NHS
North East

REPORT TO THE NORTH EAST STRATEGIC HEALTH AUTHORITY OF THE INDEPENDENT INQUIRY INTO THE HEALTH CARE AND TREATMENT OF ANTHONY STEWART

November 2008

Contents

1 Nature of the inquiry

An inquiry into the heath care and treatment of Anthony Stewart with recommendations as to future practice.

The inquiry panel was appointed by the North East Strategic Health Authority in January 2007 to enquire into the health care and treatment of Anthony Stewart. The members of the inquiry panel were:

Mr Brian C Forster	QC, Barrister A Crown Court Recorder and a President of the Mental Health Review Tribunal
Dr P Quinn	Consultant Forensic Psychiatrist, South West Yorkshire Mental Health NHS Trust, Regional Secure Unit, Newton Lodge, Wakefield
Mr H Cronin	Director of Nursing, Psychology and Allied Health Professionals, Tees Esk & Wear Valley NHS Trust

The inquiry was established under the terms of the Health Service Guidance HSG(94)27 (as amended June 2005), following the conviction on 22 March 2005 at Newcastle upon Tyne Crown Court of Anthony Stewart for the manslaughter of Lee Carl Johnson and his subsequent sentence to detention in hospital without limit of time.

The inquiry panel met between January 2007 and November 2007.

The panel heard evidence from the individuals involved in the immediate treatment of Anthony Stewart and read substantial documents from the relevant agencies that had involvement with Anthony Stewart.

All of the witnesses who gave evidence have had the opportunity to amend and approve the transcripts of their evidence.

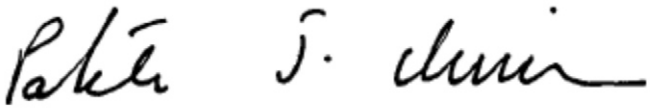
The object of the inquiry has been to investigate the events which gave rise to the death of Lee Johnson and to identify areas in which health care, treatment and practice could be improved. For this reason, and in order to encourage uninhibited contributions to the inquiry, the professionals who came into contact with Anthony Stewart are not identified by name. Furthermore insofar as is practicable, other individuals are not identified by name.

This report has been prepared on the basis that all witnesses have provided full and frank disclosure to the inquiry panel.

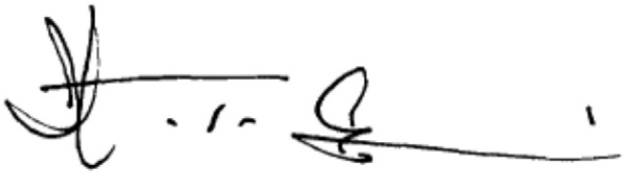
The inquiry panel would wish to express its gratitude to the Panel Co-ordinator, Mr Richard Smith, for his assistance in the administration of the inquiry.

Mr B C Forster QC (Chairman)

Dr P Quinn



Mr H Cronin



2 Circumstances giving rise to the inquiry

On the 28 August 2003 Anthony Stewart killed Lee Johnson.

At the time of the killing Anthony Stewart, who was born on 2 April 1965, was 38 years of age and the victim was 29 years of age. He was a neighbour of Anthony Stewart and lived in the flat above him.

Late in the evening other residents of the flats reported a disturbance. The emergency services attended. The victim was found to have been stabbed some seven times. Despite attempts to resuscitate him he was later pronounced dead.

Anthony Stewart was initially charged with the offence of murder.

Following the receipt of medical evidence, a plea to manslaughter on the ground of diminished responsibility was accepted. The judge stated that at the time of the killing Anthony Stewart was suffering from a delusional belief system.

Unfortunately, many members of our community suffer from severe and enduring mental illness which can have a devastating impact upon the lives of those affected. At the time of the killing Anthony Stewart was suffering from a mental illness namely, paranoid schizophrenia.

Anthony Stewart first came into contact with mental health services in Newcastle in May 1995. He was admitted to hospital on a number of occasions because of concern as to his mental health.

In January 1999 Anthony Stewart was made subject to a probation order with a condition of medical treatment from a consultant psychiatrist.

At the time of the killing Anthony Stewart was under the care of a consultant forensic psychiatrist. Anthony Stewart was an informal (voluntary) patient. He was not receiving treatment under any form of Order. Anthony Stewart had been discharged from the case work of the community psychiatric nurse (CPN) and approved social worker (ASW).

3 Terms of reference

To examine the circumstances of the surrounding health care and treatment of Anthony Stewart, in particular:

- the quality and scope of his health care and treatment, in particular the assessment and management of risk;
- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary care programme approach and the assessment of risk in terms of harm to himself and others;
- the standard of record keeping and communication between all interested parties;
- the quality of the interface between the forensic and general mental health services and other agencies;
- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health.

To prepare a report of the findings of that examination for, and make recommendations to, the North East Strategic Health Authority.

4 National Policy Framework

The national care policy for the management of patients suffering from mental illness is the care programme approach which was revised in 2000 when a further policy was issued being the Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach (2000).

Care programme approach

The Care Programme Approach (CPA) was introduced in 1991 HC(90)23/LASSL(90)11 to provide a framework for effective mental health care. Its four main elements are:

1 systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;

2 the formation of a care plan which identifies the health and social care required from a variety of providers;

3 the appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; and

4 regularly review and, where necessary, agree changes to the care plan.

Effective care co-ordination in mental health services – modernising the care programme approach (2000)

In 2000 the CPA national policy was reviewed with a view to integrating the process with care management to form a single care co-ordinator approach for adults of working age with mental health problems. The review of the policy resulted in a number of recommendations including the following:

- For two levels of CPA to be introduced; standard and enhanced.
- That the supervision register should be abolished.
- That the key worker would be known as the care co-ordinator.
- That risk assessment and risk management were essential and ongoing elements of the CPA process that would include contingency plans in regard to risk assessment and management.

The policy booklet stated that the requirement to maintain supervision registers would be abolished from 1 April 2001. However, before the Trust abolished its supervision register the offices of the then Regional Health Authorities must be satisfied that robust CPA arrangements are in place.

The implementation of the national policies is the responsibility of the individual mental health trusts who should draw up their own local policy framework.

5 Contact between patient and psychiatric services

Anthony Stewart first came to the attention of general adult services against the backdrop of serious mental illness (paranoid schizophrenia). He required admission to psychiatric hospital on 6 May 1995 under Section 2 Mental Health Act 1983 at a time when it was alleged he perpetrated an assault on a female neighbour. He was not subsequently charged. At that time he described a complex delusional system with a conspiratorial theme. He believed he was subject to a conspiracy orchestrated by the People's Theatre, Tyne Tees Television, Newcastle City Council and an ex-director of Social Services. When discharged he did not agree to attend the general adult psychiatric outpatient clinic as part of his follow-up.

Anthony Stewart's first contact with forensic services occurred following a referral to local forensic services from general adult services for a second opinion. On 19 July 1995 he was seen by the consultant forensic psychiatrist (CFP), in the absence of a colleague, in an outpatient clinic. He was not co-operative during the course of that clinical interview. It was concluded by CFP that his presentation was compatible with a continuing paranoid psychosis into which he had no insight.

He was detained under Section 3 Mental Health Act 1983 and admitted to hospital on 17 August 1995. He presented at his general practitioner's surgery and again described delusional beliefs with a conspiratorial theme. He was discharged from hospital on 25 October 1995 and diagnosed as suffering from paranoid psychosis. In late 1996 he was non-compliant with treatment and began to disengage from members of the clinical team.

His next contact with forensic psychiatric services arose following an allegation of assault. He was remanded into custody at Holme House, Stockton on Tees. On 11 November 1998 he was admitted onto Alnwick Ward into the care of CFP under Section 36 Mental Health Act 1983. On admission he was noted to have no insight. It was known to the clinical team that he had previously disengaged from treatment and after-care arrangements while in general adult services. It was also noted he had a forensic history which included offences of shoplifting and burglary. The index offence was that of an assault on an elderly male. The complainant was known to Anthony Stewart. Anthony Stewart perceived this man to be racially abusive towards him. He described being the subject of a conspiracy involving his neighbours, the People's Theatre and Tyne Tees Television.

During the course of that admission he is described as suspicious and believed the staff to be racist. He was in receipt of antipsychotic medication (Stelazine). He was subsequently bailed to reside on Alnwick Ward. He pleaded guilty to an offence of assault occasioning actual bodily harm. Discussions took place with his probation officer and it was agreed that a probation order with a condition of psychiatric treatment/supervision would be proposed to court. The CFP considered the risk of further offending in the future would be linked to his compliance with treatment. The clinical team were aware that he had previously discontinued drug treatment when in a community setting and would be encouraged not to disengage on this occasion.

It was also clear there were no statutory means of administering his drug treatment unless his mental state deteriorated to the point where it was again appropriate for him to be detained under the Mental Health Act. It was agreed that deterioration in his mental state would be a potential significant risk factor in terms of future violence.

On 22 January 1999 he was sentenced to a two-year probation order with the condition that he attended for medical treatment. It was agreed he would have contact with his probation officer, a CPN, ASW and a CFP. It was also agreed within the clinical team that he would transfer to general adult psychiatric services after three months. He failed to attend for a CPA review in June 1999 and again in August 1999. He gave his apologies for his failure to attend a CPA in February 2000. He did not attend for a re-scheduled CPA in March 2000. He continued to be seen at home by his CPN and gave his apologies for his failure to attend a CPA in June 2000. In 2000 he began to complain of impotence and requested to be treated with Viagra.

On 24 June 2001 he was discharged from the CPN's caseload. He did not attend a CPA review held in June 2001. In correspondence from the CPN to Anthony Stewart it was agreed a final visit would be made to his home address on 18 July 2001 in recognition of the progress he had made in the community.

Having secured employment with Oxfam he then gave up his employment in August 2001. He failed to attend appointments and in September 2002 left a job as a steward at a football club. At that time he was in receipt of Stelazine 5mg daily. In January 2003 he began to express his dissatisfaction with the diagnosis of paranoid psychosis. He asked to be prescribed Valium but was told that this was inappropriate and replied saying he could buy such tablets *"off the streets"*. He began to describe delusional beliefs with a similar theme (conspiracy) as before.

6 Contact between patient and psychiatric services in 2003

In January 2003 his supervising psychiatrist wrote to Anthony Stewart's general practitioner and stated that it was considered *"reasonable"* that in due course Anthony Stewart would have a trial without psychotropic medication in view of the risk of side effects from taking traditional major tranquillisers on a long-term basis. However, at that time the supervising consultant did consider that continuation of antipsychotic medication was appropriate.

In July 2003 a CPN wrote to Anthony Stewart's supervising consultant. At that time the nurse in question was supervising an outpatient from another service who lived above Anthony Stewart. Anthony Stewart alleged that this male had climbed onto the roof to tamper with Anthony Stewart's television aerial. It was the community nurse's concern that this situation had the potential to escalate.

Anthony Stewart's last contact with CFP was on 4 July 2003 in an outpatient clinic. The CFP wrote to a general adult consultant psychiatrist and clinical lead for the Crisis Assessment and Treatment Service Team (CAT) and the CPN and approved social worker (ASW) being members of the forensic team. Concerns were expressed that it was unlikely Anthony Stewart would be persuaded to re-start voluntary treatment with antipsychotic medication. At that time the CFP was the only professional directly involved in Anthony Stewart's outpatient care (Anthony Stewart had been discharged from the caseload of the ASW and his former CPN previously). The CPN made attempts, albeit unsuccessfully, to contact Anthony Stewart following this outpatient clinic. Anthony Stewart contacted the CFP secretary on 19 August 2003 requesting a prescription for Viagra but was informed the CFP was on annual leave until 1 September 2003. Anthony Stewart was made aware that a monthly prescription could be delivered to him at home by the CPN and ASW but his response to this was to express his unhappiness with this arrangement and he made it clear he did not want his CPN or ASW involved in his care.

On 28 August 2003 Anthony Stewart committed the offence of manslaughter.

7 Commentary on contact between patient and psychiatric services

There is no doubt Anthony Stewart suffered from severe and enduring mental illness in the form of paranoid schizophrenia. This illness was complicated by poor insight as demonstrated by failure to take treatment in a community setting and non-compliance with outpatient clinics, CPA reviews and disengagement from services. His contact with forensic services occurred on the first occasion at a time when general adult services requested a second opinion as to the management of his illness and advice on risk. Prior to admission to Alnwick Ward he had been admitted to hospital under the care of general adult psychiatric services.

His first contact with the CFP in the outpatient clinic ended abruptly when Anthony Stewart considered the outpatient appointment to be a *"waste of time"*.

His forensic history was known to forensic services. It was known he had prior convictions for shoplifting and burglary. He was known to be violent (on at least one occasion) prior to admission to Alnwick Ward when it appears he acted on delusional beliefs and directed his anger towards an elderly neighbour.

The offence of assault occasioning actual bodily harm occurred at a time when Anthony Stewart described psychotic symptoms. The case was dealt with by means of a two year probation order with a condition of psychiatric treatment. While forensic services attempted to engage Anthony Stewart as an outpatient through the CPA process, it is clear he did not attend all appointments and while under the care of forensic services he disputed the diagnosis of mental illness. He was discharged from the caseload of the ASW and CPN because in each case he no longer needed their help and support. This led to the CFP being the only professional involved in Anthony Stewart's outpatient care for many months.

At an outpatient clinic on 4 July 2003 it is documented that the CFP considered Anthony Stewart's mental state and concerns were as such that the CFP wrote to other members of the clinical team who had previously been involved with Anthony Stewart, namely the CPN and ASW. The CFP also wrote to the Crisis Assessment and Treatment Team highlighting his concerns and alerting the CAT that Anthony Stewart might present in a crisis. The CFP was not, however, explicit in his correspondence to his CPN and ASW. A meeting was arranged by the CPN to discuss the case with the CFP but this meeting did not take place.

Finally, it is clear that throughout Anthony Stewart's contact with psychiatric services, both general adult and forensic services, he suffered from serious mental illness. His management in a community setting was complicated by his failure to engage on a consistent, regular and meaningful basis and further complicated by a lack of insight which led to periods of non-compliance with treatment and re-emergence of psychotic symptoms.

When seen in the outpatient clinic on 4 July 2003 it appears his detention under the Mental Health Act was considered but it was decided that a Mental Health Act assessment was not required at that time. After the outpatient clinic on 4 July 2003 the CPN did attempt on several occasions to make contact with Anthony Stewart at his home address but with no success.

8 Discussion with Anthony Stewart

On 17 September 2007 we met with Anthony Stewart and his advocate at Rampton Hospital. Anthony Stewart was pleasant, co-operative and willing to talk about his situation.

Anthony Stewart told us that he did not attend the CPA meetings which were scheduled to take place about every three months.

Anthony Stewart said that he stopped taking his medication because *"I felt well and didn't want to take it for the rest of my life"*. He said his mistake was to *"try and do it of my own accord"*.

At the time of the offence he did not have input from the CPN or ASW.

He attended his GP to collect his prescription. He did not attend his GP to discuss his illness because *"he had the CFP"*.

Anthony Stewart stressed that he made no complaint about the treatment he had received.

Anthony Stewart said that he did not believe that his mental illness had contributed to the killing. He believes that his mental health deteriorated later whilst on remand in prison.

He considered that tension had been caused between himself and the victim by the very act of housing the victim in a flat above his own. Anthony Stewart told us that the victim's own problems and conduct had caused Anthony Stewart to snap.

9 Oral evidence received at the inquiry

i Consultant Forensic Psychiatrist (CFP)

ii Community Psychiatric Nurse (CPN)

iii Approved Social Worker (ASW)

iv Crisis Assessment and Treatment Service (CAT) Team Manager

9 (i) Consultant Forensic Psychiatrist

Background

We heard considered and detailed evidence from the CFP who told us of his considerable experience and his participation in the development of the Forensic Regional Service based in Newcastle upon Tyne.

The Forensic Service had been built up over a period of time and offered inpatient beds at St Nicholas Hospital, Gosforth, Newcastle upon Tyne and a Forensic Community Team.

Anthony Stewart had been a patient of the Forensic Service. Anthony Stewart suffered from a mental illness which fluctuated and which did involve periods of psychosis and the development of delusional belief systems.

The management of Anthony Stewart had at different stages involved input from both the CFP, the CPN and ASW.

Treatment had been given to Anthony Stewart:

i when detained under the provisions of the Mental Health Act;

ii when subject to a probation order with a condition of receiving medical treatment from a consultant forensic psychiatrist;

iii as an informal (voluntary) patient.

The CFP told us that he worked with the support of CPNs and ASW. Anthony Stewart had been afforded such support.

Anthony Stewart made substantial progress so that the support of the CPN was withdrawn in 2001 and the support of the ASW was withdrawn in 2003. At that time the mental illness suffered by Anthony Stewart was well controlled. He was accepting his medication. He had in a sense become a low maintenance patient whose need was for contact with a psychiatrist to monitor his wellbeing.

CFP told us that there had been difficulties over the years in returning patients to the responsibility of the general adult psychiatric services. In 2003 there were interface meetings in an attempt to facilitate the transfer of forensic patients back to the appropriate service.

An earlier attempt to return Anthony Stewart to the care of a general psychiatrist had been unsuccessful. He had not related well to that psychiatrist. In such circumstances in an attempt to ensure Anthony Stewart did have ongoing psychiatric contact the CFP decided to retain Anthony Stewart as one of his patients. At the relevant time the CFP was therefore in effect the care co-ordinator and was the only person from the forensic team working with Anthony Stewart.

Key events leading up to the killing

The CFP told us that Anthony Stewart was last seen by him on 4 July 2003. At that time it became apparent that Anthony Stewart had stopped taking his medication and that his mental health was beginning to deteriorate.

The CFP made a considered judgement to contact the CPN and ASW who had been involved in the earlier care of Anthony Stewart. He did this by sending them letters in which he set out his concern and sought a meeting with them to discuss future management of Anthony Stewart.

The CFP considered there was some urgency in re-establishing contact. He expected the CPN or ASW to make contact with Anthony Stewart over the next week or so to obtain further information to allow a consideration as to whether any active intervention was then necessary using powers under the Mental Health Act.

The CFP believed that he had also discussed the matter briefly with the CPN.

In view of the fact that Anthony Stewart when in relapse had previously presented at a local hospital the CFP decided to inform the local CAT of the circumstances in case there was such a presentation.

The CFP accepted that a full risk assessment had not been recorded and clarified this stating that this was because he did not believe he had enough detailed information to carry out a complete risk assessment. When seen he considered the risk to the public, the rights of Anthony Stewart and determined that the stage had not been reached where a compulsory detention was required.

The CFP could not recall why the arranged meeting on 17 July to discuss the management of Anthony Stewart had not taken place. He did not consider this to be critical because in his mind he expected the CPN and ASW to be involved in trying to make contact with Anthony Stewart.

Anthony Stewart was historically difficult to engage and the CFP tried to do everything he reasonably could to maintain contact with and support Anthony Stewart. The CFP considered that the treatment given to Anthony Stewart had been appropriate.

9 (ii) Community Psychiatric Nurse

Background

We were told of her considerable experience in psychiatric services leading to the taking up of a full time CPN position in 1999.

At the relevant time the witness worked alongside other CPN's and ASW from an office in St Nicholas Hospital. The consultant psychiatrists were situated in a different part of the building. The witness stated:

"Unfortunately the doctors (the consultants) were not stationed near us. They were in another part of the hospital but obviously there were regular meetings with the doctors but sometimes it was quite difficult because they were not actually there in close proximity, it was right across the other side of the hospital".

As a CPN she could be asked to become involved with a patient under the care of any of the consultants who worked in the team. The nurses were selected because of their particular skills.

At the time the team operated the CPA there were meetings, usually every three months, to review the progress of a patient. At that time there were no informal meetings to allow the exchange of views between team members.

When asked if such meetings would be useful we were told *"it would be helpful if there were more meetings of that sort"*.

We were told that allocation of patients worked well but could possibly be improved.

The CPN stated that Anthony Stewart was discharged from her case load in 2001 because of his progress and because he no longer needed her support.

The CPN was not further involved with Anthony Stewart.

Key events

The CPN described how she and the ASW each received a letter from the CFP dated 7 July 2003 in which it was stated that Anthony Stewart had discontinued his medication and that there *"is a relapse in psychosis"*. The letter requested that contact be made so that a meeting could be held as quickly as possible to talk about the issues and agree a way forward.

The CPN understood the letter to be a request to arrange a meeting.

The witness made arrangements for the requested meeting to take place and the meeting was arranged for 17 July. The meeting was cancelled by the CFP.

The CPN said that in 2003 there was the change over from CPA to care co-ordination but at the relevant time the CPA policy was in operation. The witness could not remember any CPA training directed to the team as a whole.

The witness described how it was her practice to keep detailed notes of all of her contacts with patients including Anthony Stewart. She had a monthly meeting with her manager who supervised her work. We were told that all patients within the Forensic Community Service were deemed as being at an enhanced level within the CPA care co-ordination programme.

It had been agreed that Anthony Stewart would no longer require the support of a CPN because his needs were social needs that could be best looked after by his ASW.

The CPN discharged Anthony Stewart from her caseload following which an ASW became the care co-ordinator.

The CPN later became aware on an informal basis that the ASW had discharged Anthony Stewart from his caseload.

Anthony Stewart remained an outpatient of the Forensic Service despite his discharge by the CPN and ASW. When discharged by the ASW his CFP became the care co-ordinator.

Anthony Stewart made a decision that he wanted to stay with the CFP and the Forensic Service. An attempt to move to him to a sector team in 2000 had been unsuccessful. Anthony Stewart was always suspicious and he felt more comfortable with the Forensic Service.

The CPN was asked about the relationship between the Community Forensic Team and General Adult Psychiatric Services in 2003. She explained that it was often very difficult to transfer anybody to Adult Services because they were very reluctant to take on forensic patients.

The witness thought that she would probably have spoken by telephone with CFP on receipt of his letter but could not remember doing so. She did speak with the ASW and thereafter contacted the CFP's secretary to arrange the necessary meeting.

On 7 August 2003 the CPN did call at the flat occupied by Anthony Stewart but there was no reply. She had tried to speak with Anthony Stewart by telephone on 29 July 2003 but was unsuccessful.

After the meeting was cancelled there had not been a further opportunity to discuss the case before the CFP went on vacation.

For the CPN this was a closed case and there was not any referral letter to re-open the case. If the intended meeting had taken place then that meeting may have been regarded as a CPA meeting and the case opened from that moment.

The witness emphasised that she was part of a team. In that team the care co-ordinator would usually be the CPN or the ASW. She said that she had not worked in a situation where the CFP had been the care co-ordinator.

9 (iii) Approved Social Worker

Background

We heard evidence from the ASW who was very experienced having qualified in 1993 and been approved since 1997.

The witness considered that his role was to monitor, review, support and encourage people within the community with their mental health difficulties.

Anthony Stewart had been known to social services for a considerable period of time. He became the client of the ASW from whom we heard, in August 2001. When the ASW joined the Forensic Community Mental Health Team there was a manager and three ASWs.

The ASWs working alongside the CPNs who at that time had their own manager.

The ASWs and CPNs shared the same office accommodation but this was some distance away from the accommodation used by the consultant forensic psychiatrists.

We were told that the ASWs as members of the community team worked for all of the consultant forensic psychiatrists rather than for an individual CFP.

If a patient was progressing towards discharge from hospital a referral would be received by the social work manager who would then allocate the patient to a particular ASW.

The team was a closely knit unit and the members of the team knew each other quite well.

Communication between the ASWs/CPNs and the consultant forensic psychiatrists would have been easier if they had not been in different parts of the hospital.

Key events leading to the killing

The witness described his particular role in the care of Anthony Stewart. When he first met Anthony Stewart the CPN had already discharged Anthony Stewart from her caseload.

Anthony Stewart was found to be living independently in a flat and functioning well. He did not require ongoing support from an ASW. He did not welcome contact. Anthony Stewart initiated contact on a needs led basis.

Anthony Stewart was discharged from the ASW's caseload in February 2003. At that time there were no obvious signs of mental illness. Future risk was considered to be low.

At the time the relevant policy was the CPA. The ASW could not remember receiving specific training as to the implementation of the policy.

The ASW received a letter from the consultant forensic psychiatrist dated 7 July 2003 addressed to himself and to the CPN. The letter enclosed letters which were also

addressed to the general practitioner and the CAT team. The letter warned that a situation had arisen where Anthony Stewart had discontinued medication and stated *"there is a relapse in psychosis"*.

The letter requested that the recipients make contact with the CFP so that a time could be identified for a meeting to talk about the issues and agree a way forward.

The ASW told us that the CPN had made contact with the CFP's secretary and a meeting was arranged for 17 July 2003. That meeting was later cancelled by the CFP who was unable to attend.

The witness understood that the aim was to try and re-engage Anthony Stewart so that his situation could be fully assessed.

The ASW was aware that the CPN made attempts to contact Anthony Stewart.

The situation was not regarded as one where there was a *"real serious deterioration in his mental health"* so as to require formal assessment under the Mental Health Act or immediate intervention.

There was no further contact between ASW and Anthony Stewart.

Other matters

At the time there were no multi-disciplinary team meetings outwith the CPA to allow for the exchange of views between team members.

The witness considered that an ideal could be for there to be defined teams where the CPN and ASW worked with a particular consultant psychiatrist. This in practice would be difficult to organise and implement because of different work loads. Furthermore, the CPNs and ASWs were often identified because of their particular skills.

9 (iv) CAT Manager

We received evidence from the manager of the Crisis Assessment and Treatment Service (CAT). This service is based at the Ravenswood Clinic in Heaton in the East of Newcastle upon Tyne.

Most of the referrals received by the CAT team arise from hospital accident and emergency departments and from general practitioners.

The service is designed to respond to a crisis or emergency situation with a response time of two hours.

The CAT team provide care and support in the community for only a limited period of time and then look to transfer the patient to the most appropriate mental health service.

All referrals to the CAT team were urgent and therefore the expected form of contact with the service was by telephone.

The CAT team received a letter dated 7 July 2003 from the consultant forensic psychiatrist in charge of the care of Anthony Stewart.

The manager told us that the receipt of the letter was not considered to be a referral requiring intervention by the CAT team. It was regarded as the provision of background information which was useful. The provision of information by letter was unusual. The letter was retained on file.

The manager told us the letter was not intended to be a referral and they were not involved thereafter.

10 Written contribution by general practitioner

In a letter dated 28 August 2007, the general practitioner whose practice had some involvement with Anthony Stewart made a written contribution to the inquiry.

On 24 December 2002 Anthony Stewart joined the practice list. At that time he was already under the care of a consultant forensic psychiatrist.

When Anthony Stewart joined the practice it was discovered that Anthony Stewart had missed several planned appointments with the CFP and his last contact was 18 June 2003.

During 2003 there was intermittent contact with Anthony Stewart. The purpose of the contact was not related to his mental health.

In August 2003 Anthony Stewart was informed that the practice would not be responsible for any prescribing and that this would be undertaken by the CFP. Anthony Stewart stated that he was unhappy with such arrangements and declared on 5 August 2003 that he would leave the practice. The practice had no further contact with Anthony Stewart.

11 Findings

We would like to thank all those who gave evidence for their openness and their willingness to assist the inquiry in addressing the terms of reference.

Case management

Anthony Stewart suffered from a serious mental illness over many years. His illness was managed both as an inpatient and an outpatient (in a community setting).

Anthony Stewart did not have full insight into the nature of his illness and the need to take prescribed treatment.

Anthony Stewart made a decision to stop taking his medication and his mental health began to decline. When he was seen on 4 July 2003 his mental state gave cause for concern but was not such as to lead the CFP to conclude that an assessment under the Mental Health Act was necessary. As the CFP overseeing the case his judgement was that an attempt should be made to re-engage the patient. The CFP could not have foreseen the associated behaviours that emerged. The CFP took into account that on earlier occasions where there had been such a deterioration Anthony Stewart had presented requiring medical assistance at his local hospital.

The CFP considered the balance between the right of Anthony Stewart to individual liberty and the necessity to protect members of the public by instituting procedures leading to a formal detention.

We conclude that without further information the CFP was not able to further consider the question of instituting procedures leading to compulsory detention.

We find that the correspondence dated 7 July 2003 to the CPN and the ASW was not explicit as to:

i the requirement to re-open the case;

ii the urgency attached to the case;

iii a management plan for Anthony Stewart.

so that the ASW and CPN were not clear of what was expected of them. There is no basis upon which to suggest that this contributed to the outcome.

The CFP was the only member of the forensic team still involved with the patient. We understand from the evidence of the CPN that the policy of the Community Forensic Service was that all patients would be subject to enhanced CPA. Therefore a multi disciplinary approach would be taken to all patients involving CFP, a CPN and/or an ASW with the expectation that the ASW or CPN would be the care co-ordinator.

In the case of Anthony Stewart he had been discharged from the caseload of the CPN and the caseload of the ASW so that the CFP became the care co-ordinator as the only member of the team still involved.

Good practice suggests that complex community forensic case management is appropriately delivered through multi-disciplinary team working. This allows for the multi-disciplinary team to contribute to the assessment.

Where there is a risk of deterioration or a significant change in circumstances there must be a multi-disciplinary team assessment the outcome of which is clearly recorded. Any such assessment should be in a readily identifiable document and include the risk management plan with crisis/contingency plans.

On the occasion of the last contact between Anthony Stewart and the CFP a formal risk assessment with crisis/management plans was not recorded. The operational policy of a multi-disciplinary team must provide for the risk assessment process to take place when there is any significant event or change in the circumstances of the patient.

Outwith formal CPA meetings there was no opportunity for team members to discuss the service and share information.

The care pathway between the Forensic Service and Mental Health Working Age Adults did not facilitate the transfer of cases between the services.

CPA/Care co-ordination policy

The inquiry panel requested a number of documents to aid their review of Anthony Stewart's care in particular the Multidisciplinary Care Programme Approach Policy that was in place at the time of Anthony Stewart's offence. The panel received the following policies:

- Integrated Care Programme Approach and Supervision Register (1997), Newcastle City Health NHS Trust.
- Care Co-ordination Policy (Draft 7 - March 2003) Newcastle, North Tyneside and Northumberland Mental Health NHS Trust.
- Care Co-ordination Policy (Issue 2 – March 2004) Newcastle, North Tyneside and Northumberland Mental Health NHS Trust.
- Care Co-ordination Policy (Issue 3 – February 2005) Newcastle, North Tyneside and Northumberland Mental Health NHS Trust.

In the interviews with the CFP, CPN and ASW there appeared to be a lack of clarity about which policy was in force at the time of the killing. The CPN and ASW remembered that at around the time of the offence in 2003 there was a review of the CPA/Care Co-ordination Policy and that a new policy was being introduced. However, none of those interviewed could remember any training taking place in regard to the CPA/Supervision Register Policy dated 1997 other than CPN, who recollected training taking place in 1999.

Documentation for CPA/care co-ordination

The CPN was the care co-ordinator for Anthony Stewart from January 1999 up to July 2001 when Anthony Stewart was discharged from her caseload. Throughout the time of the CPN's involvement there is clear recording of assessments including risk assessments.

The ASW remained involved with Anthony Stewart until January 2003. In fact the care co-ordinator's role was more as offering social support and advice. The ASW's contact with Anthony Stewart following the discharge from CPN's caseload was infrequent. Following discussions with the manager the ASW closed the case.

Following the discharge of Anthony Stewart from the caseloads of the CPN and ASW, the CFP retained the case and by default became the care co-ordinator. In January 2003 the CFP agreed six monthly outpatient appointments with Anthony Stewart.

At the interview with the CPN she stated that all patients attached to the Community Forensic Service would be classed as 'enhanced' CPA / care co-ordination and therefore by definition would need a multidisciplinary approach to their care.

There appeared to be a lack of clear criteria either from the CPA Policy of 1997 or the draft Care Co-ordination Policy of 2003 which would indicate those cases that should be retained within Community Forensic Services or transferred to Adult Mental Health Services. There was no clear protocol for the transfer of patients from Community Forensic Services to Adult Mental Health Services. The interviews we conducted highlight the lack of a clear pathway. This suggests a reluctance on Adult Mental Health Services to take on cases, regardless of risk assessment, that were held by the Community Forensic Team.

Management of the Inquiry

The inquiry was held almost four years after the killing. Witnesses had difficulty in giving a clear account and on occasion it was apparent that recollections may have been affected or clouded by the passage of time. It was also difficult to obtain relevant policies and documentation.

The public interest and the need to obtain best information and evidence demands that any inquiry should take place as soon as possible after the relevant events. There is necessary delay because of the need to await the conclusion of any criminal proceedings but we recommend that save in exceptional circumstances the process to appoint the panel should be commenced within four months of the conclusion of any such criminal proceedings.

12 Recommendations

1 The care co-ordinator of a forensic patient within the community (ie currently receiving treatment/service from the Forensic Service), should not be the consultant forensic psychiatrist.

2 A policy framework should be in place so as to allow for those professionals involved to be clear about their roles, the expectations of other team members and to facilitate communication within the multi disciplinary team.

3 The operational policy of a multi disciplinary team must provide for the risk assessment process to take place when there is any significant event or change in the circumstances of a forensic patient.

4 Any risk assessment must be fully documented in a readily identifiable document and include the risk management plan including crisis/contingency plans.

5 Regular team meetings are necessary to facilitate the opportunity for effective working and for the sharing of information within the team.

6 Following the risk assessment of a patient where there is concern that there may be a deterioration in mental wellbeing there should be explicit communication of this to the other members of the team.

7 In matters concerning the operation of a multi disciplinary team there must be a clear understanding between the members of the team as to priorities and the time scale in which any individual tasks are to be completed.

8 Team members within a multi disciplinary team must be allowed dedicated time to discuss the implementation of operational policy.

9 An operational policy must be agreed between the clinical leads for the Forensic Directorate and Working Age Adults supported by senior managers so as to allow for and support the transfer of those patients who are deemed to no longer require forensic community care.

10 The procedure to appoint the inquiry panel should be commenced within four months of the conclusion of any criminal proceedings save in exceptional circumstances.

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