lodger staying with him called Mick Brain who had allegedly thrown him down an alleyway and broken his arm. John had fled to Swindon and was nervous about returning to his flat. He did so later in the*

month". The team allocated John Rous to Angela Stannard who had previously known him at The Mill.

11.19 In his verbal evidence Dr Agulnik said that he then regarded Mrs Stannard as key worker for John Rous. She acknowledged this role to us, but added that from 14 September 1992 she considered it to have been transferred to or at least shared with David Marsh, Project Worker, at Jacqui Porter House. She discussed this with him once it had become clear that John Rous was settled in the house. She would 'now be in the background' and made monthly visits thereafter. We have to record that neither Mr Marsh nor any other person was aware of any change in the role of Mrs Stannard. Dr Agulnik, both general practitioners and Mrs Asprey of MIND all regarded Mrs Stannard as John Rous's key worker until the death of Jonathan Newby.

11.20 The full record of Mrs Stannard's contacts with John Rous are held in diarised notes detailing the dates and places where he was seen, the reasons for contacts and the other agencies involved. From 4 May 1989 to 12 July 1989 her efforts were mainly committed to helping him with the crisis relating to the eviction of his lodger at Riverside Court. During the following twenty four months there are one hundred and twenty five entries, mainly detailing John Rous's ongoing difficulties with lodgers and noise at Riverside Court, his appearances in Court, attendance at out patients to see Dr Agulnik and contacts with Housing Officers, MIND staff, Police and Court officials. From leaving Riverside Court on 22 July 1991 to the end of July 1992 the record has sixty entries detailing his subsequent moves, hospital treatment episodes, out-patient appointments. Contact intensified following his unsatisfactory placement in bed and breakfast at 137 - 141 Iffley Road. The entry for 4 August 1992 is summarised in Mrs Stannard's statement as *"I helped John move all his belongings to Jacqui Porter House."*

11.21. From 14 September 1992 when the note *'I would now be in the background'* appears, the entries are much less frequent and often in summarised form. This particularly applied from June to October 1993 when Mrs Stannard states *"I kept up the contact with John about every three weeks. I also observed him regularly at the Elmore Office when he accompanied his pregnant girlfriend to collect her weekly benefit."*

11.22 Most of the representatives of other agencies who gave evidence spoke very highly of the work of the Elmore Team. In particular, housing workers have found that its members provide useful advice on Difficult to Place applicants for

housing, and also that team members have been useful intermediaries to health services and social services. The effectiveness of Mr McLeavy as co-ordinator is acknowledged and Mrs Stannard's efforts on behalf of her clients are generally appreciated.

11.23 We acknowledged that the Elmore Team has been a valuable innovation in community care in Oxford. We found, however, that the records of Mrs Stannard's contact with John Rous followed an unstructured pattern, without summaries of progress, targets for casework activity and reviews of their attainment. The work as described in the notes was largely in response to John Rous's changing circumstances. The most constant component was regular out-patient appointments with Dr Agulnik, but the results of her discussions with Dr Agulnik were not noted in the Elmore case record, or in Dr Agulnik's medical notes.

11.24 It was also surprising to hear that Mrs Stannard had no contact with the general medical practitioners Dr Stevens and Dr Lee, even though they were responsible for administering John Rous's regular depot. medication. Dr Lee told us that she had on two occasions telephoned Mrs Stannard and left a message on her answering machine but had heard nothing further from her.

11.25 Mrs Stannard told us that she *"did not know the finer points of John Rous's mental state"*, and that she had not had occasion to seek or give details to Dr Agulnik or members of his multidiciplinary clinical team. Her conception of the tasks in support of John Rous did not mean that she had a particular communicating role either with Dr Agulnik's team or the general practitioners.

11.26 We also noted that her records of contacts with John Rous did not include assessments or reviews of his mental state. On several occasions his mood was noted, or his frustrations and unhappiness at events. There was, however, no summary of his mental state at the time of her handover of responsibilities to David Marsh.

11.27 The handover, and subsequent monitoring of John Rous's progress followed an unformulated pattern. It became apparent to us that some workers at Jacqui Porter House found it difficult to elicit a response from Mrs Stannard. One of them expressed the view that she was disinclined to facilitate liaison with doctors at the time when hostel workers were concerned about proposals to change the day of his depot medication.

11.28 We have reluctantly concluded that Mrs Stannard's work with John Rous, though very active and highly committed, was unsystematic and almost entirely unstructured. We do not think that her performance satisfied what could then be expected of a key worker, especially in terms of her liaison with doctors. The definition of the division of responsibilities with the staff at Jacqui Porter House was incomplete, and her subsequent role in liaison with doctors was unclear, at least to some of the staff of the house.

11.29 We feel bound to comment adversely on the content and quality of the records of the supervision, guidance and support which she is said to have received from Mr McLeavy after July 1991. The records which should have been maintained under the Team's operational policy were after that date only partially completed. The note of each supervision then comprised a list of names, to some of which a cryptic note was attached. In common with the case record system mentioned in 11.20 above there were no summaries of Mrs Stannard's progress, or targets for action. The name of John Rous appears intermittently on the list of her clients up to 15th July 1992, but with no notes of action after 27 May 1993 when *"Rob to visit for a chat"* appears below his name.

11.30 It would appear that any mechanism for the Management Sub-Committee to check that agency policy was being fulfilled did not detect these deficiencies. We can only conclude that these failings in the setting and monitoring of proper operational standards applied at all levels in the organisation.

11.31 In his oral evidence Mr Ian White, Director of Social Services, told us that the original grant to Elmore had not been tied to performance standards. The current annual grant of £35,000 is paid by Social Services under a service agreement with Elmore, but again performance standards have not been specified. We consider that Social Services should now review the standards of recording, case review and closure/transfer arrangements to ensure that work undertaken by Elmore either in relation to clients under Care Management or within the Care Programme Approach fits adequately within the recording systems of Health and Social Services. We consider this essential if the function and the standards implicit in paragraph 11.7 above, drawn verbatim from the Elmore Team's own handbook, and amplified in the revisions adopted in 1994, are to be fulfilled in properly accountable terms.

Chapter Twelve

Oxford MIND

12.1 The Mill Day Centre operated by Oxford MIND was a primary source of support to John Rous from 1983 until the time of his arrest in October 1993. The centre is located on the ground floor of Cowley Road Methodist Church, just around the corner from Jacqui Porter House. It is funded by Oxfordshire Social Services and the Health Authority under a joint services agreement.

12.2 The Centre co-ordinator Ms Kay Asprey described John Rous as *"quite easy to handle"* and she felt that he represented less of a threat than some other members at the Centre. He would quite freely volunteer the information *"I'm a paranoid schizophrenic"*, and she was aware that he abused drugs and alcohol *"most of the time"*. Although he could be loud and tended to get very noisy when he was angry, with his arms and legs particularly animated, he was never threatening to other people. She herself had never felt threatened by him and thought that his anger was like a child's.

12.3 Mrs Asprey who had been co-ordinator since 1988 understood that John Rous was originally referred there by Dr Agulnik, who confirmed that he had a major mental health problem. This was the only information sought in 1983, but new members now have to be nominated by a mental health professional who also has to inform that there is no history of aggressive or violent behaviour and no current abuse of drugs or alcohol. *"We do not ask for any medical notes or patient histories and we do not keep records of any kind on people once they become members, other than correspondence and, for the past two years, a separate record of violent incidents"*. In the case of John Rous there was no record of any violent incident held on file.

12.4 The Mill understood that Angela Stannard was John Rous's Key worker. Mrs Asprey records that she had frequent conversations concerning him, particularly difficulties he experienced with his accommodation. She described to us the difficulties he had experienced with unwelcome lodgers at his flat, his dissatisfactions with the night shelter and in bed and breakfast accommodation. In relation to Jacqui Porter House her written statement comments *"His move to Jacqui Porter House in August 1992 was again a mixture of good and bad. He was very proud of having a clean nice environment, support from staff, company*

of other people and clear street boundaries around visitors and finances. On the other hand all of these things at times seemed to make him feel angry and that he didn't have enough choice and freedom".

12.5 Mrs Asprey cannot recall any significant changes in his behaviour during 1993, when *"he seemed more settled if anything".*

12.6 The week of 18-24 September 1993 was spent on holiday in Reeth with other Mill members, a locum staff member and two volunteer workers. While they were away he did not seem depressed or angry but he had *"been drinking quite a bit and he was possibly taking some illegal substance, but there was no evidence other than his behaviour which was a bit 'high' at times. This was not however causing difficulties for any members or staff".*

12.7 Although on his return he seemed to have enjoyed his holiday, he became quite angry when pressed by Mill staff to repay a loan of £20 which he had obtained from MIND during his holiday on condition that he would pay it back in one go out of the previous week's Giro payment. He later apologised, saying according to Mrs Asprey, that *"he really had the money but hadn't wanted to repay it. Again this was fairly usual behaviour from John and although he was quite angry, he did not make threats and I did not feel in any way threatened by him".*

12.8 The Committee of Inquiry visited the Mill at a time when only workers were present. The accommodation was not large but impressed us as a warm, easy and user friendly-environment.

Chapter Thirteen

Oxfordshire Probation Service

13.1 As a result of John Rous's history of persistent offending from 1964 onwards he became well known to Oxfordshire Probation Service. From 1978 onwards his reporting Probation Officer was most often Miss Evelyn Bryant, who gave evidence to the Inquiry. The continuity of her contact with him was particularly helpful in view of the fact that all Probation Service records prior to 1988 had been destroyed under their record destruction policy.

13.2 It was also coincidental that Miss Bryant was a seconded Probation Officer on the remand wing at Bullingdon Prison, where she saw him on two occasions during the first ten days of his remand on the murder charge in October 1993. Miss Bryant's official contact with John Rous fell into three phases 1978 - 85, January 1986 - March 1989 and October 1993 - 94.

13.3 From 1978 - 85 John Rous appeared before the Courts on 15 occasions. He was conditionally discharged on 3 occasions, sentenced to imprisonment 3 times, given one suspended sentence, and made the subject of 3 Probation Orders and 5 Community Service Orders. Miss Bryant particularly noted the success of the Community Orders, one of which resulted in him continuing to undertake community work on a voluntary basis.

13.4 From 1986 - 89 Miss Bryant worked at the Probation Day Centre in Oxford to which John Rous was an occasional visitor, but there was no statutory Probation Services involvement until 1992 when a report was prepared by Gaynor Underhill, Probation Officer for Oxford Magistrates Court in respect of an offence of theft committed in December 1991, a copy of which we received.

13.5 Miss Bryant's written statement to the Inquiry and Ms Underhill's report reflect a pattern of offending related to his mental illness and exacerbated at time of stress and/or abuse of drugs. Miss Bryant particularly comments on the absence of a history of violence and that the assault on a nursing officer in 1977 had not been the subject of criminal proceedings.

13.6 Ms Underhill's report dated 10th February 1992 is concluded thus:-
"Mr Rous is a 'colourful' personality and despite his mental illness generally

copes well in the Community with support. On occasions he resents the intrusion of the workers trying to help him and can be stubborn and difficult, he has recently been in one of these phases but Ms Lawrence is hopeful that they will find him reasonable accommodation soon. Mr Rous tells me that he knew it was wrong to steal and that now the difficult Christmas period is over he does not think he will be tempted again. He is well known to the caring agencies and receives ample support. In view of this I recommend that he be made subject to a Conditional Discharge. He is aware of the implications of this and has not breached such Orders in the past."

13.7 In her verbal evidence to the Inquiry, Miss Bryant expressed her continuing amazement that John Rous had killed Jonathan Newby. In her interviews with him at Bullingdon Prison he had described having behaved aggressively to a street drugs dealer some weeks before the murder, and she had related this to the reporting Probation Officer Mr Chris Wilson.

13.8 Mr Wilson's pre-sentence report dated 15th June 1994 referred to this information and that as a result of discussing it with John Rous he talked about his growing frustrations since being a resident at Jacqui Porter House. He was experiencing stress due to his girlfriend's pregnancy and the fact that she was unwelcome by staff at Jacqui Porter House. He felt that staff displayed a lack of respect and dignity to residents and appeared indifferent towards his mental health. It is important to note that Mr Rous's Key worker, Angela Stannard of the Elmore Community Support Team, although being aware of Mr Rous's feelings towards Jacqui Porter House felt that *"during the preceding months his mental health had been relatively stable."*

Mr Wilson's report adds further: *"During my third interview on 12th January 1994, at Broadmoor Hospital, Mr Rous continued to justify his actions, stating that his treatment at Jacqui Porter House was demeaning and that action had to be taken to give a message that Government policy with regard to Care in the Community was not working. Again Mr Rous acknowledged that at the time of the offence he was suffering from symptoms of his ongoing illness and was preoccupied with the pregnancy of his girlfriend. Once again, he showed no personal remorse for the victim."*

13.9 Mr Wilson's report ends with the following Conclusion and Proposal:-
"This offence has come as a shock to all who know and have worked with Mr Rous. He was clearly unwell at the time of the offence. His continuance to justify his actions and his lack of acknowledgement as to the personal

consequences to both the victim and the victim's family are in my opinion a worrying feature, giving rise to a prognosis of a continued high risk.

I therefore concur with the conclusion presented in the Psychiatric Report which proposes that the Court make a Hospital Order under Section 37 of the Mental Health Act 1983, together with a time unlimited Restriction Order under Section 41 of the same Act."

Chapter Fourteen

The Oxford City Housing Department, the Oxford Cyrenians, and Cherwell Housing Trust

Introduction

14.1 Housing agencies took lead roles both in the development and subsequent management of Jacqui Porter House, and in the nomination of John Rous to it. The housing organisations involved therefore merit unusually important attention in this report.

14.2 The three agencies involved were:

- Oxford City Council Housing Department, the local statutory authority. As well as managing its own stock the City Council is responsible for strategic planning of housing and has statutory duties towards homeless people.
- Cherwell Housing Trust, a major local housing association. An independent charitable agency registered with the Housing Corporation, Cherwell Housing Trust has a stock of 1,055 units of general housing, and 274 bed spaces of specialist supported housing.
- Oxford Cyrenians themselves

14.3 This chapter will start by outlining the local and national context for housing, and then examine the five major areas of housing involvement in chronological order:

- John Rous's period as a City Council Housing Department tenant at Riverside Court
- the development of Jacqui Porter House
- the houses themselves
- the nominations to Jacqui Porter House
- monitoring by Cherwell Housing Trust

Context

14.4 Statutory responsibility for social housing is held by borough, city or district councils, rather than the county councils which take responsibility for social services provision. In this case, Oxford City was the housing authority and Oxfordshire County the social services authority.

14.5 Housing authorities gradually increased their stock over the first 70 years of this century, with significant expansion in the 1960's and 1970's. The late 1970's saw the tide turn, with the introduction of the right to buy for tenants, and substantial cuts in funds for new building. The council housing stock has since been substantially reduced. Changes in legislation and new funding regimes introduced in the late 1980's are now encouraging wholesale transfer of the remaining stock to housing associations. Local authorities, however, retain the lead strategic responsibility, maintaining waiting lists, keeping responsibilities towards homeless people, and co-ordinating the work of housing agencies to meet local needs.

14.6 Statutory responsibilities towards homeless people were introduced in the Housing (Homeless Persons) Act of 1977. This became consolidated into the Housing Act of 1985. The duties require local housing authorities to find accommodation for people with a local connection who are homeless and in priority need, provided that they have not "intentionally" made themselves homeless. Priority need includes families with dependent children, but also people without children who are vulnerable by reason of age, ill health, disability or other factors. About 4% of those accepted as priority homeless are assessed as vulnerable by reason of mental illness, amounting to over 6,000 people each year across England and Wales. Oxford City Council estimate that 15% of people they accept as priority homeless have a history of mental illness. Homeless people who are not deemed to be vulnerable are not entitled to accommodation, but are merely offered advice.

14.7 In practice, housing authorities have experienced great difficulties in meeting their responsibilities under homelessness legislation. The numbers of people applying have increased substantially over the years, and council housing stocks have decreased. Councils have made extensive use of bed and breakfast accommodation as a stop-gap measure, and a number of initiatives have been tried to reduce this with varying degrees of success. Attention has focused on families with children, and most single homeless people have been excluded from help. Homeless persons unit staff often have heavy workloads and little time to make detailed assessments of single vulnerable people; the Inquiry heard from Debbie Hill, an officer in the Oxford City unit, that she would typically be carrying a caseload of 40 to 50 applicants and 4 to 5 new people would present each day to the duty officer. These staff are housing personnel, not generally qualified to carry out assessments of care needs: for single vulnerable people, they rely on the advice of key workers in care agencies where they exist, and on the advice of the person's general practitioner, and sometimes on the formal

opinion of the community physician. It is important to note that housing authorities have a statutory duty to house vulnerable homeless people, even if the care they need is not forthcoming from social services or health. The duties to assess and provide care and housing are separate and fall on different authorities. This is a national case , not one unique to Oxford.

14.8 The housing association movement has seen rapid expansion over the last 30 years. Housing associations are independent charities, industrial and provident societies or companies limited by guarantee. Since 1984, their main source of funding for new housing has been the Housing Corporation, a quango established by the Department of Environment to fund and regulate associations. In 1989, the funding balance shifted somewhat as new funding rules required associations to raise some of their capital through private sector loans. The bulk of revenue funding comes from rents charged to tenants.

14.9 In the 1970's, housing associations were characterised by a charitable ethos, strong community links, and a commitment to inner city regeneration. In the late 1980's and 1990's they went through a period of professionalisation and the introduction of a more businesslike and managerial culture, in recognition of their enhanced role and the demands of private sector lenders.

14.10 Many housing associations have been involved in the development of special needs housing: hostels for homeless people, and housing with care. This had long been an interest deriving from associations' community links, but was given a major boost in the early 1980's by the introduction of favourable capital and revenue funding regimes from the Housing Corporation and Department of Environment. A complex system of funding deficits on special needs housing projects called hostel deficit grant (HDG) enabled associations to pioneer schemes for groups of people who were often neglected by the statutory authorities, particularly single homeless people. Some 60,000 bed spaces of such housing are now in management.

14.11 Special needs housing is not always directly managed by the developing housing association. Often, the association will sign a management agreement with a voluntary agency which has specialist skills and experience in work with the particular resident group. Under the agreement, the association remains the landlord of the residents but delegates the actual running of the scheme. The association is required to monitor the work of the managing agency to standards laid down by the Housing Corporation.

14.12 Funding for special needs housing has been subject to a lengthy period of uncertainty and change. In the late 1980's the Department of the Environment became concerned at the rapid and uncontrolled expansion of HDG and began a series of attempts over several years (and still continuing) to bring it under control. Because HDG was a deficit finance system, it was often paid very much in arrears, and the size of the bill only became clear some years after the event. At the same time, other elements of revenue finance were threatened. Board and lodging benefits for hostel residents were abolished in 1989 and replaced with housing benefit. One common response to this was to seek to register hostels as registered care homes to attract higher benefit levels. The NHS and Community Care Act then abolished the higher rates of benefit for new residents in registered care homes in 1993, replacing them with a system of individual assessment by social services authorities. The effects of these changes have been to create a continual sense of funding crisis in many of the organisations involved. Life became a continual scrabble for funds, and management effort was diverted away from attending to the quality of the service. The emphasis was on an entrepreneurial and creative playing of the funding regimes available to make them fit the projects which were needed.

14.13 Many special needs housing agencies have recently been going through a period of professionalisation matching that of general housing associations. Their roots were in providing for people whom the statutory agencies would not help. Now, they are major providers of community care services funded by statutory grants under mainstream community care arrangements. Social services authorities in particular have taken a much greater interest in single homeless people with care needs since picking up the funding bill for registered care homes in 1993. From battling against "the system", the sector has itself become a major part of the system. The transition has not always been easy and many organisations have felt it as a loss of their roots, an abandonment of their voluntary ethos, and a battle for the soul of their organisation.

14.14 The final part of the context is the housing and care debate. For many years, the boundary between housing and care has been the subject of intense scrutiny. At the national level, government departments have attempted to set limits to their responsibilities: the Department of the Environment has attempted to block what it considers to be misuse of housing funds for care activities, while the Department of Health has questioned why it should be funding housing for people simply because they require care. This argument has had a paralysing effect on progress, and has resulted in the introduction of sometimes bizarre rules to funding systems. The Department of the Environment Circular to

housing authorities on community care states that community care creates no new categories of entitlement to housing, and the Department has allocated no extra funds for this purpose. While the NHS has funded many special schemes for people leaving psychiatric hospitals, the number of new beds provided has not matched the number lost in hospital closures, and the new provision has focused on meeting the needs of former long stay patients rather than those of new patients in the community. The burden has often fallen on housing and voluntary agencies, with sometimes inadequate support from health and social services.

14.15 At the service provision level, practitioners have found it increasingly difficult to maintain hard and fast boundaries between housing and care activities. Many social housing tenants have care needs, and this proportion has been growing substantially. However, most housing staff have no background in care activities, and their workload leaves them little time to undertake them: the Inquiry heard from Steve Kilsby, who was a district housing manager in Oxford, that he was responsible for up to 1,000 tenancies. Yet it is a common complaint that care agencies such as social services are unresponsive when called upon for help by housing officers. Many housing agencies have attempted to respond by setting up special schemes with additional support, or with more intensive housing management to try to organise support from care agencies and Oxford is no exception. However, questions remain about the skills and experience required to run housing with care, and whether combined roles are realistic.

14.16 The local housing context in Oxford is one of intense housing stress. A research paper by Sally Gregory and Sue Brownhill[1] states that Oxford has a high number of homeless people compared to other cities of a similar size in southern England and that this has had an effect on access to housing. Oxford houses an exceptionally large student population. Housing prices are high. Access to social housing for single people has been particularly difficult: only those with "an element of vulnerability" gain enough priority for allocation, which in turn has led to a concentration of people with care needs in some social housing developments.

1 *Gregory S and Brownhill S (1994). The Housing/Care Divide: Community Care and the Management of Single Person Housing in Oxford. Oxford Brookes University.*

14.17 Oxford has a large number of psychiatric hospital beds in the Littlemore and Warneford hospitals. These were reduced quite early on in the history of

community care, and a network of group homes and halfway houses was developed. However, these appear to have been run quite separately from the network of provision for single homeless people with almost no communication between the two networks. The group homes tended to exclude people with alcohol or drug problems and those who were disruptive, and such people could therefore end up on the streets or in shelters.

14.18 Michael Hall provided the Inquiry with a detailed history of the development of provision for single homeless people in Oxford. From a position of total neglect in the early 1960's, the Simon Community made a start by opening very basic shelters. At this time, street homeless people had great difficulty in obtaining even the most basic medical help from the NHS. Progress was made in the face of strong opposition with the opening of the new Simon House and then a range of other schemes. Much of this history is described in the chapter on the Cyrenians, but it is also important to understanding the housing picture: there was a sharp divide between people housed by the statutory care agencies (mainly health) in group homes and half way houses, and those seen as street homeless who were left to the housing authority and agencies like the Cyrenians even though their care needs could be as great or greater. Attempts were made to improve co-ordination, and the City Council chaired a Joint Planning Forum on housing for single people to try to bring the agencies together.

Riverside Court

14.19 John Rous was a tenant of Riverside Court from 8 August 1988 to 22 July 1991. This appears to have been his longest period of stable accommodation since childhood.

14.20 Steve Kilsby, District Housing Manager for Riverside Court at the time, provided written and verbal evidence to the Inquiry. Amongst all the housing witnesses, Mr Kilsby stood out as clear, well informed, with an excellent understanding of his job and committed to high standards of service for his tenants.

14.21 Riverside Court was a new City Council development in 1988, of 79 units for single people. It was originally intended that 20 units would be furnished and let to people who needed and received care and support from external agencies. There was an on-site warden with a caretaking role, an office, and a laundry room.

14.22 Mr Kilsby had responsibility for around 1,000 tenancies, including Riverside

Court. His patch was later reduced to 6-700 tenancies in recognition of the time-consuming nature of Riverside Court.

14.23 Allocations to Riverside Court were not made by Mr Kilsby: he was informed of them. He was aware that many tenants had care needs and care packages to meet them. At the time, he was unaware of what care packages, key working and other community care terms really meant, coming as he did from a housing background. He was invited to a meeting of representatives from the various care agencies involved, but not briefed as to his role either at the meeting or more broadly in respect of the care arrangements.

14.24 Problems arose with John Rous's tenancy: neighbours complained about his dog, about visitors to his flat creating a nuisance, and about parties. In June 1989 Mr Kilsby contacted the Elmore Team, knowing it to be a service which supported people such as John Rous. He was not aware that John Rous had already been referred to Elmore shortly before, by Dr Agulnik.

14.25 Mr Kilsby found the Elmore Team and Angela Stannard individually very helpful. John Rous had taken in a lodger who had rather taken over the flat, refused to contribute financially, and caused nuisance to neighbours. Angela Stannard assisted him in evicting the lodger.

14.26 Noise and nuisance problems continued, however, again often caused by friends and acquaintances invited in by John Rous whom he could not subsequently control. Angela Stannard continued to liaise and assist. Eviction proceedings were considered twice. By May of 1991, the problems had reached a serious point. Steve Kilsby called a meeting with Dr Agulnik, Kay Asprey and Angela Stannard. It was felt that John Rous understood what he was doing and must take responsibility for the nuisance being caused. Eviction was considered once again, and on this occasion was recommended. A notice was served.

14.27 Before recommending eviction, Mr Kilsby had contacted a variety of care agencies. He felt confident from the response of Angela Stannard that John Rous would be picked up, housed and supported through the Elmore Team if he was evicted.

14.28 John Rous left his flat voluntarily before proceedings for eviction commenced.

14.29 Many tenants of Riverside Court presented problems and Steve Kilsby therefore had considerable experience of trying to obtain help from statutory agencies. He

found Elmore and Dr Agulnik helpful, but found it extremely difficult to get any response from social services. More widely, he found it difficult to get care agencies to take his concerns as a housing manager seriously.

14.30 It seems that Riverside Court was developed by the housing department without involvement from care agencies. People were housed there who presented risks to themselves and others. Adequate care packages were not always put in place by health or social services.

The development of Jacqui Porter House

14.31 Jacqui Porter House has a long and unusually contorted history. 39, 41 and 42 Rectory Road were owned by a private landlord and tenanted by 18 or 20 middle aged to elderly men, mainly Polish or Irish immigrants. The owner was a poor landlord and failed properly to maintain the houses; there were allegations that the tenants were being harassed. Michael Hall and Jacqui Porter were both residents of Rectory Road, and they joined a group of local people led by Richard Fordham in trying to get something done. The first plan was to form a co-operative to allow the residents of the houses, supported by well wishers, to maintain their homes in good repair. Discussions took a long time and the landlord decided to sell. The group persuaded the Council to buy the houses and hold them until the co-operative was ready to go. The plan fell through for technical reasons and when Richard Fordham moved away, but meanwhile the Cyrenians acted as agents, collecting the rents and working with the sitting tenants.

14.32 In 1990, the Department of the Environment made a special capital fund (called supplementary credit approval) available to help councils meet their responsibilities to single homeless people. The City obtained an approval for £195,000 to renovate the 3 houses, and decided to add £100,000 of its own funds, and to make the houses available to the Cyrenians.

14.33 Revenue funding would be needed to run the houses, but only registered housing associations could obtain HDG. Cherwell Housing Trust already owned a house in between the Council properties, ie No 40, and had a long standing relationship with Oxford Cyrenians on Simon House. Cherwell Housing Trust were therefore approached in June 1990 to participate in the scheme. The idea was that the Council would own and develop the houses and give Cherwell Housing Trust a lease. Cherwell Housing Trust would then appoint Oxford Cyrenians as managing agent.

14.34 The people involved at this stage were Glynis Lapage and Richard Peacock for the Council, David Belton and Richard Temple for Cherwell Housing Trust, and Michael Hall for Oxford Cyrenians. Glynis Lapage subsequently moved to Oxford Cyrenians, David Belton was also a committee member of Oxford Cyrenians, and Richard Temple had previously worked for Oxford Cyrenians. These movements between agencies and multiple roles were recurring patterns observed by the Inquiry.

14.35 The brief at this stage is set out in a note of a meeting between City Council Housing Department, Cherwell Housing Trust and Oxford Cyrenians on 24 October 1990. The hostels were to be aimed at supported move on accommodation from other hostels in the City and were not meant to be "high care". There was no intention to provide specifically for people with mental illness. However, the City Council Housing Department were to have 100% nomination rights. It appears that even at this early stage, different and conflicting agendas were emerging, and the Council have stated that they were concerned that Michael Hall wanted to use the houses as accommodation for people moving on from Simon House and other Cyrenian projects.

14.36 Cherwell Housing Trust felt they could not apply immediately for HDG because the rent level for the lease was not and could not be agreed until the "future type of occupant had been agreed". The delay took the project past a tightening up of the HDG regime in late 1990. As a result, it became apparent that HDG might not be available, and it was decided to lobby the Department of Environment and Housing Corporation.

14.37 This lobbying, led by Michael Hall, drew the Department of Environment's attention to the intended use of the houses. In February 1991, the Department of Environment phoned the City Council Housing Department to say that the SCA was only to be used for schemes that would provide accommodation for people accepted as statutorily homeless. They threatened to withdraw funding unless the brief was changed from hostel move on to statutorily homeless people. Proposals on this were set out in a letter dated 6 March 1991 from Morag McDermont acting for the City Council to Sue Jeffs of Cherwell Housing Trust, both of whom by this time taken on the lead role for their agencies.

14.38 Also in February 1991, the City Council Housing Committee required another change. The eligibility criteria for the houses were to be changed "so that it was clear that the project manager did not have the right of refusal of a nomination" (taken from minutes provided by Oxford City Council). It is clear from

correspondence at the time that neither Michael Hall nor Sue Jeffs was happy with this and that both made representations. Only a limited concession was gained: there would be a schedule of criteria for eligibility, and the project manager could refuse nominees whom he or she assessed as not meeting the criteria. A detailed explanation was to be given in writing.

14.39 The evidence is confused as to exactly how this settlement was reached and exactly how difficult it was to be for the project manager to exercise a right of veto. The Inquiry's view is that the position remained somewhat confused in the minds of the Cyrenians staff involved when the project opened. This is dealt with in more detail, along with the eligibility criteria, in paragraph 14.55 et seq.

14.40 The other debate on the brief for the houses at this time was on the level of care and style of management. The Inquiry heard that the housing department saw the scheme as providing separate bedsits with staff support. Oxford Cyrenians by contrast wanted "family style group homes" similar to their existing projects. This would involve more communal space and more care. Oxford Cyrenians meant informal and "family style" care, but it appears this was interpreted as more formal and professional care. An uneasy compromise seems to have been reached, with limited communal space and a mix of bedsits with and without kitchenettes. This was a poor compromise with design faults, described in paragraphs 14.46 to 14.54.

14.41 At this time, 39 Rectory Road was envisaged as an integral part of the scheme. There had been mention of using it as a "women only" house. Somehow - and it is not clear how - this ended up as a definite requirement by 1992, with significant consequences described in paragraph 14.72 below.

14.42 40 Rectory Road was a potential but not definite part of the scheme. Owned by Cherwell Housing Trust as general family housing, it was sandwiched in between the intended hostels and a change of use was acknowledged by all as making sense. However, the house had been damp, and an environmental health notice precluded its use without repairs. There appear to have been disputes between Cherwell and Oxford Cyrenians regarding these works and whether the dampness continued, and the property was never opened. It was eventually let by Cherwell.

14.43 By April 1991, it was clear that HDG was to be replaced by a new funding system called Special Needs Management Allowance (SNMA). It was even less likely that the project would get SNMA. The Council were therefore pressing

Cherwell Housing Trust, as the housing association which would try to claim SNMA, for alternative revenue funding options. Cherwell Housing Trust in turn were awaiting proposals from Oxford Cyrenians. On 20 May 1991, Michael Hall wrote a detailed letter outlining 7 different funding and staffing options for 39, 40 and 41 Rectory Road. All of these involved registration of at least some of the bed spaces as registered care home places. The staffing options ranged from 4 paid staff and 2 volunteers to 2 paid and 6 volunteers. Michael Hall expresses a preference for an option in which 14 beds are registered and 4 are lower care, with 2 paid staff and 6 volunteers. This was accepted by the Council in July 1991, "providing that the registration authority is satisfied that the alternative staffing is adequate for "high care" provision".

14.44 Michael Hall has put to the Inquiry that Oxford Cyrenians had always seen the scheme as a registered home in line with most of their other group homes. However, the options letter implies that this had not always been intended, and that the reasons for registration were at least in part financial. Earlier papers specify rent levels clearly suggesting a non-registered status. Only Simon House was registered at this point and Michael Hall was in the middle of negotiations for registering the other group homes.

14.45 Whatever the detail, it is clear that by the early summer of 1991, the project had changed from being a low support house offering fairly independent bedsit accommodation for people moving on from other hostels to a higher care registered house with shared housing for vulnerable people nominated 100% by the City Council with limited grounds for the project manager to refuse. Financial pressures from changed funding regimes and maladroit timing and lobbying, coupled with the unresolved conflicting agendas of Oxford Cyrenians for move on from hostels and of the City Council Housing Department for placements for vulnerable homeless people, have caused this change. Yet discussions with the Social Services authority for funding or for comments on the proposals were very limited, except with their registration and inspection arm. Nor were the health authority or local psychiatric services approached. The implications of registration were simply not recognised: no one appears to have asked the question as to how a low care project could become a registered care home with the same or even fewer staff than originally envisaged. Senior managers from Oxford Cyrenians, Cherwell Housing Trust and City Council Housing Department have all been unable to offer credible explanations.

14.46 Cherwell Housing Trust's special projects subcommittee recognised some of the dangers. In a note of 9 August 1991, Richard Temple alerts the subcommittee

to serious concerns about long term financial viability and questions how manageable the project would be with Council insistence on 100% nomination rights. The subcommittee responded by stipulating that further involvement by the Trust should be dependent on maintenance of the proposed staffing level, adequate funding to provide such staffing, and nomination procedures which gave "Oxford Cyrenians adequate control to ensure a level of need within the Project commensurate with the available staffing". Sue Jeffs for Cherwell Housing Trust expressed the view, to her own subcommittee in November 1991 and to the Inquiry, that these conditions had been met. The Inquiry take the view that the evidence points to the contrary. However, it must be acknowledged that this may not have been clear at the time.

The houses themselves

14.47 The Inquiry members visited 41 and 42 Rectory Road and were provided with plans of the layout. We did not visit No 39 but viewed the outside.

14.48 Even making allowance for the effects of security boarding and near-empty rooms, the houses did not impress. Rooms were small and circulation space even more cramped. There would have been a strong sense of "living on top of one another", a forced intimacy which research has shown is undesirable for people with schizophrenia.

14.49 The living room was particularly small. This was identified by Registration Inspectors who made a special exception permitting it as below normally expected standards.

14.50 The living room was also immediately above John Rous's room. Although soundproofing was in place, anyone using the living room late at night or early in the morning would be likely to disturb him. We know that another resident was indeed pacing the house late at night in the week before 9 October 1993.

14.51 John Rous's room was also at the front of the house and next to the front door and office door. It was a noted concern of Jacqui Porter House staff that this made him more open to calls by acquaintances he might be trying to avoid.

14.52 The office which doubled as the sleep-in room was small. There was only room for a fold-away bed for sleep-in staff. Certainly there would have been no space to have two night staff present.

14.53 The office door although sturdy opened inwards making it less secure. This was

unavoidable given the narrow entrance hall but the door could have been kicked in by a determined person. The door also had a slow and resistant fire closer on it, making it very difficult for staff to slam the door in the face of an attacker and to lock themselves in.

14.54 The office door also opened against the desk rather than against the wall. This meant that with the door open, there was in effect a short narrow corridor as the escape route in an emergency. It certainly would have slowed down any escape, and the window was too high above the ground to provide an alternative.

Nominations to Jacqui Porter House

14.55 Paragraphs 14.37 to 14.39 detail the process by which the City Council ended up with 100% nomination rights to Jacqui Porter House. The project manager could only refuse a nomination if either the nominee did not wish to move in or if they were assessed as failing to meet the eligibility criteria. A form was to be filled in if someone was refused detailing why they failed to meet the criteria.

14.56 The Inquiry heard a variety of statements as to how much of a right of assessment and veto the project manager had in reality. A number of nominees were refused, with reasons including a recent history of violence, current substance abuse, and severe mental illness. Our view is that the staff involved were unclear as to the exact arrangement and felt under pressure to accept people.

14.57 Refusal would also be based on individual assessment - there was no right on the part of the project staff to refuse someone in order to ensure an appropriate balance in the house. Yet it is a fundamental of managing shared housing that achieving such a balance is vitally important. A report to the City Council Housing Committee of 5 February 1991 considered the view of a number of agencies that the balance of needs is important, but rejected it on grounds of equal opportunities and the need to have clear, objective and publicly available reasons when refusing any nomination.

14.58 The arrangement made the written eligibility criteria particularly important. These criteria are set out below:

Eligibility Criteria for Rectory Road - Jacqui Porter House

Criteria for Registration

I	Old Age
MP	Mental disorder, other than mental handicap, past or present
A	Alcohol dependence, past or present

Eligibility Criteria within the above categories

1. Single Women and Men over the age of 18 (Persons under 18 years will only be accepted when there is no other available accommodation).
2. People who are vulnerable and in priority need.
3. People who are currently homeless or inappropriately accommodated.
4. People who would benefit from, and express a wish to live in, a staffed and supported group home setting.
5. People in hostels who are in need of longer term accommodation in a smaller and less institutionalised environment.
6. People in City Council or housing association single person accommodation who would benefit from, and express a wish to live in staff supported, shared accommodation.

The project will be unable to accommodate men or women who:

1. Have a serious current acute mental or physical illness which required a high degree of specialised care.
2. Have a persistent history of physical violence.
3. Are current drug/solvent/alcohol abusers.
4. Are unable to manage flights of stairs as access to all the accommodation is via stairs.

14.59 Considered against the staffing available at Jacqui Porter House, these criteria seem reasonable and balanced. However, much depends on the interpretation of serious illness and what constitutes requiring a high degree of specialised care, and at what point a history of physical violence becomes persistent. By limiting the exclusion on grounds of serious illness to "acute" conditions, severely mentally ill people could still be housed if their condition was chronic. These terms were not explained. The unresolved conflicts between Oxford Cyrenians and City Council Housing Department meant that no informal understanding could be reached. Specialist and expert advice was not sought. The City Council state that they saw the Cyrenians as the experts in this field and that the care assessment was therefore for them to undertake.

14.60 The process for arriving at nominations seems to have been confused. At first, inappropriate nominations were made of people who did not want supported housing. Oxford Cyrenians made representations to the homeless persons unit. A lull ensued with no nominations. Suddenly, there was a rush after the council had circulated the criteria to a wide range of agencies. At the homeless persons

unit, Robert Brown trawled their lists and selected a number of people for nomination. He had only basic information available and wrote this on a standard nomination form. He would talk to the person's key worker (if any) and rely on their view. There was no multidisciplinary assessment: Sue Jeffs of Cherwell Housing Trust had suggested such a system but had been turned down by Housing Department staff on the grounds that it would be too time-consuming.

14.61 The Inquiry examined this form. It asked which of the eligibility criteria were met by the candidate. This was completed in the briefest manner: in John Rous's case, the acronym "MP" indicating "mental disorder, other than mental handicap, past or present". Key worker and diagnosis were listed. However, the form did not ask whether people fell into the excluded categories. The paperwork therefore missed the opportunity to identify whether nominees had histories of violence, drug or alcohol problems, or serious acute illness.

14.62 At Jacqui Porter House, Joseph McGowan and David Marsh interviewed the nominees. They used a proforma, apparently designed by Michael Hall, and felt constrained to stick closely to it. Both Marsh and McGowan reported finding that the Council had not gone through the criteria carefully and that they had to go through them again. Sometimes key workers were present and sometimes not. Key workers were not asked the questions unless they were present at the interview. Corroborating evidence was sometimes sought and sometimes not.

14.63 It is commonly understood good practice in supported housing management to take great care when considering new applicants, to seek information widely, and to challenge and probe because of the common experience that referring agencies may be economical with the full truth in their desire to secure a place (we stress there is no evidence of this in respect of Jacqui Porter House), or simply not know the full picture. In this light, the confused and weak process at Jacqui Porter House is hard to understand. However, several witnesses explained that this entire process was foreign to Oxford Cyrenians: they had always filled group homes from people moving on from Simon House and therefore already well known to them. It does not seem to have occurred to any of the staff involved that filling Jacqui Porter House was a new experience for them and that they should perhaps seek advice on how to do it. A strong impression emerged that relations between group home managers and Michael Hall at this point were so bad as to preclude such rational consideration.

14.64 John Rous's referral followed this process. The files of the homeless persons

unit show that Angela Stannard assisted John Rous to apply for help on 11 March 1992. Debbie Hill from the unit interviewed them both, and heard that John Rous was suffering from schizophrenia and was homeless. She understood Angela Stannard to be John Rous's key worker, and sought further information from Dr Stevens as John Rous's general practitioner, who confirmed the diagnosis. John Rous was accepted as homeless and in priority need as vulnerable by reason of mental illness. He was placed temporarily in bed and breakfast accommodation.

14.65 It may be surprising to a non-specialist that a homeless person can be assessed as vulnerable because of a serious mental illness such as schizophrenia yet be placed in bed and breakfast. However, we were told that this was standard practice in Oxford and indeed nationally. To her credit, Debbie Hill expressed concern and sought assurances from Angela Stannard that she would continue to provide a "strong support package". These assurances were given. Had support not been arranged, she would have contacted social services to try to secure help: but the duty to provide housing remained even if no support had been forthcoming.

14.66 As far as we can ascertain, Angela Stannard did not make the homeless persons unit aware of John Rous's use of alcohol and drugs, nor of his episode of violence to a nursing officer in 1977.

14.67 Robert Brown told the Inquiry that he considered John Rous as a potential candidate for Jacqui Porter House when it was opening a few months later. He contacted Angela Stannard who agreed that Jacqui Porter House would be suitable. No further assessment was sought. Mr Brown completed a referral form which noted the contact with Elmore, medication and mental illness. No mention was made of drugs, alcohol or violence, and there is no evidence to suggest that Mr Brown knew about any of these problems.

14.68 Joseph McGowan and David Marsh interviewed John Rous, probably with Angela Stannard present. They already knew John Rous from his time in various hostels and on the street. They thought they were aware of his drink and drug use, and asked a direct question: they accepted his reply that it was not a major problem. Yet the care plan set out for John Rous a few weeks after he moved in showed drinking as the first problem mentioned.

14.69 The Inquiry panel considered the question as to whether John Rous should have been accepted by Jacqui Porter House under its eligibility criteria if the full facts

had been known. The single serious episode of violence was so long in the past as to be very unlikely to exclude him: he was by no means "persistently" violent. The drink and drugs use probably should have excluded him. However, Joseph McGowan and David Marsh were far from unique in not recognising the seriousness of this. They sought further information from Angela Stannard, and this too failed to mention a drink or drug problem. John Rous's chronic schizophrenia would certainly constitute a serious current mental illness, but staff clearly believed he was stabilised by his medication so that he did not require a "high degree of specialised care" and that his condition was not "acute". Several other residents were much less stable. On balance it is the drink and drug problem which should have excluded him, and this had been downplayed. We were left with a question mark as to whether Joseph McGowan's and David Marsh's previous knowledge of John Rous led them to relax their guard.

14.70 The other nominees to Jacqui Porter House show clearly that the Jacqui Porter House managers were accepting people with serious mental illness. Records provided by Oxford Cyrenians staff show that of 15 people accepted to Jacqui Porter House.

- 6 were referred for housing by hospitals/hospital clinics
- 5 were referred by a therapeutic project for people with mental illness
- 4 were noted as displaying aggressive behaviour
- 5 were noted as self harming

Diagnoses included paranoid schizophrenia (5), schizophrenia (1), manic depression (1) and depression (6). Personality disorders and behavioural difficulties are mentioned frequently. Clearly, such residents did indeed require a high degree of specialised care. Their needs were well beyond the capacity of the staff available to meet them.

14.71 Other characteristics of residents at Jacqui Porter House were that they were much younger and more academic than Oxford Cyrenians' usual resident group. In this regard, John Rous stood out as fitting more closely to the Cyrenians' traditional resident profile. No other residents had a background of living on the street. Many had family who would visit regularly. The house has been described as "intellectual" and different in class terms from other Oxford Cyrenians group homes. Staff were aware of the stress this placed on John Rous.

14.72 We have been told that 39 Rectory Road remained empty because of Council insistence that it should be a "women only house", and their failure to come up

with any nominees who wanted such provision. The Council maintain that nominations were made, but were discouraged from being accepted by the Cyrenians. We take no view on this, but the result was that the staff who would have run this home were not appointed. The mutual support intended between staff of 41/2 and 39 was therefore lost. When 39 did open temporarily as a decant house while another property was being repaired, the staff there worked very separately as part of a different team.

14.73 This section cannot conclude without examining why a housing department came to take the lead role in making nominations to a registered care home without social services involvement. This is exceptional. It could no longer happen - financial arrangements now require an assessment by social services. The Housing department was trying to develop a project to house people for whom it had a statutory duty, and for whom the alternative was probably bed and breakfast accommodation.

14.74 Overall, the arrangements for selecting residents at Jacqui Porter House were appalling. Housing were insisting on a 100% right to nominate, restricting the right of refusal, making assessments with inadequate advice on care arrangements, and failing to check the exclusion categories. The Cyrenians should never have accepted the house with so little control over who was housed, failed to communicate amongst themselves, failed adequately to cross-check information provided, failed to take their own criteria seriously, recognised their inexperience in considering referrals but failed to seek advice, and grossly over-estimated their capacity to cope. Their Committee failed to understand the responsibilities involved in becoming the proprietor of registered care homes, and did not take adequate steps to find out what these responsibilities were. Angela Stannard failed to communicate the seriousness of John Rous's drink and drug problem. Statutory care agencies were notable only by their complete non-involvement, save for Dr Stevens's letter to the housing department. While there would have been few grounds for concern at the risk of violence from John Rous even if all the information had been properly communicated and considered, there were overwhelming grounds for concern at the risks presented by such inadequate selection arrangements and by the balance of residents finally accepted.

14.75 For the housing department, Richard Peacock stated in his written evidence to the Inquiry that the City Council had no involvement whatsoever with the management, financing or day-to-day running of the house. In his verbal evidence, Mr Peacock said that he stood by this statement. The Inquiry found

this incompatible with the level of influence exerted by the housing department over the design, eligibility criteria and nominations to Jacqui Porter House.

Monitoring by Cherwell Housing Trust

14.76 Cherwell Housing Trust is a medium sized housing association with a stock of some 1,055 units of general housing, and 274 bed spaces of specialist supported housing. Formed in 1967, Cherwell is a charitable association which aims to provide rented accommodation for families, couples and single people on low incomes. Currently 48% of its stock is family housing, with 15% for older people and 37% for single people. It continues to develop new housing, and has a small subsidiary association which develops low cost home ownership initiatives.

Compared to most housing associations, Cherwell has an above average proportion of its stock devoted to special needs work. As its entry in the Housing Association's Yearbook states, *"Cherwell Housing Trust works throughout Oxfordshire and Berkshire in partnership with local authority, health and voluntary sectors to provide general housing and housing with care and support for those who are most vulnerable or disadvantaged."*

Cherwell Housing Trust has extensive links with other agencies in Oxford, through committee membership, staff backgrounds, and attendance at joint planning and interagency meetings. It has had particular links with the Cyrenians:-

- David Belton was General Manager for Cherwell Housing Trust from 1975 to 1990 and a committee member of Cyrenians from 1980 to 1994, acting as the Cherwell Housing Trust representative until 1990.
- Richard Temple worked first for Oxford Cyrenians, and then for Cherwell Housing Trust where he co-ordinated the early stages of their involvement with the Jacqui Porter House development.
- Oxford Cyrenians projects represented over a quarter of Cherwell Housing Trust's entire special needs housing stock.

14.77 Cherwell Housing Trust became involved in Jacqui Porter House as a registered housing association was needed to apply for HDG. Once HDG was not forthcoming, they remained involved because they owned No 40 and wanted to facilitate the scheme, and intended to continue attempts to secure funding.

14.78 Cherwell Housing Trust took on a lease, and signed a management agreement

with Oxford Cyrenians. By doing this, they took on the responsibilities of landlord. As a registered housing association, Cherwell Housing Trust must meet the standards set by the regulating body: the Housing Corporation. These standards were at the time set out in a booklet entitled "Performance Criteria for Housing Associations", published in April 1992. Section 3.3 of the Criteria state that associations must:

"Ensure that their agents provide an efficient and effective service to agreed standards;

- *by choosing suitably qualified agents*
- *by retaining enough control to ensure the association's responsibilities are met,*
- *for compliance with the registration criteria*
- *as landlord of the occupants*
- *as recipient of public funds*
- *by monitoring the service provided, and regularly reviewing the agreement"*

Section 7.7 requires that if associations provide special needs housing, they should:

"Have arrangements for ensuring that people with special needs receive appropriate management, care and support;

ensuring the association or their agent (eg voluntary agencies) have the relevant skills/experience and comply with:

- *the Tenant's Guarantee for Special Needs*
- *criteria for relevant funding (eg HAG, SNMA)*
- *Registered Homes Act requirements (where relevant)".*

14.79 The arrangements between City Council Housing Department, Cherwell Housing Trust and Oxford Cyrenians are set out in two leases and management agreements, one for 41/2 and the other for No 39. The agreement delegates the running of the houses to Oxford Cyrenians, but Cherwell Housing Trust remain responsible for monitoring and supervision of Oxford Cyrenians as their agent. Schedule 5 to the agreement sets out the monitoring reports which Oxford Cyrenians are to provide to Cherwell Housing Trust half yearly. These include health and safety issues including accidents and incidents, copies of registration inspection reports, details of lettings and move on, details of staffing levels and staff turnover, details of first aid and other training. The list is comprehensive and would certainly meet Housing Corporation standards.

14.80 No such reports were ever received by Cherwell Housing Trust. Cherwell Housing Trust staff expressed neither surprise nor concern at this. They did not chase up such reports, nor question Oxford Cyrenians as to why they were not provided. Only financial returns were received. Cherwell Housing Trust staff expressed the view that incidents were frequent in residential care and they would only expect to hear of serious incidents: they were unaware that there had been previous serious incidents at Jacqui Porter House.

14.81 The agreement also provided that Cherwell Housing Trust would appoint a representative to Oxford Cyrenians' Council. This appears to have been the only approach to monitoring which existed in practice. From February 1992, John Ewens as Cherwell Housing Trust's Special Needs Co-ordinator was their representative. His notes show that Jacqui Porter House was mentioned several times in Michael Hall's reports to Oxford Cyrenians' Council over the period to October 1993. It is apparent however that Jacqui Porter House is discussed only when Michael Hall raises it, and that Mr Ewens does not actively request monitoring reports.

14.82 Jacqui Porter House was just one of Cherwell Housing Trust's projects with Oxford Cyrenians. With over 60 residents, Simon House was much larger. Liaison with Oxford Cyrenians tended to be general rather than specific to each house except in respect of Simon House itself. The very different nature and unique problems of Jacqui Porter House were therefore missed by their monitoring.

14.83 David Belton, former director of Cherwell Housing Trust, was also a committee member of Oxford Cyrenians. Mr Ewens's predecessor at Cherwell Housing Trust, Richard Temple, had come to Cherwell from Oxford Cyrenians. These close relationships were not felt by Mr Ewens to create a conflict of interest or a difficulty in raising matters of concern.

14.84 The Housing Corporation requirements lay particular emphasis on the association's duty to satisfy itself that registration requirements were met. However, Sue Jeffs for Cherwell Housing Trust stated that she had not consulted the Oxfordshire standards for registration in order to assess the adequacy of staffing levels. There appeared to be no formal agreement with Oxford Cyrenians as to what the staffing levels would be except via the budget. Cherwell Housing Trust staff were not aware of the consequences for staffing levels of 39 remaining empty, nor did they know of the split into North and East teams at the time. Registration appears to have been left entirely to Oxford

Cyrenians. Sue Jeffs had received letters from Michael Hall stating that negotiations were continuing with registration because the scheme was so unusual and no suitable standards existed, yet does not seem to have followed up this point. Cherwell Housing Trust's files contain no copy of the registration application or certificate.

14.85 Mr Ewens was responsible for negotiating HDG settlements for Simon House. The Inquiry heard evidence from Oxford Cyrenians of uncertainties and delays in settlement and payment of HDG by the Housing Corporation. A dispute with Cherwell Housing Trust over HDG was developing in 1992/3, and caused significant financial problems.

14.86 It is impossible to avoid the conclusion that Cherwell Housing Trust failed to meet the standards of monitoring and oversight of registration expected of them by the Housing Corporation. Cherwell Housing Trust's special projects committee had noted particular concerns in respect of staffing, nominations and financial viability at Jacqui Porter House, so that the responsibility falls on the staff involved.

Housing conclusions

14.87 This Inquiry has seen both broad structural failures and failures of individual performance in the field of housing for people with severe mental illness. An abdication of responsibility by statutory care agencies for street homeless people with severe mental illness, drug and alcohol problems led to voluntary agencies filling the gap. Those voluntary agencies failed to reach adequate standards of work. A housing department, with a legal duty to house vulnerable homeless people and with a lack of assistance from social services, set out to develop a project which became high care without discussion with care agencies. A series of changes to funding rules by the Department of Environment, perhaps motivated by the desire to control budgets and limit responsibilities for the housing aspect of community care, led to a flawed scheme with serious in-built faults. Cyrenians and Cherwell Housing Trust either failed to realise the seriousness of these faults or to withdraw from the scheme if they did realise them. Individual homeless people were nominated for housing at Jacqui Porter House without assessment by social services (or in some cases by any care agency). Many had previously been placed in bed and breakfast despite their vulnerability. Cyrenians staff failed to recognise they were taking on people who presented challenges well beyond their ability to cope, and certainly well beyond the capacities of the staff numbers and skills at their disposal.

14.88 It is not possible to design housing with care services such that tragedies will never occur. It is however possible to take a series of steps to minimise the risks that they will. Steps which any reasonable agency should have taken were not taken in the case of Jacqui Porter House.

14.89 A number of improvements have taken place in these areas since October 1993, in the Cyrenians themselves, in Oxford generally, and at national level.

14.90 The Cyrenians have improved staffing, staff training and supervision, use and induction of volunteers, care planning, links with key workers and other care professionals, risk management, and matching of project aims to staff numbers and skills.

14.91 Statutory agencies in Oxford have put considerable investment into community mental health services, including a team to meet the needs of those who are homeless or with multiple problems. Regular chief officers' meetings between housing and social services have improved liaison. Automatic cross-referral has been arranged between the Housing department and social services for homeless people who are severely mentally ill.

14.92 At national level, the Departments of Health and Environment have several programmes underway to improve links between housing and care services for people with severe mental illness. These include an NHS Executive priority to encourage purchasing of high care housing provision, interdepartmental seminars, and dissemination of the work of the homeless mentally ill initiative piloted in London. The introduction of community care assessments for entry into registered homes means that social services would now always be involved in referrals such as that of John Rous into Jacqui Porter House. The move towards contractual arrangements between statutory agencies and the independent agencies they fund allows quality standards to be specified and monitored.

14.93 More broadly, there is increasing recognition on the part of all the agencies involved of the need to integrate medical and social care for people with severe mental illness, and that housing forms an essential component of the care package.

14.94 However, gaps remain. Many homeless people with severe mental illness remain outside care management and care planning, in general hostels or unsupported accommodation: up to 150 in Oxford alone.

Chapter Fifteen

Thames Valley Police:

'999' telephone call: 9 October 1993

15.1 At or about 7.32 pm on 9 October 1993 John Rous made a "999" telephone call which was received by a British Telecom operator at Leicester who transferred it to the Oxford Control Room where it was received by Mr Brian Coombs, a civilian operator employed by Thames Valley Police. The transcript of part of the call taken by Mr Coombs is set out in Chapter 4. Following the termination of the call at Oxford John Rous continued to speak to the British Telecom operator at Leicester, and we reproduce a transcript of the entire call provided by British Telecom:-

BT OPERATOR = OP
CALLER = C

"OP:	*Emergency, which service.*
C:	*Police*
OP:	*Police, thank you, what telephone number are you calling from please.*
C:	*I've no idea.*
OP:	*Is it a pay phone?*
C:	*No I'm, um 31/32 Rec.... 50. 41/42 Rectory Road.*
OP:	*OK just a minute I'll put you through to the police, I've got a (indistinct)*
POLICE:	*Police emergency*
OP:	*It's Leicester Centre, connecting you to pay phone 0865 200527.*
POLICE:	*Thank you, Police emergency.*
C:	*Yeah, it is yeah, um, I'm living at 41/42 Rectory Road, Are you with me?*
POLICE:	*I'm sorry, you're ringing from?*
C:	*Yeah, that's where I'm ringing from.*
POLICE:	*41/42 Rectory Road?*
C:	*Yeah. That's where I live.*
POLICE:	*And what's the problem there?*
C:	*The problem is, I fucking got a loan off the people who run the place and they've ripped me off for three quid and I'm in a fucking bad mood, and if I don't get that fucking money in the next*

half an hour I'm gonna take his liver out...

POLICE: *Mm. Sir, that sounds quite desperate, I do wish you'd stop swearing.*

C: *Yeah, I fucking, I deserve to fucking swear, John Major says the, calls 'em a load of bastards doesn't he. He's the Prime Minister, he can hardly get away with it so why shouldn't I. Now this is God's truth man, if he doesn't give me that money in the last half an hour he's lost his fucking liver. So you'd better get down here and sort him out. If you don't do that then you've got yourself a dead corpse. 'S Up to you, not me, I'm not fucking worried about it.*

(8 second pause)

OP: *Can you put the telephone down please, the police have cleared.*

C: *Eh? What?*

OP: *Can you put the telephone down, the police have cleared.*

C: *Are they gonna come and see me or what?*

OP: *I don't think so, not after the language you've just used, no.*

C: *Well why not, I'm a fucking criminal, what do you fucking want man.*

OP: *OK, bye.*

C: *Do you want, do you want a fucking brick in your fucking police station (pause 3 seconds). Do it again.*

Total Duration: 1 min 54 seconds"

(Police records indicate that the call was disconnected after the phrase "John Major says".)

15.2 We invited Mr Coombs to attend the inquiry, but he declined to do so. Mr Coombs was an experienced Control Room operator having served for some six years. Following this incident he was subject to an internal police disciplinary inquiry, which recommended his dismissal. On appeal the order of dismissal was reduced to the sanction of a final written warning, and Mr Coombs subsequently resigned from his job.

15.3 Superintendent McWhirter, the Officer in charge of the Thames Valley Police Control Room, attended the inquiry and gave evidence. He criticised Mr Coombs's response to the phone call. He said that Mr Coombs made no effort to elicit information which would allow him to make a judgment as to what to do. The call was terminated at an early stage. Superintendent McWhirter said

that by reason of the threat of violence this call should have been placed into 'immediate' category. This would have resulted in the content of the call being communicated to one of the two radio operators on duty who in turn would have put out a call to a police panda car requesting a visit to Jacqui Porter House. Superintendent McWhirter believed it likely that a panda car would have taken about ten minutes to arrive at Jacqui Porter House. An officer or officers would then have met with John Rous (if present), or they would certainly have discussed the situation with Jonathan Newby. He thought it unlikely that John Rous would have been taken away, the more likely scenario would be a 'calming down' of the situation to a point where the police officer and Jonathan Newby were satisfied that no threat of violence existed.

15.4 We considered whether the call could have been accidentally terminated but concluded that it was not. No telephone disconnection purr was audible, Mr Coombs made no attempt to reinstate the call, he did not report the call or any accidental termination to a radio operator.

15.5 We accept and agree with Superintendent McWhirter's criticisms of Mr Coombs's handling of the telephone call. We believe that had the radio operator been informed of this call a panda police car with one or more officers would have arrived at Jacqui Porter House by 8.00 pm. This one step alone would probably have averted the death of Jonathan Newby.

15.6 We also criticise the British Telecom operator for failing to inform the Oxford Control Room of what was said by John Rous following the termination of the call at Oxford.

Arrest of John Rous

15.7 The Thames Valley Police disclosed the documents relating to their investigation of the death of Jonathan Newby. The investigation was thorough and the Inquiry was greatly assisted by these documents not least in that they identified potential witnesses for the Inquiry.

15.8 In reading the many papers it is clear that following the stabbing but prior to his arrest John Rous was in an excited, agitated and potentially violent state. He was arrested and taken to St Aldates Police Station, Oxford. When John Rous was first interviewed a solicitor and social worker were present. The police requested a sample of blood from John Rous so that tests could be carried out to ascertain the presence and level of alcohol or drugs. John Rous refused consent to the taking of such a sample.

Chapter Sixteen

Training

16.1 Among the NHS staff involved, there was evidence of considerable specialist skills, experience, knowledge, training and qualifications in the care of the severely mentally ill.

16.2 The client group in residential care with the Cyrenians and, by implication therefore in day care at the Mill and as clients of the Elmore Team, included severely mentally ill people of equivalent severity of illness and degree of difficulty of management to psychiatric in-patients at Littlemore Hospital. Despite the amount of disability presented by such people and the potential for individual and collective disturbance resulting from this, there is a considerable discrepancy between the professional training and skills of the staff of these voluntary agencies compared with staff of the statutory authority, especially the Mental Health Unit of 1993. Elmore employed a community psychiatric nurse but prided itself in "de-roling" its community support workers; the Mill employed a trained nurse with some psychiatric experience but no pertinent qualification; there were no staff at Jacqui Porter House with any mental health professional training or qualification.

16.3 On enquiring about in-service training for the staff of the voluntary agencies, it appears that this was provided at the rate of about 6 days per year by the Oxford Network. Although this covered such relevant topics as risk assessment and management of violence there was no education on the recognition, understanding and management of mental illness. The situation appears to have developed in Oxford that a large number of very severely affected mentally ill people were receiving residential and day-care from employed staff and volunteers who were almost uniformly without specific training, qualifications or experience in any of the mental health professions and almost bereft of specific in-service training in these areas of professional expertise.

16.4 The Inquiry heard from Tony Smith, an officer of the Local Government Management Board and of the Joint Initiative for Community Care, as an expert witness on the topic of training. He commented that there had been a "total absence of nationally agreed programmes and qualifications for the majority of the workforce" in the residential care field. The position in the voluntary sector

had been revealed by reports to be particularly bad, with cost constraints and the difficulty of releasing staff for training quoted as contributory factors, along with the ad hoc nature of many of the courses on offer. Efforts to improve training in social services such as the Social Services Inspectorate's Training Support Programme had not been extended to the voluntary sector.

16.5 National Vocational Qualifications in care work had been developed in part to fill this gap. However, in 1992/3 such NVQs were relatively new and only patchily implemented. NVQs are not training courses, but rather an assessment of the competence of individuals in their workplace against nationally determined standards. Training courses or systematic staff development schemes therefore still needed to be put in place to meet skills gaps. Various reports and publications had been produced to provide advice on the training of residential staff, but these were quite new at the time.

16.6 The Inquiry looked in detail at the NVQ awards in care at levels 2 and 3 - the only levels so far available. The level 2 award contains little specific material on provision of residential care specifically for people with a severe mental illness. The level 3 award includes a core unit on the management of aggressive and abusive behaviour. Although rather weak on the specific issues of alcohol, drugs and mental illness, the unit covers the main points.

16.7 The level 3 award also has a separate option or "endorsement" covering mental health care. The units involved in this option are as follows:

"Z2 Contribute to the provision of advocacy for clients.

X2 Prepare and provide agreed individual development activities for clients

X16 Prepare and implement agreed therapeutic group activities

W1 Support clients in developing their identity and personal relationships

W5 Support clients with difficult or potentially difficult relationships

W6 Enable clients to maintain contacts in potentially isolating situations".

16.8 Although useful in themselves, these units would not provide an adequate basis for staff in residential care homes for people with severe mental illness. It does not include the basic underpinning knowledge about mental illness, its effects, commonly used treatments and their effects, the roles of the different professionals involved, the legal framework such as the Mental Health Act, current systems of care such as the CPA or care management, or how to get help

in a mental health emergency. Because NVQs are assessed on competence in the job, they are generally weaker on assessment of such essential background knowledge. Yet the mental health option in this NVQ does not even contain such basic skills as working in a multidisciplinary setting, liaising with key workers, exchanging information, knowing when to call in expert help, and so on.

16.9 The Inquiry heard that the development of a level 4 NVQ, as a bridge between vocational and professional levels of qualification, would help in this regard. If that is so, we would urge that priority is given to its development and that it includes:

- an understanding of the signs and symptoms of major mental illnesses and the ways in which people with mental illnesses may feel and experience the world;
- an understanding of substance abuse, its effects, and how to recognise and monitor it;
- interpersonal skills including the ability to communicate with people with severe mental illness and with other staff involved in their care;
- an understanding of the commonly used medical and psychological treatments and their likely effects;
- similarly, an understanding of the social care services and their roles, including housing;
- an ability to observe and monitor the well being of someone with a mental illness, and to recognise when to call for expert assistance;
- an understanding of the roles of the different professionals and agencies involved in care for people with mental illness;
- an understanding of the systems for arranging and managing care, including the Care Programme Approach, supervision registers, community care assessment, and (in the future) powers of supervised discharge;
- a competence in working as part of a multidisciplinary and multi-agency service, contributing to key working and care management, with a clear understanding of what these roles involve;
- a competence in risk assessment and the prevention and management of behaviour which is dangerous to self or others;
- competent record keeping;
- an understanding of the legal framework, including the Mental Health Act, and how to use it effectively;
- competence in obtaining emergency help for clients with acute mental health problems.

16.10 This qualification would be appropriate for all staff responsible for the care of

people with severe mental illness, whether as a stand alone qualification for staff who are not professionals in this field, or as an integrated component of nursing, medical or social work qualifications. It would need to be taken to a second, higher level for staff who are to take on key working responsibilities: such staff would also need to be competent in:

- the planning and management of care;
- guiding other staff in the provision of care and monitoring of the client's condition;
- identifying when a care plan review is necessary and organising this with all the relevant agencies;
- writing clear and relevant reports.

16.11 Such qualifications would need to be backed up by nationally available training and other staff development programmes. The Inquiry heard examples of how such programmes had been set up in their own locality by individual practitioners who saw a desperate need. Dr Phil Timms, who gave expert evidence on services for homeless people with mental illness, provided details of the training modules offered by his team which covered much of this ground. The Inquiry also heard from former volunteers and staff at the Cyrenians of how valuable even very brief training opportunities in this subject had been. Examples do exist to build upon, but a major effort will be needed to turn them into the comprehensive programme required for all the different occupations now involved in community care.

16.12 The basic qualification would be of benefit far more widely than simply for residential care staff. There are a host of other staff in different agencies who would benefit from such a basic grounding, including day centre and drop in centre workers, homeless persons officers, and professionals such as probation officers whose work brings them into regular contact with people with severe mental illness: it represents a core competence which should be common to all those involved in their care.

16.13 Even with these training programmes and qualifications, there would be a need to provide basic induction training for staff and volunteers who are just entering the field and taking on their first job or volunteer placement. The Inquiry felt that all those involved in care work with people with severe mental illness, in whatever capacity, should have an initial basic training before commencing work. This should cover:

- emergency procedures and how to get help quickly;
- clear instruction on responding to violence and danger;

- induction into the agency's procedures which the worker will be required to operate;
- guidance on the boundaries to the worker's role and responsibilities;
- information about the clients with whom the worker will come into contact.

16.14 We therefore recommend three levels of training:

- a basic level of induction before any direct work with clients;
- a detailed training programme, backed up by a stand-alone qualifications or integrated into professional qualifications, for all those responsible for the care of people with severe mental illness;
- a higher level of training and qualification for all those taking on key working responsibilities.

16.15 We have illustrated the need for appropriate qualifications by giving examples of potential NVQs which could meet the need. We have described this option because expert evidence we received indicated that NVQs are the main route to qualifications for residential care staff. Other options might be available and equally capable of meeting the need. Our point is not to advocate NVQs as the only way forward, but rather to set out the competencies required and urge that appropriate qualifications are developed and promoted as widely and quickly as possible.

Chapter Seventeen

Roles and Duties of Charity Committees

17.1 Twenty years ago, many people involved in charities and voluntary groups as trustees and committee members saw their role as simply supporting good works. Often, people with prestige and influence would join committees in order to lend their name and support to a good cause, with the best of intentions. There was no expectation that becoming a committee member brought with it the job of managing the organisation.

17.2 Gradually, the required role has changed. The Charity Commissioners are now clear that committees must bear the ultimate responsibility for every action undertaken by a charity. It is expected that trustees will be fully involved, with no room for nominal members simply recruited as names for the letterhead. The NCVO have published useful guidance on the role of trustees, and summarise this in the following eleven duties:

1. Determining the organisation's mission and purpose.
2. Recruiting, supporting and reviewing the performance of the Chief Executive.
3. Approving, monitoring and evaluating the organisation's activities and services.
4. Establishing a fund-raising strategy.
5. Ensuring effective financial management.
6. Undertaking strategic planning.
7. Recruiting and inducting new board members.
8. Understanding the distinct responsibilities of board and staff.
9. Ensuring the effective promotion of the organisation.
10. Working effectively as a Board.
11. Reviewing the relevant laws and liabilities.

17.3 Others have summarised the fundamental role of Charity Trustees as:

- purpose (what does the organisation exist to do?)
- strategy (how does it do it?)
- probity (does it do it properly?)

17.4 Legally Trustees are responsible individually and collectively for all of these duties. They cannot delegate their responsibilities to individuals or subgroups.

17.5 Oxford Cyrenians' committee were almost all recruited by Michael Hall as Director. All those we talked to had, at least during the 1970's and 1980's, seen their principal role as one of supporting Michael Hall in pursuing his "vision" for the homeless of Oxford. Individual members described how they saw themselves as "advisers" or "consultants" to the Director. Many realised that they were over-reliant on information provided by Michael Hall, but backed off challenging him about this. They did not demand reports if they were not provided, relying on Michael Hall to alert them to problems or new requirements. With hindsight, committee members acknowledged that this was inadequate. One member who began to question what was going on found himself sidelined.

17.6 Committees of charities face a tension between placing trust in their chief officer and ensuring a wider accountability which may appear to question such trust. In working with charismatic chief officers, this tension can become an emotional battleground. There are no simple answers to this difficulty but some pointers do emerge from our consideration of this case and are included in our recommendations.

Chapter Eighteen

Observations

Accident "black spot"

18.1 By 9 October 1993 a number of factors were prevalent and acting upon John Rous which we believe resulted in the creation of an accident "black spot". We list these factors:-

i. John Rous had been under pressure to repay a £20 loan to MIND. He did pay but was not pleased to do so;

ii. Resident B's behaviour was affecting John Rous. He was upset and disturbed when in Jacqui Porter House; his sleep was disturbed as B would run up and down stairs;

iii. John Rous's medication was wearing thin, he had been due to receive his depot injection on 8 October, and this was postponed to 11 October at his request.

iv. John Rous's appointment with Dr Agulnik on 5 October had been postponed, and John Rous was unhappy about this;

v. He had increased his intake of alcohol and possibly cannabis;

vi. By 8 October 1993 John Rous was in a state of high expressed emotion. The skills of those providing immediate support, namely the workers at Jacqui Porter House and Angela Stannard, were inadequate to deal with such a state. They displayed no awareness of the increase in the level of John Rous's agitation, restlessness and anger;

vii. The inadequacy of the procedures and arrangements at Jacqui Porter House meant that the elements supporting John Rous in those days prior to Jonathan Newby's death were paper thin, there was a total failure to provide a supportive environment for John Rous.

18.2 We repeat the observation made by all witnesses that an act of such violence as would result in a death was wholly out of character for John Rous. That said, we believe that, if persons possessing the necessary skill and training in the care of the severely mentally ill had been employed in Jacqui Porter House or by the Elmore Team and working as John Rous's key worker, the deterioration in John Rous's mental state would have been observed and appropriate care and support

would have been provided. We would add that had one or more people with the appropriate skill and training been employed at Jacqui Porter House, it is more likely than not that resident B would have been admitted to hospital and her disruptive and disturbing effect upon the other residents of the home would have ceased.

The Chain of Causation

18.3 We have considered carefully whether there were occasions upon which the chain of events which led to the death of Jonathan Newby could have been broken. We list such occasions:

i. In 1989 when the Elmore Community Team was set up and Angela Stannard took over the care of John Rous, thereafter being regarded by all as his key worker. The Elmore Team was set up with insufficient support and monitoring from statutory agencies, and did not recognise the skills and standards required for one who became by a process of choice or elimination the key worker;

ii. In 1992 when Jacqui Porter House was registered, the selection process for residents and resultant group dynamics were not effectively challenged by the Oxford Cyrenians nor by the Registration Authority;

iii. In 1992 when Jacqui Porter House was registered and the Oxford Cyrenians believed that their staffing rota (ie one volunteer on duty from 7.00 pm at night to 7.00 am the following morning) was acceptable to the Registration Authority and appropriate for the Residents in the house;

iv. In 1992 when John Rous was accepted for a place at Jacqui Porter House when no proper information was sought by the Housing Department nor the staff of Jacqui Porter House as to his history of mental illness and that of alcohol and substance abuse;

v. In April 1993 when Jonathan Newby began working for the Oxford Cyrenians but received no appropriate training in working with people with chronic and enduring mental illness;

vi. On 5 October 1993 and the days thereafter when there was a failure by Audrey Moore to implement appropriate procedures for resident B, namely an emergency assessment and admission to hospital;

vii. On 5 October 1993 when John Rous's appointment with Dr Agulnik was postponed;

viii. On 6 October 1993 when there was a failure by the workers at Jacqui Porter

House to act upon John Rous's documented complaint that B's behaviour was upsetting himself and other residents;

ix. On 8 October 1993 when a decision was made to retain existing staffing levels at Jacqui Porter House during the weekend and to allow one inadequately trained volunteer to work in the home where eight severely mentally ill residents would be present;

x. On 9 October 1993 - We believe that had two members of staff been present this would have acted as a significant deterrent to John Rous who would have been less likely to attack one worker knowing a second was present. Further had a second person been present Jonathan Newby could have turned to that person for advice, support or a second pair of hands in a deteriorating situation;

xi. Following John Rous's first outburst of anger and aggression the failure by Jonathan Newby to seek help or advice from colleagues;

xii. At 7.32 pm when John Rous telephoned the police and Mr Brian Coombs failed to respond to the call. We are satisfied that, had he done so, one or more police officers would have been at Jacqui Porter House by 8.00 pm and would have been present upon John Rous's return to the house;

xiii. At a time between 7.30 pm and 7.45/48 pm when Audrey Moore telephoned, Jonathan Newby gave no indication of any problem with John Rous. We are unable to be specific as to the timing of his call because of different times provided by Mrs Moore in different written statements;

xiv. At a time after 8.00 pm when Jonathan Newby allowed himself to be alone in a small office with a disturbed and aggressive resident.

Jonathan Newby

18.4 One question which deeply troubled us was whether Jonathan Newby contributed to his own death in failing after the first incident of aggression to seek help and by subsequently inviting John Rous to join him in a small office. We feel bound to record that all those who knew Jonathan, whether they were critical or supportive of the Oxford Cyrenians, expressed surprise that he had permitted himself to move into a small confined space with an aggressive and potentially violent resident. Whatever criticisms these witnesses made of the training which they received from the Cyrenians, they were in no doubt that in the event of a resident becoming violent they were taught to get out of the situation, possibly lock themselves in the office and call the police.

18.5 We have considered why it was that Jonathan did not follow the advice of which his friends and other workers were aware. We believe the reason is threefold:

i. It would have been Jonathan Newby's instinct to protect the residents who were in the lounge when John Rous exhibited threatening behaviour, by inviting John Rous to go downstairs with him.

ii. The ethos created by Michael Hall which still existed in October 1993, namely to manage the problem within and only as a last resort to seek advice;

iv. As a volunteer from an educated background he would attempt to talk through a problem. This, coupled with the absence of prescribed and repeated training, led him to respond instinctively to the situation.

18.6 Allowing for these matters we do not feel Jonathan Newby should be criticised for allowing himself to be placed in a tragically dangerous situation.

General Observations

18.7 It is a striking feature of the care and treatment provided to John Rous that he was almost entirely supported by voluntary agencies. Oxford Cyrenians had accommodated him since August 1992. Before then he had lived in the night shelter, squats and bed & breakfast houses, with the exception of his tenancy at Riverside Court from August 1988 to July 1991 and, apart from his spells on probation, social worker support and some supervision came from the Elmore Team. For his day care he had relied on The Mill Day Centre since 1983.

The only qualified professionals employed by statutory agencies who were continuously involved in the treatment of John Rous were Dr Agulnik, Dr Stevens and Dr Lee, his general practitioners, and their practice nurse.

18.8 We have noted that there were few or no trained mental health professionals within the voluntary agencies dealing with severely mentally ill people outside hospital in Oxford. We were not able to ascertain that there were any mental health professionals within Cyrenians or MIND. There was a community psychiatric nurse working in Elmore but the manner of working encouraged by that organisation was to divest workers of their original skills for which they had received training and produce a homogeneous generic project worker. It would be of benefit to volunteer organisations to have trained mental health professional workers available who could advise in particular circumstances and whose advice would be heeded.

18.9 A consistent finding from different clinical settings is that there are a greater than expected number of deaths occurring amongst those suffering from mental illness. Some of the earlier hospital studies showed a relative risk of mortality up to 20 times that experienced for in-patients suffering from schizophrenia. More recent studies and those in the community show a lower relative risk but still a significant increase when compared with the general population of up to 2 for neurotic disorders and about 4 to 5 for schizophrenia.

18.10 There is always a risk of death from suicide amongst those suffering from schizophrenia and about 3% of all suicides show a diagnosis of schizophrenia. There is also a somewhat increased mortality from natural causes. However, there is also a substantially increased risk of accidental death and such deaths are often associated with the psychiatric illness or current mental state.

18.11 In the case of John Rous and other residents of Jacqui Porter House, National Health Service provision was from the individual general practitioner with whom they were registered, and specialised psychiatric services. As far as we know all residents had previous contact with specialist psychiatric services, some would also have had contact with other specialist services for treatment of other medical conditions. By the time that Jacqui Porter House had acquired its residents the severity and chronicity of mental illness of those residents would be approximately equivalent to the chronic ward of a mental hospital in the 1970s or of a medium stay ward in the 1980s.

Responsible Medical Officer

18.12 Under the terms of the Mental Health Act the duties of the RMO are clearly defined and it is a useful concept. Many of the residents of Jacqui Porter would at some time in the past have been under the terms of the Mental Health Act and would therefore have had an RMO. Medical responsibility is a well established concept and for any in-patient, either in psychiatric or physically ill wards, there would be an identified consultant responsible for their care. However, when a person who is currently severely mentally ill is resident in the community, who is the Responsible Medical Officer? Where does medical responsibility lie, with the general practitioner or with the consultant psychiatrist? The general practitioner would consider that patients in such an establishment would need to be in contact with the practice in order to receive medical intervention, and the consultant psychiatrist similarly would provide regular out-patient appointments and surveillance and also the capacity for referral for in-patient care at times of crisis. However, if the hostel is separately managed from the NHS, neither physician would feel any direct responsibility for residents unless they

specifically made contact. This is quite unlike the situation pertaining on a psychiatric ward of a hospital.

Consultant Psychiatrist

18.13 The Consultant Psychiatrist in such a situation is in no doubt about his role as far as carrying out his own daily work is concerned. He/she is the RMO for patients under section of the Mental Health Act. He/she carries direct medical responsibility for all in-patients under their care. He/she is responsible for follow-up, liaising with other services, supporting and if necessary re-admitting those who have been discharged into the community. There is an established relationship between a Consultant Psychiatrist and Community Psychiatric Nurses working with the same patients and employed by the same Health Authority or Trust. The introduction of the Care Programme approach has not changed the method of working, it has merely formalised good practice. Difficulties come when the Consultant Psychiatrist is required to work with someone who is not employed within the Health Service and may not share the same aims and objectives for the patient. Care management has attempted to reduce these difficulties for joint working of Health and Social Services. However, in the case of John Rous the key worker came from neither Health or Social Services but from the Elmore team. Dr Agulnik recognised Angela Stannard as the key worker for John Rous but had no hand in her appointment as key worker and no opportunity to see what her mental health credentials, experience and qualifications would have been. Because of the manner of working of the Elmore team there was no community psychiatric nurse involvement in the case of John Rous, even though the management of depot injections, complicated by drug and alcohol abuse was a factor in his care. The Consultant Psychiatrist confined his care of John Rous to visits every 2 months to check medication, assess the mental state and ensure that social conditions were adequate. The key worker attended with John Rous. This type of relationship between Consultant Psychiatrist and key worker appointed by another agency is satisfactory as long as there are no major disagreements over care and the standard of care expected by both parties is similar. However, if the key worker were to be untrained in mental illness and was not delivering the level of care that was required, the Consultant Psychiatrist would have no way of achieving a better standard.

Role of General Practitioner

18.14 At the time when John Rous was resident in Jacqui Porter House, Dr Stevens and other general practitioners responsible for his care administered depot injections of anti-psychotic drugs on a regular basis. They also tried to control John Rous's benzhexol abuse both by keeping a careful check on the tablets administered and

also by notifying other general practitioners in the vicinity concerning the risk. They had a responsibility which they carried out for treating any physical conditions and they would also have served as the route to specialist services including emergency admission if this had been required. All these responsibilities were carried out effectively and John Rous was given an excellent level of care and attention. However there was no sense, and neither could there have been, of continual surveillance of John Rous from a qualified medical practitioner whilst John Rous was resident at Jacqui Porter House.

Relationship of Health Services with other Agencies

18.15 Health Service management was reorganised in the early 1990s. New working relationships were sought with Oxfordshire Social Services, Oxford City Housing Dept and other statutory agencies. There were working relationships between individual consultants and voluntary agencies such as Cyrenians, Elmore team and MIND. However the chief responsibility of Health Services and especially of the Mental Health Services was to maintain the quality of the Service for which they were directly responsible and make it available for referrals especially by general practitioners.

18.16 Because Mental Health Services had no formal responsibility for, nor control of, voluntary agencies there was no direct input from Health Services into such sites as Jacqui Porter House. There was territoriality involved - Jacqui Porter House was seen as belonging to Cyrenians and therefore Mental Health professionals could only go there by invitation from staff or individual patient. There was also a conflict of ideology - some of those working in voluntary agencies did not accept basic concepts of the existence of severe mental illness and many working in voluntary agencies had a policy of normalisation in which they attempted to treat severely mentally ill people exactly as if they were healthy people. This policy whilst attempting to reduce stigmatisation carries grave risks of giving inadequate care.

Jacqui Porter House

18.17 Most if not all of the residents of Jacqui Porter House were severely mentally ill. They were receiving treatment but not fully recovered. In terms of severity or chronicity of illness they could be compared with the residents of a medium stay ward of a decade ago and in fact many of them had been in-patients in psychiatric wards and hospitals previously. Whereas in-patients on a medium stay ward in a large mental hospital in the past would have gone to occupational therapy and other activities within the hospital during the day, the residents of Jacqui Porter House tended to go to the MIND day centre and to other places in the community.

18.18 An in-patient ward with patients of the severity of the Jacqui Porter House residents would always have had trained nursing staff on duty and also, usually untrained but experienced staff, there would be a stipulated and carefully calculated number of trained and untrained staff per resident population. There would be known procedures for any emergency. If staffing standards were not met the management would be held responsible and staff protest and union activity would be likely to result. It is unlikely that nurses practising a good standard of care would be prepared to work in the conditions that pertained at Jacqui Porter House because of the fear of eroding their standards.

18.19 Siting the severely mentally ill in a private house in the town under the care of a voluntary agency had the unfortunate consequence of no mental health professional input. There was no maintenance of professional standards, and no adequate assessment of risk.

Mixed Economy of Care

18.20 Such a "mixed economy of care" is becoming increasingly common nationally. People who previously depended mainly on hospital services and help from local authorities may now depend primarily on independent sector agencies, indeed many of them actually welcome the absence of officialdom which results. The safe and effective functioning of such arrangements does however demand a clear understanding of individual and shared roles on the part of the workers involved, and there must be clear routes for them to receive expert advice and support from professional people who are properly qualified to provide it.

18.21 In John Rous's case the sole professional person who was qualified to make judgements about his condition was Dr Agulnik. He told us that he relied on the abilities of Angela Stannard. Ms Stannard was not qualified as a psychiatric social worker or as an Approved Social Worker. No-one in the Oxford Cyrenians was formally qualified to understand John Rous's nature and needs following Joseph McGowan's departure from the organisation.

18.22 As we have said, such situations will be increasingly found as independent sector agencies increase in number and in the scope of their activities. For this reason national guidance has specified the procedures by which such jigsaws of personal care can be set in place and supported. We have referred to the Care Programme Approach elsewhere and to the fact that the necessary agreement between Health and Social Services in Oxfordshire was not set in place until October 1994. In this regard we have noted Dr Orr's and Mr White's explanations of why no action was taken locally on the Department of Health

Circular requiring action from 1 April 1991. Mr White emphasised that the introduction of Care Management procedures in April 1993 introduced a new standard in care planning and management by setting up "packages of care" for people who are resident in registered care homes like Jacqui Porter House. John Rous was, however, placed there under the pre-existing arrangements without an individual care plan or a system of reviews.

18.23 It has also become clear to us particularly from the frank comments of Dr Orr, Mr White and Ms Jean Carr that effective joint planning by Health and Social Services for Oxford's needs has only produced results very recently. Health Service resources for mentally ill people have largely been centred on Littlemore and Warneford hospitals. In this regard we understand that Dr Agulnik's out-reach work into the Oxford community has been unusual clinical practice locally; most, if not all, psychiatric teams in Oxford were until recently hospital-based. Mr White emphasised that although there had been joint planning since the 1980s, this had resulted in almost no development of actual services on the ground, until the advent of the Mental Illness Specific Grant in 1992. He felt confident that services which had not liaised before 1993 were now working collaborating much more closely.

18.24 We have no way of gauging whether this is so, but we note with concern Mr White's estimate that at present there are around 150 people with similar backgrounds to John Rous living in the Oxford area, whose care, support and risk management largely depend on these new systems. We can only conclude that the two main agencies which helped John Rous were poorly focused in their work, inadequately co-ordinated with each other and incompetently regulated. Oxfordshire Social Services was the registration authority for Jacqui Porter House, and continues to be a principal funding agency for the Elmore Team. We have to consider what registration and funding procedures might reasonably have expected in terms of the control to be executed by each voluntary management committee over the operations of its agency.

18.25 Dame Penelope Jessel told us that Oxford Cyrenians had grown "like Topsy". She acknowledged that her Council of Management had exercised insufficient control over Michael Hall and was caught up with complex restructuring and funding changes in 1993. Members of the Management Council did not routinely visit houses in their charge nor did they review management records.

18.26. It also seems quite clear to us that the Management Sub-Committee of the Elmore Community Team cannot have reviewed the supervision summaries

relating to Angela Stannard's work, which as we have noted were quite seriously inadequate. Dr Orr, Dr Agulnik and Ms Carrwere all members of Elmore's Management Sub-Committee, but they were not involved in directly examining John McLeavy's management summaries of Mrs Stannard's work load.

18.27 It has been said to us that management records are the responsibility of paid managers. We disagree. We consider that the Committees of voluntary agencies are ultimately responsible and publicly liable for the proper management of the services they provide. They should assure themselves directly that appropriate standards are maintained in the operational work of their agency. In this regard Mrs Elizabeth Leyland, in her written statement, expressed the situation which existed in the Oxford Cyrenians in 1993 as follows:

"I believe that within the Cyrenians the Council of Management was responsible legally for Jacqui Porter House. John Rous was offered accommodation there and voluntarily chose to live there.

Our role, however, is merely as advisers and consultants since the day-to-day management of the organisation is delegated to the Director. As such, we are dependent on others but mainly the Director to receive the necessary information. Until the recent changes, we mistakenly believed and trusted that we were being kept properly informed. To some extent, we may have failed to ask the right questions. We relied on the Director to give us information. We are learning from our errors and this situation has now been rectified."

18.28 It is evident that the management committee of Oxford Cyrenians and to a lesser extent the Elmore Team, failed in the discharge of their duties. This combined disastrously with the failure of the Inspector's regulation of Jacqui Porter House. Furthermore, the network of Health, Social Services and voluntary services in Oxford was unplanned and disparate, and had been so for many years, thus providing an environment in which expertise was not readily accessible to untrained workers. Therefore appropriate fail-safe mechanisms had not even been discussed between the agencies involved, let alone set in place and tested.

18.29 The lack of appropriate definition and understanding of roles and responsibilities in the care of John Rous are exemplified, perhaps unwittingly, by the written statements of Dame Penelope Jessel and Mrs Elizabeth Leyland. Dame Penelope stated:-

"John Rous was not under any constraints; he was a free agent. The Oxford Cyrenians offered him a supportive environment, which included training in

'social skills'. The object was to equip him to lead an independent life eventually. He was not, strictly speaking, under the care of Oxford Cyrenians. In so far as ensuring that the organisation is properly run, this is ultimately the responsibility of the Council of Management.

John Rous's care management was the responsibility of a variety of agencies and, of course, John Rous himself. The team would include his doctor, psychiatric consultant, social workers, and the Registered Care Home Inspectorate among others."

18.30 This view reiterated by Mrs Leyland in these terms:-
"John Rous was responsible for his own care. I therefore do not believe that any one person or agency was ultimately responsible for caring for him. I believe that the responsibility for supporting him and encouraging him to become more independent was shared between the following people and agencies: the Oxfordshire Social Services Inspection Unit; the Cyrenians' Group Homes Co-ordinator and Project Manager; the City Council Housing Department for placing him in Jacqui Porter House; and his psychiatrist Dr Agulnik, his GP Dr Stevens and his Elmore Community Support Team worker Angela Stannard."

18.31 If John Rous, as a wholly state-supported resident in a Registered Care Home, was not in their care, in whose care could he possibly have been? Angela Stannard told us that she considered she had ceased to be his key worker, but none of the other witnesses we saw were aware of that, neither had there been a formal handover from her. She had often taken John Rous to his appointment with Dr Agulnik, but these went unrecorded by either of them. The most consistent thread in John Rous's care and treatment was being provided by Dr Stevens and Dr Lee but primarily in relation to his depot medication, and their attempts to limit his abuse of Artane. They had tried on two occasions to communicate with Mrs Stannard but with no response.

18.32. All in all, we conclude that this describes a situation which could have been commonplace in Oxford. No-one has suggested otherwise to us. Dr Orr and Mr White assure us that the scene is now changing radically with the advent of Care Management, introduction of the Care Programme Approach, and with a commitment to joint planning and resourcing of new services. We are reassured by their honest acknowledgement that local services have some way yet to go before the deficiencies which have been all too apparent to the Inquiry are properly remedied.

Chapter Nineteen

Recommendations

Joint Liaison between Social Services and the NHS

19.1 **The NHS commissioning authority and Department of Social Services should make a joint plan which is then carried out to make provision for all severely mentally ill people living in their area. This should include provision for the homeless severely mentally ill for whom the high concentration of skills and professional training of the health provider Trust are particularly required. Access to services for the mentally ill, both within and outside normal working hours, both for routine and for emergency care, should be advertised to users, carers, other statutory bodies and voluntary agencies.**

Social Services

19.2 **Departments of Social Services have both statutory and moral responsibilities to those requiring community care for mental illness who are receiving services from voluntary organisations. Terms of contracts with these organisations should be defined so that standards relate to those of statutory health and social services and the standards should be reviewed systematically on a case review basis. Means of access to the advice and experience of Approved Social Workers should be defined and availability made public for the benefit of clients' carers and agencies providing care.**

Training

19.3 **Any establishment providing full-time and permanent care for severely mentally ill people will require the services and expertise of trained mental health professionals. Responsibility for this provision and for its specification lies both with the managers of the establishment and with the registration authority. In addition all employees require a programme of in-service training.**

The following should be considered:-

19.3.1 The programme of in-service training for employed staff and for volunteers should be intensified and be better directed to the needs of the severely mentally ill and the staff caring for them. To be more specific, without implying their relative importance or the amount of time that should be spent on each, the following should be considered:

i. the signs and symptoms of major mental illness

ii. understanding and learning to talk with severely mentally ill people,
iii. substance abuse and its management: alcohol and drugs,
iv. treatment and management of mental illness: physical, psychological and social,
v. Mental Health Act and its application,
vi. Care Programme Approach: Supervision Registers; power of supervised discharge.
vii. Risk assessment;
viii. emergency assessment and admission procedures;
ix. record keeping

19.3.2 These topics should be in addition to those, such as coping with violent episodes, which are already covered. There are undoubtedly members of staff of the statutory authorities who could teach and conduct seminars on the above subjects. It would be a valuable exercise in tripartite co-operation (voluntary agencies, social services and health) to organise and carry out such a programme. The staffing, funding and organisation of work of the statutory authorities should allow for such teaching and discussion to be seen as an essential activity directed towards improving the health of the people.

19.3.3 There should be developed an NVQ or similar qualification to provide a "core competence" for those working with the severely mentally ill in the community. The topics to be covered are those set out in paragraph 19.6.1.

19.3.4 In addition to providing a core competence, there should be a second accredited level for those operating as key workers.

Registration

19.4 **The registration authority (Department of Social Services) through its duly authorised arrangements for inspection (Social Services Inspectorate) should specify clearly and unequivocally the standards required for each individual residential home (whether it be a part of a larger organisation or not) in terms of buildings and their layout, amenities and equipment; type of resident and their number; number of staff on duty at any time, their experience and professional qualifications; in-service training needs. The authority has a duty to ensure that these specifications are both fully understood and comprehensively complied with. Every visit of the registration authority to the residential establishment should be recorded.**

The Registered Homes Act 1984

19.5 **The Department of Health should review its guidance to Local Authorities**

having responsibilities under the Registered Homes Act 1984 to ensure that:

i. **The regulations should require the production of staff rotas to registration & inspectiou staff.**

ii. **The regulations should require inspectors to check that the Care Programme Approach has been considered by registered homes.**

iii. **The advice contained in Annexe 5 of Home Life is clarified to ensure that ambiguities in relation to staffing levels are removed.**

Emergency Procedures

19.6 **The Health Authority and Social Services Authority should ensure that all such service providers are aware of the steps to be taken and the persons to contact in the event that an emergency assessment or admission to hospital appears necessary for a client. This information should be published and made widely available throughout the field of statutory and voluntary care, to carers themselves, to other agencies such as police and emergency services.**

Police

Drug-testing in custody

19.7 **When a person taken into police custody for a serious crime can reasonably be suspected of significant recent use of alcohol or non-prescribed drugs a police surgeon should be summoned rapidly so that appropriate testing can be carried out, subject to the consent of the suspect.**

19.7.1 The police should keep a log of all telephone calls which have been "cut off" accidentally or deliberately.

19.7.2 The police should ensure that police switchboard operators inform the radio operator of all calls which have been deliberately terminated.

Housing

19.8 **The Housing Department should, for all cases coming to their attention of people who are both homeless and severely mentally ill, consult with, take advice from and collaborate with the appropriate Social Services Department. Decisions regarding placement should be made jointly taking into account the opinion of the key worker. There is a need for exchange of information and provision of expert advice between Social Services Departments, statutory mental health providers and the Housing Department.**

The following should be considered:-

19.8.1 Homeless people assessed as vulnerable by reason of mental illness should automatically be referred for assessment by social services unless this has already been carried out. The Department of the Environment should include this requirement in guidance to homeless persons units.

19.8.2 Housing should be regarded as an integral part of a care plan by key workers and care managers.

19.8.3 Providers of housing with care should take all reasonable steps to identify the needs of people referred to them, and satisfy themselves that they can meet these needs. They should ensure that their referral forms ask direct questions regarding all their criteria for acceptance and for exclusion. They should ask these questions of the individual referred, and of all the care agencies involved: crucial information may only be known to one agency.

19.8.4 Housing associations and voluntary agencies providing housing with care should take all reasonable steps to meet the professional standards of care required by their residents. Such agencies should recognise that they are no longer meeting the needs of people who fall outside the mainstream of community care: they are providing the mainstream of community care.

19.8.5 The Departments of Health and the Environment should clarify their responsibilities for funding housing for people with severe mental illness, and ensure that their funding arrangements are fully complementary. Adequate funds should be made available to house and provide care for all those with severe mental illness, including street homeless people, those with multiple problems, and those needing continuing long term care.

Committees of charitable organisations

19.9 **Committees of charitable organisations should be, and should be seen to be, independent of their employed officers and staff. New members of the committee and the committee chairman should be selected by existing committee members. It should be recognised that committee membership confers management responsibilities. There should be regular communication between committee members and senior members of staff as well as the chief officer. Members of the committee have a statutory obligation to visit the organisation and a moral obligation to spend time there and get to know staff and residents.**

The following should be considered:-

19.9.1 Committees should never let one person become their sole source of information

about the state of affairs in the charity's work. There should always be regular personal contact between a number of committee members (not just the chair) and a number of senior staff, in an organisation of any size. No other approach is as effective as such personal contacts.

19.9.2 Management information should be required on all the main aspects of the charity's work. In the case of the Cyrenians, housing management, care services, staffing matters and complaints should have been monitored along with developments and finance. Committees should not be deterred from questioning either the figures presented or why other information has not been presented.

19.9.3 Committee representatives should be involved in the recruitment of the next tier of managers below the chief officer. Such posts should be openly advertised.

19.9.4 Committee members should regularly and actively monitor the quality of services actually being provided, either seeing it themselves first hand or obtaining independent reports.

19.9.5 Employees should be able to make direct representations to committee officers or members where line management fails to communicate legitimate complaints regarding the care of clients and the management of services. The Nolan Committee's suggestion that public bodies should designate an official or board member to investigate staff concerns may well be equally relevant to the charity sector.

Central Government and the Department of Health

19.10 **Community care for the mentally ill and contributions towards that care coming from the voluntary sector ("the mixed economy") are both frequently expressed policies of the Government via the Department of Health. Government should specify standards of care and levels of professional qualifications and in-service training required by employed staff for the care of severely mentally ill people in the community and ensure that the resources are available to meet these standards.**

19.10.1 There is a real sense, communicated to us by staff of voluntary and statutory organisations and friends and relations of Jonathan Newby alike, that the loose structures of inadequate integration of separate services and meagre distribution of professional expertise appeared to have been sanctioned by Government in carrying out a new policy without adequate preparation and resourcing.

19.10.2 The voluntary agencies, especially the Cyrenians, attempted to fill a gap in the provision of services - residential care for the homeless mentally ill. The

Social Services Department of Oxfordshire County Council had not been involved either with the identifying of or providing for this deficiency in as much as the responsibility for finding accommodation for homeless mentally ill people had fallen on the Housing Department of the City of Oxford, a separate authority. Whereas the Health Authority would have provided comprehensive care for psychiatric in-patients, it would only give intermittent out-patient care via a consultant psychiatrist to a person whose key worker came from an independent voluntary organisation and whose accommodation was provided by another voluntary agency. There is clearly a need for much better organisation and integration for the care of individuals with severe mental illness. This might be achieved by clarifying the role and responsibilities of the Responsible Medical Officer in the community and ensuring that the resources including relevant trained personnel were available to do this.

Confidentiality

19.11 **The Department of Health should complete its review of confidentiality and information exchange between the various agencies involved in community care for people with mental illness, and disseminate clear guidelines widely.**