The Report into the Care and Treatment of **Martin Mursell**

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INTRODUCTION

by Lincoln Crawford

Mulberry Court is a block of council-owned flats situated in Tompion Street, Islington, London EC1. No. 33 is on the fifth floor, where Mary Collins lived with her husband Joe Collins.

On the 28th October 1994, her son Martin Mursell, who suffered from schizophrenia, attempted to kill her by stabbing her three times in the chest, once in her back and twice to her elbow. He then left her for dead and attacked and killed his stepfather Joe Collins, who suffered from cystic fibrosis, by stabbing him 18 times to the body. As a result of her injuries, Mrs Collins remained in hospital for approximately two weeks.

On the 5th January 1996, at the Old Bailey, Martin Mursell, then aged 28, pleaded guilty to the murder of Joseph Collins aged 37 and the attempted murder of his mother Mary Collins and was sentenced to life and ten years imprisonment to run concurrently. He is now detained in Rampton Hospital. His Honour Judge Machin after passing sentence commented:-

> *"....it would appear that the defendant was certainly in need of some help and assistance. I do not know why it was not forthcoming or what in fact happened...."*

Three views have been forcefully expressed in the course of the Inquiry as contributing to the cause of the tragedy. The first is: Martin Mursell was released much too soon after his various admissions to hospital. On this view, it was felt that Martin was never given an opportunity to make a full recovery, making his relapse following discharge inevitable. The second is that the discharge arrangements for Martin were ill-prepared, unplanned and left him without a key worker whenever he was discharged. The third is that Martin was given very little help to find adequate accommodation, which resulted in him having to live in unsuitable conditions with his mother. We appreciate the strength of these views and should consider whether they were correctly held.

In this Inquiry we have sought to identify not only the quality of care given to Martin by individuals, but also the quality of care given to him by the various agencies and the level of collaboration and co-operation there was between them.

OVERVIEW

When an horrific incident such as homicide by a psychiatric patient occurs, it affects not only the family of the victim, but also the confidence of a sceptical public, and their view of caring for such patients in the community. This is largely due to the fact that the public believe that people suffering from mental illness are dangerous and potentially violent and that those charged with administering mental health services should produce a risk-free mental health care environment, conducive to harmonious co-existence with the rest of society. The widespread perception that this has not been

achieved has directly led to a pervasive sense of fear and insecurity on the part of the public, who have lost confidence in the Care in the Community Policy.

Public concern must not be allowed to diminish the benefits of care in the community, because it is now recognised by most professionals in the field to be far better than incarceration in Victorian-style institutions. Indeed most mentally ill people are not violent, do not present a risk to the public, prefer life outside hospital and most experience a better quality of life in the community.

We accept that the public's fear must be addressed, but research shows that the number of homicides by mentally ill people is not increasing significantly. The findings of the 1996 Inquiry into Homicides and Suicides by Mentally Ill People show that there are about 500 convictions for homicide each year in England and Wales. In about 80 of these cases the convicted person is found to be suffering from a mental disorder and is often convicted of manslaughter rather than murder, through diminished responsibility. The Inquiry also found that only about a fifth of people who killed while suffering from a mental disorder had been in contact with the mental health services in the previous year. As with homicide in general, most were men and most killed members of their own families. In the two years covered by the report, it was informed of only three cases in which the victim was a total stranger, and in one of these the diagnosis was a disorder of personality rather than a serious mental illness. But, how relevant are findings such as these? Are there glaring failures in the way the mental health services are operated? Could we solve the problem by merely singling out certain individuals for criticism?

Time after time and in various reports we have been warned of the shortcomings in mental health policy and practice that have given rise to tragedy. The messages are always the same – failure of reporting, failure in co-ordination, failure in communication between health and social services, poorly defined responsibilities within and across agencies and shortage of resources. Although singling out individuals for criticism has its value, the time has come for changes to be made in the delivery of mental health services, through joint planning locally and nationally.

Closer collaboration between relevant government departments would create a more effective national framework within which local agencies could ensure that there are appropriate community services for mentally ill people, instead of the patchwork of provision which came about as a result of the closing down of the large psychiatric hospitals.

THE INQUIRY

At the time of the murder and attempted murder by Martin Mursell, the mental health services in Islington were managed by the Camden & Islington Community Health Services NHS Trust, social services and housing were managed by the London Borough of Islington. Camden & Islington Health Authority commissioned this Inquiry under the terms of Health Service Guidance HSG (94)27 and the London Borough of Islington agreed to participate in an independent inquiry into the circumstances leading to the death of Joe Collins and the attempted murder of Mary Collins. The Terms of Reference were drawn up by the Health Authority. They are set out in Appendix D.

I was invited to become Chairman of the Panel of Inquiry in October 1995. My fellow members of the Panel were appointed by early January 1996.

The consent of Martin Mursell to use his medical and other records was obtained. The Panel then wrote to individuals and organisations involved with Martin during his five and a half years involvement with the mental health service, setting out the issues and the Terms of Reference, and invited the parties to submit evidence.

The Panel met in March, 1996 and, after discussion with the Health Authority, our first task was to agree the nature of the hearing. Should it be public or private? We took into account the distress the events caused to a number of witnesses, whom we hoped would be frank and open with us. I felt that in all the circumstances, the most sensitive approach was to hold the hearing in private. I recommended this to my colleagues and they accepted my recommendation.

As I had appeared as Counsel and chaired a number of Inquiries in the past, the Health Authority took the view that it would not appoint a Counsel to the Inquiry. This greatly increased my task as Chairman, not only because I had to take each witness through their evidence covering key events between 1989 – 1994 but also because it was necessary to prepare a detailed chronology covering the same period. However, I was ably supported by my colleagues on the Panel.

The written statement provided by each witness formed the basis of their evidence to the Inquiry Panel. I led with questions based upon the written statements and any relevant information contained in the documents. My colleagues then followed with a range of questions, usually covering their area of expertise, but from time to time they intervened during my questioning to clarify specific issues, which did not in any way hinder the flow of the evidence. I found their intervention often helpful and enlightening.

All witnesses were invited to bring a friend or colleague. Two of the doctors were accompanied by a solicitor, Mary Collins was accompanied by a representative from the Zito Trust, other witnesses either brought a friend or a colleague, or came alone.

We would like to thank all those who came to give evidence, and those who assisted by providing support or professional assistance.

As part of the process of informing itself about the provision of services for mental health patients, and in particular about some of the conditions which Martin Mursell would have experienced, the Inquiry Panel undertook the following visits:–

(a) Waterlow Unit, an acute psychiatric unit managed by Camden and Islington Community Health Services NHS Trust, formerly the psychiatric wing, Whittington Hospital;

(b) Jafar Kareem Ward, Waterlow Unit, formerly ward P3;

(c) Noel Harris Ward, St Luke's Hospital, also managed by Camden and Islington Community Health Services NHS Trust;

(d) Canonbury East Neighbourhood Office, London Borough of Islington;

(e) Mental Health Resource Centre at South Islington, managed by Camden and Islington Community Health Services NHS Trust.

These visits were important in understanding how the various agencies communicated with each other, and how they co-ordinated their efforts in caring for Martin Mursell.

We felt that to refer to Martin Mursell by his full name throughout the report was rather cumbersome. We obtained his permission to refer to him by his first name and where convenient we have done so.

Finally, our special thanks to Angela Greatley, the co-ordinator of the Inquiry. She faced many challenges obtaining the great volume of documents we had to consider and, organising the hearings and the visits, she overcame them and the progress of the Inquiry is evidence of her skill and patience. She was admirably assisted by Pat Shillong and Maggie Conoley and other secretaries.

CHRONOLOGY

The chronology is no more than a 'snap shot' of the events which occurred during the treatment of Martin Mursell between 1989 and 1994; accordingly, not every event is recorded. We list only some of the significant events.

Martin Mursell (MM) was born on 3/5/67. He was educated in London at primary school to age 11 years and Highbury Grove Secondary School to age 16 years. Martin was in and out of many jobs, but spent a large part of the time on social security benefits.

RMOs – Dr Bruce 8/2/89 to 5/89, Dr Taylor 5/89 to 13/6/93, Dr Dalton, 18/1/90 – 6/2/90, Dr Gurling, 18/1/93 – 21/1/93, 4/2/93 – 30/3/93, Dr Harvey 14/6/93 – 28/10/94.

We list here some of the significant events. Others are to be found in the relevant text. Where local authority or health staff are listed, this indicates their involvement during the period of time within which specific events occurred or action was taken.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
30/09/88	ABH on girlfriend 25/8/88. MM spent 4 months on remand; sentenced to 2 months imprisonment suspended for 1 year.				Separated from GH a year earlier after a relationship of 15 years. ADDRESS: 86A NORTH-CHURCH ROAD LONDON N1.
--/12/88	MM's brother leaves home.				MM's brother leaves home due to MM's behaviour.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
08/02/89	First contact with Bloomsbury & Islington Mental Health Services and Islington Social Services	Dr Sabharwal (GP) Dr Bruce (RMO)	Jeanne Smith (ASW)		Mrs Collins and MM's brother regularly had been threatened by MM. Police advised Mrs Collins to press charges.
10/02/89	First ADMISSION P3 Ward Whittington, for Assessment, Section 2, MHA.	Dr Sabharwal (GP) Dr Bruce (RMO)	Jeanne Smith (ASW)		
20/02/89	P3 Ward Round.	Dr Bruce (RMO) Dr Laverick (Registrar)	Jeanne Smith (ASW)		MM wishes to go home but Mrs Collins feels he is too unwell.
02/03/89	MM DISCHARGED on leave from Section 2. Out-patient appointment 10/03/89.	Dr Laverick (Registrar) Dr Sabharwal (GP)	Jeanne Smith (ASW)		Mrs Collins is kept awake all night by MM's disturbed behaviour.
03/03/89	MM's leave of absence revoked, brought back to hospital by Police.		Jeanne Smith (ASW)		

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
08/03/89	Section 2 ADMISSION converted to Section 3 Admission. Change of status from Section 2 to Section 3 completed.	Dr Laverick (Registrar) Dr Bruce (RMO) Murray Wallace (CPN)	Jeanne Smith (ASW)		
23-26/03/89	Home on leave for Easter weekend. Further short period of home leave followed.	Dr Bruce (RMO) Dr Laverick (Registrar) Murray Wallace (CPN)	Jeanne Smith (ASW)		
26/04/89	MM granted extended weekend leave.	Dr Bruce (RMO) Dr Laverick Murray Wallace (CPN) plan to reduce medication	Jeanne Smith (ASW)		Concerned about the high dosage of medication. Health professionals agree to reduce dosage.
08/05/89	MM remains home on extended leave.	Dr Taylor (RMO) Dr Laverick (Registrar) Murray Wallace (CPN)	Jeanne Smith (ASW)		Mrs Collins feels MM is making good improvement.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
05/06/89	Ward Round to review MM's condition.	Dr Taylor (RMO) meets MM for the first time.	Jeanne Smith (ASW)		Concern still remains about the high level of medication.
26/06/89	Ward Round. MM attends with mother. Continues to take oral Trifluoperazine.	Dr Taylor (RMO)	Jeanne Smith away		
24/07/89	Section 117 Meeting. MM released from Section 3, MHA.	Dr Taylor (RMO) Dr Laverick (Registrar) Avis Hutchinson (CPN)	Jeanne Smith (ASW)		Not present at the request of MM. He has not taken medication for 1 month.
06/08/89	MM arrested and charged with possession of cannabis and allowing himself to be carried in a stolen vehicle. Breach of suspended sentence.	Dr Taylor (RMO) Avis Hutchinson (CPN)	Jeanne Smith (ASW)		

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
08/08/89	MM's first contact with Housing. Housing Application not supported by Dr Taylor or Jeanne Smith, at this stage.	Dr Taylor (RMO) Avis Hutchinson (CPN)	Jeanne Smith (ASW)	MM does not admit to being mentally ill, therefore cannot be considered under Mental Health Quota.	Mrs Collins and MM becoming frustrated with Housing and SSD for not sorting out housing. MM takes out anger on mother.
25/08/89	MM's condition starts to deteriorate again.	Dr Sabharwal (GP) to see MM	Jeanne Smith (ASW)		Mrs Collins now accepts MM is mentally ill. She remains concerned about substance misuse.
--/09/89	MM attends Highbury Corner Magistrates Court and pleads guilty to two charges.	Dr Taylor to provide report to Probation and MM Solicitors.	Jeanne Smith (ASW)		Mrs Collins is concerned about MM's deteriorating condition and failure to take medication.
11/10/89	MM takes overdose of Temazepam and Trifluoperazine and is taken to St Bartholomew's Hospital.	Dr Taylor (RMO) Avis Hutchinson (CPN) Dr Sabharwal (GP) MM seen 4 days before overdose but no cause to section	Jeanne Smith (ASW)		Mrs Collins aware of MM's mental illness but does not want him to be sectioned.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
13/12/89	At Highbury Corner Magistrates Court, MM is fined for possession of cannabis and conditionally discharged for allowing himself to be carried in a stolen vehicle.	Dr Taylor (RMO) Avis Hutchinson (CPN)	Jeanne Smith (ASW)		MM is very up and down and is causing Mrs Collins a great deal of concern.
18/01/90	MM is arrested for smashing some glass panes in a Post Office.	Dr James (Senior Registrar) Dr Sabharwal (GP) Avis Hutchinson (CPN)	Jeanne Smith (ASW)		MM continues to be very aggressive at home.
18/01/90	MM is ADMITTED to Friern Hospital under Section 3 as no bed is available at the Whittington	Dr Joy Dalton (RMO) Dr Boothby	Jeanne Smith (ASW)		Mrs Collins is becoming increasingly frightened by MM's behaviour and plans to move out of her flat.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
30/01/90	MM fractured a bone in his foot in hospital when he kicked out in anger after a ward round.	Dr Dalton (RMO)	Jeanne Smith (ASW)		
06/02/90	MM DISCHARGED from Friern. Requests no CPN support and little SSD support.	Dr Dalton (RMO) agrees to support MM's application for housing. Avis Hutchinson (CPN) concerned and believes that very little has been achieved for MM.	Jeanne Smith (ASW) disappointed that Friern discharges MM because she believes that very little has been achieved.	No change in housing situation.	Frightened of MM but decides to have him back in the flat even though she is not happy about it. Also feels little has been achieved during this admission.
23/02/90	Mental Health Act Commission visit the Whittington Hospital. Not satisfied with Section 117 After-care practice.				

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
19/03/90	Planned Mental Health Assessment of MM fails when he leaves house before Dr James arrives.	Dr Sabharwal (GP). Dr James (Snr Reg), fails to arrive at 4.00 pm, the agreed time for the assessment.	Jeanne Smith (ASW)	Offers to arrange B&B for Mrs Collins for one night which she declines.	Mrs Collins leaves home for the night because she is very frightened of MM who is threatening to do a "Hungerford" as well as stab her.
27/03/90	MM is detained by King's Cross Police for aggressive behaviour in the street.	No beds available at Friern, MM to be taken to casualty at the Whittington. Decision made not to admit him.	Jeanne Smith (ASW)		MM's condition is deteriorating and he is making threats to her, she feels he needs to be in hosp-ital but she agrees that he can stay home.
26/04/90	Decision made not to continue with Assessment.	Dr Taylor (RMO) Dr Sabharwal (GP)	Jeanne Smith (ASW)		Recognises that MM is in need of treatment. He is deteriorating but as he had been relatively well that day she agreed to his not being admitted under Section. Said she will make contact at first sign of illness becom-ing overwhelming.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
04/05/90	MM claims that he does not need help or medication and threatens to sue Social Worker if she makes him go to hospital.	Dr Taylor (RMO) Dr Sabharwal (GP) Avis Hutchinson (CPN)	Jeanne Smith (ASW) Anne Hull (SW) and a social work colleague visit. Consideration given to Section 4. Assessed by Social Worker.		No grounds for admission under Section. Mrs Collins informed she could make Section 4 application.
08/05/90		Dr Taylor (RMO) Dr Sabharwal (GP) Avis Hutchinson (CPN)	Jeanne Smith (ASW) Mrs Collins and MS (partner) visit Neighbourhood Office to complain about manner of visit for assessment on 04/05/90.	Application under Mental Health Quota now lodged.	Mrs Collins is angry that onus to Section MM is placed upon her. She complains to SSD about the Assessment.
22/05/90	MM packs his bag and leaves home in a fit of anger, but is back within hours as he cannot find a place to live.	Dr Taylor (RMO) Dr Sabharwal (GP)	Jeanne Smith (ASW) makes frantic efforts to get a consultant to agree admission. Eventually Dr Taylor responds.		MM's condition is deteriorating rapidly and Mrs Collins, MS and MM's brother are all involved in seeking help.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
24/05/90	Assessment takes place. MM struggles with Police at the house and is put in handcuffs. ADMITTED to Whittington Hospital under Section 3.	Dr Taylor (RMO) Dr Graham (Registrar) Dr Kumar (GP) Murray Wallace (CPN) takes over from Avis Hutchinson	Jeanne Smith (ASW) Anne Mummery (SW)		MM is aggressive towards Mrs Collins. She supports admission under Section.
21/06/90	MM's application for Housing under the Mental Health Quota approved.			Offer of accommodation likely to take up to one year	
25/06/90	MM has agreed to have depot injections.	Dr Taylor (RMO) Murray Wallace (CPN)	Jeanne Smith (ASW) invites CPNs to a family meeting to discuss MM's condition.		
08/08/90	Meeting at Canonbury East to consider MM's housing application.	Dr Taylor (RMO)	Jeanne Smith (ASW) concerned about MM's returning home after period of in-patient treatment. Fears relapse if he continues to refuse support and medication. Concerned about Mrs Collins's safety.		MM has been granted home leave.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
17/09/90	S.117 meeting held to consider MM's discharge.	Dr Taylor (RMO) Murray Wallace (CPN)	Jeanne Smith (ASW)		Mrs Collins feels that MM has improved considerably, but recognises his need to continue medication
17/09/90	MM is RELEASED from Section 3 following extended period of home leave. He is to be reviewed 3/12/90.	Dr Taylor (RMO) Murray Wallace (CPN)	Jeanne Smith (ASW)		MM has become better than at any time since his involvement with the Psychiatric Service, but needs to continue on medication.
03/11/90	Review meeting at the Whittington Hospital	Dr Taylor (RMO) Murray Wallace (CPN)	Jeanne Smith (ASW)		MM and Mrs Collins attend this meeting at which it is agreed that his medication be reduced.
08/11/90	Mental Health Act Commission visits the Whittington Hospital, still not satisfied with S.117 aftercare practice.				

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
09/01/91		CPN David Jayne takes over from Murray Wallace and has his first meeting with MM.	Jeanne Smith (ASW)		MM is staying out all night and sleeping late during the day.
26/04/91	Meeting described as Section 117 Review Meeting at the Whittington which MM refused to attend.	Dr Taylor (RMO) David Jayne (CPN)	Jeanne Smith (ASW)	MM is offered a flat, but turns it down on the basis that it is in a "bad area".	MM is still smoking cannabis, but not as much as before his last relapse.
28/06/91	Family meeting described as Section 117.	Dr Taylor (RMO) refuses to put pressure on anyone for MM's accommodation unless MM comes to discuss it with him.	Jeanne Smith (ASW)		Mrs Collins wants Dr Taylor to put pressure on Housing in order to secure accommodation for MM.
13/12/91	MM is offered a one-bedroom second floor flat: 54 ALMORAH ROAD, LONDON N1.	Dr Taylor (RMO)	Jeanne Smith (ASW)	MM is to be given a grant of £170, for redecoration. Tenancy to commence on 06/01/92.	Mrs Collins optimistic about MM's progress yet remains worried about substance misuse and its effect on MM's mental illness. She is reminded by Jeanne Smith that Dr Taylor does not consider MM's psychosis to be solely drug related.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
29/01/92	MM declines mother's suggestion that he sees Dr Taylor at Hospital Outpatients to discuss possible increase in medication dose. But willing to accept home visits.		Jeanne Smith (ASW)		Mrs Collins uncertain about diagnosis of MM's illness. Wants second opinion. Considering contacting MIND. Asks whether MM should have brain scan, MM has asked to have one.
07/02/92					Mrs Collins contacts MIND, and is advised to talk to MM's consultant regarding brain scan.
20/02/92	MM receives £965 Community Care Grant	Dr Taylor (RMO)	Jeanne Smith (ASW), explains to MM that grant must be used for the purpose for which it was given, i.e. furnishing flat and not buying a car.		MM is not taking medication and is becoming abusive and threatening.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
04/03/92	54 ALMORAH ROAD now fully decorated.		Jeanne Smith (ASW)		MM's condition is deteriorating due to his refusal to take medication. Sleeps in flat & spends the rest of the time with Mrs Collins.
03/05/92	MM's birthday. Assaults Mrs Collins by punching her in the face.	Dr Taylor (RMO)	Jeanne Smith (ASW)		Mrs Collins suffers a cracked filling in her tooth and severe bruising. Calls Police and insists MM lives in his flat.
27/05/92	Joint meeting with Social Worker, MM and mother.	Dr Taylor (RMO) Tony Samarco to be Mental Health Support Worker.	Jeanne Smith's (ASW) last joint interview with MM and mother.		Mrs Collins needs protecting, MM can be physically violent.
08/06/92	Possession proceedings against MM to commence due to non-payment of rent.				Mrs Collins moves to 33 MULBERRY COURT, TOMPION STREET, LONDON, N1. Mrs Collins is unaware of proceedings against MM.
Sept '92	LBI INDUSTRIAL ACTION		INDUSTRIAL ACTION		

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
10/12/92	Mother visits MM at 54 ALMORAH ROAD.	No CPN involvement.	MM has no social work involvement.		MM does not let her in, but he does later same day when she returns with his brother.
08/01/93	MM damages his flat.	Dr Taylor (RMO). Dr Sabharwal (GP). No CPN follow up.	No Social Worker follow up.		Mrs Collins concerned. She knows he is ill and needs to be in hospital. Frustrated with Social Services' response to her anxieties.
18/01/93	ADMISSION: MM runs off when Assessment Team arrives at his flat, 54 ALMORAH ROAD, but is apprehended by the Police and is admitted to Noel Harris Ward, St Luke's Hospital.	Dr Taylor (RMO) Dr Sabharwal (GP)	MM is being assessed at the Police Station until 6.30 pm but a bed is not found until 10.30 pm at St Luke's Noel Harris Ward.		Mrs Collins is being verbally abused by MM but remains at the Police Station until 8.30 pm. Still feels disappointed with Social Services since Jeanne Smith's departure.
21/01/93	MM transferred to Whittington, Ward P4	Medication increased.			

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
04/02/93	Transferred to St Luke's, Noel Harris Ward	Dr Gurling (RMO) Intensive Care			
Feb '93	END OF INDUSTRIAL ACTION.		END OF INDUSTRIAL ACTION.		
05/03/93	Section 117 Meeting at St Luke's to consider MM's discharge Meeting agrees to defer discharge/leave until accommodation is in order. MM does not wish to have contact with his family.	Dr Hugh Gurling (RMO) Dr Ian Collins (Snr Regstr) Dr Lamb (SHO) Dr Jeubi (SHO) Patrick Mandikate (Senior Nurse)	Andrew Shuttleworth (SW) is allocated.	MM's flat is in a vandalised state. Needs to be put in order before MM is discharged or given leave of absence.	Mrs Collins's wish is that MM has reasonable accommodation to return to before he is discharged or given leave of absence.
15/03/93	New staff in post at Canonbury East Neighbourhood Office.		Yvonne Luby (Job-share Senior Social Worker) Geoff Costello (Neighbourhood Social Services Manager). Following an incident involving a child, priority is now being given to child care protection. Yvonne Luby is to supervise Andrew Shuttleworth.		

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
30/03/93	MM is once again transferred to the Whittington.	Dr Taylor (RMO) Dr Sabharwal (GP)	Andrew Shuttleworth (SW)		
05/04/93	MM very irascible and abusive on ward.	Medication increased.			
08/04/93	MM is DISCHA-RGED on leave of absence before his flat is ready or alternative accom-modation arranged.	Dr Taylor (RMO)	Andrew Shuttleworth is not informed of MM's return home, nor has he been able to sort out MM's housing problems.	54 ALMORAH ROAD still uninha-bitable. Throughout 1993 Chris Smith MP, writes several letters querying plans for housing repairs.	Mrs Collins is taken by surprise by MM's leaving hospital and is very upset and disappointed. She is also upset with Social Services for not sorting out MM's accommodation. But MM is very well, "better than she had ever seen him".
29/04/93	Section 117 Meeting. MM is RELEASED from his Section 3.	Dr Taylor (RMO) Dr Allen	Geoff Costello (NOSS Mgr). Andrew Shuttleworth (SW) still attempting to sort out MM's future housing.		MM is living with Mrs Collins in her one-bedroom flat but she is unhappy with the arrangement.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
27/05/93	Review Meeting.	Dr Taylor (RMO) Dr Allen No CPN allocated to MM, David Jayne agreed to visit regarding medication.	Andrew Shuttleworth (SW)	No action regarding MM's accommodation.	MM sleeping on the floor. Mrs Collins is angry and frustrated. Feels that Housing and Social Services are doing little to assist.
17/06/93 18/06/93	Mental Health Act Commission visits Whittington Hospital.	Deficiencies in co-working with Social Services render policy implementation ineffective.			
--/07/93			MM accepted for a Management Transfer. Priority 5 awarded.		
25/09/93	MM charged with taking and driving away a motor vehicle, case subsequently withdrawn by CPS.	Dr Harvey (RMO)			

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
22/10/93	Section 117 Meeting.	Dr Harvey (RMO). MM runs out of medication.	Andrew Shuttleworth (SW) unable to resolve MM's housing problem.	MM now spends his time with Mary Collins. Some time after this date MM began squatting in 17 PRESIDENT HOUSE, KING'S SQUARE ESTATE, EC1, a flat tenanted by Joe Collins.	MM staying up late at night and sleeping for most of the day. No information given to Mrs Collins about MM's medication.
30/10/93					Mary Collins marries Joe Collins.
18/02/94	MM signs Notice of Vacation and thereby relinquishes tenancy of 54 ALMORAH ROAD. He is offered B&B.	Dr Harvey (RMO) Lois Elliott (CMHW)	Andrew Shuttleworth (SW) Yvonne Luby (SSW)	Terry Rawles (Housing Services Manager) Central Allocations needs a homelessness application before getting involved. B&B – SPRING GRANGE HOTEL, 137 HIGHBURY, MANOR PARK offered to MM.	Very angry that MM was pressed to relinquish his tenancy.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
22/02/94	MM leaves B&B and returns to squat at 17 PRESIDENT HOUSE.		Andrew Shuttleworth (SW) advised by Mary Collins that MM is becoming unwell again.	Very little progress made in sorting out MM's accomm-odation.	Mrs Collins does have contact with MM, but he is not living with her.
30/03/94	MM is visited at President House by Social Worker.		Yvonne Luby (SSW) Andrew Shuttleworth (SW) ceases his involvement in MM's case.		Mrs Collins feels that Housing and Social Services are not put-ting sufficient effort into resolving MM's accommodation.
13/04/94	MM's case transferred to Duty.	Dr Harvey (RMO) Lois Elliott (CMHW)			Mrs Collins remains very concerned about what is happening to MM's accommoda-tion, and is angry that he was asked to relinquish his tenancy.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
24/05/94	Case discussion to address MM's housing needs and to provide support. Held at Canonbury Neighb-ourhood Offices.	Dr Harvey (RMO) Lois Elliott (CMHW)	Geoff Costello (NOSS Mgr) chairs this meeting.	Terry Rawles (Housing Manager) agrees to arrange Management Transfer as soon as possible.	Mrs Collins thinks that her various pleas for help are falling on "deaf ears" but Geoff Costello does call the meeting after one of her calls. She is accompanied to meet-ing by Becky Boyton, Mental Health Court Worker, who feels that little is achieved.
27/05/94	MM tells doctor that he had been taking heroin for past 5 years. Unwilling to take any anti-psychotic medi-cation. Expresses a wish to live in Croydon.	Dr Harvey (RMO) visits MM at home.		Still no change.	

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
05/07/94	At Canonbury East offices, follow-up meeting to 25/05/94 meeting to discuss MM's housing and community support needs. He does not attend.	Dr Harvey (RMO). Dr Garcia (SHO). Lois Elliott (CMHW). Dr Harvey challenges Yvonne Luby's attitude.	Yvonne Luby (SSW) She expresses concern about the risk of MM damaging any flat he might be given.	An offer of a flat at Finsbury Park is withdrawn, no other offers forthcoming from Housing.	Mrs Collins leaves this meeting in great distress. MM did not attend. She is frustrated with the approach of Yvonne Luby and the Housing Officers to MM's accomomodation problem.
13/07/94	MM's voluntary ADMISSION to Jafar Kareem Ward, Waterlow Unit. He refuses his Depot injection but agrees to take oral anti-psychotic medication.	Dr Harvey (RMO). Dr Garcia (SHO). During his admission, MM left the ward on a few occasions. On one occasion he was seen smoking cannabis in the car park.		No offers made to MM.	Though very concerned about MM's overall condition, she considers his first acceptance of voluntary admission to hospital as an optimistic sign.
28/07/94	Social Services invited to attend Dr Harvey's ward round to discuss support for MM.	Dr Harvey (MO) Considers that MM is not experiencing active psychotic symptoms.	Yvonne Luby (SSW) regards him as "difficult to work with".	Yvonne Haynes. General reluctance to offer MM a flat. He is to be offered short stay accommodation but will only get permanent flat if he can demonstrate he is willing to treat property with respect.	Mrs Collins desperately wants the Clinical team to agree to MM staying longer in hospital and emphasises to them the significance of his action in having sought admission.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
02/08/94	Meeting at Canonbury East Neighbourhood Office to consider MM's circumstances. This was agreed at the Case Conference on 05/07/94.	Lois Elliott (CMHW) is present but Dr Harvey sends his apologies. She is not aware that MM has been admitted to hospital since the last meeting.	Yvonne Luby (SSW) is on a day's leave.		Mrs Collins finds a job locally.
03/08/94	MM is DISCHAR-GED from Jafar Kareem Ward because he is showing no psychotic symptoms.	Dr Harvey (RMO). Dr Sabharwal (GP) informed.	Yvonne Luby (SSW).	Terry Rawles and Yvonne Haynes. B&B arranged at COSTELLO PALACE HOTEL.	Mrs Collins is now very worried about MM's future because she has two concerns: (a) She is convinced he is not better and; (b) He should not have been discharged to B&B.
16/08/94	MM goes to the Resource Centre at Insurance House to keep out-patient appointment. Used the telephone, spoke briefly to the CMHW but left before she returned to talk to him.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW). Next appointment 11/11/94.	Yvonne Luby (SSW).		Mrs Collins is still very upset that very upset that nothing is being done to provide MM with permanent accommodation.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
13/09/94	MM is moved from his present accomm-odation to another B&B.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).		MM moved to THANE VILLAS HOTEL.	Mrs Collins says that Terry Rawles agrees that B&B is wholly unsatisfactory for MM.
14/09/94	MM is moved to yet another B&B accommodation.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).		No permanent offer made to MM. He is now moved to PANO-RAMA HOTEL.	
07/10/94		Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).		MM is offered 44 MIDWAY HOUSE. Tenancy to commence 31/10/94.	
18/10/94	Mrs Collins wants to know who the Allocated Social Worker is.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).		MM at PANORAMA HOTEL	Mrs Collins calls Social Services, she has been regularly telephoning Social Services to check whether they were in contact with MM and whether they were looking out for him. 3 days later she was advised no social worker would be allocated.

Dates	Event	Health	Social Services	Housing	Experiences of Mrs Collins
27/10/94	MM visits Joe and Mrs Collins and leaves the next morning.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).			Mrs Collins sees MM in the street, talks and invites him to visit that evening.
28/10/94	6.30 pm: MM returns to Joe and Mrs Collins's flat at her invitation for something to eat. Pizza arrives shortly afterwards.	Dr Harvey (RMO). Dr Sabharwal (GP). Lois Elliott (CMHW).	Mrs Collins contacts Social Services to check if it is all right to have MM round. Assured yes, but any threats – call the Police.		They all watch TV. MM is agitated by the presence of the dog. Mrs Collins goes to the toilet, MM goes to the kitchen and picks up a knife. He goes to the toilet and stabs her then returns and stabs his step-father to death as he leaves the living room to check what was happening.
28/10/94	MM is arrested the same evening.				

CHAPTER 1

MARTIN MURSELL: THE EARLY YEARS

1.1 Martin Mursell was born on the 3rd May 1967. He is the elder of two brothers and initially lived with his parents and grandparents in the London Borough of Hackney. His mother was seventeen years of age when she married his father but they divorced when she was nineteen and Mary Collins and the two boys went to live in a council flat in South London, in Walnut Tree Walk, Kennington Road. Martin was about two years old at the time.

1.2 Martin saw his grandparents frequently. They were financially better off than his mother and they indulged him, to the extent that he often found it difficult to settle down when he returned home. He was variously described as "hyperactive" and "bubbly", and found it difficult accepting no for an answer. His mother met GH (who has no involvement in this Inquiry), whom she later married, when she was twenty four.

1.3 At primary school Martin had many friends, and his mother told the Inquiry that, when he was growing up, she never would have guessed that there was going to be any problem with him. By all accounts his life at primary school was uneventful. However, at secondary school he started truanting and when questioned by his mother about his activities, he would fabricate stories. According to her, she was unable to get a straight answer out of him. He showed very little interest in school and was very eager to leave.

1.4 A significant feature of Martin's life was his misuse of alcohol and drugs. When we visited him in Rampton Hospital, he told us that he was involved with drugs, mainly cannabis, since about the age of sixteen. However, for his mother, at this time, truanting and his lack of interest in school were the main problems so far as she was able to recall.

1.5 Martin left school at the age of sixteen with no qualifications. He wanted to work, but was never able to establish a stable work record. He had a variety of unskilled and labouring jobs, the longest period of employment being nine months. He was unemployed for most of his working life and survived on social security benefits and handouts from his mother.

1.6 Was Mrs Collins forewarned about Martin becoming mentally ill? How does a parent recognise the onset of mental illness? How easy is it for the child and the parent to accept mental illness? On these three questions Mrs Collins was very frank and said that her answer to each of them could only be given with the benefit of hindsight. She described how Martin became withdrawn, slept all day and went out at night, became isolated from the rest of the family because he never ate with them and was very

argumentative. She also described how he would "chop and change" about trying to find a job and, on the occasions when he did wake up in the morning, how he would set about banging the cupboards in the kitchen as if he had the "hump" about something. He would walk around and barge into other members of the family, and swear at them, something he did not do previously. Mrs Collins told us that at first she regarded this as "adolescent defiance", because he was trying to establish his identity.

1.7 Martin shared a bedroom with his brother and was regularly leaving death threats on his bed, such as: "I am going to kill you." The relationship between the brothers deteriorated to such an extent that the younger brother asked his grandfather, a bricklayer, to build a wall in the bedroom to partition off his part. Martin's relationship with his friends also deteriorated and they stopped ringing, calling round to see him or inviting him to parties.

1.8 Mrs Collins suspected something was wrong with Martin and raised this with her husband, but it was not until one evening in 1985, when Martin told her that his "life was becoming paranoid", that her suspicions were confirmed. He was eighteen at the time and that evening they spent a few hours talking. She recalled asking him what he meant by his "life becoming paranoid" and he told her that people were talking about him and looking at him. She suggested that they see the doctor next morning and he agreed.

1.9 The next morning Martin refused to go and the situation continued much as before. He would stay out all night and sleep all day. Often she would go out looking for him, all of which placed a great strain on her marriage over the next three years.

1.10 In about 1987/88 Mrs Collins again had a long conversation with Martin when he told her that sometimes he would stay up most of the night thinking of killing both her and her husband when they were asleep in bed. She asked him why he wanted to do such a thing, but all he would tell her was that he was worried about it. She mentioned the conversation to her husband and once again suggested to Martin that they see a doctor, but once again he refused. Martin was now about twenty/twenty one. It was at this time that Mrs Collins's marriage broke up.

1.11 Martin's condition was deteriorating rapidly. He now thought the television was talking about him and would hold conversations with it, often shouting and screaming at the screen. He would stab the radio and break electrical equipment in the house. He became moody, argumentative, suspicious and was usually angry. He was becoming violent, indeed on the 25th August 1988 he was arrested for assault occasioning actual bodily harm (ABH) on his girlfriend, whom he suspected of having an affair, and was remanded in custody for four months. At the trial he was sentenced to two months imprisonment suspended for one year. It was now January 1989 and he was back with his mother and continuing to behave in the same way.

1.12 Martin's conduct was becoming more and more unpredictable, for he would go out at night and smash car windows in what Mrs Collins described as "frenzied attacks". She told us that she was first notified by a policeman, but she had also witnessed him doing it, which she said was frightening. She described an incident when, during a party

at home, he suddenly ran outside and threw a can of drink through the window, before running down the street, smashing a car window, throwing dustbins about, and pulling up garden fences. This behaviour went on intermittently for about two years.

1.13 In early February 1989 Mrs Collins decided to see a doctor without Martin who adamantly refused to go, so one morning, together with her mother, she went to see her then GP, and sought his help. She told the Inquiry that she felt the GP was not very helpful and seemed more concerned with his own safety. However, he did suggest that she see his colleague Dr Sabharwal.

1.14 On the 8th February 1989 she saw Dr Sabharwal and, following their meeting, Martin was visited that morning by a consultant psychiatrist, Dr Bruce, who told Martin that he needed to go into hospital. The same afternoon Dr Sabharwal and Jeanne Smith, a social worker, visited Mrs Collins and they all decided that Martin should be admitted under Section 2 MHA to hospital. An ambulance was called and Martin was first admitted to hospital with a mental health problem.

CHAPTER 2

HOUSING

BRIEF HISTORY

2.1 The London Borough of Islington is the smallest borough in London and, with a population of around 165,000, is one of the most densely populated. Like most inner city boroughs, it has been under increasing pressure to accommodate homeless families, and to provide for others with special needs, including young single people and other vulnerable groups. The total number of households on the housing waiting list as at the 1st April 1994 was 7,016, and the general picture of housing provision in the Borough is one of considerable stress.

2.2 The Council has a small annual housing quota for mentally ill local residents, the aim of which is to avoid them having to make applications as homeless persons. However, there was no clear housing strategy for this vulnerable group when their need arose. In 1995 the Council's strategy states: "We will start discussions with housing associations and other independent providers to identify and develop an appropriate form of support for those service users whose mental illness or personality disorder causes them to require greater support than is currently available in council or housing association property but for whom residential care is felt to be inappropriate".

2.3 The Borough has one of the highest rates of homelessness in the country but it has developed its policies to try to reduce the number of applications from homeless people. The Concealed Households scheme provides for households living temporarily with friends and relatives to be rehoused in a programmed way based on their housing need and the length of time they have been waiting, rather than being forced down the homelessness route. Bed and breakfast hotels as temporary accommodation are kept to a minimum and the council has managed to keep the number constant at around 100.

2.4 The housing service in the Borough is provided within the framework of a Neighbourhood Services Department integrating housing, social services and administrative support through a neighbourhood structure. Originally there were 24 Neighbourhood Offices but in April 1993 the number of offices was reduced to 16 through "twinning". This was the case in Canonbury where the two previously separated neighbourhood offices of Canonbury East and West were twinned. They became a single Neighbourhood with two service outlets. In 1994 there was a further change which reduced the number of Neighbourhoods to twelve. The Council retained overall policy-making strategy for Housing and Social Services.

MARTIN MURSELL'S EARLY INVOLVEMENT WITH HOUSING

2.5 At the time of Martin Mursell's early involvement with the Housing Section, the office concerned was the Canonbury East Neighbourhood office. The Neighbourhood Manager was Kevin Thompson, the Principal Neighbourhood Officer was Jim

Demetriou and the Housing Needs Officer (lettings) was Yvonne Haynes.

2.6 Martin Mursell always expressed a wish to have his own flat and his accommodation was a matter of great concern to his mother. Although she was able to accommodate him when she lived in a two-bedroom flat at 86A Northchurch Road, London N1, his aggressive behaviour towards her when he was in relapse placed her at considerable risk. The Inquiry heard evidence from her about the many efforts she made in trying to persuade the Housing and Social Services Sections to give priority to rehousing Martin away from her, but she believed her plea fell on deaf ears as she felt very little was done for him.

APPLICATION FOR HOUSING

2.7 Allocation of accommodation under the Mental Health Quota depends upon an acknowledgement of one's mental illness, therefore the success of an application made by Martin Mursell was likely to be complicated by his unwillingness to admit that he was ill. Indeed it was precisely for that reason that his application in the Summer of 1989 for re-housing under the Mental Health Quota was not supported. He was however nominated by Sheenagh Burgess, a senior social worker, on the 14th May, 1990, but before his application was approved, his social worker, Jeanne Smith, contacted Circle 33, a Housing Association, to try and solve his housing problem. She also raised with him the option of supported accommodation like the Gwyn Jones Hostel, as she felt he was unable to cope with independent living, but he refused to consider it.

2.8 On the 21st June 1990 Martin Mursell's housing application was approved, but it made very little difference to his dependency on his mother, as he carried on living with her. She told the Inquiry that, despite her persistence in trying to obtain accommodation for Martin, there was little effort from the Housing and Social Services Section, apart from the efforts made by Jeanne Smith, and it took a further year before an offer was made to him.

GRANT OF TENANCY OF 54 ALMORAH ROAD

2.9 On the 13th December 1991 Martin Mursell was offered a one-bedroom second floor flat at 54 Almorah Road, London N1, the tenancy of which was due to commence on the 6th January 1992, but there was redecoration to be carried out. His social worker, Jeanne Smith, assisted him in applying for a Community Care Grant and he was paid the sum of £965 for furnishings and redecoration on the 20th February, 1992. By the 4th March 1992 the flat was fully decorated but Martin continued to live with his mother, hardly spending any time in his flat. This perhaps demonstrates another important aspect to Martin's case, his mixed feelings about actually leaving home. The Inquiry was told that on the 3rd May 1992 Martin Mursell carried out a serious assault on Mrs Collins by punching her in the face and cracking a filling in one of her teeth. The Police were called, but she was advised not press charges. However, she insisted that from that time he must live in his own flat.

2.10 It was anticipated by Jeanne Smith that Martin Mursell would find it difficult to cope with independent living, and so it proved. When he did not take his medication, he relapsed and would then fall into arrears with his rent – these were later deducted directly from his benefits. In the meantime Mrs Collins gave up 86A Northchurch Road

and moved to a one-bedroom flat at 33 Mulberry Court, Tompion Street, London N1, partly to help out her son who was then offered 86A Northchurch Road, and partly to encourage Martin to live independently in his own flat.

ADMISSION TO ST LUKE'S HOSPITAL FOLLOWING DAMAGE TO FLAT

2.11 By the 18th January 1993 Martin had caused damage to his flat. On that same day he was admitted under Section 3 MHA to the Noel Harris Ward of St Luke's Hospital where he was treated in intensive care. During his admission to hospital his flat was squatted and vandalised. On the 5th March 1993 Dr Hugh Gurling, the RMO, held a Section 117 MHA meeting at which it was agreed that priority should be given to obtaining accommodation for Martin before he was discharged. However, Martin was transferred to the Whittington Hospital before his accommodation problem was resolved. There should then have been contact between his RMO Dr Taylor and the social worker Andrew Shuttleworth, to try and sort out Martin's accommodation, but according to the evidence no contact was made with Mr Shuttleworth despite efforts by the medical staff.

MARTIN MURSELL IS DISCHARGED FROM HOSPITAL TO DAMAGED FLAT

2.12 On the 8th April 1993, in exercise of his power under Section 17 MHA, the RMO discharged Martin home on leave of absence. This meant that he had to return to live with his mother because his flat was uninhabitable. This discharge greatly upset Mrs Collins because she was not warned in advance and was taken by surprise. She had no alternative but to let Martin sleep on the floor of her one-bedroom flat which she was now sharing with Joe Collins. Understandably Mrs Collins grew increasingly angry and frustrated by the failure of the Social Services and Housing Section to find accommodation for Martin. Her frustration grew further when he was finally released from his Section on the 29th April 1993. It is not easy to measure the extent to which this discharge home on leave affected Martin but, bearing in mind that he had expressed a wish for some form of independent living, it is a pity that more vigorous efforts were not made to help in that regard.

MANAGEMENT TRANSFER

2.13 If a tenant of sound mind deliberately causes damage to his/her flat, it is understandable that a local authority would be reluctant to offer further accommodation of a similar type to that person. Martin Mursell was a person suffering from a mental illness, and moreover, there was some doubt as to what damage was caused by him and what was caused by his acquaintances when he was in hospital. There was evidence that some of the damage may have been caused by acquaintances to whom Martin Mursell owed money. They also removed some of Martin's personal possessions from the flat. He was unable to return to it because it was uninhabitable, but in addition to that he was in fear of violence from those who had caused the damage. His social worker Andrew Shuttleworth in a report dated the 11th June 1993 recommended him for a management transfer and forwarded his report to the estate manager of the Housing Section.

2.14 A management transfer is a transfer granted at the discretion of the Neighbourhood Officer (Housing). Such a transfer may be agreed where there is evidence of

violence, relationship breakdown or to promote the effective management of the accommodation/estate. Without a tenancy a person cannot apply for such a transfer, but as an existing tenant Martin was entitled to make such an application.

2.15 It would appear that some time between the 11th June and the 20th July 1993, Martin Mursell made an application for a management transfer – his application form was not dated. There is also no date in the documents as to when his application was approved, but it appeared to us that it may have been approved at the end of July 1993, and rated a Priority 5, though neither Martin nor his mother were told at the time. They found out when in reply to a letter from their local MP Chris Smith dated the 22nd December 1993, the estate manager wrote: "Mr Mursell (sic) has been approved for a management transfer on a Priority 5 which is a low priority. However, I am afraid that there is no immediate offer, but I shall continue to pursue the matter".

2.16 Priorities for the Transfer/Decant List of the Council are rated from 1 – 5 with 1 being the highest rating. The higher the rating, the more likely it is that a transfer will be achieved. Priority 2 is a high rating and covers "other cases involving violence, major works, foster parents and statutory overcrowding".

2.17 Was there a commitment by officers dealing with Martin Mursell to sort out his accommodation problem at this stage? Bearing in mind his case was urgent, he was a mentally ill person and that his application was based upon a fear of violence, it is surprising that his application was rated as a Priority 5 by Simon James, the Assistant Neighbourhood Officer (Housing), instead of a Priority 2. The need to resolve Martin's accommodation problem was also underlined by Dr Di Phillips the Senior House Officer (SHO) to Dr Harvey. In her letter to the Neighbourhood Housing Officer Jim Demetriou dated the 9th November 1993, she wrote: "...It would be an avoidable disaster if he were to relapse because of his current situation. I urge you to do all you can to help find a solution to Martin's housing problem". However, little or no weight seemed to have been given to his fear of violence and very little action seemed to have been taken to solve the problem, meanwhile Martin started occupying Joe Collins's flat at 17 President House, King's Square Estate, London EC1, from about November 1993.

2.18 In January 1994, Terry Rawles became the Assistant Neighbourhood Officer (Housing) at Canonbury East Neighbourhood Office. His duties were the supervision of estate management, supervision of lettings and transfers and housing advisory services. He gives two different accounts of how he became involved with Martin. First, when Martin went to the Neighbourhood Office to sign a Notice of Vacation in respect of Almorah Road. Secondly, when he was asked by Andrew Shuttleworth to do a joint interview at short notice on the 18th February 1994. At this stage, according to Mr Rawles, he knew that Martin had been approved for a management transfer by Simon James and rated Priority 5, and he also knew that Martin was "not going anywhere" on such a low priority rating. Equipped with this knowledge, we believed that Mr Rawles should have taken immediate steps to improve the rating. However, his written evidence is that he did not act immediately because he was not given any information about Martin's condition other than being told that "he was suffering from schizophrenia". His knowledge of Martin's condition was therefore important to us and he was asked:-

KEY

LC: Lincoln Crawford
TR: Terry Rawles

LC *When did you first become involved with Martin Mursell?*

TR *I saw him fleetingly. I think, in February 1994...and that was with Andrew Shuttleworth, the social worker at the time.*

LC *What was the purpose of the meeting?*

TR *That was to try and get him to go into temporary accommodation so we could eventually find him permanent accommodation. He had to go through that because...I don't know...whether he had vandalised his own flat...but it was rendered uninhabitable...*

Further on in the evidence, he was asked:

LC *Were you aware that Martin was mentally ill?*

TR *I'd never met him before this time.*

LC *...Were you aware that he was mentally ill?*

TR *I was told by the social worker that was the case and would I do a joint interview with him...*

LC *Right. So you had some information that he had been mentally ill?*

TR *Yes.*

LC *Are you aware that if someone is mentally ill then he is in priority need?*

TR *Yes.*

LC *What steps did you take on the information you had...to give effect to that priority?*

TR *All I could do was to ring the central housing office in Highbury House, appraise them of the situation and they would try to allocate whatever temporary accommodation they could, that they had available with the knowledge that he was mentally ill.*

LC *When someone is mentally ill and in priority need, is it essential for them to give up their tenancy before something is done by you?*

TR *It is my view that is the case, yes.*

For the next three months Mr Rawles did nothing to upgrade Martin Mursell's priority rating and stated that, "it was only when I attended the meeting on the 24th May 1994 that the full extent of Martin's mental problems became clear to me. At that point I took action to upgrade the priority status of his original management transfer application from 5 to 2." We are not convinced that Mr Rawles needed any more information than he already had. If he wanted to upgrade Martin sooner, he could have obtained any necessary information from Andrew Shuttleworth, but he did not do so. He could also have put in hand the repairs to the damaged flat.

REPAIRS TO 54 ALMORAH ROAD

2.19 Martin Mursell had expressed a wish not to return to 54 Almorah Road, but that should not have been an excuse for the Housing Section's failure to repair his flat. It should have been repaired prior to his discharge from hospital on the 8th April 1993, or at the very least by the time he was released from his section on the 29th April 1993. He might then have been persuaded to reside at No. 54 as a temporary measure and given a management transfer within a short period.

2.20 We have no doubt that at times Martin was a very difficult person to deal with, but the unwillingness and delay demonstrated by the Housing Section over the question of repairs would have tested the tolerance of any fit person let alone someone who was mentally ill.

2.21 On the 13th April 1993, Chris Smith MP wrote to Kevin Thompson, the Neighbourhood Manager, in these terms:

> *"...When [Martin] was discharged from hospital on the 7th April...he returned to the flat to find that nothing had been done and that his gas and electricity had also been cut off. He is now staying with his mother at 33 Mulberry Court, and she is very keen that he does not return to Almorah Road, where I understand there was a previous history of harassment.*
>
> *I would be very grateful if you could investigate how it was that Mr Mursell was discharged to a vandalised flat with no gas or electricity...Please can you...look at the possibility of rehousing Mr Mursell as a matter of urgency".*

On the 23rd April 1993 an estate manager replied as follows:

> *"My investigation has confirmed that it would appear that Mr Mursell's flat was broken into while he was a patient at the Whittington Hospital. This department has only two items of repair to be carried out, namely a repair to the FED frame and the renewal of one of the locks and also the reglazing of four squares of glass to an internal door. The latter repair I understand from his Social Worker was caused by Mr Mursell himself...*
>
> *Since his discharge we have been unable to gain access to carry out the above repairs as Mr Mursell has the only set of keys...*
> *I am not aware of...any incidents of harassment at the above address, I am therefore not in a position to make a case for a management transfer."*

These two letters were followed by a letter from Andrew Shuttleworth dated 20th July, 1993, inquiring about progress regarding Martin's accommodation. A letter from Dr Di Phillips dated 9th November 1993, which we have already mentioned, expresses her serious concern about his accommodation.

2.22 On the 22nd December 1993, Chris Smith MP wrote yet another letter, this time to the Neighbourhood Housing officer, Jim Demetriou, as follows:-

> *"...I note I've heard nothing about progress in carrying out repairs to the vandalised flat at 54 Almorah Road, nor about progress in agreeing Mr Mursell for a management transfer due to harassment. To make matters worse [Mrs Collins] contacted my office recently to say that Mr Mursell was* ***still*** *staying with her, and had not heard anything about a transfer nor a one bed offer.*
>
> *This does seem a worrying delay given Mr Mursell's medical condition. Would you please check and let me know whether he has now been agreed for a management transfer and for an offer of another one bed place?"*

On the 4th January 1994 an estate manager replied as follows:-

> *"Mr Mursell has been approved for a management transfer on a Priority 5 which is a low priority. However, I am afraid that there is no immediate offer, but I shall continue to pursue this matter...All of Mursell's repairs have been cancelled due to no access. Mr Mursell would need to come back to the Neighbourhood Office and request the repairs to be done."*

2.23 The officers involved not only knew that Martin's situation was desperate, they also knew that his mother's situation was getting more desperate by the day, yet they chose to ignore all the concerns that were being expressed to them. We have every sympathy for the pressure under which housing officers do work at times, and in particular, in an inner city borough such as Islington, but whatever the pressure, there was no reason for the Housing Section to have so disregarded the needs of an individual, in the way they did Martin Mursell. His flat was left in a state of disrepair for more than a year. The Housing Section refused to offer him a management transfer because the estate manager was not satisfied that there was a "history of harassment", in which case the repairs should have been carried out in order to make the flat habitable. If on the other hand they were satisfied that he was in fear of violence, then they should have transferred him, but they did neither. It was further claimed in evidence that Martin refused to give access to workmen to carry out repairs, but not only was there no evidence that he refused access to anyone, we are satisfied that he was never asked. It was also claimed that he had the only set of keys and therefore no one had access without him handing them over. Even if this was true, it is our belief that if the Housing Section genuinely intended to repair the flat, access would have been gained to do so.

2.24 We endorse the view expressed in the written evidence of Nigel Hamilton, the Pre Tenancy Services Manager, who said; "The long period of inactivity in respect of Almorah Road appears to be a significant failure in effective housing management".

However, we go further and say that this was a fundamental failure by the Housing Section, for which some of the senior officers must bear responsibility.

MEETING OF 18/2/94 – TENANCY RELINQUISHED

2.25 Martin Mursell's occupation of Joe Collins's flat at 17 President House was his only choice. He was faced with either going back to Almorah Road which was in a state of disrepair and uninhabitable or sleeping on his mother's floor. It seems to us that at this stage Social Services and Housing should have been working closely together to address Martin's housing needs. Instead, Yvonne Luby, Andrew Shuttleworth's senior, visited Martin at President House, spoke to him through a window, left and did very little for him because she regarded him as unco-operative. The Housing Section, while under no obligation to leave him where he was, could have done so while some attempt was made to repair his flat or to transfer him. Instead, plans were put in place to re-possess 17 President House. We regarded this action by a housing officer as short-sighted and insensitive, for once they had recovered possession, Martin would have been homeless.

2.26 Prior to the meeting between Terry Rawles and Andrew Shuttleworth on the 18th February, 1994, Mr Shuttleworth sent a letter to Martin at 17 President House, dated the 15th February 1994, which said:-

> *"Dear Martin,*
> *I have had a phone call from your mother who informs me that the tenancy of the flat you are staying in at the moment is being reverted back to the council on Friday 18th.*
>
> *This will mean that you are going to need emergency housing. If you come into the Canonbury East Office and speak to Housing Advisory they will be able to find you temporary emergency housing..."*

Mrs Collins was disappointed by the action of the Housing Section because as she told us, Martin "liked it over there" i.e. at President House, but "then Joe started getting letters telling him that his tenancy is to be terminated on the 18th February 1994". We have no doubt that the principal aim of the Housing Section at this stage was to recover both Joe and Martin's tenancies and to offer Martin such help as they felt necessary, through the homelessness route. We were also told by housing officers that Yvonne Luby, a senior social worker, had reservations about offering Martin a tenancy. Her reservations may have affected their attitude towards Martin's housing need.

2.27 Martin attended the Canonbury East Neighbourhood Office on the 18th February 1994 on the advice of Andrew Shuttleworth. On that same day, as we have already indicated, the Housing Section recovered possession of 17 President House – Joe Collins's flat. Mr Shuttleworth told us, "I recall the way for Martin to have his transfer put through quicker was to give up the tenancy of 54 Almorah Road and to move into bed and breakfast". However, this was clearly not in Martin's interest. Andrew Shuttleworth did not understand very much about the workings of the Housing Section. It was not necessary for Martin to give up his tenancy and go into bed and breakfast to achieve a management transfer. Strictly speaking, his tenancy was an essential preliminary to his

entitlement for a management transfer, in other words, without his tenancy he was not entitled to be considered for such a transfer.

2.28 It has been suggested to us that as Martin presented as homeless, the officers had no choice but to accept his application and, having done that, bed and breakfast was a necessary stage of temporary accommodation before permanent housing was found. If that is what they did, then one could not fault the officers, but we do not accept their version of events. Martin attended the Neighbourhood Office on the 18th February 1994, for advice and assistance because having been deprived of the accommodation at 17 President House, his only alternative was his mother's floor. It was in those circumstances he was advised by Terry Rawles to sign a Notice of Vacation. The material part of such a notice reads: "I the undersigned...the occupier, of the above mentioned property (hereinafter called "the premises") hereby give notice terminating my tenancy of the premises". From the evidence we have seen and heard, we believe that Martin was advised to terminate his tenancy, not in order to assist in obtaining new permanent housing, but because the Housing Section wanted his flat returned to the housing stock. The better course of action would have been to act upon the management transfer.

MARTIN MURSELL'S HOMELESSNESS APPLICATION

2.29 Once Martin had terminated his tenancy, the way was clear to process him through the homelessness route. He was then advised by Terry Rawles to make a homelessness application; while all this was taking place Andrew Shuttleworth was present, but he did not understand housing procedure and was unable to advise Martin independently.

2.30 A homelessness application in Form W6 was compiled by Terry Rawles which Martin was invited to sign. However, Section 4 of this form was incorrectly filled out by Mr Rawles. Under that section the applicant is invited to state whether he was "Homeless today". Mr Rawles stated on Martin's behalf: "...Has been staying with mother but cannot return there now". This was inaccurate, Martin was staying at 17 President House and, although inconvenient to her he could have returned to his mother's house. We believe that if the same enthusiasm had been shown in processing his management transfer as was shown in encouraging him to make himself homeless, his accommodation problem would have been solved at a much earlier stage. Martin signed the application form and Mr Rawles agreed for him to stay in bed and breakfast. He was taken to the Spring Grange Hotel, 137 Highbury New Park, London N5, in a taxi by his social worker Andrew Shuttleworth "pending further investigation". Section 62 of the Housing Act, 1985 provides:-

> "(1) If a person (an "applicant") applies to a local housing authority for accommodation, or for assistance in obtaining accommodation, and the authority have reason to believe that he may be homeless or threatened with homelessness, they shall make such inquiries as are necessary to assist themselves as to whether he is homeless or threatened with homelessness.
>
> (2) If they are so satisfied, they shall make further inquiries necessary to satisfy themselves as to:-

(a) whether he has a priority need, and
(b) whether he became homeless or threatened with homelessness intentionally..."

CENTRAL ALLOCATIONS

2.31 When a homelessness application is completed and approved, it is then forwarded to Central Allocations where it is processed. The Inquiry was told that people in temporary accommodation always hold a priority 1 or 2 and that it is the policy of Central Allocations to "expedite" permanent accommodation for them. We were also told that there is a Central Allocations Section and a Special Needs Team and therefore, if an application is marked "special needs", Central Allocations will liaise with the Special Needs Management Team to check the availability of accommodation and try and deal with the particular request. However, as Mr Rawles told us, before Central Allocations becomes involved they must receive a W6 application form.

2.32 The priority rating for a homeless applicant is 1 – 6, six being the lowest priority. The objective of Central Allocations is to minimise the use of temporary accommodation and therefore, in order to maintain the Council's statutory homelessness obligation, 50% of vacancies arising in the Council's permanent housing stock are notified to Central Allocations Section for possible allocation to approved homeless applicants.

BED AND BREAKFAST INAPPROPRIATE

2.33 Housing was always a critical issue for Martin and his mother. Mr Rawles in his written evidence claimed that he was not aware of Martin's condition on the 18th February 1994, but in his live evidence he accepted that he did know. Furthermore, in their written submissions to us, other senior housing officers involved with the case acknowledged that they were aware of Martin's mental illness and accepted that his condition was such that bed and breakfast was inappropriate to his needs. There cannot have been any doubt that Martin's case was urgent and that he was in priority need. Section 59 of the Housing Act, 1985, insofar as it is material, provides:-

"(1) The following have a priority need for accommodation:-
(c) a person who is vulnerable as a result...of mental illness..."

It was inappropriate to send him to bed and breakfast, but as Mr Rawles was now dealing with him as a homeless applicant, we acknowledge that he was strictly complying with Section 63 of the Housing Act, 1985 which provides:-

"(1) If the local housing authority have reason to believe that an applicant may be homeless and have a priority need, they shall secure that accommodation is made available for his occupation pending a decision as a result of their inquiries under section 62.

(2) This duty arises irrespective of any local connection which the applicant may have with the district of another local housing authority".

2.34 Mr Rawles knew that Martin was homeless and in priority need when he filled out the homeless application on the 18th February 1994. He ticked those two boxes on

the W6 application form. On that day he also knew that Martin was mentally ill because he ticked the relevant box. We believe that he should have indicated on the W6 application form that special needs accommodation was preferred, or at the very least draw it to the attention of some other officer. He did not do this, nor did he approach other organisations such as St Mungo's for housing. He opted for bed and breakfast without checking what other options were open to him.

WAS THE ADVICE TO END HIS TENANCY JUSTIFIED?

2.35 In his written submission to us Mr Nigel Hamilton, the Pre Tenancy Services Manager, took the view that possession of 54 Almorah Road was "long overdue", and he concluded that "ending the tenancy was a logical and uncontroversial thing to do". He stated that the Housing Section as a responsible landlord had obligations to neighbouring tenants, which responsibility over-rode any genuine concerns it might have for Martin Mursell, but there was no evidence before us that Martin Mursell in anyway interfered with other tenants when he occupied 54 Almorah Road. We believe that it is the duty of the Housing Section to act responsibly to all its tenants. If all the circumstances of Martin Mursell's case were carefully investigated, adequate accommodation and not possession would have been seen as the way forward. Mr Hamilton suggested however, that Martin Mursell was in breach of his tenancy in the following respects: (a) non-payment of rent, (b) not using his flat as his principal residence and (c) damaging the structure of his flat.

2.36 It was inevitable that Martin would have had some initial difficulty in managing his affairs. He did fail to pay rent and, we believe that it was an acknowledgement of his incapacity which led the Housing Section to withdraw the possession proceedings it had issued on the 8th June 1992. The bulk of his arrears accrued when he was in hospital and it is to our surprise that Housing was not aware of this. In any event all the arrears were backdated and cleared by the Department of Social Security. Another alleged breach submitted to us was that he had not used the flat as his principal residence. Martin was ill. Finally, Mr Hamilton contended that Martin Mursell was in breach because he damaged the structure of his flat. However, we could not accept this contention, because documents supplied to us from the Housing Section showed that it accepted that most of the damage to Martin Mursell's flat occurred while he was in hospital. It was in our view quite wrong to advise Martin Mursell to terminate his tenancy of 54 Almorah Road.

INVESTIGATION

2.37 The interim duty under Section 63 to accommodate Martin was complied with, but once this was done the Housing Section had to complete its duty to investigate under Section 62. That duty was to satisfy itself that Martin was: (a) homeless, (b) in priority need and (c) did not become homeless intentionally. It usually takes some time to gather this information, but Martin's situation was well known and he could have been dealt with in a way which avoided bed and breakfast accommodation. However, we are not in a position to say what the availability of housing was at the time, but his circumstances were not investigated. This is confirmed by Nigel Hamilton, the Pre Tenancy Services Manager, who stated, "there was never any consideration of investigating intentional homelessness". Therefore, having accepted that Martin was not intentional-

ly homeless, he should have been served with a notice to that effect. Section 64 of the Housing Act, 1985 provides:-

> "(1) On completing their inquiries under section 62, the local housing authority shall notify the applicant of their decision on the question whether he has a priority need.

2.38 Martin received no notice, but in any case, he left bed and breakfast on the 22nd February 1994, four days after he had been placed there. This was a very unstable period in Martin's life and he returned to squat in 17 President House, although Housing had by this stage re-possessed it.

2.39 Mrs Collins was very concerned about Martin's welfare. She believed the Housing Section had abandoned him, which in our view was a reasonable belief to hold. Nigel Hamilton, in his written evidence to us, says: "With hindsight, it may appear that housing staff were not very pro-active in trying to sort out Martin Mursell's housing...". However, Martin Mursell was shabbily treated over his housing problem by senior housing officers for which we believe they must bear some responsibility. It could be argued that Martin had effectively left the homelessness system by having "taken his own discharge" from bed and breakfast accommodation. This form of accommodation was wholly inappropriate for him and it was not surprising that he left. However, Mr Hamilton took the view that: "It is simply not realistic for housing staff to follow up homeless applicants when they leave temporary accommodation". But, the Inquiry believes that there was little to gain by an investigation or a follow-up. All the information required about Martin was easily available to the Housing Section and an offer of permanent housing should have been made. Section 65 of the Housing Act, 1985 provides:-

> "(2) Where they are satisfied that he has a priority need and are not satisfied that he became homeless intentionally, they shall, unless they notify another local housing authority in accordance with section 67 (referral of application on grounds of local connection), secure that accommodation becomes available for his occupation".

2.40 Information was being fed into the Housing Section about Martin. Spring Grange Hotel wrote that Martin had left bed and breakfast, which was confirmed by Housing on the 2nd March 1994. Indeed Carolle Wright, a housing officer, drew up a Section 64 notice to send to Martin on the 5th April 1994, but it was cancelled and kept on file after she spoke with Andrew Shuttleworth, who informed her that Martin was staying with his mother. Every opportunity consciously or unconsciously was being taken by Housing to wash its hands of Martin, but Mrs Collins was persistent and as a result of her many phone calls to Housing and Social Services, a meeting was arranged to deal with Martin's housing problem. At this stage two significant events had occurred. First, Andrew Shuttleworth ceased to be Martin's social worker and secondly, his case was de-allocated and transferred to the duty system on the 13th April 1994.

THE MEETING OF THE 24TH MAY 1994

2.41 The meeting of the 24th May 1994 was called by Social Services. Geoff Costello,

the Neighbourhood Manager (Social Services), invited Mr Rawles to this meeting, also in attendance were Dr Harvey, Lois Elliot, Mrs Collins and Becky Boyton. We comment elsewhere as to whether this was a true Section 117 meeting. The purpose was to deal with the pressing problem of Martin's housing. It was the common perception of most of those attending this meeting that Martin had been removed from the housing list. Martin's true situation was that he was homeless but staying with his mother or squatting because he had no other choice. The meeting concluded that Martin was to be restored to the housing list but more particularly, that he be given a higher priority. It is true that Social Services did not advise Housing on Martin's housing needs, but as we said earlier, we do not believe Mr Rawles' evidence that he only became aware of the full extent of Martin's mental illness when he attended the meeting on the 24th May.

2.42 Between the 18th February 1994 and the 24th May 1994, nothing was done for Martin except a placement into temporary accommodation of bed and breakfast at Spring Grange Hotel. Therefore, at the conclusion of the meeting on the 24th May, it would have been reasonable to expect that Mr Rawles would give Martin a Priority 2 rating as a homeless person. The situation required it and Martin was entitled to it. Instead, Mr Rawles told us that he "bent the rules" by "re-activating" the old Priority 5 management transfer which he upgraded to a Priority 2 in June 1994, but Martin had no tenancy to transfer and Mr Rawles was aware that Mrs Collins was finding her situation intolerable. Even Mr Hamilton has been driven to say that: "it seems odd to have re-activated the management transfer, rather than the homelessness application, which would have carried a higher priority". We find that there was no commitment by the Housing Section to resolve Martin's housing problem. The re-activation of the old management transfer had the effect of delaying any action. If he had been given a Priority 2 homelessness rating, there would have been a statutory obligation to act promptly.

2.43 On his evidence, by the date of this meeting Mr Rawles had a full picture of Martin Mursell's situation and was aware of the urgent need to sort out accommodation for him, but he failed to approve the homelessness application or cause it to be approved. He failed to send the application form to Central Allocations so that it could be processed and he failed to indicate either on the form or to anyone that this was a special needs case. Had he indicated to Central Allocations that this was a special needs case, it could have contacted the Special Needs Management Team to check whether any housing was available. We find that Mr Rawles' handling of this case fell far below the standard which the local authority ought to expect from a senior officer.

THE MEETING OF THE 5TH JULY 1994

2.44 It was agreed at the end of the meeting on the 24th May 1994, that this further meeting would be held in July to consider what action had been taken since May. Bearing in mind Terry Rawles was asked to try and resolve Martin's housing situation, we expected that someone from Housing would have been present at this next meeting. It is most unfortunate that no one from Housing attended. Present at the meeting were Yvonne Luby, senior social worker, Mrs Collins, Dr Harvey and Lois Elliot. Yvonne Luby should have been actively assisting with advice and encouragement to try and resolve Martin's housing situation but the evidence suggests that she was not. All that was achieved at this stage was a management transfer priority upgrade from 5 to 2. Martin was in reality no better off than when he saw Mr Rawles on the 18th February

1994 and Mrs Collins continued to endure the pressure of having Martin sleeping on her floor. On the 13th July 1994 he voluntarily admitted himself to hospital.

MEETING AT HOSPITAL 28TH JULY 1994

2.45 By the time of Martin Mursell's voluntary admission to hospital he should have had settled accommodation. He had been discharged from hospital since the 8th April 1993, but through a combination of lack of commitment on the part of Housing and lack of interest on the part of Social Services, this did not happen. On the 28th July 1994, Dr Harvey invited Yvonne Luby to his ward round at the Waterlow Unit. She asked Terry Rawles to accompany her but he was unable to attend and Yvonne Haynes was invited instead. Miss Haynes was the allocations officer and was fully aware of Martin's case. She told us that in her job as allocations officer she dealt with tenants requiring transfers, homeless applicants and people on the general waiting list. She said she allocated property on a priority basis and priority was invariably given to those people in bed and breakfast and other reception centres. Miss Haynes told us that she had some psychiatric nursing experience before joining the Housing Section and had had mental health awareness training since she joined. However, we find that her attitude towards Martin Mursell was negative, unhelpful and lacking in understanding of the problems of a person suffering a serious mental illness. Yvonne Luby was economical with the advice she gave to Housing about Martin's needs.

2.46 They both attended the meeting ostensibly to try and sort out Martin Mursell's housing problem. This is what Dr Harvey expected as Martin was soon to be discharged. In describing this meeting Miss Haynes told the Inquiry: "...during the ward round I remember standing up quite forcefully for the Housing Section, because I felt that we had tried to accommodate him, before reaching the point that he was hospitalised. They were basically saying that if Mr Mursell was offered permanent accommodation, then that would stabilise his mental health or aid recovery. I was coming from the point of view that at the end of the day Mr Mursell had been given a tenancy, he had destroyed that tenancy, there was a cost involved...I believed he would now have to go down the homelessness route". As a senior social worker one would have expected Yvonne Luby to try and temper the hard line Miss Haynes was taking, but on the evidence we found her equally unhelpful and obstructive. Her advice was, before Martin Mursell was granted permanent accommodation, he should first go to bed and breakfast, then short stay housing and only after going through those stages and satisfying those involved that he was prepared to behave himself and not damage his property, should he be granted permanent accommodation. These attitudes were unlikely to be helpful to Martin upon his discharge from hospital and were potentially adverse factors in his future stability.

MARTIN MURSELL'S LAST DISCHARGE – 3RD AUGUST 1994

2.47 On the 3rd August 1994, Martin Mursell was discharged from the Waterlow Unit. It was not a happy discharge for either Martin or his mother and all the agencies give a different version of how the discharge was handled. Dr Harvey (Health) recalled that Housing was going to offer some form of accommodation to Martin. Yvonne Luby (Social Services) recalled that Martin was being discharged at the insistence of the hospital and Simon James (Housing) recalled feeling that housing was being "dumped on", because the hospital simply rang up and said Martin had been discharged and was

coming to the office in a cab. It is not necessary for us to decide whose version is correct. Martin did attend the Canonbury East Neighbourhood Office and was seen by a housing officer and placed in bed and breakfast accommodation at the Costello Palace Hotel. What the Inquiry finds disturbing is the account given by certain officers as to how Martin Mursell came to be placed in various bed and breakfast hotels before an offer of permanent accommodation was made to him.

2.48 The Inquiry was told by Terry Rawles and Simon James in their written evidence that Martin Mursell made a second homelessness application when he was discharged from hospital on the 3rd August 1994. A homelessness application is made in Form W6, but there was only one W6 application form dated 18th February 1994. Their explanation for the absence of a second application form was that the existing "February Form" was used to deal with the second application, but we do not find this explanation credible. If the "February Form" was being used for the second application, much of the detail on the "February Form" was out of date. To take just two examples, Andrew Shuttleworth was no longer Martin Mursell's social worker although he had been in February, nor should violence have been a material factor on a second application. On their explanation, it meant that the original February application was never approved nor ever forwarded to Central Allocations. In his live evidence Mr Rawles was questioned on the various issues:

KEY

RF: Rob Ferris
TR: Terry Rawles
LC: Lincoln Crawford
PH: Patricia Hayward

RF *...he has signed away his tenancy and going into temporary accommodation...what was going to happen as far as getting another flat?*

TR *According to the W6 which you have a copy of, the final recommendation at the bottom by Simon James wasn't made until August...it is not until that point that his file is actively looked at in respect of looking for alternative accommodation.*

Later on in his evidence he was asked:

LC *...Central Allocations could not be properly informed that this was high priority and this was someone with special needs;*

TR *When the final approval was given in August, that copy of that W6 was with the homelessness file so they would know the situation regarding his mental illness...*

Later on in the evidence:

PH *So would there have been another W6 filled in? You know this was the one filled in earlier.*

TR *There should be. There should have been another one, I haven't a copy of that at all.*

PH *So when this homelessness was reactivated again, there should be somewhere another W6?*

TR *There should be another one. There would be another W6...a fresh application there should be.*

LC *And where is that?*

TR *I don't know. These are papers I just came across by accident.*

Later on in the evidence:

PH *...So when you filled this out in February, would it have gone to Central Allocations?*

TR *It would have done. Yes.*

PH *It would have done?*

TR *...It wouldn't have gone to Central Allocations until the approval had been given.*

2.49 It is of concern to the Inquiry that there was no meaningful activity on Martin Mursell's homelessness application for about six months and it is for the local authority to address the reason for such a serious management failure. The Inquiry finds that, although Central Allocations was billed by the various Hotels for bed and breakfast accommodation and was therefore aware of Martin Mursell's circumstances, there was no second homelessness application made on his behalf to that section. We also find that the W6 application form was not used a second time. We found the evidence we had from Terry Rawles, Simon James and the other officers who dealt with this point misleading and unhelpful.

EVENTS LEADING TO MIDWAY HOUSE TENANCY – 31/10/94

2.50 Martin Mursell left his bed and breakfast accommodation at Costello Palace Hotel after ten days for alleged anti-social behaviour. It would appear that at this stage the professionals within Housing and Social Services abdicated all responsibility towards him. There was no planning, no-one took stock, no one seriously tried to find a solution to what clearly was an urgent problem, involving a young man who was suffering from a serious mental illness. After Costello Palace Hotel, Martin was sent to yet further bed and breakfast accommodation, this time the Thane Villas Hotel, where he left after one day because he was alleged to have been exposing himself to the residents. It should have been clear to the Housing Section that sending Martin to bed and breakfast was not helpful. He was unhappy about this and his mental health was deteriorating. From about the 14th August 1994 he seems to have disappeared altogether.

2.51 On the 19th August 1994, Simon James approved Martin Mursell's homelessness application, six months after it was originally made. He recommended special needs

accommodation. Mr Rawles told the Inquiry that it was only then that Martin's file could be "actively looked at for alternative accommodation". However, even after the application was finally approved, it took nearly one month before he was offered some form of accommodation. On the 14th September 1994, Housing placed Martin in yet further bed and breakfast accommodation, this time the Panorama Hotel, 146 Holloway Road, London N7. Three weeks later, on the 7th October 1994, the Clerkenwell Neighbourhood Office offered Martin a tenancy of 44 Midway House, Manningford Close, EC1, which tenancy was to commence on the 31st October 1994. The tragic event occurred before Martin took up the tenancy. Housing decided to re-possess 44 Midway House and, on the 23rd November 1994, Martin Mursell was served with a Notice to Quit and a Notice of Seeking Possession while he was being held at HMP Pentonville.

CONCLUSION

2.52 Housing must be recognised as a central element when planning community care for the mentally ill, but we find that even within the constraints of its resources, very little priority was given to community care housing for this group by the London Borough of Islington. Martin Mursell was a vulnerable person who was repeatedly placed in bed and breakfast accommodation. There was no assessment of his needs and no joint planning with social services to ensure that his housing needs were met. Communication between Housing and Social Services ought to have been automatic in a case such as this, and central to a Neighbourhood structure such as Islington's, which is meant to provide an integrated service, but, although there was some liaison with Social Services, it was not effective. We therefore recommend that an officer of appropriate seniority be appointed to ensure that there is effective co-ordination in mental health cases between Health, Housing and Social Services. We applaud the existing informal practice of monthly "callovers" whereby a member of the Mental Health Social Work Team meets with the Housing Client and Contract Manager to review mental health cases on the Neighbourhood housing list. We recommend that this practice is immediately adopted as a formal procedure between Health, Housing and Social Services and appropriate guidelines be developed.

2.53 The Director of Neighbourhood Services is ultimately responsible for the action of officers within the department. He/she must therefore be kept informed of important housing issues within mental health services. We recommend that as part of a regular monitoring exercise, housing officers report to the Housing Committee at each cycle, on all decisions taken in mental health cases.

2.54 Part VII of the Housing Act, 1996 came into force in January 1997, and there are now new guidelines for local authorities when dealing with homelessness. However, interim accommodation for homeless people is provided on the same basis as under the 1985 Act. We believe that there should be some distinction in the way mentally ill people are treated. Accordingly, we recommend that the Secretary of State should consider amending the current guidelines to ensure that mentally ill people are not required to pass through unsuitable transitional accommodation, for example, bed and breakfast accommodation, before being furnished with permanent accommodation suitable for their needs.

2.55 Martin Mursell presented a challenge to the Housing Section. He was an aggressive and difficult person who would have been challenging in most situations. We are therefore pleased to note that since the events of 28th October 1994 the London Borough of Islington has acted swiftly to make a number of improvements within the Housing Section to address some of the problems we have identified.

2.56 The Borough is now working with St Mungo's and together they have opened a reception centre in Holloway Road which will allow mentally ill street homeless people to be accommodated on a shortstay basis. The Borough and St Mungo's have also opened a hostel for mentally ill people who need a period in supported accommodation. It has provided 20 homes to St Martin of Tours with whom it is also working, with a "floating support" staff, to provide support for mentally ill people in these tenancies. In addition, funding for the "Homeless Mentally Ill Initiative" from the Department of Health has been agreed to provide support to mentally ill homeless people who are having difficulties maintaining the tenancies which they hold.

2.57 Work is also being undertaken with Stonham Housing Association to provide special needs housing for mentally ill people approved under the mental health quota. Further, the establishment of 2 pilot home support workers for Clerkenwell and Highbury Vale Mental Health Teams has been agreed and funded from the Mental Illness Specific Grant (MISG 1996/97).

CHAPTER 3

SOCIAL SERVICES

APPROVED SOCIAL WORKERS FOR THE SERIOUSLY MENTALLY ILL

3.1 It is essential that social workers who work with people with severe mental illness are trained and have experience in mental health. They should be "Approved" social workers, i.e. those with specialist experience rather than "Generic", i.e. those with only general social work experience. This is not only sensible, the law requires social workers working with the mentally ill to have a degree of competence. Under Section 114 of the MHA, Local Authorities have a duty to approve social workers "having competence in dealing with mentally disordered people" and under Section 13(1) of the MHA, the approved social worker has a duty to assess people "within the area" for their admission to hospital, if appropriate. The duty to provide social workers to the Mental Health Services is to be found under Section 28(3) of the National Health Service Act 1977, which places a duty on local authorities to provide a Social Work service to hospitals in their area. The Act states that "Every Local Authority shall make available to the Health Authority...the services of persons employed...for the purpose of the local authority function under the Local Authority Social Services Act 1970".

3.2 Up until March 1995, the approach to social work services in the London Borough of Islington was generic. It was a decentralised locally integrated service operating in small teams and relating to small Neighbourhoods. There was a strong commitment to this Neighbourhood structure. In a study commissioned by the Borough a former Director of Social Services from another authority described the arrangements as creating no inherent problems in actually delivering a good and effective social work service. By this time there were approximately 66 Approved Social Workers in the service, 21 of whom were managers, but there were amongst others, two important problems. First, the approved social workers were unevenly spread across the borough and secondly, not many of them were experienced in mental health work. Furthermore, the way ASWs were deployed meant that some were not undertaking a sufficient number of assessments to warrant their continuing approval under the Act.

3.3 There were some Neighbourhood offices without any ASWs, but when Martin Mursell first made contact with the Social Services, he was allocated an ASW, Jeanne Smith. This allocation was fortunate for him and Mrs Collins because Jeanne Smith was very experienced in mental health work, had vision and was effective. After she left in June 1992, neither Martin nor his mother were ever served as well by a social worker. The reason was not that the social services department could not deliver a good service. In many respects it did so. The problem was structural. There was a fundamental belief in the correctness of the generic structure which became so embedded in the culture of management that even when that structure was failing to meet the needs of mentally ill

persons such as Martin Mursell, there was a reluctance to review genericism. It was the failure to move from a generic structure to a specialist structure much earlier than it did which was in part responsible for the lack of specialist social work involvement with Martin after Jeanne Smith's departure. Some officers believed that the structure was failing some users to the point where it was becoming unsafe.

JEANNE SMITH ASW

3.4 During Jeanne Smith's involvement with Martin he had four hospital admissions. It should have been an opportunity for Dr Taylor, the consultant responsible between May 1989 and June 1993, to have drawn up a care plan with Jeanne Smith as the key worker before she left in order to keep the very strong link which she had built with Martin and his mother. We believe that an important opportunity was missed which had it been taken could have improved Martin's compliance with treatment. Jeanne Smith told us of her experience with Section 117 procedures from her previous job but try as she did to arrange meetings "to get the doctors into the house because Martin wouldn't ever get to hospital", she could not succeed. That resulted, she said: "...in my close involvement with the CPN and basically the way we worked was that I set up with the CPN for us to have regular meetings at my office, so that the two of us could have close contact with what was going on...he would also bring back information from hospital, but it meant that we were splintered off...from the psychiatrists...". It is a matter of some regret that while Jeanne Smith and the CPN Murray Wallace and later Avis Hutchinson were prepared to operate as a unit in relation to Martin's ongoing care, the psychiatrists, apart from Joy Dalton who worked closely with Jeanne Smith during her involvement, did not show the same willingness to operate as a team. More than one witness told us that the Section 117 meeting which ought to have been for multi-disciplinary care planning, was no more than a convenient meeting "tied to the ward round as part of the management of the in-patient facility ...", we were told that when the clinicians decided to hold the ward round, the telephone would ring and social services would be expected to send a social worker. They were using the ward round time to attempt some discussion in a multi-disciplinary setting. That this has been the perception of very senior officers within the social services department, was further illustration to us of the ineffective use of Section 117 procedure. We accept the tradition of ward rounds is to discuss and plan in-patient care but these are no substitute for the requirements of effective discharge planning and community care.

3.5 The approach taken by Jeanne Smith was a credit to the social services at that point in Martin's care and an example which other professionals should have followed. She told us: "...whenever I went on leave, my colleagues knew about the case...I always made it clear that if there were any concerns, that they had to be treated seriously...if mother said that she was worried, then her judgement should be trusted...I reached a point after the initial assessment period, when I did trust mother's judgement completely on what she was saying about her son...". Her close co-operation with the CPN had its advantages. We accept that the most successful period of Martin's compliance with treatment was the period when Jeanne Smith and Murray Wallace worked together. She was driven to continue her co-operation with Murray Wallace because she "always felt that Martin was dangerous in terms of what was happening at home". She said that she shared an opinion with Murray Wallace that "Martin was very dangerous

and could end up killing...". However, Martin's dangerousness was never comprehensively assessed by the hospital. Murray Wallace left in January 1991, and another CPN, David Jayne, took over on 19th January 1991. Jeanne Smith left in June 1992, and so ended a chapter in Martin's life when the CPN and the social worker with whom he was involved carried out their duties compassionately and effectively.

3.6 Jeanne Smith was concerned about Mrs Collins's safety due to Martin's violence and recommended reallocation. She wrote in the case file: "Evidence of deterioration (in the state of Mr Mursell's mental health) is usually second hand through the mother, whose judgement can be relied on. However, she needs protecting from coping with him beyond the point where he has become a danger, in particular towards her." After Jeanne Smith left in June 1992, there was never again that level of social worker or indeed CPN involvement with Martin. We find that the service given to Martin Mursell and Mrs Collins from June 1992 onwards, was poor and fell short of what is expected from a social services section. In addition, a number of events occurred which led to his case being given a much lower priority than it deserved. Those events were the industrial action, restructuring of the service and a number of serious cases involving children which for a time led officers on the ground to give priority to child protection cases.

INDUSTRIAL ACTION AND ADMISSION TO ST LUKE'S HOSPITAL

3.7 Industrial action in the Islington Social Services began in September 1992, and ended in February 1993. Martin in this period was not taking his medication and his condition was deteriorating, but there was no social worker or CPN involvement, nor was there any RMO follow-up. His condition continued to deteriorate and he caused damage to his flat at 54 Almorah Road. Following this incident he had his last compulsory admission to hospital on 18th January 1993. It was also the occasion as we point out, when Martin was, for a short period, under the care of an excellent team on the Noel Harris Ward at St Luke's Hospital. He was discharged home on leave from the Whittington Hospital on 8th April 1993, and released from his section on 29th April 1993.

ANDREW SHUTTLEWORTH – THE SOCIAL WORKER ALLOCATED TO MARTIN MURSELL'S CASE

3.8 On 5th March 1993, Martin's case was allocated to Andrew Shuttleworth. He told us that the allocation was made to him because he was the only male in a team of women. However, he was not an approved social worker, nor did he have any mental health experience. In this same month, the Mental Health Act Commissioners visited the London Borough of Islington and were critical of some aspects of its service delivery in mental health. On this visit the Commissioners insisted that the Borough introduce a system of re-approval, as they felt approved social workers did not have enough experience of assessments to warrant their continuing approval. They also felt that the spread of ASWs across the borough was very thin. This adverse Commission comment prompted a report to the Social Services and Health Policy Sub-Committee by Andy Nash, the Principal Mental Health Adviser, proposing a review of mental health services in the borough, which we applaud. What was not put in place, however, having accepted the criticisms of the Commission, was any interim measure to deal with existing problems.

ANDREW SHUTTLEWORTH – LACK OF EXPERIENCED SUPERVISION

3.9 The Commissioners were particularly concerned about the lack of experienced approved social workers, yet Andrew Shuttleworth's allocation to the case of Martin Mursell was not reviewed. We felt that this was a bad management decision. Andrew Shuttleworth was inexperienced in mental health and should not have been involved with a complex case such as Martin Mursell. That error of judgement was compounded further when Yvonne Luby became his supervisor. She told us that "it was too much for me to handle" and explained that her background was working with elderly people. She said: "I was down as a qualified ASW, but I never thought of myself as that because I'd done very little mental health work. I worked in a team in Haringey which mainly dealt with elderly people. We had a specialist mental health team and if you needed specialist advice they did it and you always had someone who was qualified in mental health on the duty rota...I didn't feel I was qualified to be called an ASW...I didn't do the 60 days training. I did the 28 days training."

THE BURDEN ON SENIOR MANAGERS MADE SYSTEM UNSAFE

3.10 The reluctance of management to review genericism and the reduction of 24 Neighbourhood Offices to 16 placed an enormous burden on senior managers in an unsafe environment. There was a feeling that this insistence by management was primarily due to the fact that most of the managers were without a social work background. Geoff Costello, Neighbourhood Officer Social Services (NOSS) for Canonbury East, told the Inquiry, "It was clear to me in March 1993 that the setting I would be moving to was not a setting I would be comfortable with". Yvonne Luby told us that she never wanted to go to the Canonbury East Office. She said she had no knowledge of the area, no knowledge of the estate and she did not know what was expected of her. She was also uncertain about her ability to cope properly with the job. Geoff Costello then described to us what he was actually being asked to do in management terms. He said, "I was being asked to manage what had previously been two generic social work teams. They were located in two separate settings. I was being given a reduction in the Senior Social Work posts, and I was still being asked to manage and line manage day care and residential establishments. I felt that the task was too generic, it was too broad and that the needs of the Service would not be addressed in terms of us being able to focus professionally as social workers on our task and support social workers in carrying on with their work". From the evidence, it appeared to us that he was being asked to operate a system which was not viable and which some would regard as unsafe.

3.11 It was unfortunate that when Geoff Costello moved to Canonbury East he was confronted with a very high profile case involving the death of a child. He admitted to us quite openly that "the dominant pressure on us was to cover our backs in terms of child care work", and he went on to say, "I have no hesitation in saying that that case dominated my management of the workload, and within that I constantly made sure that mental health was not losing out".

3.12 We accept that Geoff Costello intended that mental health should not lose out, but in fact it did. He was not experienced in mental health work, nor was Yvonne Luby, therefore, in order for mental health not to lose out, he would have had to manage the resources at his disposal effectively. He acknowledged "that it wasn't enough for some-

one like Yvonne Luby...to come in and try to generically manage generic workers on a part-time basis who was finding it impossible to juggle priorities between the various lines". Yvonne Luby was employed to work as half of a Job-Share (17.5 hours per week) her responsibilities were not properly shared. The other half of her Job-Share worked solely with child care, which meant that Yvonne Luby carried full responsibility for all other specialisms. The burden placed upon her made it difficult for her to make herself available to either become actively involved in Martin's case or to supervise Andrew Shuttleworth properly.

3.13 There is no doubt that the new team at Canonbury East worked under great pressure, and it is our view that Geoff Costello did find it difficult to manage his resources effectively. However, it ought to have been apparent to him that Andrew Shuttleworth was too inexperienced to handle a complex case such as Martin Mursell's and that Yvonne Luby was the wrong person to supervise him.

3.14 Notwithstanding the pressure he was under, Geoff Costello accepted that he had to get on with the task in hand. He told us that a rota was established across the Borough consisting of approved social workers who were called on to cover for other Neighbourhood Officers. He said "There was a variety of arrangements made around that which was just focusing on the mental health side, that it was constant ammunition for me to say this is not a safe setting". He said he felt as if "we are sitting on a time bomb, in terms of adult services, mental health and child care services. We are being encouraged to carry out greater participation with the public, spend more time with our clients, more time with client's carers, more time doing preventative and promotional work, when we haven't enough time to do crisis work". We recognise the area of his responsibility was very broad, but he knew that Martin Mursell's case was allocated to an inexperienced social worker and should have ensured that adequate supervision was provided.

3.15 Yvonne Luby told us that she was unable to adequately carry out her supervisory function in relation to Andrew Shuttleworth, although she gave him as much help as she was able to provide, not only because she was overworked, but because she was out of her depth. She said she pointed this out to Geoff Costello on more than one occasion. However, we found that there was a conflict between Yvonne Luby and Geoff Costello's evidence on this point. It seems to us, from what we can ascertain, there was at best a breakdown in communication within the department, but whether or not Yvonne Luby did communicate her difficulties to Geoff Costello, it is very important for all social workers to be supervised in order to ensure that they conduct their cases properly. This is particularly so where the case is complex or difficult. We were struck by the inexperience of senior and basic grade staff in mental health work who cared for Martin Mursell after June 1992, and how little supervision there was of those staff who were involved with his case. We recommend that a directory should be kept which details the expertise of all prospective supervisors, and before such individuals are asked to supervise inexperienced social workers, the person making that decision must ensure that the proposed supervisor has the required skills and expertise.

3.16 Between March 1993 and November 1993, the date when David Jayne, the CPN, went off sick, there was no evidence of Yvonne Luby meeting with him or attempting

to discuss with him any aspect of Martin Mursell's care. For a senior officer who had so little experience in mental health work, contacting the CPN is something we would have expected her to do at an early stage.

CHILD PROTECTION WORK GIVEN PRIORITY BY OFFICERS?

3.17 In June 1993 Dr Harvey took over from Dr Taylor as RMO and, although Yvonne Luby continued to supervise Andrew Shuttleworth, there was very little social work involvement with Martin. She told us that her life was made particularly difficult because of the priority which was being given to child protection work. She said it was expected of her to give her time to this area of work and less to mental health. However, if by this she meant that the Borough had a policy that child protection work should be given priority over mental health work, we reject that suggestion. There was no evidence that the Borough had such a policy or had given instructions or guidance to managers to prioritise child protection work. Managers in the Canonbury East Neighbourhood Office were under the media spotlight regarding an issue concerning a child care case and understandably for a time gave priority to child protection cases, but Martin Mursell's case should have been given a higher level of priority than it received on the grounds of his vulnerability and dangerousness.

KEY WORKER – ANDREW SHUTTLEWORTH

3.18 At the Section 117 MHA meeting at St Luke's on the 5th March 1993, it was agreed that Andrew Shuttleworth would be the key worker for the plan which was drawn up. Accommodation was at the heart of the after-care plan, but Mr Shuttleworth told us he did not know what his duties were as a key worker and was not conversant with the requirements of Section 117 MHA. However, pursuant to his role as key worker he made some contact with Housing to try and get a management transfer for Martin, but as we have noted elsewhere, Mr Shuttleworth did not understand housing procedures and believed Martin Mursell's housing problem was being sorted out when it clearly was not. Consequently, he gave inaccurate information to the rest of the multi-disciplinary team and to Mrs Collins. He was not easily contactable and although he was in communication with Lois Elliot the CMHW, their communication was minimal and did not enhance the service Martin Mursell was receiving. Neither Yvonne Luby nor Geoff Costello was informed about the breakdown of the plan. Indeed, none of the professionals involved in the plan was informed. It is important that they should have been. We therefore recommend that where a social worker is the key worker in an after-care plan, immediate notice must be given to the Team Manager if there is a breakdown in the plan, setting out the full reason for the breakdown. This should be in addition to the social worker's responsibility to the rest of the multi-disciplinary team. We also recommend that the Borough makes provision for induction training for officers at all levels from Housing and Social Services to ensure that there is familiarisation with and a better grasp of the policy and practice of each others' responsibilities.

MARTIN MURSELL'S CASE IS 'DE-ALLOCATED' AND TRANSFERRED TO THE DUTY SYSTEM

3.19 On the 30th March 1994, Andrew Shuttleworth ceased to be involved in Martin's case because he and another social worker were allocated to a complex child care case. Martin Mursell's case was at a critical stage, yet Yvonne Luby, together with Dennis

Howard, a locum social worker, took the decision to transfer the case to duty instead of allocating it to another social worker. There was no proper assessment of the case before it was transferred to the duty system. Yvonne Luby, the senior social worker who was charged with the duty of supervising Andrew Shuttleworth, knew that it was a difficult case and that once it was transferred there would be no consistency in its handling. This was highly unsatisfactory for a case of such complexity, which in our view required the services of an experienced Approved Social Worker.

CASE TRANSFERRED TO DUTY SYSTEM – NEITHER MARTIN NOR MRS COLLINS INFORMED

3.20 It was an important decision and both Martin Mursell and his mother should have been informed about it. The Inquiry raised the point with Andrew Shuttleworth who told us he informed them both. He was asked how:-

KEY

PH: Patricia Hayward
AS: Andrew Shuttleworth
LC: Lincoln Crawford

PH *...When a case is transferred back to duty, is that individual informed that they no longer have an allocated social worker?*

AS *They should be, yes.*

PH *And what would be the process for that?*

AS *Well, it would be down to me to do closing interviews with relevant parties. So that would be with Martin who was informed that I was no longer his social worker...*

PH *So you did see him and tell him?*

AS *Yes. And with the mother who was informed that I was no longer the social worker.*

LC *Did you actually see him to tell him?*

AS *Yes...*

PH *And Mrs Collins was?*

AS *The mother was also informed.*

Mrs Collins gave evidence on this same point as can be seen from the following extract:-

PH *...in April 1994, Social Services actually had a meeting and unallocated Martin.*

They took his allocation of a social worker away...and decided that he wouldn't be allocated any further, that it would all be through duty. We were just wondering if you had ever actually been informed of it?

MC *They didn't tell me, no.*

3.21 Andrew Shuttleworth said he minuted the meeting with Mrs Collins and Martin Mursell in which he informed them about the case being transferred to duty. He told us that these and other notes have been deliberately removed from the file which he kept. We do not accept Mr Shuttleworth's explanation and found his evidence on this point unreliable. We accept the evidence of Mrs Collins that neither she nor Martin was informed by anyone that the case was being transferred to duty. We recommend that before a case is transferred to the duty system, a detailed risk assessment should be undertaken and recorded. The decision to transfer the case should then be communicated to the client in writing and to the Team Manager.

3.22 Geoff Costello told us that he had no doubt in his mind that Martin Mursell's case was a case that needed to be allocated. He also said "a case like Martin Mursell...needed a specialised mental health team". Yet, although he was in touch with Andy Nash the mental health adviser, he never sought any advice from him about how best to handle Martin's case and, from the evidence we are not aware of any advice Andy Nash may have volunteered to the team at Canonbury East.

3.23 Martin Mursell's case was of such importance and complexity it should have remained allocated. Jeanne Smith emphasised this point before she left in June 1992, and we would have expected that on such a vital issue as allocation a clear decision would be taken. But the evidence demonstrates that there was great confusion. All three parties involved had a different view about what had taken place. Geoff Costello told us that "there was an agreement between Yvonne Luby and Andrew Shuttleworth that his involvement with Martin's case would be frozen for a short period of time. My understanding is that Andrew interpreted that as him not being the allocated worker, but that was not correct". Geoff Costello was clear that Andrew remained the allocated social worker until he left the authority later in 1994. He explained to us that a case would either be closed, de-allocated or frozen. Martin Mursell's case was 'frozen' because there had been a very complex child care case and Andrew Shuttleworth was one of two social workers allocated to that case. He told us that transferring the case to duty was a preferred option rather than leaving it with a social worker who was heavily committed to other work.

3.24 On Geoff Costello's evidence, Yvonne Luby was still involved in Martin's case. This was reinforced by Dr Harvey who also regarded her as the person involved, particularly as she chaired the case conference which was called on the 5th July 1994, and had called other meetings. He said "Ms Luby told me that Mr Mursell no longer had an allocated social worker and that she was acting in this capacity until someone was appointed". Dr Harvey's evidence is that he made it clear to Yvonne Luby that Martin required an allocated social worker and she gave him every assurance that that would happen. Yvonne Luby on the other hand regarded the case as one which was within the duty system and not allocated.

3.25 It is not clear from the evidence whether the decision to 'freeze' Martin's case was made by Geoff Costello or Yvonne Luby. In any case, the decision was made on the basis that Lois Elliot, the community mental health worker, was very involved in Martin's case. They relied upon her to monitor the case while Andrew Shuttleworth was engaged on a child care case, but this was an extraordinary decision. Lois Elliot had minimal involvement with Martin. She did not seem to have a clear view of her role and functions and she had only met Martin twice, moreover, Yvonne Luby thought she was a CPN. Was Martin Mursell's case allocated, de-allocated or frozen? In the light of this evidence, we asked all three parties questions about the allocation of the case:-

KEY

MD: Manny Devaux
GC: Geoff Costello
LC: Lincoln Crawford
AS: Andrew Shuttleworth
RF: Rob Ferris
PH: Patricia Hayward
YL: Yvonne Luby

MD *Do you recall a meeting held on the 13 April 1994, when it appeared that the case was transferred back to duty?*

GC *....Andrew Shuttleworth remained the allocated worker until the time he left the Authority.*

LC *So your view is that the case was allocated?*

GC *Yes.*

LC *And was allocated to Andrew?*

GC *To Andrew.*

In his evidence Andrew Shuttleworth dealt with the question of allocation as follows:-

AS *.....around March 1994, it was agreed that I would be taken off certain cases....and given another large children's case to co-work with another social worker.*

LC *So far as you are aware, did Yvonne Luby take any interest in Martin's case?*

AS *After I was taken off the case....the case was passed over to duty....as far as I remember it wasn't allocated to another worker....*

MD *Can I ask you, what was your view about this type of case being de-allocated....?*

AS *....I was actually pleased to be taken off the case at that time because I had so much other work to be getting on with.*

MD *....You knew that it was going to be non-allocated....you mentioned to be dealt with on duty.*

AS *As far as I was aware, the case was not allocated and I know that the case was dealt with on a duty basis because several times when I was on duty there were issues that I had to pick on.*

RF *....so you did feel....relieved to have had the case taken away from yourself?*

AS *Yes.*

The extract from Yvonne Luby's evidence on the same point runs as follows:-

PH *Where had the case been transferred to?*

YL *Duty, it remained on duty.*

PH *Whose responsibility is it to look at duty cases and decide this needs to be real-located?*

YL *There was a waiting list of people who were waiting to be allocated and that was looked at once a week....*

PH *Whose responsibility was that?*

YL *It was the duty senior. Lisa, mine and Geoff's.*

LC *Why did you decide to transfer Martin's case to duty?*

YL *Well, it was partly that Andrew wanted that particular case to be removed from his caseload. It was partly Andrew's choice. That's what he said he wanted.*

LC *But you had a high risk mental health case on your hands. It ought to have been given priority.*

YL *Yes....It would have been much better if Martin had been allocated to someone who was skilled in mental health and who had the time to chase Martin up....*

LC *....he should have been allocated to a skilled and experienced social worker in order to take things forward, and you weren't doing that.*

YL No.

3.26 Although we take into account the pressure under which these senior officers had to carry out their functions, Geoff Costello and Yvonne Luby must bear some of the responsibility for the confusion which existed over the allocation of Martin Mursell's

case. Whether the case was allocated, de-allocated or frozen – we were not given a clear definition of frozen – there should have been a management report on file indicating the status of the case, but there was none. It seems to us hardly surprising that Mrs Collins became exasperated by the way Social Services were handling Martin's case. The effect of transferring the case to duty meant that when Mrs Collins rang Social Services for information, she was passed around from one social worker to another, the inevitable result of cases being held on duty where there is poor management oversight. We find that Martin Mursell's case was poorly co-ordinated when transferred to the duty system. Despite Mrs Collins's cry for help when she telephoned the duty social workers, very little notice was given to her concerns and no attention was paid to the danger she faced.

GENERICISM V SPECIALISATION

3.27 In considering the care and treatment of Martin Mursell we must examine the actions of individual officers, it is nevertheless important to consider the structure within which they worked. We were told that at the time of this incident, social workers did not have their minds focused on mental health. And, although the principal mental health adviser was in a position to offer advice on a day to day basis, the generic workers were not sufficiently experienced to recognise the issues they faced. We believe that there is force in the argument that if you organise your management structure on a generic basis you cannot then expect your social workers to have an in depth knowledge in all areas of social work, there has to be a degree of specialisation. The Mental Health Act Commissioners' criticisms confirm this.

3.28 Hannah Miller was employed as the Chief Officer Social Services from January, 1994. She told us that there had to be a move away from the generic structure to specialisation but she had difficulty in breaking the ethos of genericism at every level in the organisation. She had hoped to deal with the criticism of the Mental Health Act Commissioners sooner, but it was not until September 1994, when she was given the go ahead and by March 1995, specialisation was in place. We have no doubt that in order for social workers to make an adequate response to the mental health issues which they face, there must be a degree of specialisation and we commend the Social Services and the work of Hannah Miller in that regard.

3.29 It is not easy to say what, if any, difference a specialist service would have made to the life of Martin and his mother. It may be that a specialist social worker would not have allowed Martin to slip away from care and would have kept him under closer supervision, we can only speculate. With specialist knowledge it is likely that a social worker would have been more sympathetic towards him when he needed accommodation. As we have seen, Mrs Collins was very distressed when Martin was discharged from hospital into bed and breakfast following his voluntary admission. When Mrs Collins called the social services on the 18th October 1994, to find out who was the allocated social worker, they refused to tell her. When she wrote to them at the height of her despair about a week before this tragic incident, a senior duty social worker replied to her rather negatively, as follows: "We are unable to allocate a social worker because Martin does not wish to work with me, as you are probably aware. We will of course provide appropriate services if there is a further crisis." At this stage there was no social work or CPN contact with Martin. Seven days later on the 28th October 1994, Martin stabbed Joe Collins to death and seriously injured Mrs Collins. A social worker with

specialist knowledge might have taken a very different approach. Whether it would have made a difference we shall never know. It may be that a duty social worker with some awareness in mental health work would have responded differently. We therefore recommend that all Duty Social Workers should have some basic awareness in mental health work, and should have ready access to an ASW for advice.

CHAPTER 4

HEALTH CARE OF MARTIN MURSELL

SCHIZOPHRENIC ILLNESS

4.1 The mental state of Martin Mursell prior to the homicide was affected by mental illness, namely schizophrenia, and drug and alcohol misuse. His schizophrenic illness had an insidious onset beginning at about the age of 17 years. His mother recognised that he was becoming ill but his condition was not diagnosed until his first admission to hospital four years later.

4.2 Throughout the course of his illness, Martin suffered for much of the time from positive symptoms of schizophrenia; positive symptoms include hallucinations, delusions and thought disorder. He experienced auditory hallucinations in the form of voices that were critical and hostile. He developed the delusional belief that a bug had been planted in his ear. Ideas or delusions of self reference included a belief that people in the street were laughing and talking about him, and that television broadcasts were referring specifically to him. These are only examples of the symptoms he suffered over time.

4.3 Negative symptoms were less prominent but included apathy which led at times to social withdrawal and marked self-neglect.

4.4 There was a past history of drug misuse, including cannabis, amphetamines and heroin. The evidence of his drug misuse came from Martin, who admitted to his mother that he took "everything" in the way of drugs, which evidence was confirmed by his friends who told her that he did indeed misuse drugs. He also told Dr Harvey that he had been misusing heroin from the age of 16. At the time of his admission to hospital in July 1994 marks believed to indicate injection sites were noted on his arms. During that admission he returned after absenting himself from the ward and was considered to show clinical evidence of having taken an opioid. No urine test for Group A, which includes opioids, was possible at the time of that admission. The only positive reading confirming drug misuse was obtained from a blood screen carried out on admission to hospital on the 18th January 1990 which contained metabolites of cannabis.

4.5 It is likely that, because mental illness was recognised from the time of his initial contact with mental health services, an additional diagnosis of personality disorder did not feature prominently in hospital records and was never emphasized by any of the clinical witnesses who gave evidence to us. Although one report described him as "hyper active" during early childhood and there was some truancy from school, we did not find evidence to confirm a diagnosis of childhood behavioural or emotional disorder or of personality disorder in adulthood. While he may have displayed some

anti-social personality traits, we believe that the principal cause of the changes in "behaviour and moods" which his mother Mary Collins noted from the age of sixteen years onward was the insidious onset of the mental illness from which he has suffered ever since.

4.6 Given that Martin Mursell received treatment and help from Mental Health and Social Services over almost five years before the attack on his mother and stepfather, what can be said about the quality of the treatment he received?

THE LAW

4.7 Section 117 of the Mental Health Act, 1983 imposes a legal duty on the District Health Authority and the Social Services department to provide after-care for people who have been detained compulsorily under Sections 3 (Compulsory Treatment Order), 37 and 41 (Court Orders) and 47 and 49 (Transfers from Prison).

4.8 In order to decide what level of aftercare is required, an assessment must be made. In the Health Service it is the Care Programme Approach and in the Social Services it is Care Management. Section 47 of the NHS and Community Care Act, 1990 imposes a duty on the local authority to assess under the Care Management Scheme anyone who needs health or social care because of problems associated with mental illness.

4.9 The Care Programme Approach (CPA) was introduced on the 1st April 1991 by the Department of Health, as a cornerstone of the Government's mental health policy. It was designed to improve the co-ordination of care, and it should now be available to everyone who has been in contact with the specialist psychiatric services, whether they have been admitted to hospital or not. It should comprise a multi-disciplinary team assessment with the participation of informal carers; a care plan about which all members of the team, including the service user, are agreed; and the appointment of a key worker to co-ordinate the delivery of the appropriate service. Department of Health circular HC(90)23 in April 1991 specified an expectation that health and social services should by October 1991 have set in place procedures for the Care Programme Approach.

4.10 The CPA does not require the involvement of the whole multi-disciplinary team in every assessment or in the delivery or review of every care plan. It is intended to meet different levels of need and respond particularly to those patients who pose a serious risk to themselves or others. In Camden and Islington the three CPA levels which indicate increasing levels of involvement and review are: Simple Needs (Level 1), Complex Needs (Level 2) and Supervision Register (Level 3).

4.11 Level 3 CPA, to which Martin Mursell might have been assigned according to the evidence of Linda Massie, Mental Health Commissioner, Camden & Islington Health Authority, applies to patients who present a serious risk to themselves or others and require a high level of supervision in the community. It is intended for the most severely mentally ill people.

ADMISSIONS

4.12 Martin's hospital care involved the Whittington Hospital (Waterlow Unit), St

Luke's Hospital (Noel Harris Ward) and Friern Hospital. He was admitted for treatment of his mental illness on a total of six occasions. Five admissions involved detention under the Mental Health Act and the last was voluntary. During the period of his various admissions, his contacts with the Psychiatric Out-patients Service, Community Psychiatric Nurses and Social Services were varied.

4.13 He was first admitted to the Psychiatric Unit of the Whittington Hospital on the 10th February 1989, under Section 2 of the MHA, following a domiciliary visit by Dr Bruce, the consultant who then became responsible for his care. After in-patient assessment, he was discharged on leave of absence on the 2nd March 1989, but his condition swiftly deteriorated and he was recalled the next day and detained under Section 3. He remained in hospital for about two months and, despite treatment with high doses of anti-psychotic medication, he did not gain insight into his mental illness. He was discharged on leave of absence on the 23rd March 1989 – the Easter weekend – and stopped taking his medication. Leave of absence was regularly extended while he was at home until he was finally released from his section on the 24th July 1989. We believe that some confusion is caused when the word 'discharge' is used in different contexts, and therefore some consideration should be given to its use. Accordingly, we recommend that the Trust should use the words "release from section" instead of "discharge from section".

4.14 There was good CPN involvement at this stage, and we note that the CPNs Murray Wallace and Avis Hutchinson had a good rapport with Martin and his family, though he was refusing to take depot medication first prescribed on his admission. He told the CPN that his reason for non-compliance with the medication was that the high dosages of oral Chlorpromazine and Haloperidol were too strong, made him drowsy and left him feeling like a "zombie". In October 1989 the consultant who had seen him, Dr Joy Dalton, altered his medication to lower dosages of Trifluoperazine, but his compliance remained poor and his condition continued to deteriorate. On the 11th October 1989 he attempted to commit suicide by taking an overdose of Trifluoperazine and Temazepam, following an argument with his girlfriend, and was taken unconscious by ambulance to Saint Bartholomew's Hospital. Despite the serious nature of the attempt, he was discharged home the following day, as there were insufficient grounds for detaining him under the MHA.

4.15 By the time of his next admission to Friern Hospital on 18th January 1990, under Section 3 of the MHA, Martin had become very aggressive and threatening towards his mother, who was so frightened of him that she was planning to move out of her flat. It is unfortunate that the case notes from Friern Hospital for this period cannot be found by the Trust. However, Dr Dalton said in her discharge letter sent to the GP that Martin's symptoms included "Gedankenlautwerden", the abnormal experience of hearing his thoughts spoken aloud. Martin was unhappy about his detention at Friern Hospital and fractured his foot when he kicked a wall in anger at his detention. He was discharged home and released from his section on the 6th February 1990. The discharge summary dated the 21st February 1990, says: "...his mother visited him on the ward, and found him calm, frank and communicative. She was reassured, so much so that she welcomed the idea of his return home." (A signature appears at the foot of the discharge summary, but is is not clear whether it is that of the ward doctor or some other person.) We find it

difficult to reconcile that assertion with the evidence of Mrs Collins which is that she was not pleased about Martin being discharged home. There was also some dismay on the part of Jeanne Smith, the social worker, and Avis Hutchinson, the CPN, who felt little was achieved by this admission. Referring to Mrs Collins, Jeanne Smith wrote in the case file: "5/2/90 – She elaborated in her phone call to Martin on Thursday when she made it clear to him that she did not want him to return home at present as she was frightened that the same situation would recur. 6/2/90 – Mary agreed that she would have Martin back home in the interim...explored long term options, c) Whether Mary should refuse to have Martin back home again – she could not. It was further agreed that Mary should not continue to take responsibility for Martin taking his medication. At the end of this meeting Mary, myself and Avis felt concerned that the hospital did not consider Martin was in need of further in-patient treatment, deflated in that little seemed to have been achieved during this admission." The following month Avis Hutchinson wrote in the case notes: "6/3/90 – spoke with J Smith. Martin was discharged last week and is now back home with his mother. (The ward had not informed me of this. No request had been made for follow-up to indicate that Martin had changed his mind re CPN involvement)". Martin only agreed to continue contact with Jeanne Smith on the issue of housing and we accept that Mrs Collins was not happy to have him home.

DR TAYLOR

4.16 In the community, Martin once more showed poor compliance with medication, but Mrs Collins was reluctant to see him re-admitted under section despite the continuing risk of violence to herself. On 24th May 1990, Dr Taylor, the consultant responsible for his care, had Martin compulsorily detained at the Psychiatric Unit of the Whittington Hospital under Section 3 of the MHA. He had by now become floridly psychotic and was regularly threatening violence to his mother. Anti-psychotic medication, Haloperidol given orally, was part of his in-patient treatment, but he refused initially to receive depot medication by intramuscular injection. Eventually, he was persuaded to accept this, and remained in hospital for just over a month, before weekend home leave of absence was granted on 2nd July 1990. He was released from his section on 17th September 1990, having given an undertaking that he would accept injections of 500mg of Zuclopenthixol Decanoate (Clopixol) fortnightly, from the CPN, who was now Murray Wallace. This dosage was reduced to 400mg after his review on the 3rd December 1990.

4.17 Martin Mursell's case had variables which were associated with risk to others, namely: previous violent behaviour and substance misuse. In the evidence we received from Dr Taylor, the consultant responsible for his care at this stage, he stated: "Martin Mursell was highlighted as a potential risk of violence to others at an early stage in his involvement with the Mental Health Service, although the incident with the knife which led to his initial admission would have been perhaps more at the forefront of attention, had supervision registers been in existence and a detailed risk assessment recorded for all to see...In the climate of the times in which I cared for him (prior to CPA, Supervision Register and Supervised Discharge), I believed that if I had not discharged him when he was free of psychotic symptoms, then a Mental Health Tribunal would have done so."

RISK TAKEN IN DISCHARGING MARTIN MURSELL

4.18 We accept that Martin could not have been kept in hospital indefinitely. Nevertheless, to discharge him from hospital and, eventually, release him from detention

under Section 3, was to take a risk. The risk was increased by the likelihood that Martin would eventually stop complying with medication and that he would resume substance misuse. We recognise that the findings of recent research would not have been available to Dr Taylor, however, we were told in expert evidence from Professor Kevin Gournay that the co-existence of serious mental illness, in particular schizophrenia, and substance misuse significantly increases the risk of violent behaviour.

4.19 Factors acting to reduce the risk at the time he was released from his section included the apparent absence of psychotic symptoms, the month he had successfully spent at home on leave of absence and, most importantly, his acceptance of depot injections of antipsychotic medication. Factors acting to increase the risk included his refusal to attend outpatient appointments, his stated unwillingness to accept supported accommodation and the continuing lack of independent accommodation. The latter obliged him to return to live with his mother, directly increasing the potential risk to her in the event of further relapse. We find that even without the benefit of recent research, Dr Taylor was aware of Martin Mursell's previous violent behaviour and substance misuse. He posed a potential risk of violence to others and Dr Taylor ought to have made an assessment of that risk which should have been combined with appropriate arrangements for review and monitoring upon Martin Mursell's discharge. We believe that before a severely mentally ill patient is discharged into the community, it is important that there be some record of the risk that patient poses to himself/herself and to others. Therefore, where there are variables associated with a patient who is mentally ill, such as violence, drug misuse and non-compliance with treatment we recommend that the risk of violence must be assessed before that patient is discharged.

4.20 The only means of monitoring his progress after he returned home, apart from Martin's self-report, were the observations of his mother, the CPN who saw him fortnightly to administer injections, and the Social Worker, with whom he also retained contact. Should any one of these have raised concern then the Section 117 review meeting scheduled for three months later could be brought forward. The adequacy of these arrangements depended on Martin's continued co-operation, both in taking medication and remaining in contact with the CPN and Social Worker. It was also dependent on the quality of communication between these two community based workers and the medical staff who had cared for him during his in-patient stay, particularly Dr Taylor. This was not good and was therefore another factor which increased the risk. We recognise that when implemented the above recommendation will fall under the CPA, but at the time when Martin Mursell was involved with the mental health services, CPA was not implemented by Camden and Islington Health Authority.

DAVID JAYNE – CPN TEAM LEADER

4.21 On the 17th September 1990, Martin Mursell was released from his section. His CPN was Murray Wallace who made his last home visit to Martin on the 9th December 1990. David Jayne, team leader of the Community Mental Health Team, took over as allocated CPN on the 9th January 1991. He made regular visits at least twice monthly and followed up calls when Martin Mursell was not at home. He worked with him until about August 1991, when he ceased. Martin then spent almost two and a half years in the community before his next hospital admission. During this period he was initially very stable while receiving regular depot injections and maintained contact with both

the social worker and the consultant psychiatrist. However, in the following months contact between Martin and the CPN virtually ceased, during which time he discontinued his medication. Dr Taylor in his evidence wrote: "Despite my concerns about his decision to discontinue medication, he was apparently currently well and not sectionable. There was no system for enforcement of medication or for enforcing service contact. I offered an urgent assessment to Martin's mother if she were to contact me by telephone should matters break down". Dr Taylor was contacted and Martin Mursell was admitted to hospital on the 18th January 1993.

4.22 It was suggested to us in evidence that Martin's variable co-operation made it very difficult for the professionals to deliver care. We accept that for much of the time he was unwilling to take medication and to have contact, as an outpatient, with mental health professionals. In the absence of statutory powers to coerce him into accepting treatment while in the community, this predictably increased the risk of relapse.

4.23 However, he was not refusing to comply all of the time, even as an outpatient, and we are of the view that the fragmented and poorly co-ordinated approach to his care which prevailed at times compounded the problem of his non-adherence to treatment.

4.24 The frequent lack of a key worker was highly significant in this regard. We accept the evidence of Professor Gournay, of The Maudsley Hospital and Institute of Psychiatry, who gave us his opinion that a prerequisite for compliance is that the patient should have a relationship with someone over a long period of time, generally the key worker from the multi-disciplinary team. However, the Panel acknowledges the difficulties in recruitment and retention of staff.

SINGLE CARE PLAN

4.25 In May 1993, David Jayne once again became involved with Martin Mursell, although on this occasion he was not the allocated CPN. We have no explanation as to why his work with Martin was so different from the previous occasion, but he seemed to be working in isolation from other professionals. Whatever his reason, we believed that the absence of a care plan contributed to the poor quality of care which Martin received. The Inquiry therefore raised with Mr Jayne its concern about the lack of a care plan and he told us: "I am of a generation of Psychiatric Nurses who were brought up not writing care plans...I saw a care plan as being a formalisation of a way of thinking...and my view of it was, they were a tool to be used where they were helpful". He had no clear idea of who the key worker was at any given time and during this period of involvement with Martin, appeared to have little knowledge of the hospital's policy on care plans.

4.26 Indeed, the Code of Practice relating to aftercare under Section 117 says those who should be involved in the discussion are: the patient's RMO; a nurse involved in the care of the patient in hospital; a social worker specialising in mental health work; the GP; a community psychiatric nurse; a representative of relevant voluntary organisations (where appropriate and available); the patient if he wishes and/or a relative or other nominated representative. The Code also gives guidance as to what issues would be considered in discussion, namely: the patient's own wishes and needs; the views of any relevant relative, friend or supporter of the patient; the need for agreement with an appropriate representative at the receiving health authority if it is to be different from

that of the discharging authority; the possible involvement of other agencies, e.g. probation, voluntary organisations; the establishing of a care plan, based on proper assessment and clearly identified needs, in which the following issues must be considered and planned insofar as resources permit: day care arrangements, appropriate accommodation, out-patient treatment, counselling, personal support, assistance in welfare rights, assistance in managing finances, and, if necessary, in claiming benefits; the appointment of a key worker from either of the statutory agencies to monitor the care plan's implementation, liaise and co-ordinate where necessary and report to the senior officer in their agency any problems that arise which cannot be resolved through normal discussion; the identification of unmet needs.

4.27 There were large gaps in Martin Mursell's care management. Different people were involved at different times and care was not always co-ordinated. There was no coherent team approach to care nor was there a single person with whom Martin could build a long term relationship save for early relationships with Jeanne Smith, Murray Wallace and Avis Hutchinson. There was very little attempt to build such a relationship with him once they had left. We regard it as important to treatment and care that there should be a relationship with a team or an individual over a long period of time. We also found it most remarkable that the CPN David Jayne had so little faith in using a single care plan. We question the quality of leadership he provided and the example he set for the other CPNs in his team. A single care plan as required by the Care Programme Approach, shared by doctors, social workers, CPNs, GP and Carer, would in our view, have assisted compliance, and made it easier to identify any problems where compliance was lacking. Even if he did not know about CPA, at the very least he should have had a nursing care plan for Martin Mursell, setting out Martin's needs, the goals he set for him and the actions needed to achieve those goals. We believe that in order to assist the efficient working of the Community Mental Health Services, the Community Mental Health Team should be led by someone who appreciates the value of a care programme and who is prepared to work with other professionals. We find that David Jayne as a team leader showed little appreciation for the need to have a care plan and worked in isolation from other professionals. His poor leadership had an adverse impact on Martin's care. Accordingly, we recommend that the Trust and the Borough meet urgently to consider whether the introduction of the CPA will also ensure there will be a single care plan for all clients of the mental health services. We would suggest that housing needs should be at the centre of any assessment under the plan, which should also include a consideration of the patient's employment opportunities and leisure activities with the aim of removing him/her away from dependency on the carer.

4.28 On 18th January 1993, Martin Mursell was admitted to the Noel Harris Ward of St Luke's Hospital for intensive care. Upon his admission, an initial care plan was drawn up to provide what was described to us as "baseline assessment". He was then transferred to the Whittington where he remained from 21st January 1993 to 4th February 1993, when he was transferred back to Noel Harris Ward. On 5th March 1993, a Section 117 meeting was held. This was properly documented and listed all the professionals who participated. A clear strategy was agreed and the key worker was to be Andrew Shuttleworth, the social worker who attended the meeting. It was agreed that Martin would not be discharged until his 'accommodation was sorted out'. Andrew Shuttleworth made some attempt to try and achieve this by writing to the Housing

Section and was optimistic that he would succeed. However, it was a false optimism. Housing was making little or no attempt to "sort out" Martin's housing problem but Andrew Shuttleworth did not understand housing procedure, and as a result gave the wrong impression to Dr Taylor and Mrs Collins. After Martin was transferred back to the Whittington Hospital on the 30th March 1993, Andrew Shuttleworth did not contact Dr Taylor and despite the efforts of the medical staff, Dr Taylor was unable to contact him. On the 8th April 1993 Martin was discharged home on leave of absence by Dr Taylor, the consultant responsible, before his accommodation was "sorted out", forcing him to return to his mother's one bedroom flat. He was released from his section on the 29th April 1993.

4.29 We were impressed with the professional approach taken on Noel Harris Ward and in particular, the senior nurse, Patrick Mandikate, who gave evidence to the Inquiry. They were all as busy as their colleagues at the Whittington, but showed a particularly high level of professionalism in the way they cared for Martin. A care plan was carefully drawn up, with accommodation placed at the heart of their strategy. It is a pity that before Martin was transferred back to the Whittington, Dr Taylor was not informed about the discharge date and arrangements. There should have been co-operation between the two Units so that the care plan drawn up by St Luke's was put into effect upon transfer. An expectation was therefore created by the setting of the discharge date, so that Martin Mursell expected to be discharged as soon as he was back at the Whittington; but Dr Taylor did not have the St Luke's care plan. He should in any event have ensured that a new care plan was written, but we believe that it was important that he was aware of what steps had been taken by St Luke's, accordingly, we recommend that where a patient is transferred from one hospital to another before his care plan becomes operational, the plan must also be transferred with the patient and should be taken into account when a fresh plan is being devised. All the case notes in total must always accompany a patient who moves within the Trust to ensure continuity of care.

THE CODE OF PRACTICE AND SECTION 117 MHA

4.30 The Code of Practice to the Mental Health Act sets out what is required under Section 117 MHA, namely, prior to discharge a Section 117 meeting is called to establish a care plan and thereafter review meetings are called until the plan is no longer necessary. So far as is material, The Code of Practice states:

> "27.6 When a decision has been taken to discharge or grant leave to a patient, it is the responsibility of the RMO to ensure that a discussion takes place to establish a care plan to organise the management of the patient's continuing health and social care needs. The discussion will usually take place in multi-professional clinical meetings held in psychiatric hospitals and units...
>
> 27.11 the care plan should be regularly reviewed. It will be the responsibility of the key worker to arrange reviews of the plan until it is agreed that is no longer necessary. The senior officer in the key worker's agency responsible for section 117 arrangements should ensure that all aspects of the procedure are followed."

DR HARVEY

4.31 Dr Harvey became the consultant responsible for Martin's care from the 14th

June 1993. He provided a written statement to the Inquiry and appeared with his solicitor to give oral evidence. In addition he wrote extensive letters to us dated the 20th August 1996, 23rd October 1996, 26th November 1996 all of which we considered very carefully. In his evidence to us he said that three Section 117 meetings were called before Martin was admitted to hospital on the 13th July 1994. We believe that his reference to all these meetings as Section 117 "meetings" rather than "reviews" is confusing and may have reflected a lack of understanding of the purpose of a Section 117 meeting. Dr Taylor had called a Section 117 meeting on the 29th April 1993, when Martin was released from his section. He had a review on the 27th May 1993, and in our view, the three meetings referred to by Dr Harvey were reviews. Furthermore Dr Harvey pointed out that a Section 117 review meeting should be arranged by a key worker, yet we had on file a Section 117 review meeting being called by his secretary for 7th October 1993.

4.32 After-care for mentally ill patients has always been considered to be of such importance that the procedure has been enshrined in law. We expected all the professionals involved with the after-care of a patient to have a sound knowledge of what is required under Section 117 MHA. The Mental Health Act Commissioners had on more than one occasion raised the issue of how poorly Section 117 meetings are planned at the Waterlow Unit, and how little documentation existed in the hospital records regarding such meetings, yet a common feature of this case was the incomplete understanding of Section 117 and how meetings should be conducted. We recommend that the Trust and Social Services urgently set up a working party to consider the best way of delivering and updating training in Section 117 procedures and ensuring compatibility with CPA training. We suggest that training be given in the following areas:-

(a) the requirements of Section 117 MHA and the national and local guide lines on this procedure;

(b) the role of each professional involved; and

(c) how such meetings should be conducted.

4.33 In the year between 27th May 1993 and 27th May 1994 there were seven home visits by David Jayne to Martin Mursell which occurred between 4/6/93 – 28/8/93, although on two occasions he was not at home. There is then an unexplained gap of three months in the CPN notes until 15/11/93 when Lois Elliot wrote to him. Further letters followed but there was no response from Martin. An out-patient appointment was fixed by letter for the 20/1/94. By this time it was five months since Martin had been seen by a CPN or CMHW, meanwhile Mrs Collins continued to ring Lois Elliot to let her know that Martin was breaking down. In response to her many calls an outreach meeting was arranged for the 21/1/94 but this was cancelled by Dr Harvey who did not arrange a domiciliary visit until four months later. On 21/2/94 Martin called in at the drop-in centre with a list of the clothing he needed and was seen by Lois Elliot, the CMHW, for the first time in seven months. After this, no attempt was made to visit Martin and no notes were made until 5/5/94. Dr Harvey made a domiciliary visit on the 27th May 1994. We believe that the work with Martin ought to have been better planned bearing in mind that Dr Harvey told us: "...in the course of a couple of months of my

taking over... I would have got a cumulative picture of the dangers and problems that Mr Mursell faced," and that he also knew, "...there was always a threat of unpredictable behaviour and aggression..." We accept that Martin had already been released from his section by the time Dr Harvey became the consultant responsible, but having attended at least three reviews it must have been evident to him that there was no proper care plan in place, nor was there a key worker. He should in our view have taken the lead to ensure that these things were done. Dr Harvey had some initial doubts about Martin's illness which he described to us as follows: "... he also took drugs, and there is a history of him having taken amphetamines for prolonged periods, which is known to give symptoms in many cases indistinguishable from schizophrenia, so that the drug taking was a complicating factor which could have given a picture of schizophrenia. I believe looking through the notes and going right back into the picture, that he probably had schizophrenia, but this is a complicated factor." Even if Dr Harvey was not sure about the illness, he accepted that there was a potential for danger.

4.34 During this year Martin's compliance with treatment was poor, but he had suffered three oculogyric crises and was reluctant to take his medication which produced "dystonic side-effects", including a slight tremor in his legs. The dosages were reduced but compliance was not improved and he seldom kept out-patient appointments. We recognise that there may be occasions when coercion may be necessary to ensure compliance with treatment. Patients who misuse drugs or alcohol present particular difficulty in complying with treatment. Notwithstanding these challenges, we believe achieving compliance is so important that every step must be taken to maintain it or improve upon it. We therefore recommend that where there is evidence of poor or non-compliance with treatment or persistent failure to keep out-patient appointments, the key worker should bring this to the attention of the multi-disciplinary team who devised the original plan, and a clear strategy worked out to try and improve compliance.

4.35 In November 1993, Martin's CPN David Jayne went off sick and was replaced by Community Mental Health Worker Lois Elliott. The status of Lois Elliott became an important issue, because a significant difference between a community psychiatric nurse and a community mental health worker is that the former is a Registered Mental Nurse able to give depot injections whereas a community mental health worker, who can come from various backgrounds, may not. Although by this time Martin was consistently refusing depot injections, we regard it as important that the consultant responsible should appreciate this difference and also be aware of the professional background of his team members, because otherwise there is likely to be deficiency in the patient's treatment. The following extract from the exchange with Dr Harvey during the course of his evidence demonstrates this point:-

KEY

NH: Dr N Harvey
MD: Manny Devaux
PH: Patricia Hayward
RF: Dr Rob Ferris

MD *So you would describe her as a CPN?*

NH *...she was working at the time...as a community psychiatric nurse.*

PH *She was not.*

NH *Wasn't she working at that time as a community psychiatric nurse? I always thought of her as a community psychiatric nurse.*

RF *Her description to us was that she was a community mental health worker.*

NH *That means community psychiatric nurse though. That's the new name given to what was then called community psychiatric nurses...I don't know what her background was.*

PH *She isn't a registered mental nurse, let's be clear about that, she's not a registered mental nurse. When she signs her notes, she signs community mental health worker.*

NH *That surprises me because...the distinction between workers and nurses is a recent one and I'd like to look at when it came in.*

PH *You thought she was a nurse?*

NH *Yes. She may even be, because she definitely wasn't a social worker at the time was she?*

MD *She trained about 15 years ago as a social worker.*

It is important that the roles of a community psychiatric nurse and a community mental health worker are clearly understood. We therefore recommend that the boundaries between the duties of a community psychiatric nurse and a community mental health worker be clarified by the Trust and other professionals informed.

4.36 The meeting held on the 24th May 1994, was not a section 117 review. This meeting was called by Social Services in response to a letter and a phone call from Mrs Collins. Decisions were taken regarding Martin's housing situation, however. Becky Boyton, mental health court worker, who at the time was attached to Highbury Corner Magistrates Court and who attended the meeting to give support to Mrs Collins, told us that in her opinion no-one new the exact status of the meeting and there was confusion as to its purpose. In addition to the housing decisions it was also decided that Dr Harvey should visit Mrs Collins at her flat to see Martin Mursell, which he did on the 27th May 1994. However, according to the documents before us, it was the first time in the year since he became the consultant responsible for Martin's care that Dr Harvey had met him. Dr Harvey disputes the record and told us that he saw Martin at a review meeting held on the 22nd October 1993. Following the domiciliary visit on the 27th May 1994, Dr Harvey wrote a number of letters on Martin's behalf and also referred him to the Hampstead Road Drug Dependency Unit.

4.37 Lois Elliott at this stage had not met Martin. There is no evidence of discussion

between her and Dr Harvey concerning him. She occasionally wrote to Martin, but when she was questioned about her failure to make personal contact with him, she told us that she wrote to him but he did not reply. She was asked how she tried to follow up his lack of response and her view was : "If Martin didn't want contact with me, then you know...I had to respect that." It was vital that someone in Martin's position should have had a key worker. We recognise that Dr Harvey took a strong line on accommodation for him but his other concern at this stage was Martin's non-compliance with medication. Lois Elliott should have been the principal source through which information flowed, but we believe that not only was her involvement with Martin minimal, she failed to deal adequately with the complexities of the case.

4.38 On 5th July 1994, a review meeting was held at which Dr Harvey argued strongly for accommodation for Martin, and challenged the views of Yvonne Luby, senior social worker, who was not eager to find Martin a flat.

4.38 When Dr Harvey met Martin at home on 27th May 1994 he agreed to take him into hospital, but it would appear no date had been fixed for his admission. Although this fact was reported to the review meeting on 5th July 1994, on past experience no one expected Martin to come into hospital unless he was admitted under a Section. However, within a few days of his visit, Martin telephoned the hospital and asked for a bed. He admitted himself voluntarily to Jafar Kareem Ward at the Waterlow Unit on the 13th July 1994. For Mrs Collins this was a major event. It was the most important action taken by her son, because it signaled to her his recognition of his illness and the need for treatment. She was very optimistic and expected a similar response from the clinicians as they all knew about his potential for violence, his drug misuse, his failure to keep out-patient appointments and his non-compliance with treatments. She told the Inquiry: "I thought that it was a breakthrough," but it seemed to us that the clinicians did not see it that way.

4.39 At the meeting of the 5th July 1994, Dr Harvey agreed to admit Martin Mursell, although on past experience no one expected Martin to come into hospital unless he was admitted under a Section. However, within a few days of his visit, Martin telephoned the hospital and asked for a bed. He admitted himself voluntarily to Jafar Kareem Ward of the Waterlow Unit on the 13th July 1994. For Mrs Collins this was a major event. It was a most important action taken by her son, because it signalled to her his recognition of his illness and the need for treatment. She was very optimistic and expected a similar response from the clinicians whom she believed all knew about his potential for violence, his drug misuse, his failure to keep out-patient appointments and non-compliance with treatment. She told the Inquiry: I thought that it was a breakthough", but it seemed to us that the clinicians did not see it that way.

4.40 Martin Mursell was seen by Dr Garcia on the day of his admission. Dr Harvey told us that Martin admitted to taking some heroin just before his admission, and had marks on both arms from injections. He was observed for physical signs of opioid withdrawal but he showed none. He denied psychotic experiences and refused to take depot injections through he did agree to take oral anti-psychotic medication.

4.41 During the three weeks that Martin remained in hospital he frequently left the

ward, sometimes for up to two days, and returned smelling strongly of alcohol. Dr Harvey's evidence is that the doctors knew that he was misusing drugs and alcohol during this period. On one occasion he was observed in the hospital car park with three other men smoking what was suspected to be cannabis. His behaviour towards staff on the ward was aggressive, abusive and generally disruptive, all of which we believe were strong indicators that Martin's discharge had to be carefully planned. It appeared to Mrs Collins that the prevailing attitude of all the professionals involved seemed to be the sooner we can discharge him the better. Emphasis was placed on his accommodation alone rather than on drawing up a detailed care plan with adequate accommodation featuring as an important part of the strategy.

MARTIN MURSELL'S LAST DISCHARGE FROM HOSPITAL – 3/8/94

4.42 On 28th July 1994, Dr Harvey held his ward round and invited social services. Yvonne Luby, senior social worker, attended on behalf of social services and Yvonne Haynes whom she had invited attended on behalf of the housing department. As we said in the chapter on Housing, these two officers were not very sympathetic to Martin and Yvonne Luby was only prepared to advise that he be offered bed and breakfast accommodation. Dr Harvey's evidence is that his SHO Dr Garcia had discussed the housing offer with Mrs Collins who was pleased with it and happy with the discharge plan which was: "(a) he would be encouraged to continue taking his medication, which would be monitored at the psychiatric out-patient clinic; (b) he would be encouraged to agree to depot medication to improve his likelihood of compliance; (c) social services would find accommodation which would gradually reduce the stress and potential danger of his close and ambivalent relationship with his parents; (d) the CPN would provide support to Mr Mursell and his mother."

4.43 We were not shown a copy of this plan. We were referred to a record of four brief entries written in the medical notes upon which Dr Harvey relies as forming part of the care plan on discharge, but when one contrasts his care plan with that which had been drawn up by the medical team at St Luke's, it was woefully inadequate. It also fell short of what is required in a care plan because there was no key worker, no allocated social worker and no meaningful involvement by the CMHW. Accommodation should have been central to Martin Mursell's discharge, especially as Dr Harvey himself had pursued this issue in the past, but Martin was discharged to bed and breakfast which as we have already found, was inadequate for his needs. However, Dr Harvey insists Mrs Collins was happy with the discharge arrangements. His source of information for that view was Dr Garcia. As this was an important discharge, the Inquiry considered carefully Dr Garcia's evidence on this point.

4.44 In his written statement Dr Garcia said that his involvement with Martin Mursell was limited to the period of 13th July 1994 to his discharge on the "2nd August 1994". Martin was actually discharged on the 3rd August 1994. Dr Garcia said he had a conversation with Mrs Collins but: "This conversation is not recorded in the notes and I therefore make this statement in the belief that it will be of assistance to the Panel in the absence of other records. I clearly recall discussing Martin's discharge with his mother over the telephone. This was one of several telephone conversations I had with Mr Mursell's mother during his period of confinement on the Unit. I recall discussing plans relating to Martin's discharge with his mother and that she appeared to agree with those

plans. She thought it was sensible for him to be discharged at that stage, and was also happy with the proposed housing arrangements which had been put in place by the Social Services for Martin's accommodation when he was released into the community. (This involved a bed and breakfast type accommodation being immediately available to him, following which short-stay accommodation would be made available to him in due course with the aim of Martin obtaining his own flat eventually.) I clearly recall that when I spoke to her, Martin's mother did not raise any objection to the fact that he was going to be discharged into the community the following week. I was, accordingly, surprised by subsequent comments which she made to various newspapers indicating that her son had been discharged against her wishes. I did not record the contents of my conversation with his mother in Martin Mursell's records, as he was over 16 and the issue of parental consent to his discharge was of no clinical significance."

4.45 In his live evidence to the Inquiry the issues of the care plan, discharge arrangements and accommodation were raised with Dr Garcia. He was asked:-

KEY

LC: Lincoln Crawford
BG: Dr B Garcia
PH: Patricia Hayward
MD: Manny Devaux

LC *...could you tell me...who was the key worker at the time...?*

BG *The key worker on the ward or in the community?*

LC *On discharge.*

BG *I cannot remember who was the key worker on discharge but there was...I cannot remember, that is in the notes somewhere because I've been through the notes and I cannot remember the thing from two years back.*

PH *It really would be helpful for us if you could find it in the notes...if we could find where it's recorded that there is a key worker on discharge...I can find nothing there.*

BG *I think that there is something there in the notes somewhere...*

PH *Do you write a care plan, would there normally be a care plan...?*

BG *No, there was no care plan. There was I think, I am not sure, I cannot remember that because I've been working in a different hospital, I think there was a blue form...*

PH *Some pro forma that you'd write out?*

BG *I think it was...at the time of discharge...some sort of urgent information to the*

GP on those things, with the medication and the arrangements and those things...

PH *Do you accept that there should be a care plan on discharge?*

BG *There's no care plan. The care plan is not proper care plan like these days...But there were arrangements made.*

Later on in the evidence.

MD *Who then becomes accountable to co-ordinate what happens in the community about Mr Mursell?*

BG *Well, the person that is allocated for that, the key worker.*

MD *So there was one in this case?*

BG *I don't know who was the key worker...I am referring to the community team.*

Later on in the evidence.

PH *You're saying the social worker was the key worker?*

BG *Well, he was the most important person there at this stage. I can't call him the key worker because I can't recall who was the key worker.*

PH *Were you aware that Martin Mursell did not have an allocated social worker?*

BG *Well, my understanding is that at some time he had an allocated social worker but something happened and they had to give him half of one.*

PH *So when he was discharged in August he didn't have an allocated social worker?*

BG *Well, I don't know about that.*

PH *You don't know about that?*

BG *I didn't know.*

4.46 As regards accommodation Dr Garcia maintained that Mrs Collins told him in a telephone conversation on the 28th July 1994 that she was happy and that she felt that bed and breakfast accommodation was acceptable. He was asked:-

MD *...what I want to test...is whether you and Dr Harvey understood very clearly that he was going to go into hotel accommodation.*

BG *Well...the hostel in my notes...*

MD *Hotel, not hostel...*

BG *Hotel?*

MD *Yes. That's what bed and breakfast is about. Bed and breakfast is a...hotel, it's not a bedsit or...hostel.*

Later on in the evidence.

MD *So you are saying that it was right for him to be discharged to bed and breakfast.*

BG *Yes.*

MD *Because you didn't think he was mentally ill.*

BG *Well, I don't say that he wasn't mentally ill, I said that we couldn't see any major symptoms, any psychotic symptoms or affective disorders. He didn't display any features on his admission. This was a very difficult case for drugs were involved and that is making the situation much more difficult for everybody.*

Later on in the evidence.

MD *What I am trying to find out is whether Dr Harvey or yourself was happy for him to go into bed and breakfast or, because nothing was available, you...accepted the worst.*

BG *Well, it's not the worst. I don't think that it's the worst. I think that it's a quite well organised plan...in my personal view, I would have to be quite happy because we have to be pragmatic and realistic and we cannot have flats and accommodation with 24 hour staff there for everybody. We need to be realistic in this line. And...working in London you learn quite quickly because the resources in London...are limited.*

4.47 Dr Harvey had the impression that Mrs Collins was pleased with bed and breakfast accommodation for Martin and happy with the discharge arrangements. She told us that she was thoroughly displeased with this arrangement. She said that they, the doctors, "...couldn't see any psychosis and that Martin was being discharged from hospital. He was offered drug rehabilitation, he'd refused it and as far as they were concerned he was leaving hospital". We cannot be certain of what passed between Mrs Collins and Dr Garcia. She may have drawn the wrong conclusion from the doctors' action. However, we are certain that bed and breakfast was not in Martin's interest upon his discharge from hospital.

4.48 Dr Harvey was aware of Martin Mursell's previous violent behaviour and substance misuse. Indeed, he had seen at first hand Martin's aggressive behaviour on the ward towards staff and his general abusive and disruptive conduct. He posed a potential risk of violence to others and Dr Harvey ought to have made an assessment of that risk which should have been combined with appropriate arrangements for review and monitoring upon Martin Mursell's discharge.

4.49 As Martin's last admission was voluntary, Section 117 of the MHA did not apply to that discharge, but we found that there were in existence very good local and national guidelines for the discharge of patients, with which Dr Harvey should have been familiar. The Internal Inquiry states that Martin was placed on Level 3 of the CPA, but does not give the source of this comment and indeed we could find no written evidence to support this. The CPA was not fully implemented by the time of Martin's last discharge and we found it regrettable that it had taken more than three and a half years to implement this very important policy which had been outstanding since 1991. However, we accept that since then the Trust has gone a long way towards implementing this policy. We recommend that the Trust should ensure that the CPA policy and a supervision register are in place and effectively monitored, and that the Health Authority makes this a point of review in contract monitoring.

RECORD KEEPING

4.50 We found in general the record keeping at the Waterlow Unit was at best disorganised and at worst non-existent. We recommend that immediate steps be taken to improve the standard of record keeping at the Waterlow Unit and in the community mental health services.

RECENT PROGRESS

4.51 We are pleased to note that since this tragic incident, the Trust and the Health Authority have made considerable progress in tightening up procedures.

4.52 The Trust has now fully implemented CPA and is currently revising this policy in conjunction with the Health Authority and local authorities. The Health Authority has also put in place working procedures between health, housing and social services and in this current year proposes to invest in 24 hour crisis centres.

CHAPTER 5

MARTIN MURSELL: CRIMINAL HISTORY

5.1 Martin Mursell's drug misuse and potential for violence were known to the professionals involved with him from the time of his very first contact with the mental health services. Although he did not have a long criminal record, he had been and still was potentially violent and his mother knew it. However, it seemed to us unlikely that it would have made any difference to the course of events had he been admitted under section a year earlier than he was. Mrs Collins wanted Martin to have treatment in 1988 for what she correctly assumed was mental illness, but was prepared to ignore her suspicions – for a while at any rate – upon the advice of her solicitor. Martin's previous convictions confirms his potential for violence and involvement with drugs.

5.2 On 22nd July 1985, near his mother's home in Northchurch Road, London N1, Martin carried out one of his "frenzied attacks" on a motor car, smashing its windows and causing damage for which he was fined at Highbury Corner Magistrates Court. This conviction was followed by another conviction three years later, when he was fined at the same court for possession of cannabis. Warning signs were there, but many people are understandably slow to recognise the onset of mental illness in a family member or close relative, and it may take a very serious event before help is sought. We believe that when the decision to seek help is made, it is vital that as much information as possible is provided to the person seeking it.

5.3 Martin's girlfriend had no idea of how ill he was becoming, but he developed the belief that she was unfaithful to him and on the night of 24th May 1988, while on a visit to his home, he carried out a very serious assault on her lasting several hours, during which he head-butted her, forced her to strip naked and beat her around the legs with a baton and a shoe. He was arrested and remanded in custody for four months. On 30th September 1988, he was sentenced at Snaresbrook Crown Court to two months imprisonment suspended for one year. His mother wanted to take this opportunity to secure treatment for him but before doing so she sought advice from her solicitors, whose attitude was "you don't want him locked up for life in a mental institution do you?". We feel it is a pity that Mrs Collins was not at that stage encouraged to raise her concerns with the Police. Had she been so encouraged, the intervention of officers with mental health awareness training may have been able to assist in securing a proper assessment for him at this stage rather than have him remanded in custody for four months. We were unable to obtain any information about his time spent on remand and so cannot comment on whether any form of psychiatric assessment was carried out.

5.4 On 10th February 1989, just over four months after his conviction for ABH, he had his first admission to hospital after Mrs Collins overheard him talking about killing

her. On 13th December 1989 he was again convicted at Highbury Corner Magistrates Court for possession of cannabis, for which he received a fine. His aggression and threats of violence towards Mrs Collins continued. On 3rd May 1992, on the occasion of his birthday, he assaulted her as a result of which she suffered a cracked dental filling and severe bruising and on 28th October 1994, he injured her almost fatally.

5.5 We do not intend to comment on Martin's involvement with the criminal justice system after his arrest on 28th October, except in relation to two matters. The first, covered elsewhere in the report, concerns the psychiatric assessments carried out during the months before his transfer to Rampton Hospital. These are mentioned briefly in relation to his mental state at the time of the homicide.

5.6 The second concerns his convictions for murder and attempted murder. By the time his case was dealt with in January 1996, Martin was considered fit to plead. Although advised, on the basis of psychiatric assessments carried out during his time on remand, that a defence of diminished responsibility was available to him in relation to the charge of murder, he did not accept this advice. He insisted on pleading guilty to murder and attempted murder. However, although it was acknowledged by the trial Judge that the doctors who had assessed him probably held the opinion that the defence of diminished responsibility was available because of mental illness, the Judge accepted a submission that in the circumstances Martin's wishes must be upheld. Martin Mursell received a mandatory life sentence for the murder of Joe Collins and a sentence of 10 years imprisonment for the attempted murder of his mother.

CONCLUSION

5.7 Mrs Collins was aware of Martin's potential for violence from the onset of his illness. As his condition deteriorated and his violence grew towards her she sought advice from her solicitor before she went to her GP or became involved with social services. This is hardly surprising, because a solicitor is very likely to be the first point of contact for a relative of a mentally ill person. She was advised in good faith by the solicitor. However, as regards raising the issue of Martin's illness, she was advised not to say anything which might cause him to end up in a 'mental asylum' for life, but in order to treat his condition, the issue of his illness had to be raised and this aspect of the advice was not particularly helpful. We believe that like the Police who have now included mental health awareness as part of Police training, solicitors should also include it as part of theirs. Accordingly, we recommend that the Law Society should now give consideration to including mental health awareness training for solicitors as part of its continuing education programme.

CHAPTER 6

NEAR DOUBLE TRAGEDY: 28TH OCTOBER, 1994

6.1 The Police arrived at No.33 Mulberry Court just after ten o'clock in the evening of 28th October 1994, following an emergency call. As they entered the flat Mrs Collins was seen in the hallway kneeling next to her husband who lay dead on the floor. At first no one realised that she was severely injured and near death, because in her final act of comfort towards her dead husband, she held on to his hand, lent over him and was repeating the words, "he's been stabbed." Shortly after the Police arrived she let go of his hand and clutched her chest. It was then they realised that she was also injured. Pressure pads were applied to her wounds and she was later taken by the police to St Bartholomew's Hospital. In a statement which she gave to the Police, she said: "I can't believe he's done it, I knew something like this would happen."

6.2 Although Mrs Collins endured great distress and suffering prior to Martin's first admission, she was confident that once he was admitted his problems would be successfully treated and he would be back to normal very soon. She had no idea that what was to follow was a repeating cycle of admissions, partial response to in-patient treatment, discharge from hospital, followed by cessation of treatment leading to relapse of illness and re-admission to hospital. Mrs Collins did believe that successful treatment of Martin would bring an end to her own suffering.

6.3 Treatment was only partially successful and could not bring an end to the suffering of either Martin or his mother. Martin was usually discharged to her home from hospital and as he fell into relapse he was often aggressive towards her. The level of his aggression increased and she became more and more frightened of him. As he began to fall into relapse on one occasion he threatened to stab her and do a "Hungerford" on her. Many other threats were made and on one occasion he was threatening to "cut the bitch's head off". Following a birthday party for him, he assaulted Mrs Collins so violently that she suffered severe bruising and a cracked filling in her tooth, but she endured the threats and aggression until he was admitted under section.

6.4 When Martin voluntarily admitted himself to hospital on 13th July 1994, Mrs Collins's immediate reaction was that it was a "breakthrough". She hoped that he would remain in hospital for a long while until his condition significantly improved, but after about three weeks the doctors began suggesting that he should be discharged because he was not psychotic. They believed that his problem at this time was drug misuse. Mrs Collins and her husband Joe Collins were so concerned about this discharge that they went to the hospital to try and persuade the doctors to keep him in for longer until he was really well. Mrs Collins told us she thought that Martin was ill, but the doctors wanted to send him to a drug rehabilitation clinic. She was desperate for him to be treat-

ed further in hospital and therefore decided to take a holiday on the south coast, partly to have a break from her distressing circumstances, but more importantly to try and forestall the discharge which the hospital was determined to carry out. She went away on holiday on or about 31st July 1994 and returned on Sunday, 7th August 1994.

6.5 On her return, Martin was waiting for her. She told us that: "he came over straight away and told me he was in bed and breakfast...and he wanted me to go and see it there and then." She offered to go and see it the following day because she was tired, he then suggested Tuesday, 9th August 1994. She told us: "I said that was OK and I never saw him anymore until the Thursday before this happened." Mrs Collins was able to learn of his whereabouts with the help of housing rather than social services who showed very little interest in her concerns. She told us that she would leave messages at his bed and breakfast accommodation but he would not reply. No one she said, was "looking out for him". On one occasion he did reply, but he was very aggressive and abusive on the telephone. She told us that she knew he was ill and should be "put into hospital".

6.6 None of the professionals were involved with Martin at this critical stage. Mrs Collins's many telephone calls to social services seemed to "fall on deaf ears". On one occasion during this period she did manage to get through to the duty social worker whom she informed about Martin's aggression and the fact that she believed that he was ill, but the social worker's reaction was to "call the Police if he is aggressive towards you".

6.7 On or about 18th October 1994, Mrs Collins saw Martin for the first time in several weeks, she said: "I was standing outside the Oakley Arms Pub in Goswell Road talking to my sister and I looked across the road and I saw Martin." She waved him over and he barged past her sister and went into the pub. She described him as very talkative. She bought him a coke and he told her about the tenancy to the flat which he had just been granted. The flat was 44 Midway House. Mrs Collins was on her own because her husband Joe had taken their puppy to the vet. Before she saw Martin that afternoon, Mrs Collins had telephoned social services in the morning to express her concern about Martin because she was very worried that no one was in contact with him, but there was no follow up to her telephone call. It is not clear where Martin was living after the 18th October, what is clear is that he stayed with his mother on Thursday, 27th October 1994.

6.8 On 28th October 1994, Martin left his mother's flat at about midday and she invited him back for dinner because she knew there was nothing in the new flat. He returned at about 6.15 pm, they had dinner and then sat down to watch television. Mrs Collins in her statement to the Police said:

> *"...I went up to the bathroom at some stage leaving Joe and Martin in the living room. Next thing there was someone at the bathroom door trying to get in. I thought someone was messing so I shouted out. Next thing Martin barged in through the bathroom door. He was carrying a large kitchen knife and he started stabbing me. I started screaming and shouting but I couldn't get past him out the door...I kept banging the window, shouting for someone to call the Police...I began feeling dizzy and I fell to the floor...I remember crawling out of the bathroom and all I could see was Joe's legs. I crawled towards him and the next thing I saw was the Police ..."*

6.9 Martin gave himself up to the Police in the street. He had with him a bag which contained a pair of shoes and a pair of trousers. When asked about his possessions, he told the Police, "That bag is all I have." He later explained to the Police that he stabbed his mother and Mr Collins because they were "giving him looks" and because the dog was being troublesome.

6.10 Unfortunately, the Inquiry was not able to obtain detailed information about Martin's mental state at the time of the offences. He had not seen any mental health professionals since his discharge from hospital on 3rd August. Similarly, his mother had not seen him between 7th August and 18th October and his whereabouts between 18th October and 27th October are not known in detail. On 29th October, the day after his arrest, he told Dr Dattani, a Forensic Medical Examiner, that he had injected heroin three days earlier, and taken methadone by mouth on 27th October, the day before his arrest. He complained of withdrawal symptoms but no physical signs of withdrawal were noted on clinical examination. Blood samples taken from Martin approximately 51/2 hours after the offences showed that he had not misused drugs for at least 6 hours before the offences and was therefore not under their influence at the time.

6.11 Dr Dattani, who first saw him at 8.45 am on 29th October, found him to be coherent in his speech, calm and co-operative, and declared him fit to be detained and to be interviewed. He stipulated that an appropriate adult should be present, according to the provisions of the Police and Criminal Evidence Act (1984).

6.12 Martin was interviewed by the police on the afternoon of 29th October in the presence of his solicitor and a social worker, acting as appropriate adult. During the interview he was asked what was going through his mind immediately before the assault. The following is an extract of that interview:-

DS Shanks: *Do you remember what you were thinking?*

Mursell: *No, I just, I just thought, what I thought is I might not wake up in the bloody morning.*

DS Shanks: *Why were you thinking that?*

Mursell: *I mean well the way they was looking at me and everything, you know, and the way they just burst out and started sort of determinedly, sort of,..., pointing his words at me and everything.*

And slightly later in the interview:

Mursell: *Yeah, yeah, and you know it made a bad atmosphere and everything and I thought, you know, you know I just had the strangest feeling that I wouldn't be around in the morning.*

DS Shanks: *What, you thought he might hurt you if you stayed there?*

Mursell: *Yeah.*

DS Shanks: *What about your mum, did you think she'd hurt you?*

Mursell: *I did actually yeah.*

6.13 Martin spoke further in the interview of a fear that Mary and Joe Collins were going to kill him, and of them glaring at him with "exactly the same look in both their eyes".

6.14 It appeared from the evidence that Martin had suffered a relapse of his schizophrenic illness and was again experiencing symptoms of psychosis at the time he committed the offences. It would be inappropriate to try and specify the various mental phenomena experienced by him at this time, but it appears likely that he held, however transiently, abnormal persecutory beliefs about both Mary and Joe Collins, which may have been delusional in quality, and caused him to feel a powerful sense of threat, when in objective reality, no such threat existed.

6.15 We were not able to gain access to any prison medical records and therefore have little information about Martin's condition and treatment during the months he spent in prison on remand. He was sent to HMP Pentonville on 31st October 1994, to HMP Brixton on 9th March 1995 and then to Rampton Hospital on 25th July 1995. While in prison he was assessed by several doctors and by May 1995 it was felt that his mental state was deteriorating further, hence the request for assessment by a special hospital consultant, and his subsequent transfer.

CONCLUSION

6.16 Throughout the Inquiry it has been suggested to us by a number of those who gave evidence that Martin's care, particularly when he was in the community, fell short of what it ought to have been. However, we were not told that if he had received better care then the events of 28th October 1994 would have been avoided. That we will never know. What we do believe, on the basis of the evidence, is that Martin Mursell, having been discharged from hospital almost three months earlier, had very probably suffered a relapse of his schizophrenic illness. This relapse occurred against a background of loss of contact with mental health professionals, social services and his family. His compliance with prescribed medication was very likely to have been poor or absent, and he was probably misusing substances, though not immediately before the offences.

6.17 The re-emergence of active symptoms of mental illness affected Martin's mood and behaviour and was in our opinion likely to have been the causal factor which made the most important contribution to the offences.

6.18 This relapse was predictable, as was the increased risk of violence which accompanied it and, although the tragic outcome was something which could not have been predicted in advance, the care which Martin received in the community fell short of what was needed to such an extent that it became more likely that a serious incident would occur.

CHAPTER 7

CARERS AND USERS

7.1 The needs of carers have been firmly placed at the bottom of priorities of policy makers, health and local authorities, even though the carer's role is often central to the life of people with enduring mental illness. The carefully researched project, "The Silent Partner", confirms that carers of people with schizophrenia and other severe mental illness have needs: particularly support from family and friends. They also need information, understanding, and recognition from professionals, respite services to give them a break from caring and crisis services when they are no longer able to cope.

7.2 From her very first contact with the Mental Health Services, it must have been obvious that Mrs Collins was giving Martin a very high level of support and that it was taking its toll on her well-being. Indeed, at the time of his first admission, Martin, who was trying to conceal the severity of his own illness, said to the Psychiatrist and Social Worker, "Look at the state of her and look at me." Mrs Collins told us in evidence, "I was in pieces at this stage, I was really upset, although I'd made the decision, and I thought it the best and right thing to do to get him help, it still wasn't easy for me to do that."

7.3 There was nothing Mrs Collins could have done to avoid being the mother of a schizophrenic son, yet instead of creating a climate in which she felt confident to deal with the problems that she faced, few of the professionals involved with Martin treated her as an equal or showed a sympathetic interest in her plight. She had to deal with conduct and behaviour by Martin which she did not understand and her experience over long periods was very corrosive in the sense of the distress and fear which his behaviour had created.

7.4 There was little value placed upon or consideration given to Mrs Collins's contribution as a carer. Those professionals who should have worked more closely with Martin when he was well seemed to regard her contribution as a convenient substitute for the after-care plan which they ought to have prepared. If Martin was not in hospital and in need of care, she provided it and, in her evidence to this Inquiry, she said: "They told me that if he was not harming himself or someone else, he couldn't be sectioned." There was a failure to appreciate the effect on her of dealing with someone who was suffering from a long-term illness. From her point of view the emphasis placed on the need for Martin to relapse before he could be admitted under section, was entirely at odds with her own needs, which were overwhelming, in fact, she told us, "I was becoming worn out and to a degree I was giving up hope of ever getting real help." In July 1994, when she took a week's holiday to the south coast, she said that she did so partly to force the hospital to keep Martin longer than they were prepared to do. We

recommend that the Trust and the Health Authority ensure that provision is made for carers to have respite breaks.

7.5 The pattern of Martin's condition of being well, then falling into relapse, was something with which Mrs Collins had become very familiar. However, at the heart of this revolving pattern was Martin's non-compliance with his medication. When this happened, she was the one who suffered the abuse and threats, but more particularly, she was the one who had to endure the stress of his non-compliance. This pattern was known to those involved with him, but apart from the social worker, Jeanne Smith, who was "always there" for her, she was largely left to cope by herself which caused her to worry so much that she began to question her own sanity. We recommend that the Trust ensures that all after-care plans include a consideration of the patient's employment opportunities and leisure activities, with the aim of removing him/her away from dependency on the carer.

7.6 Throughout Martin's illness, Mrs Collins effectively placed her own life on 'hold', in the sense that all her attention was focused on his needs. She needed to be trained, in order to give herself a chance of finding a suitable job, but as she told us, she felt that constantly caring for Martin without any respite caused her to become depressed. Her energy felt sapped and she was not able to make the efforts she should have been making to put her own life in order. However, she did some voluntary work for the social services department, but this lasted only for six months. Meanwhile, Martin remained dependent upon her for his food, accommodation and general keep, with no one offering any advice to him or providing support for her. At one stage she had to tell him that if he did not give her money for his food and general keep from the money he was receiving from social security, he would have to leave her home.

7.7 There is little doubt that Martin's conduct was often unpredictable, which prevented Mrs Collins from planning her own life, but with one exception, no one provided him with guidance, or assistance, or opportunities that might have steered him away from dependency upon his mother and towards independent living. He was reliant on benefit and apart from the encouragement he had from his mother to find a job, it seems to us that employment or leisure activity did not form any part of such after-care that may have been in existence.

CONCLUSION

7.8 We have touched in this brief discussion of carers and users on only some aspects of a large and increasingly important subject, which seems to us directly relevant to our terms of reference. The involvement of the carer in after-care planning, we suggest, must be formalised and incorporated as part of the process of caring for those people with enduring mental illness. The evidence we heard leads us to submit that emphasis on carers' involvement as a necessary part of community care is urgently needed. We recommend that the Trust makes arrangements so far as is practicable for carers to be involved in the after-care process on an equal footing with professionals. We also recommend that the Trust ensures that information shared by professionals must also be shared with the carer, subject to the user's consent.

7.9 In any household where there is a mentally ill person, it is only right that services

should be focused on that person, but we believe that the carer's needs are so important that meeting them should not be left to the discretion of the professionals. Their contributions are crucial to the policy of care in the community, and everything must be done to enable this group to continue to make these contributions. We recommend that the Trust and the Local Authority ensure that the patient's key worker is involved at all times with the carer.

CHAPTER 8

AGENCIES WORKING TOGETHER

THE HEALTH AUTHORITY AND THE TRUST

8.1 The reforms in the National Health Service (NHS) introduced a separation of responsibilities between service providers and service purchasers – purchasers later became known as commissioners. The Trusts are the providers of service and the Health Authorities and GP fund holders are the purchasers, or commissioners of the service.

8.2 The purchasers or commissioners of service are responsible for ensuring that they arrange contracts for health care that will best meet the needs of their local populations, and they work with a range of providers, which as far as the health services are concerned, are generally formed as NHS Trusts.

8.3 The Trust's responsibility as provider of service is to deliver the level and quality of treatment and care agreed in negotiation with health purchasers. The Trust is also responsible for managing the services effectively within available resources.

8.4 The new structure meant that separate organisations had to be established for providing and purchasing service. However, as regards mental health services, most employees with mental health experience remained with the providers, in this case principally the Camden & Islington Community Health Services NHS Trust (C&I CHS NHS Trust). This imbalance in experience had an effect upon the Health Authority, because when it began to commission work, in common with all health authorities, there was not only a shortage of expertise in the process of commissioning, but more significantly, there was no one with specific mental health experience working as a commissioner. This point was readily conceded in evidence by Terry Roberts, Divisional Director of Camden & Islington Health Authority, who told us that someone was now in post with the relevant experience. It is our view that the lack of expertise available to the Health Authority in purchasing mental health services meant that its early contracts with the Trust did not make adequate provision for mental health or the way that service was to be monitored.

8.5 The contract is important, for it not only tells you what service has been purchased, it provides a means of ensuring that the Health Authority obtains a certain quality of service for the resources it agrees to deploy. Both purchaser and provider are required to monitor carefully, in order to ensure that the contract is delivered.

8.6 It seems to us that at the material time, however, mental health as a service was not given careful attention. Mr Roberts acknowledges in his evidence to us that in the early days the contracts were not very sophisticated, and that there were gaps in terms of standards and monitoring, but we are not convinced that lack of sophistication alone

was the explanation. For example, there had been extensive discussions between the Health Authority and the London Borough of Islington which had led to targets being set in the 1992 Community Care Plan, regarding Department of Health circular HC(89)5. These targets and the agreed way forward however, are not reflected in the early contracts. Furthermore, it must have been clear that the CPA was important, both nationally and regionally, to the policy of discharging mentally ill people into the community. That policy was initially introduced in April 1991, and although we accept that it was not implemented uniformly across the country, it remained a centrally important part of policy. Yet there was no direct mention in any of the contracts of the requirement to implement the CPA, until the 1994/1995 contract.

8.7 It is understandable that in the early days of commissioning, contracts might not have been as precise as they should, but the gaps which we found to have existed in the contracts were very basic and should have been dealt with in early contracts. For instance, there was no reference in the Health Authority's contract, nor in the monitoring arrangements of the Trust, to the need to improve Section 117 procedures on discharge, notwithstanding the fact that, on each of the visits which the Mental Health Act Commissioners made between 1989 and 1994, they reminded the Health Authority of the importance of improving Section 117 procedures. In their evidence, both purchaser and provider agreed that the setting of standards and monitoring had not been entirely successful, but quite apart from the setting of standards in the contract, it is the responsibility of the Trust to monitor the standards it has set for its services.

THE TRUST AND SOCIAL SERVICES

8.8 Social Services and Health were moving along parallel lines in the early 1990s in their different purchaser/provider roles. The provider function of these two agencies required them to work closely with one another, and there were some early attempts at collaboration between these agencies, in care planning and the CPA, which were successful as far as the shaping of the policy was concerned; but these efforts had few practical results because communication between them was not clear. We were told in evidence that an obstacle in the way of collaboration was the fact that there were different boundaries between the neighbourhood social services and the community mental health teams, and that this lack of coterminosity presented a real problem. Indeed, David Stout, Director, Mental Health & Learning Difficulties Services, of Camden & Islington Community Health Services NHS Trust, told us that some of the structures they had in place at the time "did not marry". It is our view that even though the differences in boundaries may have caused some problems this could have been surmounted by effective communication between all the practitioners, a view shared by the Mental Health Act Commissioners who, following a joint visit to Health and Social Services, found that communication between the two agencies was poor. Had there been collaboration and effective communication between the Social Services and the Trust, the outcome of the meetings following Martin's various discharges from hospital might well have been very different. However, as the Mental Health Commission pointed out, Social Services and Health did not collaborate clearly on Section 117 MHA discharges, with inadequate notice often being given to Social Services, or there being an unwillingness on the part of Social Services to attend Section 117 meetings.

8.9 Following one Mental Health Act Commission visit, the London Borough of Islington carried out a Mental Health Review. This was a brave attempt to deal with its mental health service problem, by way of a structural solution which we commend. The Borough had come to the conclusion that it required specialist staff to work with mentally ill people and therefore specialisation had to be introduced. Since the incident in this case, the Social Services and health providers have worked hard to establish a multi-disciplinary response to mental health problems and the effective working of the CPA.

THE HEALTH AUTHORITY, SOCIAL SERVICES AND HOUSING WORKING TOGETHER

8.10 The Camden & Islington Health Authority and its predecessor, Bloomsbury and Islington Authority, have worked very closely with the London Borough of Islington on a collaborative basis to develop community care policies. In Islington there was much good early joint planning concerning the implementation of community care and careful attention was paid to the creation of dynamic structures that involved users, as well as the statutory agencies and the voluntary sector, in the development of those policies.

8.11 However, the close collaborative working that has existed between these two agencies over the past few years at a strategic level has not been sustained. In mental health there were no written strategies in the early 1990s, even though there had been extensive discussions and a sharing of thinking between the agencies. The Inquiry was told that work towards producing a strategic document was now well on the way, which we commend and suggest that on completion the document is kept up to date and shared between them.

8.12 Housing is a crucial issue for those people with enduring mental illness. In Martin's case, adequate accommodation could have made an enormous difference, and might well have affected the tragic outcome. We felt it was unfortunate that in the London Borough of Islington, with a neighbourhood structure to deliver its housing services – a potentially strong and sensible structure – so little was delivered to Martin. There was little evidence of joint planning with Health, but more importantly, there was no effective planning between Housing and Social Services, which ostensibly operated an integrated service within the neighbourhood structure. We recommend that Health, Housing and Social Services should work together to develop a strategic approach to accommodation for mentally ill people and that co-ordination of service provision be monitored regularly.

CONCLUSION

8.13 We have emphasised how important it is for the Health Authority and the Trust to set clear standards, with proper monitoring arrangements in their contracts. Further, it is our view that the Trust could not know whether it was delivering an effective service without its own proper monitoring arrangements in place. Neither the Trust nor the other agencies – Housing and Social Services – could deliver a high quality service working in isolation. They must plan, communicate and work together and, where their structures are so different that it prevents this joint approach, steps should be taken to harmonise them. We recommend that Health and Social Services purchasers and providers agree the essential requirements of service and ensure that proper arrangements are made so that contract monitoring and any audit will readily indicate the degree of effectiveness of the services delivered.

CHAPTER 9

MENTAL HEALTH: A WIDER PERSPECTIVE

9.1 In this report we have had to consider carefully the conduct of individuals, their performance and responsibilities. We have been critical of some for the part they played in this incident. However, we firmly believe the time has come to look beyond individual blame, and to consider a new approach to what must be described as a crisis within Mental Health Services, particularly in inner cities – a crisis which those individuals did not create. Neither are they individually or collectively responsible for the apparent lack of public confidence in care in the community; nor can they be expected by themselves to change this attitude. Resolution of this apparent crisis cannot in our view be achieved solely through recommendations arising from an Inquiry into a catastrophe such as this. There have been several such inquiries in recent years. It is our view that in order to achieve real and lasting change we must address the wider context of the systems and structures within which Mental Health Services are delivered.

9.2 Mental health has become a national priority, for we as a nation have taken the decision to move away from the old Victorian asylums to care in the community. We must recognise what is involved in that decision. It is of vital importance that the intersection between Health, Housing and Social Services is co-ordinated.

9.3 In spite of guidance this has so far failed to occur. For example, when the Government published the paper Caring for People in 1992, followed by a joint circular from the DoH and the DoE in the same year, it was expected that a more co-ordinated approach towards health and housing would be pursued. In the event, neither the DoE, which takes the lead on housing at central Government level, nor the DoH, which leads on community care, has prioritised housing as a vital component of community care.

9.4 A recent review of the relationship between health and housing found that there was a lack of common understanding and, in some instances, a lack of political or managerial will to make inter-agency working effective. The review also found that links with primary care are particularly weak, with GPs and housing managers demonstrating little mutual understanding. These findings were similar to those of a DoH special study that was equally critical of links with the acute sector. Hospital staff were reported in this study as often failing to identify housing needs through out-patient consultation or in-patient discharge planning, with few attempts to review access to the general housing stock for those assessed as in need of care. In the case of Martin Mursell, we see both how necessary and how difficult it was for the two agencies to work together, and how they largely failed to do so in the face of the challenges posed by his illness. At one point the Housing department of the Council was determined to place him in bed and breakfast accommodation. The hospital staff knew this to be

unsuitable for someone as vulnerable as he was, yet there was no effective planning or co-ordination between the two agencies to find him accommodation which was appropriate to his needs after he was discharged.

9.5 There was disagreement between the parties as to whether Martin should have been discharged as early as he was on some occasions. Mrs Collins and Jeanne Smith, his former social worker, felt he was discharged too soon and that he should have been treated longer in hospital, whereas the doctors felt that he had been discharged when he was free of psychotic symptoms.

9.6 It is very likely that Martin would have benefited from a longer period in hospital, but as Dr Taylor stated in his evidence, "by 1993 the Whittington Psychiatric Service was in crisis, in that beds were running at well in excess of 100% occupancy and patients would often wait up to eight hours in A&E for a bed. The unit was always highly disturbed with the seriously mentally ill as the only clientele. There were for an extended period no rehabilitation beds within the service..." The evidence also shows that on every visit to the Whittington Hospital between 1993-1996, the Mental Health Act Commissioners noted that there was such pressure on beds that "some patients were frightened to take extension of leave in case their beds were no longer available" and they felt that this pressure on beds was "leading to adverse effects on patient care".

9.7 It is possible that the pressure on beds had a part to play in some of the decisions which led to Martin's discharge. We understand the frustration and desperation which psychiatrists, particularly those working in the inner cities, feel about running a mental health service with constant pressure on beds. The evidence we have considered suggests that the demand for mental health services may be growing, and that the pressure on beds will continue.

9.8 Martin Mursell was a difficult patient and posed a serious challenge to those who were involved with him. His relapses in the community were as a direct result of his non-compliance with treatment. In this situation, what degree of coercion is the right response? At present, the power both to coerce patients into treatment in the community and to recall them to hospital is confined to a Restriction Order. This can only be imposed by a Crown Court following a conviction.

9.9 This limitation has been part of a long debate about the rights and wrongs of using compulsory powers in the community. In 1987 the Royal College of Psychiatrists introduced proposals for a Community Treatment Order, but powerful objections from civil libertarian organisations led to the withdrawal of the proposal. In 1993 this same body made new proposals for a Community Supervision Order but these where also rejected by the Government on the basis that overtly forcing treatment in the community, other than under a Restriction Order, would contravene article 5 of the European Convention on Human Rights.

9.10 The rejection of these two proposals led to the Department of Health's own internal review report which resulted in the Mental Health (Patients in the Community) Act, 1995. This Act, which came into force on the 1st April 1996, amends Section 17 of the

MHA to allow for extension of leave of absence from six months to twelve months and introduced supervised discharge.

9.11 An application for supervised discharge is made by the RMO at the point where the patient is about to be discharged from hospital. Other members of the team who have been involved with the patient's care in hospital must be consulted as well as those who will be involved – whether professionally or as an informal carer – in his/her after-care. It is designed for so-called 'revolving door' patients who go through a cycle of repeated admission to hospital under the Mental Health Act followed by the breakdown of arrangements of care in the community, often because they have stopped taking medication, or they have lost contact with the after-care services arranged for them.

9.12 A patient subject to supervised discharge will be required to abide by the terms of a care plan, drawn up under the principles of the Care Programme Approach, agreed by all concerned following consultation with the patient.

9.13 A supervisor, who will in most cases also be the key worker, will be appointed with the powers to: (a) require the patient to reside in a specific place, (b) require the patient to attend for medical treatment and rehabilitation and (c) convey a patient to a place where he/she is to attend for treatment. The supervisor may be any member of the multi-disciplinary team involved in delivering the care programme, for example a community mental health nurse, doctor or social worker. If however, there is non-compliance with treatment, there are no powers for the patients to be given treatment against their will in the community. The care team, in such a case, would be required to review the case, and if appropriate, compulsorily admit the patient to hospital, using existing powers under the MHA.

9.14 After-care under supervision provided by this new Act gives powers of control and compulsion – regarded by some professionals as limited – over some patients discharged into the community. Martin Mursell was a very challenging patient and could have been an appropriate case for supervised discharge had it been available at the time. No one yet knows how effectively these new community powers will work in practice, what is clear is that the patients likely to be placed under supervision are those who pose the greatest risk of harm to themselves and to others. The exercise of these powers would in our view require careful monitoring, and we therefore recommend that consideration be given to extending the remit of the Mental Health Act Commission to monitor the use of supervised discharge in the community. In making this suggestion, we bear in mind the fact that in this case there was persistent failure by the Waterlow Unit (formerly the Whittington Hospital) to comply with Section 117 procedure which affected the after-care Martin received and which was regularly raised as a concern by the Commissioners. We believe that it would be an opportunity missed if the role of the MHAC is not extended at this stage to protect the interest of patients who are discharged under supervision.

9.15 We believe that although statutory powers to actively coerce Martin into receiving maintenance treatment with (depot) anti-psychotic drugs would have reduced the risk of relapse, such powers should only become necessary in extreme cases. In any event, the much under used guardianship power under the MHA was available to the

doctors involved with him. However, we acknowledge that the existence of this power may not have been of assistance to the doctors in this case.

9.16 Martin Mursell did however comply some of the time, therefore it is our view that if certain clinical and organisational measures such as 'assertive outreach' or cultivating stable relationships between him and a single key worker (or team) over time were pursued, compliance with treatment may have been significantly improved. The effectiveness of the agencies' joint working was critical to Martin's stability.

9.17 Poor co-ordination between health, social services and housing was in our view a key barrier to the delivery of a good quality service to Martin Mursell. This has been a consistent finding of Inquiries into mental health scandals and disasters.

9.18 We believe that the approach to mental health services must be based on the recognition that there has to be collaboration between agencies, co-operation between professionals and participation by users. This approach may require a review of the way mental health is funded. We welcome the recent Government initiative to consider whether new 'mental health authorities' should be created as a means of co-ordinating the funding, organisation and development of mental health services, and we await its outcomes. However, organisational change alone will not resolve an additional fundamental problem which we must address in seeking to improve mental health services in the era of care in the community, and that is, the level of expertise of professional staff.

9.19 The Inquiry notes with some alarm the surprising number of staff working in all of the different agencies who had a remit to assess Martin's needs, and those of his mother, and to provide services to them, who appeared to lack the experience and expertise to deal in an effective and efficient way with what was presented to them. The preceding chapters provide a number of examples to justify this assertion. In the course of this Inquiry it has become clear to us that the environment within which mental health care is planned and delivered has changed considerably. In the era of care in the community, for example, it is now very important that professionals should work in partnership with the carer and family members and take into account their willingness and ability to continue in the caring role.

9.20 It is the view of the Inquiry that, in the main, professional staff working with Martin Mursell had not been trained adequately to respond to this new environment of mental health care. We have heard evidence on the issue of training and have concluded that, whilst mental health services have changed radically in recent years, requiring new and challenging roles for professionals involved in the field, their skills and training appear to have lagged behind.

9.21 The evidence to us suggests that professional staff now working with mentally ill people need opportunities to obtain post-basic qualifications in contemporary mental health care. This is particularly required of staff with managerial and supervising responsibilities. We believe that it is the responsibility of employers to ensure that senior staff are provided with opportunities to equip themselves with training appropriate to practice as seniors in contemporary mental health. We believe that this should be applicable to all professional staff. The circumstances of this case have led us to believe

that a basic qualification, whilst preparing staff to work in mental health services, cannot be expected to equip staff with the extremely high level of expertise necessary to work with highly vulnerable and challenging people such as Martin Mursell.

9.22 Training of social workers, mental health nurses, housing workers and other members of the community mental health services, must go beyond the basic which is now offered. We have no doubt that a need for further training is also applicable to GPs. Although Martin was certainly in need of specialist mental health services, it seems to us from the evidence that both he and his mother received a poor service from primary care on at least one occasion.

9.23 It is also our view that the training of psychiatrists needs to be reconsidered. The evidence which we considered suggests that the psychiatrists involved in Martin's care and treatment were focused on their role as consultants within the acute hospital setting, rather than on the wider aspect of community mental health care in which the links between the hospital and community care must necessarily be closer. Appropriate training to practice in the new mental health environment would assist psychiatrists in adapting their practice in line with contemporary developments. We recommend that (a) all professional staff should be afforded the opportunity by employers to obtain a post-basic qualification in their chosen specialty, (b) that staff with basic qualifications must receive regular supervision from senior staff who are qualified to practice in contemporary mental health services and (c) staff without a post-basic qualification in mental health care should not work with people on level 3 CPA unless under the supervision of a suitable qualified senior.

9.24 Furthermore, the extremely diverse and responsible role of the consultant psychiatrist, embracing clinical, managerial, strategic, research and development, liaison and teaching functions, requires that a continuous programme of training is provided. In this regard, we commend the Royal College of Psychiatrists for introducing 'Continuing Professional Development' education for doctors.

CHAPTER 10

SUMMARY OF FINDINGS AND RECOMMENDATIONS

INTRODUCTION

10.1 Martin Mursell was severely mentally ill, violent, misused substances and often refused to take his medication. In this respect he was not untypical of those patients who pose the sternest test to the professionals charged with their care. Some of them undoubtedly failed him but their failure must be viewed against the current turmoil in the mental health service. The fact that there was a breakdown in his care which allowed him to slip out of the net of care between 3rd August 1994 – 28th October 1994, when he committed the offence, does not mean that he should not have been cared for in the community.

10.2 Care in the community for severely mentally ill people is the right policy, but it comes with a number of risks. By far the greatest risk is that of people with severe mental illness harming themselves. Another risk that society takes is that from time to time homicides and other untoward incidents involving harm to others will occur. We cannot reassure the public that there will be no risks attached to the care of the severely mentally ill. However, these risks can be greatly reduced if, before the discharge of a patient into the community, proper assessment is made of the degree of risk posed to the patient and to others, and a plan drawn up detailing the arrangements for after-care and setting out the goals to be achieved. The professional responsibility for community care must be shared between the Health Authority, Trust, Housing Department and Social Services Department.

10.3 We believe that in addition to inter-agency co-operation, training is a vital component of the mental health services. We regard it as of such importance that there should be a measure of central control on it, rather than leaving it to the idiosyncrasies of local consortia.

HOUSING

FINDINGS:

10.4 Martin Mursell's re-housing difficulties started when a housing manager failed to give him a correct priority rating for a management transfer. He should have been given a Priority 2 rating, but instead he was given a Priority 5. (Paragraphs 2.14 – 2.17)

10.5 Despite representations from doctors, his local Member of Parliament Chris Smith and his mother, the Housing Section:-

(a) refused to offer him a management transfer;

(b) left his flat at 54 Almorah Road uninhabitable and in a state of disrepair for more than one year. (Paragraphs 2.13 – 2.28 & 2.36)

10.6 The inactivity shown in respect of 54 Almorah Road for more than one year by housing officers was a fundamental failure of housing management for which senior housing officers must bear some responsibility. (Paragraphs 2.19 – 2.24)

10.7 Although Martin Mursell was not intentionally homeless, he was repeatedly placed in bed and breakfast accommodation which was wholly inappropriate for his needs. (Paragraphs 2.33 – 2.40 & 2.50 – 2.51)

10.8 The handling of Martin Mursell's homelessness application raises serious questions about the effectiveness of the Housing Section in that:–

(a) he was advised by a housing manager to relinquish his tenancy of 54 Almorah Road and become homeless;

(b) he acted on the officer's advice in the belief that immediate action would be taken to find him permanent accommodation;

(c) the officer failed to process his application promptly and took six months before notifying Central Allocations that he was a special needs case;

(d) it took six months before a final recommendation was achieved confirming that he was a special needs case;

(e) he relinquished his tenancy on the 18th February 1994 and was not provided with another one until the 31st October 1994, three days after the tragic event. (Paragraphs 2.41 – 2.43 & 2.51)

10.9 Although Martin Mursell's homelessness application was not sent to Central Alloc-ations, it was aware that he was in bed and breakfast accommodation and in priority need, but no offer of permanent accommodation was made. (Paragraphs 2.45 – 2.49)

IMPROVEMENTS

10.10 The London Borough of Islington has acted to make a number of improvements within the Housing Section to address some of the problems we have identified:-

(a) It has developed a specialist reception centre in Holloway Road which is managed by the St Mungo's Housing Association;

(b) It has opened a hostel for the mentally ill in Barnsbury Road which is also managed by the St Mungo's Housing Association;

(c) It has developed a scheme with St Martin of Tours Housing Association, whereby 20 London Borough of Islington tenancies are managed with support worker in-put; these 20 tenancies are open to people nominated from the mental health quota;

(d) It has a specialist in-house Special Needs Housing section. (Paragraphs 2.55 - 2.57)

RECOMMENDATIONS

10.11 We recommend that an officer of appropriate seniority be appointed to ensure that there is effective co-ordination in mental health cases between Health, Housing and Social Services. (Paragraph 2.52)

10.12 We recommend that the existing practice of monthly "callovers" whereby a member of the Mental Health Social Work Team meets with the Housing Client and Contract Manager to review mental health cases on the Neighbourhood housing list be immediately adopted as a formal procedure between Health, Housing and Social Services and appropriate guidelines be developed. (Paragraph 2.52 – 2.53)

10.13 We recommend that as part of a regular monitoring exercise, housing officers report to the Housing Committee at each cycle, on all decisions taken on mental health cases. (Paragraph 2.53)

TO BE CONSIDERED BY THE SECRETARY OF STATE FOR THE ENVIRONMENT:

10.14 We recommend that the Secretary of State should consider amending the current guidelines for local authorities when dealing with homelessness, to ensure that mentally ill people are not required to pass through unsuitable transitional accommodation, for example, bed and breakfast accommodation, before being furnished with permanent accommodation for their needs. (Paragraph 2.54)

SOCIAL SERVICES

FINDINGS:

10.15 The Borough's failure to move from a generic structure to a specialist structure much earlier than it did was in part responsible for the lack of specialist social work involvement with Martin Mursell. (Paragraphs 3.3, 3.27 – 3.29)

10.16 It was a bad management decision to allocate the case of Martin Mursell to Andrew Shuttleworth, when it was known that he was not an ASW and lacked experience in mental health work. (Paragraphs 3.9 & 3.13)

10.17 The decision to place Andrew Shuttleworth under the supervision of Yvonne Luby raises serious questions about the management of the Neighbourhood Social Services Office, as she had neither the time nor the experience to provide him with proper or adequate supervision. (Paragraphs 3.9 & 3.15)

10.18 The services given to Martin Mursell and Mrs Collins from June 1992 onwards were poor and fell far short of what is expected from a Social Services Team.(Paragraph 3.6)

10.19 The reluctance to review genericism and the reduction of 24 Neighbourhood Offices to 16 placed an enormous burden on senior officers to the point where they regarded the service they were delivering as unsafe. (Paragraphs 3.10 & 3.14)

10.20 Although circumstances were largely responsible for managers giving priority to child protection cases, Martin Mursell's case should have been given a higher level of priority than it received on the grounds of his vulnerability and dangerousness. (Paragraph 3.17)

10.21 There was no proper assessment carried out before Martin Mursell's case was transferred to the duty system. (Paragraph 3.19)

10.22 Martin Mursell's case was poorly co-ordinated when it was transferred to the duty system. (Paragraph 3.26)

10.23 Martin Mursell's case needed to be allocated at all times, and it was a serious management failure to have left the case with duty and not ensured allocation. (Paragraph 3.24 – 3.26)

PROGRESS TO DATE

10.24 We commend Hannah Miller and her team for the speed with which she moved to introduce specialisation once the decision had been taken. (Paragraph 3.28)

10.25 All Team Managers are now ASWs who maintain their expertise by undertaking regular ASW assessments. Since the move to specialisation six Social Work Managers with knowledge and experience of mental health work have been appointed. (Paragraph 3.27 – 3.28)

RECOMMENDATIONS

10.26 We recommend that a directory should be kept which details the expertise of all prospective supervisors, and before such individuals are asked to supervise inexperienced social workers, the person making that decision must ensure that the proposed supervisor has the required skills and expertise. (Paragraph 3.15)

10.27 We recommend that where a social worker is the key worker in an after-care plan, immediate notice must be given to the Team Manager if there is a breakdown in the plan, setting out the full reason for the breakdown. This should be in addition to the social worker's responsibility to the rest of the multi-disciplinary team. (Paragraph 3.18)

10.28 We recommend that the Borough makes provision for induction training of officers at all levels from Housing and Social Services, to ensure that there is familiarisation with, and a better grasp of the policy and practice of, each others' responsibilities. (Paragraph 3.18)

10.29 We recommend that before a case is transferred to the duty system a detailed risk assessment should be undertaken and recorded. The decision to transfer the case should then be communicated to the client in writing and to the Team Manager. (Paragraph 3.21)

10.30 We recommend that all Duty Social Workers should have some basic awareness in mental health work, and should have ready access to an ASW for advice. (Paragraph 3.29)

HEALTH

FINDINGS:

10.31 We recognise the enormous pressure under which professionals in the mental health services operate. It is not easy for them. It may be that even if all the proper steps had been taken, and thoroughly documented, this tragedy would not have been prevented, but Martin Mursell had a history of violence and substance misuse. He posed a potential risk of violence to others. To discharge him was to take a risk. We find that Dr Taylor, and Dr Harvey at a later date, failed to take this risk sufficiently into consideration when discharging Martin Mursell. However, we acknowledge that the prediction of violence by clinicians in any one mentally disordered individual is notoriously inaccurate. One of the most dangerous features of violence is its unpredictability, and most studies suggest that clinicians' predictions of violence by patients are little better than chance. The literature on the relationship between violence and mental disorder has consistently found that the best predictor of future violence is past violence, and this was the state of knowledge in 1994. Thus Martin Mursell's history of violence alone should have acted as a "red light" to his clinical team. (Paragraphs 4.18 – 4.19 & 4.42 – 4.48)

10.32 The pressure on beds in the Mental Health Services is well recognised. It may be that some patients are discharged before they should be. However, proper discharge arrangements should be made, or attempted. If this is not done, patients are done a double disservice, first by not having the additional length of in-patient stay, but secondly by not being provided with appropriate aftercare. In the light of Martin Mursell's past history of violence, substance misuse and the risk he posed to others, appropriate arrangements for review and monitoring prior to discharge should have been made. We find that Dr Taylor and Dr Harvey did not respond adequately to the danger he posed and their discharge arrangements did not reflect his level of risk to others. (Paragraphs 4.19 – 4.20 & 4.42 – 4.48)

10.33 Professionals within the mental health service did not clearly understand how to operate the Section 117 MHA after-care procedure. (Paragraphs 4.30 – 4.32)

10.34 To assist the efficient working of Community Mental Health Services, a Community Mental Health Team should be led by someone who appreciates the value of a care plan and who is prepared to work with other professionals. David Jayne as team leader showed no appreciation for the need to have a care plan and for a period worked in isolation from other professionals. (Paragraphs 4.25 – 4.27)

10.35 Different people were involved at different times with Martin Mursell, but care was not co-ordinated. (Paragraph 4.27)

PROGRESS TO DATE

10.36 It is important to re-evaluate systems and procedures after a tragic event such as this and we are pleased at the speed with which the Trust and the Health Authority have moved to improve on their systems and procedures. (Paragraph 4.51)

10.37 The Trust has now fully implemented CPA and is currently revising this policy

in conjunction with the Health Authority and local authorities. As part of the joint agreement on CPA procedures the Health Authority has now agreed to the creation of a single care plan. It has also put in place working procedures between health, housing and social services and in this current year proposes to invest in 24 hour crisis centres. (Paragraph 4.52)

RECOMMENDATIONS

10.38 Some confusion is caused when the word 'discharge' is used in different contexts. We recommend that the Trust should use the words "release from section" instead of "discharge from section". (Paragraph 4.13)

10.39 Where a mentally ill patient has a past history of violence to others, we recommend that a risk assessment must be carried out by the Trust and recorded prior to discharge, regardless of the presence or absence of other variables such as drug misuse and non-compliance. (Paragraph 4.19)

10.40 We recommend that the Trust and the borough meet urgently to consider whether the introduction of the CPA will also ensure a single care plan for all clients of the mental health services. (Paragraph 4.27)

10.41 We recommend that where a patient is transferred from one hospital to another within the Trust before his/her care plan becomes operational, the plan must also be transferred with the patient and should be taken into account when a fresh plan is being devised. All the case notes in total must always accompany a patient who moves within the Trust to ensure continuity of care. (Paragraph 4.29)

10.42 The Trust and the Local Authority should ensure that all professionals concerned with the discharge of a patient are familiar with the requirements of Section 117 of the MHA and any supporting local or national guidelines. We therefore recommend that the Trust and the Social Services urgently set up a working party to consider the best way of delivering and updating training in Section 117 procedures and ensuring compatability with CPA training. We suggest that the training be given in the following areas:-

(a) The requirements of Section 117 MHA and the national and local guidelines on this procedure;

(b) the role of each professional involved; and

(c) how such meetings should be conducted. (Paragraph 4.31)

10.43 We recommend that where there is evidence of poor or non-compliance with treatment or persistent failure to keep out-patient appointments, the key worker should bring this to the attention of the multi-disciplinary team who devised the original plan, and a clear strategy worked out to try and improve compliance. (Paragraph 4.34)

10.44 We recommend that the boundaries between the duties of a community psychiatric

nurse and a community mental health worker be clarified by the Trust and other professionals informed. (Paragraph 4.35)

10.45 We recommend that immediate steps be taken to improve the standard of record keeping at the Waterlow Unit and in the community mental health services. (Paragraph 4.50)

CRIMINAL HISTORY RECOMMENDATION

TO BE CONSIDERED BY THE LAW SOCIETY:

10.46 We recommend that the Law Society should now give consideration to including mental health awareness training for solicitors as part of its continuing education programme. (Paragraph 5.7)

NEAR DOUBLE TRAGEDY

FINDINGS:

10.47 The re-emergence of active symptoms of mental illness affected Martin's mood and behaviour and was in our opinion likely to have been the causal factor which made the most important contribution to the offence. (Paragraph 6.17)

10.48 This relapse was predictable, as was the increased risk of violence which accompanied it and, although the tragic outcome was something which could not have been predicted in advance, the care which Martin received in the community fell short of what was needed, to such an extent that it became more likely that a serious incident would occur. (Paragraph 6.18)

CARERS AND USERS

RECOMMENDATIONS

10.49 We recommend that the Trust and the Health Authority ensure that provision is made for carers to have respite breaks. (Paragraph 7.4)

10.50 We recommend that the Trust ensures that all after-care plans include a consideration of the patient's employment opportunities and leisure activities, with the aim of removing him/her away from dependency on the carer. (Paragraph 7.5)

10.51 We recommend that the Trust makes arrangements so far as is practicable for carers to be involved in the after-care process on an equal footing with professionals. We also recommend that the Trust ensures that information shared by professionals must also be shared with the carer, subject to the user's consent. (Paragraph 7.8)

10.52 We recommend that the Trust and the Local Authority ensure that the patient's key worker is involved at all times with the carer. (Paragraph 7.9)

AGENCIES WORKING TOGETHER

RECOMMENDATIONS

10.53 We recommend that Health, Housing and Social Services should work together to develop a strategic approach to accommodation for mentally ill people and that the co-ordination of service provision be monitored regularly. (Paragraph 8.12)

10.54 We recommend that Health and Social Services and purchasers and providers agree the essential requirements of service and, ensure that proper arrangements are made so that contract monitoring and any audit will readily indicate the degree of effectiveness of the services delivered. (Paragraph 8.13)

WE INVITE THE TRUST AND SOCIAL SERVICES TO CONSIDER:

10.55 Drawing up an agreed joint management structure for community mental health services with a jointly appointed officer to ensure that planned services are not only relevant but also delivered. Joint monitoring arrangements should be put in place at the same time to ensure that the service is actually delivered. (Paragraphs 8.8 & 9.17)

WIDER PERSPECTIVE

FINDINGS:

10.56 Poor co-ordination between health, social services and housing was in our view a key barrier to the delivery of a good service to Martin Mursell. We believe that the approach to mental health services must be based on the recognition that there has to be collaboration between agencies, co-operation between professionals and participation by users. (Paragraphs 9.17 – 9.18)

10.57 Professional staff working with Martin Mursell were not adequately trained to respond to the new environment of mental health care. (Paragraph 9.20)

RECOMMENDATIONS

MENTAL HEALTH ACT COMMISSION – TO BE CONSIDERED

10.58 We recommend that the Secretary of State for Health should consider extending the remit of the Mental Health Act Commission so as to enable it to ensure that:-

(i) the new powers of Supervised Discharge are correctly exercised and applied strictly in accordance with the statutory requirements;

(ii) by a process of observation and monitoring over a number of years, the use of the powers is of benefit to the patients involved and to the community into which the patients have been discharged. (Paragraph 9.14)

TRAINING

10.59 We recommend that:-

(a) all professional staff should be afforded the opportunity to obtain a post basic qualification in their chosen specialty;

(b) staff with basic qualifications must receive regular supervision from senior staff who are qualified to practice in contemporary mental health services;

(c) staff without post-basic qualification in mental health care should not work with people on level 3 CPA unless supervised by a suitably qualified senior. (Paragraphs 9.19 – 9.24)

APPENDIX A

GLOSSARY

ASW	–	Approved Social Worker
CPA	–	Care Programme Approach
CPN	–	Community Psychiatric Nurse (this term is used throughout and is taken to be synonymous with the current term Community Mental Health Nurse)
CMHW	–	Community Mental Health Worker
CPS	–	Crown Prosecution Service
DoH	–	Department of Health
MHA	–	Mental Health Act
MHAC	–	Mental Health Act Commission
NHS	–	National Health Service
RMO	–	Responsible Medical Officer
SHO	–	Senior House Officer
SSD	–	Social Services Department