Report of the Independent Inquiry into the Care and Treatment of Lorna Thomas and Nicholas Arnold

June 2000

A report commissioned by

Buckinghamshire Health Authority

INQUIRY PANEL

Mrs Vivyenne Rubinstein, MA, FRSA, (Chairman).

Mrs Mandie Lavin-Smith, MA, RN, LLB(Hons), Barrister at Law.

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INTRODUCTION

On 9 November 1995, after an attempted overdose, Lorna Elaine Thomas was admitted to the Campbell Centre acute psychiatric admissions ward on Milton Keynes General Hospital site, as an informal patient. Loma was a 21 year-old with a mild learning disability and some behavioural problems. While there, she met Nicholas Arnold, a 40 year-old man who was also an informal patient receiving treatment for alcohol abuse.

Nicholas Arnold was discharged from the Campbell Centre on 24 November 1995 and Lorna Thomas was discharged on 29 November 1995. Evidence to the Inquiry revealed that, by then, they had struck up a relationship which soon became a full sexual relationship, and they continued to see each other regularly in the community. On Saturday 30 December she spent the evening and night with him at his flat, during which time there was a considerable disturbance. Police were called at 2:20 a.m. on 31 December 1995 and Lorna Thomas was found with severe injuries. She was taken to Milton Keynes General Hospital where she died shortly after arrival. Nicholas Arnold was remanded in custody and was charged with her murder.

The Inquiry Panel is independent of the criminal justice system in which Nicholas Amold was tried. We have, however, had access to transcripts of the trial proceedings and copies of witness statements, including the contribution of expert witnesses. This material provided information not available elsewhere.

We note that the Court was invited to consider the plea of diminished responsibility and, to that end, heard the testimony of a number of expert witnesses in psychiatry and drug and alcohol dependence.

However, that plea was rejected and Nicholas Arnold was convicted of murder at Northampton Crown Court on 4 October 1996, and sentenced to life imprisonment. Subsequently, he appealed, but the appeal was dismissed in July 1998.

The *National Confidential Inquiry into Suicide and Homicide by Mentally Ill People,* or people in contact with mental health services, defines a *"Mental Illness Homicide"* as one carried out by *"a person convicted of homicide who had symptoms of mental illness at the time of the offence".*

Also identified is a more common category, homicide where the perpetrator was *"without symptoms of mental illness at the time, where alcohol is thought to have contributed to the offence."* Fifty-five percent of cases considered by the National Inquiry came within this latter definition.

It would appear, from the evidence presented during the trial, that the killing of Loma Thomas by Nicholas Arnold should not be considered a *"Mental Illness Homicide"*, but a homicide where *"alcohol is thought to have contributed to the offence"*. However, it was still necessary to hold an independent inquiry as both parties had so recently been patients of the Milton Keynes mental health services.

The Inquiry Process

Following the requirements laid down by the *NHS Executive Guidance Circular* (HSG(94)27), Buckinghamshire Health Authority set up an Inquiry *"independent of the providers involved"* to examine the care and treatment received by Lorna Thomas and Nicholas Arnold in the light of their history and assessed health and social care needs. The full terms of reference and procedure for the Inquiry are set out in Appendices 1 and 2 of this Report.

The Inquiry team was appointed soon after the event, but was not able to begin its work until after the conclusion of the appeal. The Panel Members were Mrs Mandie Lavin-Smith, who is a nurse and lawyer, Mr Mike Lindsey, a former Deputy Director of Social Services with experience in mental health and drug and alcohol services, Dr David Richardson, a Consultant in General Adult Psychiatry, Dr Ashok Roy, a Consultant in Learning Disability Psychiatry, and myself as lay Chairman. Mr Jerome O'Brien was appointed Inquiry Manager, with Mrs Anne Aitkins as his Assistant.

The first step was to seek the consent of Nicholas Arnold, via his solicitors, to the use of his medical and other records. This we received, with the exception of access to the psychiatric records made subsequent to the event. The medical records of both Loma Thomas and Nicholas Arnold were made available by the Milton Keynes Community NHS Trust, and Buckinghamshire Health Authority provided the GP records.

We then requested documentary evidence from the other organisations involved in the care of Lorna Thomas and Nicholas Arnold, namely Buckinghamshire County Council Social Services and Education Departments, Milton Keynes Borough Council Housing Department, Thames Valley Police, the Probation Service, Milton Keynes Christian Foundation, White Spire School, Jephson Housing Association, Carr-Gomm Housing Association, The Richmond Fellowship, Milton Keynes MIND, Luton and Dunstable Hospital, Hope House at Luton, Peterhouse Project at Bedford, Alcoholics Anonymous and Milton Keynes Rape Crisis.

We received most of the relevant material. However, the education records for Lorna Thomas had been routinely destroyed in 1996, before the Inquiry was set up, and probation records for Nicholas Arnold were only available from 1991. We did not receive any Social Services records for Miss Thomas for the period from May 1992 to September 1994. In general, we received full co-operation from all the organisations and agencies approached, and we are grateful to them for the trouble they took to meet our requests for information. Some records were examined on site at Thames Valley Police HQ in Milton Keynes and at the Family Protection Unit HQ at Bletchley.

These requests resulted in a very large quantity of material, which was paginated and copied to all members of the Panel by the Inquiry Manager and his Assistant. From this we were able to draw up a list of people from whom we would seek written statements and Mrs Mandie Lavin-Smith, who agreed to act as legal adviser to the Panel, prepared detailed chronologies for Nicholas Arnold and Lorna Thomas with the help of Mr O'Brien and Mrs Aitkins. Each person whom we approached was reminded of their involvement in the patient's care or treatment and was given access to appropriate documents. Some witnesses had already retained relevant documents. Letters were sent to 65 people, and on the basis of their replies we invited 44 people to give oral evidence. In addition, the Panel carried out site visits to the following locations: Campbell Centre Inpatient and Day Hospital, Pegasus, Granby Court and New Bradwell. This enabled the Panel to have a more complete understanding of these tragic events and we are indebted to Mr. Derek Nickless for making our extensive tour possible.

The Witnesses

We decided not to call as witnesses people whose association with the parties was not recent, though we did in some cases quote from their notes. Some people proved impossible to contact, having moved away, and one witness was unable to attend due to ill health. We are grateful to one witness who attended despite being on crutches.

The involvement of the Police Family Protection Unit with Lorna only became known to the Panel towards the end of the Inquiry, but that evidence proved to be extremely significant. A passing reference to the identification of Lorna's body contained in a witness statement led to contact being made with WPC Vandersteen-Hague and, as a result of this, she and another Police witness were called to give evidence to the Inquiry.

Before any hearings were held the Inquiry Manager visited the Milton Keynes Community NHS Trust and spoke to relevant staff, explaining how the Inquiry would be conducted. Mr O'Brien and I also met Lorna's parents, Mr and Mrs Thomas, and Nicholas' mother, Mrs Arnold. I explained to them the objectives of the Inquiry and invited them to be witnesses if they so wished. All three accepted the invitation. The experience of re-living the events of 1995 can

only have been painful for them, and the Panel was deeply appreciative of their contributions, which were invaluable to us.

We noted with regret that, in the aftermath of Lorna Thomas' death, no one from Thames Valley Police explained to her parents what exactly had happened to her, so that when they attended the trial they heard for the first time the horrific details. Although this omission had no causal link with the murder, it nevertheless prompted us to make a recommendation.
(See Recommendation 36, Pg. 100)

In order to protect their privacy we have not listed the names of other members of the public who were witnesses at the Inquiry and their evidence has been anonymised in the report. Nicholas Arnold was interviewed by the Panel at HM Prison Gartree in the presence of his solicitor and his mother. We were grateful to him for agreeing to see us and to HMP Gartree for facilitating the meeting.

The Panel also received evidence from three expert witnesses: Dr M Abou-Saleh, Clinical Director, Addictive Treatment Centre, St.Georges' Hospital Tooting; Dr D Cameron, Senior Lecturer (Clinical) in Substance Misuse, University of Leicester and Mr C Lozinski, Chairman of the Care Programme Approach Association, who all gave generously of their specialist knowledge. None of these experts interviewed Nicholas Arnold and their views were formulated from the documentary material available to the Panel.

The Hearings

At the start of the Inquiry it was agreed with Buckinghamshire Health Authority that the hearings should be held in private but that the findings would be made public.

Witnesses were invited to bring a legal or trade union representative, friend or colleague with them and most did so. We are grateful to all those who gave evidence and to those who attended in support. Mrs Lavin-Smith prepared the schedule of questions for each witness on the basis of their written statements and took them through their evidence with patience and skill. She also made a comprehensive analysis of all the oral evidence after the transcripts had been amended and agreed. Witnesses were not formally asked to take an oath, but all were asked to affirm they were telling the truth.

Other Panel Members posed supplementary questions from time to time and witnesses were invited to add any further comments they wished. The members of the Panel were very appreciative of the frankness and honesty of the vast majority of the witnesses. In some cases they had clearly been unhappy about the decisions they had had to make. We were also impressed with, and would like to commend, the courage and caring attitude

of one of Nicholas Arnold's neighbours. All witnesses were sent a copy of the transcript of their interview, inviting them to amend any factual inaccuracies.

The Draft Report

Extracts from the draft Report which might be perceived as containing criticism of any witnesses were sent, in confidence, to the relevant people, who were invited to comment in writing. The full draft was shared, also in confidence, with the Chief Officers of Buckinghamshire Health Authority, Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council. All individuals and organisations signed confidentiality undertakings before any text was released to them. The responses were carefully considered by the Panel and the draft Report was amended on matters of factual accuracy and where the Panel considered that concerns were justified.

The Structure of the Report

The Report is set out in several parts. In view of the fact that so much was changing in the structures and administration of Buckinghamshire and Milton Keynes local government and health services around the time of this sad event, we concluded that it might be helpful for members of the public if we set out, in some detail, the position which existed in the latter part of 1995. Part I, therefore, attempts to explain how the organisational and policy context which existed in 1995 differs from today.

Part II describes the events relating to the care and treatment of both parties with only limited comment by the Panel. Due to the sheer quantity of information it was decided to present Nicholas Arnold's medical history in tabulated form, for ease of reference as well as for ease of absorption, This approach was not necessary in the case of Lorna Thomas as she had a shorter and less complicated medical history.

Part III contains the Panel's analysis of the events and the bulk of our comments on the actions which were taken, followed by our conclusions and, finally, the recommendations. These have been drawn together and grouped according to the issues which they seek to address, with those we considered most significant being placed first in each group. We tried wherever possible to avoid professional jargon in the Report and, where it was unavoidable in the cause of accuracy, to explain the terms we used in ordinary English, either in the text or in the Glossary.

In making our comments and recommendations we sought to place them in the wider context of standards and practice elsewhere in the country. We also sought to explain the underlying behaviour of these two people, in order to help towards an understanding of why the tragedy happened.

Panel Members agreed with the advice contained in *Inquiries After Homicides* (Ed. Jill Peay, 1996) that Inquiry Panels should not avoid the difficult issues, but should seek to propose solutions. To that end, we have sought to offer constructive proposals to meet some of the very difficult issues illustrated by this case, such as the extent to which information should be exchanged between agencies.

Acknowledgments

The organisation of a complicated double Inquiry such as this is an extremely demanding task and the Panel Members felt themselves very fortunate that this was undertaken by the team of Mr Jerome O'Brien and Mrs Anne Aitkins. Their experience in the field proved invaluable, and their ready willingness to find solutions to the problems which arose was warmly appreciated.

Our thanks are also due to the team from Harry Counsell & Co., who transcribed the hearings with the most remarkable speed and accuracy, and to the copy editor Mr Dan Leissner.

From the point of view of organisations as well as of individuals, to be subjected to an Inquiry such as this is a stressful experience, and the Panel Members were grateful for the high level of co-operation we received, and also for the support – always at arms length – of Buckinghamshire Health Authority who sponsored the Inquiry.

Finally, I would like to express my personal gratitude to my fellow panellists. Each brought to our work their own wide individual knowledge, wisdom and experience, and gave their time unstintingly in analysing the evidence and in the shared drafting and amending of the text. As Chairman, I can only say that it has been a privilege to work with such colleagues, and I am profoundly grateful for their guidance and support.

Vivyenne Rubinstein
Inquiry Chairman

LIST OF WITNESSES REGARDING THE CARE AND TREATMENT OF LORNA THOMAS

[Positions given are those held at the time of the individual's involvement in the matters under inquiry. Persons who gave oral evidence are marked with an *].

Bailey W*	Social Worker, Adult Disability Team, Buckinghamshire County Council.
Baxter R*	Ward Manager, Ward 1, Campbell Centre, Milton Keynes Community NHS Trust.
Carter N*	Head of Care Management – Adult Services, Buckinghamshire County Council, Social Services – Southern Division.
Chamney S*	Senior Care Manager/Social Worker, Adult Mental Health Services, Buckinghamshire County Council.
Champion K* (nee King)	WPC – Family Protection Unit, Thames Valley Police, Bletchley.
Chiari A*	Community Nurse, Learning Disability Centre, Stantonbury, Milton Keynes Community NHS Trust.
Coeshall V*	Clinical Services Manager – Elderly Directorate, Milton Keynes Community NHS Trust.
Connolly P	Parish Priest, Church of St. Mary Magdalene, Stoney Stratford, Milton Keynes.
Coutts B	Nursing Assistant, Ward 1, Campbell Centre, Milton Keynes Community NHS Trust.
Critchley S*	General Manager, Learning Disability Services, Milton Keynes Community NHS Trust.
Cullinan G*	Director, Mental Health Services, Milton Keynes Community NHS Trust.

Domah V	Community Psychiatric Nurse, Psychiatric Services Link Project, Milton Keynes Community NHS Trust.
Eastham C	Staff Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Hansell B	Social Worker/Care Manager, Adult Disability Team, Buckinghamshire County Council.
Jamson A*	Care Programme Approach Co-ordinator, Campbell Centre, Milton Keynes Community NHS Trust.
Jeffrey J*	Director of Social Services, Buckinghamshire County Council.
Joseph A*	General Adult Psychiatrist, Campbell Centre, Milton Keynes Community NHS Trust.
Jones S	Care Manager/Social Worker, Buckinghamshire County Council Mental Health Team.
Lefevre F	Disability Services Manager, Buckinghamshire County Council.
Lockwood J*	Charge Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Lozinski C* *Expert Witness*	Chairman, Care Programme Approach Association.
Luckock B J*	Trainee Psychotherapist, Learning Disability Centre, Milton Keynes Community NHS Trust.
March A J	Staff Nurse, Inpatient Services, Ward 1, Campbell Centre, Milton Keynes Community NHS Trust.
Mason D J*	Community Nurse, Learning Disability Team, Milton Keynes Community NHS Trust.
Monaghan M A*	Occupational Therapy and Day Hospital Manager, Campbell Centre, Milton Keynes Community NHS Trust.
Sister Monica	Convent of the Holy Child Jesus, Milton Keynes.

Must B J*	Staff Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Nickless D*	Deputy Director of Housing, Milton Keynes Borough Council.
Norrish S	Director, Milton Keynes Christian Foundation.
Platt J*	Community Support Worker, Milton Keynes Community NHS Trust.
Page L*	Clinical Nurse Manager, Milton Keynes Community NHS Trust.
Pollard T*	Detective Sergeant, Thames Valley Police.
Punch D	GP, Whaddon House Surgery, Bletchley, Milton Keynes.
Putman S*	Senior Staff Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Ricote F	Senior House Officer, Campbell Centre, Milton Keynes Community NHS Trust.
Roberts Y*	Charge Nurse (Night Duty), Campbell Centre, Milton Keynes Community NHS Trust.
Roy M*	GP, Eaglestone Health Centre, Milton Keynes.
Singh K*	Consultant Psychiatrist, Milton Keynes Community NHS Trust.
Stanley K*	Chief Executive, Milton Keynes Community NHS Trust.
Taylor S*	Senior Care Manager, Adult Disability Team, Buckinghamshire County Council Social Services.
Thomas E*	Father of Lorna Thomas.
Thomas M*	Mother of Lorna Thomas.
Vandersteen-Hague C * (nee Vandersteen)	WPC, Family Protection Unit,Thames Valley Police, Bletchley.
Wilson T*	Disabled Living Adviser, Adult Disability Team, Buckinghamshire County Council.

LIST OF WITNESSES REGARDING THE CARE AND TREATMENT OF NICHOLAS ARNOLD

[Positions given are those held at the time of the individual's involvement in the matters under inquiry. Persons who gave oral evidence are marked with a *].

Arnold N*	Subject of Inquiry.
Arnold S*	Mother of Nicholas Arnold.
Abou-Saleh M T *Expert Witness*	Reader in Addictive Behaviour and Clinical Director, Addiction Services, St. George's Hospital, London.
Baxter R*	Ward Manager, Ward 1, Campbell Centre, Milton Keynes Community NHS Trust.
Cameron D* *Expert Witness*	Senior Lecturer (Clinical) in Substance Misuse, University of Leicester, Leicester.
Carter N*	Head of Care Management – Adult Services, Buckinghamshire County Council, Social Services Department.
Chidyausiku N	Staff Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Coeshall V*	Clinical Services Manager – Elderly Directorate, Milton Keynes Community NHS Trust.
Conboy P	Community Psychiatric Nurse, Neath Hill Health Centre, Milton Keynes Community NHS Trust.
Cowley C	Care Manager, Buckinghamshire County Council, Neath Hill Health Centre, Milton Keynes.
Cox T*	Staff Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Cullinan G*	Director, Mental Health Services, Milton Keynes Community NHS Trust.

Honour M*	Probation Officer, Oxfordshire and Buckinghamshire Probation Service, Milton Keynes.
Jayaram P*	GP, Purbeck Health Centre, Milton Keynes.
Jamson A*	Care Programme Approach Co-ordinator, Campbell Centre, Milton Keynes Community NHS Trust.
Lockwood J*	Charge Nurse, Campbell Centre, Milton Keynes Community NHS Trust.
Lozinski C* *Expert Witness*	Chairman, Care Programme Approach Association.
Monaghan M A*	Occupational Therapy and Day Hospital Manager, Campbell Centre, Milton Keynes Community NHS Trust.
Mowbray F*	Senior Occupational Therapist, Campbell Centre Day Unit, Milton Keynes Community NHS Trust.
Nazir F	Senior House Officer, Campbell Centre, Milton Keynes Community NHS Trust.
Nickless D*	Deputy Director of Housing, Milton Keynes Borough Council.
Plumb T*	Counsellor, Pegasus Alcohol and Drug Advisory Service, Milton Keynes Community NHS Trust.
Pollard T*	Detective Sergeant, Thames Valley Police.
Roberts Y*	Charge Nurse (Night Duty), Campbell Centre, Milton Keynes Community NHS Trust.
Shiong L*	Senior Charge Nurse, Day Hospital, Campbell Centre, Milton Keynes Community NHS Trust.
Stanley K*	Chief Executive, Milton Keynes Community NHS Trust.
Strangeway P*	Consultant Psychiatrist, Campbell Centre, Milton Keynes Community NHS Trust.
Thompson N	Occupational Therapist, Campbell Centre, Milton Keynes Community NHS Trust.

Weir N	Consultant Psychiatrist, Campbell Centre, Milton Keynes Community NHS Trust.

Also, three neighbours.

CHRONOLOGY OF EVENTS

Lorna Thomas

2.2.74	Date of Birth - Lorna Elaine Thomas.
20.3.74 - 22.7.91	Reports expressing concerns about Lorna's development.
1976	Entered special education needs nursery in London at age two-and-a-half years and proceeded through special educational needs primary and secondary schools until family moved to Milton Keynes.
17.1 86	Entered mild learning disability special school in Milton Keynes.
22.7.91	Left school.
7.10.91	Started training course at Milton Keynes Christian Foundation.
2. 3.92	Letter from Dr Punch (GP) to Dr Singh, Consultant Psychiatrist, expressing concerns about Lorna's development and tantrums.
23.3.92	Assessed by Dr Singh.
15.4.92	Seen again by Dr Singh and referred to Social Services re: accommodation.
28.5.92	Referred by Dr Singh to Dr Kathy Chapman, Clinical Psychologist. Put on waiting list.
17.11.92	Seen by Dr Singh while on YTS scheme.
4.2.93	Letter from Dr Labrum (GP) referring Lorna to Dr Singh for behavioural problems.
8.2.93	Referred by Dr Singh to David Mason, Community Nurse, for support prior to group therapy.

11.2.93 - 20.4.93	Seen fortnightly by Dr Singh.
18.4.93 - 14.5.93	David Mason, Community Nurse, meetings with Lorna.
5.5.93	Alleged sexual assault on Lorna.
13.5.93	Seen by Dr Singh.
Sept. 93	Attended group therapy session run by Dr Chapman.
25.10.93	Attended Milton Keynes General Hospital (MKGH) after alleged rape on 21.10.93.
3.2.94 - 12.2.94	Visits to MKGH Casualty Department.
20.9.94	Social Services Department attempted to find Lorna alternative accommodation.
30.11.94	Social Services Department decided no further action on housing.
Jan.1995	Found new accommodation at Granby Court .
26.1.95	Seen by Dr Singh for depression.
6.6.95	Attempted overdose. Admitted to MKGH and discharged on 7.6.95.
8.6.95	Dr Morrell, Registrar in Psychiatry, requested Dr Singh to arrange for a social worker to be allocated. Contact with Social Services' duty officers.
12.6.95	Seen by Dr Roy (GP) following recent overdose.
17.6.95	Attended Casualty Department at MKGH - diagnosed as having acute mental illness.
27.6.95	Duty GP visited Lorna - hyperventilating and hysterical.
18.9.95	Assessment at MKGH Casualty Department following another overdose. A&E Link Project arranged follow-up with CPN. No record.
19.9.95	Seen by Dr Singh following overdose on 18.9.95. Letter from Dr Singh to Dr Labrum suggesting Keystone referral.

25.9.95	Dr Singh arranged support and weekly monitoring. 3.10.95 Contact with Jackie Platt, Community Support Worker. Further contact on 10.10.95, 3.11.95, 6.11.95.
6.11.95	Attended MKGH Casualty Department following third overdose and admitted.
9.11.95	Admitted to Campbell Centre.
14.11.95	Absconded from ward, reported missing and brought back by Police.
16.11.95	Ward round team meeting – Lorna to be allowed to leave the ward for short spells if she informed staff.
21.11.95	Given leave of absence to go shopping with fellow patient Nicholas Arnold.
22.11.95	Allegations of indecent assault against Nicholas Arnold. Both parties counselled.
23.11.95	Noticed spending more time with Nicholas Arnold.
23.11.95	Unwilling to return to her flat. CPA meeting decided discharge date of 28.11.95. Accommodation issue referred to Social Services. Community support worker to visit and Day Hospital to assess needs.
29.11.95	Discharged back to Granby Court.
30.11.95	Appointment offered at Day Hospital at Campbell Centre for assessment on 5.12.95 - appointment later cancelled by hospital.
30.11.95	Brought to Campbell Centre by the Police on a Section 136, discharged.
1.12.95	Seen informally at Campbell Centre. No record.
5.12.95 & 18.12.95	Day Hospital appointments cancelled by hospital. Appointment offered 8.1.96.
8.12.95	Seen by Dr Singh following fifth overdose.
12.12.95 & 19.12.95	Seen by Brenda Luckock, Trainee Psychotherapist, for counselling.
20.12.95	Attendance at A & E after falling off bike on ice.

21.12.95	Discharge summary to Dr Roy from Dr Ricote, SHO to Dr Joseph, reporting on Lorna's inpatient stay.
25.12.95	Spent Christmas with her family.
27.12.95	Drinking session with Nicholas Arnold and friend.
31.12.95	Brought to MKGH –multiple injuries. Declared dead.

CHRONOLOGY OF EVENTS

Nicholas Arnold

30.4.54	Date of Birth - Nicholas Arnold.
21.11.64	Admitted to Luton and Dunstable Hospital with head injury following road accident. No abnormalities noted.
1965	Parents divorced.
1969	Left school at 15.
1973 [approx.]	Mental health problems first noted.
20.12.76	Convicted for Actual Bodily Harm.
16.6.77	Convicted for shoplifting.
11.1.79	Overdose – Diazepam (Valium) and alcohol.
13.2.79	Referred to psychologist by Dr Pinto, Consultant Psychiatrist, Luton and Dunstable Hospital.
18.10.79	Reported as being aggressive at girlfriend's house. Dr Chester, Consultant Psychiatrist, Luton and Dunstable Hospital, to arrange for further psychological assessment. No record of outcome available.
7.7.80	Convicted of three drug related offences.
Jan.1982	Moved to Milton Keynes.
1982/83	Went to live with mother. Continuing to be in trouble with Police.
26.4.82	Convicted for possession of cannabis.
17.2.83	Referred by Dr Prisk (GP) to Dr Price, Consultant

	Psychiatrist, Milton Keynes Community NHS Trust.
7.4.83	Dr Price suggested Nicholas Arnold contact a social worker, for social rehabilitation.
Aug. 1984	Father died.
29.10.84	Letter from Dr Prisk to housing officer detailing Nicholas Arnold's severe personality problems and alcohol dependency.
Jan. 1985	Moved into his own flat which was later repeatedly vandalised. Perceived by Dr Price as "going downhill" thereafter.
7.6.85	Visited at home by Dr Price. Drinking heavily although his mental state was normal.
19.6.85	Convicted of burglary.
28.6.85	Admitted to MKGH following road traffic accident.
2.7.85	Letter from Dr Price to Probation Officer suggesting private psychiatric treatment.
22.8.85	Admitted to MKGH suffering from alcoholic hepatitis, discharged 30.8.85 and referred to psychiatrist.
28.8.85	Seen by Dr Lennard , SHO – Psychiatry, at MKGH. Probation Service trying to assist with rehabilitation.
12.11.85	Letter from Probation Officer to Dr Lennard : drink situation worsening.
18.6.87	Robbed and beaten up - seen by new GP. GP tried to reduce Diazepam.
19.12.88	Convicted for possession of controlled drugs.
9.2.90 - 27.12.90	Treated at MKGH Casualty Department on occasions for various injuries including those from a bicycle accident.
1.10.90	Convicted for possession of cannabis.
21.1.91	Seen by Dr Weir, Consultant Psychiatrist, at home (living at mother's house).
1.2.91	Referred by Dr Griffin (GP) to Pegasus, Alcohol and Drug Advisory Service, Milton Keynes Community NHS Trust.

Feb. & Mar.91	Charged with theft, attempted theft and breaching bail conditions.
5.4.91	Admitted to MKGH following drug overdose, discharged 6.4.91.
17.4.91	Appeared in court for alleged indecent assault – case dismissed.
May 91	Put on probation for theft, attempted theft and going equipped.
1.6.91	Admitted to MKGH following road traffic accident and alcohol abuse. Discharged 4.6.91.
Jun.91	Assaulted by teenagers. Allegedly selling prescribed drugs at City Centre.
3.7.91	Treated at MKGH for fractured rib.
17.7.91	Removed from GP's list. (Reasons not given).
24.7.91	Attended new GP practice.
19.8.91	Admitted to Peterhouse Project, Bedford. Discharged 27.8.91.
12.6.92	Attended MKGH for an injury to his face and right hand.
16.9.93	Attended MKGH - alcohol abuse and collapse.
28.7.94	Admitted to MKGH with abdominal pain and diarrhoea. Discharged 31.7.94.
29.9.94	Attending Pegasus – seen by Trevor Plumb.
16.11.94	Admitted to MKGH following an overdose, discharged 22.11.94. Assessed by Dr Nazir, SHO.
15.3.95	Attending Pegasus "abstained since Nov. 1994".
Apr. 1995	Eight year relationship with girlfriend ended.
19.5.95	Referred to Dr Strangeway, Consultant Psychiatrist, by Dr Jayaram (GP).
15.6.95	Seen by Dr Beber, SHO – Psychiatry, at Dr Strangeway's clinic at Neath Hill Health Centre. Referred to Pegasus for anxiety management.

3.7.95	Pegasus unwilling to accept referral.
16.8.95	Referred to Day Hospital at Campbell Centre by Dr Strangeway.
20.9.95	Letter from GP supporting housing application to leave Milton Keynes.
28.9.95	Seen by Fenella Mowbray, Senior Occupational Therapist, for Day Hospital assessment. Reply to Dr. Strangeway 6.10.95.
8.10.95	Seen by doctor from GP deputising service who was accompanied by Police escort.
30.10.95	Mother requested Nicholas be admitted to Campbell Centre due to excessive drinking.
10.11.95	Offered a relaxation course at the Campbell Centre Day Hospital commencing 22.11.95.
10.11.95	Attended the Day Hospital feeling suicidal, but declined to be seen.
11.11.95	Admitted informally to Campbell Centre for detoxification following a disturbance at home. Care plan: to continue Day Hospital and refer to Alcoholics Anonymous and Pegasus.
17.11.95	Went on evening leave.
18.11.95	Friendship with Lorna noted at the Campbell Centre.
22.11.95	Nicholas and Lorna counselled about their relationship following an allegation of assault.
24.11.95	Discharged from Campbell Centre with plan for Day Hospital attendance and outpatient appointment in four weeks.
24.11.95	Referred for Day Hospital re-assessment on 27.11.95.
27.11.95	Day care recommenced, attended fairly regularly until Christmas week.
15.12.95	Discharge letter to GP (from inpatient stay).

19.12.95	Phone call from Lee Shiong, Charge Nurse, Campbell Centre Day Hospital, to Social Services regarding support for housing transfer.
20.12.95	Did not attend Day Hospital. Team meeting called– agreed to his request for referral to social worker.
21.12.95	Attended Day Hospital party.
25.12.95	Spent Christmas with mother.
27.12.95	Drinking session with old associate and Loma.
31.12.95	Killed Loma Thomas.

PART I

CHAPTER 1 : General Organisational and Policy Context

1.1 The events which are the subject of this Inquiry took place in the context of very considerable changes in the organisation, operation and delivery of health and social services. These changes were prompted by new legislation and guidance as well as major alterations in the way in which services were funded. A significant factor was the creation of purchaser/provider relationships in the National Health Service. These new models of management required underpinning by increasingly interactive behaviour on the part of all concerned and necessitated joint planning, sometimes joint commissioning, and joint training. Appropriate evaluation and audit arrangements also needed to be developed. The implementation of these changes profoundly affected the principal agencies involved, in Milton Keynes.

Health Services

1.2 In 1995, Buckinghamshire Health Authority served a resident population of 668,581 and had a budget of £202.4 million. It purchased acute care from Milton Keynes General Hospital Trust, and a range of mental health inpatient and outpatient services as well as extensive community services from the Milton Keynes Community NHS Trust, which had been created in April 1992 as the main provider of mental health services in Milton Keynes. The Inquiry was told that in the year 1995/96 a sum of £26.2 million was allocated to those services across the county to support and integrate inpatient and community mental health services.

1.3 Within the Mental Health Directorate in 1995, acute inpatient services were provided as now, in the 38-bed Campbell Centre Unit, and Community Services were arranged in four area teams. Day Hospital provision was, and still is, housed in an entirely separate wing of the same building as the acute mental health inpatient services. The Directorate also included a very small psychology department, a sub-regional secure unit, a forensic services department, the drug and alcohol service and a mental health day hospital for the elderly.

1.4 The drug and alcohol service took the form of an outpatient treatment clinic, called Pegasus, which was focussed mainly on drug abusers. Inpatient treatment for alcohol problems was not generally provided unless there was also thought to be some level of mental illness, in which case beds were made available at the Campbell Centre. Patients were occasionally sent for inpatient detoxification to Oxford. Criteria for admission to the Campbell Centre have been tightened since 1995 and now specifically exclude patients with acute alcohol intoxication or learning disability unless they also have a serious mental illness. It should be noted that there were several changes in the leadership of the Mental Health Directorate in 1995.

1.5 The Learning Disabilities service was a small sector within the Disability and Elderly Directorate, as it was called in 1995. It consisted of two small residential units for people with profound multiple disability, and a nine-bed unit for adults with challenging behaviour, plus a Community Team of five Registered Learning Disability Nurses supporting clients in the community, with the help of other professionals allied to medicine who ran group sessions and one or two community support workers. There was also an "outreach" challenging behaviour team.

1.6 The department was overseen by a Director and administered by a General Manager. On the clinical side there was one Clinical Psychiatrist, who had the services of a part-time psychologist and was joined in December 1995 by a trainee psychotherapist. The remit of the department was to provide services to all adults in Milton Keynes with a learning disability. Patients could be referred by a wide range of people and self-referrals were also accepted. Referrals were discussed in weekly meetings of health professionals and in fortnightly joint meetings with Social Services colleagues.

1.7 In 1998, a strategy group called Milton Keynes Health Forum was set up to look at a range of interlinked issues with the active involvement of Social Services, the Housing Department, the Health Service and the Police. More recently, an NHS Primary Care Group (PCG) has been established covering the whole of Milton Keynes. It is co-terminous with the present Unitary Authority and is represented on the Health Forum.

Social Services

1.8 Whereas today, Social Services in Milton Keynes are provided by the Neighbourhood Services Directorate of the Milton Keynes Unitary Authority, in 1995 they were the responsibility of Buckinghamshire County Council. The Local Government Review in 1997 resulted in a transfer of responsibilities. This included transfer of Social Services

employees, files and associated documentation from the County Council to Milton Keynes Council, the new Unitary Authority.

1.9 The County Council, in 1995, served a population of 663,950 people, slightly fewer than the Health Authority because the boundaries were not co-terminous. Of these, about 29.4% (195,201) lived in Milton Keynes, which was growing rapidly. In 1995/96 some £18.2m, approximately 25.9% of the County Council's Social Services annual revenue budget, was allocated to services for people with mental health and learning disabilities problems. The Inquiry learnt that an Audit Commission report showed Buckinghamshire County Council's investment in learning disabilities services to be below the national average, although above an average based on a grouping or "family" of similar authorities.

1.10 Within the County Council, the Social Services Committee made the decisions on provision, but responsibility for reviewing all resource issues lay with the Policy and Resources Committee. The Social Services, Adult Services Division, was divided into two operational divisions, Northern and Southern. Milton Keynes lay within the Northern Division. This Division had an establishment of 14 social workers, in two separate but parallel specialist teams, one for Mental Health and the other for Adult Disability, which included physical as well as learning disability [see Appendix 3 (b)].

1.11 Social workers were attached to all the Milton Keynes Community NHS Trust Mental Health Teams and attended team meetings. Social Services also provided the Emergency Duty Team for the whole of Buckinghamshire for all service user groups including mental health and learning disability clients. Although working largely with the Trust, the social workers' line management was through senior officers in the Social Services Department. The ethos of social services for people with learning disabilities was built around the concept of enabling clients to live independent lives in the community. To this end, social work trained Disabled Living Advisers (now called Transitional Social Workers) were available at a Centre for Integrated Living in Milton Keynes.

1.12 In October 1995, the Buckinghamshire Social Services Committee decided to introduce a revised system of eligibility criteria which identified those categories of people for whom it would, in future, provide services. Details of the criteria and the financial and legal context are described in the document *Living Within Our Resources,* produced by the Buckinghamshire Social Services Department in 1995, which spelt out the options available to the County Council for rationing services, in order to keep costs within the available resources. The revised eligibility criteria were initially to be applied to services for older people, but by the end of 1995 they had been

applied to all user groups except those with learning disabilities, and to-date, no official decision has been made to apply the criteria in respect of people with learning disabilities. A joint publication, *Health and Social Services Review of Services to People with Learning Disabilities,* was published in 1994 but we were told that it was never implemented.

1.13 However, the evidence given by operational staff makes clear that for people with learning disabilities Social Services were, in fact, operating narrower eligibility criteria at the end of 1995 than those operated by the Trust, and that the principle of determining low/medium/high need was already being used by Social Services in relation to them. Witnesses told the Inquiry that people with mild learning disability were "not core business" for Social Services unless they also had mental health problems. This, we were told, was to ensure that expenditure was contained within a cash limited budget.

1.14 In evidence, in response to the Inquiry, the local authority stated that they were acting as advised by national bodies such as the Audit Commission (*Taking Care,* 1993) which recommended local authorities to set their eligibility criteria in order that they *"let through just enough people with needs to exactly use up their budgets (or be prepared to adjust their budgets)".* The Panel heard that NHS staff perceived the Social Services criteria as "tighter" for people with learning disability than those applied by the NHS which "cannot refuse to accept a referral", and that therefore Social Services would sometimes ask Trust staff to take on a person whom they felt unable to support. The impact of this policy and practice is described in Chapter 9.

1.15 The policy in operation for people with mental health problems at the end of 1995 was that set out in a document entitled *The Care Programme Approach, Care Management and Supervision Register Policy* issued jointly by the Trust and Buckinghamshire County Council and in place by December 1995. This is described in Chapter 15 and, though designed primarily for those with serious mental illness, covered anyone accepted by the specialist psychiatric services and is therefore relevant in this case.

1.16 The Panel was advised that Buckinghamshire County Council's criteria for assessing entitlement to a service have changed and, according to current criteria, a person with a learning disability would now receive a service if this would significantly enhance their quality of life or significantly reduce their risk of deterioration. In Milton Keynes, we heard that policies have become more collaborative. The Panel also heard in evidence that there has been a considerable shift in spending since the setting up of the Milton Keynes Unitary Authority in 1997, in particular towards supporting children's services. There

has been an improved level of investment and adult social services budgets are healthier.

Education

1.17 Specialist educational needs were the responsibility of the County Council in 1995 and the Panel was informed that provision for the transition of disabled school leavers to adult life was undertaken by social workers. They made the decision as to whether a young person's disability was sufficient to warrant support, in which case an assessment was made; and in the case of those with a learning disability, the young person could be added to the Learning Disabled Register, if they or their carers so wished. This process is discussed in Chapter 9.

1.18 Today, the Learning and Development Directorate of Milton Keynes Unitary Authority, as the Local Education Authority, looks after children in special schools. The Inquiry Panel learnt that there have been improvements in the transition process for learning disabled school leavers, with more emphasis on multi-disciplinary input, following the highlighting of shortcomings by the Social Services Inspectorate. Inclusion in the Learning Disabled Register remains a matter of personal choice for the individual or their carers and the Register is, therefore, not comprehensive.

Housing

1.19 In 1995, housing was the responsibility of the Housing Department of Milton Keynes Borough Council, which had taken over the housing stock of the original Milton Keynes Development Corporation and which handed over, in turn, to the Milton Keynes Unitary Authority in 1997. In the early 1990's, Milton Keynes was very successful economically, with significant inward migration and good employment prospects. However, the Panel heard evidence that there were difficulties in meeting housing needs. There was also significant homelessness because some people who had bought properties in the late 1980's were struggling to maintain them. Balancing service provision with rate of growth and demand was one of the key challenges for local government. The Development Corporation had managed many local issues and much of that experience was lost when the Corporation was disbanded. Milton Keynes was a new community "thrown together" and, as the Panel heard in evidence, "did not have the support mechanisms that existed in most towns and cities".

1.20 A Joint Special Needs Housing Strategy for Buckinghamshire was in operation in 1995, having been agreed between all the neighbouring local authorities in December 1993. This set out to *"ensure people with special needs are not disadvantaged by lack of appropriate housing"* and described the existing system as being based on *"comprehensive multi-disciplinary individual assessments"*.

1.21 A number of small, staffed residential units for people with learning disabilities existed in Milton Keynes, managed by various independent, non-profit making organisations, such as the Fremantle Trust or the Macintyre Housing Association, in conjunction with the local authorities. These units were only available to people with medium or high levels of dependency or disability. Low dependency clients were offered tenancies, with support packages in partnership with Social Services, Health Authorities and voluntary organisations.

1.22 The Inquiry Panel heard that there were a number of "group homes" mainly in the south of the county, but these were being phased out in Milton Keynes. Vacancies that occurred were difficult to fill. The social work team assessed the suitability of people for entry into a group home. The Panel heard that in 1995 there was little understanding between Housing and Social Services of each others' priorities and challenges. There was some joint training, but it was considered ineffective and exchange of information between agencies was generally imperfect.

1.23 The majority of Social Services residential homes had been transferred to the Fremantle Trust in 1991, in keeping with the Social Services' objective of being an enabler of services rather than a provider. However, the housing needs of people with drug or alcohol problems, although significant, were not a high priority. Following a review of vulnerable groups a different approach, called the "Supported Housing Strategy", has recently been devised to meet their housing needs.

Voluntary Agencies

1.24 Information given by witnesses to the Inquiry confirmed that, in 1995, the voluntary sector within Milton Keynes was substantially underdeveloped. The rapidly rising population had also made the funding of services a challenging issue. There is, today, significant voluntary support for persons with mental health problems and learning disabilities in the Milton Keynes area.

Collaborative Working

1.25 In 1995, joint procedures had been written to integrate the NHS Care Programme Approach with the Care Management process for assessment as used in Social Services; however, risk assessment strategies and procedures to assist those involved in assessment were underdeveloped.

1.26 The Inquiry heard that co-operation between Health and Social Services was and is essential to provide effective services. It also serves to maximise the benefits from central govemment grants for funding services and for special funds for development of services. Other forms of special funding, e.g. for substance misuse work, also required joint submissions between Health and Social Services and often with other agencies, in order to demonstrate success criteria.

1.27 Specific statutory requirements in good practice guidance have been issued by the Department of Health in recent years. Many documents have been concerned with care and after care, discharge planning arrangements and the central involvement of service users in those care planning systems. However, *NHS Executive Guidance Circular* HSG(94)27, which superseded an earlier circular, HC(90)23, the *Health of the Nation* publication (DoH, 1992) and *Building Bridges* (DoH,1995), whilst facilitating joint and collaborative working, gave little detail of how this might be achieved in practice. Joint procedures now exist in Buckinghamshire for the operation of the Care Programme Approach.

PART II - Events

CHAPTER 2 : Lorna Thomas

Early Development and Childhood

2.1 Loma was born on 2 February 1974, four weeks premature, and developed breathing problems soon after birth. She had very mild jaundice but this was not measured and she was sent home after nine days. She was noted to have a strawberry naevus (birthmark) on her chest and a large head.

2.2 Lorna was followed up regularly and was observed to have a tendency to scream and to feed poorly. She was found to have a delay in the onset of crawling, walking and talking, and was assessed to have a global delay in development, functioning at a level of between 18 to 24 months when she was 40 months old (IQ between 45 and 60). She was re-assessed to be functioning at the level of 24 to 27 months when she was four years old (IQ between 50 and 56). This was consistent with a diagnosis of mild learning disability. She was observed to be symbolising well, but was noted to have some difficulty in walking and poor muscle tone as well as having a large head. At the age of 17 she was seen in Casualty with signs of an epileptic seizure. This was not investigated at the time.

Family History

2.3 Loma's father worked as a train driver on the London Underground. Her mother worked as a theatre recovery nurse in Milton Keynes General Hospital. Lorna had a younger brother. There was some wider family history of schizophrenia and of mild learning disability.

Education

2.4 Lorna attended a special nursery school in London between the ages of two-and-a-half and five, moving to another special school until the age of nine. She was then integrated into a mainstream school until she was 12. The family then moved to Milton Keynes and Lorna was

placed in a special school, White Spire, until she finished at 17, in 1991. There are no educational records for Lorna still in existence and no record of plans made for her before leaving school.

2.5 The Inquiry learnt that, at that time, Education Service records were retained until pupils were 21 years old, and Lorna's records were destroyed in 1996. Staff at White Spire nevertheless recalled Lorna as "academically above average for this type of school" and that she "could read and comprehend to a satisfactory level. Her main problems were with relationships". According to the Deputy Head, "she did not fit the parameters of Special Educational Needs provision", although there was "no evidence that she could predict the consequences of her actions, let alone take responsibility for them". Lorna herself told a neighbour in 1995 that she used to run away from school because she could not cope.

2.6 The Inquiry Panel learnt that Local Education Authorities now keep education records until individuals are 25 years old. We also heard in evidence that pupils at White Spire School were mostly deemed by the County Council to be only mildly learning disabled and so not likely to need social services support in the community. Lorna was perceived in that category and therefore was not assessed by Social Services on leaving school nor entered on the Learning Disability Register.

Employment

2.7 After leaving school Lorna attended work experience schemes. At age 17 she spent approximately six months attending the Milton Keynes Christian Foundation and also helping at a day nursery. She did not obtain employment after 1992.

Contact with Social Services

2.8 Lorna's first contact with Social Services was in December 1991 while she was receiving training at the Milton Keynes Christian Foundation. Staff there were finding Lorna's temperament and behaviour difficult to handle. Lorna resented being grouped with people who were considerably more learning disabled than herself, but at the same time she did not have the capacity to cope with the work expected of her. A Disabled Living Adviser from Social Services, Trish Wilson, who was visiting the Christian Foundation for other reasons, was asked to speak to Lorna, and continued to spend about an hour a month with her while Lorna was at the Foundation.

2.9 This was the first indication to Social Services that Lorna might have

behavioural problems as well as her mild learning disability, and Trish Wilson formed the view that, as well as finding it difficult to socialise, Lorna had low self-esteem and was vulnerable. Trish Wilson's view was reported to the then Senior Care Manager for Adult Disability in Buckinghamshire Social Services, but Lorna's problems were not deemed sufficient to trigger an assessment.

Medical History

2.10 Lorna was diagnosed to be having pre-menstrual tension, which was managed with Depo–Provera (injectable contraceptive). She had no other medical problems as an adult. In February 1995, she was given a Norplant (hormone) implant and her Depo–Provera was discontinued.

Mental Health History (prior to attending the Campbell Centre) :

2.11 Lorna was referred to the psychiatric service in 1992 by Dr Punch, her General Practitioner, who had received a letter from the Director of the Initial Training Scheme at the Milton Keynes Christian Foundation. Lorna had made contact with the clergy in the area and had made emotional demands on them. They were unable to meet these demands and they felt that Lorna's religious obsession was a sign of her emotional immaturity and a means of avoiding reality. They felt that she was "deteriorating and running out of possible support". The Director said of Lorna that "her feelings run so deep and are such an obsession that they prevent her from progressing".

2.12 Dr Punch said in his referral letter that Lorna's mother had reported "outbursts of temper that may last for several hours and during these she tends to shout, throw things and slam doors". Lorna also felt that people were saying nasty things about her appearance. Though originally described by her paediatrician as slightly dysmorphic (asymmetrical in appearance), Lorna was described to the Panel by various witnesses as "a pretty girl".

2.13 She was first seen by Dr Ken Singh, Consultant Psychiatrist for Learning Disability in Milton Keynes Community NHS Trust, in March 1992. He felt that Lorna was "at the borderline of learning disability" and that her behaviour problems resulted from "her interaction with the circumstances of her life, whether real or imagined".

2.14 He ruled out the possibility of Lorna having a seizure disorder by arranging an EEG (electroencephalogram) for her. He then tried to refer her to a psychologist. The Inquiry learnt that Lorna had to wait for over a year to receive psychological input. While waiting for this,

she was again referred to Dr Singh by another general practitioner, Dr Labrum, in February 1993. It was reported that Lorna had become increasingly aggressive and had intensified her level of contact with the local clergy. Her relationship with her father had become extremely strained. Dr Singh took the view that the length of the waiting list for the psychologist meant that Lorna would have to be considered for group therapy. He then saw her regularly over a period of two months and spent time discussing her relationship problems with her. **(See Recommendation 11, Pg. 103)**

2.15 In April 1993, Dr Singh arranged for a member of his team, Community Nurse David Mason, to support Lorna by visiting her at home and encouraging her to describe her feelings and discuss the causes. They had four meetings spread over one month. During this time Lorna left her parent's home for a while after a disagreement with them about the use of the telephone. She was found accommodation by the Police Family Protection Unit, but stayed there only a short while.

2.16 In the course of these contacts with David Mason, Lorna wrote at length about her relationships with others, and revealed a good command of language and ability to express her feelings in writing. The Inquiry Panel learnt in evidence that Mrs. Thomas had spent much time reading with her daughter during Lorna's childhood. However, Lorna's ability to convey her own inner world did not appear to help her to understand the impact her intensity had on those around her. Dr. Singh noted in 1993: "it is going to be a long slow process ... She is stuck in a vicious cycle of people being unkind to her and she re-acting back in anger".

2.17 In May 1993, Lorna experienced the first reported incident of alleged sexual assault. She went to the Wolverton Social Services Offices, near where she was living at the time, in a very distressed state and asked for Trish Wilson. Lorna had written a letter of complaint to the alleged offender's employer. The incident she described was serious but fell short of rape. Trish Wilson, who was based at Stantonbury, was contacted by telephone and sought permission to support Lorna at this time, but the Inquiry Panel was told that she was prevented from doing so by the Care Manager/Co-ordinator of the Social Services Adult Learning Disability Team, Felicity Lefevre, who is reported as saying that as Lorna was only mildly learning disabled, she was therefore "not our business". Unfortunately, the Inquiry Panel was unable to verify this account of actions directly with Felicity Lefevre as, due to ill health, she was unable to attend the Inquiry to give evidence. Trish Wilson arranged for another social worker at Wolverton to escort Lorna to the nearby Police station. At that point Lorna did not wish her parents to know what had happened to her.

2.18 According to the Police records, Lorna's statement was taken by WPC Vandersteen of the Police Family Protection Unit, who herself contacted Social Services and was told by Trish Wilson that, in the view of the Department, Lorna did not need the help of an "appropriate" adult (as detailed under the Home Office Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers under Section 66 of the Police and Criminal Evidence Act 1984) to make her statement. The alleged offender was interviewed, but the case did not proceed, due to insufficient evidence. WPC Vandersteen saw Lorna a couple of times to report progress and tell her the outcome and that the man had been "spoken to" as Lorna wished. WPC Vandersteen was concerned about the Social Services' decision that Lorna did not need to have an "appropriate" adult with her for the purposes of making a statement.

2.19 Lorna mentioned this episode to Community Nurse Mason who advised her to see her GP for some contraceptive protection. David Mason only reported back to Dr Singh in general terms about his conversations with Lorna. There is no mention of the assault in Dr Singh's notes. It is noteworthy that after this episode all support for Lorna from Dr Singh and Community Nurse David Mason as well as from Social Services stopped, until September 1993 when she was finally offered a place by Dr Kathy Chapman on the psychological group sessions. Lorna attended one session but did not find it helpful and did not continue despite being invited to return by Dr Chapman. It would appear that Dr Singh did not see Lorna between September 1993 and January 1995.

2.20 In October 1993 there was an allegation of a second, serious, sexual assault. Lorna went to Milton Keynes General Hospital, in pain, and told A & E staff that she had been raped. They called the Police. Lorna said that on 21 October an older man, with whom she had had a short relationship in the past, had raped her and carried out a further brutal sexual assault. Lorna was very distressed. The case was passed to the Police Family Protection Unit and is recorded in detail in their records. On 29 October, WPC King visited Lorna. It was immediately apparent to WPC King that Lorna had learning difficulties and that the interview would need to be conducted in very basic language. WPC King's impression was that she was a nice girl, and easy to speak with, but vulnerable and naive. Lorna was very upset and did not, at that point, wish her parents to be involved.

2.21 WPC King contacted Social Services directly on 29 October 1993, spoke to Sheila Taylor and informed her specifically of the nature of the alleged assault and that Lorna was very distressed; and asked for Social Services Department assistance in interviewing Lorna. Sheila Taylor stated to WPC King that, as Lorna was 19 years old and therefore an adult in the eyes of the Department and only mildly

learning disabled, in their view she was capable of making the complaint by herself and did not need Social Services support.

2.22 WPC King arranged for Lorna to attend the Police Station the next day, Saturday 30 October, for a medical examination and to make a full statement. She was sufficiently concerned at the lack of an appropriate person to support Lorna that she arranged for a Police Inspector to read the finished statement to Lorna and countersign it.

2.23 On Monday, 1 November, WPC King again spoke to Sheila Taylor, informing her of her concerns, and said that she felt Lorna was in need of further support. Sheila Taylor informed the Police on 4 November 1993 that Lorna's details would be passed to Rape Crisis and Social Services would then withdraw their help. On 9 November, WPC King spoke to Trish Wilson, whom she learnt had finally been permitted to take on Lorna's case for a limited time to deal specifically with this incident, and who hoped to see Lorna a few days later.

2.24 The Inquiry Panel heard that Buckinghamshire County Council social workers were under pressure at the time to "signpost" people with lesser levels of disability to other organisations and "not to become involved in any depth themselves". This policy was determined by their line managers "responding to national directives". The White Paper *Caring for People – Community Care in the Next Decade and Beyond* (HMSO, 1989) which was the basis of the NHS and Community Care Act 1990 states, (Pg 5) : *"The key components of community care should be ... services that concentrate on those with the greatest need".*

2.25 The evidence from the medical examination on 30 October supported Lorna's allegations and it was decided to press charges. WPC King spoke to Lorna on 27 November to tell her how the case was proceeding. At that point Lorna was deeply angry at what she saw as a betrayal of trust by the alleged offender and was determined to go to court. In the event, the accused man committed suicide before the case came to court. WPC King went to see Lorna to inform her of the suicide on 11 December 1993, and checked on her welfare on 15 December. Lorna was overcome by the news and blamed herself for his death.

2.26 On 17 December, WPC King spoke to Trish Wilson and informed her of Lorna's distress on receiving the news of the suicide and that the Police investigation was concluding now that the case could no longer be pursued. Social Services' involvement with Lorna ceased in January 1994. It is understood that Lorna visited Rape Crisis once but did not stay. There was no formal meeting between Social Services and the Police Family Protection Unit regarding Lorna, and WPC King was "unaware of any detailed plan of action from Health or

Social Services or any other organisation to provide any structured support for Lorna".

2.27 Evidence to the Inquiry showed that Lorna was increasingly troubled over this episode in the following years, blaming herself for her alleged assailant's death. However, the Panel could find no evidence of support being given to Lorna to assist her in coming to terms with this traumatic series of experiences. Nor was there any re-evaluation of Lorna's status by Social Services in spite of her having been allegedly subject to two serious sexual assaults within a short period of time. The Panel heard in evidence that no information about this episode was passed by Social Services to those in the Trust responsible for her care.

RECOMMENDATION 7: The Milton Keynes Council and Buckinghamshire County Council Social Services Departments should review their "appropriate" adult procedures to support people with a learning disability who are to be interviewed by the Police and should provide the necessary continuing support afterwards.

2.28 The Social Services file supplied to the Inquiry Panel contained no entries between April 1992 and September 1994. This was particularly surprising in view of the high level of detail in the records at other times, and the seriousness of the contacts not recorded. However, Social Services witnesses did refer to the alleged rape in evidence, though they did not mention their contacts with the Family Protection Unit. Contact by Social Services with Lorna between November 1993 and January 1994 appeared to consist of one meeting and two telephone calls. Again, there was no mention of any of this in Lorna's Social Services file. It was unclear whether Loma's case file remained "open".

RECOMMENDATION 38 : The Social Services Departments of Buckinghamshire County Council and Milton Keynes Council should ensure that when they "close" a case, this is handled with sensitivity and openness. The client and their families should be aware that the case has been closed, and the reasons notified in writing.

2.29 Lorna's behaviour at home continued to deteriorate. She appeared to give vent to her frustrations arising from her relationship difficulties and this would manifest itself in shouting and screaming, door banging and playing her music loudly. As her father was working night

shifts he needed to sleep in the daytime, but this was made impossible by Lorna's actions. He eventually contacted the Social Services Disability Team and asked for Lorna to be helped in finding alternative accommodation. In September 1994 he wrote a letter supporting her housing application.

2.30 Trish Wilson was again assigned to help, but was unable to find suitable accommodation for her. Each attempted solution was blocked because Lorna did not fit the relevant criteria or degree of disability. The Panel was concerned to learn that Mr. Thomas's letter, which contained negative remarks about Lorna, was given to her to use in her approaches to other housing associations. We heard in evidence that this increased the friction between Lorna and her family. Lorna was eventually allocated a flat at Granby Court, in Bletchley, Milton Keynes in January 1995. This was a complex designed for young single people and run by Milton Keynes Borough Council and Jephson Housing Association.

2.31 Several witnesses described Granby Court as a grim environment with problems of drugs and crime and "not suitable for vulnerable people". Though the external design seemed quite pleasant when Panel Members visited, there were some signs of neglect, with narrow dark passages and some boarded windows. The Inquiry heard that some of the flats were privately owned. Though Lorna's flat was fitted out and decorated by her family, she could have felt isolated and vulnerable there. Lorna told Dr Singh that she did not go out after dark, but spent her evenings watching TV and listening to, or making, music which she said calmed her. Although Lorna sometimes claimed to be unsupported in her flat, she in fact received support from her family who telephoned regularly, arranged lifts when necessary, and took her shopping every week. Indeed, Lorna described her mother as "very supportive and helpful".

2.32 When Dr Singh saw Lorna again on an individual basis in January 1995, he noted that she was sleeping poorly, losing her appetite and was finding mornings to be the most difficult part of the day, after which time her mood improved. She stated she was depressed. He felt that in order to improve her self worth she should see the local Disability Rehabilitation Officer to help find her part-time training for jobs. This suggestion does not seem to have been implemented.

2.33 She was diagnosed to be depressed by her GP early in April 1995 and given antidepressants (Amitriptyline). This depression was attributed to the break-up of a relationship with another older man. She then took an overdose in June 1995. The diagnosis at this point suggested the possibility of "acute mental illness" and it was documented by Dr Morrell, Psychiatric Registrar, that she had indulged in self-injurious behaviour in the past year by pouring hot

water on her foot, and had punched herself during an argument with her ex-boyfriend. She had also cut her wrists superficially in May 1995 following "feeling rejected by a group of friends". Social Services duty officers Bill Bailey and Anne Flitney, who saw her in June, commented in their notes that "Lorna needed a service - is this a service deficit?". The Panel found no evidence of this concern being followed up.

2.34 Loma changed her general practitioner in 1995 following her move to Granby Court and was prescribed a new anti-depressant (Lofepramine). She then took an overdose of Lofepramine and was again referred to Dr Singh in September 1995 and a CPN (Community Psychiatric Nurse) visit was arranged.

2.35 Dr Singh found that her self-esteem was low and she felt "low in spirits". She felt that life was not worth living. Dr Singh observed that Lorna had a "reactive affective state in keeping with the circumstances that she finds herself in". He and Lorna agreed to stop her antidepressant medication as it was not helping her. He was very concerned that she needed support and thought that she would benefit from day care. He suggested Keystone, a day centre run by Social Services for people with mental health problems. The Inquiry learnt that, at that time, Keystone accepted referrals from social service staff and psychiatrists in adult mental health, though not from psychiatrists in learning disability.

RECOMMENDATION 4 : The Milton Keynes Council and Buckinghamshire County Council Social Services Departments and the Milton Keynes Community NHS Trust should review their referral policies to allow Psychiatrists in Learning Disability to refer patients with a mild learning disability and mental health needs, who may benefit from the service, to Keystone or any other similar service.

2.36 In October 1995, Jackie Platt, a community support worker in Dr Singh's team, began to see Lorna on a weekly basis until 6 November 1995. The Inquiry heard in evidence that Jackie Platt only had second-hand knowledge of Lorna's needs because she was under the impression that community support workers did not have direct access to the patient's case notes. The Panel was later advised that in fact all staff within the Learning Disabilities Service had always had access to patients' files.

RECOMMENDATION 32 : The Milton Keynes Community NHS Trust should ensure that all community support workers and other professionals having direct contact with patients are aware that they are allowed access to patients' notes to enable them to have a better understanding of clinical needs.

2.37 Lorna appeared to be low during her contacts with Dr Singh and took another overdose of Lofepramine in November 1995. This time she was admitted into hospital and was transferred to the Campbell Centre for assessment on 9 November, as she was still feeling suicidal and hysterical. Although Dr Singh had no beds for learning disability patients, discussion took place with a colleague, Dr Joseph, Consultant in General Adult Psychiatry, and an agreement was reached that she would be admitted to a bed in the Campbell Centre.

RECOMMENDATION 5 : The Buckinghamshire Health Authority should ensure that the Milton Keynes Community NHS Trust provides a more comprehensive inpatient service for people with mild learning disability. This should include access to beds within the Campbell Centre or other appropriate local resource, for those who are or may also be suffering from mental illness and need a period of observation and treatment. Even though day to day management decisions could be the responsibility of the sector Consultant, overall clinical responsibility for such individuals should remain with the Learning Disabilities Consultant(s) to ensure continuity of care. These services need to include some staff trained in both mental health and learning disability.

CHAPTER 3 : Nicholas Arnold

Childhood and Adolescence

3.1 Nicholas Arnold was born in Luton on 30 April 1954. His father worked in the aircraft industry and in his spare time he played in a band. His mother was a housewife and interested in Spiritualism. Nicholas had two brothers, one of whom was five years older than himself and the other was five years younger.

3.2 He was described as being very shy and quiet as a child. He attended normal schools but is reported to have suffered from a degree of dyslexia which was not diagnosed at the time. As a result he did not do well academically and left school at the age of 15. He had enjoyed schooling from the social point of view and had made some friends.

3.3 He described his childhood as having been happy until the age of 11, when his parents divorced. As his mother was moving away and Nicholas and his brothers did not want to change schools and have to make new friends, they elected to remain with their father.

3.4 The Inquiry Panel learnt that Mr. Arnold snr. drank heavily, and he was described by Mrs Arnold as "always ranting and raving" when he came in. She found him difficult to please; she felt that she could do nothing right for him and alleged that he was both verbally and physically abusive towards her. She did not witness him being physically abusive to Nicholas, but the latter reported in an interview with Fenella Mowbray, Senior Occupational Therapist at the Campbell Centre, that his father often beat him and his brothers. Nicholas had earlier spoken of his father having "very little consideration or time for him" and that his father undermined his confidence.

Adulthood

3.5 Nicholas left home at the age of 21 after falling out with his father. He subsequently shared flats with several young people (six different

addresses mentioned in GP records between 1969 and 1979). He then lived with a girlfriend for approximately three years between 1979 and 1982. After the break-up of that relationship, he lived on his own for a short time until he and his mother re-established contact after several years, and he subsequently moved to Milton Keynes to live with her. In 1984 his mother had two heart attacks and in the same year his father died. Although Nicholas was not close to his brothers he maintained some contact with his elder brother until the death of Lorna.

3.6 Towards the end of 1984 Nicholas was given a flat of his own after his GP had contacted the housing department. In approximately 1987 he established a relationship with a woman which lasted about eight years. During part of that time he was living with her, at other times he either lived with his mother or maintained a place of his own. He lived at several different addresses in Milton Keynes before moving to New Bradwell in about September 1993. The relationship finally ended in April 1995 and she married her new boyfriend a few months later. Nicholas claimed it was the news of her marriage which precipitated his relapse into very heavy drinking and his admission to the Campbell Centre in November 1995.

Other Significant Relationships

3.7 According to his mother, Nicholas had had a very good friend from school days who took an overdose and died at the age of 16 or 17. In later years almost all his friends were said to be alcoholics.

Work History

3.8 After leaving school Nicholas worked for about five years as a cutter in the "rag trade" but had to discontinue this because of his shaking. Subsequently, he worked for a time at an engineering company where, he stated, he associated with after-work drinkers. After moving to Milton Keynes he worked from time to time in the construction industry but appears to have been unemployed in the years leading up to the death of Lorna. He did odd jobs of gardening and equipment repairs and he spent time with other unemployed people who were also heavy drinkers.

Medical History (prior to attending the Campbell Centre)

3.9	November 1964 (Aged 10 years)	Admitted to Luton and Dunstable Hospital with head injury following a road traffic accident. No neurological abnormalities noted.
	Approx. 1970/71	Had "out of body" experiences.
	Approx. 1973 (Aged 19 years)	Nervous troubles started, shaking and anxiety. Discovered that alcohol enabled him to feel confident and socialise well. Diazepam (Valium – a tranquilliser) prescribed from December 1977 with regular prescriptions from 1980.
	January 1979	Took overdose of 100 Diazepam tablets and alcohol. Wanted to die because his wallet was stolen.
	February 1979	Beaten up by neighbour – black eye but no injuries seen on X-ray. He was seen by Consultant Psychiatrist at Luton, Dr R Pinto – complaining of people disliking him and making fun of him. He claimed to feel constantly tense in company and was taking up to 30 mgm per day of Diazepam to reduce feelings of tension and agitation. Dr Pinto described him as "an inadequate and anxious man" and suggested referral to a psychologist for group therapy.
	October 1979 (Aged 25 years)	Seen by Dr B Chester, another Consultant Psychiatrist in Luton, who described him as tense, nervous and anxious and said his "main complaint now of shaky hands". Referred for further assessment by the psychologists. Nicholas subsequently claimed to have benefited from the treatment which followed but its exact nature is not known.
	August 1981	GP commented that he was having too many Diazepam.
	January 1982	After the move to Milton Keynes his new GP, Dr Prisk, suggested he should try reducing the dosage of Diazepam but this was only partially successful.

February 1983	Referred by GP to Dr J S Price, Consultant Psychiatrist, because of "depression, anxiety and recent history of alcohol tendency". Dr Price diagnosed "social phobia and attacks of shaking and anxiety even when alone". He recommended social rehabilitation at the Richmond Fellowship, a voluntary sector organisation providing residential rehabilitation facilities (Nicholas did not go).
February 1985	Complained of lodger stabbing him.
June 1985	Was re-referred to Dr Price because of a desire to stop alcohol and Diazepam. Dr Price suggested referral to chemical dependency facilities or, alternatively, private alcohol treatment facilities (Nicholas had recently inherited a sum of money). Later in the same month he was admitted to Milton Keynes General Hospital after a road traffic accident. He had crashed through a car windscreen and had glass removed and his neck sutured. He discharged himself after two days.
August 1985	Admitted to Milton Keynes General Hospital suffering from alcoholic hepatitis. Liver function tests were grossly abnormal and he had a period of DTs whilst in hospital. Referred again to Psychiatrist. Seen by Dr Lennard (SHO) who noted: "New resolution about giving up drinking". Ex-alcoholics hostel, to be suggested by Probation, or support from CPN in substance abuse to be requested by Dr Lennard. No evidence that he took up either, but he promised to join AA.
May 1986	Failed to attend two outpatient appointments with Dr J Lourie, Consultant Orthopaedic Surgeon, for treatment of olecranon bursitis (inflammation of the elbow joint).
July 1986	GP advised reduction in Diazepam.
April 1987	GP reported that less than 4 mgm of Diazepam led to severe shaking.
June 1987	Recently robbed and beaten up (no injuries noted).

May 1988	GP successfully weaned him off Diazepam.
February 1990	Treated for cut wrist at Milton Keynes General Hospital – no indication of cause.
July 1990	Fell off bicycle – treated for fractured collar bone and laceration to right palm at Milton Keynes General Hospital.
November 1990	Healing lesions around mouth and vertex of head – seen by GP. Allegedly caused by an assault. Anxious about further possible assaults. GP recommenced Diazepam.
December 1990	Attacked when drunk – walked out of A & E before being seen. GP described massive swelling on left side of face, bruises on right temple and right hip. Subsequently treated for infected laceration of lips at Milton Keynes General Hospital Casualty Department.
January 1991	Arrived drunk at the GP's surgery, abusive and depressed. Referred to Dr Weir, Consultant Psychiatrist. Dr Weir diagnosed alcoholism and stress reaction to potential court case, and suggested referral to Pegasus Alcohol and Drug Advisory Service (NHS).
February 1991	Attended Pegasus. GP stated: "patient's mental health has deteriorated greatly". Subsequently seen by a counsellor at Pegasus - no notes available, but Nicholas told GP he attended from February to mid-April.
April 1991	Admitted to Milton Keynes General Hospital following drug overdose with Diazepam in response to losing his wallet. Attending AA meetings.
1 June 1991	Admitted to Milton Keynes General Hospital following an accident when he was drunk and was knocked down by car. Minor injuries to forehead, left knee and chest. Discharged next day.
15 June 1991	Cut above eye while drunk – later said he was assaulted by teenagers. Alleged to have sold prescribed drugs.

22 June 1991	Further assault – bruising to left arm, back of thigh and legs. Also pain in chest. On X-ray found to have fractured rib.
July 1991	Removed from GP's list (reason not given).
August 1991	Admitted on 19 August to Peterhouse Project, an alcohol rehabilitation unit, run by Bedford Probation Service. Discharged from there on 27 August, following alcoholic relapse, disruptive behaviour and damage to property.
August 1991	New GP prescribed Amitriptyline (anti-depressant) and weaned him off Diazepam by September 1991. No mention of alcohol in GP records.
June 1992	Attended Milton Keynes General Hospital Casualty Department complaining of injuries to his face and right hand. X-rays normal – no specific treatment given.
September 1993	Attended Milton Keynes General Hospital Casualty Department after collapsing. Thought to be suffering from alcohol abuse.
July 1994 (Aged 40 years)	Three-day admission to Milton Keynes General Hospital via Casualty with abdominal pain and diarrhoea. Treated with intravenous fluids and an antibiotic.
September 1994	Re-referred to Pegasus by GP - continued to attend until April 1995. Counselled by Trevor Plumb.
November 1994	Took overdose of Zopiclone (sleeping tablet) and Amitriptyline and admitted to Milton Keynes General Hospital for six days. Assessed by Dr Nazir, SHO. Noted to have bruises over his body and developed alcohol withdrawal symptoms. Treated with Chlormethiazole and discharged on Chlordiazepoxide, both mild tranquillisers.
March 1995	Report from Pegasus to GP: "seems to be improving. Receiving acupuncture, has abstained since November 1994. No signs of psychiatric disturbance".

May 1995	Referred by GP to Dr P Strangeway, Consultant Psychiatrist, Milton Keynes Community NHS Trust, Campbell Centre, "he has become very depressed and complains of insomnia".
June 1995	Seen in Dr Strangeway's outpatient clinic – diagnosed alcohol abuse and social phobia. "No treatable depression" but end of eight-year relationship with girlfriend noted. Admitted to smoking cannabis regularly. Anxiety management training recommended. Initially suggested to be done at Pegasus.
July 1995	Pegasus declined to accept referral due to his previous failure to apply anxiety training.
August 1995	Referred by Dr Strangeway to Day Hospital at Campbell Centre which provided activities and group therapy for outpatients.
September 1995	Assessed at Campbell Centre Day Hospital: "Mr Arnold reticent to attend any group activities" but did agree to attend woodwork classes, which he commenced on 9 October 1995, and gardening which he particularly enjoyed.
8 October 1995	(1:30 a.m.) GP Deputising Service called out by his mother. Found Nicholas to be drunk and in a distressed state. It was suggested that he be assessed when sober by the GP. Police accompanied Deputising Service GP to flat.
30 October 1995	Visit by mother to L Shiong, Charge Nurse, Campbell Centre Day Hospital, asking how to get Nicholas admitted to the ward. GP contacted, who phoned duty doctor, and sent ambulance to Nicholas' flat. He refused to get into the ambulance.
6 November 1995	L Shiong discussed relaxation course with him to commence 22 November 1995.
10 November 1995	Nicholas arrived at Day Hospital but declined to wait to be seen. Left to go to the pub with a friend.

11 November 1995 Admitted to the Campbell Centre as an informal patient for alcohol detoxification.

Criminal Records

3.10 Nicholas had eight criminal convictions from 1976 to 1991 – the first was for Actual Bodily Harm and he was fined £25.00. Subsequent offences included shoplifting, possession of cannabis, possession of controlled drugs, supplying drugs, burglary and attempted theft. These were dealt with by fines, probation orders or suspended sentences. He was put on probation three times, which enabled the service to form a very full picture of his character and needs, and these were recorded in detail.

3.11 In July 1991, his Probation Officer commented: "he is an uninspiring man with little going for him. He has been abusing alcohol for over twenty years and has no motivation to stop despite health problems and worries attached to the lifestyle of a persistent drunk". In later notes, after he had been expelled from the Peterhouse project in Bedford, Nicholas told the Probation Officer that he was not to blame for what happened because friends had turned up and had taken him drinking. His Probation Officer later made the comment: "since then he has been sullen and unpleasant. he expected me to sort out his problems and nanny him. Since I told him it was time for him to do things for himself, he has sulked".

3.12 In March 1992, she wrote: "Nick has continued to refuse the idea of work and is once again waiting for something to be done for him rather than try to do something for himself ... he is unenthusiastic (about going to an alcohol project in London) because his mother wouldn't want him to go to London".

History of Aggressive Behaviour

3.13 As mentioned, Nicholas was convicted of Actual Bodily Harm in 1976 (details no longer available). In October 1979, Dr B Chester, Consultant Psychiatrist at Luton, wrote that he had shown repeated aggression at his girlfriend's home between February and July 1979. In 1984, his mother reported to his GP and to the probation officer that Nicholas had threatened and actually been violent towards her whilst he was under the influence of alcohol. However, in evidence to the Inquiry Mrs. Arnold stated that the violence was to property rather than to herself.

3.14 From 1987 to 1990, whilst living with his girlfriend, Nicholas was said

to have frequently become violent after drinking alcohol and caused damage to the house. She coped with this by leaving the house with her children if he returned home drunk. In the early 1990s, she recalled that he assaulted her in the face and threw her around the house prior to leaving. She found that it was better when they each had their own home but she continued to leave his company if he started to drink too much.

3.15 At about the beginning of 1991 there were allegations of indecent assault by Nicholas on a young girl but the Panel was told by the Police that the case was dismissed through lack of evidence when he appeared at the Crown Court in April 1991. At this time he was subjected to a number of assaults, and his GP noted that "the alcohol makes him very abusive".

3.16 The Inquiry was told in evidence that whilst living at New Bradwell, Nicholas wrote graffiti on the walls of the stairwell abusing one of his neighbours. He also hit her door and threw fireworks which exploded outside her window. She reported him to the Council for noise nuisance. On another occasion he pushed a drinking friend's partner against the neighbour's door and threatened another neighbour directly that he would "kill him" and "knock his legs off". The Panel heard in evidence that in spite of frequent reports of such incidents, his neighbour felt that the Police never took this potential for violence seriously.

3.17 The Inquiry also heard in evidence that in October 1995 a man at an all-night party at Nicholas' flat was beaten up. Nicholas told a neighbour that the man had been "interfering with a girl" and that he "was not going to let him do that". The man was "left for dead" at the bottom of the stairs which led to Nicholas' flat. Another neighbour called an ambulance and the man later recovered in hospital. It was at about this time that the GP Deputising Service requested a Police escort when visiting Nicholas early one morning.

3.18 On the evening prior to Lorna's death, Nicholas warned a neighbour that somebody might have to die if they argued with him, but did not specify whom. This neighbour stated that on occasions she felt afraid of Nicholas.

CHAPTER 4 : At the Campbell Centre - Lorna Thomas

4.1 At the Campbell Centre, Lorna said she felt safe and that her problems were being acknowledged. She was anxious not to be discharged back to her flat as she lived alone and did not feel safe there. She felt that she might be better served in a group home with people like herself. An inpatient assessment was undertaken on 13 November 1995, by Julie Lockwood, her keyworker in the Campbell Centre. On account of Lorna's low mood and suicidal ideation she was placed on a high level of observation. It was decided that her difficulty in relating to others would be dealt with by encouraging her to be involved in the ward occupational therapy groups and her accommodation concerns would be dealt with by liaising with the learning disability team and referral to a social worker.

4.2 Lorna remained unsettled during her hospital stay, frequently becoming anxious, noisy and demanding of staff attention. Several members of the Campbell Centre staff said in evidence that they had felt very concerned about Lorna's admission to the unit. They did not believe they had the appropriate training or experience to deal with a learning disabled patient and thought that an acute psychiatric environment did not seem helpful for Lorna herself.

RECOMMENDATION 33 : The Department of Health and the training bodies should encourage cross-disciplinary training in mental health, substance abuse and learning disability for nurses, social workers and all those who might be appointed as keyworkers to persons who have dual diagnosis.

4.3 On 14 November, Lorna absconded from the ward and claimed to have taken an overdose (though the levels were not traceable) because she was afraid of imminent discharge. She was reported near a Catholic school and subsequently found, in a very disturbed state, at Milton Keynes railway station. The Police were called and WPC Vandersteen volunteered to attend the incident, as she already knew Lorna through her contact in 1993 after an alleged sexual

assault. She found Lorna in a state of distress and initially unwilling to return to the Campbell Centre. Lorna expressed feelings of guilt about the suicide of her alleged assailant in October 1993. WPC Vandersteen tried to comfort her and convince her that she had done the right thing to report it. She eventually persuaded Lorna to return to the Campbell Centre.

4.4 WPC Vandersteen noted the general deterioration in Lorna's condition over the two years since their last meeting. She felt that Lorna had become much more emotionally volatile and appeared to be "unaware of her surroundings" and had "lost her way". There was no opportunity to share these observations with the ward staff. According to Police records, the facts of the incident were communicated to Social Services. There was no mention of this incident in the Social Services records supplied to the Panel.

4.5 Panel Members were concerned that we only inadvertently came upon WPC Vandersteen's involvement in Lorna's case. The involvement of the Family Protection Unit seemed not to be known to Detective Sergeant Pollard who had co-ordinated the murder inquiry, and WPC Vandersteen-Hague (now married) was not approached for any information in the course of the murder inquiry even though she had identified Lorna's body. Furthermore, there was no mention at all of the two allegations of sexual assault, the episode on 14 November 1995, or the Police Family Protection Unit in the Social Services records supplied to the Panel. We were given to understand, and would have expected, that these were complete. We did receive records covering Lorna's contact with Social Services in early 1992 and from September 1994 onwards. All Social Services records relevant to Milton Keynes were transferred to Milton Keynes Unitary Authority in April 1997, as were most of the relevant staff.

4.6 Since we were assured that we had received the complete file, the Panel was, therefore, forced to conclude that there was a severe lapse in record keeping covering this period of Lorna's engagement with Buckinghamshire County Council's Social Services Department.

RECOMMENDATION 35 : The Thames Valley Police Authority should review the systems and the links in place between the Family Protection Unit and the rest of the Police service. Information sharing should extend not just to inter-agency but also intra-agency in circumstances such as Lorna's case.

RECOMMENDATION 29 : The Directors of Social Services for Buckinghamshire County Council and Milton Keynes Council should take steps to ensure the accuracy and completeness of Social Services record keeping.

4.7 On her return to the ward Lorna kept asking for more staff time but could not engage in meaningful dialogue with them. She participated in some of the ward activities, particularly enjoying the art and pottery, but on occasion would shout and bang the walls of her room. She spoke to nurses and doctors and to Jackie Platt, about the alleged rape in 1993 and the nightmares she was having as a result of her alleged attacker's death. This is recorded in the nursing notes and the clinical notes and should therefore have been known to the ward staff and all those involved in her care, though some senior staff claimed in evidence to be unaware of it.

4.8 At this time, Loma wrote about friends who "have turned away from me because I have relied on them" and that at the Campbell Centre " it feels like it is a crime to be depressed, that I should be happy and mix with other patients and pretend like nothing has happened so they can discharge me". The Inquiry learnt from notes of a ward round on 16 November that Loma had been seen by Dr Singh and "her social worker". It was decided that as she was reluctant to go home she would not be discharged, but would be allowed to leave the ward for short spells if she informed the nursing staff. A pre-discharge meeting was scheduled for 23 November.

4.9 Loma and Nicholas soon met and were observed by staff to be spending time together on the ward, talking and watching TV. On 21 November, Lorna went to the local off-licence with him and came back to the ward, three-quarters of an hour later, in an intoxicated state. She attributed her behaviour to the feeling of rejection and her continued fear of discharge from the Campbell Centre. On 22 November, she accused Nicholas of indecently assaulting her but this was found to result from her misinterpreting him giving her a hug and she continued to spend time with him on the ward. They were both counselled by staff. Nicholas was discharged from inpatient care on 24 November and started re-attending the Day Hospital. However, he continued to visit the inpatient department to see Loma.

4.10 Loma's discharge planning meeting on 23 November was attended by the mental health team including Dr Joseph (her consultant during the inpatient stay), Dr Singh, Jackie Platt, Ray Baxter (the Ward Manager), a mental health social worker and a staff nurse. Trish Wilson, the learning disability social worker who had helped her in the past, was also present, delegated by her line manager to attend on a one-off basis, though this was not understood by others at the meeting who saw Trish Wilson as Loma's allocated social worker. Loma herself was not recorded as being present.

4.11 Although Mrs Thomas considered herself to be Loma's carer, she was not invited to the discharge planning meeting. On one occasion,

Lorna had stated she did not wish her parents to be told about one of her overdose attempts. Her own writings suggest this was because she knew how her mother would react, having taken away all her pills on a previous occasion, for fear that a suicide attempt might succeed. Unfortunately, this was taken by some staff to mean Lorna wanted no contact at all with her parents, which, to judge by her own writings, was clearly not the case.

RECOMMENDATION 14 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that there is an express recognition of the need to engage service users and carers as far as possible in the planning and delivery of care and after care. Service users and carers should be active participants in the assessment of need, planning, treatment, risk assessment, discharge and follow-up support. Special consideration should be given to home circumstances. The views of service users and carers should be sought and recorded.

4.12 It was considered that Lorna's mental state had improved but she did not wish to go back to her flat. It was felt that she would not fit into a group home but that she could perhaps be treated as homeless and an application would be made to a hostel. It was decided to discharge her to her flat and that she should wait for her psychotherapy appointment while living there. Trish Wilson would attempt to find alternative accommodation and Jackie Platt, who was identified as Lorna's Community Support Worker, would visit regularly. No further meeting was scheduled to finalise arrangements in spite of the fact that a five-day gap was envisaged before Lorna's discharge.

RECOMMENDATION 17 : The Milton Keynes Community NHS Trust should ensure that where an intended discharge is delayed for further consideration a full review meeting is held immediately prior to the discharge taking place. All documentation should contemporaneously record the discharge process. Once an inpatient is discharged, action should be taken to ensure greater clarity of responsibility than exists at present.

4.13 Later the same day, Trish Wilson contacted the Housing Department but was informed that Lorna could not be declared homeless as she was "adequately housed". The Housing Department appeared to

take no account of the particular circumstances of the case. Trish Wilson also contacted Carr-Gomm, a voluntary organisation providing residential facilities for people with mild learning disability, but they had no vacancies.

4.14 The Inquiry Panel considers that there should be greater links between the Housing Department, Social Services and health agencies to enable the Housing Department to take account of assessed dependency and support needs when deciding on options for housing. This would allow for appropriate support to be built in.

RECOMMENDATION 37 : The Milton Keynes Council should review its housing policies in order that more effective consideration can be given to the health and social needs of individuals when deciding on the merits of a request for rehousing.

4.15 Loma started to spend even more time with Nicholas. According to the nursing notes, she visited his home on 25, 26 and 28 November; and met him on 27 November. He also visited the Campbell Centre. She revealed the sexual nature of the relationship to staff at the Campbell Centre and was counselled to be careful. She continued to be fearful of discharge and social isolation. This was then followed by an attempt at self-injury with a knife on 26 November, in the kitchen of the Campbell Centre.

4.16 Loma expressed concern about her emotional involvement with Nicholas and felt that she would "be taken advantage of". Both were counselled by ward staff about the risks of forming a relationship in their vulnerable state, but the view of staff generally was that they were consenting adults and informal patients, therefore, staff could not intervene. It should be noted that this judgment was made by staff without training in learning disabilities. There was no reference to this budding relationship at the meeting on 23 November in spite of the fact that several of those present were aware of it and of Loma's extreme vulnerability. Social Services colleagues were not informed of this relationship.

RECOMMENDATION 6 : The Milton Keynes Community NHS Trust should review its policies regarding relationships developing between inpatients in psychiatric units, especially in relation to people with a learning disability. Assessment of mental capacity to give valid consent and vulnerability in sexual relationships may require the individuals concerned to be separated or protected in some way. Relevant training of staff should take place.

4.17 It is clear from the evidence that Lorna was deeply unhappy and depressed about being discharged back to Granby Court where she felt lonely and vulnerable. She said so on many occasions with her usual lucidity : "it's living on my own that I can't cope with in a cruel world with a load of uncaring and heartless people who don't give a toss". But staff recorded that she was "accepting of discharge with the understanding that more appropriate accommodation is being sought".

4.18 The Care Programme envisaged for Lorna in the community was intended, firstly, to find her alternative housing, and, secondly, to provide in Dr Singh's words, "a supported day activity that would take her out of her flat for the best part of the day and where she could socialise as well" and it was felt that this could best be achieved at Keystone, to which he had tried unsuccessfully to refer her in October.

4.19 According to the contemporaneous notes of one of those present, Dr Joseph made the suggestion at the ward meeting on 23 November that Lorna might attend the Campbell Centre Day Hospital as an interim measure as there was likely to be some delay in obtaining a place for her at Keystone. The Day Hospital is situated adjacent to the inpatient unit and receives referrals from the staff of the admission unit as well as from GPs, consultant psychiatrists and other mental health professionals. This is followed by an assessment carried out by the Day Hospital staff.

4.20 There may have been some uncertainty about the need to refer to the Day Hospital, since even as late as Monday 27 November, her Campbell Centre keyworker, Nurse Julie Lockwood, who was not at the meeting on 23 November, noted that they were "awaiting Dr Joseph to come and see if she needs referral to day hospital before discharge". In the event, Ray Baxter, Ward Manager, Campbell Centre, took the positive step and made the referral to the Day Hospital on 28 November with a diagnosis of "mixed developmental disorder" and "personality disorder", for assessment regarding her "inability to cope with relationships, feelings of worthlessness, frustration, temper tantrums and manipulation". There was no mention of her continuing distress over the alleged rape. In view of the fact that referral to the Day Hospital appears to have been intended as a means of giving some content to her days while waiting to attend Keystone and this was stated at the meeting on 23 November, it is perhaps surprising that there was no explicit indication of urgency about this referral.

4.21 The Inquiry learnt in evidence that patients were usually referred to the Day Hospital for separate assessment as to whether that provision was relevant to their needs and that it could take several

weeks to achieve this assessment. However, if a case was known to be urgent and that fact was conveyed to the Day Hospital managers, assessment could be carried out while the individual was still an inpatient of the Campbell Centre; and in such cases transfer from the Campbell Centre to the Day Hospital could be immediate. Unfortunately, no such recommendation was made in Lorna's case and Lorna had not been assessed at the Day Hospital by the time she died. It is the Panel's view that a five-week delay in assessment is unacceptable in any circumstances.

RECOMMENDATION 21 : The Milton Keynes Community NHS Trust should ensure that every attempt is made to assess referrals to the Campbell Centre Day Hospital promptly. If the allocated assessor is not available for any reason, the assessment should be made by another qualified staff member with the minimum of delay.

RECOMMENDATION 22 : The Milton Keynes Community NHS Trust should ensure that all referrals to their services, or requests to different parts of their services, clearly indicate the degree of urgency. There must be clarity about the consultant who is to be responsible for the care of the individual.

4.22 As a further element of support for Lorna in the community, Dr Singh had proposed that she should have regular weekly psychotherapy sessions with Brenda Luckock, a trainee psychotherapist, who was due to start work in his team in December. On 29 November, Dr Singh rang the ward to confirm that an appointment had been made for Lorna to see Ms Luckock on 12 December. It had also been agreed that Jackie Platt would resume her weekly contacts with Lorna, but not until the New Year as it was expected that Lorna would be occupied with the Day Hospital until then; an appointment had been set for Jackie to see Lorna on 8 January 1996.

4.23 All these elements together represented what could have been a comprehensive and satisfactory initial Care Programme for Lorna on discharge, giving her the help and support that she needed. In practice, however, apart from the sessions with Brenda Luckock, the package did not materialise.

RECOMMENDATION 12: The Milton Keynes Community NHS Trust should ensure that the Care Programme Approach leads to the appointment of a care co-ordinator who has responsibility for ensuring that the care plan is individualised, effective and timely, also that it is implemented and regularly reviewed.

CHAPTER 5 : At the Campbell Centre - Nicholas Arnold

5.1 Nicholas Arnold was admitted to the Campbell Centre at 11:30 p.m. on 11 November 1995. Earlier, the Police had been called by neighbours to his flat. Nicholas had been banging on the walls with a hammer but when neighbours went to see what was amiss, he said he thought other people were in the flat and that one of them had been hammering on the wall. He said that he believed everyone was trying to get him and he had set fire to a work surface in the kitchen by putting a red hot kettle on it. He had seemed unaware that the work top was on fire. He told the admitting doctor that he felt he was being pulled into something that he did not want to do and voiced ideas of wanting to end it all. He talked of believing that "they" wanted to put him away.

5.2 It was difficult for the admitting doctor to get a proper history because Nicholas was obviously seriously intoxicated. He reeked of alcohol, his face was flushed, his clothes soiled, his speech slurred, he used a great deal of foul language and was unsteady on his feet. He told the doctor he did not remember hammering on the wall and seemed unaware that he was in hospital. During his interview he seemed to have difficulty in holding his head up and made no eye contact with the doctor and nurse. He talked of drinking heavily 24 hours a day and said that he was an alcoholic. He also told them that he had been attending the psychiatric day hospital.

5.3 In spite of a clear admission policy which suggested that intoxicated individuals should not be admitted, Nicholas was admitted as an informal patient to the Campbell Centre, under the care of Dr Strangeway, and placed on level 3 observations, i.e. nurses should check his whereabouts, activity and mental state every five minutes. He was too intoxicated to co-operate with a physical examination, his gait was extremely unsteady and he had to be assisted by nursing staff to undress before getting into bed.

5.4 By late the following morning he had sobered up quite well and had not been showing any signs of paranoia. A junior doctor was able to examine him physically, no serious abnormality being noted. The

doctor then made a number of observations which were recorded in a bizarre fashion and look more like rough notes than a case record. No attempt was made to obtain a comprehensive history, as is normally expected when an individual is first admitted to a psychiatric inpatient unit. A good history had been obtained by a previous SHO when Nicholas attended the outpatient clinic, but this was not referred to and from evidence given to the Inquiry, it is doubtful if it was available for reference during the inpatient episode. Although a later note gave a little more information, it has to be said that the medical note-keeping throughout the admission was poor. The Inquiry heard that many of the SHO's were in their first post in psychiatry. In view of the very heavy clinical load, it appeared to Panel Members that the posts in general psychiatry might be more suitable for doctors who have already had some psychiatric experience, rather than new recruits, and the Trust should give some thought to this issue.

5.5 Nicholas told the doctor that he was liable to become frightened and "wound up" easily and that outside hospital he felt paranoid and thought that he might be attacked; and that this had happened on occasions when he had been drunk. On the other hand, alcohol seemed to ease his frightened feelings. He claimed that a neighbour had shouted at him and hammered holes in his door after he had disturbed him. In contrast to his remarks the previous evening, he said that he would rather live than die. He admitted that when he started drinking he lost count of the number of drinks he had had, that he became noisy in these circumstances and that the neighbours then became annoyed with him. He also admitted his chronic intake of Chlordiazepoxide (Librium – a tranquilliser) and Zopiclone (a sleeping tablet) , but also stated that he could go weeks without drinking. When asked whether he had ever had any involvement with the Police, he said "no". The examining doctor concluded that the paranoid ideas were probably justified rather than delusional and that he was a binge drinker with dependency symptoms which encompassed minor tranquillisers as well as alcohol. He was taken off observations and allowed to go with his mother to collect some belongings.

5.6 By 14 November Nicholas appeared settled enough on the ward to be allowed to go out of hospital alone to pay some bills. According to the notes, on the same day he was able to tell the team doctor that he had become very upset when his girlfriend, with whom he had had a relationship for eight years until that April, had married somebody else the previous Saturday. He admitted drinking bottles of sherry the previous Thursday and said that he had continued to drink cans of beer the following day. He claimed that people living down the road had been shouting at him and calling him "mad". He had started to shake and drank more and more to try to get rid of the shaking. He remembered having put the kettle on the cooker to make tea but said

he had forgotten about it so that it boiled dry. The handle of the kettle caught fire and it was when he took it off the cooker and put it onto the worktop that it also was set on fire. He seemed to have amnesia for subsequent events. However, he told the doctor that he did not think the counselling with Trevor Plumb at Pegasus had helped him and he did not like the other people who attended there. He also spoke of AA attendees making him nervous.

5.7 At a ward round on 16 November, at which Dr Strangeway was present, Nicholas claimed that a neighbour from downstairs had hammered on his door and had been verbally abusive to him three weeks earlier. He said that he drank in order to calm his anxiety and that he really did not want to drink. For the future, he wanted to move out of Milton Keynes and go to London, where he believed that there was work to be found. He claimed to feel frightened of going back to his flat.

5.8 It was decided on that day that he should be discharged on 24 November. The following day he went out on overnight leave. Meanwhile, he had been taking part enthusiastically in ward group activities and seemed relaxed and settled, according to the nursing reports. On 17 November, he attended a Creative Art Group and seemed to interact well and appropriately. After a brief note in the medical records on 17 November, there is no further entry until 23 November. The Inquiry Panel could find no valid explanation for this omission.

5.9 Nicholas went on overnight leave from 17 to 18 November, but did not return to the ward until 6:15 p.m., too late to meet some AA members who had come to see him on the unit. He was noted to have been drinking and told staff that his drinking friends had arrived at his flat and that he was scared that they would continue to encourage him to drink on discharge. The night nursing report records him being very friendly with Lorna Thomas and that they socialised together for long periods.

5.10 On 19 November, Nicholas asked for day leave but instead of returning by 12:00 noon as promised, he did not arrive until just before supper time. There was no evidence of intoxication on this occasion. On 21 November he went out to the shops with Lorna at 6:30 p.m. and returned 45 minutes later. He appeared sober, but Lorna was "obviously intoxicated". He claimed to have lost her during the shopping trip and also that she had been drinking when he found her again.

5.11 On 22 November, he attended the first session in an eight-week course of relaxation treatment at the Day Hospital which he intended to continue after discharge. On the afternoon of 22 November, he

was reported to have been spending time with Lorna, who subsequently approached staff claiming that he had assaulted her. Several of the nurses spoke to Nicholas and it was concluded that Lorna had misinterpreted his attempts to comfort her and that he had stopped hugging her when she asked him to. It is noteworthy that, in spite of Loma's concern, she subsequently spent much of the evening in his company and that this continued the following day, in spite of nursing advice to limit their time together. **(See Recommendation 6, Pg. 59)**

5.12 Surprisingly, this growing relationship does not seem to have been mentioned at the Care Programme Planning meeting for Nicholas which took place in the course of a team meeting on 23 November and was attended by Dr Strangeway's SHO Dr F Nazir, Paul Conboy, CPN , T Cox, Staff Nurse at the Campbell Centre, C Castey, CPN and Nicholas Arnold himself. The Panel learnt that Dr Strangeway had gone on leave and therefore consultant responsibility for Nicholas Arnold's care fell to Dr Joseph, but there had been no formal handover or exchange of information about him prior to Dr Strangeway's departure because "Nicholas was not a particular cause for concern" .

5.13 The meeting confirmed the decision to discharge Nicholas the following day, he was to be sent an outpatient appointment for four weeks later and to re-commence attendance at the Day Hospital for group work. He was also to attend AA. Although Julie Lockwood had been Case Co-ordinator on the ward, there was no new community Case Co-ordinator designated. Nicholas is recorded as subsequently spending the evening until 1:00 a.m. next day in the company of Lorna Thomas. After attending some occupational therapy groups, he left the inpatient unit at 2:00 p.m. on 24 November.

Medication During Admission

5.14 Nicholas was treated with a reducing dosage of Chlordiazepoxide 30 mgm four times daily for the first three days, followed by 20 mgm four times a day for the next three days. After a day for which no Chlordiazepoxide was written up, he was subsequently prescribed Chlordiazepoxide 10 mgm four times a day and was discharged on that dosage. During the first 36 hours he also had some additional dosages of Chlordiazepoxide (10 mgm) and although prescribed Temazepam on an "as necessary" basis, in fact he took it every night, mostly in dosages of 20 mgm.

CHAPTER 6 : After the Campbell Centre - Lorna Thomas

6.1 Lorna was discharged from the Campbell Centre on 29 November 1995 and Trish Wilson, the Disabled Living Adviser previously involved, was informed. From the moment of her discharge there seems to have been confusion and uncertainty about who would be Lorna's keyworker in the community, responsible for co-ordinating her after care. Ray Baxter rang the Trust's Community Learning Disability Team on 29 November to ask if it would be appropriate for Jackie Platt to be the keyworker. Anthony Chiari, Jackie's line manager, replied that he was unhappy about this. As Jackie was not qualified in this field, this would be "more than her remit" and would therefore be "inappropriate". Also, Jackie would not be available for several days. Anthony Chiari said in evidence that he perceived Lorna as having more of a psychiatric, or emotional, problem than a learning disability, and considered that the keyworker, therefore, needed to be "somebody with experience in the mental health field".

6.2 However, later on 29 November 1995, Anthony Chiari telephoned the social workers to say that the keyworker issue was not as urgent as he had thought, as Dr Singh had arranged psychotherapy for Lorna every Tuesday. This reduced Anthony Chiari's concern about Lorna having adequate psychiatric support, though, in fact, as we have heard, the first session was not scheduled till Tuesday 12 December 1995.

6.3 The question of a keyworker was left in the air, though Anthony Chiari was still clear in his mind when giving evidence that Jackie Platt was not to be looked on as the keyworker. In his view, this type of dual need, part psychiatric and part mild learning disability, sometimes led to difficulties over who should co-ordinate care. The allocation of the keyworker would have been Anthony Chiari's duty if it had been purely the responsibility of the Community Learning Disability Team. However, it is the Panel's view that the question should have been resolved.

RECOMMENDATION 13 : The Milton Keynes Community NHS Trust should ensure that the respective roles, responsibilities, grades and competencies of named nurses, keyworkers and care co-ordinators are reviewed and clarified, including the extent of the responsibility to ensure delivery of services to individual patients.

6.4 Dr Joseph, on the other hand, had no doubts in his mind, both at the time and in evidence, that he was handing Lorna back to the overall care of the Trust's Community Learning Disability Team, and to Dr Singh, when she was discharged from the Campbell Centre, and that his clinical responsibility transferred across when she ceased to be an inpatient.

6.5 Also, on 29 November, Shirley Chamney, Senior Care Manager of the Social Services Mental Health Team, telephoned the Social Services Adult Disability Team, whose responsibilities included Social Services community support for learning disability patients, to say that the "Care Programme Approach discharge, like Community Keyworker, is the responsibility of Health and Social Services" and as "Lorna did not have a mental illness. Need is a social one. Would need help from the Adult Disability Team". This call was taken by Trish Wilson, and the message passed on to her line manager, Sheila Taylor, Senior Care Manager of the Social Services Adult Disability Team.

6.6 However, the Adult Disability Team managers had determined, early in their dealings with Lorna, that she had a low priority for social work input and that her case did not warrant an allocated social worker. This view was maintained after her discharge, and it was decided that her social work needs would be met on an *ad hoc* basis by the duty team. The Inquiry heard evidence that only by the time of her death were the Adult Disability and Mental Health Social Services becoming aware of the increasing level of Lorna's difficulties.

6.7 The Trust's Community Learning Disability Team clearly had some concern that confusion existed about Jackie Platt's role, and Anthony Chiari set up a meeting for 17 January 1996. Dr Singh perceived this meeting as being intended "to try and demarcate the roles of Health and Social Services personnel involved in Lorna's care", in order to resolve the keyworker issue and secure a dedicated social worker for her. Social Services, according to their own records, saw the meeting as being purely "to discuss what support could be offered to help Lorna with her request for re-housing".

6.8 The stark fact remains that no one took on the role of Lorna's keyworker after her discharge. There was a perception among learning disability staff that Lorna was suffering from a mental health

problem and was a candidate for mental health services. For their part, mental health staff felt that Lorna had a learning disability and was well known to the disability team and therefore should receive services from that team. These conflicting concerns could not be reconciled before her discharge and so, from the two specialist services of both agencies, nobody took on the clear responsibility of being her key worker in the community. It became clear in evidence that each service thought that some other professional had taken on the responsibility. Consequently, the immediate aftermath of the discharge was a series of disasters for Lorna. **(See Recommendation 12, Pg. 61)**

6.9 Lorna found her first day back in the community extremely daunting. By the evening of Thursday 30 November she was found crying and praying in a shop doorway and saying she could not cope with looking after herself, felt let down by everybody and had tried to kill herself. Police were called, and they dealt with the situation by removing her to a "Place of Safety", the Campbell Centre, under Section 136 of the Mental Health Act 1983. Lorna stated she was "angry at being discharged" the day before, and that no one had explained she would have to wait before attending the Day Hospital.

6.10 Nurse Yvonne Roberts, who knew Lorna, received her and referred her to the duty SHO for assessment and to the Emergency Duty Team. The duty Approved Social Worker (ASW), was contacted and he advised that Lorna should be seen by the consultant and an approved social worker. He himself was engaged with another case some distance away and would not be free for some time. Lorna was seen and assessed by a junior psychiatrist, who concluded that she should be discharged and return the next morning, 1 December 1995, to see her discharging Consultant Psychiatrist, Dr Joseph. She was not seen by a Consultant Psychiatrist and an ASW before discharge, as required by the local procedures for Section 136 arrangements.

RECOMMENDATION 23 : The Milton Keynes Community NHS Trust , the Milton Keynes Council and Buckinghamshire County Council Social Services Departments, working with Thames Valley Police, should ensure that their staff follow local Section 136 procedures. There should be a system of monitoring and clinical audit of the handling of Section 136 episodes, the results of which should be included in the annual report of each Authority.

6.11 The following morning, Lorna returned to the Campbell Centre, but Dr Joseph was engaged on other duties. It seems that she talked to other staff members informally and had left the hospital by the time he

was available, but there is no record of this in the notes. Dr Joseph said in his witness statement of 21 February 1996: "She was seen again the following morning and re-referred to the learning difficulties team. No follow-up arrangements were made by the adult psychiatric team, as she continued to be under the care and supervision of the learning difficulties team".

6.12 It was suggested to Lorna by Ray Baxter that she could attend sessions at MIND and it is believed that she visited their Bletchley premises that day, but did not stay.

6.13 On 4 December, Lorna attended her General Practitioner who noted that she was on Fluoxetine (Prozac, an anti-depressant) and felt better for "not taking any more overdoses". She was prescribed more Fluoxetine. The Inquiry noted that the discharge summary for Lorna's inpatient stay (9 November – 29 November 1995) was written on 21 December 1995, just over three weeks after her discharge. There appeared to be no record of any communication to her GP about her subsequent visits to the Campbell Centre or to A & E on 30 November, 1,7 and 8 December. The discharge summary did not explain why she was prescribed anti-depressants and discharged on them when she was diagnosed to have "Mixed Development Disability" and "Personality Disorder" and did not mention any form of depression.

RECOMMENDATION 19 : The Milton Keynes Community NHS Trust should ensure that discharge summaries to GPs are timely and accurate in order to assist in the management of patients after their discharge from hospital. Information must be given to the GP on the day of discharge. Compliance with this recommendation and the quality of subsequent discharge summaries should be monitored through an audit trail.

6.14 The Inquiry noted that the medical records were often illegible, too brief and infrequent. Important events in Lorna's inpatient stay such as her absconding from the hospital and her allegation of indecent assault against Nicholas Arnold, were not referred to in the medical notes. (See also Chapter 14, Para. 14.8).

RECOMMENDATION 34 : The Milton Keynes Community NHS Trust should ensure that a review of arrangements for the clinical management, training and supervision of junior medical staff is undertaken including assessment of record keeping skills; and should introduce a regular random audit of case notes with the results reported back to the medical staff, as well as through the Quality Assurance mechanisms of the Trust.

6.15 On 5 December, Lorna had a meeting with Trish Wilson and a referral to Keystone was made for her. She was shown around and told that she could start attending in January 1996. Her appointment for assessment at the Campbell Centre Day Hospital on 5 December, was cancelled due to the illness of Nurse Bob Must. A new appointment was made for 18 December, but this was also cancelled due to illness and "due to festive season, and the complications this brings for arranging appointments".

RECOMMENDATION 20 : The Milton Keynes Community NHS Trust should ensure that a Consultant Psychiatrist is urgently identified to lead the Campbell Centre Day Hospital and should review the staffing levels to ensure that there are enough staff to maintain the weekly programme whilst allowing for both initial and regular individual assessments and ongoing one to one work when required. Allowance also needs to be made for annual leave and sickness. (See also Recommendation 21, Pg. 61)

6.16 On 7 December, Lorna took an overdose of 94 paracetamol tablets and attended Casualty. Her blood levels were high and she received intravenous treatment. She was discharged on 8 December after being seen by Dr Singh, who simply reassured her and encouraged her to discuss her problems with the psychotherapist on 12 December. She was sent back to her flat. The Inquiry learnt from the trial evidence that one trigger for this attempted overdose was her fear that Nicholas might not wish to continue their relationship.

6.17 Throughout this period Lorna was expressing anger that people were "interfering" in her relationship with Nicholas, and advising him to break it off. He stated in evidence that he felt he could not end the relationship for fear that she would take an overdose. They continued to see each other on an almost daily basis.

6.18 On 11 December, Lorna went to the Day Hospital without an appointment. She was told by Bob Must, who seemed unaware of any urgency or of her overdosing, that he was too busy to see her and that she should return on 18 December. On 18 December her appointment at the Day Hospital was cancelled by telephone. **(See Recommendation 18, Pg. 128)**

6.19 On 12 and 19 December, Lorna was seen by Brenda Luckock who believed that Lorna was troubled and felt unsupported. Brenda Luckock informed the Inquiry that Lorna did not appear to be suicidal during these sessions or at the times she took the overdoses. She felt that Dr Singh was of the same view and that Lorna's overdoses

were "half-hearted". Lorna made a commitment to Brenda Luckock not to attempt another overdose.

6.20 Over the Christmas period Lorna spent two days with her family and appeared to them to be quite happy. She also visited friends. By the middle of the following week she was back with Nicholas and was with him on 28 December when they were joined by a friend of his for a drinking session.

6.21 On 29 December, she was offered a new appointment at the Campbell Centre Day Hospital for 8 January 1996. On Saturday 30 December, Lorna made her way to Nicholas's first floor flat. The events of that evening and night are described in the next chapter. Tragically, Lorna died early on the morning of 31 December 1995.

CHAPTER 7 : After the Campbell Centre - Nicholas Arnold

7.1 Perhaps because Nicholas Arnold had already been attending the Day Hospital from 9 October 1995 and, indeed, had commenced attending a relaxation course at the Day Hospital on 22 November while still an inpatient, his transfer from inpatient to day patient care appeared to go much more smoothly than was the case for Loma. Contrary to the usual procedure, he was allowed to attend a woodwork group on 27 November without being re-assessed first. In addition to woodwork and relaxation classes, he was booked to attend problem solving and gardening groups. The Day Hospital notes seemed to indicate that his attendance was somewhat erratic and this information was relayed to Dr Strangeway at a team meeting on 20 December, which was one of the occasions when Nicholas failed to attend. He did, however, attend the Day Hospital Christmas party on 21 December.

7.2 At the time of his initial interview for the Day Hospital on 28 September 1995, Nicholas reported that he had applied for a housing transfer and, during his attendances at the Day Hospital, he asked for a social worker to help him in this aim, in order to distance himself from drinking friends and to enable him to change his life style. An appointment was arranged for mid-January 1996 with a social worker, Cheryl Cowley, to discuss his housing needs. The Panel heard in evidence that he also requested access to a psychiatrist while at the Day Hospital but was told one was not available.

7.3 It was reported that, although he participated and made contributions in problem solving and relaxation groups, he continued to claim to feel anxious and it was noted that he perspired profusely at times. No smell of alcohol was detected, but his eyes sometimes appeared red and glazed; and during woodwork sessions he was observed to rush into new projects, which were sometimes unrealistic, without due care and consideration.

7.4 After 21 December it appears that Nicholas did not have any further contact with the local psychiatric service. Although he visited his GP's surgery on 28 December, it appears that he merely called to pick up

a prescription and that there was no consultation. All that is known about his mental state at that time, therefore, comes from statements made either to the Police at the time of the trial or to this Inquiry.

7.5 Nicholas and Lorna each spent Christmas with their own relatives, then between Boxing Day and 30 December they spent the time visiting each other's flats. It is not clear how long he remained off alcohol following his discharge from the Campbell Centre, but one of the witness statements collected by the Police described Nicholas and a friend drinking cider together on Wednesday 27 December 1995. The manager of a local off-licence recalled that Nicholas, Lorna and another man had visited his shop on Thursday 28 December, though he did not say what they purchased. It appears that Nicholas and Lorna spent the following night at Lorna's flat and that he remained there until lunchtime on Saturday 30 December.

7.6 Nicholas then went into Milton Keynes central area where it is believed he purchased cans of strong lager and met some friends. When he returned home, his neighbours described him as being "very wound up" and he told them that some friends had been "having a go" at him. He went off to find Lorna, who had arrived at his flat earlier. They returned and spent time playing music and drinking. It is likely that he also took cannabis. When he talked to his neighbour again, Nicholas threatened that somebody would die. The neighbour realised that he was not talking of suicide and he did not specify who might die; she felt bound to warn him about what the likely consequences would be. As his music was causing disturbance he agreed to turn it down and even sent Lorna round to the neighbour at about 8:00 p.m. to check if the volume was quiet enough.

7.7 Somewhere around 9:30 p.m., they went to the off-licence, but because Nicholas was unsteady on his feet the manager would not allow him to buy alcohol; however, he did sell them some lemonade and cigarettes. He described them as both being in a happy mood and remembered Nicholas saying that when they got back to the flat, they would play some music and Lorna would dance to it and take her clothes off. On the way back to Nicholas's flat they called at a friend's home. The friend did not open the door when he saw them outside, because he did not want to go drinking that evening. He observed Nicholas staggering away and, like the off-licence manager, concluded that he was already drunk.

7.8 On their return to the flat, music was played loudly and a short time later Nicholas began shouting. He was described as sounding angry and the shouting was directed towards Lorna. The music stopped but Nicholas continued shouting and swearing, Lorna was heard making squealing noises and crying.

7.9 Shortly after 11:00 p.m. Nicholas knocked on his neighbour's door; he had no trousers or shoes on. He asked his neighbour to call the Police if anybody came knocking on his door later and said that if the Police didn't come, he would deal with it himself and "kill them". The neighbour described Nicholas as being "wound up and drunk" and noticed that he was carrying a very long screwdriver. She asked about Lorna and was told that she was asleep. A few minutes later, crashing and banging started as though furniture was being thrown around, and Nicholas was heard shouting and screaming, words like "slag", "who was it?", "are you just using me?", "who smashed up my f—ing flat?", "I want compensation - £5,000". Another neighbour reported that she had heard a woman crying. The banging and shouting continued and sometimes there were screams from Lorna interspersed with periods of silence.

7.10 The neighbours reported that noisy sessions at night were not unusual at Nicholas's flat; they could occur both when he was alone and when he had company. Eventually, however, at least two neighbours called the Police who arrived at about 2:30 a.m. and spoke to Nicholas. As he did not open the front door, a forced entry was made. He was found to be under the influence of alcohol and Lorna was found with serious head wounds, lying on the floor and covered in blood but still breathing. There was blood all over the flat and over Nicholas. An ambulance was called and Lorna was taken to Milton Keynes Hospital where, despite attempts to revive her, she was pronounced dead at 03:25 a.m. on 31 December 1995. A post mortem revealed that she had suffered a sustained and violent attack over several hours and there were 113 separate areas of injury. Samples taken some hours after the incident showed that Nicholas had 139 mgs of alcohol per 100 mls of blood in his system, significantly over the "drink drive" limit, which is 80mgs per 100 mls.

7.11 By chance, WPC Vandersteen was on duty on 31 December in the early morning. When she heard who the dead woman might be, she agreed to go to Milton Keynes Hospital and was able to confirm that the victim was indeed Lorna Thomas.

PART III : Analysis and Conclusions

CHAPTER 8 : Post - Incident Internal Investigation

8.1 In the week following Lorna Thomas' death Kevin Stanley, Chief Executive of the Milton Keynes Community NHS Trust, and Dr Zapata, Medical Director, initiated an investigation. Dr Strangeway and Dr Singh were asked to start the process. However, although the written brief drawn up by Dr Zapata was explicit, there was no detailed response and the required content of the report was not compiled until 24 March 1996. The incident was first reported to the Trust Board at its meeting on 25 January 1996. Individual papers were prepared by Gerry Cullinan, Director of Mental Health Services, by Dr Singh and Sue Critchley, General Manager, Learning Disabilities Services, and a letter from Dr Strangeway dated 16 February 1996 was considered by the Trust Board on 22 February 1996. At that time, a more detailed report was requested but never received. No comprehensive final report or action plan was ever prepared. There was no further internal investigation.

8.2 In the view of the Panel this was an inadequate response to a serious incident. It is important that all relevant records are secured and that the factual background and implications are considered in depth as soon as possible after an incident occurs, whether or not Police investigations need to take place. The Inquiry team could not identify any changes in practice or matters addressed, directly, as a result of this case. There should have been a detailed internal investigation, possibly with an independent element, and more consideration of this incident by the management of the Trust and Social Services than seems to have occurred. At the very least there should have been an acknowledgement of the failure of the Care Programme Approach and remedial steps should have been taken.

8.3 Both the Social Services Department and the Trust held their respective documentation as confidential to themselves during this Post-Incident Investigation. Neither provided information to the other although a joint meeting, convened by Social Services, did take place. At the Trust Board meeting on 25 April 1996, Kevin Stanley reported that he had met with Dr Strangeway on 3 April 1996 and no

further information would be given. Dr Strangeway told the Inquiry that he had made a full report to the National Confidential Inquiry into Suicides and Homicides and that he did not wish to break the confidentiality of that report. Further briefings were given to the Board in relation to the setting up of this Independent Inquiry. At the time, the guidance in the NHS Executive Guidance Circular HSG (94)27 was being followed. This Circular specifies in paragraph 33: *"if a violent incident occurs it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event, action by local management must include: an immediate investigation to identify and rectify possible shortcomings and operational procedures with particular reference to the CPA. Where court proceedings in relation to the incident have started or are thought likely, legal advice should be sought with a view to ensuring the investigation does not prejudice those proceedings."*

8.4 The internal investigation set up by Milton Keynes Community NHS Trust did not follow that guidance in full. It did not amount to an immediate investigation or have any independent element, and it did not publish any interim report or action plan. At a later date (1997) an Incident Policy was introduced by the Milton Keynes Community NHS Trust Mental Health Directorate.

RECOMMENDATION 30 : Following a serious incident involving patients currently receiving care and treatment, the Milton Keynes Community NHS Trust, in addition to following national guidance, should appoint an incident officer to liaise on a multi-agency basis to ensure collection and retention of all relevant records and press material. A comprehensive review should take place and an action plan be devised and implemented.

8.5 The Health of the Nation document *Building Bridges* issued in March 1995, sets out more detail on the process of audit and Inquiry, and this is also supplemented by the regular reports in *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* The National Inquiry, whilst a vital element in ensuring that homicides are prevented, should be supplemented by detailed, multi-disciplinary audits locally.

CHAPTER 9 : Assessments
- Lorna Thomas

9.1 In order to consider the quality of the assessments made in the cases of Lorna Thomas and Nicholas Amold, it is helpful to look first at the generally accepted standards and processes for assessment in use nation-wide.

9.2 The purpose of an assessment usually determines who does the assessment, which in turn determines the nature of the assessment carried out.

ASSESSMENT OF NEED IN LEARNING DISABILITY

9.3 This is usually carried out to determine eligibility for services. If an individual is eligible, the needs identified determine the nature of services considered necessary for that individual. When children either attend special schools or have a statement of special educational need, even in a mainstream school, they are entitled to an assessment of need as they prepare to leave school. This should be carried out jointly by the Education Services and Social Services, and be a global assessment covering educational, vocational, recreational, social and health needs. Information is usually obtained from school records, school staff and other sources. Following this, a decision is made about the need for a service and the nature of the service to be provided. As this process is meant to be carried out for all children with special needs, it can happen that it is done by staff who may not have previous knowledge of the child. So the assessment may not always incorporate all the information about the child nor take into account the views of all professionals or carers who may be involved with the child. If the individual is offered a service, then any significant omissions from the needs assessment may be rectified and the service suitably modified to meet the person's needs.

9.4 If, however, it is felt that the individual is not eligible for a service, or that the required service is not available and thus not provided, it becomes much more difficult for the individual to access a service

subsequently, if their needs change. This is, firstly, because the individual may have no contact with any services and there may also be no professional involved who can be called upon to respond. Secondly, once an individual has been declared ineligible on account of not having a significant degree of learning disability, it is, in practice, difficult for this position to be reviewed. This is because the degree of learning disability in an individual is considered by some practitioners to be relatively fixed, although this is not the view of the Panel.

Psychiatric Assessment

9.5 The purpose of a psychiatric assessment in a person with learning disability is to determine the nature of any psychiatric, developmental or behavioural disorder suspected. It is also concerned with looking at the physical, psychological and environmental factors causing or contributing to the primary problem. The process usually consists of the psychiatrist obtaining a comprehensive history from the individual, their carers, professionals and other significant people involved with the client. This is followed by an assessment of the mental state (attention and concentration, memory, orientation, mood, thought process and content, perceptual abnormalities, volitional disturbance and insight). This is supported by a physical examination. Depending on the abnormalities suspected or detected, further testing (e.g. of the blood) may become necessary.

9.6 The psychiatrist needs to assess the nature of a psychiatric disorder if present, developmental abnormalities (such as the presence of autistic traits), degree of intellectual disability (mild, moderate, severe), presence of physical disorders (e.g. epilepsy, Down's syndrome, thyroid disease, dementia) and environmental and psychosocial factors (e.g. bereavement, homelessness, institutionalisation). Only after this multiaxial assessment is completed is it possible to draw up a comprehensive treatment plan that deals with all the problems highlighted.

Risk Assessment

9.7 Risk assessment and management is an essential and ongoing part of high quality mental health care for people with learning disabilities. It is not a form filling exercise but a dynamic process in which all service providers must participate by carrying out, sharing and recording the assessment of risk. Some of the common questions which should be asked in order to obtain a risk profile in a person with a learning disability are shown in the box below. The list is not exhaustive but forms a useful tool for screening for risk in a clinical setting.

9.8 **Assessing Risk**

Abuse by others	YES / NO
Self Neglect	YES / NO
Coexisting autistic traits	YES / NO
Self-injury, overdose	YES / NO
Suicidal ideation or threat	YES / NO
Unacceptable social or sexual behaviour	YES / NO
Fire setting	YES / NO
Aggression or violence to staff or carer or other	YES / NO
Alcohol or drug abuse	YES / NO
Destruction of property	YES / NO
Paranoid delusions or command hallucinations	YES / NO
Severe mood abnormalities or swings	YES / NO
Coexisting personality disorder, hyperactivity	YES / NO

9.9 A positive answer to any of these questions represents the presence of clinical risk. Other significant factors include history of poor compliance with treatment, recent discharge from hospital, having been detained under the Mental Health Act, suffering from certain types of personality disorder especially with prominent paranoid, emotionally unstable, impulsive and psychopathic traits. Risk factors are further exacerbated if the individual has poor social and family support networks. At the end of risk assessment a judgment needs to be made about the complexity of the problems faced by the individual with a learning disability, the consequent complexity of the service needed and the risk to and from the individual.

9.10 Once the risk assessment is done and a decision is made to proceed

with the Care Programme Approach, care planning must be carried out.

Assessment of Capacity

9.11 The determination of intellectual capacity is a fundamental part of the assessment of an individual with learning disability as it provides a measure of the degree to which an individual is able to process information, make choices and decide autonomously on a course of action. It is an important consideration in deciding if an individual can give, or withhold, informed consent for any action that they may be asked to perform. Some underlying principles in determining mental capacity and the ability to give consent are worth mentioning.

9.12 In people with a learning disability, intellectual development may continue for a longer period of time than in the general population. So, a person deemed not to have capacity at one point in time might develop capacity, even ten years later.

9.13 Secondly, the ability to give consent may depend on the complexity of the task. Hence, while an individual may be able to decide on a particular course of action they wish to take, based on a simple choice such as choosing a pain killer, they may find it difficult to weigh up multiple treatment options, for example, for a suspected malignancy. Similarly, they may be able to understand the short-term consequences of actions but may find it more difficult to appreciate long-term consequences.

9.14 Another consideration is that multiple carers and professionals may have multiple views about the individual's capacity. It can be difficult to arrive at an objective view when taking into account conflicting statements.

9.15 A final consideration is that an individual may have significant communication problems which may give a misleading impression of capacity.

ASSESSMENT OF LORNA

9.16 When Lorna was initially assessed by Dr Singh in 1992 at the age of 18, he considered her to be "at the borderline of learning disability" with behavioural problems, arising mainly from her inability to establish satisfactory relationships, and leading to aggressive outbursts. This assessment appears to the Panel to have been fair at the time and was based on Dr Singh's belief that Lorna did not have a chronic enduring psychotic or depressive illness and not only on her

level of intellectual functioning. However, when she started having problems at home and eventually had to leave, and later when she reported being a victim of sexual assaults, a fundamental reassessment was not undertaken.

9.17 Dr Singh saw Lorna a few days after the first alleged sexual assault, but there is no mention of it in the notes. Loma may have been reluctant to mention it to him; however if it was known to him, this episode should have heightened his concern about Lorna's vulnerability. Similarly, when she started taking multiple overdoses and suffered from low moods, this was not incorporated into a comprehensive assessment to review her service needs, although in 1995 Dr Singh did express considerable concern over her need for support, but was prevented from referring her himself to the service she needed. Repeated holistic assessments might have produced a more complete list of needs and therefore a more complete service response.

9.18 In spite of the high number of risk factors indicated in Lorna's history (abuse by others, self-injury, overdoses, suicidal threats, unacceptable social behaviour, aggressive behaviour, destruction of property) no formal risk assessment was ever undertaken for her and these factors remained unacknowledged. The alleged sexual assaults seem to have been brushed aside by both health and social care services, and it was not until the Panel examined the Police records and interviewed the Police officers involved that we became aware of the seriousness of what had happened to her. It is not surprising that, despite the support of her family, she felt at times that no one cared. Because of this failure to re-assess her increasing needs and deteriorating state, the Panel concluded that Dr Singh was mistaken in saying, in his report dated 24 January 1996, that "in view of her assessed mental needs, Lorna got a service over and above that which her actual needs justified", or that "in terms of the care programme approach Lorna's needs were low priority".

RECOMMENDATION 1 : The Milton Keynes Community NHS Trust should ensure that people with learning disability are automatically reassessed at regular intervals using the WHO recommended multiaxial system of diagnosis to record diagnoses in their psychiatric, developmental, intellectual, physical and psychosocial domains. Life events, changing clinical presentations (including frequent contact with services) and regular risk assessments should trigger a CPA review. The Department of Health and Royal College of Psychiatrists should consider issuing appropriate guidance to all Mental Health and Learning Disabilities Services on this issue of regular re-assessment.

9.19 It is clear from careful examination by the Panel of the information on Lorna Thomas, kept separately by hospitals, Education Departments, Social Services Department, Housing Department, GPs and Police, that there were substantial grounds for a multi-agency case conference about Loma's complex needs. Tragically, it seems that this may only have been beginning to be recognised by the key agencies after her discharge from the Campbell Centre on 29 November 1995. A meeting was scheduled for 17 January 1996, over two weeks after her death, although it must be noted that this was perceived by the Trust as being to deal with demarcation issues and by Social Services, according to their own notes, as concerned solely with re-housing.

9.20 There seemed to be no agency which took the lead in reviewing her care needs in a holistic manner. Dr Singh is to be commended for maintaining the most contact with Lorna in spite of his being single-handed and her being seen as "marginal" to the service.

9.21 Lorna did not receive a Social Services assessment of need on leaving school in July 1991. The Inquiry heard in evidence that it was not the policy to consider pupils leaving White Spire School for assessment unless they were specifically referred for the attention of Social Services by the school. As already stated, Lorna's school records no longer exist, so it is not possible to know whether any such referral was made. Her initial contact with Social Services a few months later led to the view that her degree of learning disability was not sufficient to warrant the provision of services. Later, when her family applied for help with housing in 1994, the decision made by Buckinghamshire Social Services, that she was not entitled even to a community care assessment, on the grounds that she had "only a mild learning disability", appeared to be based solely on the fact that she had attended White Spire School, a "mild learning disability" establishment. No other information was sought or obtained and no account seems to have been taken of the trauma Loma had suffered the year before.

9.22 Sheila Taylor, Senior Care Manager for the learning disability social workers, explained in evidence:

> "In Lorna's case I recognised her already, from previous involvement, as being somebody who had a mild learning disability and made a judgment, by myself, that it was appropriate for the matter to be dealt with on a duty basis. ...
> I ... thought that I knew enough about Lorna to take that decision by myself and to ask that Trish should do a piece of duty work on the problem that was being presented, which was her need for housing ... .We dealt with what was being asked of us rather than looking further.

It did not appear to me, at that stage, that her emotional needs were significantly greater than a lot of other young people who had problems with their parents, had mild learning disabilities and things like that .... I do not remember Lorna standing out in that category".

9.23 She was, therefore, considered not to reach the minimum threshold established by the Social Services Department to define eligibility for a financially constrained service. This judgment was made by the Senior Care Manager without the benefit of formal assessment, consideration by the normal referral group or input from any other agency. The Panel believes this was unacceptable. Lorna's experiences in 1993, and other risk factors in her history, should have influenced the decision about her level of need, and re-assessment at this point would almost certainly have moved her to level 2 of CPA (see Chapter 15). This would, in turn, have ensured a keyworker in the community for Loma with direct responsibility, according to the joint policy document *The Care Programme Approach, Care Management and Supervision Register Policy:*

"(i) To keep in regular contact with the client
(ii) To monitor that the agreed programme of care is delivered
(iii) To take immediate action if it is not, for whatever reason."

9.24 The decision not to undertake a community care assessment, under Section 47 of the NHS and Community Care Act 1990, even after the alleged serious sexual assaults were reported in 1993, and the decision not to allocate a social worker or care manager meant that there was to be no continuity or longitudinal view of Lorna's changing needs. Trish Wilson should be commended on her commitment to maintaining what contact she could with Lorna, whom she perceived as needing an environment with consistency of therapy and counselling, but she was told clearly that Loma's needs were not seen as "core business" for the Social Services Learning Disabilities Team. The series of "one off" contacts with various professionals, duty officers, approved social worker and hospital mental health social worker never triggered a case review which could have been the start of effective multi-agency intervention.

9.25 Lorna was not denied services, but the decision was to "deal with her on a duty basis". As this was described to us, this meant that Lorna could see a social worker (or care manager, as they were re-designated) by calling in at one of the offices, which she did on occasions. Her needs would then be addressed by the duty officer, who would assist by "signposting" relevant services. This, we were told, meant that her problems with benefits, housing or health related issues were dealt with by facilitating her contact with the appropriate agency. In this way her application for housing was completed by

Trish Wilson who helped Lorna with the application form which led, eventually, to her being allocated the flat at Granby Court.

9.26 The issues involved in raising the threshold of eligibility criteria to focus Social Services resources upon those with greatest need, in line with central government guidelines, were addressed at length in the report produced by the Buckinghamshire Social Services Department, *Living Within Our Resources* (1995), (see Chapter I). The *Longcare Inquiry Report* (1998), which examined Social Services provision in Buckinghamshire in 1995, noted that Buckinghamshire had, in fact, done more work around eligibility criteria than many other authorities and its approach was highlighted by the Audit Commission in *Balancing the Care Equation, Progress within Community Care* (1995)

9.27 In summary, therefore, although Lorna's initial assessments seemed reasonable, no attempt was made, either by the NHS or Social Services, to re-assess her formally in the light of changing circumstances. This failure was unacceptable and led to her having inadequate support in the community. Attempts to achieve appropriate care and treatment for her were blocked by insufficient provision of psychological services, by a bureaucratic referral system and by resource restraints on County Council staff.

CHAPTER 10 : Assessments
- Nicholas Arnold

ASSESSMENT FOR GENERAL PSYCHIATRIC PATIENTS

10.1 Whilst needs assessment is clearly of paramount importance in those thought to have a learning disability and is something which is often undertaken quite separately from any clinical assessment, in those not having a learning disability a needs assessment would usually form part of a clinical assessment, either in the inpatient or outpatient setting.

10.2 Patients would normally be routinely asked about their living arrangements and, where appropriate, their ability to look after themselves and their coping skills. Sometimes, physical presentation or doubts about level of functioning may lead to requests for a practical skills assessment, usually undertaken by an occupational therapist once the overt symptoms of mental illness are under control. This, in turn, may subsequently trigger referral to a specific unit where rehabilitation is carried out either on an inpatient or outpatient basis. In some cases the learning of inter-personal skills may be as important as the acquisition of practical skills in paving the way for a successful life in the community and usually forms part of the programme in a rehabilitation unit, but may also be taught in a Day Hospital or outpatient setting, usually with some input from a clinical psychologist.

10.3 With patients who abuse alcohol, domestic circumstances may additionally govern whether detoxification is possible at home. This would normally necessitate the presence, at least intermittently, of a responsible person to keep an eye on the well-being of the individual being treated in between visits from the community nurse; and who can summon additional help and make sure the basic needs of the patient are met, especially in the early stages when heavy sedation and residual effects of alcohol may make it difficult for the patient to undertake tasks such as preparing food for themselves.

Clinical Assessment

10.4 Ideally, a full psychiatric history should be taken from every patient attending a psychiatric facility for treatment and whilst this may be difficult in the acute phase of many psychiatric illnesses, every effort should be made to complete the information as the patient's condition improves. In the meantime, information should be sought from relatives and friends wherever possible.

10.5 In the case of those suffering from the effects of alcohol or drug abuse or where these conditions are suspected to be contributing to or co-existing with another psychiatric illness, detailed additional enquiry needs to be made regarding the history of abuse, its pattern of occurrence, the presence or absence of possible physical or psychological complications and the effects the abuse is having on family, social and sexual relationships, work and finances. Additionally, the occurrence of frequent minor injuries or visits to A & E departments may be found. Enquiry into criminal records will often reveal convictions for motoring offences, petty theft and aggressive behaviour, both towards property and people. A physical examination normally forms part of a comprehensive clinical assessment for general psychiatric inpatients, and may also be done for outpatients, although the time constraints in clinics may necessitate special arrangements being made. The findings of such an examination may help to confirm a diagnosis and/or point to the need for laboratory investigations, brain scans or other tests. Sometimes, the history itself may prompt such assessments.

Risk Assessment

10.6 To some extent this has always formed part of the clinical examination of mentally disturbed individuals and perhaps this is nowhere better evidenced than in the detention papers for compulsory admission to hospital. Even under the 1959 Mental Health Act, medical practitioners were required to assess whether, in addition to suffering from mental disorder, the patient ought to be detained either in the interest of the patient's health or safety and/or with a view to the protection of other persons. More recently, under the 1983 Act, the functions of health and safety have been separated, but essentially at least one of the three must be present. Of course, the fact that a patient may be treated informally quite successfully, either as an inpatient or outpatient, does not necessarily remove them from the possibility of harming themselves or other people, either with or without intent, and the concept of risk assessment is an attempt to estimate the size of the problem in any particular individual.

10.7 In order to do this, a number of assessment schedules have been

produced in recent years. The Royal College of Psychiatrists produced *Assessment and Clinical Management of Risk of Harm to Other People* in 1996 and, even more helpful, the *Manchester Care Assessment Schedule* (1998) has a *Risk Assessment, Prompts and Check-List* which looks at both the history and mental state. The former is directed towards self-neglect, self-harm and harm to others, but reminds the user to seek key information from friends, relatives, GPs and others as well as enquiring about prison and hospital detention periods, compliance with medication and withdrawal from services.

ASSESSMENT OF NICHOLAS

10.8 Looking at Nicholas on this risk assessment scale, it is apparent from the history that he was susceptible to exploitation by others, that he occasionally had accidents at home, that he had a history of frequent attendance at A & E departments because of accidents and getting into fights. Conversely, he seemed to look after his appearance and diet quite well.

Self-Harm

10.9 Apart from the unintentional self-harm caused by his heavy drinking, the only instances of self-harm were three overdoses, two of which were apparently prompted by the trauma of losing his wallet. No reason is given in discharge summaries for the third of these overdoses.

Harm to Others

10.10 In the "harm to others" section, damage to property seems to have been directed to his own home and to the homes of his mother and girlfriends and it is towards the latter that actual violence was unleashed in the past. The A & E and GP records make it clear that he was quite often involved in fights, although whether he was the instigator or the victim of such activity is not clear. He was only once convicted of Actual Bodily Harm (in 1976) and since the magistrates fined him only £25.00 it seems unlikely that this was a serious incident. There is, of course, the alleged incident reported by a neighbour when a man was beaten up at an all-night party at Nicholas' flat in October 1995.

10.11 Although his mother supported him and regularly visited him in hospital it is not clear whether he had any other visitors who might

have given information to the doctors and nurses. No such source is mentioned in the medical or nursing records. He had never been in prison or detained compulsorily in hospital. Given the regularity with which he attended to collect prescriptions for benzodiazepines, his GPs may have been lulled into thinking that his compliance was good, whereas the fact that a considerable quantity of Chlordiazepoxide was found in his flat suggests that his compliance may have been erratic. Certainly, he had a frequent history of walking out of A & E or discharging himself from inpatient care prematurely and his attendance at the Campbell Centre Day Hospital was also somewhat irregular.

10.12 The conclusion from all this must surely be that although Nicholas was a continuing risk to himself because of his alcohol abuse, the people who were at most risk from him were women with whom he was in a close relationship, at least two of whom had complained about his aggression in the past. The first of these occasions was found buried in the GP records for 1979, i.e. 16 years prior to his admission to the Campbell Centre and the death of Lorna. The second incident was to be found nowhere in the GP records but came from evidence collected prior to his trial, and since the relationship in which it occurred had ended and the girlfriend concerned was by then in another relationship, she would not have visited Nicholas in hospital.

10.13 This information, therefore, was not available to the medical staff who were treating him. The Probation Service had ceased their involvement in 1992 and saw him as predominantly apathetic but with some potential to damage property when drunk. Of those who had had recent contact with him, his neighbour was almost certainly grateful for the respite from his noise and was unlikely to visit him in hospital, whilst Trevor Plumb at Pegasus, who knew he had been violent on occasions when drunk, saw him as "not in the same league" as many of his other clients when it came to aggressive behaviour. Again, there is no record of anybody, other than his mother, accompanying Nicholas on his visits to Pegasus.

10.14 It has to be said that none of the professionals interviewed by the Inquiry Panel saw Nicholas Arnold as having a serious potential for violence. Although full of foul language on admission to the Campbell Centre, once the alcohol had left his system he was seen as charming and helpful on the ward. There were concerns about the developing friendship with Lorna but these were more about the large difference in age, Lorna's vulnerable nature and his alcohol abuse, rather than any fears of him becoming violent towards her. The relationship was seen as unwise or undesirable rather than potentially dangerous for Lorna, and the staff all believed that there was a limit to the amount they could do to discourage it. Moreover, it seemed to

be having some positive effect on Lorna who was known to get on better with older people than with her own contemporaries and had had previous relationships with older men.

10.15 In summary, in spite of evidence of potential dangerous behaviour hidden in his history, a comprehensive multi-agency risk assessment was never undertaken. The Panel learnt that in July 1999 the Mental Health Directorate of Milton Keynes Community NHS Trust, in conjunction with Neighbourhood Services of Milton Keynes Council, introduced the Core Mental Health Risk Assessment and Management Tool. This tool and the accompanying guidance notes are available to all clinicians and professionals until a further decision is made as to the most effective tool to use in the longer term. Staff have been given training in the use of the tool, and an ongoing programme in risk management has been started as part of the joint agency training plan. The Panel welcomed this development but suggested that an early review should take into account the Panel's recommendation on this issue:

RECOMMENDATION 16 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that risk assessment is an on-going feature of psychiatric treatment and that in all cases this entails a comprehensive multi-disciplinary summary compiled by the keyworker with relevant contributions from medical, nursing, Social Services, and Police and Probation staff where appropriate. This should be completed at a multi-disciplinary review meeting where the responsibilities of each agency are agreed and recorded. There should be regular audit of risk assessments.

Non-compliance

10.16 Nicholas experienced a range of responses from the NHS, the main agency involved in his care. Following his various criminal offences he was also involved with the Probation Service.

10.17 He received help principally from his GPs. Primary care is, by design, the proper initial contact for alcohol related problems. On a number of occasions he was referred to the local specialist alcohol agency, Pegasus, a "secondary" service. He also had opportunities to attend residential rehabilitation, the tertiary services. In 1983 Dr Price, Consultant Psychiatrist, recommended social rehabilitation at residential facilities provided by the Richmond Fellowship. He did not go. Eventually, in 1991, a placement was arranged by the Probation Service at the Peterhouse project, in Bedford. He was discharged

when he began drinking and engaging in disruptive behaviour. In November 1995, he was admitted to the Campbell Centre as an inpatient for alcohol detoxification.

10.18 It can be seen, on each of these occasions except the last, that he either failed to take up a place or left before treatment was complete.

10.19 In his evidence to the Panel whilst in prison Nicholas made clear the extent of his non-compliance with treatment. He described how, upon leaving the Pegasus project, where he told staff he was abstaining, he would immediately go drinking; and also how he continued to drink whilst an inpatient at the Campbell Centre in November 1995.

10.20 The Inquiry Panel is concerned about this history of non-compliance. Nicholas gave verbal reassurance to supervisors but appeared not to participate honestly in the treatment provided. This also extended to his treatment for physical injury, as is evident from his A & E record. For example, following a road traffic accident he said in evidence that:

> "He (the driver) had been drinking and I had been drinking. He lost control of the car ... I was thrown about a hundred yards so they say. ... I was out and I woke up in a bed. I had stitches everywhere, all over the place. ... I released myself from the hospital after three days and I walked back in the pub. It was a silly thing to do, I know, and I got drunk in there. They think we are all dead and we are not. I just did it to show off."

Understanding Nicholas Arnold

10.21 It is probable that Trevor Plumb, the counsellor at Pegasus, had the most understanding of Nicholas Arnold. He had had some psychodynamic training and saw ambivalence in Nicholas' relationship with his mother and that the same ambivalence was present in another long-term relationship which Nicholas was having for part of the time he was attending Pegasus. Trevor Plumb saw that Nicholas wanted both women to give him attention, he did not want to be dependent on them but, in fact, was dependent on both in some ways.

10.22 Trevor Plumb also believed that Nicholas had been "unable to complete the process of adolescence and become his own man". Certainly, adolescence had been traumatic for Nicholas. As indicated previously, his father drank heavily and his mother reported that his father was always "ranting and raving" when he was at home and was abusive towards her. Nicholas reported on various occasions that life with his father was unpleasant to say the very least and one can understand him becoming resentful about the past. Mrs Arnold

confirmed to the Inquiry that she had been out of contact with him from 1965 until about 1981, when he was 27. In these circumstances the aggression shown by Nicholas at his previous girlfriend's home can be seen as copying his father's behaviour when intoxicated; and also that early resentments were being displaced onto his girlfriend.

10.23 The events of 1995 were in many ways a replication of those earlier incidents. Nicholas himself told a doctor at the Campbell Centre that it was the news that his former girlfriend had married her new boyfriend that had led to his inpatient admission, and it may be that once again he felt that he had been rejected by a woman.

10.24 It could well be that on 31 December 1995 Lorna was the recipient of displaced anger. Her ability to resist or remove herself from the attack may have been impaired because of the alcohol and Zopiclone which she had taken. Lorna was not used to taking sleeping tablets and in these circumstances she would have been very drowsy. Also, Lorna had shown herself to be naive in previous relationships, reporting sexual assaults and rejections.

10.25 To understand how a normally rather anxious and socially withdrawn individual like Nicholas Arnold could change under the influence of alcohol, some statements in Dr W Sargent and Dr E Slater's book, *Physical Methods of Treatment in Psychiatry* (4th Edition, Livingston,1963), would appear to be relevant. They describe how the technique of abreaction or nacroanalysis was developed:

> *"The technique of abreaction or nacroanalysis (often misleadingly called the 'truth drug') was developed out of the observation that 'under the influence of alcohol a man reveals tendencies that remain hidden in everyday life and may become suggestible, obstinate, euphoric and boastful. Tongues are loosened by drink, critical judgement is suspended and secret aspirations, damaging confessions and dramatic falsifications of previous events come pouring out'.... '(However) giving alcohol by mouth ... the effects take some time to appear, and are unreliable and difficult to control' hence psychiatrists developed a range of techniques to have the cathartic effect without the drawbacks of alcohol ' To abolish inhibitions and allow underlying thought processes and preoccupations to appear ... Aggressive feelings which would terrify the individual in his normal state can be expressed without excessive anxiety and the emotional experiences of the past can be lived anew'"*

10.26 In using drugs to produce effects of this kind, dosage is critical, too little and the desired result is not seen, too much and the patient may become too drowsy, too disturbed, or incoherent and uncoordinated. It can be seen that Nicholas was producing the same effect with the

original agent – alcohol. The small amount of other substances he had taken merely added to the effect. As with therapeutic agents, it appears that he was able to hold himself in control after small amounts of alcohol, but with increasing doses, he began to express the aggressive feelings and resentments which he had. Sadly, it appears that Lorna became the recipient of his underlying feelings of anger, tension and aggression.

CHAPTER 11 : Service Deficiencies - Lorna Thomas

11.1 The service that Loma received was affected by a number of factors which may have increased the level of risk to which she was exposed.

11.2 There was no evidence of any formal assessment of Lorna's level of intellectual capacity at any stage in her life after the age of four. This lack of clarity may have led to inappropriate plans being made for her as she left school. Due to her language skills and ability to write, it is likely that the level of her learning disability was underestimated. The early assessments revealed an IQ of approximately 45 – 60. This placed her clearly in the middle of the range for mild learning disability.

11.3 The two main components of learning disability are low cognitive ability and diminished social competence *(WHO International Classification of Diseases* – 10th Edition (ICD 10) *Classification of Mental and Behavioural Disorders).* Once the diagnosis is made the two components need to be assessed distinctly, as levels of support can only be accurately planned if both are considered. Lorna consistently displayed higher levels of cognitive skills than social competence. As her diminished social competence was not properly taken into account she encountered increasing interpersonal problems from an early age at home, education, work and in her social life.

11.4 As Lorna became more and more argumentative and demanding, both Health and Social Services were called in to help. The diagnosis of borderline learning disability at the first psychiatric assessment in 1992 minimised the degree of disability and Lorna was directed to wait for psychology services. There followed a prolonged period of delay when she continued to show greater problems and suffered a further lowering of self-esteem gradually leading to a vicious cycle, a fact documented on many occasions in 1992 and 1993. A serious service deficiency existed in the provision of psychology services, due to lack of resources, and resulting in unacceptably long delays for patients needing this help. **(See Recommendation 11, Pg 103)**

11.5 Though never formally diagnosed to have depression by Dr Singh, Lorna was prescribed a variety of anti-depressants by her GPs in Spring and Summer 1995. There was no evidence recorded to support the view that an approach involving psychology, psychotherapy or anti-depressant medication would be more helpful to Lorna than an approach involving support with housing, employment and leisure in a supervised environment. These latter approaches were only considered late in 1995.

11.6 When a referral was made to Social Services, Lorna was not perceived as a person having significant problems of social competence as part of her mild learning disability. Her relatively good cognitive skills led professionals in the services to over-estimate her abilities and to feel that she did not meet the eligibility criteria, which are based on more easily gauged dependency needs. These are determined by perceived (not measured) degree of learning disability.

11.7 This led to Lorna never being allocated a social worker and all subsequent demands for services from her, her family and health services being dealt with slowly and on a reactive basis. Even as Lorna's situation continued to deteriorate and she had to leave home after yet another crisis, she was left, after initial support from Social Services, to find her own single accommodation which she continued to find unsuitable and unpleasant all the time she lived there until her death. The failure to re-assess her following the alleged sexual assaults in 1993, referred to in Chapter 9, contributed to her deterioration.

11.8 The Inquiry Panel was concerned about the information available to senior management and to the elected representatives who formed the Social Services Committee in Buckinghamshire. Although members of staff recorded the view that there appeared to be a service deficit in provision for people like Lorna, we were unable to find any clear path for the issue of "unmet need" to be reported in such a way as to inform resource allocation. Forms existed for recording unmet need in Buckinghamshire County Council, and there was a requirement that such needs should be reported to the Social Services Committee, but the Panel could find no evidence in the minutes of the Committee, to confirm that this took place.

11.9 We are aware that the very concept "unmet need" is problematic because, under the community care legislation, when any individual is considered to have a "need", the local authority has a duty to make provision and many local authorities have simply not recorded the needs of those on the margins of services. However, elsewhere, the terms "service deficit" and "necessary service development" have been used to provide the essential "feedback loop" in the planning system so that people in need, but not in receipt of services, could

receive consideration. The absence of an effective "feedback loop" itself constitutes a service deficiency.

11.10 Health and Social Services Departments for Adults with a Disability could not agree to a shared care plan and this was largely due to the fact that most of the professionals who provided a service for Lorna did so in relative isolation. When she started displaying increasing distress by taking a series of overdoses in 1995, with medication that she did not find helpful, there was still no joint strategy to help and support her. The Panel heard evidence of some good practice, in the formation of an A & E Service linking those patients who overdose with the Mental Health Service, but the A & E Service at Milton Keynes General Hospital, her GPs and her psychiatrist, were unable to develop a joint action plan to deal with Lorna in a co-ordinated way. Thus, Lorna was prescribed anti-depressants by her GP while Dr Singh was not convinced of their usefulness.

11.11 The range of psychiatric services for people with a mild learning disability in Milton Keynes was very limited and this led to Lorna being admitted to a mixed-sex acute psychiatric assessment and treatment unit. Lorna's admission was viewed with apprehension by the ward staff who felt ill equipped to deal with her. **(See Recommendation 33, Pg 55)**

11.12 At the Campbell Centre Lorna was expected to participate in programmes designed for people of normal intelligence but with major mental illnesses. Her repeated expressions of concern were to do with her being isolated and unable to cope in her home. She subsequently reacted to being sent home on 29 November 1995 and, as a result, was brought back in to the Campbell Centre under Section 136 on 30 November 1995 and then to A & E after an overdose within one week.

11.13 Lorna had repeatedly stated that she was aware of the problem patterns in relationships she entered. She described, firstly, a feeling of gratitude to any kindness from another person followed, secondly, by a period of her emotional demands being met, sometimes in the context of a sexual relationship, followed finally, by being rejected and being left angry and unhappy. In spite of this, when the relationship with Nicholas Arnold commenced, following his paying attention to her at the Campbell Centre, and progressed rapidly, bearing in mind her isolation and unhappiness, there was little realisation on the part of the staff of the likelihood that this relationship could rapidly deteriorate. While the Campbell Centre staff did their best to help Lorna, their lack of training and experience in dealing with people with her type of learning disability inhibited their ability to understand the limitations of her capacity to make considered judgments, particularly in the context of a sexual relationship. Knowledge of the relationship

was not shared by health service personnel with their Social Services colleagues at the discharge meeting. **(See Recommendation 6, Pg 59)**

11.14 The effectiveness of discharge planning and the application of the Care Programme Approach were weakened by there being no clearly designated key worker to implement and co-ordinate her aftercare. Shortages of staff, worsened by the festive season, led to cancellations and delay in providing assessments to Lorna, especially in helping her to achieve a more structured day, either in the Day Hospital or at Keystone. **(See Recommendations 12 and 21, Pg 61)**

11.15 The process for gathering together information for the allocation of housing appeared not to identify the health and social needs of people with a mild learning disability in spite of this being a clear objective of housing policy. This led to Lorna living in unsuitable accommodation that appeared to exacerbate her feelings of isolation and insecurity. It also appeared to be difficult to improve matters for Lorna even when she clearly stated her negative views about her accommodation. **(See Recommendation 37, Pg 59)**

11.16 The Inquiry heard that in 1995 Dr Singh was a single-handed consultant for people with learning disability for a population of over 200,000. He did not have any junior medical support in the form of trainees or career grade doctors and his only back-up was from the Learning Disabilities Consultant in Aylesbury. In 1999, while there were increased residential facilities in the Trust for people with a learning disability and the catchment area population was increasing, he was still single-handed and did not have any closer links with his general psychiatry colleagues. He was also sharing the role of Trust Medical Director with no reduction of clinical responsibilities. It was noted that the Trust had plans to increase consultant numbers but there was still no change in the learning disability field at the time of this Inquiry. This remains a major deficiency in service.

11.17 An internal report in 1997 showed acute awareness by the Milton Keynes Community NHS Trust of the serious shortcomings in mental health services provision in Milton Keynes and action was initiated to achieve an improved service. The first steps included developing community mental health teams, extending out-of-hours CPN work, launching a Liaison Consultant Psychiatrist role and beginning to improve access to psychological therapy. It is to be hoped that Milton Keynes Community NHS Trust will have the necessary resources to be able to continue the planned improvements in its services and that Buckinghamshire Health Authority will see this as a priority.

RECOMMENDATION 2 : The Buckinghamshire Health Authority and the Milton Keynes Community NHS Trust should review the level of medical staffing in learning disabilities, to ensure that it is in keeping with the recommendations of the Royal College of Psychiatrists (one whole-time consultant for 100,000 population) and to ensure that the consultants are supported by junior medical staff. We understand that this recommendation could apply equally to other Health Authorities and Trusts in England and Wales.

11.18 The Inquiry heard in evidence from Lorna's GP that he did not have much information from the learning disabilities staff in both health and social services about Lorna. He also said that there were few opportunities to have more knowledge about learning disabilities and learning disabilities services. Several recent publications have described examples and models of good practice that were not in existence in 1995, such as information booklets for GPs, regular health checks for people with a learning disability, joint clinics between GPs and learning disability psychiatrists, health education, health promotion, etc. (*Signpost for Success,* DoH 1998; *Once a Day,* DoH 1999).

11.19 It is the Panel's view that systems and procedures for involving GPs, patients and carers in the assessment planning, delivery and monitoring of services, especially in the area of discharge and discharge planning and after care support, should be more formal.

RECOMMENDATION 15 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that every effort is made to encourage GPs to make an effective contribution to discharge planning and the CPA, particularly for patients requiring ongoing treatment, including people with learning disabilities. Meetings should be notified in good time to help ensure the attendance of the GP or a practice nurse. Failing this attendance, the Community Nurse should make early contact with the GP as well as with the patient.

11.20 Although there were letters of condolence and offers of support from the Trust and from Social Services, Mr and Mrs Thomas received little information from Thames Valley Police following Lorna's death. It was not until they attended the trial as members of the public that they learnt the extent of her injuries, and they were unprepared for the shock of that information. We consider it is important that a bereaved family should be treated with dignity, respect and sensitivity where

there has been a homicide. It is extremely important for the family of the victim to know what happened to their relative if they choose to know. We think that there should have been further contact by Thames Valley Police with Mr and Mrs Thomas and with other individuals involved.

RECOMMENDATION 36 : The Thames Valley Police Authority is asked to review its procedures for dealing with families of victims and for notifying specialist agencies in the case of any concerns they may have about individuals in the community, or in the aftermath of a major incident such as homicide.

CHAPTER 12 : Service Deficiencies - Nicholas Arnold

DIAGNOSTIC AND THERAPEUTIC ISSUES

12.1 In considering these aspects of Nicholas' case, the Inquiry had the assistance of expert witnesses, Dr M T Abou-Saleh, Reader in Addictive Behaviour and Clinical Director, Addiction Services, St. George's Hospital, London, and Dr D Cameron, Senior Lecturer in Substance Misuse, University of Leicester.

Personality Disorder and Anxiety Symptoms

12.2 The limited availability of psychological services in Milton Keynes also affected the treatment of Nicholas.

12.3 As we have seen, all the early assessments of Nicholas Arnold concentrated their attention diagnostically on anxiety states. It was not until June 1985 that alcohol featured in the Consultants diagnosis. Furthermore, although Nicholas had shown many features of personality disorder over the years, there is little to suggest that this was given much consideration, although Dr Pinto in 1979 described him as being "inadequate" and in October 1984 his GP, writing to the Housing Department, described him as "having severe personality problems".

12.4 Expert medical opinion available to the Panel indicated that Nicholas Arnold showed some features of three diagnostic sub-groups of personality disorder as described in the *WHO International Classification of Diseases* – 10th Edition (ICD 10), namely : Schizoid personality (not to be confused with Schizophrenia), dissocial personality and emotionally unstable personality (F60.1, 60.2 and 60.3 respectively). It is not necessary for people to show every feature of the disorder to warrant the diagnosis. Dr Abouh-Saleh concluded in his report to the Panel that "it is likely that he has also suffered from personality disorder with avoidant, impulsive, passive-

aggressive and over emotional characteristics", whilst Dr Cameron described him as "over-aroused and poorly socialised".

12.5 It is the view of the Panel that, because of the limited nature of psychology services in Milton Keynes, Nicholas was not offered the necessary treatment for his underlying problems. Instead, attention was focussed on his alcohol abuse and on relieving his anxiety symptoms.

12.6 Nicholas seemed to believe that his anxiety symptoms started in about 1973 when he was 19 and still living with his father. Benzodiazepines were much more frequently prescribed in those days to treat anxiety and Diazepam, one of that group of drugs, is recorded in the GP notes from December 1977, with regular prescriptions recorded from 1980. Dr Pinto's first suggestion on seeing Nicholas in 1979 was that he should attend group therapy sessions run by psychologists, but Nicholas claimed to have found that this experience caused him to feel even more anxious, so he only attended one group. When re-assessed by Dr Chester later the same year, she also suggested assessment and treatment by psychologists. Unfortunately, there are no records of exactly what form this treatment took, but Nicholas himself told the Inquiry that he had attended an annexe of Luton Hospital for a course of treatment and that he had benefited from it.

12.7 After his move to Milton Keynes in 1982 no further attempts to treat Nicholas along psychological lines appear to have taken place until he was referred to Pegasus in September 1994. There Trevor Plumb "tried to do an amount of cognitive work with Nick ... which certainly included relaxation techniques and anxiety management" in the course of his counselling sessions. Because of Nicholas's failure to apply these techniques, Trevor Plumb was reluctant to take him on for further anxiety management training, as suggested by Dr Strangeway and Dr Beber in May 1995. Eventually, Nicholas started a relaxation course at the Campbell Centre Day Hospital on 22 November 1995 while he was still an inpatient. Interestingly, Trevor Plumb told the Inquiry that whilst at times Nicholas appeared very frightened and agoraphobic, at other times when he was apparently off alcohol he had appeared a very different individual and did not seem unduly anxious.

12.8 Thus, for most of the 18 years between 1977 and the end of 1995, apart from a period between May 1988 and November 1990, Nicholas was taking benzodiazepines prescribed by his GP, as the main treatment for his anxiety. Even around the time that these drugs were first prescribed for Nicholas, many psychiatrists were starting to be much more reluctant to prescribe them than previously, and nowadays they are mainly used for short periods as an adjunct to

other medication in the treatment of the acute phase of psychotic illness. They are also frequently used to control withdrawal effects in persons who have long term abuse of alcohol, in the "drying-out" phase.

12.9 Instead, modern day treatment of anxiety states tends to focus on the use of psychological treatments and, in particular, cognitive behavioural therapy. This aims at helping people to learn new strategies to cope with their problems by changing their behaviour, thoughts and beliefs and is regarded as a first choice treatment.

12.10 Although Nicholas had some psychological treatment for his anxieties whilst he lived in Luton, such psychological treatments as he received during his 13 or so years in Milton Keynes were relatively simple relaxation training at Pegasus and the Campbell Centre Day Hospital, and some cognitive work with Trevor Plumb. However, it should be noted that the latter's training is in counselling techniques and not as a clinical psychologist.

12.11 Numerous witnesses spoke to the Inquiry about the paucity of psychological services in Milton Keynes. Although there is a Department of Clinical Psychology, it appears to have been poorly staffed. It was difficult for some mental health workers to refer patients to it and even if the Clinical Psychology Department accepted the referral, there was a long waiting period before treatment could be started. Notwithstanding a nation-wide shortage of clinical psychologists, the situation in Milton Keynes appears to have been unacceptable.

RECOMMENDATION 11: The Buckinghamshire Health Authority and Milton Keynes Community NHS Trust should undertake a comprehensive review of psychology and psychotherapy services including staffing establishment and pathways of referral. Particular consideration should be given to developing the psychology services for people with learning disability and to introducing specific sessions for drug and alcohol services, in order to avoid patients having to wait unduly long for assessment and treatment.

Abuse of Cannabis, Benzodiazepines and Similar Drugs

12.12 In Nicholas' medical history there is no record of him using "hard" drugs. As early as 1980, however, he began to have convictions for possession of cannabis and some witnesses suggested that he might have supplied others, either from his flat or in the Milton Keynes central area.

12.13 Certainly, when Police carried out a close inspection of his flat after the death of Lorna, they discovered 31 cannabis plants of various sizes being cultivated in the roof space. Dr Cameron advised the Panel that this number of plants would only supply enough leaves for Nicholas to feed his own habit and that the cannabis produced in this way would not have been very potent.

12.14 The Panel wondered if Nicholas' consumption of cannabis might have contributed to his lack of motivation. He had talked of using a quarter of an ounce per week but this was not felt to be much by the experts – certainly not enough to put him in the unmotivated, "dropout" group of heavy cannabis users. Pipes smelling of cannabis, found in the flat, suggested that he was using it himself, and cannabis was found in his blood after the death of Lorna. The Inquiry was told by Dr Cameron, however, that it was possible to detect cannabis in the blood stream up to six weeks after it has been used. We were also told that the illusory effects of cannabis are reduced by drinking alcohol at the same time.

12.15 The concurrent use of benzodiazepines with alcohol is apparently a common finding. Dr Cameron and his colleagues have found it in about a third of their alcohol-abusing clients. Other than the period between June 1988 and November 1990, Nicholas appeared to be taking prescribed benzodiazepines for at least 15 years before Lorna's death – first Diazepam (Valium) and later Chlordiazepoxide (Librium). The quantities prescribed for him, as stated in the GP's records, were within the range suggested by the British National Formulary for therapeutic use, although he could have taken more of it at some times than at others or supplemented his legally prescribed drugs with illegally purchased ones. However, the latter seems unlikely given the reference to him selling benzodiazepines illegally to teenagers in Milton Keynes town centre and the fact that a considerable quantity of Chlordiazepoxide was found in his flat after Lorna's death – all apparently legally supplied. It may be that he wanted to have enough of these drugs to be able to manage his own withdrawal from alcohol without going into hospital.

12.16 Zopiclone (Zimovane) is not a benzodiazepine but is a widely used sleeping tablet. It has been claimed that Zopiclone has anxiety reducing properties as well as sleep promoting ones. In view of the fact that many patients suffering from psychiatric illnesses have some symptoms of anxiety even if that is not the principal diagnosis, it is not surprising that Zopiclone has become the most widely prescribed sleeping tablet in many inpatient psychiatric units. Given the common use of Zopiclone, it follows that the paradoxical effects of increased tension and aggression which can sometimes occur with Zopiclone must be very rare. Certainly, Nicholas had demonstrated his potential for aggressive behaviour when inebriated long before the advent of

Zopiclone. Toxicology results following the death of Lorna suggested that he had taken only a therapeutic dose. He had been prescribed the drug for a period of approximately two years and it seems almost certain that he had taken it in combination with alcohol and cannabis on previous occasions.

12.17 Recent data sheets for most tranquillisers and sleeping tablets suggest that they should only be prescribed for short periods and the vast majority of medical practitioners do try to adhere to such guidelines most of the time. There are, inevitably, occasions when life circumstances make it impossible to comply with this ideal. Nicholas certainly claimed that at times he found great difficulty in getting out and about without resort to his benzodiazepines and it is possible that using them may have reduced somewhat his need to take alcohol on these occasions.

Treatment for Depression

12.18 Both in May 1995 when Nicholas was first referred by his GP to Dr Strangeway, and again in November 1995 when he was admitted to the Campbell Centre, he was described as being depressed. It should be noted, however, that individuals with alcohol dependency in relapse often attend for treatment with depression which usually clears during the drying-out process. Often, as in the case of Nicholas in both May and November 1995, the depression is reactive to some event or circumstance, and only in a small proportion of such cases does a clinical depression, as described in ICD 10, co-exist and require treatment in its own right.

12.19 Nicholas was prescribed the anti-depressant Amitryptiline by his GP for a period from late July 1991. However, there is no clear evidence that he was clinically depressed at that time. It seems to have been given to help him to withdraw from Diazepam and a note in 1992 suggests that he was taking it as a hypnotic (sleeping tablet). Amitryptiline is one of the most sedative of the Tricyclic group of anti-depressants.

Treatment for Alcohol Abuse

12.20 Here it is necessary to look more closely at the history of Nicholas' drinking. The fact that Nicholas might have a problem with alcohol dependence seems to have been first recognised by his general practitioner, Dr A J Prisk, in February 1983, who was, however, mainly requesting a psychiatric opinion because of depression and anxiety. In his response, Dr J S Price mentioned that Nicholas had been drinking eight pints of strong beer daily when he had lived in Luton

prior to moving to Milton Keynes in January 1982. Even then, the therapeutic direction of Dr Price's thoughts seemed more towards social rehabilitation rather than any specific treatment for his excessive alcohol intake.

12.21 Late in 1984, Nicholas' GP seemed to have recognised that he clearly had a serious alcohol dependency problem, as well as dependency on tranquillisers. In spite of denying taking alcohol for most of the early months of 1985, Nicholas himself went to his GP in June 1985 saying that he wanted to stop drinking and taking Diazepam, and it was this request that prompted the GP to request a further assessment by Dr Price. The latter reported that Nicholas had gone downhill since he moved into his own flat six months earlier, that he had been drinking very heavily and was living in a considerable state of squalor. Dr Price commented: "he certainly needs help with his drinking and chemical dependency and with his general life style and I think the best person to do this is the probation officer who has been allocated to him" (because of two burglary charges). He also suggested referral to the chemical dependency facilities, but subsequently wrote again to the GP suggesting that Nicholas might use some of a recently inherited sum of money to pay for private inpatient treatment for his alcohol dependency.

12.22 The Inquiry Team was unable to access any probation records covering this period and there was nothing in the general practice records to suggest that Nicholas had attended local chemical dependency facilities or the private ones suggested by Dr Price. In fact, it can be seen from his medical records that he was involved, while drunk, in a road traffic accident in Milton Keynes later in June 1985 and that in August of the same year he had an admission to Milton Keynes General Hospital suffering from hepatitis which was believed to be due to alcohol. This experience, which included a period of DTs (a toxic confusion state due to alcohol withdrawal) and, no doubt, warnings from the medical staff about his grossly abnormal liver function tests, may have persuaded him to modify his alcohol intake.

12.23 However, there is no evidence that he took up other suggestions made by the SHO in psychiatry who saw him at the time and discussed his case with his Probation Officer. She said she would try to get him into an ex-alcoholics hostel, and another possibility was a referral to a CPN in the substance abuse service. There is no evidence that he took up either of these two suggestions, although he may have had some contact with AA at this time. His probation officer wrote to Dr. Lennard (SHO in psychiatry) in November 1985 saying that although Nicholas had managed to abstain from drinking for a few weeks following his hospital admission, the situation now seemed to be worsening and that Nicholas was against the possibility of

accepting counselling sessions.

12.24 For the next few years there are relatively few entries in the general practice records. However, we know from a witness statement to Thames Valley Police, that during this time Nicholas used to go to the city centre frequently with others and return home drunk and become violent.

12.25 His alcohol abuse appears to have increased towards the end of 1990, about the time of the allegations of indecent assault on a young girl and the subsequent assaults on him. His drunken appearance at the surgery prompted his GP to request a further psychiatric opinion and led to his first referral to Pegasus.

12.26 At the beginning of May 1991, Nicholas was put on probation for 18 months for offences of going equipped, three thefts from shops and attempted theft. The probation notes give a very good picture of how he was at that time. His Probation Officer also found out by contacting Pegasus directly that he had discontinued attending there even before May. The Probation Officer managed to persuade him to attend Pegasus again at the end of July and made arrangements with Bedford Probation Service for Nicholas to go to the Peterhouse Residential Project at Bedford. As we have heard, this visit ended abruptly after one week. Although he subsequently tried to persuade the Probation Officer to find him an alternative hostel place, he was told that his behaviour at Peterhouse would make it difficult for such a place to be found.

12.27 In November 1991, his Probation Officer commented that he had not attended Pegasus and that he seemed to "just want to sit passively whilst I worked miracles for him". She felt very pessimistic about his future. In December 1991, Nicholas went to stay with his girlfriend again, but when her ex-husband arrived he ran away, got drunk and when his mother refused to let him in, he broke in through a window. Although charged with criminal damage, his mother withdrew her complaint before the case went to court. Early in 1992, the Probation Officer discussed a hostel in East London with Nicholas who was most unenthusiastic. The Probation Officer found it very frustrating that Nicholas was reluctant to take up any of her suggestions, whether about rehabilitation or work. She also tried to place him in a hostel in Dover but he was turned down for this. Probation supervision ceased in October 1992.

12.28 There seems to be a paucity of information about his alcohol problems in 1993 other than the fact that he attended the Casualty Department in September of that year after collapsing, probably due to alcohol abuse. Nicholas referred himself back to Pegasus in July 1994 but after the assessment session he did not attend again for

two months, until referred back by his GP. On assessment, he claimed to have not drunk since July, after a hospital admission for gastro enteritis, and professed the desire to remain abstinent. At this assessment, he requested acupuncture as soon as possible and this was subsequently commenced, along with counselling from Trevor Plumb. He had a severe relapse in November 1994, turning up at Pegasus on 9 and 10 November very drunk and without an appointment. He attended again on 11 November, apparently sober, with his mother. However, on 16 November he took an overdose of Amitriptyline and Zopiclone and, during inpatient treatment, he developed alcohol withdrawal symptoms which needed to be treated with Chlormethiazole and Chlordiazepoxide.

12.29 He missed some appointments at Pegasus around Christmas and early in the New Year, but attended late in January 1995 and claimed to have been sober since Christmas. His apparent good progress continued into March, with him being concemed about old drinking friends trying to persuade him to drink. It was the following month that his girlfriend for eight years finally told him that she had found another boyfriend, which started him off drinking again and led to the referral to Dr Strangeway's outpatient clinic where the diagnosis of alcohol abuse and social phobia was made. Attendance at the Day Centre did not appear to have much effect on his drinking, which seemed to deteriorate, especially when he knew his former girlfriend was going to marry her new boyfriend. His mother became increasingly concerned about his welfare and intervened to assist, but even when an ambulance was sent to his flat on 30 October 1995, he refused to go to hospital.

12.30 In general, alcohol and drug dependency are excluded from the Mental Health Act 1983 in respect of the possibility of using compulsory powers to insist on a patient being treated. Occasionally, however, alcoholics and drug dependent individuals can display symptoms which are very similar to other psychotic illnesses, usually in the withdrawal phase, and sometimes in such cases they may be compulsorily treated until the psychotic features have resolved. Also, such people can be sent to treatment agencies as a condition of a probation order from the courts, in which case, if they fail to attend, they can be recalled to court for an alternative sentence. Other than in these limited circumstances, persons suffering from alcohol and drug dependency must voluntarily comply with whatever treatment may be on offer to them.

12.31 Dr Cameron, in his report, emphasised the importance of timeliness. In other words, "if somebody does not wish to modify their drinking or drug taking behaviour, then however much effort is expended it will be to little avail". The corollary of this, however, is surely that if the individual is showing some inclination to change their ways, then, in

the view of the Panel, every effort should be made to take advantage of it. There were moments when Nicholas was expressing some initiative towards making a break from alcohol which might have been decisive for him, but only the Probation Service seemed to make any determined effort to help when he was considering moving away from Milton Keynes and his drinking friends. The Panel recognises, however, that without considerable support a move to London, or anywhere else, would have been unlikely to have had a successful outcome as far as his alcohol consumption was concerned. One of the keys to success, according to Dr Cameron, is the establishment of a good social network – not easy in a place where one knows nobody.

12.32 Even though the Consultant Psychiatrist who saw Nicholas suggested referral to various treatment facilities, there seemed to be little attempt to follow up the domiciliary visits which were made in 1985 and 1991, although one of the key elements of a modern alcohol and drug addiction service is "vigorous after care or assertive outreach", according to Dr Cameron, who commented that "Instead of saying come up and see me some time ... if one can go pestering people in the community and have a sustained declaration of interest for them, they do better".

12.33 The Panel could find little evidence of assertive outreach in respect of Nicholas Arnold and the reasons for this are not difficult to discern. There has been no consultant specialist in drug and alcohol addiction services in Milton Keynes Community NHS Trust and this would seem to us to be a serious omission. The final draft of the *Milton Keynes Community NHS Trust Group Report* (1997), on the Mental Health Services required by 2002 for an estimated population of 208,000, suggests that to meet the Royal College of Psychiatrists standard, "1.2 whole-time-equivalent" consultant-psychiatrists specialising in substance abuse should be appointed, and it would seem to the Inquiry Team that, given that Milton Keynes is a new town, with the resettlement problems that brings, such appointments should be given a high priority. A common arrangement elsewhere in the UK is for a consultant to serve two or more adjacent health districts and such joint appointments could be considered as a second-best option for Milton Keynes if finances so dictate.

RECOMMENDATION 8 : The Buckinghamshire Health Authority and the Milton Keynes Community NHS Trust should review the level of medical and nursing staffing within addictions and substance dependency, in order to offer a more comprehensive treatment service, including Consultant led outpatient clinics and home detoxification services to supplement the services offered by Pegasus. In particular, a Consultant Psychiatrist and

support staff should be specifically appointed to co-ordinate drug and alcohol dependency services in Milton Keynes.

12.34 When the Inquiry Panel interviewed Dr P Strangeway, under whose care Nicholas was admitted to the Campbell Centre, they were surprised that he seemed totally unaware of the plan contained in the Trust's service development proposals for 2002 to appoint a consultant specialising in substance abuse, and stated that he was not sure that this would be a complete solution. This appeared to the Panel to confirm the inadequate involvement of senior consultants in strategy planning within the Milton Keynes Community NHS Trust. **(See Recommendation 25, Pg 117)**

12.35 In the absence of a Consultant dedicated to working whole time in drugs and alcohol, Milton Keynes had an arrangement with one of the general psychiatrists to undertake an extra session in order to act as lead consultant. In the period leading up to Nicholas' admission to the Campbell Centre, Dr A Joseph was the lead Consultant. However, his view of the role seemed to be that he should be available for advice and, if necessary, to offer a consultation service to other agencies such as the General Hospital and Pegasus, which at that time was, and still remains, the mainstay of drug and alcohol addiction services in Milton Keynes. Panel Members were surprised to learn that Dr Joseph had visited the premises of Pegasus only two or three times in as many years. They would have expected him to meet regularly with members of the team, to discuss problems in day to day management, as well as with mutual clients. However, he did make arrangements to see some individual clients of Pegasus at the Campbell Centre and from time to time had discussions with the manager of Pegasus.

12.36 The Panel heard from Trevor Plumb about the staffing and treatment on offer at Pegasus. With regard to staffing, we were told that in addition to the manager (at that time it was Robin Preston who had a background in social work) there were two full time professional counsellors, one trainee counsellor, two voluntary counsellors and two attached CPNs. According to Trevor Plumb, the CPNs were mainly concerned with drug abusers rather than those patients with alcohol problems. The Panel was surprised to hear from Nicholas himself that he had never been offered community CPN support to deal with his alcohol problems. **(See Recommendation 8, Pg 109)**

12.37 The Oxford Brookes University *Evaluation of Specialist Drug and Alcohol Service Provision in Milton Keynes* (March 1996) was very much in favour of developing community detoxification and rehabilitation services. The Inquiry Panel would concur with this view, whilst at the same time recognising that a substantial minority of patients might not be suitable for services of this nature and would still

require inpatient facilities. Staffing of such a service would need an increase in the number of CPNs working in substance abuse.

12.38 The overall impression of Pegasus gained by the Panel was that here was a dedicated band of individuals working extremely hard but essentially offering only a limited range of choices for the client group. Dr D Cameron told the Panel that there was "precious little difference between one treatment modality and another", but clearly some treatments appeal more to any given individual than other treatments. When Nicholas was assessed for Pegasus, a form was completed which lists the services on offer as acupuncture, aromatherapy, homeopathy and counselling. Nicholas opted to have counselling and acupuncture. Both he and Trevor Plumb commented about his preference for acupuncture which, essentially, is a passive treatment, whereas both Trevor Plumb and the probation staff found him peculiarly unwilling to look at his own motivation and the reasons for his continued alcohol abuse.

12.39 The only regular medical input into Pegasus was from a community health physician who was essentially responsible for prescribing Methadone for heroin users. His prescribing did not extend to Antabuse, a widely used and effective prophylactic treatment for alcoholics which was never offered to Nicholas. There was an arrangement that clients of Pegasus could be sent for detoxification at a clinic in Oxford and, rarely, a possibility that people could be sent for a course of residential rehabilitation.

12.40 We heard from our expert witnesses that there has been a move away from inpatient alcohol treatment units, or at least from the package deal which used to be offered of detoxification followed by group therapy, which sought to help the individual to identify the roots of his problem and help him to make adjustments in life. Whilst, in general, the cost was high and the efficacy poor, some experts believe that there is still a place for some people with more long-standing alcohol addiction problems to benefit from such programmes of treatment. As it was, up until his admission to the Campbell Centre, Nicholas' only detoxifications occurred when he was admitted to hospital for other reasons.

12.41 The only attempt at residential rehabilitation came from the Probation Service and this failed very quickly. Whether the outcome would have been any different if he had been put through an old-style NHS programme or, indeed, one of the rehabilitation courses offered by the private sector, can only be a matter of speculation, but we believe it should have been tried, and almost certainly there would have been greater supervision than in Bedford, where the Peterhouse Project was not staffed at weekends.

RECOMMENDATION 9 : The Milton Keynes Community NHS Trust should explore the possibility of offering the prescription of prophylactic drug treatments at Pegasus, to assist in achieving and maintaining abstinence, for people with alcohol related problems, at least until consultant led clinics are set up.

12.42 One other serious omission in the Pegasus portfolio of treatments is the lack of any clinical psychology input. As Dr Cameron put it, "most of the best researched and most validated treatments for people with alcohol and drug problems are psychological". A variety of psychological treatments may have a place depending on the circumstances of the individual, and most alcohol and drug treatment services have regular sessional input. To make matters even worse, the Panel was told that the staff of Pegasus were not allowed to refer patients directly to the Clinical Psychology Department; instead they had to request the GP to do so. This inevitably added both delay and the possiblity of refusal to the already formidable difficulties in accessing such services .

12.43 The Panel felt that there was a clear need for the Health Authority to review the level of funding available to send more long term alcohol abusers on NHS/private sector rehabilitation courses, and to introduce revised arrangements to allow direct referral by Pegasus staff to the Clinical Psychology Department. **(See Recommendation 11, Pg 103)**

12.44 Several witnesses told the panel that Pegasus was seen as being "a slightly hippie outfit" and whilst this seemed to suit younger drug addicts particularly, it may have been something of a deterrent to older alcohol addicted clients. Figures for the time when Nicholas was attending suggest that Pegasus was in contact with around 200 people with alcohol addiction problems each year. This must represent only a small proportion of those eligible to access the service.

12.45 The Inquiry Panel was told by Dr Cameron that, essentially, the treatment of alcohol dependent individuals nationally was one of assisted self recovery and that this was likely to involve a whole range of different services - individual, group and rehabilitation - at different stages. Against such a requirement, the Milton Keynes range of facilities appears woefully lacking.

12.46 There is often reluctance by Health Authorities and Trusts to spend money helping people with drug and alcohol problems, because they are seen as sane and self-willed. To some extent this reluctance has been countered, in the case of drugs, by specific earmarked funds being allocated by the Government. The Panel is aware that local

authorities can bid for funds from the Alcohol and Drug Specific Grant, which enables them to pay voluntary organisations to expand and / or to improve local community care services in accordance with local authority community care plans.

12.47 However, no such specific grant appears to be available in the NHS to set up, expand and run alcohol treatment services. The Panel is aware that the Government has commenced a process of hypothecated, or dedicated, funding for specialist services in the NHS, e.g. for smoking, and we can see considerable advantages to extending this to include funding for alcohol addiction services.

RECOMMENDATION 10 : The Department of Health should consider providing specific grants to Health Authorities for the development of local alcohol treatment and rehabilitation services, possibly funded from the tax on alcohol sales.

Voluntary Organisations

12.48 Voluntary organisations often make major contributions to the care and welfare of those experiencing problems as a result of drug and alcohol abuse. Several witnesses mentioned the fact that, because Milton Keynes was a new conurbation, such organisations had not been present to the same extent as in older established communities. Alcoholics Anonymous seemed to be the only such organisation in this field during the period under consideration, although the Panel was pleased to hear that other organisations had started to operate in Milton Keynes in the last two to three years. It has to be said that Nicholas' participation in AA activities did not seem to be either persistent or particularly enthusiastic. Although AA does not appeal to some alcoholics, lack of motivation to change was a major factor in Nicholas' failure to progress for most of the period under review. In evidence to the Panel, NHS staff expressed the view that they lacked information about the available voluntary sector services and that more information would be helpful in their care planning.

RECOMMENDATION 39 : The Milton Keynes Community NHS Trust should maintain a regularly updated directory of support agencies which should be made available to health and social care professionals in the inpatient areas, within the community mental health teams and to GPs, as a source of reference for people with a range of mental health and learning disabilities.

CHAPTER 13 : - Joint Working

13.1 The Inquiry Panel heard from staff of all agencies about a distinctly insular culture in most settings. This was both intra-disciplinary as well as being inter-disciplinary. Despite the fact that the NHS multi-disciplinary mental health team retained on-going responsibility for patients, the general psychiatrists appeared to have no formal "handover" meeting when beginning to provide cover for an absent colleague. Nor did they have much contact with the lone learning disability psychiatrist, other than on an individual case basis. Nursing staff tended to train within a defined patient group, with general psychiatric nurses having little or no experience of adults with a learning disability and specialist learning disability nurses claiming little experience of mental health nursing.

13.2 The culture seemed to involve assessing people as one category or another and then passing on full responsibility, rather than working jointly with an individual with complex needs.

13.3 Buckinghamshire Social Services Department also seems to have had rather rigid client categories, reinforced by the changes introduced following implementation of the significantly named NHS and Community Care Act 1990 ; these changes created entirely separate budgets for each client group and redefined social workers as care managers. Whilst this was a national pattern, the local implementation in Buckinghamshire was viewed by some as disruptive. Two social workers, previously based with NHS colleagues at Stantonbury Health Centre, were withdrawn from what was seen as an effective working arrangement because they had become "purchasers" while their NHS colleagues were considered "providers". Social Services Department's elsewhere seemed to have interpreted the legislation and guidance in ways which extended rather than reduced collaborative activity.

13.4 There appeared to be a considerable divide between the mental health social workers and learning disability staff; although working in the same Social Services division (Adult Disability Team), mental health and learning disability staff operated as "quite separate" [see

Chart in Appendix 3(b)]. For service users who needed help from both services, the Panel heard in evidence from a Care Manager:

> "this was a sort of four cornered affair, because of the two health services and the two social services. Within the health service there was usually a fairly clear definition by virtue of which psychiatrist was working with a person concerned. Within social services it was often quite a difficult grey area".

13.5 The organisational problems were reinforced by financial structures and resource constraints. It was explained that :

> "It is very difficult to be clear as to who best should take things forward. Some of that, of course, was about resources and about people having a lot of commitments and wanting, if possible, to find the appropriate service somewhere else. Some of it was about such things as labelling. If a person had a very mild learning disability, I think they should be conscious that, if they became labelled as having a learning disability, they might have less call on mainstream mental health services".

> "the main issue in this case was that Lorna was perceived as not having a high level of either learning disability or mental health need".

13.6 We understand that the existence of separate budgets can be an issue when an individual may need services from both sectors. There can be problems of "cost shunting" or protection of scarce resources. We were told that senior managers intervened, as required, to resolve such issues.

13.7 This case by case pattern of deciding who provided what appears to have stemmed from the absence, at the time, of any effective strategic joint planning, joint commissioning or joint providing. Although there was some evidence of collaborative working between Health and Social Services in 1995, this appeared to the Panel to have been insufficient at strategic, operational and service delivery levels, especially in relation to service provision and monitoring.

13.8 Insufficient joint working may also have inhibited access to central government grants for community care, though some limited grants have been secured recently. Failure to identify the lead agency for joint commissioning may also have led to difficulties in achieving this goal. In the view of the Panel, there is still a major absence of joint commissioning and continuing attention needs to be given to developing training strategies and programmes, on a multi-disciplinary basis, to support all service developments.

13.9 Dr Joseph and Dr Strangeway, as well as Dr Singh, spoke of a disconnection of senior doctors from the strategic planning of NHS developments. Being unaware of planned changes even in the NHS, they neither expected nor received any detailed information on developments in Social Services.

RECOMMENDATION 25 : The Milton Keynes Community NHS Trust should ensure full multi-disciplinary discussion with and involvement in strategic mental health planning of the Director of Mental Health, the Clinical Director, all relevant Consultants, Heads of Departments and Nurse Managers and including appropriate input from Social Services. Such a group should also regularly review existing services.

13.10 Senior social workers took the view that "someone at HQ" dealt with service planning issues. However, we did hear from the Director in 1995, Jean Jeffrey, that she had regular meetings with groups of social workers, to hear directly of their experiences in operating services. It was at such a meeting that social workers raised their concerns about the national guidance to work only with those in the higher categories of need. Sheila Taylor recalled :

> "Social Workers found it very difficult not to be able to work with people who were vulnerable ... even though we fully accepted that they did not have a high level of a particular disability or a particular mental illness. Social workers were arguing for there to be a generic team of some description, perhaps a small duty team, a group of people who would work with others who did not come within our specific remit ... the Director was very dismissive of that suggestion."

13.11 The concerns expressed in the *"Longcare Inquiry Report" (1998),* appeared to be well founded, to judge by Lorna's experiences:

> *" At the time of the Longcare Inquiry, Buckinghamshire was proposing to introduce revised eligibility criteria for services, and as a consequence of budget reductions, proposed to reassess all current service users to determine their present needs and to consider the eligibility for continuing support. Not surprisingly the proposal engendered widespread anxiety and concerns that some vulnerable people with learning disabilities would lose services because they presented a 'cluster' of more moderate disabilities rather than a single severe level of disability. Additionally, families were concerned that their needs may be overlooked."*

13.12 The Longcare Inquiry commented further on resources:

> *"Living Within Our Resources is a common and indeed necessary theme for all local authorities, including Buckinghamshire. However, there is a lack of national guidance as to what constitutes a* ***reasonable level of provision*** *for people with a learning disability within a local authority; the weight which may be given to a family's needs as opposed to the needs of the person with learning disability ..."*

13.13 The Panel agrees that there is a definite need for such national guidance and so also recommends that clear guidelines are issued about people with less severe or "marginal" needs, a category into which both Lorna Thomas and Nicholas Arnold fell.

RECOMMENDATION 3 : The Department of Health should issue guidelines to local Social Services Departments about the levels of resources which should be made available to support the provision of services in the community required by people with mild learning disabilities, who have additional health and social needs and who are vulnerable.

13.14 The Inquiry Panel was assured by Social Services senior managers that any individual with a similar mixture of problems to those of Lorna would now be dealt with as a vulnerable adult, and was shown recent locally agreed policies and procedures dealing with such people, but we were unable to put this claim to the test.

13.15 Furthermore, the most recent Department of Health Guidance on the Protection of Vulnerable Adults, *No Secrets,* (DoH, March 2000) requires active joint working by all agencies to develop policies to protect vulnerable adults and to help and support vulnerable adults who have been abused. The guidelines adopt the broad definition of vulnerable adults suggested by the Law Commission (referred to by the Lord Chancellor in his paper *Who Decides (1997).* That is a person who:

> *" is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."*

13.16 The guidelines specifically include in that category learning disabled people and those who may have suffered *"sexual acts to which the vulnerable adult has not consented, or could not consent or was*

pressured into consenting" (Para. 2.7). This new guidance would appear to provide the cover that was lacking for Lorna; however, there remains the issue of eligibility. In discussing the degree of abuse which could justify intervention (Para. 2.20), the document suggests elements to be taken into consideration, including :

> *"Does the person suffering or causing harm/exploitation meet the NHS and Community Care Act (1990) eligibility criteria ?".*

13.17 In view of this emphasis on eligibility criteria, the Panel was not confident that, in practice, someone with either Lorna's or Nicholas's range of needs would necessarily be considered eligible for services. It still remains a fact that, in 1995, NHS Learning Disability Services saw her as marginal, the impact on her of the alleged sexual assaults appeared to have been ignored and the Mental Health Services, after hospital admission for observation, decided she had: "no diagnosable mental illness."

13.18 It therefore remains the case that another young woman like Lorna, perceived as having only a mild learning disability and behavioural and relationship problems, but no serious mental illness, could still fail to be accepted by the key agencies (see also Chapter 15).

13.19 All the services the Panel has examined for this Inquiry would benefit from being planned, commissioned, and provided on a multi-agency basis. The most recent Government statement on mental health, the *National Service Framework* issued in September 1999, develops this policy by requiring *Partnership Working:*

- between different clinicians and practitioners;
- across different parts of the NHS;
- between the NHS and local government;
- reaching out to the whole community, including the voluntary, independent and business sectors.

13.20 It also requires that *"services should be commissioned through a unified commissioning process".*

13.21 The Panel heard evidence that work is being undertaken jointly between Health and Social Services in Buckinghamshire to implement the targets of the National Service Framework for Mental Health and the Partnership Working agenda, which should lead to greater integration of health and social care provision and sharing of information; and we understand that a high level of co-operation has been established at managerial level with managers serving on numerous joint planning groups. However, from evidence given to the Panel, it is clear that this needs to be translated into improved joint working at clinical and practice level.

RECOMMENDATION 24 : Buckinghamshire Health Authority, Milton Keynes Community NHS Trust, Buckinghamshire County Council and Milton Keynes Council Social Services Departments, liaising as necessary with Thames Valley Police, the Probation Service and voluntary agencies, should improve local arrangements for jointly planning, commissioning and providing services for vulnerable adult groups including people with learning disabilities and substance dependency.

13.22 The new *National Service Framework for Mental Health* also advises on setting of priorities:

> *"Local health and social care communities will have to establish clear and agreed priorities.*
>
> *In many areas the first priority will continue to be addressing gaps in current services for people with severe and enduring mental illness -including 24-hour staffed accommodation, assertive outreach, Home treatment and secure beds.*
>
> *In those areas where local services are able to meet these needs, the most cost-effective focus will now be on people with common mental health problems."*

13.23 Mrs. Jean Jeffrey stated in evidence to the Inquiry that for seven years in succession Buckinghamshire Social Services had to work within budgets that did not even provide for the continuation of existing services, let alone any service extensions or improvements.

13.24 If the Buckinghamshire/Milton Keynes local authorities, as we were informed, continue to be "the lowest spenders in a low spending Region" it is difficult to imagine that there will be sufficient resources available both to close gaps in mental health services for those in the greatest need and to extend services to "people with common mental health problems".

13.25 This concern about adequate resource allocation in social services can also be expressed in the NHS context for those people with a range of alcohol and drug related problems, like Nicholas Arnold, when there is not even a specialist consultant psychiatrist to lead the development of an appropriate network of local services.

CHAPTER 14 : Information Sharing

14.1 The Inquiry has been made aware of the limits of the transfer of information on patients or clients between what are apparently fragmented and demarcated services.

14.2 It is not uncommon for long term users of statutory services to use multiple services. So, a NHS user may be known to Social Services or to Police or Probation Services. Each agency has its own guidelines for information disclosure and confidentiality. There is a strong likelihood that information from one agency may not be available to another. This can lead to an incomplete assessment, and possibly an inaccurate assessment, of clinical risk or capacity.

14.3 A key example in the case of Lorna Thomas was the lack of information sharing between Education and Social Services. As far as can be ascertained, no referral was made by the Education Department to Social Services at school leaving age, in spite of her having been educated almost entirely in special educational needs schools.

14.4 The Panel accepted that not everyone with learning difficulty needs, or would necessarily benefit from, Social Services involvement. However, it is quite clear that Lorna's behavioural problems whilst at school should have triggered a referral to the Social Services Department (SSD) which would have ensured that critical information about her was not left in education files and later lost, even if Social Services had then continued to view her as not meeting the threshold for services or having a "permanent and substantial disability". The issue of eligibility is discussed further in Chapter 15.

14.5 The Inquiry heard about the practice then and now for the "transitional arrangements between Children's and Adult Services" and how in 1991, when Lorna left school, referrals by the Education Service to Social Services were not made routinely but "on a positive basis where services would be needed". The Education Act 1996 was not implemented until after Lorna left school and this, together with proper application of the Disabled Persons Act 1986 in relation to

school leavers, should improve the situation today.

14.6 We were told that Buckinghamshire Social Services now employ two staff to identify school leavers with special needs. Two Transition Panels are held in accordance with the Disabled Persons' (Services Consultation & Representation) Act 1986. The first is an Opinion Panel which normally meets in November, and considers individuals aged 14 who have a Statement of Special Educational Need, and confirms whether their disability is severe and substantial enough to offer an assessment under the Disabled Persons' Act. There is also an Assessment Panel which meets in June, which summarises the assessments undertaken in relation to young people due to leave school within the next year. These assessments usually take place when individuals are between the ages of 18 and 19. These Panels are organised by Social Services and are multi-disciplinary, involving representatives from Education, the Careers Service, Occupational Therapy, Paediatrics, Psychiatry and Educational Psychology Services.

14.7 The Inquiry Panel recognised that the new arrangements should be much more robust, and is not in a position to question the opinion of current senior staff that a young person like Lorna would now be identified for joint consideration with a proper exchange of information. We have been informed that carers' views are now taken into account and their needs also assessed under the 1996 legislation. The practical impact of such arrangements is difficult to assess and is beyond the terms of reference of this Inquiry.

14.8 In other respects, the failure to share information within the Trust, and between the Trust and Social Services, affected the care of Lorna. Senior ward staff stated they were unaware of her experiences in 1993, although these were described in both the clinical and nursing notes. Knowledge of the trauma experienced by Lorna in 1993 was not passed on by Social Services to those in the Trust responsible for her treatment, and in 1995 knowledge of her growing relationship with Nicholas was not shared with Social Services by the Trust staff.

14.9 In relation to Nicholas Arnold, there was no communication between the Probation Service and either the NHS or SSD. Probation and the Police were the only agencies who seemed aware of his substantial criminal history. As we heard, the Mental Health Service relied on a direct question to Nicholas about any previous criminal history, which he denied (see Para. 5.5).

14.10 This reliance upon self-reporting is patently unsatisfactory and means that mental health staff are basing their risk assessments (self-harm, risk to the public, risk to staff) on totally inadequate, indeed sometimes deliberately misleading information. (See also Chapter 10)

RECOMMENDATION 27 : Health and social care agencies in Buckinghamshire and Milton Keynes should meet with the local criminal justice agencies to review and reconsider policies and protocols on the exchange of information in the light of national guidance and the experience of this homicide.

14.11 The transfer of confidential information between professionals clearly raises important issues ranging from civil liberties on the one hand to public protection on the other.

14.12 These issues have been addressed recently in the following publications :

(a) The *Caldicott Report on the Review of Patient Identifiable Information* (DoH 1997) proposed a framework providing:

- objectives of a locally agreed protocol;
- general principles governing the sharing of personal information;
- setting parameters for sharing personal information;
- defining purposes for which information is required;
- holding personal information, access and security;
- ownership of information and the rights of individuals.

(b) In *Probation & Health* – (Home Office & Department of Health,1995) it is stated that:

> *"the development of an effective working relationship between health and probation services has significant mutual benefits. Of paramount importance is the contribution provided by effective joint working to the establishment of healthier communities and increased public confidence in the ability of both services to provide for their safety."*

The benefits of sharing information, some of which can be achieved quickly, can be summarised as follows:

- improvements in overall risk assessment and management of mentally disordered offenders and others presenting any risk of public harm;
- health gain for victims of crime through earlier and more systematic responses;
- increased opportunity to reduce re-offending rates amongst sex offenders and offenders with alcohol, drug and mental health problems;

- increased opportunities to promote healthier lifestyles;
- increased value for money in purchasing specialist services.

(c) The same document identifies another publication, *Dealing with Dangerous People: the Probation Service and Public Protection* (Home Office, 1995), which drew attention to:

> *" the need for the quality and effectiveness of risk management systems to be addressed and for health and probation services to share approaches to risk assessment/management.*
>
> *It is also clear that some individuals in the community will be shared users of both services and it will be valuable to establish clear policies that include: ensuring a co-ordinated service response ... , the sharing of information whilst maintaining the rights to confidentiality of the user, and agreement on lead agency.*
>
> *Alcohol misuse presents both services with a high proportion of their caseload either as a direct problem or as a contributory factor in other presentations. One study indicated that 45% of violent crime was committed by people who had been drinking ... . It is also recognised that alcohol misuse contributes to a significant portion of motor vehicle accidents and hospital admissions."*

(d) The Social Services Inspectorate report *Recording with Care* (SSI, 1999), after examining Social Services records, stated that: *"SSD's generally saw the need for protocols with other public care agencies in covering the sharing of information, and the storage of third party reports in a separate module of the case file".* The report provided a *"case recording policy checklist"* which included *"Agreements on third party and inter-agency information – Health, Housing, Police, Benefits Agency."*

(e) A report from the University of Sheffield on *Information Needs of Youth Offending Teams (YOT - 1998),* in addressing the needs of young offenders, drew general principles of transfer of information which apply equally to adult offenders. The report states :

> *"other areas where information sharing is not straightforward are health and education. YOT managers strongly believe that information from these agencies could critically improve risk assessments with young*

offenders: health and education workers are keen to protect the confidentiality of the young people, and are not sufficiently aware of risk assessment issues in relation to youth offending to decide what is appropriate information to divulge.

The problems of sharing information are not just in relation to obtaining relevant information from other agencies. There are also concerns within the YOTs about other agencies having access to sensitive information about young offenders."

14.13 There are general pressures and duties on health care professionals which have a profound effect on the way in which services are delivered. There is a necessary and proper emphasis on the human rights of individuals. However, on occasion this may inhibit professionals from acting due to a fear of complaint. This can have dangerous consequences. The patient's right to confidentiality is recognised across a range of services, but the information sharing required between agencies appears at times, to be constrained unduly by confidentiality rights. The Panel knows of no evidence that sharing of information as part of risk management deters people from accessing services.

14.14 The importance of listening to family, friends and to patients must be stressed, and the importance of good record keeping practice as a pre-requisite for information sharing.

14.15 There is a need for policies by agencies, and guidance to practitioners, on the necessity of obtaining a full history of those people for whom they accept professional responsibility.

RECOMMENDATION 28 : The Milton Keynes Community NHS Trust and the Milton Keynes General Hospital Trust should ensure that there is one health care record for every patient going through all contacts with the Milton Keynes General Hospital, the Campbell Centre, the Day Hospital and the Learning Disability Service, in order to improve availability and sharing of information.

14.16 It is the view of the Panel that the concept of patient confidentiality needs to be modified not just in Milton Keynes, but nationally, within tight limits, to reduce the number of instances where inadequate information sharing has contributed to fatalities and other serious incidents among people with mental health problems.

14.17 The most recent Government guidance on information sharing *No Secrets* – (DoH, March 2000) , recommends all local agencies, in order to achieve an effective flow of information, to draw up agreements which recognise that *"in certain circumstances it will be necessary to exchange or disclose personal information"* that might normally be regarded as confidential. It stresses the need to distinguish between secrecy and confidentiality. It also refers agencies to the Office of Data Protection Commissioner, which issues guidance and a checklist to help ensure that disclosure of personal information does not breach data protection principles :

- What is the purpose of information sharing ?
- Is it necessary to share personal information to fulfil that purpose ?
- Do the parties have the power to disclose personal information for the purpose?
- How much personal information will need to be shared in order to achieve the objectives ?
- Should the consent of the individual be sought before disclosure is made ?
- What action is appropriate if the consent of the individual is not sought, or is sought but withheld.

14.18 Considerable thought, therefore, needs to be given to the question of when it becomes appropriate for agencies to disclose information about clients to professionals from another agency. It is the Panel's view that a decision to share information, to assist in the assessment of risk, needs to be based on a number of factors including, for example :

Violence and aggression: Previous history of aggression and violence is a good predictor of similar behaviour in the future. It may be worthwhile incorporating into routine clinical assessment procedures in such cases a requirement to check with the Police and Probation Services for a history of contact in the event of specific concerns about an individual.

Drug and alcohol abuse: There is a strong association between violence and aggression and drug and alcohol intake. This means that a positive history of substance abuse with or without a history of violence and aggression may also be a trigger for health professionals to check with law enforcement agencies for past contact.

Frequent change of addresses and agencies: This is often associated with loss of continuity of historical information. In order to formulate accurate risk assessments, and hence effective intervention strategies, information may have to be sought from other agencies directly.

14.19 Individual factors considered in isolation may not amount to an increased risk being identified. However, cumulatively they become strong indicators and should trigger professional concerns.

RECOMMENDATION 26 : The Department of Health and the Home Office should continue to promote the development of joint agreements for a higher level of information exchange between the NHS, Police Authorities and Social Services Departments where relevant, with appropriate safeguards for respecting confidentiality. This should help to ensure better risk assessments and more effective treatment.

Holiday Periods

14.20 The Inquiry Panel was concerned to observe the adverse impact of Christmas holidays and associated service closures upon Lorna following her discharge from the Campbell Centre in November 1995. This followed a failure to engage with her promptly, caused by the absence of a member of staff, due to sickness, on two occasions. This was made worse by the apparent absence of any "cover" or deputising arrangement. The Panel heard that limited resources and service provision left no other option but to cancel the appointments.

14.21 It is critical that the responsibility for vulnerable individuals is accepted by the Campbell Centre team. It follows that any appointments for an absent member of staff need to be dealt with by colleagues on a pre-planned basis. This staff cover arrangement is a key management responsibility and its absence reflects badly on management competence.

14.22 Also, when one member of staff, for example a Consultant, takes over responsibility for a patient from another, it is essential that there should be proper and adequate exchange of information. Considering that the risks associated with inadequate health and care back-up over holiday periods are so well known, it is surprising that there was not a more pro-active attitude.

14.23 Additionally, those providing services to mental health and learning disability clients should take account of the heightened emotional

atmosphere of Christmas and New Year which can be particularly difficult for those people who are vulnerable, lonely and self-harming. Christmas has a cultural dimension as a time for families being together and for party going. New Year is a time for reviewing the past and looking to the future. All of these expectations can have an adverse effect on those who are, or see themselves, as friendless, alone or socially excluded. There is also strong cultural pressure to drink during the festive season, particularly harmful for those people with alcohol related problems.

14.24 It is apparent that Nicholas' heavy drinking, before and after meeting Lorna on the day before the attack, contributed to his loss of control which led to her death.

14.25 All services for vulnerable people should have regard to the guidance in the new *National Service Framework for Mental Health:*

> *"All mental health service users of CPA should receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk ... and be able to access services 24 hours a day, 365 days a year."*

14.26 This may not mean that all services should be working at all times but that some residual service should be available during holiday periods for those considered at risk, or those who may need to access help urgently.

14.27 The Panel considered that if an assessment appointment with a patient had to be cancelled because of staff sickness or other unexpected absence, that assessment should be carried out as soon as possible, if necessary using another member of staff. There should be a careful joint examination of the need for residual services for vulnerable people over holiday periods.

RECOMMENDATION 18 : The Milton Keynes Community NHS Trust should ensure that planning for holiday periods is an integral part of each individual care plan to cover contingencies such as unavailability of staff and ensure continuation of adequate support for patients in the community. Arrangements should be notified clearly to all agencies, including the Police if appropriate.

RECORDS AND RECORD KEEPING

14.28 In order to share information effectively, adequate records must be kept. The Panel believes that improved documentation, coupled with adequate training and effective managerial oversight, would have

avoided some of the confusion associated with the cases of Nicholas Arnold and Lorna Thomas.

14.29 Particularly in relation to records and notes, we were very concerned about the adequacy and availability of these records. In very many places they were totally illegible, frequently disordered, initialled rather than signed, and misfiled so that adjacent pages could be, not just weeks or months apart, but years apart. We find it difficult to believe that, in the light of modern technology, it is impossible to introduce some order into this chaos. Even if action were confined to following the wisdom of the Audit Commission document *Setting the Record Straight* (1995), some improvement could be achieved.

14.30 As noted in Chapter 3, a particular concern regarding Social Services records was the apparent absence of any records at all for Lorna from May 1992 to September 1994. **(See Recommendation 29, Pg. 56)**

14.31 We consider that, as soon as an incident such as this homicide occurs, an incident officer should be assigned by the lead agency to ensure collection, retention and safe-keeping of all relevant records. **(See Recommendation 30, Pg. 78)**

14.32 Probation Service records were of an exceptionally high standard in their quality, clarity and completeness. However, we noted that the different agencies retain their records for very different periods of time so that, for example, early probation records for Nicholas Arnold and all Education Department records for Lorna Thomas were lost to the Inquiry. The Panel considers that the various agencies could usefully review this aspect and harmonise retention time spans wherever possible, with a minimum period of at least ten years.

14.33 As regards the Trust, we found that with a few honourable exceptions, there was clearly a problem about the adequacy of record keeping by junior staff. This reflected poorly on the supervision they received from the consultant leadership regarding the legibility, accuracy, detail and frequency of making entries in the case notes. The Care Programme Approach documentation was sparse and difficult to use. **(See Recommendation 34, Pg. 70)**

14.34 It is clear to us that on the issue of records, notes and information exchange, standards need to be set and protocols established in the interests of patients and the wider community and indeed of those who have to work in the various services.

RECOMMENDATION 31 : The Health, Education, Social Services, Probation, Police and Housing Authorities in Buckinghamshire should review current arrangements for record keeping to raise standards to those of the best and to harmonise retention time spans for records wherever possible.

CHAPTER 15 : The Care Programme Approach

15.1 The key issue for the application of the Care Programme Approach is the existence of a diagnosable mental illness. The implementation in 1991 under DoH circulars HC (90)23/LASSL(90)11 focused upon the care of people with a mental illness referred to specialist psychiatric services.

15.2 Government guidance was updated in the document *Building Bridges* in 1995, which stated that: *"It is government policy that the specialist mental health services target their resources and efforts first and foremost on severely mentally ill people."* (Para. 1.0.3). It was, however, acknowledged, that *"there was no generally agreed definition"*. Later, the Department of Health provided a framework to assess the existence of Severe Mental Illness, within which the key elements to be considered are : **S**AFETY, **I**NFORMAL / FORMAL CARE, **D**ISABILITY, **D**IAGNOSIS, **D**URATION. This became known by the acronym of the "SIDDD Framework." Para. 1.2.3. clarified the position as follows:

"In referring to 'people suffering from severe mental illness' we mean individuals who:

1. *Are diagnosed as suffering from some sort of mental illness (typically people suffering from schizophrenia or severe affective disorder, but including dementia).*

2. *Suffer from substantial disability as a result of the illness, such as an inability to care for themselves independently, sustain relationships or work.*

3. *A. Are currently displaying florid symptoms, or who*

   B. Are suffering from a chronic, enduring condition.

4. *Have suffered recurring crises leading to frequent admissions and interventions*

5. *Occasion significant risk to their own safety or that of others."*

15.3 Additional and alternative definitions of the severely mentally ill had been given in the *Health of the Nation* (1994) key area handbook on mental illness. However, *Building Bridges* (1995) makes clear that:

> *"the CPA is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by the specialist mental health services."*

15.4 The Milton Keynes Community NHS Trust established a Care Programme Approach Group in November 1993. A document referred to in Chapter I (see Pg. 31) was jointly produced by the Trust and Buckinghamshire County Council Social Services Department entitled *The Care Programme Approach, Care Management and Supervision Register Policy.*

15.5 As required by Government policy, its aim was: *"to improve the delivery of care to people with a severe mental illness . . .".* However, it required:

> *"individually designed care programmes for all inpatients about to be discharged from mental illness hospital and for all new patients accepted by the specialist psychiatric services".*

15.6 The document introduced a tiered approach to CPA, stating: *"patients can be divided into three groups, depending upon the severity of their illness and the level of professional intervention they need".* There was to be:

- Minimal CPA
- More complex CPA
- The full, multidisciplinary CPA

15.7 The system was to have : *" a screening process which is applied consistently"* (Para. 4.3). It introduced the Social Services criteria for involvement:

> *"Social Services have their own system for prioritising the need to be involved with patients ... . This will mean that social services staff are most likely to be involved with patients on levels two and three of the CPA."*

15.8 It is clear from the above evidence that there was a joint policy for CPA in operation in Milton Keynes at the time Lorna Thomas and Nicholas Arnold were receiving care. However, in practice, as the Panel heard in evidence, Social Services were operating a more stringent policy of access to care than the Trust, and operational staff

confirmed to the Inquiry that these were the criteria to which they were working.

15.9 The question is whether the responses of Health and Social Services staff were within their local policy and national guidelines. Both national and local priorities were focussed on the "severely mentally ill." Simpler services were planned for people with a diagnosed but less severe mental illness. However, Dr Joseph, Consultant Psychiatrist, in relation to Lorna Thomas, gave evidence that he "felt she had no evidence of a formal mental illness", and this view was supported by Dr Singh.

15.10 Chris Lozinski, Chairman, Care Programme Approach Association, an expert witness to the Inquiry, took the view that : "people with a learning disability ... would normally only be included in the CPA and Severe Mental Illness priorities if they had a dual diagnosis of learning disability and serious mental illness".

15.11 *Building Bridges* (Chapter 4) is clear on the issue of learning disability; in a Q & A section relating to risk registers, it reads:

> *"**Q.** Should a patient with a learning disability deemed to be at risk of suicide or self neglect be placed on a register?*
>
> ***A.** Yes, but only if they are suffering from a severe mental illness, and meet the other risk criteria outlined in the guidelines. This should apply to very few people."*

15.12 As we have seen, although Lorna did not appear to have a formal mental illness, she did meet many of the risk criteria. There remains the issue as to the extent of her learning disability. Dr Singh stated in evidence that: "I have known Lorna for three years. Lorna had a very mild learning disability and seemed to have major problems in making and sustaining relationships." In his verbal evidence to the Inquiry he said : "on my clinical impression I felt that she had a mild learning disability because of the things she could do, she could read, write and do lots of things for herself. She was quite articulate and I could find no evidence on that initial assessment of her having a formal psychiatric illness ...". This view was shared by most of those who dealt with Lorna.

15.13 However, in spite of being described as "marginal", she received a number of services from the NHS learning disability team, and following a number of overdoses, she was admitted to the Campbell Centre, under the care of the Adult General Psychiatrist, Dr Joseph, and received a psychiatric assessment, treatment and a period of observation on the ward. A care programme inpatient assessment was conducted on 23 November 1995, when an action plan for Lorna was agreed (see Paras. 4.18, 4.19 & 4.22).

15.14 Dr Joseph gave evidence that he believed that he had discharged Lorna to the care of the Trust's Learning Disabilities Team. There appeared to be no plans for continuing involvement of the NHS Mental Health Team, although she had in fact been referred to the Campbell Centre Day Hospital, a mental health facility. It would appear that the Care Programme Approach was discontinued after her discharge. **(See Recommendation 12 and 22, Pg. 61)**

15.15 As far as the care of Nicholas Arnold is concerned, the same issue of entitlement to inclusion in the Care Programme Approach is raised. *Building Bridges* has a clear statement in chapter 4 on "alcoholic dependence" :

> *"**Q.** Do patients with alcoholic dependence fit into the category of 'severe and enduring mental illness', and are they therefore liable to be put on a register?*
>
> ***A.** We would not regard patients who suffered from alcohol dependence alone as coming within the above definition."*

15.16 As Chris Lozinski remarked, alcohol and drugs dependency would not normally be included in the CPA or Severe Mental Illness definitions unless there was an additional diagnosis of mental illness, i.e. dual diagnosis. More fundamentally, alcohol dependency is specifically excluded from mental health legislation. The Mental Health Act 1983, Section 1(3) states :

> *"nothing ... above shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."*

A General Note adds :

> *"this exclusion does not rule out the possibility of a person being detained on the ground of a mental disorder arising from, or suspected to arise from, alcohol or drug dependence or from the withdrawal of alcohol or a drug."*

15.17 A report in June 1995 by Dr Strangeway's SHO described Nicholas as having "a 20 year history of social phobia and alcoholism ... . There was no treatable depressive disorder present".

15.18 Nicholas' care programme form, completed on 12 November 1995, identified his problems as "depression and excessive alcohol intake". However, he received no specific anti-depressant treatment during

his inpatient stay at the Campbell Centre or on discharge on 23 November 1995. He was given an outpatient appointment and referred to the Day Hospital for "groups". A Campbell Centre confidential report commented: "on 12 November 1995, Nicholas was seen and assessed by the duty doctor. No identifiable mental illness was evident ...". His discharge summary on 11 December 1995 gave his final diagnosis as "Alcohol Abuse - F. 10" and it appears that Nicholas was considered for only minimal CPA.

15.19 The whole issue of achieving integration of assessment remains open. The latest document on *Effective Care Co-ordination in Mental Health Services; Modernising the Care Programme Approach* (DoH, 1999) observes:

> *"most SSDs have developed eligibility for services using descriptions of vulnerability and risk, while many CPA systems define access to service and level of expected monitoring by legal status or diagnosis."* (Para. 38).

15.20 It would appear, therefore, that since neither Lorna nor Nicholas were diagnosed by their Consultants as displaying any formal mental illness, let alone any serious mental illness, their eligibility for inclusion in the CPA was held to be minimal, in spite of the fact that their symptoms fell within the broad definitions of the SIDDD framework. The issue of diagnostic accuracy and, therefore, of whether they could have crossed the threshold for a more complex CPA is dealt with in Chapters 9 and 10. Each received an individual care programme plan on discharge, ostensibly in accordance with the basic requirement of local and national policy, but as we have seen, only one element of Lorna's plan was implemented, no keyworker was appointed in either case, and neither plan was monitored in the community.

CHAPTER 16 : Conclusions

16.1 The terms of reference of this Inquiry required us to examine the suitability of the health and social care received by Lorna Thomas and Nicholas Arnold in the light of their history, their assessed needs and the extent to which that care corresponded with national and local guidance and policies. We were also required to consider the exercise of professional judgment and the adequacy and monitoring of their care plans.

Lorna Thomas

16.2 Considering Lorna's case in the light of our terms of reference, the care she received was quite extensive and supportive over short periods in 1993 to 1995. In the context of her history, however, it is the view of the Panel that her health and social care did not get to the heart of her problems and did not meet her needs, which remained inadequately assessed. No assessment of her needs took place after the incidents in 1993 and there was no holistic appraisal.

16.3 Within this inadequate and limited assessment, her care corresponded in the main with statutory obligations, but fell short, even of local operational policies, in implementation of the Care Programme Approach and support in the community.

16.4 The professional judgment of both NHS and Social Services staff was at fault in failing to diagnose or recognise her increasing mental deterioration and continuing trauma, and to implement treatment and support in the final weeks. The very serious issue of psychological damage resulting from the alleged sexual assaults was virtually ignored by both services.

16.5 It is the view of the Panel that Lorna had an increasing mental health problem, which should have been treated. We also consider that the low level of her social competence, and therefore her vulnerability, was masked to some extent by her articulate presentation. Therefore, although the true level of her need was recognised by

some who worked with her, it was not acknowledged by those making the decisions, and she did not receive the degree of support she should have had.

16.6 The care plan on discharge from the Campbell Centre would have been acceptable if it had been implemented, but only one element materialised; no keyworker was appointed for Lorna in the community, her care after discharge was not monitored, and no risk assessment was carried out. She was left for one month without constructive activity. A greater sense of urgency about her needs and a more explicit recognition of her extreme vulnerability could have led to the support needed to counterbalance the emotional dependence which she increasingly placed on Nicholas Arnold in the final weeks.

16.7 While it is accepted that as long as Lorna remained in the community there would always have been the possibility of risk from one source or another, it was the duty of the statutory authorities to provide this very vulnerable young woman with a higher level of support than they did. Even after the event, Social Services remained convinced that their only duty to Lorna had been to help her find more suitable accommodation. The Panel rejects the view, expressed by Dr Singh after the incident, that "in view of her assessed mental needs, Lorna got a service over and above that which her actual needs justified".

16.8 The Inquiry Panel found a lack of strategic planning in the Milton Keynes Community NHS Trust in 1995 and poor standards of record keeping, particularly in the Campbell Centre medical records. We learnt that a strategic planning group now exists, though clinicians still appeared to us to be functioning in a compartmentalised service. We also heard that there has been action to improve record keeping in the Trust, though we were unable to put this to the test.

16.9 We were concerned at the hierarchical attitudes and rigid approach among some staff of the Trust and Social Services. This was evidenced in the lack of multi-disciplinary working necessary to achieve the highest standards of care. We found that joint working, both within the statutory services and between services, is still very limited in practice and clinicians still appeared to be isolated, although numerous joint groups now exist at managerial planning level.

16.10 We were also concerned at the continuing lack of clinical support staff for the Learning Disabilities Consultant, the absence of a Consultant lead for the Day Hospital, the still limited staffing establishment of, and access to, psychological services, and the minimal Consultant input to Pegasus and the Drugs and Alcohol Dependency Service. All these clinical staff shortages need to be addressed before the service on offer to patients can be considered adequate.

16.11 Although we understand work has been undertaken to improve risk assessment, this can still be seriously undermined by inadequate sharing of information, which affected the care offered to both Lorna and Nicholas.

16.12 Major shortcomings in the care available for people with mild learning disabilities existed at the time within both the NHS and Social Services and were noted and reported upwards by staff. Some changes have been implemented by the Milton Keynes Community NHS Trust since 1995, but there is still no designated provision by either Health or Social Services for people in Lorna's category, with mild learning disability and other borderline problems, and they receive no automatic assessment by Social Services or NHS on leaving school and no automatic periodic review to consider whether their diagnosis should be amended. It is left to chance whether any deterioration in their condition comes to light. In spite of being reported upwards, the Panel could find no evidence that the unmet need of this category of client was ever specifically reported to the Buckinghamshire Social Services Committee's elected County Council members.

16.13 The Panel was deeply disturbed to find no mention whatsoever in Social Services' records of the extensive contacts between the Social Services Adult or Learning Disabilities Teams and the Police Family Protection Unit in 1993 and 1995, or any record of long term action taken in the light of the alleged serious sexual assaults on Lorna in 1993 and her resulting trauma.

Nicholas Arnold

16.14 At the onset, Nicholas Arnold's problems were perceived as springing from social phobia and anxiety. He did have some psychological treatment at Luton which he claimed to have found useful, but for most of the time he was treated with benzodiapines, gradually developing an addiction. He also developed alcohol dependence.

16.15 The care he received in later years was undermined by his basic unwillingness to co-operate in treating this longstanding addiction to alcohol and to prescribed drugs. He continued to use either or both substances throughout treatment periods. He received occasional unplanned sessions of detoxification from alcohol and was weaned from benzodiazepines for one short period in 1988 – 1990. The techniques used in attempting to treat his alcohol abuse did not extend to prophylactic chemical treatments, and there was no attempt at detoxification in the community. The Panel was concerned to learn that, although the possibility may have been discussed in 1985, Nicholas never had psychiatric nursing support in the community.

16.16 There is no statutory requirement to treat alcohol dependency per se, and provision for such treatment in Milton Keynes remains limited and mainly focused on people with additional serious mental illness. While some degree of personality disorder was recognised from time to time by some of those who treated Nicholas – notably an earlier GP and his counsellor at Pegasus – his unwillingness to participate actively in counselling hampered attempts to reach a full understanding of, or to treat, his underlying psychological problems, whilst his reluctance to apply lessons learnt during his treatment at Pegasus and the difficulty of access to the psychology department compounded the issue.

16.17 A fuller understanding of Nicholas' problems and his nature was also impeded by inadequate information about his history. A comprehensive multi-agency assessment was never undertaken. The Milton Keynes Community NHS Trust staff who dealt with him relied on his self-reporting, which omitted any reference to his contacts with the Police or Probation Service. If information had been available to the psychiatrists from the Probation Service, or even from his early GP records, they could have probed more deeply and re-assessed their diagnosis. No account seems to have been taken of the possible implications of his frequent attendance at A & E.

16.18 In the event, such prior evidence of Nicholas' capacity for serious violence as existed was not known to the mental health staff. Although they knew him to be noisy and offensive when drunk he appeared to them to have been the victim of violence more often than the perpetrator. No one we interviewed from the staff team expressed any concern for their personal safety while in his presence. Whilst he was well known to the Police, they stated that they saw him as a local nuisance and petty criminal rather than someone who was likely to be seriously violent.

16.19 The persona which he presented to the staff in the Campbell Centre and the Mental Health Teams was of someone who, when sober, was quiet and co-operative, even helpful. It is, therefore, unlikely that any Mental Health Team, with the same limited information available to them, could have predicted Nicholas Amold's underlying capacity for serious violence or for murder.

16.20 However, this persona contrasted sharply with the aggression and bravado seen by neighbours and girlfriends and even his mother, who all knew that he was capable of physical violence if people argued with him when he was drunk, to the extent that some stated in evidence that they were afraid of him at times.

16.21 There is evidence, both from his mother, and from a long term woman friend, of his threatening behaviour and actual violence towards one

of them when drunk. Both seemed to have had techniques of handling this, principally by departing from his vicinity. Evidence from the scene of the crime suggested that Lorna may also have tried to depart, but on the night of the murder Nicholas had secured the door of the flat and removed the door handle, thus preventing her exit. Loma had also taken both alcohol and at least three Zopiclone sleeping tablets (normal dose 1-2 tablets), which probably rendered her too drowsy and unco-ordinated to make a successful escape. It is unclear why Loma was found to have taken this medication as this was not medication prescribed for her.

16.22 If the mental health staff had had access to the information necessary for a better understanding of Nicholas Arnold they might have been even more concerned about his growing relationship with Lorna and have at least discussed it in their discharge planning meetings. More diligent attention to monitoring of both of them in the community might have revealed Nicholas' increasing intake of alcohol over the holiday period and therefore his increasing instability and Lorna's increasing danger.

16.23 As it was, the Mental Health Service did not appear to undertake any substantial risk assessment of Nicholas, or of Nicholas and Lorna jointly, and although his discharge care plan may have seemed adequate for his needs as then perceived, it did not address his real need, to have psychological treatment for his underlying personality disorder, which remained unacknowledged. There was no keyworker in the community, or monitoring for either Nicholas or Loma, and Nicholas appears to have had no contact with Social Services. We acknowledge that considerable steps have been taken recently to improve training and implementation in regard to risk assessment and CPA.

16.24 We recognise that it is not the responsibility of the NHS or Social Services to try to "cure " every alcoholic, even though their behaviour represents a huge cost to the nation. For the most part they are left to fend for themselves. In Nicholas' case the key question is whether he had an additional mental health need which should have been more constructively tackled. We conclude that he did have such a need, although not sufficient to substantially diminish his responsibility for his actions. However, in view of his basic attitude of non-compliance, whether any additional psychological treatment would have been successful is uncertain.

General

16.25 These conclusions have given rise to a number of recommendations and suggestions for improvement of the services provided both by the

NHS and Social Services in Milton Keynes, which are set out in the following chapter, grouped according to their content and significance. There are also some which have national relevance.

16.26 It is worth noting that several of the concerns reflected in this Report have arisen in other Inquiries and have led to very similar recommendations. In *Inquiries After Homicides* (1996), Jill Peay and her colleagues put forward the suggestion that there should be a national audit of NHS Inquiry recommendations. It is the view of this Panel that such an audit is very necessary, together with monitoring of the responses.

16.27 Although some of the recommendations in this report would involve re-alignment of resources, many require no more than a shift of attitude among professionals, away from the present culture of insular working, which we found to be continuing among many Health and Social Services staff, and towards the more flexible approaches proposed in the policy documents. This could create the safety nets needed, to provide more effective help to people with Nicholas Arnold's problems, and to support and protect vulnerable people such as Lorna Thomas, who deserved better of us all.

CHAPTER 17 : Recommendations

LEARNING DISABILITY SERVICES

RECOMMENDATION 1 : The Milton Keynes Community NHS Trust should ensure that people with learning disability are automatically reassessed at regular intervals using the WHO recommended multiaxial system of diagnosis to record diagnoses in their psychiatric, developmental, intellectual, physical and psychosocial domains. Life events, changing clinical presentations (including frequent contact with services) and regular risk assessments should trigger a CPA review. The Department of Health and Royal College of Psychiatrists should consider issuing appropriate guidance to all Mental Health and Learning Disabilities Services on this issue of regular re-assessment. (Page 83)

RECOMMENDATION 2 : The Buckinghamshire Health Authority and the Milton Keynes Community NHS Trust should review the level of medical staffing in learning disabilities, to ensure that it is in keeping with the recommendations of the Royal College of Psychiatrists (one whole-time consultant for 100,000 population) and to ensure that the consultants are supported by junior medical staff. We understand that this recommendation could apply equally to other Health Authorities and Trusts in England and Wales. (Page 99)

RECOMMENDATION 3 : The Department of Health should issue guidelines to local Social Services Departments about the levels of resources which should be made available to support the provision of services in the community required by people with mild learning disabilities, who have additional health and social needs and who are vulnerable. (Page 118)

RECOMMENDATION 4 : The Milton Keynes Council and Buckinghamshire County Council Social Services Departments and the Milton Keynes Community NHS Trust should review their referral policies to allow Psychiatrists in Learning Disability to refer patients with a mild learning disability and mental health needs, who may benefit from the service, to Keystone or any other similar service. (Page 43)

RECOMMENDATION 5 : The Buckinghamshire Health Authority should ensure that the Milton Keynes Community NHS Trust provides a more comprehensive inpatient service for people with mild learning disability. This should include access to beds within the Campbell Centre or other appropriate local resource, for those who are or may also be suffering from mental illness and need a period of observation and treatment. Even though day to day management decisions could be the responsibility of the sector Consultant, overall clinical responsibility for such individuals should remain with the Learning Disabilities Consultant(s) to ensure continuity of care. These services need to include some staff trained in both mental health and learning disability (Page 44)

RECOMMENDATION 6 : The Milton Keynes Community NHS Trust should review its policies regarding relationships developing between inpatients in psychiatric units, especially in relation to people with a learning disability. Assessment of mental capacity to give valid consent and vulnerability in sexual relationships may require the individuals concerned to be separated or protected in some way. Relevant training of staff should take place. (Page 59)

RECOMMENDATION 7 : The Milton Keynes Council and Buckinghamshire County Council Social Services Departments should review their "appropriate" adult procedures to support people with a learning disability who are to be interviewed by the Police and should provide the necessary continuing support afterwards. (Page 41)

ADDICTION SERVICES

RECOMMENDATION 8 : The Buckinghamshire Health Authority and the Milton Keynes Community NHS Trust should review the level of medical and nursing staffing within addictions and substance dependency, in order to offer a more comprehensive treatment service, including Consultant led outpatient clinics and home detoxification services to supplement the services offered by Pegasus. In particular, a Consultant Psychiatrist and support staff should be specifically appointed to co-ordinate drug and alcohol dependency services in Milton Keynes. (Page 109)

RECOMMENDATION 9 : The Milton Keynes Community NHS Trust should explore the possibility of offering the prescription of prophylactic drug treatments at Pegasus, to assist in achieving and maintaining abstinence, for people with alcohol related problems, at least until consultant led clinics are set up. (Page 112)

RECOMMENDATION 10 : The Department of Health should consider providing specific grants to Health Authorities for the development of local alcohol treatment and rehabilitation services, possibly funded from the tax on alcohol sales. (Page 113)

PSYCHOLOGY & PSYCHOTHERAPY SERVICES

RECOMMENDATION 11: The Buckinghamshire Health Authority and Milton Keynes Community NHS Trust should undertake a comprehensive review of psychology and psychotherapy services including staffing establishment and pathways of referral. Particular consideration should be given to developing the psychology services for people with learning disability and to introducing specific sessions for drug and alcohol services, in order to avoid patients having to wait unduly long for assessment and treatment. (Page 103)

DISCHARGE PLANNING AND CARE PROGRAMME APPROACH

A) KEYWORKERS

RECOMMENDATION 12 : The Milton Keynes Community NHS Trust should ensure that the Care Programme Approach leads to the appointment of a care co-ordinator who has responsibility for ensuring that the care plan is individualised, effective and timely, also that it is implemented and regularly reviewed. (Page 61)

RECOMMENDATION 13 : The Milton Keynes Community NHS Trust should ensure that the respective roles, responsibilities, grades and competencies of named nurses, keyworkers and care co-ordinators are reviewed and clarified, including the extent of the responsibility to ensure delivery of services to individual patients. (Page 68)

RECOMMENDATION 14 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that there is an express recognition of the need to engage service users and carers as far as possible in the planning and delivery of care and after care. Service users and carers should be active participants in the assessment of need, planning, treatment, risk assessment, discharge and follow-up support. Special consideration should be given to home circumstances. The views of service users and carers should be sought and recorded. (Page 58)

B) DISCHARGE

RECOMMENDATION 15 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that every effort is made to encourage GPs to make an effective contribution to discharge planning and the CPA, particularly for patients requiring ongoing treatment, including people with learning disabilities. Meetings should be notified in good time to help ensure the attendance of the GP or a practice nurse. Failing this attendance, the Community Nurse should make early contact with the GP as well as with the patient. (Page 99)

RECOMMENDATION 16 : The Milton Keynes Community NHS Trust, Milton Keynes Council and Buckinghamshire County Council Social Services Departments should ensure that risk assessment is an on-going feature of psychiatric treatment and that in all cases this entails a comprehensive multi-disciplinary summary compiled by the keyworker with relevant contributions from medical, nursing, Social Services, and Police and Probation staff where appropriate. This should be completed at a multi-disciplinary review meeting where the responsibilities of each agency are agreed and recorded. There should be regular audit of risk assessments. (Page 91)

RECOMMENDATION 17 : The Milton Keynes Community NHS Trust should ensure that where an intended discharge is delayed for further consideration a full review meeting is held immediately prior to the discharge taking place. All documentation should contemporaneously record the discharge process. Action should be taken to ensure greater clarity of responsibility than at present once an inpatient is discharged. (Page 58)

RECOMMENDATION 18 : The Milton Keynes Community NHS Trust should ensure that planning for holiday periods is an integral part of each individual care plan to cover contingencies such as unavailability of staff and ensure continuation of adequate support for patients in the community. Arrangements should be notified clearly to all agencies, including the Police if appropriate. (Page 128)

RECOMMENDATION 19 : The Milton Keynes Community NHS Trust should ensure that discharge summaries to GPs are timely and accurate in order to assist in the management of patients after their discharge from hospital. Information must be given to the GP on the day of discharge. Compliance with this recommendation and the quality of subsequent discharge summaries should be monitored through an audit trail. (Page 70)

DAY HOSPITAL

RECOMMENDATION 20 : The Milton Keynes Community NHS Trust should ensure that a Consultant Psychiatrist is urgently identified to lead the Campbell Centre Day Hospital and should review the staffing levels to ensure that there are enough staff to maintain the weekly programme whilst allowing for both initial and regular individual assessments and ongoing one to one work when required. Allowance also needs to be made for annual leave and sickness. (Page 71)

RECOMMENDATION 21 : The Milton Keynes Community NHS Trust should ensure that every attempt is made to assess referrals to the Campbell Centre Day Hospital promptly. If the allocated assessor is not available for any reason, the assessment should be made by another qualified staff member with the minimum of delay. (Page 61)

REFERRALS

RECOMMENDATION 22 : The Milton Keynes Community NHS Trust should ensure that all referrals to their services, or requests to different parts of their services, clearly indicate the degree of urgency. There must be clarity about the Consultant who is to be responsible for the care of the individual. (Page 61)

RECOMMENDATION 23 : The Milton Keynes Community NHS Trust , the Milton Keynes Council and Buckinghamshire County Council Social Services Departments, working with Thames Valley Police, should ensure that their staff follow local Section 136 procedures. There should be a system of monitoring and clinical audit of the handling of Section 136 episodes, the results of which should be included in the annual report of each Authority. (Page 69)

JOINT WORKING

RECOMMENDATION 24 : Buckinghamshire Health Authority, Milton Keynes Community NHS Trust, Buckinghamshire County Council and Milton Keynes Council Social Services Departments, liaising as necessary with Thames Valley Police, the Probation Service and voluntary agencies, should improve local arrangements for jointly planning, commissioning and providing services for vulnerable adult groups including people with learning disabilities and substance dependency. (Page 120)

RECOMMENDATION 25 : The Milton Keynes Community NHS Trust should ensure full multi-disciplinary discussion with and involvement in strategic mental health planning of the Director of Mental Health, the Clinical Director, all relevant Consultants, Heads of Departments and Nurse Managers and including appropriate input from Social Services. Such a group should also regularly review existing services. (Page 117)

INFORMATION SHARING

RECOMMENDATION 26 : The Department of Health and the Home Office should continue to promote the development of joint agreements for a higher level of information exchange between the NHS, Police Authorities and Social Services Departments where relevant, with appropriate safeguards for respecting confidentiality. This should help to ensure better risk assessments and more effective treatment. (Page 127)

RECOMMENDATION 27 : Health and social care agencies in Buckinghamshire and Milton Keynes should meet with the local criminal justice agencies to review and reconsider policies and protocols on the exchange of information in the light of national guidance and the experience of this homicide. (Page 123)

RECORDS

RECOMMENDATION 28 : The Milton Keynes Community NHS Trust and the Milton Keynes General Hospital Trust should ensure that there is one health care record for every patient going through all contacts with the Milton Keynes General Hospital, the Campbell Centre, the Day Hospital and the Learning Disability Service, in order to improve availability and sharing of information. (Page 125)

RECOMMENDATION 29 : The Directors of Social Services for Buckinghamshire County Council and Milton Keynes Council should take steps to ensure the accuracy and completeness of Social Services record keeping. (Page 56)

RECOMMENDATION 30 : Following a serious incident involving patients currently receiving care and treatment, the Milton Keynes Community NHS Trust, in addition to following national guidance, should appoint an incident officer to liaise on a multi-agency basis to ensure collection and retention of all relevant records and press material. A comprehensive review should take place and an action plan be devised and implemented. (Page 78)

RECOMMENDATION 31 : The Health, Education, Social Services, Probation, Police and Housing Authorities in Buckinghamshire should review current arrangements for record keeping to raise standards to those of the best and to harmonise retention time spans for records wherever possible. (Page 130)

RECOMMENDATION 32 : The Milton Keynes Community NHS Trust should ensure that all community support workers and other professionals having direct contact with patients are aware that they are allowed access to patients' notes to enable them to have a better understanding of clinical needs. (Page 44)

TRAINING

RECOMMENDATION 33 : The Department of Health and the training bodies should encourage cross-disciplinary training in mental health, substance abuse and learning disability for nurses, social workers and all those who might be appointed as keyworkers to persons who have dual diagnosis. (Page 55)

RECOMMENDATION 34 : The Milton Keynes Community NHS Trust should ensure that a review of arrangements for the clinical management, training and supervision of junior medical staff is undertaken including assessment of record keeping skills; and should introduce a regular random audit of case notes with the results reported back to the medical staff, as well as through the Quality Assurance mechanisms of the Trust. (Page 70)

POLICE

RECOMMENDATION 35 : The Thames Valley Police Authority should review the systems and the links in place between the Family Protection Unit and the rest of the Police service. Information sharing should extend not just to inter-agency but also intra-agency in circumstances such as Lorna's case. (Page 56)

RECOMMENDATION 36 : The Thames Valley Police Authority is asked to review its procedures for dealing with families of victims and for notifying specialist agencies in the case of any concerns they may have about individuals in the community, or in the aftermath of a major incident such as homicide. (Page 100)

HOUSING

RECOMMENDATION 37 : The Milton Keynes Council should review its housing policies in order that more effective consideration can be given to the health and social needs of individuals when deciding on the merits of a request for rehousing. (Page 59)

CASE CLOSURE

RECOMMENDATION 38 : The Social Services Departments of Buckinghamshire County Council and Milton Keynes Council should ensure that when they "close" a case, this is handled with sensitivity and openness. The client and their families should be aware that the case has been closed and the reasons notified in writing. (Page 41)

DIRECTORY

RECOMMENDATION 39 : The Milton Keynes Community NHS Trust should maintain a regularly updated directory of support agencies which should be made available to health and social care professionals in the inpatient areas, within the community mental health teams and to GPs, as a source of reference for people with a range of mental health and learning disabilities. (Page 113)