BURY PRIMARY CARE TRUST

Report of the Inquiry into the Care and Treatment of Simon Rawcliffe by Mental Health Services of Bury

NHS

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Executive Summary

In September 1999, Simon Rawcliffe was living in bed & breakfast accommodation in Bury. There, he killed another resident. Simon Rawcliffe had recently been discharged from mental health services in Bury where he was an inpatient.

The Inquiry Panel were asked to examine the circumstances of the treatment and care of Simon Rawcliffe. In order to understand this, it was necessary to understand the development of his mental illness by reviewing his contacts with Mental Health Services from the very beginning. His first assessment by Mental Health Services was in 1993. Simon Rawcliffe was admitted to a number of inpatient Mental Health units across the North West, and had had more than one admission to Fairfield General Hospital, Bury.

Our independent external review was helped by the detailed internal inquiry report which was presented to Bury Health Care NHS Trust, the organisation responsible for Mental Health Services in Bury. However, we were able to take a broader view, which we believe is still of relevance today, even though some time has lapsed since the 1999 homicide.

It became clear to us that it was impossible not to address the whole system in our understanding of the events leading to the homicide.

As we set out in more detail in the body of this report there were, in our view, three important strands to the understanding of the care and treatment of Simon Rawcliffe:

i. The quality and effectiveness of the clinical care and decision making,
ii. the historical underfunding of the mental health service in Bury,
iii. and, the quality and effectiveness of management and decision making in the mental health service, Bury Health Care NHS Trust, and the relationship between the Trust and the Health Authority.

Whilst underfunding and management issues cannot excuse failures in clinical care, they help at least in part, to understand why the event that we reviewed occurred.

We have based our findings on the evidence of written and oral records from individuals and agencies. Those individuals that we interviewed, and the documents that we reviewed are referred to at the end of this report.

During our work, the most recent re-organisation of local health and social services took place, and mental health services in Bury were taken into the new mental health organisation, Pennine Care NHS Trust. It became clear that the new Trust is making progress in correcting a number of the deficits that we identified, both in clinical care, management structures, and financial investment. A progress report, prepared by the new Bury Borough Director, Pennine Care NHS Trust, is enclosed with the report as an Appendix, in recognition of this work. This report describes the changes in patterns of service delivery, processes, protocols and more recently management structural changes; that address some of the identified recommendations.

What we found striking, was that there still remained much to be done in Bury, despite the passage of four years since the homicide. We believe that this report can be used to encourage further positive developments within mental health services in Bury. We are hopeful that Pennine Care NHS Trust will be serious in translating the action plan that will flow from this report into meaningful improvements in mental health care that will make a difference for both users and carers.

We do not wish to be part of the "blame culture". It is for this reason that we agreed to the request made by the Strategic Health Authority to remove from this report the names of all of those professionals involved in the care of Simon Rawcliffe. However, we are assured that the action plans will focus on individuals where this is appropriate.

Findings

We found much that was good in Bury and there were examples of good practice. There are many individual members of staff who have remained loyal to the service. There are also excellent examples of team working, though it has to be said that medical staff were (and are) peripheral team players. This is discussed in more detail in the report.

A number of recurrent themes emerged from our inquiries that have influenced the recommendations contained in this report. These can be summarised as:-

- A lack of a consistent approach to and a poor understanding of Simon Rawcliffe mental illness leading to a lack of formulation of his case and inappropriate and inadequate risk assessment. Clinicians appear to have made no connection between Simon Rawcliffe's behaviour and the relationship to his illness
- Frequent closure of episodes of care, incomplete medical and social notes made the transfer of the case less efficient. Concern is also consistently expressed about the lack of dating and signing of notes making them difficult to put into context. This also contributed to his care being uncoordinated.
- Early in his last period of care at Fairfield General Hospital, his complete set of notes went missing and no attempt was made to retrieve this information. The loss of this balanced history of his contact with other services, also contributed to the poor understanding of his mental health needs and risks.
- A diagnosis of personality disorder was viewed by the inquiry as too simplistic and was considered to be a means of managing Simon Rawcliffe out of psychiatric service.
- Poor implementation of CPA and risk assessment and management.
- The need for clinical supervision of nursing staff is highlighted, and deficits in training are identified.
- We identified problems for individuals who moved from one area to another, and how social services respond, and take responsibility for individuals in this situation. We are also critical of the use of a bed and breakfast accommodation list for vulnerable adults with mental health problems.
- There were also problems in the use of the 1983 Mental Health Act which we comment on in our recommendations.
- We express concern over the lack of stability within the medical workforce and the loss of training status within Bury Health Care NHS Trust, which in turn has led to recruitment difficulties.
- The level of investment in mental health services comes under scrutiny, with a request to ensure that funding is reviewed.
- Poor and inconsistent strategic management following the initial incident report with a lack of transparency and openness.
- A failure to learn lessons from prior internal review process and inadequate systems to monitor the implementation of action plans.

We wish to thank all of those who agreed to be interviewed. At the end of our report we comment on the decision by the former Chief Executive of Bury Health Care NHS Trust not to meet the Panel.

Finally, the value of this process lies not in apportioning blame, but in identifying and driving sustained improvements in mental health services in Bury, which we hope this report will achieve.

Dr. Peter Snowden (Chair)

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We also wish to thank Associated Verbatim Reporters, the transcription service that we used throughout the Inquiry.

Dr Snowden would also like to thank Ms Jane Mishcon, Barrister, Temple, London. Her fair and thorough style of conducting similar Independent Inquiries has been the model followed in this Inquiry.

Members of the Inquiry Panel & Related matters

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Ms Catherine Grimshaw
Solicitor
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Mr Robert Bamlett
Social Worker

Mr Dudley Ainsworth
Senior Nurse,
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Mr Dudley Ainsworth was struck down by a serious illness part way through the Inquiry and was unfortunately unable to contribute to the preparation of this Report. The Panel was helped a great deal by the work that he had completed before his sudden illness. It was agreed that as most of the interviews of clinical staff had been completed it was unnecessary to appoint a new nurse panel member.

Dr Snowden was asked to Chair the Inquiry and agreed to do so when still employed by Mental Health Services of Salford. He moved to take up a new post at Ashworth Hospital on secondment in July 2001, and was appointed to a substantive post in March 2002. In the process of collecting documentation relating to Simon Rawcliffe, it became clear that there was a possible conflict of interest as he was a patient of the Scott Clinic and Ashworth Hospital, and both are now part of Mersey Care NHS Trust, the employer of Dr Snowden. This matter was brought to the attention of the Chief Executive of Bury PCT and of Mersey Care NHS Trust, and both were satisfied that Dr Snowden should continue to Chair the Panel in an independent manner, as if he was employed by another unrelated NHS Trust. These matters were discussed with all those interviewed from Mersey Care Trust and though present, Dr Snowden took no part in the interviews of staff from Ashworth Hospital, or the Scott Clinic.

Terms of Reference

With reference to the murder committed by Mr. Simon Rawcliffe in September 1999, to examine the circumstances of the treatment and care of Mr. Simon Rawcliffe, by the Mental Health and Social Care Services in Bury, in particular, and his periods of Health and Social Care elsewhere, including Bolton, Warrington NHS Trust and the Scott Clinic in Merseyside.

i. The quality and scope of his health care, social care service, probation service and risk assessments in Bury and also in relation to his periods in Bolton, Warrington NHS Trust and the Scott Clinic in Merseyside.

ii. The availability of local and specialist services to meet his needs.

iii. The appropriateness of Simon's treatment and supervision in terms of:

- His assessed health and social care needs;
- The assessed risk of the potential to harm others or himself;
- Previous psychiatric history and compliance with treatment, any history of drug and alcohol abuse;
- Comparison with contemporary practice in other NHS psychiatric services;
- Statutory obligations including compliance with Mental Health Act 1983, national guidance (including Care Programme Approach), HC (90) 23/LASSL (90) 11, supervision registers, HSG (94) 27 and local operational policies for the provision of Mental Health Services.

iv. The extent to which Simon Rawcliffe's treatment and after care plans were in line with policies current at the time:

- Documented;
- Agreed with Mr. Rawcliffe;
- Adequacy of the collaboration and communication between professionals involved in assessment, care planning and delivery of care;
- Complied with by Mr. Rawcliffe;
- Care plans reflected assessed needs.

v. Examine the appropriateness of the training and development of those involved in Mr. Rawcliffe's care and the supervision and monitoring of their performance;

vi. Comment on the Internal Inquiry and its recommendations and any actions that follow from this;

vii. To prepare a report of the Inquiry's finding and make recommendations as appropriate to Bury Primary Care Trust.

Introduction

Liaquat Ali was born on 28 November 1968. He had been living apart from his wife and child for some time, and prior to his death he was living in a bed-sit at 8/10 Wash Lane, Bury. This accommodation comprised of two houses knocked together to form bed sitting rooms that were let to persons in receipt of housing benefit.

Sometime in the early hours of the 16 September 1999 he met his death. The exact order of events remains unclear. At about 0340 hours he was heard moaning outside the property by another resident. She went to help and found him lying outside on the path. She brought him in and left him lying on a sofa in the sitting room. She checked on him just over an hour later, and he appeared comfortable. Another resident got up at around 0840 hrs and went downstairs to find Liaquat Ali lying on the settee. There was blood and broken glass on his face and shirt. There was broken glass and pieces of broken wood on the carpet near to the settee. An ambulance was called, but he was found to be dead.

This was a tragic loss of life. His eldest sister described him as a quiet man who would not harm anyone. However he had an alcohol problem, had lost stability in his life, and because of this he could place himself in difficult situations. Simon Rawcliffe was convicted of his murder.

The task of the Inquiry Panel was to examine the circumstances and care of Simon Rawcliffe. He was a man with a seven-year history of a severe and enduring mental illness who was convicted of this murder whilst under the care of Bury mental health services. However, we wish to state at the outset that we do not forget the victim. We extend our condolences to the family of Liaquat Ali. They must all have been traumatised by the circumstances of his death. We are grateful to his sister, for her bravery in coming to see us. Talking about her brother was very difficult for her and we acknowledge that this Inquiry may have reawakened her feelings of grief. We are also sorry if we have caused further distress to other members of the family of Liaquat Ali in the preparation and publication of this Report.

Simon Rawcliffe was arrested a little after 0636 hours on the morning of the 16th September 1999, at the bus station at Bury town centre. He was wanted for the theft of a mountain bike six days earlier. He was known in the Ramsbottom area as someone who behaved unpredictably. At times (it was never clear if this was just when unwell) he presented with racist attitudes towards Asian people in the community and when an inpatient. He was known to the police, but was not believed by them to be someone prone to serious violence.

At the police station, it became clear that immediately prior to his arrest he had been responsible for a number of violent incidents at the bus station. He had assaulted an unknown Asian man who never made any complaint to the police and a further three other men. He was subsequently convicted of affray, two common assaults and assault occasioning actual bodily harm for these offences.

A connection was subsequently made between Simon Rawcliffe and the death at 8/10 Wash Lane some hours before, as he was also a resident there. When questioned by the police, he denied any knowledge of this address. He said that he did not remember anything of that night. He declined to answer questions about his attitude to Asian people. He denied killing Liaquat Ali. He claimed to know nothing about his death, or the events leading up to his arrest.

His mental health appears to have deteriorated in 1991, following the death of his father. There was no contact with health or social services prior to 1993. When well his mother described him as *"…very amusing and makes me laugh. We are very close……*(and when unwell) *……a pain in the neck……very awkward. He gets a thing in his head and no one can change it"*.

In 1993, he was admitted to Fairfield Hospital, Bury after a conviction for theft and burglary. A diagnosis of schizophrenia was made, but he did not co-operate with discharge arrangements. There were further admissions after this, and he was at various times an inpatient at Fairfield Hospital, the psychiatric inpatient unit at Bolton General Hospital, and Winwick Hospital, Warrington.

His admissions all followed contact with the police. When unwell, he presented as grandiose, deluded, elated, overactive, disinhibited, and aggressive. In hospital, he was at times threatening and he could be violent. He was difficult to keep on the ward, and when absent without leave, drank alcohol and probably used drugs. When discharged to the community he avoided follow up, there was little stability of accommodation, and he used illicit drugs, which complicated his mental health assessments. He had no insight into his illness, was non compliant with medication, and between admissions was lost to mental health services.

In 1997 he was admitted to the Scott Clinic, St. Helens from HMP Manchester. The Scott Clinic is a medium secure unit, now part of Mersey Care NHS Trust. This was his second admission to a secure psychiatric unit. At the time, he had an address in Bolton, but was arrested in Bury after walking through the streets with what appeared to be a gun. He aimed it at people, made threats to kill, and was aggressive and abusive. He had been drinking alcohol and smoking cannabis. In prison, he presented with clear symptoms of schizophrenia.

He would normally have been admitted to his local medium secure unit, the Edenfield Centre, in what was then Mental Health Services of Salford NHS Trust, but for clinical reasons an arrangement was made to admit him to Scott Clinic, in St. Helens.

During this admission he improved greatly and by the time of his discharge he was better than he had been for some years. This was certainly the view of his mother. He was treated with antipsychotic and mood stabiliser medication. His consultant, Consultant 4 made a diagnosis of schizophrenia with a strong affective component. Attempts were made to find appropriate accommodation, and there was liaison with Bolton social services and Consultant 1 a consultant psychiatrist based in Bury.

The only accommodation available was with a friend, and this broke down soon after his discharge by a Mental Health Review Tribunal, in late February 1998. By the time he was seen by Consultant 1 he was living in a tent in his mother's back garden. He had stopped taking his oral (mood stabiliser) medication and after mid June refused his depot antipsychotic medication. He refused community nurse involvement but he was prepared to see his social worker 1.

He was admitted to Fairfield Hospital for the last time in March 1999, via police custody, after disturbed behaviour in the community. His mother reported that he had been carrying a hammer for 2 days. Consultant 1 and Social worker 1 interviewed him in the police station.

Consultant 3 took over as his responsible medical officer (RMO) on admission. His assessment was made more difficult by the loss of all his notes before the 5 March 1999; the nursing notes are present from the 5 March onwards, and the medical notes begin from the 18 March. These notes have never been recovered, and Simon Rawcliffe has said that he took the notes and destroyed them.

Bury mental health services, at that time were described to us by some of those working in the service as under funded, and unsupported by Bury Health Care NHS Trust. Morale amongst frontline staff was described as high. However, management input was under resourced, the training status for psychiatrists had been lost, and the involvement of consultants and the trust grade doctors on the wards and in the community care was poor because of staffing deficits.

Those interviewed from the Acute Trust in Bury (at Board level) disagreed with this analysis.

The inpatient service was described as 'nurse led'. The community nursing staff were overloaded by excessive caseloads. Relationships between frontline nursing and social work staff were good, but made difficult by working out of different bases.

According to the information available to the Panel, Bury was probably one of the most poorly funded mental health services in the country. We also received evidence that this problem was further compounded by the poor relationship between the Bury Health Care Trust and Bury and Rochdale Health Authority, with little trust on either side. There were fears that money given to the Trust for mental health would not be spent in this service. The management structures in place for the mental health service were inadequately resourced and there was no strategic vision.

It was to this service that Simon Rawcliffe was admitted to in 1999. He remained a difficult management problem on the ward, but because the missing notes were never recovered and no attempt was made to collect a new set of past psychiatric reports and summaries, the experience of the Scott Clinic, acquired over a thirteen month period was not utilized. This resulted in misjudgements about the extent of his recovery and the likelihood of him cooperating with aftercare.

Nursing reports describe the difficulties he caused to staff, and he was eventually detained under Section 3 of the 1983 Mental Health Act. Because of their high workload, Consultant 3 and his then Trust grade psychiatrist Consultant 2 usually saw their patients in the ward round or in emergency situations. The ward round notes indicate leave being granted despite violent and challenging behaviour continuing. There does not appear to have been a joining together of the nursing notes recording his problem behaviour and the decisions made at the ward rounds.

His mental state did appear to improve as his psychosis resolved with medication. Despite this on the 11 April he was arrested and removed to a local police station after assaulting a patient. He was returned to the ward and he threatened to shoot nursing staff. His leave permission was stopped. Two days later he was noted to be settled and no management problem, and he was again given leave. On the 13 May he was discharged from his section. It was thought that he would agree to remain on the ward, as an informal patient. His history would suggest that this was unlikely, and he did not do so. He wanted to leave the ward and as a suitable community placement was not available, he was given a list of Bed and Breakfast accommodation in Bury. He found his way to 8/10 Wash Lane, because it was closest to the hospital.

He was finally discharged from hospital in his absence. The arrangements to follow him up did not come together until early June. Again, he did not comply with medication. He behaved in a sexually inappropriate way towards two female community psychiatric nurses on a joint visit. Following this visit a risk assessment form was completed, but it is clear from this form that the risks that he presented were not appreciated. The contribution of his illness, his drug and alcohol misuse, and underlying personality were perhaps not well understood by the mental health team at Bury. He appears to have been viewed as a man primarily with personality difficulties compounded by his use of alcohol and drugs. There were some who considered his mental illness to be fairly quiescent by this stage.

The last community psychiatric nurse (CPN) Community Nurse 1 to see him described 8/10 Wash Lane as the worst environment he had ever visited in order to see a discharged patient.

Following his arrest, his mental state deteriorated during his remand to prison and he required transfer to Ashworth High Security Hospital. He improved enough for his trial to go ahead. He pleaded not guilty, but was convicted of murder and he received a life sentence. His legal team did not propose a psychiatric defence.

It was our task to understand what happened to Simon Rawcliffe during his contact with mental health and social services particularly from his time at the Scott Clinic until his arrest. We have been careful not to apply the benefits of hindsight to explain what happened.

As in most cases of homicide by those suffering from mental disorder subject to Independent Inquiries, it is often not possible for such events to have been predicted. There is certainly no evidence that in this case one could have predicted a homicide. Nevertheless, his risks at the time were not adequately assessed. His mental illness was poorly understood, and there was not an agreed clinical formulation for all staff to work with.

There were aspects of his care, which we believe should have been managed in a different way. However, we recognise that clinical and local management staff were working under tremendous strain and stress within a Trust where psychiatric services were in competition with other acute services. They felt let down by their Trust.

In our effort to understand the working environment that the mental health service operated within we sought to interview the recently retired chief executive, of the Trust, but he refused to meet the Inquiry Panel. We comment on this later in the Report.

We have tried our best to be thorough in our task. We obtained a number of documents (see page 73) and interviewed 41 individuals, and everyone we interviewed was helpful and cooperative. We thank all of those who took the time to see us.

We tried to interview Simon Rawcliffe at the beginning of our work. He was in Manchester Prison, serving a life sentence. However, there had been a relapse of his psychotic illness and he was waiting to be readmitted to Ashworth Hospital. He was too ill for us to see him, and was unable to give consent for the Inquiry Panel to see his medical and social services records.

Legal advice from Bury Primary Care Trust was obtained. The advice was that it was reasonable to obtain these records on public interest grounds. This was what we did.

His mental condition improved at Ashworth Hospital where he remains, and he has subsequently given consent for his records to be reviewed. He improved enough for the Inquiry Panel to interview him on the 14 October 2002.

We appreciate that since 1999 mental health services have developed. The services in Bury are now part of a new Mental Health Trust. We found a great deal of optimism and hope that Bury would be better resourced and supported within the new Trust. This is essential. Liaquat Ali and his family deserved better. Similarly, the community of Bury deserve better, as do the staff working in the mental health service, as did Simon Rawcliffe and his mother. It is our hope that this Report will provide a focus and direction for the work that still needs to be done.

Background and Comment

Simon Rawcliffe was born in June 1972. He was an only child. His parents separated when he was around 3 years old. His father continued to see him for a period, but contact was then lost until Simon Rawcliffe was fourteen. There was occasional contact after this, but his father, who was a lorry driver, was often away. He later remarried.

Simon Rawcliffe's birth and early development was normal. There were no significant events in his childhood. He was a healthy child, but was investigated by a paediatrician after a febrile convulsion at the age of 7. Nothing of significance was uncovered apart from an underlying infection. There were some problems at school and he was excluded on one occasion. He left school with GCSE qualifications to join a catering course at a local college. He moved out of the family home and found employment until 1991, as a chef in a local pub restaurant. At the age of eighteen Simon initiated contact with his father and they used to spend time in each other's company on a regular basis. They would go fishing and shooting together. His father died unexpectedly of a heart attack at the age of forty-seven.

Up to this stage in his life there is no history from the documents that we read to suggest any significant behavioural (conduct) disorder as a child, or significant personality difficulties in his teenage years. The only suggestion of difficult behaviour came from a single detailed report that mentioned the school expulsion.

Simon Rawcliffe's mother believes that the death of Simon's father was the catalyst for the mental health, and other problems, suffered by her son. Also at around the same time a close friend of his died in an accident.

Following the death of his father he began to abuse drugs, and he lost his job. He committed property offences to fund his drug habit. He also presented with aggressive behaviour for the first time, to our knowledge.

During an admission in 1998, a social worker (at the Scott Clinic) prepared a report for a Mental Health Review Tribunal. He had organised a number of conjoint sessions with Simon Rawcliffe and his mother. In that report he described his understanding of Simon's reaction to his father's death:

> *"The explanation for Simon's abnormal grief reaction to his fathers death almost certainly lies in the inconsistencies and the ambivalence which underlay Simon's relationship with his father……*(Simon's Mother)*… recalls having informed Simon of his father's death…he refused to accept what had happened. He became "suicidal" requesting to be given the keys of a motorcycle in order to kill himself……Simon and his mother were unable to discuss their feelings……."*

He noted in evidence to us that she provided a great deal of support to her son during his illness, despite his difficult behaviour at times.

Simon Rawcliffe abused a variety of illicit drugs between 1991 and 1995. He was a regular user of cannabis, ecstasy, heroin, amphetamines, and LSD. He also began to drink alcohol heavily from this time. His lifestyle became more chaotic, and he regularly got into arguments and fights. In 1992, there were two separate court appearances and convictions for burglary with intent to steal, and threatening behaviour.

It has been difficult to accurately piece together his early psychiatric history as during his last admission to Fairfield hospital, Bury, his case notes disappeared. All medical notes from Bury are missing up to 18 March 1999, and nursing notes up to 5 March 1999. The following information has been collated from his other medical records and from the general practitioner's notes.

In July 1993 he was conditionally discharged for the theft of a policeman's hat from an unattended police vehicle. His first psychiatric contact was in 1993 following his arrest for breaking into a dwelling house. He was seen in HMP Liverpool by Consultant 5, consultant forensic psychiatrist at the request of the prison medical officer. She said:

> *".....Mr Simon Rawcliffe told me that he entered a restaurant by breaking a window in order to shelter from the rain.....he denied he wanted to steal anything.....he was distracted and perplexed.....he showed poverty of speech and his conversation was woolly. There was no spontaneous conversation. There was some suggestion that he may be suffering from thought block. He had multiple delusions including that his fellow inmate could read his mind, and that his own mind had been changed with that of a fellow inmate. He also had second person auditory hallucinations....."*

He was convicted of burglary with intent to steal in November 1993, after entering a public house through an open window. He was at first transferred to Fairfield Hospital, Bury under Section 35 of the Mental Health Act 1983. Bury Social Services became involved at this time.

The social services chronological note on October 22 1993, (no name is attached to this note) described the position at that time:

> *".....Consultant 6 has done the report. Prognosis poor, but first admission and room for improvement re medication as has not been on therapeutic amount in Walton....."*

He was seen again by Consultant 5 at Fairfield Hospital, who noted some improvement. Following recommendations to the court, he was made the subject of a hospital order (Section 37 of the 1983 Mental Health Act) and he was an inpatient at Fairfield Hospital between October 1993 and January 1994.

The clinical notes describe him as psychotic at this time. He was thought disordered, and believed that two gold caps lodged in his lung, were transmitting his thoughts and controlling his actions. He was difficult to manage and went frequently absent without leave (AWOL). A diagnosis of schizophrenia was made. He did improve with treatment and by the end of the year, was considered ready for discharge.

The Community Care Assessment of 22 December 1993 completed (but unsigned) records his use of cannabis, magic mushrooms, and LSD. The only identified need is *"alternative accommodation"*. The social services notes of the Section 117 pre-discharge meeting on the 12 January 1994, describe the problems in finding suitable accommodation for him. He had not completed the housing application form, or made any inquiries about Bed and Breakfast accommodation. Simon Rawcliffe's mother was unwilling to take her son home.

Apart from the social work input (described above) that he received in 1998 when he was a patient at the Scott Clinic, the social work role in this case has been interpreted as being primarily about his accommodation and financial needs.

It is unclear what happened after he was discharged from detention, but he left the ward soon after to an unknown address. A CPN visited him at *'home'* (presumably his mother's address) on the 31 December 1993, but he was not there. A social worker phoned mother on the 17 January 1994, but there was no reply. Simon Rawcliffe's mother phoned Community nurse 7 on 21 January to say that her son was a resident at the Lindon Guest House. A CPN assessment at Lindon Guest House was arranged, but he was out, and even his landlady had difficulty pinning him down.

On the 16 February 1994, there was a planned Section 117 multidisciplinary review meeting. Simon Rawcliffe did not attend. His CPN at the time reported several failed attempts to see him. He had not kept any appointments and had failed to take his depot. On the 8 March 1994, he was discharged from Section 117 aftercare by Consultant 6, as the situation remained unchanged. The social services case file was also closed.

He was readmitted on 6 April 1994 to Ward 16, Fairfield General Hospital, under Section 3 of the 1983 Mental Health Act. He was at this time facing burglary charges and theft. He described unusual visual phenomena, which were investigated further in case he had temporal lobe epilepsy, but this diagnosis was not confirmed. He described hearing voices, and also a number of bizarre beliefs. He described a 'presence' inside his body, which he thought was Michael Jackson, and at other times Jesus and Tutankhamen. He was treated with antipsychotic medication. Although his psychosis improved, he was described in the notes as *"rude and obnoxious"* and he was taken off his section.

This is not the only time that professional records describe Simon Rawcliffe using language that could be viewed as unprofessional and pejorative. Similar examples are to be found in his psychiatric and social work records from Bury.

Nurse 3, charge nurse, (who had nursed Simon Rawcliffe during the first admission) was the link between the ward and Social worker 8, the social worker. In a post admission 117 review, Simon Rawcliffe was described as uncooperative, verbally abusive to staff, unmotivated, and lying on his bed all day. Consultant 6 thought that there were personality changes caused by the schizophrenic illness. He was uncooperative and frequently left the ward. There were problems in identifying suitable accommodation because Simon Rawcliffe was uncooperative. A court appearance resulted in unconditional bail. He was discharged from his Section 3 on the 9 May 1994. On the 12 May 1994, Nurse 3 contacted Social worker 8 to say that Simon Rawcliffe had been arrested for theft the day before. Social worker 8 noted:

> *"……Simon due to be discharged tomorrow. I enquired about pre-discharge meeting and suggested this tomorrow……According to Nurse 3, Simon has an address to go to and has said he does not want follow up via S117. Simon will not be returning to the ward."*

He had indicated that he would be staying with a friend. What then occurred was that he took money and other items from a CPN Office. He was arrested and he remained in custody overnight on the 13 May 1994. This admission ended at this point. There was no follow up arranged by medical or CPN services. The social service case file was also closed. He received a conditional discharge.

In July 1994 he was back in prison. He was seen by Registrar 1, senior registrar, and Consultant 7, consultant forensic psychiatrist. There was clear evidence that he was psychotic at this time. He described hearing voices, he thought he was being controlled by others, and was the subject of persecution. He was grandiose in manner, and expressed suicidal ideas. He was prescribed antipsychotic medication, which he accepted.

When he was seen a month later by Consultant 1, consultant psychiatrist from Bury, the opinion was that there was no evidence of mental illness. He considered Simon Rawcliffe to have a personality disorder. Consultant 7 noted when interviewed by us, that Simon Rawcliffe's illness had a fluctuating pattern even in the prison. He received a 12-month sentence of imprisonment for the earlier burglary and a conditional discharge for the theft from the CPN office.

There is in our view no reason for Consultant 1 to have made a diagnosis of personality disorder on the basis of a single assessment in prison. Simon Rawcliffe may well have improved, and he was accepting treatment, but the assessments by other experienced clinicians clearly indicated that he was suffering from a psychotic illness. His psychiatric history suggested schizophrenia. This was the diagnosis made by Consultant 6 and Consultant 5.

On 27 February 1995 Social worker 8 was contacted by a court based probation officer, as Simon Rawcliffe was appearing in court that day for breach of the peace and criminal damage to his mother's house. She described the difficulties other agencies had faced in achieving compliance with community care. He refused bail conditions and was remanded in custody.

In March 1995 he was admitted to Bolton General Hospital under the care of Consultant 8, consultant psychiatrist. A general practitioner had requested a domiciliary visit to Clare Court, a hostel for homeless people, where Simon Rawcliffe he had been causing concern because of threatening behaviour. He was suspicious, agitated and responding to hallucinations. He thought that hostel staff were plotting against him. Bolton Social Services had become involved before this admission because he was living on the streets. He was detained under section 2 of the Mental Health Act 1983. On the ward he refused a drug screen and was treated with antipsychotic medication.

His detention was extended to a Section 3 in April 1995. He made it clear that he would not cooperate with medication when discharged. He expressed concern that he had no accommodation to go to on discharge. He went repeatedly absent without leave (AWOL) and was difficult to manage.

An unsigned entry in the Bolton Social Services notes on 22 May 1995 records his arrest for breaking and entering whilst AWOL, and that he was in custody.

The Panel found it unhelpful that the authorship of some social work notes from Bolton social services could only be guessed at. There were similar problems in the Bury Social Services records.

On the 24 May 1995 the medical entry was:

> *"Has been AWOL. Returned by the police today following arrest……charges of burglary……tried to review, gone AWOL again."*

A Section 117 meeting took place in June 1995, when he was still AWOL. There was no follow up arranged. At a ward round on 9 June 1995 staff were informed that he was in HMP Manchester. He had been assessed by a police surgeon to be fit for custody. The information was that he was facing a theft charge and he was also facing breach of the peace charges. He was discharged from his detention in his absence.

He was bailed to a probation hostel, but broke the rules and was taken into custody. The prison records note that he was depressed but not psychotic. He received a conditional discharge. He had no settled accommodation and lived 'on the streets'.

An undated entry in the social work record by Social worker 9 closed the case. She stated that he was put on probation for the recent offences and that the offences happened in the Bury area and this was where he was living.

The Bolton medical records suggest that Bury Social Services were contacted, but the social work records do not show that this was ever done.

Simon Rawcliffe was back in HMP Manchester on 22 December 1995 and presented with symptoms of paranoid psychosis. He was at times bizarre and threatening. The prison records are unclear, but it appears that he was on remand for offences including criminal damage. He received a further conditional discharge and returned to live rough on the streets.

The Bolton Social Services Emergency Duty Team saw him on 17 January 1996 at the request of the police doctor. This followed his arrest for taking a shower in a room in the Pack Horse Hotel, after taking a key. He was admitted on that day to Bolton General Hospital, and at first was an informal patient. He was deluded and grandiose, with flight of ideas and pressure of speech. The clinical picture appeared to be of hypomania. He was made the subject of a Section 5(2) and then a Section 2 on the 17 January. The next day, the police again contacted the Emergency Duty Team. He had left the ward and been arrested for aggressive behaviour in a local supermarket, after claiming that he had won a lottery ticket. He was returned to the ward. On the 19 January 1996, he was arrested again after trying to break into the Pack Horse Hotel, where he had been sleeping on the hotel roof.

He was aggressive on the ward and assaulted a nurse. He refused medication. There were further threats, physical and sexual assaults on staff, elderly patients and female patients. He made sexual advances towards male and female staff. He explained other assaults on staff as because they were calling him Hitler. On one occasion he was found to have a knife hidden on his person. On 22 January 1996 the police returned him after going AWOL and threatening to jump off a bridge. He required substantial doses of medication.

This aspect of his illness involving beliefs about Hitler emerges at various times when he is unwell and in contact with mental health services. The police recorded comments about Hitler when he was arrested following the index offences in 1999. Sexually inappropriate behaviour also appears to be a part of his illness and was noted by two female CPNs not long before the index offences.

He told Social worker 8 his social worker on 5 February 1996 that he had not come to terms with the death of his father. He became tearful. He presented with aggressive and challenging behaviour towards nursing staff and because of this he was referred to P1 ward, an intensive care unit at Withington Hospital, Manchester, but a bed was not offered.

On the 13 February 1996 Consultant 8 referred Simon Rawcliffe to Consultant 5, with a view to transfer to a medium secure unit. The Edenfield Centre, which is now part of Bolton, Salford and Trafford Mental Health Care Partnership, is the medium secure unit that would normally serve Bury. There is no evidence from the Bolton or Edenfield notes, that Consultant 5 saw him. There was a conversation the next day between Social worker 8 and a Probation officer who had prepared a recent probation report for theft of watches and a sandwich from Marks and Spencers. The probation officer described the offences as *'survival tactics'*. A psychiatrist had told the probation officer from Bury (unnamed) that Simon Rawcliffe had *'a personality disorder'*. By this stage he was on a Section 3.

On the 16 February 1996, a charge nurse catalogued no fewer than fifteen incidents over a 3-week

period, where he had made threats of violence, or had been involved in acts of violence to staff or other patients. Soon after this he was transferred to the high dependency (secure) unit at Winwick Hospital. He appeared to be hypomanic. Problems with his behaviour continued and he exposed himself to a female patient. He said that Hitler was making peace with him.

He was placed on special observations, and began to improve and returned to Bolton Hospital on 5 March 1996. However he was at times still intimidating and he was thought to be using drugs.

At a Section 117 meeting on 19 March 1996, Consultant 8 said to Simon Rawcliffe that he was not mentally ill but personality disordered with drug-induced psychosis.

His needs were recorded by Social worker 8 as:

> *"Mainly social care, CPN not warranted and Section 25 does not apply because he does not have a mental illness."*

He was discharged to Clare Court where a flat had been allocated. The diagnosis on discharge was a manic episode (drug induced), and underlying personality disorder.

Personality disorder was clearly used here as a diagnosis to exclude him from psychiatric services. His history of schizophrenia was ignored and any psychotic symptoms he had were attributed to drugs.

Simon Rawcliffe continued to associate with friends who used illicit drugs. His mother expressed concern about his behaviour and told Social worker 8 on 21 June 1996 that he had been arrested for an assault on a 15-year-old paperboy. In June 1996 his social worker also noted that his neighbours in the flat where he was staying were disturbed by his behaviour. Social worker 8 expressed concern that his mental state was deteriorating, and the police were given this information. He was bailed for the assault on a paperboy.

In July 1996, he was arrested for possession of an imitation firearm with the intention of resisting arrest. The exact circumstances are unclear. We believe he was brandishing this weapon outside a school. He was additionally charged with affray. The Bury Social Services duty officer and a psychiatrist at Bury Police Station saw him. He had signed his name George V. We are surprised that no evidence of psychosis was found. The approved social worker described Simon Rawcliffe as personality disordered to Social worker 8.

The law regards possession of an imitation firearm and affray as particularly serious offences. The professionals responsible for the care of Simon Rawcliffe may not always have appreciated this. This is important to consider in any risk assessment, as is the history of his 1996 Bolton admission, and the violence he presented with at that time. The loss of his clinical notes during his last admission to Bury, allowed the information about his past behaviour and his presentation of mental illness during the early years of his contact with mental health services to be lost to the collective clinical memory.

He was interviewed and remanded in HMP Manchester. The witness statements described a man acting bizarrely. He appeared intoxicated and was pointing what appeared to be a gun at people, making threats to kill, whilst threatening and swearing. In prison Consultant 5 and other members of her medical team saw him again. He was described as eccentric, bizarre, suspicious, uncooperative and disinhibited. In appearance he had a shaven head and bright clothing worn oddly. He described a number of (first rank) symptoms characteristic of schizophrenia. There was some improvement on medication.

He was placed on the waiting list for the Edenfield Centre, because it was recognised that he presented a risk to others and was mentally ill, and not personality disordered. He needed in patient treatment under secure conditions.

At this time the Scott Clinic, the medium secure unit for Merseyside, wanted to admit a person from prison. However, this individual was known to a number of staff there and it was not thought appropriate to admit him. Negotiations took place with the Edenfield Centre to take this patient. Simon Rawcliffe was seen in prison on the 23 December by a senior registrar, from the Scott Clinic after it was agreed that they would take the first patient from the Edenfield Centre waiting list. This was Simon Rawcliffe, and on the 3 January 1997 whilst still on remand he was admitted to the Scott Clinic under Sections 48/49 of the 1983 Mental Health Act.

He was interviewed by Consultant 4, consultant forensic psychiatrist on the 10 January:

> *"Simon told me that he was very ill at the time of the last offence believing that he was King George V and experiencing a variety of first rank symptoms……Simon remains much improved from the mental state that he was clearly presenting with at Strangeways. He remains psychotic however."*

Nursing staff record him discussing a number of grandiose beliefs only three days later.

> *"……he was to inherit a large sum of money from his father and what was the quickest way to increase this to a million pounds……he was going to buy a Ferrari……he had royal blood in his veins as his uncle was a beefeater."*

He was at times elated and giggly. Eventually he accepted long acting intramuscular antipsychotic medication. On the 13 January 1997 he was made the subject of Section 38. and this section was extended. The Judge at Bolton Crown Court wanted to hear from Consultant 4 why a restriction order (Section 41 of the Mental Health Act 1983) was not appropriate. Consultant 4 recommended a Section 37, and suggested that a supervised discharge would be considered when Simon Rawcliffe was ready to return to the community.

The team social worker Social worker 2 made contact with Simon Rawcliffe's mother who showed a great deal of commitment to her son, but she made it clear that she did not envisage her son returning home to live with her. She was willing to offer as much support as she could. Social worker 2 also made contact with Social worker 3, of Bolton Social Services, who confirmed that the Great Lever Team would provide future social work support.

In late February 1997, Simon Rawcliffe told a doctor that he used to fund his drug habit by selling drugs. He used cannabis, speed and LSD to *"cope with grief"*. At this time there had been a finding of an illicit substance on the ward. He refused drug screens and this was taken to indicate a positive result, though he disagreed with this.

There was deterioration during the weeks leading up to his court case. He was involved in a number of silly pranks, and was bullying and intimidatory towards other patients. He shaved his head, and his dress became bizarre. The suspicion was that he had abused drugs but he again refused drug screening.

On the 7 March 1997, he was returned from Crown Court with a Section 37 without a restriction order. On 17 March, Social worker 8 transferred the social work case to Social worker 4, at Bolton Social Services.

Simon Rawcliffe's mental state settled slowly. The behaviour described as *"buffoonish, fatuous, often anti-authoritarian"* was the last to improve. However he began to show more insight and began to accept for the first time the need to continue medication to treat his mental illness. It required a strict behavioural reward programme to contain his limit testing of both staff, and the unit rules. By late April 1997, he was praised for his improvement, although it became clear that he still occasionally used cannabis and this led to brief periods of deterioration in his mental health. For example on the 14 July 1997, he was so disturbed and threatening, that he required a brief period of seclusion.

Social worker 2 commenced conjoint sessions with Simon Rawcliffe and his mother in June 1997. By this stage he was receiving escorted parole with a member of nursing staff. His medication was adjusted and the mood stabiliser lithium carbonate was added in late August.

A nursing note in early September 1997 describes his variable presentation:

> *"Simon's behaviour continues to fluctuate between being appropriate and at other times being unacceptable."*

On the 6 September 1997, he was given two hours unescorted leave each day in the local area. The multidisciplinary notes are generally more positive from this time. There appears to have been a noticeable improvement when his blood lithium levels reached therapeutic range.

Social worker 4, visited Simon Rawcliffe at the Scott Clinic on the 14 November 1997. He told Simon Rawcliffe that he would try to negotiate a place at Hawthorne House. This is not recorded in the Bolton Social Services notes. Within days he was on full unescorted leave. He did not return to the ward after attending an aunt's funeral. He turned up at his mother's home and asked to be collected by nursing staff. His mother returned him to the ward the next day. He explained that he had become emotional at the funeral. He was also upset about the breakdown of a relationship he had with another patient. He was moved to another ward at this time.

Contact was made with his local mental health service in Bury. Consultant 4 wrote to Consultant 6, to arrange follow up from Bury. The referral to Hawthorne House did not result in an assessment by this community placement. With a Mental Health Review Tribunal date approaching on the 28 January 1998, Social worker 2 began contingency planning. Simon Rawcliffe indicated that he would prefer to be discharged to the home of his friends where there was a spare room. They lived relatively close to Simon Rawcliffe's mother in Ramsbottom. It was recognised by Social worker 2 that this address in Bury presented a problem for the ongoing social services involvement from Social worker 4 at Bolton Social Services. A Section 117 meeting was arranged for the 13 January 1998.

Social worker 2 visited the proposed discharge address and was satisfied that Simon Rawcliffe's friends would set clear boundaries. They were aware of the problems that Simon Rawcliffe had with drugs and alcohol, as he had known him for many years. It appeared that this was a reasonable place for him to live and there were no other alternatives. A series of overnight leaves were arranged to test this out. Everything went well. Social worker 2 saw Simon Rawcliffe at a meeting arranged with mother and his friends. All parties were agreeable to the discharge arrangements.

There were telephone discussions with Consultant 1 of Fairfield Hospital in Bury and he agreed to take responsibility for follow up, although he could not attend the Section 117 Meeting. A general practitioner was identified. It was left for Simon to register with the doctor, and Bolton Social Services took on responsibility for follow up.

Consultant 4 took the minutes of the Section 117 meeting. Social worker 4 was present, and for part of the meeting Simon and his mother. The notes record that mother was anxious about discharge, and thought her son would ultimately put pressure on her to come and live with her. Nevertheless she felt that the discharge plan was the best available. The discharge plan, which was sent to Consultant 1, stated that:

1. Social worker 4 would be the key worker until arrangements were in place to hand the care over to Bury Social Services.

The social work notes from Bolton Social Services are poor and there are only a few handwritten and unsigned notes from this period. It does not appear that the work undertaken by Social worker 2 was recorded in the social work notes from Bolton.

2. Simon Rawcliffe should be on the Supervision Register in Bury, and will be on the Scott Clinic Supervision Register until transfer had taken place.

It was not thought helpful to place him on supervised discharge, because the likely outcome was that this would increase his anti authoritarian attitudes and his cooperation would be less likely.

He was never subject to the Supervision Register after discharge.

3. He was given permission for a series of overnight leaves prior to the Tribunal.

4. His medication was Modecate 100mgs every two weeks, Lithium 1200mgs nocte, and procyclidine three times daily.

A note on the 27 January 1998 from Registrar 2 a senior registrar comments on the attempts to arrange follow up:

> *"……Consultant 1 from Fairfield Hospital has been invited to take over his care and we are expecting to make contact with him. The CPN is aware and it is hoped that Simon is already registered with his old GP. Social worker 2 will be handing over to, social worker 4, next week, who is expected to be involved for the next three months."*

On the 28 January 1998, the Tribunal granted a deferred discharge for four weeks because he still did not have a general practitioner. His first choice general practitioner had a full list. He was allowed out on extended leave. He was reviewed at two subsequent meetings and on the 17 February 1998 Simon Rawcliffe visited the ward for his last clinical review. His mother attended, as did Consultant 1. His history was presented to Consultant 1. It was clear that Simon had still not registered with a General Practitioner, and therefore there was still some uncertainty as to whether Consultant 1 was to be the psychiatrist who would see Simon after discharge. The clinical notes state:

> *"Consultant 1 agrees to arrange an out patient appointment in the next couple of weeks and will arrange for a CPN to give Simon his injection in a fortnight's time.* (Simon Rawcliffe's mother)…… *will let the clinical team know when Simon has a GP so that a discharge summary can be sent. In addition a copy will be sent to Consultant 1. Consultant 1 questioned where Simon would be referred to if he needed secure placement in the future and this is something we will need to discuss with the Edenfield Centre……."*

He was discharged on the 27 February 1998 by which time his general practitioner had been identified. On the same date a detailed discharge letter was sent to Consultant 1. Simon Rawcliffe's next depot injection was due on the 3 March 1998. This letter was not sent on to the CPN notes until 21 May 1998.

His mother described him as 'almost back to his normal self' by the time of discharge. It is unfortunate that the after care plan was so poorly coordinated after this discharge, by services at Bury.

We could find no evidence that there had been any discussions between the Scott Clinic and the Edenfield Centre about what would happen if he required a secure bed following discharge.

On 23 March 1998, Bolton Social Services referred the case to Bury Social Services. The Bury Adult Services Referral Form records an address in Ramsbottom, a diagnosis of manic depression and the case was allocated to Social worker 1. She made attempts to see him. She finally managed to do so on the 6 April 1998, with a colleague from Bolton. When he moved to a new address in Lancashire, she referred him on to Social worker 5 of Lancashire Social Services.

It is unclear what information was given to his new social worker. requested background details from Bolton Social Services and from Social worker 1 who sent a psychiatric report to him by Fax. He also wrote to Consultant 1 asking for information about the after care plan and who was the CPN.

Consultant 6's hospital secretary in a phone call to Community Nurse 2 triggered CPN contact on the 7 May 1998. Her note illustrates the poor handover arrangements:

> *"…… Apparently Simon was discharged in February this year (27.2.98) from the Scott Clinic in Liverpool. Depot was due 3.3.98. Previously known to Social worker 9 – Bolton. D.N.A. for appointment in March. Further appointment 21.5.98 @ 1.45pm. Referred to Social worker 1 who has transferred case to Social worker 5 in Rossendale. Unsure of Simons address. Not known if Simon has been receiving treatment since discharge. To assess as soon as possible."*

On the same day she spoke to Social worker 5, who was apparently told her that he had no information about Simon Rawcliffe. Simon Rawcliffe's mother told Community Nurse 2 that she thought he was attending appointments at Fairfield Hospital. He had been receiving his depot medication at the out patient clinic there. Community Nurse 2 completed a CPN referral form herself on the same day.

On the 11 May 1998, Community Nurse 2 found Simon Rawcliffe to be uncooperative at this first assessment, which took place in Ramsbottom Health Centre. He refused a further appointment.

Social worker 1 took over the case again on the 19 May 1998, following a telephone call from Simon Rawcliffe. He told her that he was sleeping in a tent in his mother's garden. The new referral documentation was completed on that day. Community Nurse 2 contacted Social worker 1 the next day and was told that Social worker 1 would take on the social work responsibilities again. On the 21 May, a review took place at Fairfield General Hospital. In attendance were Community Nurse 2, Social worker 5, Consultant 1, another member of staff, and Simon Rawcliffe with his mother. He insisted on a reduction in his medication and Consultant 1 reluctantly agreed. Community Nurse 2 told Consultant 1 that she had not had any formal referral and no care programme approach (CPA) documentation. There was also no identified key worker.

Simon Rawcliffe told the Inquiry Panel when he was interviewed on the 14 November 2002 that he stayed with his friends for around two months. They then moved to different accommodation, and as he was not getting on with them he moved into the tent.

At a CPA review Social worker 1 agreed to be the key worker. He agreed to see Social worker 1, but refused to see Community Nurse 2. He continued to receive his depot medication at Ramsbottom Health Centre until he refused all further injections from late June. After missing two injections he was visited by nursing staff. His mother told the nurses that he was in bed and was refusing medication. The general practitioner and Consultant 1 were informed.

Witness statements from local people at the time of the trial described Simon at around this time as *"a bit of a nutter"*. He was loud and inappropriate at times in the community. He was known for making threatening and racist remarks:

> *"……he hated Asian lads who attended the Asian College…… he would shout ' you fuckin black bastards……fuck off from our country……."*

Another witness in August 1998 described him as walking the streets with a baseball bat and heard him say:

> *"I'm going to kill another Paki soon, I hate them."*

He was known to the police as a local nuisance, but not a man with a potential for serious violence.

On 3 September 1998, Community Nurse 2 held a discussion with Social worker 1. He was still refusing CPN contact and medication. The case was handed over to Community worker 1, who worked for part of her time on the mentally disordered offender's team. He was not seen again by a CPN until he next presented in custody.

The next CPN note is 7 months later, shortly after his next admission to Fairfield General Hospital. Community worker 1 did not see him.

Community worker 2, the Deputy Manager of the Community Mental Health Team, told us that Community worker 1 was on sick leave, and some cases on her caseload were not allocated. We understand that Simon Rawcliffe became a patient on Community worker 2's caseload in September 1998 when she joined the Trust.

He did remain in contact with Social worker 1, though she noted his continued refusal to co-operate with CPN contact. In February 1999 he appeared well although he was a little elated. Consultant 1 was by this stage considering whether mental health services should remain involved.

On the 5 March 1999 Consultant 1 and Social worker 1 interviewed him in a police station. He had been taken into custody for a driving offence. He was sleeping rough. His mother reported that he had been carrying a hammer for 2 days and had said that he was going to put it through Hitler's door. There had been a deterioration over the week before his arrest. He was drinking alcohol heavily. A drug screen later proved positive for cannabis. He was grandiose, talking about King George and was looking for Hitler. He was elated, disinhibited and making sexual remarks.

He was admitted informally that day to Ward 21B (now ward 27) and Consultant 3 took over as his consultant within days of this admission, for catchment area reasons.

Ward 21B was a 21 bed acute ward. It was usually unlocked, but the nurse in charge could lock the door, if the judgement was that the ward atmosphere, or particular patient problems required this. Social worker 1 recorded that he tested positive for cannabis on this admission. A nursing plan was written but is undated. The case notes contain a nursing observation-recording chart. Close observations were commenced on the day of admission.

Nurse 1, a staff nurse at this time, was the allocated key worker. He described Simon Rawcliffe as:

> *"……presenting with paranoid ideas, a delusional state, very agitated, quite confused in manner……highly disturbed."*

There is no other record of the early part of this admission. Nurse 3, Inpatient Manager, noted in a brief report on the 23 March 1999 that the medical notes were reported missing on the 18 March. There were no medical notes prior to 18 March, but nursing notes begin from the 5 March. All the Bury notes and correspondence prior to this are missing. Simon Rawcliffe was interviewed on the 23 March and admitted stealing the notes and *"had them burnt"*. There was no attempt to make up a new set of notes, by obtaining information from other services involved in Simon Rawcliffe's previous care, or from his general practitioner.

Simon Rawcliffe remained intrusive and disinhibited. He refused urine samples for drug screens. Consultant 2, *then the* Trust grade doctor, was contacted on 8 March 1999, as Simon was demanding to leave the ward. The next day he was rude and threatening, oral medication was given. After a further incident involving staff he was given an injection of Clopixol. He indicated to staff that he was scared of needles. He remained on close observation but there was no recording of this. Observation meant knowing his whereabouts every 15 minutes. We were told that close observations should have been recorded in the nursing records.

Not surprisingly, his mother who attended a ward round on 11 March 1999 did not want to take her son out of the hospital. Over the next few days his behaviour still presented challenges to nursing staff. On 12 March, he was found to have cannabis. His urine tested positive for cannabis. On 13 March, he was described as verbally and physically abusive in manner and constantly confrontational with staff and patients. The next day he was inappropriate at times, but was allowed out shopping with his mother.

He wanted to leave the ward, and was detained under Section 5(2) on the 16 March 1999 by Consultant 2. Acuphase (short acting Clopenthixol) was given by intramuscular injection. There is no record of his consent or otherwise when given this medication. The next day (approximately 30 hours later) when seen by Consultant 3, he was described as compliant but unwell. He had received a further dose of Acuphase by this stage, *"no restraint used but unhappy"*. Consultant 3 did not place him on Section 2, and was intending to let the Section 5(2) lapse.

At the ward round on the 18 March 1999 (also attended by his mother), Consultant 2 described him as changeable, distractible and demanding a *"white doctor"*. His mother was not willing to look after him. He was detained under Section 3 on the same day.

The notes from this stage are written without any connection or reference to his past history and the diagnosis of schizophrenia or a schizoaffective illness. The 'clinical memory' of his past care was that his behaviour and general presentation were not due to any mental illness, and this is particularly evident in the nursing notes.

It became clear that when the ward round notes suggest that his mother was in attendance, this was not really accurate. His mother told us when interviewed that she was invited into the meeting after discussions. She said:

> *"I do not think parents are listened to…..Fairfield appeared to wash their hands of Simon. At all the ward rounds I had to wait for an invitation to go in to the meetings."*

The nursing notes on 20 March 1999 describe his behaviour as:

> *"Immature……enjoys being the centre of attention……no evidence of psychosis."*

There were many entries recording threatening and difficult behaviour, and he remained on close observation. Nevertheless, Consultant 3 gave consideration to allowing him off the ward with his mother, though staff and mother were unhappy about this.

At the ward round on the 25 March 1999, he was given escorted ground leave. He was told that he had a paranoid psychosis.

It is unclear what the symptoms were at the time for this diagnosis to be made.

He punched the wall the same day and it was subsequently clear that he had fractured his 5th metacarpal. On 28 March 1999, nursing notes record inappropriate and disinhibited behaviour to strangers during time off the ward. There is no record of when he got permission to leave the ward, but after this incident, leave was cancelled. He was said to be no problem the next day, but on 30 March difficult behaviour continued. Despite his unpredictability periods of leave continued.

There was no connection between his behaviour and the decisions to give him time off the ward. There was no clear understanding or formulation of the case, and no risk assessment. Also periods of leave were often authorised by Consultant 2, a staff grade doctor at the time, and not always the RMO, Consultant 3. This was contrary to the Section 17 leave policy in place at the time.

Social worker 1 attended the ward round on 1 April. She told the team that he stopped medication after discharge from the Scott Clinic:

> *"He has had a paranoid psychosis with hypomanic type……he lacks insight into his illness……he has requested leave – mother agrees – leave Friday – Saturday – further leave next week."*

There is no such condition described as paranoid psychosis – hypomanic type in any classification system used in psychiatry.

At the ward round a week later, Social worker 1 said that he was disruptive during his leave, was often not at home and his mother was unhappy with him having further periods of leave. No weekend leave was granted but he was given brief periods of unescorted ground leave twice each day, even though, at times he broke leave conditions.

On the 10 April 1999, he went without permission to see his mother. Although this was outside the permission in the Section 17 Leave Form in place at this time, Consultant 2 agreed to allow this visit.

On the 11 April 1999, he returned to the ward after a brief period of leave and was noted to have drunk alcohol. Later, he assaulted another patient, and staff felt so intimidated that the police were called. He was arrested (there were no subsequent charges), but was returned to the ward at midnight. He said that he would get a gun and shoot three named nurses. Risk was assessed as high, medication was given and special observations were implemented. There was no serious incident review.

There was no reassessment of Simon Rawcliffe after this significant event, and his management continued as if nothing had happened.

Consultant 3 prepared a Tribunal report dated 15 April 1999. His history was summarised and was incorrectly said to have been admitted to the Edenfield Centre. A diagnosis of schizoaffective illness was given:

> *" Mr Rawcliffe has made some progress but not sufficient to be considered for leave. About four days ago he was sent out on trial leave in the care of his family, which did not go well. He was also allowed out for an hour unescorted leave but he got drunk and after return to the ward he had an episode of aggressive behaviour. He physically assaulted a fellow patient and the police had to be involved. He needed to be sedated……still needs to continue inpatient admission……."*

Social worker 1 and Nurse 1 also prepared reports for the forthcoming Tribunal and both recommended continued detention, in contrast to a nursing note on the 15 April 1999, which describes, *"no mental health needs"*.

This is perhaps the clearest example of the lack of a consistent approach and a common understanding of Simon Rawcliffe. On the same day one group of staff recommended continued detention because of mental illness and another described him as having no mental health needs.

At the ward round on the 16 April 1999 he was noted to be overbearing and *"pushes limits"*. He was off close observations at this time. There was said to be no evidence of psychotic symptoms, and a diagnosis of schizophrenia was recorded. He was allowed unescorted ground leave again. There is no reference to the events of the 11 April and a reassessment of risk.

Over the next two weeks he is described at various times as childish, immature, and demanding. On 20 April 1999, AWOL procedures were activated after he failed to return to the ward. The police were involved and he arrived later in an intoxicated state.

The notes record:

> *"……in view of Simon's past history of violence and unpredictable behaviour, and in view of his present agitated state and confrontational behaviours it was decided to offer Simon IM medication……."*

He remained disturbed and was given intramuscular (IM) medication. The medication was given on the basis of the as required (PRN) prescription in place at this time without him being seen by any member of medical staff. He was given no leave and there was still no formal assessment of risk.

This prescription for Acuphase contained no frequency advice or maximum dosage limit.

On the 23 April there was a nursing entry from Nurse 3:

> *"DUE TO RISK FACTORS WHEN MR RAWCLIFFE TO HAVE NO FURTHER LEAVE PERIODS UNTIL DISCUSSED BETWEEN CONSULTANT 3 AND MYSELF (NURSE 3 SENIOR NURSE). SIMON HAS BEEN INFORMED OF THIS ACTION."* (Sic)

Later that night he asked a female nurse where he could 'get a woman'. He continued on close observations with no time off the ward. On 25 April 1999 he exposed himself to staff and made suggestive comments. There is no evidence of any significant improvement from the notes apart from settled behaviour over the two days leading up to the ward round on 29 April. He was said to be more settled and he was given leave:

> *"…1/2hourly times 2 daily recommenced. Improvement noted can have home leave for overnight providing mother agrees. Possible discharge 10 days or 2/52. Need to continue with displaying improvement and controlling behaviour."*

This decision ignored the problems with his behaviour earlier that week. No comment is made about close observations. The nursing notes suggest that when he was on the ward close observations continued, though the last note confirming that he was on close observations was 1 May 1999.

At the ward round on the 6 May 1999, discharge plans were progressed, as he was mostly settled in behaviour:

> *"Compliant with treatment……shouts but this is part of his personality……Social worker 1 looking into accommodation……no evidence of mental health problems……req more leave…seen his mother she is happy to have him for his day leave tomorrow."*

This entry in the notes further reinforces the impression that he was not viewed as being mentally ill, and that his problematic behaviour was a reflection of underlying personality difficulties, though at this time he was also being prescribed medication. We were told by Nurse 1 that there was not a leave policy at the time, and decisions were a matter of judgement and compromise.

Consultant 3 entered a note on 12 May 1999:

> *"Cheerful stable and rational. Cooperative and not showing any overt signs of psychosis. He agrees to comply with treatment. He agrees to stay as an informal patient.*
> *Plan - to stay as an informal patient*
> *- to allow him on leave today*
> *- to look for accommodation*
> *- possible discharge tomorrow after ward round CPA meeting."*

The medical records contain Mental Health Act details, which confirm that the Section 3 detention was rescinded on the 12 May 1999.

This was the day before the ward round. The decision was not made with the rest of the clinical team. There was still no evidence that there was an appreciation of his past history of mental illness, and non-compliance with medication and follow up. There was no recorded consideration of supervised discharge.

The Tribunal due to take place on the 4 June 1999 was cancelled. Consultant 3 did not attend the ward round on the 13 May 1999, but later in the day noted that the patient would find accommodation with the help of Social worker 1, and was to be discharged after this. The unsigned nursing note for that day reads:

> *" Social worker 1 says a place is available at Woolfield House. Social worker 1 is to try to arrange B&B there……despite staff, mother + Social worker 1 asking him to wait for Monday. Simon adamant he will leave today. Says he wants to go to Woolfield House today, go to 'START' tomorrow and will take medication etc……."*

In her note on the same day Social worker 1 said she called Woolfield House but there were no vacancies. Woolfield House was the best of the residential staffed accommodation options available in Bury at that time. She then gave him *"……the list of Bed and Breakfast accommodation."*

He said to us that Social worker 1 gave him a list of Bed and Breakfast accommodation. Wash Lane was chosen by him, because it was the closest to the hospital, it was the first on the list that he came across when he left the ward.

He described the accommodation to us as:

> *"Awful…. dirty, no running water…hardly….hot water."*

Social worker 1 did not at first know where he had gone. In her absence, Community nurse 3 was the identified CPN.

The community nursing team were not involved in the discharge planning process.

Consultant 3 was informed that Simon Rawcliffe had left the ward. Consultant 2 records on the 14 May 1999:

> *"Was well……informal now……if does not return to the ward then discharge in his absence."*

He was discharged at 4pm on the 14 May1999. Consultant 2 prepared a discharge letter for his General Practitioner dated 7 June 1999, some three weeks after discharge.

The discharge date is given incorrectly to be the 18 May:

> *"Mr Rawcliffe was discharged in his absence after he refused to return to the ward following a leave of absence. He is on CPA Level and a Section 117 meeting will be arranged in a few weeks time. And that is when I will write to you regarding the full follow-up package. However, I must state that he has got a CPN Community nurse 3 and also a Social Worker. Consultant 3 will continue to see him in Outpatients……with treatment he began to get more stable."(Sic)*

There is no mention of medication or a clear diagnosis in the discharge summary. The description of the events leading to the discharge was incorrect.

The CPA aftercare plan documentation is dated 10 June 1999. The CPA 1 document checklist was fully completed by Consultant 3 and Social worker 1. The CPA 3 form describes the medical plan as an outpatient appointment 15 June.

We reviewed his outpatient attendance between 1994 and September 1999. Of the 18 outpatient appointments made he only attended 30%, with nine episodes of non-attendance and four were cancelled by the hospital. These problems in compliance were not mentioned in the plan.

The social work plan was to engage with services and enable him to access appropriate accommodation. There are no other details and a number of sections including the CPN section were unfilled.

Nurse 1 signed the CPA 4 Risk Assessment document on the 2 June 1999 and by Consultant 3 on the 3 July 1999. He was thought to be a risk of neglect, but no risk to self, others or property was noted. This risk assessment or more properly risk checklist is wrong as in this case there is a clear history of risk to property and others.

He was described as non-compliant with medication. Alcohol was noted to be a problem.

On the 17 May 1999, Community nurse 2 recorded that his medication was due on that day but she did not know his address. Later that day she found out he was at 8/10 Wash Lane. When he was seen the next day he refused his depot medication but said he would attend the clinic at Fairfield Hospital in late May, but did not do so. He failed to attend two outpatient appointments in June. He failed to see his social worker and when his CPN Community nurse 2 tried to see him at 8/10 Wash Lane he was not there. She informed Social worker 1 on the 15 June 1999 of his non-compliance and also Consultant 3 and the General Practitioner.

Until this letter from Community nurse 2 there was no communication between members of the team to raise awareness that he was totally uncooperative with aftercare. There was no action plan to deal with his non-compliance with medication and follow up some 4 weeks after discharge. We also note that his mother was in contact with Simon Rawcliffe throughout this period. There is no evidence that the care team were in regular contact with her, or that she was used to facilitate communication with her son.

Community nurse 2 did finally see him at 8/10 Wash Lane on the 21 June 1999 with Community nurse 4 CPN.

He was with another resident, possibly the deceased:

> *"Caught him in with an Asian friend."*

Again he refused his depot. He said he was drinking on a regular basis but denied drug use. She went on to describe his behaviour:

> *"I felt quite intimidated by Simon and feel it would be better if Simon had a male CPN……was unpredictable in his behaviour, making sexual remarks etc.,……I feel it inappropriate for a female CPN, to carry out this role due to his inappropriate behaviour."*

She spoke about this to her line manager Community worker 2 and a message was left for Consultant 3. Community worker 2 took on an organising role, and the next day contacted Social worker 1 to find out that she was no longer involved and that the case was to be reallocated, though she did update her. Community worker 2 realised at this stage that there was no risk assessment in the CPN records, and she completed on the 21 June 1999 the first detailed risk assessment documentation. However the information available to assess risk was incomplete as the earlier records were missing. She had not

actually met Simon Rawcliffe and she acknowledged that it would have been better for a person who knew him better to have done this. However she was concerned enough about the situation to do this herself as *"alarm bells were ringing"*. She arranged for a male CPN, Community Nurse 1 to take on the case.

Community worker 2 arranged a meeting with Consultant 3 on the 25 June 1999. Consultant 3 suggested that the sexual intimidation might be an indicator of relapse. Community worker 2 thought drug use could be the reason for this.

Until Community worker 2 completed the detailed risk assessment, there was little appreciation of risk in this case. The CPA information on risk was inadequate and incorrect. There was still a lack of understanding about the case and relapse signature information (the earliest symptoms present in a relapse of his illness) was still missing, as the 'lost' notes were never replaced. The past mental health records would have suggested that Consultant 3 was indeed correct, and that sexually inappropriate behaviour was a clear warning of a deterioration in his mental health.

The meeting on the 25 June 1999 should have been a multidisciplinary review, as the patient was refusing engagement with services, was non compliant with medication, and was viewed as a risk to female staff. This would have been an opportunity to be clearer about the management plan and respective roles.

On the 18 June 1999 Social worker 1 completed a Change Form to transfer care to a new social worker. No reason is given under the heading *"reason for change"*. On 22 June she prepared a transfer summary for the new (mentally disordered offender) social worker Social worker 6 with clear advice:

> *"He does not appear to want mental health professionals in his life and does not accept he suffers from a mental illness. However, due to previous risks associated with his behaviour when he is ill, services need to be involved and to be persistent in accessing him."*

We agree with this statement. It is unfortunate that neither Consultant 3 nor the CPN service was informed about the change of social worker, even though Social worker 1 was the named key worker and the patient was on CPA Level 3.

Community Nurse 1 saw Simon Rawcliffe at 8/10 Wash Lane on the 5 July 1999:

> *"Home visit to introduce myself to Simon as his new CPN. Pleasant and friendly shook my hand smiled. Still declined to have his depot medication or any oral preparation. Agreed to see me on a fortnightly basis. Requesting to see a social worker re. accommodation nearer to his mum…"*

On the 6 July 1999, Community Nurse 1 received a telephone call from Social worker 6 the new social worker, and a mentally disordered offender specialist. He was informed about Simon Rawcliffe's accommodation wishes. There was never a meeting between Social worker 6 and Community Nurse 1, who both worked out of different clinical bases. Social worker 6 made an impromptu visit to see Simon on the 15 July.

Simon Rawcliffe was now receiving care from two *new* members of the community team. Their understanding of the case was necessarily limited and there had been no team meeting to review the care plan. The key worker change from Social worker 1 to Social worker 6 and the transfer between CPN's were made without any reference to other mental health professionals.

He was not in, when Community Nurse 1 went to see Simon Rawcliffe as arranged on the 19 July 1999. Social worker 6 saw Simon again as arranged on 20 July, to progress a housing application. On a visit on the 1 September Social worker 6 saw Simon Rawcliffe with other residents in the lounge at Wash Lane. Liaquat Ali was thought to be present at this time. Social worker 6 felt that there was no tension, and that everyone appeared to be getting on well with each other.

Social worker 6 told us that Simon Rawcliffe was:

> *"……very rooted in the real world. I've described him as perhaps a bit arrogant and self centred……there appeared to be no problems with his mental health."*

There was no further contact with local mental health services after this and he failed to attend an outpatient appointment on the 7 September 1999.

On 10 August 1999, the social work team leader was told that there was a property on offer, and on the 12 August he visited Simon Rawcliffe. He did not see him as he left a note on his door 'not to be disturbed'. However Simon Rawcliffe phoned on the 12 August to refuse the support package, which was a condition of the tenancy offer. Simon Rawcliffe then saw Social worker 6 on 23 August to say that he had changed his mind.

> *"Lucid and coherent and spoke rationally – very confident and self assured. No evidence of mental illness."*

On the 1 September he was described as:

> *"arrogant and cocky, but no grandiose ideas."*

This was his last contact with his social worker.

On the 6 September 1999 he saw his general practitioner complaining of headaches and was noted to be *"loud and intimidating"*.

He had no contact with any other professional until after his arrest.

8/10 Wash Lane comprised of two houses knocked together to form 12 bed sitting rooms on three floors, which were let to persons in receipt of housing benefits. There were 5 toilets, 2 bathrooms and 3 showers. The cooking facilities were not shared, and were used by another resident, in exchange for board and lodgings at another property at 3 Wash Lane.

Liaquat Ali lived in Flat 2 on the same side of this accommodation as Simon Rawcliffe who lived in Flat 3. Simon Rawcliffe was said by a number of witnesses to have bullied and assaulted Liaquat Ali. On one occasion in June 1999 another resident intervened to protect Liaquat Ali. She was assaulted by Simon Rawcliffe, and suffered a fractured arm.

Liaquat Ali was clearly scared for his own safety. He often slept in another room (Flat 6) because he was scared to remain in his own bed-sit. One witness described Simon as making *"life hell"* for Liaquat Ali. On the 28 July 1999 the deceased received a head injury, which required 5 stitches. He said he had a fall. We did not have any information to support any other explanation.

We interviewed the eldest sister of Liaquat Ali. She told us that in Court it was said that only days before his death, her brother was seriously assaulted by Simon Rawcliffe, and suffered a broken nose. He was taken to hospital. We did not read an account of this event in the police records that we reviewed, and we did not have a transcript of the trial. Nevertheless this incident reinforces the view that prior to his death Liaquat Ali was the victim of verbal and physical abuse from Simon Rawcliffe. This was not known to his CPN, and was not brought to the attention of mental health services by anyone else.

As was highlighted to us by the eldest sister of Liaquat Ali there was a communications failure. In part Simon Rawcliffe contributed to this by his lack of cooperation with mental health services. There was also no attempt to seek advice by the residents of 8/10 Wash Lane or from the owners of this accommodation, as far as we are able to judge from all the information available.

Within the property Simon Rawcliffe's behaviour was the subject of a series of other complaints by the occupants. He was loud, he knocked other bedroom doors of other resident's rooms late at night, and he let off fire extinguishers. He was described as a bully. He was asked to leave. He was difficult to track down, but when spoken to he apologised and he was allowed to stay.

On 10 September 1999, Simon approached a youth and took his mountain bike, got on it and rode off.

On the evening of the 15 September 1999, various residents at 8/10 Wash Lane were watching TV in the sitting room late at night. Liaquat Ali was woken up and brought to join the group. Simon Rawcliffe came into the room and was said to have punched Liaquat Ali on the head. He then demanded and obtained a cigarette from him. In the early hours of the 16 September 1999, everyone went to bed, leaving Simon Rawcliffe and Liaquat Ali alone. Shortly afterwards a resident heard banging and moaning noises, and the voice of Simon Rawcliffe shouting:

"Shut up……black boy."

At around 0340hrs on the 16 September 1999, another resident heard moaning outside the property. She looked out and saw Liaquat Ali lying on the path, outside the property. She brought him inside and left him lying on the living room sofa. She went back around 0455hrs to check on him. He appeared to be settled.

It has never been clear what happened prior to him being found outside the property in a distressed state.

Another resident got up at 0840hrs and found Liaquat Ali to be lying on the sofa on his side, with blood on his shirt and a pool of blood around his mouth, with what appeared to be pieces of glass in it. There was broken glass on the floor and pieces of wood on the floor in front of the sofa. He contacted another resident who phoned for an ambulance. She then checked Liaquat Ali's room and she saw there a smashed lamp, which she recognised as having come from the room occupied by Simon Rawcliffe.

The paramedical service attended at 0915 and Liaquat Ali was found to be dead. Glass in a head wound was noted. At the post mortem it was clear that he had died from severe blunt force impact injuries to his head. The appearances suggested punching, kicking and stamping in the room where he was found. The pathologist thought a glass weapon and a piece of wood caused the scalp injuries.

In Simon Rawcliffe's room a missing glass storage jar lid was noted (possibly the glass weapon), and a blood stained piece of tree branch. DNA evidence linked blood from the deceased to the tree branch and the shoes, trousers and belt worn by Simon Rawcliffe on his arrest.

Simon Rawcliffe has always maintained no involvement in the death of Liaquat Ali.

Simon Rawcliffe was arrested a little after 0636hrs on the 16 September 1999, at Bury Bus Station. He was initially apprehended by the police in relation to the pedal bike theft. As he was put into the police van he said for no apparent reason:

> *"It's those German Bastards."*

It was not clear at first, but there had been a number of violent incidents just before his arrest. He had approached a woman at the bus station and asked for a cigarette. He was agitated and made her feel uncomfortable. He then walked up to and head butted an Asian man, and returned after a few minutes to hit him again. This man was never found. He then assaulted, in an unprovoked manner another three men.

At the police station he was uncooperative. He appeared to the Police Medical Examiner to be childish and attention seeking:

> *"……in keeping with the previous diagnosis of personality disorder."*

There was no evidence in his view of psychosis. Contact was made with his social worker. He was found fit to be detained. A link was soon made with the events at 8/10 Wash Lane.

Social worker 6 acted as the appropriate adult during the police interview and described Simon Rawcliffe as:

> *"……arrogant, cocky and blithely unconcerned at what is happening to him … denied everything…refused to acknowledge the offence, the victim or that he knew the Wash Lane address."*

The police interview record confirms that when interviewed he replied not guilty to many questions. He denied living at Wash Lane, or any memory of that night. He said that the clothes seized by the police on arrest did not belong to him. On the evening of 18 September 1999 he was formally charged with the murder of Liaquat Ali, assault on a resident on 8 June 1999, theft of the mountain bike, and affray and three assaults at Bury Bus Station on 16 September 1999.

Sergeant 1 of Bury Police was one of the investigating officers. He had no previous knowledge of Simon Rawcliffe, but found out that he was known in the Ramsbottom area as an immature man who associated with youths younger than him. He had *"problems"* but was not thought to be a *"candidate for murder"*.

When seen in the police cells on the 20 September 1999 by Social worker 6, he was described as *"aggressive and unpredictable"*. He was interviewed through the cell door bars and was *"scowling and staring"*, in the corner of his cell. He tried to grab Social worker 6 and threatened to get him later. In court he complained loudly of being handcuffed. He grinned and nodded to himself when details of the offences were read out. He was remanded to HMP Manchester.

On reception into the prison he was vague in manner and claimed not to know why he had been arrested. The next day, a nurse described him as grandiose with flight of ideas. He was thought disordered, and presented with vague paranoid ideas. He was admitted to the prison health care centre.

On 8 November 1999, he appeared more settled when Social worker 6 and Community nurse 6 a CPN saw him in HMP Manchester. He said he was in prison for bicycle theft and not murder! When asked about the incidents at the Bury Bus Station, he said that he was *"fighting the Germans"*, that his fingernails had been contaminated.

He spoke about:

> *"…George……papers with George on the front……lots of mad people …… (living at his mother's house)…… there were guards in it. "*

Social worker 6 attended court and described Simon Rawcliffe as:

> *"……alternated between looking over to his mum (in tears in the public gallery), glaring at me and glaring at the bench and CPS when details of the offence were read out."*

We were told that Social worker 1 was asked to provide support to Simon Rawcliffe's mother during the court case. We are unclear if this was the case.

The eldest sister of Liaquat Ali told us that the family received no information, support or any expression of regret from mental health services in Bury or from any senior member of the Trust Board.

There was concern that Simon Rawcliffe was unfit to plead because of his mental illness. He was unpredictable, and at the end of January 2000 he hit a member of staff in the face, knocking him to the floor. Consultant 5, who referred him to Ashworth High Security Hospital, saw him in HMP Manchester, on 28 February 2000. He was admitted on the 11 April 2000, under Sections 48/49 of the 1983 Mental Health Act.

At Ashworth Hospital, he presented with violent outbursts and required periods in seclusion but he did show some improvement on medication. He continued to deny any involvement in the killing. When he had improved enough to be fit to plead he attended court under escort from Ashworth Hospital. At trial he pleaded not guilty, but was found guilty of murder. On the 22 January 2001, he received a life sentence and was returned to HMP Manchester. The next day he refused his depot medication, though he accepted oral medication. In mid April he was moved to a normal wing as his behaviour was more settled and he appeared well. He then became reluctant to take oral medication and by August he was described as erratic and confrontational. He was transferred back to the prison health care centre. His threatening behaviour and intimidation of staff resulted in a period in the segregation unit.

He was referred back to Ashworth Hospital, and was admitted under Sections 47/49 of the Mental Health Act 1983 on 19 July 2002. When we interviewed him he was still a patient at Ashworth Hospital. There had been a significant improvement on Clozapine, one of the newer antipsychotic drugs. His current RMO Consultant 9 is more optimistic that many of the characteristics that other professionals had attributed to Simon Rawcliffe's personality were due to his illness.

Analysis of the Care provided to Simon Rawcliffe

This section of the Report cannot be properly understood without first reading the detailed background section. The structure of this part of the report assumes that the reader will have knowledge of this case from the previous section.

We became aware early in our work that over a six-month period in 1999 there had been four serious incidents: two homicides, a suicide and an attempted murder in Bury. Each of these incidents involved patients in the community subject to CPA. We read documents suggesting that the reviews of three of these incidents had not been satisfactory. When the Trust established the Internal Review under the chairmanship of a Board Member, it was agreed that both homicides would be reviewed. Our Independent Inquiry focussed only on Simon Rawcliffe and not the other serious incidents.

However we urge those in a better position than ourselves to review these other incidents in the development of a new action plan (see below) triggered by this report.

In considering how best to critically review the care and treatment of Simon Rawcliffe it was inevitable that we would in this case have to understand better Bury Health Care NHS Trust, as it was responsible for the mental health service in 1999. The care and treatment provided to Simon Rawcliffe by front line staff could not be our only consideration. The risks of managing patients cannot be borne only by clinical staff. Management at all levels in a Trust must share the responsibilities. We heard from the clinical staff who worked in the Bury mental health service, that their effectiveness was limited by organisational and resource issues. This led us to consider the relationship between the mental health service and the parent Bury Health Care NHS Trust, then its relationship with Bury and Rochdale Health Authority, and the recent emergence of Pennine Care Mental Health Trust. At each stage in our journey we asked ourselves whether we were straying outside of our remit. We do not believe we have, and we are strongly of the view that a review of clinical practice and decision making alone, without an understanding of the environment that the mental health service functioned within, would have been a disservice to the sponsors of this Inquiry, those working in the service, and to the deceased and his family.

Chief Executive 2 of Pennine Mental Health Trust agreed with our approach when we saw him:

> *"…the contextual issues and fundamental issues in this service make it impossible to make much progress without addressing the whole system."*

Therefore, we wish to make it clear that there were, in our view, three important strands to the understanding of the care and treatment of Simon Rawcliffe:

i. **the quality and effectiveness of the clinical care and decision making,**
ii. **the historical under-funding of the mental health service in Bury,**
iii. **and, the quality and effectiveness of management and decision making in the mental health service, Bury Health Care NHS Trust, and the relationship between the Trust and the Health Authority.**

The under-funding and management issues cannot excuse failures in clinical care, though they help, at least in part, to understand why events occurred.

However the clinical failures in this case do not explain the whole story, and so we have tried our best to balance what we have said, and to be fair to all concerned. Each of the above three major strands need to be considered separately and together so that lessons will be learnt by all of those involved, not just the clinical staff.

Finally the focus of this section is on the services at Bury. In our inquiries we reviewed Simon Rawcliffe's mental health care from the onset of his mental illness and this is described in detail in the background section. However, the starting point for this section of the Report was the admission to the Scott Clinic on 28 February 1998.

Discharge from the Scott Clinic through to the last admission to Bury Mental Health Service

There is clear evidence that all the professionals involved in the care of Simon Rawcliffe were clearly aware of the role of the Mental Health Act in providing the legal authority for the use of compulsion to secure his admission to hospital, and subsequent treatment. Where recourse to the Act was made, it was entirely appropriate on each occasion. Every attempt appears to have been made to consult and inform the nearest relative (his mother) prior to admission, in accordance with the Act. The use of the Act by the courts and the Scott Clinic (Section 47/49 transfer from HMP Manchester, followed by Section 38 by the Crown Court on 13 January 1997 and the imposition of a hospital order on 7 April 1997) undoubtedly created a period of stability for Simon Rawcliffe, and his mother who was, and remained, actively involved in planning his aftercare.

It is clear from the information that we received from the witnesses and the documents we reviewed, that by the time of his discharge from the Scott Clinic he was as well as he had been for some years. This was his longest admission. He was managed in a secure environment and this allowed his excesses in behaviour to be managed more easily. He received medication for his illness, and for a long enough period to be clearer about the contribution of the illness to his behaviour as opposed to his underlying personality, and use of illicit drugs. He was given a clear diagnosis of a schizoaffective illness.

Consultant 4 told us:

> *"……He presented initially as silly, fatuous, awkward and with fluctuating moods … periods of sort of mild elation. I have no doubt that he had a schizophrenic illness diagnostically. When we reviewed his old notes plainly people had had a variety of views about him…essentially that he had had a recurrent psychotic illness…that it had a strong association with drugs and various forms of intoxication…that he was not an easy man to manage and that he had been quite difficult when he had been psychotic. We experienced difficulties with him, which are in the notes and which persisted. The grosser aspects of his psychosis settled……we had problems in deciding which aspects of his presentation were still illness and what aspects were personality……and also the extent to which one could say even if it arose, as mother seemed to imply, following the onset of his illness, as it seemed to have done, whether what had happened was that his personality development had been substantially impaired by the onset of his illness……there was some evidence of a mood component……and there did seem to be an improvement when he was put on Lithium……."*

We agree that the history clearly supports a psychotic illness and that substance misuse does not explain the clinical presentation. Patients with dual diagnosis, that is problem (or dependent) use of illicit substances and a psychotic illness are not uncommon nowadays and were not uncommon in 1998. If his use of drugs explained all of his illness, he would not have presented as he did in prison or in the Scott Clinic. In this case there is an underlying illness process. His use of cannabis

and other drugs will have contributed to episodes of relapse, his poor compliance with treatment, and his instability of lifestyle. We agree also with Consultant 4 that the personality development was damaged by the illness. There is no evidence that his presentation over the years can be understood as due to an abnormal personality.

The treatment at the Scott Clinic was broad based and included therapy sessions between Social worker 2 and Simon Rawcliffe with his mother. This was the first and only attempt that we have discovered where family relationships and bereavement issues were explored.

There were clearly difficulties around discharge, because the Scott Clinic was in Merseyside and the discharge was to Greater Manchester. We are not critical of the Scott Clinic. Every effort was made to communicate with relevant agencies and to provide a service bridge between in patient and outpatient care, with involvement from Bolton Social Services and Consultant 1 from Bury. Nevertheless, the Scott Clinic had no real experience of working with these local services. Consultant 4 went on to tell us that:

> *"One of our biggest problems was discharging him. Actually the process of discharging somebody into a region you do not know because you do not know the personnel…you do not know the systems…you do not know the sorts of things that happen between different institutional structures that you do in your own region……we sought some advice from the Edenfield Centre. At one stage we were wondering whether we should be saying ' we are struggling with Simon, what about him going either to you or the Bowness Unit'…we were very much dependent on what people told us was around because we did not know."*

We believe that the three medium secure units in the North West should come to some formal agreement about how 'out of catchment' area inpatients are discharged. It is not uncommon in the network arrangement that exists for one of the medium secure units (Scott Clinic, Merseyside, Edenfield Centre, Greater Manchester, and Guild Lodge, Preston) to take a patient from another's catchment area. In such cases it would be helpful to involve the appropriate medium secure unit in the discharge discussions and arrangements, even if the route is to the local service, and to share information. Local knowledge and experience could be of help, and details about the admission and discharge arrangements can be copied to the catchment area medium secure unit in case there is a further contact in the future. Whilst the discharge arrangements will naturally fall on the team and service that has the inpatient care responsibility, we believe that our suggestions would enhance the discharge and contingency planning process.

We understand why many witnesses told us that Simon Rawcliffe was not seen as at risk of committing a homicide. The police only knew him as someone with problems, who was immature in behaviour. Sergeant 1 the investigating officer confirmed he was not considered to be a *"candidate for murder"***. Without the benefit of hindsight we can understand how this view of Simon Rawcliffe emerged.**

A thorough appreciation of Simon Rawcliffe's history suggests however that he did present a risk to others. His difficult admission in 1995 led to a period of care in a low secure unit. In 1996 he was on remand at Manchester Prison charged with having an imitation firearm and affray, both extremely serious offences. With the benefit of hindsight, perhaps his risk to others was underplayed, though in placing Simon Rawcliffe on the supervision register, Consultant 4 was signalling his view that he represented a significant risk.

Supervision registers were introduced from 1 April 1994 by the Department of Health (HSG (94) 5) to "identify those people with a severe mental illness who may be a significant risk to themselves or to others, and to ensure that local services focus effectively on these patients who have the greatest needs for care and active follow-up. Supervision registers are *local* registers for which individual provider units are responsible".

We agree with Consultant 4, who correctly concluded at a Section 117 meeting held on 13 January 1998 that:

> *"Simon should be on the Supervision Register in Bury. He will be on our Supervision Register until the transfer is effected."*

There is no evidence that he was ever on a supervision register in Bury.

Supervised discharge was introduced from 1 April 1996. It amends the 1983 Mental Health Act, and is intended to operate as an integral part of the Care Programme Approach. Department of Health Guidance (HSG (96) 11) says that:

> *"Supervised discharge is intended for patients whose care needs to be specially supervised in the community because of risk to themselves or others. This applies particularly to "revolving door" patients who have shown a pattern of relapse after discharge from hospital. Relapses often follow the breakdown of arrangements for care in the community, for example when a patients stops taking their medication."*

The oral evidence of Consultant 4 to us and the notes of the Section 117 meeting, show that proper consideration had been given on more than one occasion to whether Simon Rawcliffe met the criteria for supervised discharge. The notes set out in some detail why this was not pursued:

> *".....It was not our view that it will increase his co-operation with follow-up and in fact, given what we have seen of Simon's personality in the past, it is likely to increase his lack of co-operation because of his anti-authoritarian attitudes. It will not enable medication to be insisted upon. The only discernible benefit might be that he could not live at his mother's without the consent of his supervisor but the reality is that should he choose to be uncooperative the pressure he could put on his mother would be undimmed by a Supervised Discharge Order....."*

Consultant 4's report to the Tribunal dated January 1998 concludes:

> *"I made reference in the original Section 37 report to the possibility that a Supervised Discharge Order would be necessary. However, after discussion of this matter with the clinical team and with Consultant 1 in Bury it is our view that it is not necessary. Simon is proposing a mode of life somewhat different from that to which he has previously returned after episodes of mental illness. He has shown a level of co-operation latterly somewhat beyond his previous achievements and our view is that it is unlikely that a Supervised Discharge Order would result in the better provision of aftercare than not using it."*

The independent psychiatric report prepared for his Tribunal added:

> *"The team have considered whether the Supervised Discharge Order is a useful adjunct to the discharge plan but on balance do not consider it to add to anything at present to the s117 care plan. I concur with this view."*

Whilst we may not agree with the assertion that supervised discharge would not work because of his anti-authoritarian attitudes, the clinical team's findings are not unreasonable, and their conclusion was one that it is perfectly entitled to reach, and was supported by the independent psychiatrist at the Mental Health Review Tribunal.

Unfortunately, the discharge plan for him to live with friends broke down quickly. What is disappointing is that the service response following his discharge from the Scott Clinic was so poorly organised. In his evidence Social worker 2 described the problems he experienced in receiving appropriate support from Bolton Social Services:

> *"…….our choice of discharge plan would have been for Simon to be transferred to a local inpatient facility……."*

Attempts were made to find a suitable placement without success, and so the alternative of staying with friends was considered. The problem was that his accommodation was in Bury, and that up to this point Bolton Social Services had been involved during the admission. The expectation was that they would follow him through to discharge, and then hand the case over to Bury Social Services.

A further complication was that consultant involvement in the Bury mental health service was linked to the patient's general practitioner. Consultant 1 had been well briefed by Consultant 4 and had been involved in the discharge planning. Because of the missing medical notes it is unclear what contact Consultant 1 had with Simon Rawcliffe during this admission. On interview Consultant 1 had no clear memory of the events before or after discharge from the Scott Clinic, and first saw him on the 21 May prior to his last admission.

From the initial referral to Bury Social Services in October 1993, Simon Rawcliffe had almost continuous involvement with social care services up to his arrest. Individual social care staff from Bury, Bolton (and very briefly from Lancashire County Council) attempted to provide appropriate services during this period.

Although initial referrals to mental health services indicated a diagnosis of serious long-term illness, the fact of that illness appears not to have been accepted by social care staff. This perhaps led to a ready acceptance that the case could be closed due to his periodic non-cooperation with professionals. This meant that he was 'lost' to social care staff in 1994, and again in 1995. On each occasion the re-referral came about as a result of further offending, which brought about police involvement.

The Bolton social care notes, although recording periodic contact and action, contain a number of unsigned (and therefore unattributable) comments. This caused problems for the panel in understanding whether consistent individual support was available to him during this period.

We do not blame social care staff for the lack of weight given to Simon Rawcliffe's illness, as mental health staff should lead the clinical formulation. However, it does appear that each new referral was not assessed by reference to previous patterns of presentation. His mother's views and the information that she had about her son were largely ignored.

During Simon Rawcliffe's admission to the Scott Clinic, he and his mother received positive and well-documented social care support from social work service based at this secure unit. The forward care plan for his after care was well coordinated. However, the organisation of local services following discharge was poor, and there were unacceptable delays.

The transfer from Bolton to Bury following discharge was not well handled. The unsigned Bolton social care notes indicate the need to transfer the case to Bury in early January 1998. Transfer to Bury Social Services took over three months to occur. Social worker 1 referred him on to Social worker 5 of Lancashire Social Services, because of a change of address, but he was not given background details. Simon Rawcliffe was not seen by Social worker 5 and went back to Social worker 1 on the 19 May 1998, when it became clear he had returned to his mothers' address and was living in a tent in the garden.

The transfer of cases between Borough social services departments and within services in a Borough should occur more efficiently, with greater speed and there should be proper handover processes with background information.

From the final involvement with Social worker 1 until September 1999, there was consistent and well-documented support provided by Bury social care services, principally by Social worker 1.

However, Simon Rawcliffe's main problems were still seen as his need for supported accommodation, and his non-compliance with services. The effect of his serious and long-term mental illness was not included. Given that the indication in the CPA documentation following his final discharge was that his needs were considered to be at the highest level, the lack of comments in the notes concerning his mental illness are perhaps surprising. Similarly, information about his aggressive and sometimes threatening attitude towards staff, and towards members of the public, were not recorded.

The mental health service delivery in Bury following discharge was also poor. CPN contact was triggered not by Consultant 1 in advance of discharge but by another consultant's secretary in a phone call to Community Nurse 2 on the 7 May 1999, over two months after discharge. The depot injection was due on the 3 March 1999, and this was clear in the discharge letter from the Scott Clinic dated the 27 February 1999, the day of the discharge.

Community Nurse 2 described her first involvement with Simon Rawcliffe, when a medical secretary phoned her:

> *"……it wasn't actually a referral……she actually rang……I remember it quite distinctly……she actually rang to ask if I was doing Simon's injection……to which I informed her that I had never heard of Simon at that point and she said 'Well somebody needs to be doing it and it falls in your area,' which is probably why I've written referral. I took it then as a referral……."*

She had received no information from either Consultant 1 or from the Scott Clinic. She then obtained information, contacted Simon's mother and Social worker 5. Community Nurse 2 triggered the CPA review meeting on the 21 May 1998, which Simon Rawcliffe attended. Consultant 1 found no active symptoms of mental illness at the time. The medication was reduced with the frequency of his depot changing from every 2 weeks to every 3 weeks.

It should be noted that Consultant 1 made a diagnosis of personality disorder in 1994 at a time when Simon Rawcliffe was noted in prison to be psychotic by other psychiatrists. We wondered whether Consultant 1 was unconvinced by the diagnosis. In answer to questions about the basis of this diagnosis of personality disorder in 1994, Consultant 1 replied:

"It was not conclusive. One was the absence of mental illness or symptoms at that time. Second was the history of drug abuse……."

It is difficult to believe that the acute symptoms present in the Summer of 1994 were absent when assessed in prison by Consultant 1. A diagnosis of personality disorder needs to be as robust and carefully applied as a diagnosis of schizophrenia. It should be made for positive reasons, and is a diagnosis based on historical patterns of inflexible behaviour, interpersonal functioning, affectivity, cognitive processes and impulsivity and not on the basis of a snapshot assessment at a particular point in time. It can be a pejorative label, which can be used to exclude people from services. Being in prison, using illicit drugs and an absence of symptoms of mental illness are not necessarily indicators of personality disorder, even though many people in prison and who use drugs may have an appropriate diagnosis of personality disorder.

The view of Simon Rawcliffe as a man with social needs and personality based behavioural difficulties flows from the above formulation. This formulation is too simple and in our view contributed to his management style during his last admission to Bury.

This was probably why the CPA policy in place at the time had not been considered by Consultant 1 of discharge from the Scott Clinic. There was no CPA documentation, no communication with the CPN service, no key worker/care coordinator, no coordination with his social worker, and he had missed his important injection of depot medication. We are critical of this total lack of coordinated care delivery for Simon Rawcliffe who prior to his discharge from the Scott Clinic was considered a possible candidate for a supervised discharge, because of his poor compliance with treatment for his mental illness. It is therefore ironic that the first assessment after discharge by Consultant 1 resulted in a reduction in his medication.

It may be that the lack of multidisciplinary working was at least in part, inhibited by the lack of a shared clinical base.

When Community Nurse 2 saw him he was angry and she felt intimidated by him. He soon refused medication again. His choice of key worker was an example of the lack of appreciation of his mental health needs. Community Nurse 2 told us that Social worker 1 was identified for this role as social issues (accommodation) was seen as a priority rather than his mental health needs.

The final admission to Bury Health Care NHS Trust in March 1999

Consultant 1 admitted Simon Rawcliffe from police custody and within days his care was taken over by Consultant 3. Consultant 1 said that this was for *'sectorisation reasons'*. Consultant 3 had no previous knowledge of him, and his recollection was that Simon Rawcliffe disliked Consultant 1, and wanted to change consultants.

Consultant 3 said that his knowledge about this patient came primarily from the nursing staff. Because the clinical notes prior to this admission disappeared he was not able to read about the background for himself.

He indicated that he asked Consultant 2 to:

> *"……put things together……but we could not do all the things we wanted to do at the time."*

By the time of discharge none of the reports or letters detailing his past history had been obtained. Consultant 3 was asked if decision-making in this case would have been improved if this information were available.

> *"I don't think it is going to make a very big difference because other people knew him from before, knew the background history. I remember the social worker Social worker 1 who knew him quite well, knew him from the previous admission as well in the Scott Clinic, and told us about the information……so we had a fair idea. I am not saying that we went in any depth about things but yes…we knew what was happening, we had a fair idea."*

Social worker 1 was not involved during the Scott Clinic admission. She subsequently became involved after discharge, though she never saw him. The failure to collect the missing information, which detailed his past history of mental illness, and in particular his Scott Clinic admission, was a serious error by the whole team. We were disappointed that even now Consultant 3 does not recognise the shortcomings of relying on the subjective memory of nursing and social work staff, some of whom had never seen him before.

Infact Consultant 3 took the view that much of his difficult behaviour was due to:

> *"……some sort of personality element."*

He described him as:

> *"Very difficult, an extremely difficult person, very intimidating, very challenging and as I say he could be rude but at the same time he was quite disturbed, agitated, and aggressive as well. It was difficult to have any useful or meaningful conversation…because I don't know, he was not able to concentrate very much."*

We do not doubt this, but clearly it was not appreciated that his mental illness could contribute to this presentation. The struggle to understand this case illustrated in the notes from the Scott Clinic, the link with the mood disorder aspect of his illness, the impact on personality development, the damage caused by schizophrenic illnesses on personality, are debates notable by their absence in the Bury notes or in the evidence we took from Consultant 3 and others.

Inevitably, as Simon Rawcliffe's admission to Fairfield Hospital and discharge occurred not long before the homicide, particular scrutiny has been made of the application of the 1983 Mental Health Act at this time.

Consultant 2 placed him on a section 5(2) and he was given Acuphase. Consultant 3 said that the authority to prescribe Acuphase was under common law to control a disturbed situation. The available notes are unclear as to the clinical decision making at the time. Consultant 3 indicated that he was so busy, as was Consultant 2, that nursing staff were left to make notes of the conversations with the doctors.

We will consider clinical supervision, service management and the role of Bury Health Care Trust later in this Report. Whilst we are critical of some aspects of the care provided by Consultant 3 and his team, we are clear that he was himself a victim of the dire situation in the service at this time. He remained loyal to the service. He did not leave for another post, and he could have done bearing in mind the national shortage of psychiatrists for vacant posts. The same could be said for many of the other staff we interviewed. They should be commended for this loyalty.

The sequence of events leading to his detention under Section 3 is unclear from the notes, but it appears that this was done on the 18 March. There are then regular nursing notes detailing his difficult behaviour, and periods on close observation. Nurse 2 the ward manager for ward 21B described the process of close observation as difficult, because of the low staffing levels and the mix of patients. The recording of close observation should have been documented on a separate sheet for each patient.

We are critical of how close observation was undertaken and recorded. There was in this case no record of observation. Line of sight observation, without any regular recording, would even in 1999, not be considered as a *'close'* observation procedure. It was unclear what were the standards underpinning the operation of close observation. We found no evidence that a written observation policy existed at this time.

The recording of incidents and the response to these events was lacking. The most serious, the incident of violence that led to his removal by the police, and his later threat to shoot staff, should have resulted in some form of incident review by the clinical team, and consideration by management. This did not take place. We were concerned to find out that Social worker 1 had no knowledge of the incident that led to Simon Rawcliffe being removed from the ward by the police, and the threats he made at this time.

We found it difficult to understand why he was given periods of leave. The disparity between the ward round decision-making and the nursing notes was discussed with Consultant 3.

> *"……there was some improvement. It was always mentioned he was still very disturbed but less disturbed compared to the time of admission, so yes he was under close observation but he was demanding to go out and we felt we should give him some freedom, that would probably settle his behaviour down, that might help him, so it was to give him some fresh air……."*

The decision-making was reviewed in detail during the interview with Consultant 3 who told us that he responded to the views of nursing staff.

> *"They are decisions with their help. If they are not happy about anything, they have got to say that in the ward round, but if they are agreeing with everything, and completing Section 17 form, then I sign it." (Sic)*

We were again disappointed that Consultant 3 did not review again the management of this last admission of Simon Rawcliffe in a spirit of learning any lessons for future practice. Our findings were very similar to the Internal Inquiry, which Consultant 3 would have read.

Any objective reading of this last admission would suggest that the leave permission was not linked to the behaviour of Simon Rawcliffe. Either the clinical team were not working together and communicating, or information was held back by nursing staff so that he could be encouraged to leave the ward, or Consultant 3 was not listening. We thought that the former was the most likely.

In other words to manage his risk to others on the ward, he was kept under close observation. At the same time he was allowed off the ward. There was it appears no consideration of the risk he might pose to others whilst off the ward and out of the supervisory control of nursing staff.

Simon Rawcliffe was authorised episodes of leave by Consultant 2 on a number of occasions during his detention. The Mental Health Act Code of Practice paragraph 20.1 makes it clear that only the patients RMO can grant leave outside the grounds of the hospital to a detained patient. Consultant 2 was not the RMO.

The Code of Practice also requires that decisions about leave, and use of leave are reviewed, and the outcome recorded. It is evident from the clinical notes made at the time that Simon Rawcliffe's behaviour on the ward was at times so aggressive that the nurses refused leave on the grounds that it would be unsafe to allow him off the ward. There is nothing in the clinical notes to reflect those concerns.

This questionable decision-making was of such concern to Nurse 3 on 23 April 1999 that he entered a prominent note in the clinical records to stop leave. He cancelled the Authorisation for Leave form dated the 24 April. Despite this entry, six days later Simon Rawcliffe was again given leave as improvement was noted.

The entry on 29 April 1999 reads:

"……very settled. No management problems during this week……."

However the improvement was of only two days duration. On the 25 April 1999 he exposed himself to staff and made suggestive comments. The possibility that such behaviour was a manifestation of his illness, as had been the case in the past was not considered from the evidence in the notes. However Nurse 1, his key worker expressed the view in oral evidence that Simon Rawcliffe had a serious mental illness, but that he found it difficult to accept this label. Nurse 1 was not supportive of a personality disorder diagnosis.

We could find no copies of any leave forms signed by the RMO after 24 April 1999. Consultant 2 completed a leave form on 6 May 1999 authorizing leave for that day, together with periods of leave of 1 hour twice a day at the discretion of the nurse in charge. However, the nursing notes indicate that he was also taking leave from the ward that was not authorised. The nursing notes for 7 May for example noted that:

"Simon has gone out for day. Due back at 8pm."

The absence of any proper procedures for the documenting of leave and the failure of the RMO to authorise it are serious matters. There was at the time no policy, which covered the authorisation of leave from the hospital. This is contrary to section 17 of the Act, and the guidance set out in Chapter 20 of the Code of Practice.

The failure to follow the Act and Code of Practice in relation to the authorisation of leave and aftercare planning, indicates that practice not only fell well below the standard expected of the Trust, it was also at times unlawful.

The care given by staff to Simon Rawcliffe by staff during this inpatient stay was described to us as *'symptom control'* and it was thought that he would not engage in *'talking therapies'*. Nurse 1 described

him as difficult to engage. The treatment approach at the Scott Clinic and joint work with his mother was never considered. It was probably not known about. The supportive relationship with mother was used to encourage compliance. Nurse 1 said:

"……basically, you know…calm down and you can go out with your mother……."

Nurse 2 admitted that nursing care plans and the objectives set for Simon Rawcliffe were more about containing his behaviour than actually doing something about it. There were no specialist therapeutic interventions for patients on the ward. Staff could not be released for training even if there was funding. Care was reactive rather than proactive.

Supervision was ad hoc, and was described as peer supervision and not clinical supervision. Any one to one supervision took place when the staffing and acute ward work allowed.

We recommend a review of skill mix and training needs of the current staff complement in Bury. Pennine Care must also ensure that adequate nurse supervision systems are in place.

The sequence of events leading to the discharge from his Section 3 is also unclear. Consultant 3 appears to have exercised his powers under Section 23 of the Act to order that he be discharged from the Section 3. This occurred on 12 May 1999.

The entry in the clinical notes of the same date made by Consultant 3 records that it is his intention to:

"……take off Section 3……possible discharge tomorrow after Ward round and CPA meeting."

There is no written record of any discussion with other members of the care team before Consultant 3 completed the form ordering discharge from detention under the Mental Health Act. In his oral evidence Consultant 3 stated that he did have a discussion with a senior nurse on the ward. They concluded that Simon Rawcliffe was not ill enough to continue to be detained under Section 3. We tried to understand the discharge process better.

Question:

"One of the things that was just confusing us because we have heard different things from different people, was when was the discharge meeting held, the 117 meeting?"

Consultant 3:

"It was going to be held when we were going to review him in the clinic. I think an appointment had been arranged."

Question:

"I am a bit confused about the process of discharging the patient. Did his mother know that he was being regraded to informal at the time you made that decision?"

Consultant 3:

I am sure nursing staff must have informed the mother. I didn't do it personally. Normally the nursing staff inform. He was not going back to live with the mother, he was going to have his own independent accommodation so I don't know."

Question:

The reason why I am pressing you on this is of course the mother was his nearest relative and therefore the Code of Practice says the nearest relative needs to be informed about the patient's discharge. I

would have expected as Simon's RMO you would have wanted to hear her views about taking him off this section."

Consultant 3:

Her view was yes, he is getting better. She had him for a day but as I said earlier it was not possible for him to go and live with the mother……."

In the event, Consultant 3 did not attend the ward round on the 13 May 1999, though he made a note later that the patient would be discharged after accommodation was found for him. Social worker 1 who did attend the ward round on the 13 May with his mother noted that he did not wish to remain an inpatient and that he would refuse to take medication. She telephoned Woolfield House, but there was not an immediate vacancy. He refused to wait on the ward for a further period. She gave him a list of bed and breakfast accommodation. He left the ward (the exact time is not recorded) and was discharged from hospital in his absence on 14 May.

The nursing notes state:

"Social worker 1 says place available at Woolfield House. She is to try to arrange B and B there and get domiciliary care in place. (S.R) says he wants to go to Woolfield House today…… will take medication etc……."

We were unable to reconcile the discrepancies in these entries. Perhaps Simon Rawcliffe was giving contradictory information. Perhaps the members of the clinical team were not quite together in their approach to this case and this was compounded by different disciplines entering notes at different times.

As a matter of strict law, there is nothing unlawful about the manner in which Simon Rawcliffe was discharged from his detention by his RMO. Nevertheless it falls far short of acceptable practice to rely on informal, unrecorded discussions with other members of the care team before a Section 23 discharge is effected. At best, it was either disingenuous to have expected him to remain in hospital as an informal patient when his history indicated otherwise, or this was another example of the failure to understand his past history, and to retrieve the missing information from his medical notes.

Equally, it falls far short of acceptable practice for the social worker to hand a list of bed and breakfast accommodation to a patient subject to Section 117 aftercare under the Act. Events of the 12 and 13 May 1999 demonstrate the haphazard and wholly inadequate nature of the process of planning for discharge, with scant regard being paid to the principles of inter-agency working and the guidance laid down in Chapter 27 of the Code of Practice.

As the list of bed and breakfast accommodation was given to Simon, and from that list he found his way to 8/10 Wash Lane, the responsibility for the inadequacy of this discharge address must fall on Social Services. There was no communication system set up between this address (owners/residents) and those responsible for his aftercare. If it was not possible to set up this level of cooperation he should not have been given this address. Giving an address such as 8/10 Wash Lane suggests implicit approval that it is an appropriate place for someone with severe mental illness on level 3 CPA, subject to Section 117 aftercare, to be a resident.

We asked for further clarification about the completion of the aftercare arrangements and CPA documentation.

Question:

"He left the ward on the 13 May, is that right?"

Consultant 3:

"Yes."

Question:

"What happened after that in terms of arranging his aftercare? There appears to have been paperwork carried out by yourself and Nurse 1."

Consultant 3:

"Yes I remember discussing with Nurse 1."

Question:

"I think you completed a risk assessment……."

Consultant 3:

"……It was done by the nursing staff during the period of assessment. It is not done on one sitting."

Question:

"It has got your name on it and Nurse 1 on it?"

Consultant 3:

"That is right, they wanted the consultant to sign the form……I didn't complete the form, no…it is not completed by me. The nurses do it ……."

Question:

"It has got your signature on it?"

Consultant 3:

"You read it and then you have to sign it. I don't know why they wanted the consultant to sign it but that was the policy at the time……it is all different now."

The impression is of the consultant staff, semi-detached from the rest of the team, leaving the form filling to others. Perhaps this is what was meant by a nurse 'led service', a comment we heard on more than one occasion.

It is therefore not surprising that the CPA Aftercare Plan and accompanying checklist are so poorly completed. It is not clear why this documentation was signed off as long as 3 weeks following Simon Rawcliffe's departure from the hospital. The CPA aftercare plan documentation is dated 10 June 1999.

The CPA 1 document checklist was fully completed by Consultant 3 and Social worker 1.

The CPA 3 form describes the medical plan as an outpatient appointment 15 June 1999 with no mention of medication, or the response of the service if he relapsed or presented with disturbed behaviour. A better understanding of the case could have highlighted a relapse signature if his psychotic illness had been better appreciated. The sexually inappropriate comments that were later noted by CPN staff, may have led to consideration of admission, rather than a change to a male CPN.

Nurse 1 signed the CPA 4 Risk Assessment document on the 2 June and by Consultant 3 on the 3 July. He was thought to be a risk of neglect but no risk to self, others or property was noted. This risk assessment or more properly termed the risk checklist is completed incorrectly, as it is suggested that there is no history of risk to property and others. The only risk factor noted was risk of self-neglect. Compliance with medication was correctly identified as a problem, and that non-compliance could lead to antisocial behaviour.

All the care professionals involved in this case must bear some responsibility for these arrangements.

Our findings are similar to the Internal Inquiry, which also found that there were major problems with adherence to the CPA policy in place at the time.

Had an accurate and informed risk assessment been completed before discharge, and there was ample opportunity to do this, during this lengthy admission, it may not have been felt to be appropriate to discharge Simon Rawcliffe from detention, allow him to leave hospital as he did, to unsuitable accommodation.

Consultant 3 indicated that the plan was to place Simon Rawcliffe on Level 3 CPA following discussions on the ward.

Paragraph 27.6 of the Code of Practice states that the RMO is responsible for ensuring that: "*consideration is given to whether the patient meets the criteria for after-care under supervision…and consideration is given to whether the patient should be placed on the supervision register in accordance with HSG (94) 5*".

There is some confusion as to whether Consultant 3 did indeed address these criteria as there are no written entries to that effect, although in his oral evidence to the Inquiry Panel, he indicated that discussions had taken place on the ward, but stopped at the point when they decided that Simon Rawcliffe could be managed on level 3 CPA.

Despite Consultant 3's assertion that there was enough knowledge about this case, if the notes from the Scott Clinic had been obtained we believe that at the very least there would have been more detailed consideration of supervised discharge. We found no objective evidence of any such discussion. The only comment was in a report for the cancelled Mental Health Review Tribunal prepared by his key worker, Nurse 1.

In our view Simon Rawcliffe would have met the statutory criteria for supervised discharge. His behaviour prior to admission in March 1999 (aggressive, hostile, carrying a hammer with intent to harm) was referred to in Consultant 3's report to the Tribunal, dated 15 March.

The tribunal report also described his behaviour on the ward as:

> *"…unmanageable, aggressiveness and severe disruptive behaviour and has threatened violence towards people."*

This suggests that a much more rigorous approach should have been taken to consider the powers professionals had under the Act, and were expected to utilize. It is worth noting that none of the factors on which the Scott Clinic placed weight for rejecting supervised discharge, were present in May 1999.

Accordingly, at the very least, the RMO should have recorded in writing why a decision was taken not to proceed in this way. It is indicative of the attitude of this service towards supervised discharge in 1999 that no patient appears to have been made subject to it. We were told this is not the case now.

It is also unclear why Simon Rawcliffe was not on the supervision register in Bury. Department of Health policy makes it clear that when Simon Rawcliffe was transferred from the Scott Clinic (where he was on their register) *"the receiving unit should review the patient's needs, and produce a new entry on its own supervision register"*.

If Simon Rawcliffe had been placed on the supervision register in Bury, both aftercare planning and follow up in the community ought to have been far more robust.

The Trust is not assisted by the inadequate Policy it had in relation to the supervision register, which makes no reference whatsoever to Department of Health guidance and fails to describe the purpose of keeping such a register. It therefore comes as no surprise to learn that the Trust had only two patients on its register in 1999 and three patients on supervised discharge.

It is, of course, not possible to say with any certainty whether the use of the supervision register and supervised discharge would have made any difference to the tragic outcome of Simon Rawcliffe's care in the community. However, the absence of any evidence to indicate that these initiatives were actively considered, and the absence of any record summarising why they were not appropriate in this case, is unsatisfactory.

We were told that there is now a new CPA policy in place and a risk screening assessment policy. We were pleased to here this and reviewed the policies. However new policies will not be followed if they are not accepted by all staff. There is nothing to prevent staff incorrectly completing the current CPA forms, in the same way as we have seen with Simon Rawcliffe in 1999. Compliance with such policies relies on training of staff, audit, and adequate time to do this, in a properly resourced service.

We recommend that the new Trust review the implementation of CPA particularly in Bury, through a quality audit. That a form has the correct ticks is unhelpful; is the information underpinning the tick choice correct? Training should also be reviewed. This cannot be done without improving the staffing situation. Overworked and under pressure staff will always take short cuts in documentation and coordination of care.

The guidance provided to all services by the successive publications about the Care Programme Approach, underlined the need for consistent follow up to anyone on the highest level of CPA. The recommendations following the Report on the murder of Jonathan Zito by Christopher Clunis included the advice that individuals who moved across local authority boundaries should continue to be followed up, until such time as the next service is actually in contact.

We recommend that there be a review across Greater Manchester as to how individuals in contact with one mental health and social care service are handed over to new services. Each of the new Mental Health Trusts should consider how such movements are managed within Trusts and Borough's and between Trusts.

The Department of Health might wish to consider issuing advice to all Mental Health Trusts on good practice in this area.

We found other problems with documentation. Nurse 2, the ward manager in 1999, became aware of the significant discrepancy in the clinical notes after the Internal Inquiry report. Nurse 1, who is now a ward manager, in the same service told us that he was still dissatisfied with the separation of notes into medical and nursing records, and would like to move towards integrated notes.

Various reasons are often given to support the separation of professional notes. The notes at the Scott Clinic are integrated, and there is a running record of inpatient care with contributions from medical, nursing and social work staff. Patient need and a longitudinal account of inpatient stay for everyone to read should drive such a change. We recommend the new Mental Health Trust reviews note keeping, in terms of integration and standards in Bury and if necessary across the whole Trust.

Finally during the period leading up to his arrest there were two changes to his care with the introduction of a new social worker and CPN. It is unfortunate that both changes (for good reasons) occurred at the same time, independently, and without any reference to the consultant. Good practice would have suggested that a joint meeting should have been arranged. Both Social worker 6 and Community Nurse 1 told us that they had good information available. From the information at our disposal we disagree.

Simon Rawcliffe lived at a number of addresses in Bury, Bolton and Lancashire County, as well as being homeless during the period 1993 to 1999. Most attempts to provide him with a settled address, at which he could receive appropriate support, seem to have been in Bury. However, the approach adopted to manage his mental illness would appear to have made these attempts of little benefit. In the late 1990's there existed a joint strategy for Community Care and Homelessness. Some staff had been appointed, to improve joint working at both the strategic and operational level between Housing and Social Services.

The team was very small, and so following up individual referrals was sometimes a problem.

It was felt that Simon Rawcliffe would not make an application for housing himself, and so the referral was made to the social needs panel, by Social worker 1. The Panel decided that the application should be referred to the Homelessness Section. There was a delay between that decision being made and an emergency assessment, which was made in 1998. Simon Rawcliffe was at this time living in a caravan in Rawtenstall. He was appointed 30 points by the Social Needs Panel, under the criteria of 'risk of institutional care' criterion and he was placed on the housing list.

In January 1999, Community worker 7 (Community Care and Homelessness Manager) enquired what had happened to the application, and was told that Simon Rawcliffe was asking for the Ramsbottom area. As this was a high demand area, his application was still on the waiting list. The application then seems to have been dormant. When a property did come up, Simon Rawcliffe lost the tenancy chance because the view was taken that he was not cooperative with services, and it was left for his social worker to contact housing again when it was felt that he was ready.

He was given a list of bed and breakfast accommodation on two occasions. This was a list prepared by the Urban Renewal section of Environmental Health, and contained details of houses in multiple occupation, which met certain environmental standards.

Some of the addresses on that list would not have been considered suitable for most single homeless people, and certainly not for someone with mental illness. In view of the comments that we heard about the conditions in existence at 8/10 Wash Lane we are concerned that it featured on any official approved accommodation list.

The use of Bed and Breakfast accommodation in Bury was in great part a reflection of the abysmal state of accommodation at the time. Since 1999 there have been major strategic and funding changes in single person accommodation and support.

It is the opinion of the Panel that Simon Rawcliffe was not considered a high risk individual. For this reason he was not one of those individuals referred to the system whose needs were regularly discussed. There are no records to suggest otherwise. His accommodation needs were felt to be linked to his unwillingness to accept support, rather than his mental illness.

As a result his housing needs were largely unmet. His social and health care services reacted to the situation at each period of his contact with the services: a reactive rather than a planned and strategic process.

The mental health service in Bury in 1999

Consultant 1 explained that at this time he had taken on a large caseload from a consultant who had left the service in addition to his own caseload of general adult and learning disability patients. Then and subsequently he felt under pressure because of the failure to recruit substantive consultants, and there were a succession of locums. The training status for psychiatrists had been removed by this time by the Royal College of Psychiatrists, as there were concerns around the appropriateness of the service to provide appropriate training. There had been one senior house officer working with Consultant 1, primarily for learning disability experience. The service has since that time been completely staffed below the consultant grade by non-training grade Trust doctors and staff grade doctors.

Consultant 3 described at this time working as a general adult psychiatrist covering a catchment population of up to 30,000. When an old age psychiatrist left post he then took on these responsibilities. He was also clinical director for the mental health service.

We agree that the medical staffing situation was most unfortunate at this time. There was little stability in the workforce apart from Consultant 1 and Consultant 3. There were no psychiatrists in training. There were a succession of locum doctors and little has changed since that time except Consultant 2, then a staff grade is now a locum consultant, having achieved his membership of the Royal College of Psychiatrists.

All the psychiatrists that we saw described excessive workloads and difficulty in coping with all the demands upon their time. They ran lengthy outpatient clinics, did domiciliary visits, and provided advice to community and inpatient unit staff. Apart from emergencies, the consultant input on the ward was mainly through the ward round, when unavailable the staff grade doctor deputised. CPA was described as a process that the doctors had not really signed up to, although Consultant 3 said that he tried to encourage a more coordinated process. Nevertheless, he described feeling overstretched by his heavy workload, and unsupported by management. About 18 months ago he had to contain his work and he said that he decided unilaterally to focus on old age psychiatry and to drop his adult caseload and clinical director role.

Consultant 3 recognised the need to develop a teaching ethos for the non-training grade psychiatrists:

> *"We did not have a training post…… we lost our training status quite a while ago. The whole thing was, I don't know, was going from bad to worse type of thing and I felt I had to do something at least, do something for the non teaching, non training doctors, so we started our own."*

When asked how much Study Leave time he now takes, Consultant 3 said in the present tense:

> *"……we can't actually take study leave it is a matter of finding the time and it is the fear. I don't know I mean I feel ……if I take one day off God knows what is going to happen to my patients and my work. You are always on your toes running around everywhere trying to keep everything under control……."*

He went on to describe taking *"minimal"* study leave days, and not taking all of his annual leave entitlement.

This is unacceptable; no caring organisation should allow this state of affairs to continue. Consultant 3 told us that he had met with the Medical Director of Pennine Care, and the new Mental Health Trust. He was hopeful that the situation would improve, and that services in Bury would receive a fairer share of the financial cake, than was the case in the previous Trust.

The service in the mid 1990's and onwards was described to us by many witnesses as 'nurse led'. The psychiatrists though in the main supportive, were marginal to the clinical teams. Nurse 3 described the service as 'nurse led', and it was the nurses who put the patient management options to the ward round. The nursing staff told the doctors what had been happening on the ward. It would be the exception for the nursing notes to have been reviewed by the doctor. Nurse 3 informed us that he audits some of the medical notes, roughly once a year. They are still a collection of ward round notes as opposed to any type of commentary.

In our view the medical staff were let down by the Bury Health Care Trust, the Chief Executive and the Medical Director. It appeared as if the medical staff were left to sink or swim. Consultant 3 himself was clearly driven by the best of intentions. He took on more than he should have done, as did many other staff. There does not appear to have been any real review of workload by the Medical Director of the previous Trust. We were told he was aware of the problems but because of funding difficulties, there was nothing that he could do. We were told that the timetables for the doctors had no time set aside for the community teams. Consultant 10, a psychiatrist, who with Social worker 7 prepared a report on the mental health service in Bury for the Trust following the killing of Liaquat Ali, described the situation as he found it to be:

> *"…from the medical staff point of view one of the worst situations I had seen as I have wandered round the country looking at services in trouble."*

There does not appear to have been a proactive attempt to review the loss of training status by Bury Health Care Trust in 1995, and how this could be rectified. A training centre is more attractive for consultant recruitment. Other mental health services in Greater Manchester managed to do better, despite the manpower shortages in psychiatry.

We were not convinced that the current consultant establishment would be able to provide the leadership to change the service. The Medical Director will need to provide more direct input and support for the Borough Director, until the staffing situation improves. The action plan which will be developed from this Report must have, as an urgent priority, improvements around recruitment, training, continuing professional development (CPD), and job planning to bridge the gap between Bury and other services in Greater Manchester.

The situation was little different for inpatient and community nursing staff. Nurse 3 told us that there was a low staff base. The inpatient wards ran on three nurses per shift in 1999. Although there has been some improvement he told us that four nurses per shift was still inadequate.

It was difficult to support training because of the staffing situation.

> *"……it is very difficult to support training in terms of time…… there is holiday and there is sickness to cover……I am the first one to admit there was a lot of, as you say, symptom containment, risk containment and trying to keep the lid on the pressure cooker……that's how it felt to me as a nurse manager and I am sure my staff felt exactly the same."*

The service in Bury in 1999 did not have access to an intensive care ward (ICU). Had there been an ICU, Simon Rawcliffe would have spent some of his last admission on one. The ICU in Cheadle Royal (in the independent sector) was used but there had to be purchaser permission. We were told that the door on the acute ward 21B was locked occasionally, but this would not have been a real physical deterrent. There were problems in 1999 with patient mix, and it was the confused elderly patients rather than the disturbed younger male patient that led to the acute ward being locked. The situation is little different today. The ward design is based on the original psycho geriatric (EMI) ward structure (as this was what the wards were originally for) and was not ideal for acute patients to be managed well by nursing staff, let alone psychotic young men, those with learning disability, and elderly patients.

Consultant 7, a consultant forensic psychiatrist who, in the early 1990's was responsible for the Bury catchment area told us:

> *"The thing that always struck me was there seemed to be a lot of psychopathology in Bury…it was always a very busy catchment area. Now I do not have any information for the last five, six, seven years but certainly then it was not an easy area to manage. The facilities (particularly in terms of inpatient facilities) were very limited. They had, I think, two or possibly three acute inpatient wards and very little else and they did seem to have difficulty in managing disturbed behaviour."*

We understand that funding has been approved for a new inpatient facility. This must happen if the mental health service in Bury is to modernise. Access to an ICU facility is also necessary, either in Bury or within the wider resources available in Pennine Care Trust. Staff should also receive training in managing difficult and aggressive behaviour, and therapeutic engagement with problematic patients. Control and Restraint (C&R) training is a last resort. There are strategies that should be considered before C&R becomes necessary.

The community nursing situation was equally fraught. The average CPN caseload was 60-70 clients in 1999. Community Nurse 2 at this time of her involvement with Simon Rawcliffe, following the discharge from the Scott Clinic was a G grade nurse, with day-to-day responsibility for another nurse based at a health centre in Ramsbottom. Her line manager was Community Nurse 6. She was carrying a mixed caseload of over 80 patients, with approximately 75% primary and 25% secondary care patients. In addition she supervised her colleague. There was no assertive outreach team at the time (we understand that there is now). It was left to the assigned CPN to find the time to find reluctant and non-compliant patients. Community nurse 2 described similar caseload pressures.

Community worker 2 described difficulties in community team working because the North team CPN staff worked from a different base to the social workers. Although everyone got on, the roles of CPN and social work staff was muddled and there was no clear structure around the management of individual cases. Notes were kept in an individual way; there were no standards around note keeping, content or format. She went on to say:

> *"……There was not any glue between the different services so everything felt very separate with separate standards, separate aims and objectives……."*

We were told that there have been improvements in the service with a reduction in the CPN caseload to 25 or below. There is now an Accident and Emergency liaison team, an assertive outreach team, and there was optimism that the inpatient unit would have a new build to improve the patient environment. Pennine Care Trust has now appointed a Borough Director for Bury and there was optimism that this would encourage further change.

Nurse 3 informed us that the Mental Health Act Commission had raised the issue of Mental Health Act training. However this had to be done on the cheap, with him attending a course and cascading information, although there had been some joint training with social workers in the past. Other staff commented on the lack of training opportunities and feeling that they were not valued.

All of the frontline staff that we interviewed described the situation at the time in similar and somewhat desperate terms. Everyone appeared to be overstretched, doing more than a normally acceptable job of work. There was an element of learned helplessness. The quality of clinical work was sacrificed, in order to get the job done, by the poorly resourced workforce.

Community worker 2 told us with some insight:

"…if there is not a strategic structure within an organisation then everything else falls down…"

We agree that the failings in clinical care were largely a result of management failures and resource issues.

Perhaps because of the shared adversity, everyone had to get on with each other to get the work done. It became obvious to the Inquiry Panel that the service in Bury had and has, extremely good working relationships, across professional groupings including social services. There was perhaps not enough time or energy for the usual professional rivalries to emerge. This is a major service strength and should not be lost as the new Trust becomes more influential. In part this appears to have occurred because of the marginal role played by the doctors in teamwork, because of the demands on their time. It should not be seen as a threat to good professional relationships for improvements in the medical workforce to put at risk this team cohesiveness, if the focus is on patient need.

There were recruitment difficulties across all staff groups, but especially nursing. Director 1 told us, that over time funding for nursing posts was used for occupational therapy and psychology staff. The resulted in under established wards, and the funding was not available to rectify this situation. The in patient wards were and are under established still, and burn out and retention issues made things worse.

We noted that the medical manpower situation was probably worse now than it was in 1999. This needs to be addressed urgently by the Medical Director of Pennine Care.

There is no nurse consultant working in the current service. We believe the nursing service would benefit greatly from a nurse consultant post which could be focussed on the inpatient unit, or if this was not possible elsewhere in the service at Bury.

The pressure on staff working in the mental health service was compounded by the significant DNA (did not attend) rate for outpatient appointments. For the mental illness service in 1999 the DNA rate ranged from 34% - 51%, and this places the 30% DNA rate for Simon Rawcliffe between 1994 and 1999 into perspective. However for 1999 he only attended one appointment out of eight appointments, though one appointment was cancelled by the hospital.

Although we did not receive any evidence about the independent advocacy service in the current service, we know that this did not exist in 1999, and that the present service in Bury is minimal.

An independent advocacy service for patients in Bury is an essential component of a well functioning service that listens to patients.

Management of the mental health service in 1999 including the arrangements in Bury Health Care Trust.

We were told by Director 2 that her recollection was that either the Nurse Director or Manager 1 were asked to make contact with the family of the deceased, to identify whether they required any counselling or support. We did not receive similar information to support this account. In fact we were saddened to hear from the eldest sister, on behalf of the family of Liaquat Ali that they had received no contact, explanation or expression of regret from Bury Health Care Trust or the mental health service. Even after the Internal Inquiry, and the court case, they received no contact.

This is poor and insensitive practice. Someone should have checked what was being done to offer some support to the family, and if no contact was welcome, then this should have been recorded. Some recognition that the deceased had a family, and that a patient being looked after by the Trust had perpetrated a homicide, would not have compromised the Trust in terms of possible litigation at some future date (if that is an explanation for this omission). The reality is that the family of Liaquat Ali were forgotten, and are still the forgotten victims.

We were told, and we agree that the major problems in the service were (and still are) the quality of inpatient services, the calibre of management within the service (medical and nursing), and the integration of services: it is this fragmentation, with all the implications for communication and continuity of care which allows individuals such as Simon Rawcliffe to fall through the safety net of care from health and social services.

There was no strategic management of mental health services in Bury, or any clear operational management group. A psychiatrist (we understand the clinical director) chaired the clinical care team, which was really a multi professional forum. The Clinical Director and service manager, Manager 1, worked together. However both were overstretched. The Clinical Director still had normal clinical duties.

In 1999, Nurse 3 was the senior nurse in charge of all the in patient wards. His remit was to oversee the inpatient wards, the day hospitals, Mental Health Act, and CPA. He knew Simon Rawcliffe, as he was a charge nurse in 1994:

> *"Everybody in Bury has two or three jobs……my line manager, Manager 1……he managed ENT and Dental and something else Priorities……what were today's priorities and, I will be frank, it changed as what the Trust Board were looking at today."*

He told us that his managerial focus had to switch from Mental Health Act Commission if they were due to visit the service, or CPA documentation, if this was to be scrutinised. Then if there was a problem on the ward the priority would be the inpatient unit. Sometimes he helped out on the ward, and covering for colleagues even at weekend.

In his view he thought that the service had *'no money'* and the Trust no real understanding of mental health, and the pressures that the service was under.

Question:

"Did you have any contact with anyone from the old Trust……."

Answer:

"The contact we had was ……why aren't the bookshelves tidy? They came down when the Trust Board came round. It was an entourage. It was to look at environmental things. It was not about patient care."

In 1999, Manager 1 was the mental health service manager. He was also responsible for a range of other services including ENT, catering and switchboard. His wide portfolio of responsibilities was similar to other middle management posts in the Trust at that time. He estimated that half of his time was devoted to mental health:

"……we were part of a corporate Trust which was struggling with resources but we were probably the poorest resourced in terms of mental health compared to other areas, mental health areas, but the Trust generally was seen to be the lowest funded in the country…… (the mental health service was)*……poor…poor capital stock, poor resources, limited or no education or training budget at all. I think our budget was £1,500 which came to £10 each member of staff a year. Poorly resourced wards, hot spots in the community……assertive outreach teams, 24 hrs operational – couldn't do that…poor IT structures. I wouldn't say a lack of support from the Board but the Board had other priorities than mental health at that time."*

Director 2 told us that the infrastructure of the Bury Health Care Trust was poor across all the specialties. She also agreed that the Trust was in a difficult financial position. She appreciated that there were fundamental problems in the mental health service.

A further example of the under funding in the mental health service was that staff often had to rely on free training courses. The workforce in 1999 was untrained in risk assessment. There was no CPA coordinator, no policies to cover risk assessment or serious incidents. We were told that there were policies for observation, and use of alcohol and drugs, leave and discharge policies.

Even though we accept that the under funding of services was significant, there should have been at least some consideration of national policies and guidance. There was no focus on the NHS Plan, what it meant for nursing and other professional groups. Other documents such as 'Making a Difference' and Acute Inpatient Guidance from the Department of Health were not considered. Even more worrying was the finding that in 1999, there was no Serious and Untoward Incident policy, though one came into existence in March 2000. This explains why the four serious incidents that occurred in 1999 were not reviewed properly by the services.

When Pennine Care Trust came into existence in April 2002, Manager 1 gave up these additional roles but is still the mental health service manager. He told us that the new Trust has a good profile in Bury and that Chief Executive 2, and the Medical Director, visit Bury, and are aware of the difficulties faced by the service.

There were some that we saw who were critical of Manager 1. Perhaps he could have done more to officially flag up any concerns that he had about the mental health service. He should for example have made certain that a Serious Incident Policy was in place, so that the service could learn from the findings of the internal reviews, which a Policy would have triggered. His leadership could have been more effective, but would the Trust have listened? Would he have been supported? We were not convinced that any of these answers would have been in the affirmative. Manager 1 in our view felt disempowered. Whatever was his effectiveness as a manager, we believe he was unfairly blamed by those more senior than him for the failings of the service, failings that they were more responsible for.

The Internal Inquiry into the circumstances that resulted in the death of Liaquat Ali, which was chaired by a non-executive director produced an action plan. Social worker 7 an external consultant, who had been involved in the Internal Inquiry, was asked to monitor and advise on the implementation of the most urgent procedural recommendations. Resources were identified for a CPA coordinator, a trainer across Bury and Rochdale for Control and Restraint and a new trust grade doctor post. The appointment of a CPA coordinator was an early success. However it became clearer that there were long-term issues that would need a broader based and sustained effort by the Trust. A Mental Health Subcommittee was formed under the chairmanship of a Board Member, as the Trust Board was not able to devote enough time to moving forward with the action plan. It was recognised that some of the recommendations could not be progressed without dealing with the structural resource deficiencies.

Director 2 commissioned a review of the Bury mental health service by Social worker 7 and Consultant 10. Social worker 7 was of the view that she was the only Executive who appreciated that the service was unsafe. Social worker 7 undertook a service stock take and Consultant 10 was recruited specifically to address medical staffing issues. This report identified a whole raft of major structural and resource issues, which required urgent attention. This report resulted in a further action plan.

The Mental Health Subcommittee managed to push mental health higher up the Trust agenda. It was not an operational management group. Progress was reviewed at Board meetings. It is of concern that Social worker 7 told us that his report was not discussed at two of the three meetings of the subcommittee that he attended, and he was under the impression that the executive team was suppressing it.

However when it was by this clear that there would be a new Mental Health Trust there was a slowing down of the change process. It was thought that many of the Internal Inquiry Report actions would only be possible once the service was in the new Trust. It seemed to us that when the consultation process for the new Trust commenced the Mental Health Sub Committee relinquished its work. Social worker 7 informed us that his fear was that the new Mental health Trust would inherit an impossible situation.

It became apparent as we interviewed senior individuals in Bury Health Care Trust, and others in Bury and Rochdale Health Authority that the distribution of the original Internal Inquiry Report and action plan was limited. In part this is understandable, as the work was undertaken during the lengthy period from the arrest of Simon Rawcliffe, through to his conviction. However even after his conviction, there was no formal distribution of the Report. In a similar way the Internal Inquiry Report was not shared at a senior level and even those who were commissioning services had difficulty in obtaining a copy. Manager 2, who later took on a management role for the mental health service during the transition to the new Mental Health Trust, was not given a copy. He subsequently saw a copy of this report, but had to contact Social worker 7 directly. This lack of openness contributed to the difficulties in monitoring the actions from both Inquiries, progress chasing, and revisiting recommendations.

We were told that when the Health Authority Commissioners directly involved in the purchasing of mental health services first saw the Internal Inquiry Action Plan in 2001 progress was limited, some 2 years after the death of Liaquat Ali.

At the time of the Internal Review, there was not only a focus on the case of Simon Rawcliffe, but on another serious incident. The Report was thorough, and in clinical terms our findings were similar to the Internal Inquiry. However there were limitations, in that the Inquiry was narrowly

focussed on the last period of his care, some of the information from other services that Simon Rawcliffe had been involved with was not available, and only the clinical issues were mentioned. The Trust was not able to look at itself in this Report.

Social worker 7 told us that the Trust did not really understand mental health and he was commissioned to help support the work of the Internal Inquiry by Director 2, an Executive Director, whom Social worker 7 viewed as one of the only members of the Trust Board who appreciated that something was wrong with the mental health service. However the Trust clearly appreciated that the Internal Inquiry Report did not address all the issues. It is creditable that the Mental Health Subcommittee was formed and the work of the Internal Inquiry undertaken, but it was wrong for this work to have been hidden from so many people. Even Chief Executive 2 as Project Director for the new Mental Health Trust was not at the time given a copy, though he was contacted by Social worker 7 and told what the recommendations were.

It was only when we saw Social worker 7 that we realised that the report that he produced with Consultant 10 was an Interim Report. They were so concerned with what they found that they produced very quickly an Interim Report, to stimulate thinking and to encourage change. They were not asked to continue their work. Social worker 7 never saw the action plan that followed his report.

This secrecy and lack of action must not happen with this Report and at the outset we obtained agreement that everyone who was interviewed would receive a copy. The action plan, which is subsequently produced from this Report, should be shared with clinical staff so that there is ownership of the plan, and systems should be in place to review the recommendations. We request that the new Trust reviews the recommendations of this Report with the Internal Inquiry Action Plan and the Action Plan from the Internal Inquiry Report (and the other Internal Review Action Plans following the serious incident reviews that were undertaken at around the same time) so that a new Action Plan can be drawn up with names, review dates and timescales. We understand that Director 1 may already have commenced some of this work.

Drawing up an action plan is in itself fairly easy. It is the translation of actions into reality that is the more difficult task. It requires commitment, time, energy and stamina to see through all the tasks, with oversight by the Board. We saw the Bury Health Care Part II Board minutes in which the progress made by the Mental Health Sub Committee with the Action Plan was *"noted"* and reports were received. There is perhaps an understandable lack of detail in these papers.

It has become clearer, through the work undertaken by Director 1 that progress has in fact been limited.

Funding for a consultant and staff grade post has not been transferred to Pennine Care Trust by the new Pennine Acute Trust. There has been no action to work towards re-accreditation by the Royal College of Psychiatrists for training posts. Little had happened to progress the information technology recommendations. Many other examples of lack of progress are available including, problems around the development of CPA. Significant changes in culture and practice underpinned by training are necessary.

Pennine Care has to find a way of making certain that any new action plan (as described above) is progressed, and that successes (and failures) to meet the targets set out in the plan are discussed openly. The Borough Director must take the lead for Bury actions, and the Chief Executive for any

Trust wide actions. There should be regular staff briefings, and there should be no reason why the action plan cannot be communicated widely, within the service. This will help to bring everyone together in understanding the direction of travel and the rate of progress. Clearly, if there are any actions that focus on an individual, then normal rules of confidentiality apply.

In April 2001, a Directorate structure was developed in the mental health service without any new resources. Manager 2 the clinical psychology manager was appointed to this post. He still kept some clinical commitments. As lead for mental health services in Bury, he was responsible for moving the service through the transition to the establishment of Pennine Care Mental Health Trust, and he began negotiations about the integration of services. He also became a member of the Mental Health Subcommittee.

He said to us:

> *"There was a need to pull together mental health a little bit and think about a management team, which we didn't have. We'd had a mental health subcommittee that had sprung out of this Inquiry……we hadn't had actually a management team. We had, I thought a rather overloaded mental health service manager, Manager 1. We didn't have a structure, so I saw the role as about trying to put some structures in place, provide some leadership, a point of responsibility, support staff in transition, keep them informed about where we were up to with Pennine Care……."*

The Internal Inquiry Report, which was critical of the Trust, was not widely circulated. Manager 1 described some difficulty in accessing this report. He never saw the action plan.

We are critical of the management arrangements for the mental health service in the Bury Health Care Trust. The management structures in other Trusts at this time were different. There does not appear to have been a real understanding of the different needs of a mental health service. Bury mental health services were left behind.

In reviewing a homicide perpetrated by a person in contact with mental health services it is usual to focus on the clinical staff involved, the clinical service, resources, policies and procedures. We have done this, but could not ignore in this Inquiry the wider picture. Liaquat Ali was it is clear the primary victim. He paid the ultimate price and lost his life. It is clear that the clinical care offered to Simon Rawcliffe can be criticised and we have commented on this above.

However the staff working in the service were the *'secondary'* victims, working in a Trust where the service management was inadequate, and overstretched. There was consequently no strategic vision. Whether this was in fact the case, the management team felt that senior Trust management were remote and uninterested, we believe that a better managed and resourced service would have offered more to support good clinical practice, and a better level of care to Simon Rawcliffe.

It took the death of Liaquat Ali to focus the previous Trust on the mental health service, through the Internal Inquiry and the Mental Health Subcommittee. However events were overtaken by the emergence of the new mental health organisation Pennine Care.

Director 1 described her understanding of the previous culture of Bury Health Care Trust in this way:

> *"……it is still something that we are grappling with today……mental health wards were not proper wards, so they did not need things like infection control, proper mattresses, proper beds, proper*

cleaning, things like that……not worth investing in, they were not a priority……any vacancy would be clawed out of mental health services and into the Acute Trust."

Director 1 briefed the panel about the plans to develop a clear and integrated management structure, with a focus on functional service units.

We support this work, which is now underway, and we were confident that Director 1 and Pennine Care Trust would succeed in this task.

Bury and Rochdale Health Authority and Bury Health Care Trust

It is again important to remind then reader that the historical under-funding of the mental health service and its connection with the dynamic relationship between the Trust and the Health Authority is not the only explanation for poor quality clinical practice. However we would have been remiss if we had not tried to explore these matters.

Social worker 7 described the relationship between the Trust and the Health Authority as poor, but other people interviewed did not universally accept this opinion. There were clearly tensions from time to time, but we were unable to clearly identify whether these tensions had a direct and adverse effect on the mental health service.

Manager 3 who in 1999 was the local implementation officer for the National Service Framework described his perception of the difficulties in the mental health service. He told us:

"……I think services were being pinched at both ends really. The allocation was low and then the extent to which that allocation got steered towards frontline services was equally low……so I think it is fair to say…acknowledged as under resourced at the time, and still are."

Director 3, the Director of Public Health for Bury and Rochdale Health Authority told us that the management attention given to mental health services was less than in other similar organisations. He indicated to us that it had a low reputation, the service was unsupported by the Trust, and that this resulted in recruitment problems. They were concerned about putting more resources into the mental health service as, it would be diverted by the Trust away from mental health, and they would not be able to recruit good quality staff if the money reached the service.

This certainly suggests some lack of trust existed between the two organisations.

In August 2001 Manager 2 and Chief Executive 2 (then Project Director for the establishment of the new Trust) made Bury Health Care Trust aware that the mental health service was unsafe, and that the service had not been safe for some time, and this was the case in 1999. A successful meeting between the Trust Board and the Health Authority agreed a funding increase for additional staff, though it was made clear that improved inpatient facilities were also necessary.

We did our best to research the independent information available to us. The North West Mental Health Development Centre in October 2000 found Bury and Rochdale (and two other services in the North West) had the lowest weighted expenditure on secondary health care in the country. The regional average cost per bed was £37,130, and for Bury and Rochdale £21,351. The figure for the number of consultants in post per 100,000 population, was on average 3.10, and for Bury 1.30. The Mental Health National Service Framework Autumn 2001 Monitoring Report is also interesting

reading. This is a national comparison, following the completion of self-assessments by the 126 national Local Implementation Teams. Compared to other services nationally, and in the North West, Bury scored poorly on clinical governance, acute inpatient services, though by this stage the improved funding was reflected in the report. In 2001/2002 the expenditure per head of the population (for adult services) on mental health was £62 for England, in North West Region £52, and at the bottom of the league Bury and Rochdale with £36. All of these figures confirm that Bury (and Rochdale) was at the bottom of the resource league, and had been for some time.

How did this sorry state of affairs develop? We have seen an exchange of letters over 2000/2001 between Chief Executive 1 and Chief Executive 3, the Chief Executive of the Health Authority, which indicates that the funding problems were recognised. However, until the 2001 meeting with Manager 2 and Chief Executive 2 the Health Authority was of the view that money given to the Trust for mental health would be spent elsewhere, on other services. There was some evidence of this from the information that we were given. The Local Implementation Planning (LIP) process began in 2000. The total spending on mental health services by the Trust was £2,719,000 and the Trust received £4,000,000. Not all of this difference can be attributed to corporate overhead costs. To place these figures in context, this was for the year after the death of Liaquat Ali. If the situation was similar pre-2000, then this would explain why, over time, an unsafe service developed.

We received different accounts and explanations depending on which side of the 'divide' we spoke to. Perhaps the truth was that there was not enough money going into the mental health service in Bury from the Health Authority, but the priority given to these services by the Trust resulted in funds going to other acute services.

We were unable to explore these issues further because Chief Executive 1, the Chief Executive (now retired) of Bury Health Care Trust, was unwilling to meet with us.

Even now there are financial disagreements around the funding that has moved from the new Pennine Care Acute Trust to the Pennine Care (Mental Health) Trust, which may well go to arbitration. There were improvements in funding from Bury and Rochdale Health Authority in 2001/2002, of around £330,000, but there still needs to be recognition of the historical under funding of the mental health service in Bury.

There has been improved financial support from Bury and Rochdale PCT, but there are also complications for this PCT as it has contracts with the Manchester Care Partnership and with Bolton, Salford and Trafford Mental Health Services, because of the geography of Bury. Nevertheless the situation is not helped by the fact that £200,000 in the mental health budget has not been transferred from the new Acute Trust to Pennine Care, and that during our work Pennine Care Trust asked the PCT to agree a recovery plan for around £111,000. We were concerned that one of the wards had been recently closed in Bury, to help to deliver a balanced budget.

The problems around the funding of mental health services in Bury remains, a grave concern to us. An agreed solution must be found urgently. Bury should be viewed as a special case. The mental health service has been languishing near the bottom of the league in terms of funding and other resources, for too long. It will take some time to catch up. We are aware that funding has now been identified for a new inpatient facility.

We were so concerned that we wrote a letter to the Strategic Health Authority and Bury PCT to (we hoped) influence the annual review of funding, so that service gaps can begin to be rectified.

We interviewed Chief Executive 2 of Pennine Care Trust. We were told that Bury may not be the only service that requires support to develop, and that there may well be problems in Rochdale, Tameside, Oldham, and in Stockport. However we believe that Bury has special needs and is a special case.

Whilst we do not want to undermine the effectiveness of Director 1, the new Trust based in Tameside must find a way (at least for a period until the situation improves), to increase visibility in Bury. It is not for this Panel to dictate how this should be done, but this should be considered as a matter of urgency. The Medical Director must also have an increased presence in Bury, until the staffing situation has improved.

This is important, as there may still be discomfort about Bury within the new Trust, because of its reputation. We were told by Director 3 that there were concerns that other services would be 'pulled down' by Bury. He gave to us a quote from a senior manager in one of the other services before the new Trust was formed:

"It's a bit like the merger of East and West Germany, and we don't want that to happen to our service"

This sort of thinking must be changed if the situation and reputation of the Bury mental health service is to be improved.

We are both disappointed and concerned that Chief Executive 1 chose not to meet the Panel. Although we accept that he is no longer in the employ of the Trust, and under no obligation to afford us the opportunity of hearing his comments on the mental health services that existed under his stewardship, nevertheless his absence from the proceedings was one that we cannot ignore.

Our Inquiry was set up to review a homicide. This is a very serious matter. We believe that his refusal was at the very least disrespectful to the family of the deceased. In our view, his failure to respond to our invitation that he meet with us, reflects a lack of public spiritness that is in marked contrast to his former staff and colleagues who were open and willing to share their professional practice with us, even if that might prove painful or difficult at times.

We believe that we are not unreasonable in expecting a high standard from those public servants who are charged with the heavy responsibility of managing a local health service. Termination of those responsibilities, whether as a result of retirement or otherwise, does not, in our view, extinguish or moderate the duty of fidelity that Chief Executive 1 owes to his former Trust and the residents it served. At the very least, as a matter of good faith, we placed weight on the expectation of Chief Executive 1's cooperation in a formal inquiry established to understand the lessons arising from the care and treatment of Simon Rawcliffe, a patient of Bury mental health services.

Chief Executive 1's failure, either to attend or indeed furnish us with a reason for his lack of participation (in the exchange of correspondence between us) exposes a lacuna in the powers of these kinds of inquiry. It is one that we would like the Department of Health to address, and also the Commission of Health Improvement, whom we understand will have the responsibility in the future to set up External Independent Inquiries.

We would not be in favour of compelling witnesses to attend, as this might alter the balance in such inquiries from learning lessons to a more legal and judgemental process, which could be viewed as persecutory. In such circumstances those interviewed could be defensive to avoid blame.

On the whole, we were struck in our inquiry by how open and helpful everyone was when interviewed.

However, an alternative would be to make it a contractual term that senior managers working in the health service cannot surrender their accountability for services managed in their name, simply because they are no longer in the employ, or are retired from the National Health Service. There would be similar arguments for clinical staff.

Recommendations

We acknowledge that there have been developments both before and during the work of this inquiry. We enclose, as an appendix, a progress report prepared for us by the Borough Director for Bury.

We have tried to list our recommendations under headings which relate to the body of the text. Each service heading has recommendations relevant to that service, but which may also have wider implications. It was tempting to produce a grid with recommendations on one side and all of the relevant services/professions on the other, but we thought that was unhelpful.

1. *Pennine Care NHS Trust*

i. In the development of the Action Plan that will follow the report, the Trust should draw together the recommendations of the other three incidents that occurred in 1999, to make absolutely certain that all lessons are learned.

ii. A progress system should be put into place to monitor the completion of action points and any remaining obstacles to progress.

iii. This process should be transparent to prevent a repeat of the lack of progress we noted following the internal inquiry and the Internal Inquiry report. However, it is important that this report should be widely shared in its entirety.

iv. We recommend that the Trust review the implementation of CPA, particularly in Bury, through a quality audit.

v. The Trust should be satisfied that the Borough Director in Bury has the necessary management support to enable her to progress the modernisation of Bury Mental Health services.

vi. We appreciate that the Trust has responsibility for Bury, Rochdale, Oldham, Tameside & Glossop and Stockport. The Trust clearly has a demanding and wide agenda, and all of these services will have their strengths and weaknesses. Nevertheless, from our perspective, the situation in Bury is in some respects unique. We, therefore, recommend that the Chief Executive considers how he could provide the leadership and presence required to move the services forward. We are not convinced that a base in Tameside will allow this to happen.

vii. We understand that there is an independent Mental Health Advocacy service in Tameside, where the Trust's Headquarters is based, but we are aware that independent advocacy input into Bury and Rochdale, for example, has been substantially reduced. We recommend that Bury (this is the focus for our enquiry) should receive a better advocacy service, so that patients and their carers can be empowered to make comments about the services that they receive. Also, this would allow their rights to be considered as part of the decision making process.

viii. In the handling of any serious incidents, when a person in contact with Mental Health services harms another, the Trust should consider their response to the victim and the victim's family. We cannot suggest what that response should be, as much will depend on the nature of any injuries caused, and if the Criminal Justice System is involved, where, in the process,

the individual with mental health problems is. The Trust should make certain that these considerations are part of any serious incident review.

ix. Patients in Bury must have access to an Intensive Care Unit facility.

2. *Bury Mental Health Service*

i. Medical

a. We recommend that the Medical Director of Pennine Care NHS Trust review with Consultant 3 the relevant sections in the report in order to support Consultant 3, and to agree an Individual Personal Development and Continuing Professional Development Plan. We make similar suggestions for Consultant 1.

b. The Medical Director will need to focus carefully on the appraisal of all the medical staff in Bury. In our view this means that the Medical Director will need to do all of the annual appraisals, for all of the medical staff, until he is satisfied that the Associate Medical Director in Bury is able to take on this task.

c. The Medical Director should monitor the use of annual leave and study leave for the Doctors in Bury to make sure that they are not working through their annual leave entitlement, and are making good use of their study leave entitlement.

d. Trust grade doctors and every non-training grade doctors should receive one hour protected and timetabled supervision each week. This should be over and above any other clinical advice.

e. Whilst we understand the pressures on the time of the Medical Director, we believe that until it is possible to appoint new Consultants to Bury, there will need to be time set aside to become more involved in the services in Bury. We cannot find evidence that the situation with regard to medical staff has changed dramatically. We leave it to the Medical Director and in discussion with the Chief Executive to decide how this recommendation can be translated into action.

f. The Medical Director should take the lead in ensuring that the necessary changes take place in Bury for an application to be made through the Local Training Scheme to the Royal College of Psychiatrists for approval to train psychiatrists.

ii. Nursing

a. A nursing clinical supervision system should be in place to support modern-day nursing practice. A reflective nursing model might be considered.

b. Nursing staff should receive regular training in managing difficult and aggressive behaviour, and therapeutic engagement with problem patients. Whilst control and restraint is a last resort there should be regular training in this also.

c. There should be a clear policy for close observation of patients, which reflects standards proposed by the Royal College of Nursing.

d. Consideration should be given to the appointment of a Nurse Consultant with a particular focus on inpatient services in Bury.

iii. Social Work including Social Workers seconded to Lancashire Care Trust

a. The recording of information should follow agreed guidelines. For example, those provided by the British Association of Social Workers on confidential and ethical recording.

b. Patients who move out of one area to another should remain the active responsibility of the original authority until a formal handover can be arranged. A formal handover implies real team to team discussion, nor merely a paper passing exercise, and which should be timely and include:

- Team to team discussions
- The provision of background information
- A contingency plan with, for example, a system of rapid transfer back to the original system if the patient moves.

c. The provision of an approved local authority list of bed and breakfast accommodation to vulnerable adults with mental health problems implies that the addresses on the list are suitable for this group of people.

We appreciate the difficulties of managing individual cases when there is a degree of non-cooperation. However, even when there is a lack of appropriate accommodation this practice (of providing the approved list) should be reviewed as a matter of some urgency.

iv. General Issues for the Mental Health Services

a. Training in dual diagnosis and in personality disorder is urgently required for all clinical staff. We recommend multidisciplinary training is set up on a regular basis to prevent mental health issues being obscured by either illicit drug use or personality difficulties.

b. We recommend that the Trust consider facilitating team-working development in Bury, with medical staff, in order to encourage efficient multidisciplinary processes and decision-making. The medical staff in particular, need to be included in these proposed team-working developments.

c. We recommend the review of the skill mix and training needs for all staff not just nursing staff.

d. We do not support the continuation of separate nursing notes and would strongly suggest that multi-disciplinary integrated notes is the model that Bury services (proposed all services) should move towards.

e. The Trust should develop standards for record keeping consistent with national agreed standards for mental health.

f. Similarly, the Trust should develop a procedure for the retrieval of appropriate clinical and other information in circumstances where the original records have been lost, stolen or damaged.

g. All staff, particular including medical staff, should receive regular training in CPA. Which should emphasise the real benefits of the care planning process to individual patients, and stress that it is not just a form filling exercise.

h. All staff should receive training in clinical risk assessment and management. For example, a clinical base tool such as HCR20 is of use. This is not to suggest that all patients require such a risk tool, but the structure and questions asked in the HCR20 are to help in assessing risk in all patients.

i. The use of CPA in Bury should be regularly audited.

v. 1983 Mental Health Act

a. All staff should have regular training on the use of the Act and Code of Practice, including any changes in case law, which may affect their professional practice. Wherever possible, training should be multi-disciplinary and multi-agency.

b. All leave for detained patients must be authorised in accordance with Section 17 of the Act and Chapter 20 of the 1983 Mental Health Act Code of Practice. All leave should be documented on the Trust's Section 17 Leave Form, which should contain all the information requested on each occasion when leave is authorised.

c. Audit systems should be put in place to monitor compliance.

d. Senior Managers and staff working on the wards should be made aware of the provisions of Chapter 19 of the Code, which relates to the management of patients presenting particular problems, as a result of their disturbed behaviour. This chapter gives guidance on the response of the clinical team to a serious incident.

e. The patient's nearest relative should be actively involved in aftercare planning, if the patient consents, and their views must be documented and properly taken into consideration by the care team.

f. Aftercare planning, including the granting of leave and discharge arrangements, should comply with paragraph 27.6 of the Code of Practice.

g. The patient's Responsible Medical Officer should discharge their responsibilities as set out in paragraph 27.6 of the Code, in particular the assessment of any risk to the patient or third parties and the consideration of the criteria for supervised discharge or guardianship.

h. The Trust and the local social services authority must strengthen their Section 117 procedures. Individuals who are entitled to aftercare should not be discharged from hospital before appropriate aftercare facilities have been identified. Once discharged, the patient's progress must be actively monitored. Regular Section 117 meetings should be held, with a contribution to those meetings from the patient's Responsible Medical Officer.

i. The Trust's Supervised Discharge Policy needs to be re-written to better reflect the Department of Health's Guidance. Staff should receive training on the use of supervised discharge and guardianship.

j. Although a patient, subject to Section 117 cannot be compelled to accept those services, a failure to engage with services should not be seen as an early opportunity to rescind Section 117. Rather, such failure should trigger an action plan, which seeks to address the patient's non-compliance with aftercare and, if necessary, allows for a reassessment of the patient's mental state in order to ascertain whether admission to hospital is indicated.

k. The Trust and social services authority should give active consideration to the provision of an independent mental health advocacy scheme to assist patients and their carers make comments about the service they receive, and to articulate their own needs and preferences.

3. *Bury Primary Care and Pennine Care NHS Trust*

i. Urgent agreement on the allocation of resources from Bury Acute Trust to Pennine Care Trust needs to be reached. It is clear that not all of the funds were fairly distributed between the two Trusts.

ii. A review of funding for the Mental Health Service in Bury is, in our view, necessary so that there can be proper consideration of the years of under-funding that the service has had to endure. We accept that the service in Bury will not be able to catch up in one leap, and that progress is being made, but from our understanding of the financial situation, the chronic under-funding problems have still not been resolved. We recommend that an agreement be reached between the Pennine Care Trust, the Primary Care Trust, and the Strategic Health Authority.

4. *Forensic Mental Health Services*

i. We recommend that the three North West Medium Secure Units and the Secure Commissioning Team consider how to manage, from a service perspective, a North West patient admitted to a North West Medium Secure Unit who is out of their catchment area.

In our view, the Forensic Service needs to consider:

- Involving the local catchment area MSU in the discharge discussions and arrangements
- Using the local catchment area MSU for its knowledge of services and community facilities
- Copying discharge details to the local catchment area MSU
- Whether the local catchment area MSU should have any active involvement with the patient, for example, by sending the member of staff to attend clinical team meetings.

ii. We suggest that the lead clinicians in each of the three MSUs should come to some agreement about how to manage such cases and this agreement should be supported by the Secure Commissioning Team.

5. ***Department of Health, Strategic Health Authority, and the Commissioning for Health Audit & Inspection***

i. We appreciate that there will be changes in how enquiries, following the homicide committed by an individual in contact with Mental Health Services, will be set up and arranged in the near future. However, any review of clinical decision-making, and the organisation, will be hampered if the senior staff use retirement as a means of absenting themselves from the process. In our view this is particularly serious if a Chief Executive takes this stance. We therefore recommend that the Department of Health should consider issuing advice to all Mental Health Trusts on how individuals in contact with one Mental Health and Social Care services are handed over to new services. Good practice in this area should be highlighted.

ii. We suggest that consideration be given to more general advice in relation to l (viii) in the above recommendations.

List of Interviewees

* = the individual's position at the time
+ = their current position

*+ Ms. Pauline Ambrey,
Mental Health Service Manager,
Bury Social Services.

+ Mr. John Archer,
Chief Executive,
Pennine Care Trust.

*+ Mr Paul Bardsley,
Mental Health Service Manager,
Bury Social Services.

*+ Mr. Mick Booth,
Mentally Disordered Offenders Social Worker,
Bury Social Services.

*+ Mr. Keith Campbell,
Ward Manger – Ward 21B,
Pennine Care NHS Trust

*+ Ms. Helen Carson,
Community Mental Health Team,
Bury Social Services

* Ms. Lynne Clark,
Owner,
8-10 Wash Lane,
Bury.

+ Dr. James Collins,
Consultant Forensic Psychiatrist,
Ashworth Hospital,
Mersey Care NHS Trust

* Dr. Dave Finnegan,
Consultant Forensic Psychiatrist,
Edenfield Centre,
Mental Health Services of Salford

*+ Mr. Tony Gibbons,
Manager, Mental Health Services,
Pennine Care NHS Trust

* Sgt. Andy Greenhalgh,
Bury Police Station

* Mrs. Joanne Greenwood
Deputy Manager,
Bury Community Mental Health Team,
Bury Social Services

\+ Mr. Roger Hargreaves,
Independent Social Work Consultant.

\+ Dr. Vic Harris,
Medical Director,
Pennine Care NHS Trust

\+ Mrs. Deborah Hather,
Programme Director, Commissioning & Priority Services,
Bury Primary Care Trust.

*+ Mr. David Heywood,
Social Worker,
Scott Clinic,
St. Helen's & Knowsley Hospitals NHS Trust.

\+ Ms. Lynne Heywood,
Social Worker,
Ashworth Hospital.

*+ Dr. Josanne Holloway,
Consultant Forensic Psychiatrist,
Edenfield Centre,
Mental Health Services of Salford.

\+ Mrs. Pat Horan,
Assistant Director, Adult Services
Bury Social Services.

*+ Mrs. Ann Kavanagh,
Co-worker,
Assertive Outreach Team,
Bury Social Services.

*+ Mr. Andy Kerr,
Senior Nurse In-Patients, Ward 21B,
Pennine Care NHS Trust

* Mrs. Sarah McCarthy,
Community Care and Homelessness Manager,
Bury Social Services.

* Mrs. Pam McKee,
Director of Planning (Bury)
Pennine Care NHS Trust.

*+ Mr. Shane Mills,
Ward Manager,Ward 21B,
Pennine Care NHS Trust

*+ Mr. Steve Munbodhowa,
Organisational Manager, Community Psychiatric Nurses,
Pennine Care NHS Trust

* Mr. Mario O'Dwyer,
Community Psychiatrist Nurse,
Mile Lane Health Centre,
Bury.

\+ Ms. Alison Pearsall,
Mental Health Liaison Service,
Bury Trust & Bury Social Services.

\+ Dr. Rob Poole,
Consultant Psychiatrist,
Mersey Care NHS Trust

*+ Dr. M.K. Prasad,
Consultant Psychiatrist,
Pennine Care NHS Trust.

Mr. Simon Rawcliffe.

*+ Mrs. Denise Richardson,
Community Psychiatric Nurse,
Ramsbottom Health Centre.

Mrs. Yasmine Simpson,
Relative of Deceased.

*+ Mr. Mark Singleton,
Clinical Director, Psychology,
Pennine Care NHS Trust.

* Dr. Kevin Snee,
Director of Public Health,
Bury Primary Care Trust.

* Mrs. Vera Stringer,
Non-Executive Member,
Bury NHS Trust.

+ Dr. K Thomas,
Consultant Psychiatrist,
Pennine Care NHS Trust.

+ Dr. M.C. Waziri,
Consultant Psychiatrist,
Pennine Care NHS Trust.

Mother of Simon Rawcliffe.

+ Mr. Barry Windle,
Local Implementation Officer,
Bury Primary Care Trust.

*+ Dr. Carl Wilson,
Consultant Forensic Psychiatrist,
Edenfield Centre,
Mental Health Services of Salford.

+ Mrs. Bev Worthington,
Borough Director,
Pennine Care NHS Trust.

List of Documents

1. EXTERNAL REVIEW PANEL DETAILS

2. TERMS OF REFERENCE

3. MENTAL HEALTH NATIONAL SERVICE FRAMEWORK

4. CRIMINAL JUSTICE SYSTEM

- 4.1(a) Greater Manchester Probation (Bury office)
- 4.1(b) Greater Manchester Probation (Bury Office)
- 4.2 Bolton Probation
- 4.3 Crown Prosecution Service
- 4.4 HMP Manchester Prison Records
- 4.5 Summary of Police Records (Bury Station)
- 4.6 Previous Convictions of Simon Rawcliffe
- 4.7 HMP Liverpool Prison Records

5. SUPPORTING INFORMATION

- 5.1 Report to Bury Health Care Trust from members of Internal Inquiry Panel on recommendations
- 5.2 Bury Health Care Trust's Action Plan on recommendations
- 5.3 Recommendations from joint Internal Reviews
- 5.4 Hospital appointment records from 1994-1999
- 5.5 Financial Resources, Pennine Care Trust
- 5.6 Bury Health Care Trust Mental Health Section Papers
- 5.7 Bury Health Care Trust Supervision Register in 1999
- 5.8 Medical Workforce Mental Health, Bury Health Care Trust
- 5.9 DNA Information for outpatient appointments - 1999
- 5.10 Discussion Paper – Joint Management of Mental Health Services in Bury
- 5.11 Investment Priorities in Bury Mental Health Services
- 5.12 Report of the Internal Inquiry
- 5.13 Extracts from Bury Health Care Trust Minutes
- 5.14 Bury Primary Care Trust – Mental Health Funding to Bury Health Care Trust – 2000/2003
- 5.15 Confidential Health Authority Report into Quality of Services in Bury & Rochdale (by Dr. Kevin Snee)

6. HOSPITAL NOTES

- 6.1 Bury
- 6.2 Bolton
- 6.3 Winwick Hospital, Warrington
- 6.4 Scott Clinic, St. Helens
- 6.5 Edenfield Centre, Salford

7. NURSING NOTES

7.1 Inpatients & Community Psychiatric Nursing notes (Bury)
7.2 Bolton
7.3 Winnick Hospital, Warrington
7.4 Scott Clinic, St. Helens

8. POLICIES & PROCEDURES

8.1 Social Services
- 8.1.1 1999 Care Programme Approach
- 8.1.2 Current Mental Health Service
- 8.1.3 Other Social Services (non-Mental Health) Policies
- 8.1.4 Miscellaneous Personnel Policies/Working Documents
- 8.1.5 Status of the Community Mental Health Teams in 1999
- 8.1.6 Accommodation provision in Mental Health
- 8.1.7 Policy & Procedures for Serious & Untoward incidents for Bury and Rochdale Health Authority (Sept. 2000 and June 2002)
- 8.1.8 Mental health locality session
- 8.1.9 Care Programme Approach Protocol Group documents
- 8.1.10 Mental Health Services Referring Pathways

8.2 Health
- 8.2.1 Care Programme Approach Policy (1995)
- 8.2.2 Care Programme Approach/Risk Assessment & Management (2001)
- 8.2.3 Care Programme Approach Policy (Prior to 1995)
- 8.2.4 Mentally Disordered Offenders
- 8.2.5 Training Policies/Strategies
- 8.2.6 Safety Policy for Community Psychiatric Nurses working in Primary Care (2001)
- 8.2.7 Observation Policy from 1999
- 8.2.8 Section 117 Policy (Reviewed 2000)
- 8.2.9 Checklist for Aftercare Care Programme Approach /Discharge Policy
- 8.2.10 Absconding Policy
- 8.2.11 Teaching Programme Jan-Aug. 2000

9. SOCIAL CARE NOTES

9.1 Bury
9.2 Bolton
9.3 Lancashire

10. PROFESSIONAL ORGANISATION REPORTS

10.1 Mental Health Act Commission Reports and the Trust's response
10.2 Royal College of Psychiatrists Training Report
10.3 Additional Mental Health Act Commission correspondence, extracted from Bury and Rochdale files
10.4 Mental Health Review Tribunal correspondence with the Scott Clinic
10.5 Mental Health Act Commission report of the visit made to Pennine Care on 6.9.2002

11. FAMILY INFORMATION

11.1 British Medical Journal written by Yasmine Simpson

12. ADDITIONAL INFORMATION

12.1 Correspondence from Hempsons Solicitors re advice on "patient consent"
12.2 Overview of Social Services Involvement - Bury & Rochdale 1993-1999
12.3 Analysis of Joint Implementation Plans & Resource Profile (North West Mental Health Development Centre)
12.4 Bury Social Services Housing Information
12.5 Bury Metropolitan Borough Council Housing Information
12.6 Documents pertaining to three other serious incident enquiries
12.7 Newspaper article dated 31/1/03 concerning ward closure at Fairfield General Hospital
12.8 Bury mental health service leave policy in 1999, number of patients on supervision register and number of patients subject to Section 25 for the same year
12.9 Summary of Ashworth Hospital social work report
12.10 Overview of Health Involvement Bury and Bolton 1995-1999
12.11 Public Health Information Report (Chapter 9)

13. GENERAL PRACTITIONER

13.1 Patient's General Practitioner's notes

Appendix

Progress Report

Re: External Inquiry into the Care and treatment of Mr. S.R. by Mental Health Services of Bury.

Introduction

Having concluded their inquiries into the care and treatment of Mr. S.R. by Mental Health Services in Bury, in line with the original terms of reference, the Panel noted that improvements in service delivery had been made since the original incident in 1999.

This paper details the progress made by staff working in the service since the time of the incident and latterly under the management and direction of Pennine Care NHS Trust.

The paper draws on the draft recommendations produced by the Inquiry Panel in June 2003 as an appropriate framework for reporting such progress.

Recommendations

Systems for monitoring action points arising from Serious and Untoward Incident Reviews (Rec. l:i, ii, iii, viii)

Pennine Care NHS Trust has implemented a rigorous policy for all Serious and Untoward Incident Reviews, based on the Root Cause Analysis methodology. The implementation of the policy is supported by robust I.T. systems with reports to the Trust Board via the Borough's Governance Group and the Trust's Governance Sub-Committee. The policy also makes provision for contact with victims and victims relatives as appropriate.

The Borough's Governance Manager is developing a reporting process for monitoring progress locally and the Borough is in the process of appointing an audit-co-ordinator, funded through Tier II monies, to further strengthen the monitoring process.

Implementation of CPA (Rec: I iv,)

The Trust has produced a comprehensive CPA policy, which details minimum standards of service provision for both standard and enhanced levels of care. A Trust wide group chaired by the Director of Service Development is leading the implementation.

The Trust in partnership with Bury MBC have agreed a project plan, funded through Supplementary Credit Approval to develop a mental health module within the RAISE Information System operated across Local Authority Services. The projected timescale for implementation is October 2003.

The RAISE System (Referral; Assessment; Information, System and Environment) is an integrated computerised system that tracks service provision (activity and outcomes) for an individual from referral through to discharge or closure. This will significantly improve both the quality and accuracy of CPA data, will increase access to timely information for clinicians and will improve service monitoring.

Record Keeping (Rec iv,e)

The Trust has established a Clinical Records Management Group and is in the process of agreeing a protocol for record management in keeping with National standards.

Risk Assessment and Management (Rec iv,h)

Staff in Bury have had access to risk assessment training since this review. Since Pennine Care was established, a Risk Management Policy has been agreed and training to support its implementation.

The Borough is in the process of appointing a training co-ordinator jointly funded by Pennine Care and Bury Social Services who will take forward training initiatives within the Borough.

Mental Health Act (Rec v)

The Trust has appointed a Mental Health Act Manager who is in the process of reviewing and standardising all Mental Health Act policies to ensure compliance with the Code of Practice.

Management Arrangements

Following the appointment of the Borough Director, the Trust and Local Authority have agreed to formally integrate the management of mental health services in Bury. The management structure has been approved and the process of implementation is being overseen by a Strategic Steering Group comprising of Senior members of the key partner agencies, Bury PCT, Bury MBC and Pennine Care NHS Trust. This group is responsible for ensuring that mental health has a high profile on the agendas of all local agencies.

Summary

Whilst significant progress has been made since 1999 the Trust is not complacent and acknowledges that there are many issues still to be addressed. It is recognised that both the pace and extent of progress has been inhibited by limited funding and that the progress to date is a measure of staff's commitment to deliver a high quality service. The Trust is equally as committed in supporting staff in this ambition. Whilst further progress in some areas will be entirely dependent on additional funding being made available, the Trust accepts its responsibility in ensuring that the performance and practice of staff working in the service is of a high quality and in keeping with the standards of the relevant professional regulatory bodies.

It is also our view that the action to date and the development of the integrated management structure presents a solid foundation from which Mental Health Services in Bury will go from strength to strength.

Bury Borough Director, Pennine Care NHS Trust
June 2003