THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF A PATIENT KNOWN AS P

COMMISSIONERS:

SOUTH WEST PENINSULA STRATEGIC HEALTH AUTHORITY

2004

INQUIRY PANEL MEMBERSHIP

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INTRODUCTION

We were commissioned to undertake this Inquiry by the South West Peninsula Health Authority to examine the care and treatment of a patient to be known as P, provided by Plymouth Teaching Primary Care NHS Trust, which incorporated the Mental Health Partnership. The Inquiry was required following guidance, HSG (94)27, published in 1994. The guidance states 'in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved'. The guidance was further reinforced in the document *Building Bridges* (Department of Health 1995) and, as yet, has not been amended.

The remit of any inquiry is not about apportioning blame but should be an opportunity to obtain a truthful version of events which covers what was or not done, and whether there was a possibility that the incident could have been prevented. It is also an opportunity to state good practice. The climate and culture of such an in-depth inquiry of one incident may not necessarily instil confidence in the constituent professional groups but when anything is 'inquired into' there will always be room for improvement.

An external inquiry should demonstrate and promote good practice by being open and honest in addressing any shortfall in service provision to service users and carers. The introduction of a Clinical Governance framework of setting standards, sharing information and developing partnerships should encourage a culture of openness in which quality of care and service to patients can flourish and move away from the 'blame culture'. The main outcome must be to increase public confidence and to promote professional competence.

There are other external issues in mental health services which, since 1994, may have had much more of an influence, such as the constant attempts to reach an appropriate management structure. This may result in staff not always knowing who their manager might be or what their individual responsibilities might be.

Therefore such an inquiry should establish the facts, provide an independent perspective on the events, extract areas for development to improve services and thus endeavour to prevent a similar happening. To enable us to carry out this task we were given the following Terms of

Reference, which were discussed and agreed with the Chief Executive of the South West Peninsula Strategic Health Authority:-

1. With reference to the homicide that occurred on 12 May 2002, to examine the circumstances of the treatment and care of P by the mental health services, in particular:
   (a) The quality and scope of health care, social care and risk assessment

   (b) The appropriateness of his treatment, care and supervision in respect of any of the following that are relevant:
      i. His assessed health care and social care needs;
      ii. His assessed risk of potential harm to himself or others;
      iii. Any previous psychiatric history, including drug and alcohol abuse;
      iv. Number and nature of any previous court convictions.

   (c) Statutory obligations, national guidance (including the Care Programme Approach, HSG 90) 23/LASSL (90) 11); Discharge Guidance HSG (94) 27; Mental Health Act 1983 and code of practice as well as any local operational policies for the provision and support of mental health services.

   (d) The extent to which P's prescribed treatment and care plans were
      i. Documented;
      ii. Agreed with him;
      iii. Communicated with and between relevant agencies and his family;
      iv. Delivered;
      v. Complied with by P.

2. To examine the appropriateness of the training and development of those involved in the care of P.

3. To examine the adequacy of the collaboration and communication between Health, the Housing Authorities, Social Services and any other agencies, which were, or might appropriately have been, involved in the care of P.

4. To review the structure of the internal inquiries into the care of P.

5. To consider such other matters, relating to the issues arising in the course of the inquiry, as the public interest may require.

6. To prepare a report and make recommendations as appropriate to the South West Peninsula Health Authority.

NATIONAL CONTEXT TO THIS INQUIRY

The National Confidential Inquiry into Suicides and Homicides, *Safer Services* (1999), recommended that alternatives to the existing system of external inquiries should be considered. To date there have been something in the region of 120 mental health inquiries but with little published evaluation. However, anecdotally, there are concerns about variable standards in rigour, methodology and aptness of recommendations and with their subsequent implementation. Further concerns are about timescales and the financial cost of some inquiries.

In 2000 the Department of Health published *An Organisation with a Memory,* the report of an expert group on learning from adverse events in the NHS. The implementation of the recommendations, *Building a Safer NHS for Patients*, included the creation of the National Patient Safety Agency to improve patient safety by reducing risk of harm through error by establishing a system of adverse event reporting across the NHS.

The Trust completed a 'Critical Incident Review' using the Root Cause Analysis approach. This review revealed some fundamental problems with the Inner City PCLT's response to managers and management, which led to a fuller investigation taking a comprehensive and wider view of the various management activities in the Adult Mental Health services.

In completing our Inquiry we were indebted to having access to all the documents created and discussed in the investigation carried out by the Trust, and in particular to Mrs Karen Howard, now Deputy Head of Service – Adult Mental Health Services, for writing the final report in which she completed a detailed chronology and set out her findings. We have drawn heavily on this report with its accompanying documentation and do not underestimate the amount of time and effort its completion must have taken.

LOCAL CONTEXT TO THE INQUIRY

We know that prior to our Inquiry there had been conflict and tension between some members of the team caring for P and their managers. Most organisations experience differences in opinions and perceptions, which in many situations can be healthy and lead to constructive debate and good working arrangements. But in this Trust the tension has been ongoing for a number of years and seemed to take more time and energy than it should have done.

More than one member of staff described a previous employee as being highly manipulative. It was alleged that he would find a way to threaten people and send unpleasant emails. Since he left he has continued to correspond about the organisation and about individuals within the organisation, requiring the Trust to seek legal advice.

We also know that in the run-up to the Inquiry Ms Ann James, Chief Executive, was sent a series of emails, of which we were given copies.

We are aware that we conducted our Inquiry with the benefit of hindsight and realised that there were other existing factors we needed to take into consideration. For example, the changes in the delivery of community mental health services following a 'reconfiguration' of the service in 1998, which changed ways of working from one large generic team to smaller specialist teams, had implications for primary care provision as well as secondary care services. We were also told about long-standing managerial issues that had major implications for the well-being and functioning of the Waterfront Primary Care Liaison Team. These included alleged poor staffing ratios, the amount of work of some individuals caused by constant staff sickness, poor record keeping and staff mistrust of change and managers.

We know that the outcome of the internal investigation resulted in the dismissal of one member of staff and others being suspended awaiting further action. Whilst these actions were not the main focus of our inquiry it was inevitable that they crept into the evidence we heard and therefore we have made comment about them.

ACKNOWLEDGEMENTS

The members of the Inquiry Team wish to express their sympathy to the family and friends of Mr Roy Warnes, whose tragic death led to establishing this Inquiry. We met with his daughter, and we are grateful to her and her husband for being so helpful in what we know were difficult circumstances.

Unfortunately we were unable to meet any member of P's family although they were given the opportunity to attend. We did, however, meet P at the Butler Clinic and by all accounts he was much improved.

The Inquiry took oral evidence for two weeks in January 2004 in the Department of Psychology meeting room at the Mount Gould Hospital. We wish to thank the staff for their forbearance in coping with the constant disruption to their everyday activities.

We were greatly indebted to the help and support of Mrs Anthea Watson who ensured that we had all the documentation we required. We wish to record our thanks to her employing organisation, Somerset Social Services, for releasing her from some of her duties to provide all the administrative support to our Inquiry. We also acknowledge the sensitive way in which Mrs Watson dealt with all the witnesses who were invited to give evidence.

We were also helped by the efficient manner in which the Fiona Shipley Transcription Service promptly provided us with the transcriptions of all our interviews.

The Inquiry Team would like to acknowledge the effect this incident had on everyone involved. We were grateful to all the people who came and gave their evidence despite the personal cost this might have caused.

The process adopted by us for the Inquiry proceedings can be seen at Appendix 1. In all we interviewed 33 people, some at short notice and some at their own request. All witnesses were invited to bring a supporter in recognition of the serious nature of the proceedings. A full list can be found in Appendix 2. It was unfortunate that we were unable to interview Ms

Jeannette Callus, the Approved Social Worker (ASW) in this case as she was no longer at work.

We also received written evidence in answer to our requests, as well as other information that we found extremely helpful. We are grateful to all the respective organisations for the time spent on photocopying documents we had requested and listed at Appendix 3.

SUMMARY OF EVENTS

P was born 24 June 1968 in Plymouth and brought up by his mother. She married when P was about one year old and thereafter he took his stepfather's surname.

P attended several primary and secondary schools where he said he was bullied. When he left school he held a variety of manual jobs in the building trade and on the fishing boats but in latter years was unemployed. He moved to live in the Saltash and Torpoint area of Cornwall, returning to live in Plymouth when he was about 28 years old. His family had little contact with him. His mother and stepfather were divorced when he was in his late teens and she later married his stepfather's uncle.

He used drugs for some years and latterly regularly used amphetamine which, he told us, he injected intravenously.

P's General Practitioner (GP) first treated him for a mental illness in 1993 when he complained of suicidal thoughts and depression. In 1994, aged 26 years, he was referred to a Community Psychiatric Nurse (CPN).

In 1996 Dr Peter Urwin, Consultant Psychiatrist Cornwall Healthcare NHS Trust, saw him and described him as "*this rather strange young man with primarily panic attacks*". He was seen again following a normal EEG (electro-encephalogram) and a psychometric assessment, which demonstrated he was of low intelligence, although some of the tests he undertook were dependent on a certain level of social understanding and education which he lacked. P did not keep his next appointment in July 1997 and no further follow up was arranged.

In April 1998 P was admitted to the Glenbourne Unit, Derriford Hospital, in the care of Dr Howard James, Consultant Psychiatrist, using section 2 Mental Health Act 1983 (MHA) from Charles Cross Police Station. Dr Christine Dean and Dr Stephen Robinson completed the papers requesting admission for assessment. He stated that he had recently 'broken up' with his girlfriend, with whom he had daughter, after almost ten years. He was discharged on 1 May 1998, to be followed up by Ms Jeannette Callus, ASW.

From March 1999 until June 1999 P was on remand at HMP Exeter, charged with a serious driving offence and not complying with his bail conditions. Dr Howard James saw him and arranged for his transfer to the Glenbourne Unit under section 38 MHA 1983 later converted to section 37 MHA 1983. In September P went on section 17 leave and it was alleged that whilst in the community he administered a noxious substance and raped a fellow patient.

27 September 1999

P was again remanded to HMP Exeter. The victim was admitted to the Glenbourne Unit and was unable to give evidence, which delayed the court proceedings.

February 2000

Dr James saw P in prison as the section 37/17 MHA 1983 had lapsed. On this occasion he was fit and well and did not fulfil the criteria for further detention under the Mental Health Act 1983.

March 2000

P was acquitted of the charges and as such became a 'free agent'. He failed to attend numerous appointments with either Ms Callus or Dr James.

November 2000

P was charged with driving whilst disqualified and remanded on conditional bail at Plymouth Magistrates' Court.

January 2001

Dr James completed a further court report in which he stated that Ms Callus was the key worker and that a CPN would administer the depot injections (a long acting injection of an anti-psychotic drug). He went on to recommend that a Probation Order with a condition of treatment would provide the means of ensuring that P continued to receive treatment.

February 2001

P was made subject of a Probation Order with a Condition of Treatment. Ms Valerie Stewart, Probation Officer, wrote to Dr James informing him of the Order and requesting a meeting. Mr Edward Read, CPN, became the allocated community nurse.

April 2001

Ms Giulia Pridmore, Probation Officer, wrote to Dr James informing him that she was P's Probation Officer and asked for an update on his mental health status and whether he had an allocated CPN. Ms Callus and Mr Read undertook a joint visit to P to inform him that Mr Read would continue to give his injection and that there was no further need for social work input.

May 14 2001

Mr Read administered a test dose of Zuclopenthixol depot injection when P attended the Nuffield Clinic without an appointment.

June 2001

Dr James saw P at the Nuffield clinic on which occasion he requested his injection. A further test dose was given.

August 2001

Ms Jill Narin, Probation Support Officer (PSO) wrote to Dr James introducing herself as P's new Case Manager, requesting an update on his mental state and enquiring if he had an allocated CPN.

27 September 2001

Ms Narin saw P and wrote to Dr James informing him of this and that P was 'low in mood'.

23 November 2001

Mr Read wrote to Dr James informing him that he had not seen P since 17 August 2001.

7 January 2002

P was sent a final warning letter because he was 'in breach' of his Probation Order.

22 February 2002

P was arrested and appeared in court, charged with breaching his Probation Order. The Order was revoked and he received a 12 month Conditional Discharge for the original offence of driving whilst disqualified.

25 April 2002

Mr Paul McGarry (Housing Manager) telephoned Ms Callus about concerns regarding P's antisocial behaviour. A referral was made to the Gateway Service (the service which carried out assessments). Dr Brian Pollard (GP) visited but was unable to see P.

3 May 2002

Ms Callus informed Dr James about P's antisocial behaviour and he also received a letter from the GP who had tried to see P at home. P's ex girlfriend telephoned Gateway Service for advice because P wanted contact with their daughter. On 7 May 2002 Dr James took the GP letter to the team meeting with the intention of discussing its contents with Mr Read.

12 May 2002

Another tenant, who lived at the same house as P, went downstairs at about 07.30hrs and saw that the panes of glass in the inner hall doors were broken. He found Mr Warnes dead in the vestibule. He telephoned the police who attended the scene.

P was charged with murder and pleaded guilty to manslaughter with diminished responsibility. He was made subject to a Hospital Order with an accompanying Restrictions Order (section 37/41).

CHAPTER 1

P'S HISTORY PRIOR TO CONTACT WITH PLYMOUTH MENTAL HEALTH SERVICES

P was born 24 June 1968 in Plymouth and brought up by his mother. She married when P was quite young, after which he took his stepfather's surname. He has two half sisters and a stepbrother. His family had little contact with him. His mother and stepfather were divorced when he was in his late teens and she later married his stepfather's uncle.

He attended several primary and secondary schools, where he said he was bullied. He was reported to have taken seven GCSEs of which he passed six. He was believed to start using drugs from the age of 15, trying Lysergic acid diethylamide (LSD) on a couple of occasions, and continued to use amphetamines for many years.

1984

P left school at 16 and joined a YTS scheme working in a hire shop and completing a car body repairs course. He only stayed a year and left to work on a building site. From 18 until 21 he worked on the trawlers but in latter years was unemployed.

22 December 1988

P was seen at the Royal Naval Hospital Casualty Department after injuring his right wrist in a fight.

21 October 1989

P was seen in the Casualty Department. He required sutures after punching a glass window in anger.

November 1994

P, whilst living in Saltash, Cornwall, was referred to a CPN. His landlord had requested that the GP see P as he was becoming "*more isolated and refusing to come out of his room*". The GP's referral letter stated:

> *"He was near to tears, having felt depressed for some time and reluctant to leave the house during the day… He has had a rather unsettled life in recent years and a few years ago was due to get married but his girlfriend had a miscarriage, this*

seemed to destroy the relationship. He denies excessive alcohol consumption. He does smoke and admits to using Pot. He used to smoke quite heavily but since being unemployed for two years he has been unable to afford very much. I don't feel that this chap has a depressive illness as such but he has personality difficulties and these may be exaggerated by his consumption of cannabis".

December 1994

P did not keep his appointment with the CPN. At the same time, his landlord contacted him and said that, as he had not paid his rent because he had been unable to collect his benefits, he was to be given notice to leave his accommodation.

March 1996

P moved to Torpoint and was referred to Dr Peter Urwin, Consultant Psychiatrist at St Lawrence's Hospital, Bodmin. Dr Kevin Mattolie, GP, saw him twice and on each occasion P was quite disturbed and agitated, and felt he was going mad. During the interview he was both defensive and aggressive. Dr Mattolie went on to say

"I don't know whether this is just his personality or whether there is some schizophreniform at work here"

July 1996

Dr Mattolie wrote again to Dr Urwin because P did not keep his earlier appointment. He was apparently involved with the 'underworld' in Torpoint. He had been attacked and had his possessions stolen. P had been prescribed Dothiepin since April. Dr Urwin saw P who he described as a *"strange young man"*. P described himself as

"...psychic and I have a problem with boundaries. I have always felt that something was different about me".

P complained of a poor memory and his concentration was difficult. Dr Urwin thought he was probably thought-disordered and might be suffering from auditory hallucinations. He also thought that P's motivation in attending was linked to a possible Court appearance. Dr Urwin recommended that the medication be changed to either Stelazine 2mgs twice daily, or Fluanxol 2mgs daily. He also arranged for P to have an EEG.

January 1997

Dr Urwin saw P again and came to the conclusion that he was suffering from some residual drug induced psychosis. The EEG was reported as showing no abnormality and the detailed psychometric test indicated that he was of low intelligence. He performed badly in the tests, which required a level of social understanding and/or social education. Given his lack of education the results might have been unreliable.

July 1997

P failed to attend Dr Urwin's outpatient clinic. Dr Urwin felt there was little more he could offer him and did not send another appointment. He recommended that the GP continue to prescribe Stelazine for another nine to twelve months.

CHAPTER 2

P'S CONTACT WITH MENTAL HEALTH SERVICES IN 1998

21 April 1998

P was arrested on suspicion of stealing a saxophone and taken to the Charles Cross Police station. Ms Jeannette Callus, Social Worker, saw P and agreed to visit his flat to make arrangements for his bird. He was admitted to the Glenbourne Unit under section 2 MHA 1983. He was exhibiting bizarre behaviour and had pressure of speech. His medication was continued as Thioridazine 100mgs and Zopiclone 7.5mgs.

23 April 1998

During conversations, P was observed to be responding to auditory and possible visual hallucinations, and did not seem to understand why he was in hospital. The following day, P was quite agitated. His agitation was thought to be due to Risperidone and so it was discontinued. Chlorpromazine 50mgs was commenced four times a day. He became verbally hostile towards the staff and wanted to be discharged. He kicked and threw chairs around, although he quickly calmed down and apologised. However at 21.40hrs P was missing. The absent without leave procedures were implemented. At 04.45hrs the Police returned him to the ward. He had been back to his home.

25 April 1998

P became agitated when a fellow patient was 'acting out' but calmed down when he was removed from the scene. His girlfriend visited him, as he had asked her to look after his bird.

26 April 1998

In the evening P was sexually provocative and became hostile and angry when confronted by staff. He was removed from the main area, away from patients.

28 April 1998

P attended Dr James' ward round and behaved appropriately. He told Dr James he had experienced voices for many years. Dr James agreed for him to have Section 17 MHA 1983 leave, so that he could go to his flat with a health care assistant and see to his bills. P agreed to return to the ward the following day at 17.00hrs. He was to continue with Chlorpromazine medication, with the possibility of having depot injections in the future.

29 April 1998

P did not return to the ward and although the Police found him at home they were reluctant to take him back to the ward.

30 April 1998

P was discussed at the sector meeting and Ms Callus agreed to continue as his key worker. She had seen him that morning with a colleague, Mr Mark Warner, ASW trainee, who continued to carry out some of the home visiting. P returned that afternoon at 14.30hrs and, although still psychotic, his behaviour was appropriate and Dr James decided to discharge him. The plan was for weekly visits by either Ms Callus or, in her absence, Mr Warner.

> **Comment**
>
> **We were surprised that P was discharged given that he was still psychotic, on section 2 MHA 1983, had not adhered to his leave arrangements and, as a patient relatively new to the mental health service, was an 'unknown quantity'.**

1 May 1998

P was discharged from hospital and no longer a detained patient under section 2 MHA 1983. He was prescribed Olanzapine 10mgs daily and Chlorpromazine 100mgs nightly.

7 May 1998

Dr Pollard (GP) and Ms Callus visited P at home, and found him much improved.

20 May 1998

Mr Warner, on behalf of Ms Callus, visited P at home because he wanted to move from his existing accommodation and Ms Callus wanted to support his housing application. When Mr Warner arrived he noticed that the panes of glass in his door were smashed and that there was blood on the floor. P told him that he thought there were people, of different backgrounds, some good and others bad, in his television prompting him to act in certain ways and controlling him. He appeared to be taking his medication. When asked about the blood, P initially said it was paint but then said he hurt his hand mending his bicycle and was so angry he smashed the glass panes. P told Mr Warner about his family and the 'collection'

of objects he was taking from other people's bins and skips, which were making his flat cramped and unkempt. Mr Warner discussed his concerns about P's behaviour with his practice supervisor.

27 May 1998

P continued to collect more items from skips and rubbish bins, including four broken chairs and a sideboard.

9 June 1998

Mr Warner made a home visit during which P told him that his future accommodation plans had fallen through, and he agreed to a referral to the housing Mental Health Assessment Panel (MAP).

13 June 1998

P attended his GP who renewed his prescription.

19 June 1998

Mr Warner made a home visit and, although he did not see P, he saw the landlord who explained that P presented no problem when he was with his girlfriend, but this relationship had broken up and following this P started collecting old pieces of furniture. P also accused the landlord of being the devil and being evil. Mr Warner gave the landlord the telephone number of the Westbourne Unit to use if he was concerned and needed help. Mr Warner spoke about the situation to Dr James, who felt it might be necessary to consider readmission. Dr James wrote to the house officer in support of P's housing application stating

> *"I can confirm that P suffers from a long term and enduring mental illness and therefore meets the necessary criteria for a MAP referral. His present accommodation is unsuitable and detrimental to his mental state and therefore it is a priority in a long term plan to help P".*

3 July 1998

P's landlord spoke to Ms Callus about P because the other tenants in the house were complaining about the noise made by P at night. By now he had priority housing and was just waiting for the appropriate property.

23 July 1998

Mr Warner made a home visit and P said he was coping despite feeling 'hassled' by the landlord. His motor bicycle had been stolen, which he reported to the police. Despite being lucid P was more aggressive in demeanour and his delusional thoughts were still evident. P still had not seen the Housing Officer and so Mr Warner agreed to take him the following day, which he did.

10 August 1998

P drove friends to a party. After seeing a police car he drove away at speed. There was a car chase that ended when P hit a kerb. He had no insurance or current tax disc. These 'minor' motoring offences were dealt with in the Magistrates' Court. He was later charged with the more serious charge of dangerous driving.

17 August 1998

Mr Warner telephoned the medical records department at the Nuffield clinic and was told that Dr James had closed the case at the beginning of the month.

Comment

We were concerned that P had at this point been discharged from the ward for three months and Dr James had not seen him in his outpatient clinic. In the internal investigation and our Inquiry, Dr James stated that the case had been closed on the electronic patient register without his knowledge. There was no explanation for how this had come about. Neither Ms Callus, key worker, nor the GP appeared to know that this had happened. If it had been an administrative error the Inquiry Team could not verify this as the secretary was no longer in post.

21 August 1998

Ms Callus and Mr Warner visited P at home. As he was out, they left a note asking him to contact the Westbourne Unit if he required further assistance. Mr Warner spoke to the duty GP who confirmed that P had collected his medication and had said he was seeing his Probation Officer regularly, and coping with life. The GP was unable to recall any concerns.

Comment

Mr Warner telephoned the Probation Service and confirmed that no-one was currently working with P.

11 September 1998

P had not completed the appropriate paperwork to be rehoused and so was not considered to be 'homeless'. Three days later Ms Callus had a conversation with an Environmental Health Officer because there had been complaints from the other tenants about the noise from P's music and television.

4 November 1998

P visited his GP for a repeat prescription. He appeared well and was no longer in contact with his social worker or the psychiatric services.

11 November 1998

Ms Callus had not seen P since July. She ascertained that a property was now available for him.

24 December 1998

Ms Callus spoke to the Housing Manager who confirmed that P had moved to his new address about three weeks previously.

Comment

During the course of the Inquiry the Inquiry Team visited the Nuffield Clinic, where the Primary Care Liaison Team and Dr James were based.

P's new accommodation, a bed-sit in a Victorian style house, was no more than 150 yards from the clinic.

CHAPTER 3

P'S CONTACT WITH MENTAL HEALTH SERVICES IN 1999

23 February 1999

Ms Callus spoke to Mr Paul Falkingham, Probation Officer, who was P's allocated officer since he was charged with a 'dangerous driving' offence. She informed him of her contacts with P.

25 February 1999

Mr Falkingham completed a Pre Sentence Report. P appeared to minimise the offence, saying that the Police had made a *"mountain out of a molehill"* exaggerating what had happened – despite P jumping red lights, going around a roundabout the wrong way, and breaking the speed limit. In the report he said

> *"...because P's view of his own offending is apparently one of minimisation, but because also it is unclear how far this reflects his psychiatric problems, it is very difficult to analyse his offending, or predict future behaviour with any confidence"*.

Mr Falkingham concluded that, because of his health problems, P was unsuitable for a Community Service Order and had concerns should he have to serve a custodial sentence.

26 February 1999

P failed to attend the hearing at the Crown Court.

1 March 1999

The Housing Officer telephoned Ms Callus to inform her of the latest complaints from P's neighbours about the noise he was making by banging on the walls and shouting. He was still collecting his prescriptions from the surgery, most recently on 30 January 1999.

5 March 1999

Ms Callus saw P at home. He told her he had been to Court and was expecting to be 'sent down'. He was taking his medication.

15 March 1999

P did not attend his outpatient appointment at the Nuffield Clinic.

17 March 1999

P was remanded in custody to HMP Exeter, as he did not comply with his bail conditions of reporting to the police station.

13 May 1999

At the request of the solicitor, Dr James visited P in prison to complete a report.

18 May 1999

Ms Callus spoke to Dr James and he informed her that he had seen P in prison. Despite receiving his medication he still experienced psychotic symptoms. P told Dr James that he had not been responsible for driving the car but was instead *"controlled by the spirits inside him"*. P also said that he had had some blackouts when he was first in prison, but these had now stopped.

Dr James wrote in his report

> *"... P has a history of psychotic illness, substance abuse and low/normal intelligence. It appears that he was psychotic at the time of the offence, although he had been taking amphetamines at the time. It is my view that at no stage has he been unfit to plead to the charges.*
>
> *I have discussed the case with his Probation Officer. Currently Mr Falkingham feels that P would not be able to comply with the conditions of a Probation Order. It is noted that he could not be easily accessed by a key worker when he was discharged from Glenbourne under the Care Programme Approach.*
>
> *P continues to have treatment with an antidepressant and an antipsychotic agent and is apparently compliant with taking these. It is possible that review of his medication might improve his symptomology.*
>
> *... I would agree that it is unlikely that P would comply at this stage with a Probation Order coupled with a condition that he has medical treatment. The court might well, with respect, deem it appropriate that P be remanded to hospital for further treatment under Section 36(2) of the Mental Health Act 1983.*

I have discussed this with Dr Davis, Prison Medical Officer, and Mr Falkingham. Dr Davis supports this suggestion. Mr Falkingham also supports the suggestion and has added that such a further period of treatment might allow him the opportunity to update his pre-sentence report and to review the possibility of a Probation Order with a condition of medical treatment once his behaviour in a hospital situation can be evaluated. Should the Court therefore feel that this disposal appropriate I would be happy to make a bed available for P at the Glenbourne Unit Plymouth".

Comment

At this time both the Probation Officer and Dr James shared the view that P would not be suitable for a Probation Order with Condition of Treatment, because it was not easy to continue contact in the community and he did not always keep appointments.

7 June 1999

P was admitted to Harford Ward, Glenbourne Unit. He told the admitting nurse that he had a dead pigeon in the bin and the food in the refrigerator had been there for three weeks. He was feeling 'good'.

11 June 1999

Ms Callus saw P on the ward and obtained his keys to deal with a dead pigeon in his flat and clean out the refrigerator. She did a joint visit with the Housing Officer later in the day, after which she returned P's keys to him.

13 June 1999

P was shouting in the lounge and appeared to be talking with a woman, becoming louder and more aggressive. The duty doctor saw him and prescribed Droperidol 10mgs and Lorazepam 2mgs. P was moved to a side ward and a less stimulating environment. Staff found two cans of beer in his belongings.

17 June 1999

P became more agitated and disturbed, responding to hallucinations and voices. He was angry and abusive refusing to give a urine sample, but agreed to take his medication. He had a large quantity of tobacco and may well have had other substances, as he had been very deluded.

22 June 1999

Ms Callus saw P on the ward. He told her that he was still experiencing visual and auditory hallucinations, which he said he had had since his childhood.

15 July 1999

P continued to experience some auditory hallucinations and reported seeing 'spirits' in the trees and curtains. He told the doctor he had not used amphetamines for two weeks. He used them because they made him feel 'happy'.

21 July 1999

The police visited later in the day, as they had received a report from an ex school friend of P. He had been telephoning her, wanting to see her, and she felt intimidated. He was told that if he continued telephoning her he would be charged with 'harassment'.

30 July 1999

Ms Callus informed P that the housing department needed to change the locks because the keys were missing, and also that he might lose his tenancy if he went to prison.

3 August 1999

P had been leaving the ward without informing staff and was told he could not so without the Court giving permission.

6 August 1999

P became involved in a 'verbal brawl' with another patient, requiring physical separation by the staff. P felt there was a conspiracy in the ward but would not elaborate further. He eventually went to bed at 01.00hrs.

9 August 1999

P was transferred to Bridport Ward and settled. Dr James saw him the following day, as he hoped to change the Hospital Order to a Section 37 MHA 1983. Dr James discussed prescribing depot injections for P. When discussed with P, he was happy to have it.

15 August 1999

P presented quite differently than previously noted, being elated in mood, laughing and talking in strange voices, and behaving in a 'juvenile' way.

17 August 1999

P was discussed at the ward meeting. Dr James undertook to write to the Court to recommend Section 37 MHA 1983. Dr James completed the *Incapacity for Work* forms in respect of P's mental illness.

19 August 1999

Dr James sanctioned leave for P to attend the Court hearing. No ward escort was available and so a Police escort was requested for the following day.

20 August 1999

P attended Court but did not return to the ward. At 18.30hrs, when the police were contacted, they did not know where he was, stating that they had 'closed the case' at 16.45hrs.

21 August 1999

P arrived back on the ward, elated and shouting in a high pitched voice. He remained subject to Section 38 MHA 1983 until the paperwork was changed to Section 37 MHA 1983 without restrictions.

22 August 1999

P was still elated, with inappropriate shouting and increasing challenging and 'cheeky' behaviour.

24 August 1999

Dr James contacted the Magistrates' Court to clarify the paperwork.

7 September 1999

P was angry during the ward round because of earlier events on the ward when he said that, although another patient stole a ring from him, he was being punished, which he considered to be unfair. He was granted section 17 leave MHA 1983 from the following day. A test dose of Zuclopenthixol 100mgs was administered to P without any side effects.

8 September 1999

P was asked to leave Bridport Ward because of his inappropriate behaviour. He returned to Harford Ward at 21.50hrs.

14 September 1999

P attended the ward round during which the staff realised he had had no medication. He was given Zuclopenthixol 200mgs by injection.

Comment

This dose and the test dose were well documented in the inpatient records, which could have been accessed by Dr James who, in turn, could have informed the CPN who was later responsible for administering the injections in the community.

21 September 1999

P attended the ward round. The agreed Plan was:

"Referred to the PCLT for continued Depot injections, to be given by Ms Emily Spick, CPN.

Discharge today on unlimited section 17 leave.

Review in outpatients and discharge from section.

Meds. Straline (Sertraline) 100mgs daily

Olanzapine 15mgs

?section 25a

Jeannette will sort it."

Comment

This plan lacks clarity both with respect to the intended actions and to the individuals responsible.

27 September 1999

A staff nurse from Harford Ward telephoned Ms Callus to inform her that P had been charged with *"? rape,? attempted murder and/or Grievous Bodily Harm (GBH)"* to a female who lived in the same vicinity as P. The incident occurred on 20 September 1999 and the alleged victim was an ex-patient.

28 September 1999

At the ward round Ms Callus agreed to find out where P was. She found out that he was on remand at HMP Exeter and due to appear in Court again on 5 October 1999.

Comment

The police took this incident very seriously, as a forensic medical examination demonstrated that the young woman had been sexually assaulted. P was arrested and remanded to HMP Exeter. Given the nature of the allegations a multi-agency meeting should have been called to assess the level of P's risk should he be returned to the community. As a consequence of P's arrest Ms Spick, who attended the ward round with a view of following up P in the community, never met P.

29 September 1999

Ms Callus discussed P with Mr Neil Gardiner, the Clinical Nurse Manager, who agreed to telephone and write to HMP Exeter to ensure P received his oral medication and depot injections. Dr Wiki Jenkins, SHO, wrote to the medical officer at HMP Exeter

"…P's medication is as follows

Sertraline 100mgs nocte

Olanzapine 15mgs nocte

Clopixol 200mgs im depot next due 5/10/99 and to be given three weekly, i.e. every three weeks (last given 3.09.99)"

Comment

Prison healthcare records are not automatically 'married up' with records for previous admissions. For each occasion that people are sent to prison, either on remand or sentenced, they are invariably allocated a new number.

As a result, even if existing records are still in the prison, unless a member of staff recognises them there is no system for retrieving old records. Some prisons destroy the records after an agreed period of time and others send them to a central area for long term storage.

The Prison healthcare records we were given only included those following the homicide in May 2002. However we had no reason to believe that they did not continue with depot injections as requested in Dr Jenkins' letter.

7 October 1999

A Probation Officer telephoned Harford Ward and informed that P was in fact in HMP Exeter.

4 November 1999

Ms Callus completed a Social Services Review Form (SS3). She was unable to see P as he was currently in HMP Exeter

5 November 1999

Ms K Morris Assistant Chief Probation Officer advised that the Probation Service should not be involved, since P was subject to Section 37 MHA1983 and as such the case was closed to the Probation Service.

11 November 1999

P was further remanded in custody to appear at the Magistrates' Court on 23 November 1999.

30 December 1999

P appeared in Court charged with 'causing an obnoxious thing to be administered which could endanger life', and rape. He was remanded to appear in Court in the new year.

CHAPTER 4

P'S CONTACT WITH MENTAL HEALTH SERVICES IN 2000

12 January 2000

Dr James wrote back to the Mental Health Administrator in answer to his letter dated 20 December 1999, reminding him of P's legal status. He said:

> *" Thank you for your recent reminder of 20.12.99 about P 's section 37 expiry date. As you may know he is currently remanded in custody facing serious charges and I think we will need to discuss his current mental health act status"*

25 January 2000

The Mental Health Act Administrator again wrote to Dr James stating that P's current section would expire 19 February 2000.

9 February 2000

P's solicitor, Mr Macdonald, telephoned Ms Callus to inform her that P had appeared in Court that morning. He suggested that P may be 'bailed', possibly to the Glenbourne Unit, in view of the length of time proceedings were taking as the victim was not fit to give evidence.

10 February 2000

Ms Callus telephoned Mr Terry Harris, Court Diversion CPN, who thought that P would be returned to HMP Exeter on remand, as the victim was now a patient on Harford ward, and because of P's history of taking illicit drugs and his non compliance with medication. She discussed the situation with Dr James the following day and he agreed to see P the following week with a view to regrading him to an informal patient. Ms Callus had a further discussion with Dr James on 22 February – section 37 had lapsed and P was due in Court 25 February 2000.

> **Comment**
>
> **We were surprised that Dr James did not see P until February despite knowing the legal position for over two months. Dr James allowed the section to lapse without making an assessment.**

23 February 2000

Dr James saw P in HMP Exeter on 21 February, and wrote to his solicitor. He said

"I was pleased to see that P is fit and well, and really not fulfilling the criteria for liability to detention under the Mental Health Act. His section has now lapsed. P felt he would like to have his depot neuroleptic injection in addition to his medication, should he leave custody and I told him that arrangements could be made for this. He said he was compliant with medication while on section 17 leave although it was apparent to his key worker that he had started smoking cannabis again and possibly using some amphetamines. P readily admitted that this was the case but he denied other drug abuse or injecting. The time between his date of trial leave from hospital and his arrest was so short that it is otherwise difficult to give an assessment of how he might have progressed in the community.

I have spoken to Jeannette Callus ASW, of the Westbourne Unit who is happy to remain his key worker.

He will also need to be allocated a CPN for his depot injection, and this will be arranged immediately upon his discharge from prison, if this occurs. I have made arrangements with the prison medical authorities for P to have a supply of his oral medication for treatment of his schizophrenic illness to take home with him should he be granted bail. P is invited to come to the Nuffield clinic at any time between 9.00am and 5.00pm on Monday 28 February 2000 in order to resume his depot neuroleptic injection.

He is also invited to attend for a Care Programme Approach review with myself and his key worker on Wednesday 1 March 2000 at 10.30am".

Comment

This letter was copied to Dr Pollard (GP), Ms Spick (CPN) and Ms Callus. There was no suggestion in this letter that P had not received the depot injections in prison. The Inquiry Team were given only those prison healthcare records relating to P's remand for the homicide, and so were unable to clarify to their satisfaction whether P had received the depot injections. In the Inquiry Dr James was of the view that the Depot injections were discontinued in prison, although this is not stated in the above letter.

Dr James wrote to the Mental Health Administrator again

> *"...further to our correspondence about this gentleman. I have allowed his section to lapse and for him to be re-graded to informal status. He is fit and well and in my opinion no longer liable to detention in hospital".*

25 February 2000

P appeared in Court, was not given bail, and returned to HMP Exeter to appear in Court a week later.

3 March 2000

P appeared in Court and was acquitted of the charges.

10 March 2000

P visited his GP and informed him that he had been released from HMP Exeter the previous week. He requested oral medication, and from the notes it appeared that he had not had the injection for seven months. The note stated

> *" needs follow up ?depot inj not had one for 7/12. M H problem".*

> **Comment**
>
> **We could find no evidence that any further action was taken in respect of the administration of the depot injection.**

22 March 2000

Ms Callus confirmed with Mr Harris, CPN, that P was no longer in prison. She also telephoned Dr James the following day and learnt that he was not aware of this.

> **Comment**
>
> **Mr Harris (CPN), who as part of his role was the liaison nurse with HMP Exeter, wrote to Ms Callus confirming that P was acquitted. It was unfortunate that he did not copy his letter to Dr James, as there was a need for P to receive ongoing depot medication. This needed to be arranged with one of the community nurses, and there was a possible need to review his care now he was in the community**

27 March 2000

Because Ms Callus had not been able to make contact with P and there was no sign of life at his flat, she telephoned P's solicitor, who confirmed that P was acquitted and that all the relevant agencies had been informed.

Comment

We found no evidence that the relevant agencies had been informed.

29 March 2000

Ms Callus wrote to Mr Ian Clewlow, Assistant Chief Probation Officer, as there had been no communication from the Probation Service about P's situation.

"I write concerning the above client who has been an open case to me since April 1998 when P was an inpatient at the psychiatric unit here in Plymouth. From March – June 1999 P was remanded at Exeter prison and subsequently transferred to Glenbourne Unit under section 38 of the Mental Health Act. In September 1999 this was changed to section 37 of the mental Health Act at which point P was given leave from hospital to his local authority flat. Within a few days P was charged with a major offence and returned to the remand wing of Exeter Prison. I endeavoured to keep tabs on the situation by liaising with Mr T Harris, Mental Health Assessment and Court Diversion CPN.

Only in the last few days has it come to my attention that P is no longer in Exeter prison and in endeavouring to clarify the sequence of events have I discovered that at a court appearance in Exeter on the 3rd March 2000 he was acquitted of all charges. I also understand that the Section 37 Order to which he was subject lapsed during February, effectively, therefore, this man is a free agent; however under the terms of the mental health act he is subject to Section 117 Aftercare and we do have a duty to ensure that an appropriate care package is formulated with the client's agreement. Unfortunately I have been unable to trace P at his home address and in spite of liaising with the housing department, P consultant psychiatrist Dr H James, Mr Harris, Mental Health Assessment and Court Diversion CPN and P's solicitor, no one has seen P or has any idea of his whereabouts other than his stated intention to return to his home.

In speaking with Mr Macdonald, solicitor, on the 27th March he informed that on the day of P's acquittal at the crown Court all relevant agencies had been notified. I do find this quite concerning as I certainly have not received anything in writing nor to my knowledge has there any telephone contact on this matter. I would be grateful if you copy me any relevant documentation and I will of course endeavour to ascertain P's whereabouts."

The letter was copied to Dr James.

14 April 2000

Ms Callus wrote to Dr James, further to their brief discussions, informing him that she had been unable to contact P, although he had been seen back at his address. She made an appointment for Dr James to see P at the Nuffield Clinic.

17 April 2000

Mr Clewlow replied to Ms Callus' letter.

" I understand that you have discussed this matter with Mary Mitchell, Senior Probation Officer and that the matter has been resolved".

3 May 2000

P did not keep his appointment with Dr James. Ms Callus had not seen him either. Dr James, on 16 May 2000, wrote to Dr Pollard informing him that P did not keep his appointment and that Ms Callus was trying to find out if P was still in Plymouth. She discussed the case with her practice supervisor and agreed that she would write to P, which she did on 30 May 2000. He was informed of his rights and that Social Services had a duty to provide ongoing follow-up and aftercare, such as treatment and support to enable him to live successfully in the community. This letter was copied to Dr James and Dr Pollard.

16 May 2000

Dr James wrote to P's GP informing him that P did not keep his appointment. He went on to say

"Ms Callus is trying to find out whether he is still in Plymouth and so far the indication seems to be that he is. I will keep you in touch with any news this end".

Comment

We were concerned that we could find no evidence of any assertive follow up or any attempt to involve the CPN to give the depot injection, despite the Consultant Psychiatrist knowing that it needed to be given. In 1999 Dr James had already expressed concern that it was difficult for a key worker to have access to P in the community.

Neither could we find any evidence of a formal risk assessment, given the alleged rape charge and that the victim was known to the mental health services.

According to the electronic recording system (ePEX) used by the Trust, Dr James terminated his contact with P. This was the second time that P was 'closed' to Dr James, apparently without his knowledge

20 July 2000

Ms Callus closed the case as P was not responding to any form of communication, and completed Social Services Review Form (SS3), which was copied to Dr James.

3 August 2000

P was seen by his GP.

14 August 2000

P was charged with driving whilst disqualified and therefore having no insurance. He was remanded on conditional bail and due to attend Court in October. A friend, who was also banned from driving, had asked him to drive and had agreed to 'pay' P with amphetamine sulphate.

20 September 2000

Dr James wrote to Ms Callus thanking her for the 'CPA review' form. He asked whether there was any evidence that P was still in Plymouth.

Mrs Maggie Lister, Probation Officer, saw P in order to prepare a Pre-Sentence Report (PSR). She thought he looked unwell. He had not attended a Court hearing.

2 October 2000

Ms Callus wrote to Dr James that P was still receiving oral medication from his GP. In her PSR Mrs Lister requested an adjournment to obtain a psychiatric report, which would enable the Court to make a suitable community sentence and re-establish P's mental health treatment.

19 October 2000

P appeared before Plymouth Magistrates' Court charged with driving whilst disqualified and without insurance. He was remanded on conditional bail until 16 November 2000. Dr James was asked to prepare a Psychiatric Report for the Court.

3 November 2000

A CPA referral form in the medical notes stated that the Probation Service request for a report was further referred for a forensic opinion and sent to Dr Adrian James, Consultant Forensic Psychiatrist, based at the Butler Clinic.

16 November 2000

P attended Court and was given conditional bail, requiring him to keep in touch with the Probation Officer and the psychiatric services.

19 November 2000

Dr James wrote to Mrs Lister saying

> *"I now think it would be appropriate for a forensic psychiatric opinion on P given all the circumstances and thank you very much for agreeing to make the referral to either Dr Donovan, Dr James or Dr Dorkins"*.

1 December 2000

The Magistrates' Court administrative Officer again wrote to Dr James requesting a psychiatric report for the next Court appearance 14 December 2000. The previous request had been sent to Dr A James and following a telephone conversation with Dr Howard James, He wrote

> *"At the current time a referral to the Forensic Service by the court is not appropriate. This is particularly so given the relatively minor nature of his offence and the fact that*

you are looking for additional community resources which are not available to the Forensic Service.

Dr Howard James agreed that a referral to his service would be more appropriate. He may then need to assess P for further community interventions or even detention under the Mental Health Act depending on the outcome of the assessment.

I have agreed with Dr Howard James that I will asses P, at his request, on a variety of matters if felt appropriate.

A further complicating factor is that Dr Howard James has a difficulty in establishing contact with P and it seems unlikely that P would attend for an appointment in Exeter anyway.

I would therefore respectively recommend that the Court approach Dr Howard James directly. He can investigate the local input into his care and ask for a Risk Assessment if he feels it appropriate".

7 December 2000

Dr H James' secretary wrote to P, copying it to Mrs Lister, informing him of the appointment with Dr H James on the 3 January 2001.

12 December 2000

P visited his GP, as his prescription required renewing. The GP notes state

" … says injecting himself with clopixol?? +amphetamines. Manic has appointment with Dr James. I did not issue Clopixol…..…"

Comment

When we saw P he confirmed that he was giving himself the depot injections, telling us that at first he was injecting into a vein until he was told they were intramuscular injections. The Inquiry Team was not able to either confirm or disprove this assertion.

CHAPTER 5

P'S CONTACT WITH MENTAL HEALTH SERVICES IN 2001

3 January 2001

P kept his appointment with Dr James at the Nuffield Clinic. P was unkempt with poor concentration and appeared distracted at times. He was still hearing voices, although they were not as bad as they had been 18 months previously. He had not seen Ms Callus, as he did not feel he needed any help. At the same time Dr James confirmed with her that she was prepared to continue as his key worker. P told Dr James that he was taking his oral medication and self-administering his depot neuroleptic injection, sometimes every other day.

4 January 2001

P's solicitor wrote to Dr James informing him that P had been charged with a driving offence in August 2000 and, as P pleaded 'guilty', the Court required a Pre Sentence Report.

19 January 2001

Dr James completed the Court Report, in which he confirmed that P would need an allocated CPN to administer the depot injection, and would benefit from further counselling about his illicit drug usage.

Dr James wrote

> *"Mental state 3.1.01*
>
> *P appeared unkempt, with poor concentration and he appeared distracted at times. He said he felt "not too bad" and added that he kept in touch with his general practitioner at Wycliffe surgery. He told me that he continued to take his oral antipsychotic medication, olanzapine, 15mg. and his depot neuroleptic injection, Clopixol 200mgs, together with the antidepressant, Lustral 50mg. For the last month, he said that he been asking his general practitioner for a stronger antidepressant than Lustral. P added that he was regularly given the depot neuroleptic to self-administer. Sometimes, he did so every other day. He agreed that I could ring the surgery to confirm these prescribing arrangements, and later did so, and this proved to be the case".*

Comment

The conversation with the GP is not recorded in the GP notes. When we asked Dr James about P self administering his injections, he told us that it was a mistake and the report should have read '…. *proved <u>not</u> to be the case*'

Dr James concluded his report

"P remains in need of supervised treatment, and such treatment is likely to reduce the risk of re-offending. A Probation Order with condition of treatment would provide the means of ensuring that P continues to receive the help he needs, and I would be willing to supervise his treatment should the Court with respect, see fit".

Comment

In 1999 Dr James had expressed concern about P being compliant with a Probation Order with a Condition of Treatment. Since then he had proved to be difficult to follow up and keep in touch with whilst in the community. On two previous occasions P had been electronically discharged from Dr James, which further compounded the difficulties in keeping in touch. If anything, the situation was worse at this point in time as no proper risk assessment had been carried out, he had been charged with a serious offence, and it was possible he had not been having his depot injections.

12 February 2001

Dr James' secretary wrote to P changing the time of his appointment on 14 February 2001, which he did not keep. Dr James also wrote to Ms Callus, dated 21 February 2001 but dictated on 13 February 2001, asking for news of P's Court case, as he had not come to the notice of the PCLT and there was a need to organise his depot injections.

Comment

Although we have learnt that, at the meeting on 12 February, Mr Edward Read, CPN, was allocated to give the depot injection, he was not copied in to this letter

18 February 2001

P was made subject to a one year Probation Order with a Condition of Psychiatric Treatment (after April 2001 known as a Community Rehabilitation Order under the Criminal Justice and Court Services Act 2000). He was allocated Ms Valerie Stewart, Probation Officer, who wrote to him with an appointment for 26 February 2001. She also wrote to Dr James on 20 February 2001, informing him that she was the case manager who was to oversee the Probation Order. She wrote

> *"I note that there is a condition attached to the order for P to receive treatment as directed by you. I should be very grateful if you would keep me informed of appointments offered to P and whether or not he attend them. I should also like to arrange a meeting with you so that we each have some understanding of what we can expect of each other. I look forward to hearing from you regarding a convenient time for a such a meeting"*

21 February 2001

Dr James wrote to Ms Callus, asking whether she had heard the outcome of P's Court Case. Two days later he also wrote to Mr Adams, Court Administrator – Devon Probation Services, to inform him that P did not keep his appointment, and to find out the outcome of the Court case.

28 February 2001

Dr James wrote to Ms Stewart, voicing his concern at not hearing anything. He stated that his Care Co-ordinator had now returned from leave and they would try to allocate a CPN. He agreed to a meeting when contact with P had been re established. He ended the letter

> *"...perhaps when everyone has re-established contact with P over the next week or so, we could then arrange the meeting which you quite rightly suggest".*

> **Comment**
>
> **This letter was copied to Ms Callus and Ms Elaine Longbottom, acting PCLT Manager, but was not copied to Mr Read, CPN. From the content, it does not nominate him as the CPN in this case. We also know that no such meeting between the Probation and mental health services ever took place.**

6 March 2001

A Probation Service employee visited P at home as per Probation National Standards and stated "*everything ok*", and that P was due to attend an appointment with Ms Stewart on 8 March 2001. Arrangements were in hand for P to attend the usual induction course and a six-week programme, *Counting the Cost*, to look at his offending behaviour.

> **Comment**
>
> **The Inquiry team was concerned to learn that in fact this Probation Service employee was P's maternal aunt, and wondered how objective her assessment might have been.**

23 March 2001

There is an entry in the GP notes stating that A/E (Accident and Emergency) wanted P seen.

> **Comment**
>
> **We have not been able to ascertain that this attendance ever occurred, as we were not able to obtain any records, if indeed there were any.**

2 April 2001

Ms Giulia Pridmore, Probation Officer, was appointed as P's case manager. She informed Dr James by letter dated 27 April 2001.

10 April 2001

Ms Callus and Mr Read, CPN, saw P together at the Nuffield Clinic. Ms Callus completed a Referral Form (SS1):

> *"Client seen at N Clinic with Ted Read, CPN. Condition of sentence/probation order that client attends psychiatric service re monitoring/ medication etc. CPN to arrange regular depot injections/ monitoring. NFA from social work"*

In the Case Record Sheet she wrote

> *"P seen at the Nuffield clinic together with Ted Read, CPN. Arrangements made for medical assessment to sanction depot injection. P says social situation ok, agreed no role therefore for me at present. CLOSE"*.

Comment

In closing the case Ms Callus handed over P's care to Mr Read, as it had already been decided that it was more appropriate for a male member of staff to be involved. She told Dr James on several occasions that P was 'closed' to her. It was her understanding, as Mr Read was now involved, that he was now the Care Co-ordinator, and she had no recollection that a decision was made that Dr James was the Care Co-ordinator.

18 April 2001

Ms Pridmore wrote to P explaining that, as he had not kept his appointment the day before, he was in 'breach' of his Probation Order and as such he was being returned to Court. He was given another appointment for 23 April 2001.

26 April 2001

Ms Pridmore telephoned the Nuffield clinic to inform Dr James that P was in 'breach' of his Probation Order. She also wanted to know if a CPN had been allocated. As Dr James was on holiday she followed up this telephone call with a letter dated 27 April 2001. She wrote

"Since being P's new officer I have not been able to see him. He is as a consequence, of missing the compulsory appointment he has been sent, in Breach of his probation order. I would therefore be grateful if you could let me know when you last saw him what his current mental health status is, and whether he has been allocated a CPN and if so who this is".

14 May 2001

P attended the Probation Service saying he had not seen Ms Stewart and had been expecting an appointment. P confirmed he had received the 'breach' letter but not any other letters from the Probation Office. A further appointment was given to him to attend on 18 May 2001. He kept the appointment but due to a misunderstanding did not see Ms Pridmore, and was sent away. He was sent a further written appointment for 23 May 2001. Unfortunately this time he did not attend and so a further appointment was sent for 30 May 2001.

Comment

The correspondence to P from the Probation Officer was not copied to Dr James. Dr James does not appear to have responded to Ms Pridmore's letter of 27 April 2001.

P attended the Nuffield clinic without an appointment and was seen by Dr James and Mr Read. Mr Read administered a test dose of Zuclopenthixol and gave P an appointment to return on 25 May to have the full dose.

Dr James wrote to Dr Pollard (dictated but not sent until 4 June 2001) copying it to Ms Callus, Ms Pridmore and Mr Read. In the letter he said

"A note to let you know that I saw P again today. In fact he turned up at the Nuffield Clinic asking for his injection. My secretary checked with your surgery and it seems that he had not been along to receive his medication since 15.03.01, and in this case, I decided that he should have 100mgs test dose of Clopixol which Ted Read kindly administered. I would recommend 200mgs. 3 weekly from 25.5.01.

... I do hope that he will now keep his appointments with all those concerned in his care. Ted Read did tell me that he missed an appointment recently, although Jeannette said she last saw him on 15 March. I will keep in touch through Ted Read".

Comment

This test dose was administered despite P having had a previous test dose and follow up injection of Zuclopenthixol (Clopixol) as an inpatient whilst in

Dr James' care in 1999, and possibly whilst in prison as well. It only served to delay the therapeutic dose required in the treatment plan. Whilst we have reservations about this strategy in this situation, it is the case that some psychiatrists repeat test doses when there has been a gap in the receipt of depot injections of more than a few months.

15 May 2001

P attended GP surgery and entry stated *" doing o.k. Having depot regularly"*.

25 May 2001

Dr E Doyle, Senior House Officer to Dr James, wrote to P's GP to inform him that, as P had failed two appointments on 4 and 25 May (this one scheduled at the GP surgery), he was not sending another, but would be happy to do so if the GP so wished. The letter was dictated on this date but not sent until 6 June 2001.

30 May 2001

Mr Read wrote to P asking him to contact him to arrange another appointment.

P met with Ms Pridmore. He described his illness to her as "paranoid schizophrenia". He said he used drugs and his arms were badly bruised and scarred. He told her that *"he was the next coming"*, that he knew what people were thinking before they said anything and he considered himself a medium, and that he was able to understand animals, although he did not have any anymore as they had been beheaded by drug dealers. A further appointment was given for 1 June 2001, which he kept.

Comment

It was unfortunate that this information was not shared with Dr James. Ms Pridmore told us that, on reflection, she should have written to Dr James as she was a bit concerned about the kind of comments that P was making. Since she was new in the service at the time, and had had no training in mental health awareness since qualifying as a social worker, it did not cross her mind.

5 June 2001

P was due to commence the *Counting the Cost* Course but failed to attend.

Comment

These appointments count towards the Probation Standards for attendance and if not kept incur 'breach' proceedings.

6 June 2001

P telephoned Ms Pridmore. He had found the letter about attending the course and explained that he had a lockable post box and had not checked it. P went to the Nuffield Clinic to see Mr Read who was on annual leave.

Comment

To ensure continuity of care during Mr Read's annual leave there should have been arrangements for another CPN to see P and give him the depot injection especially as P infrequently kept appointments. Mr Read's practice was to hand over care of his patients to another nurse but frequently, because of staff shortages, this might well be someone in another team. In any event, when it was not possible to identify another nurse, all patients requiring ongoing support should be discussed with the manager.

12 June 2001

P attended the *'Counting the Cost'* Course – a course designed for offenders to examine their behaviour which led to their conviction. He was expected to attend 26 June, 3, 10, and 17 July 2001, which he did.

19 June 2001

Dr Julia Beresford, GP in the same practice as Dr Pollard, replied to Dr James' letter. She confirmed his oral medication as being Sertraline 100mgs and Olanzapine 15mgs nightly. P told her he was having regular depot injections and she assumed they were being given by one of the CPN team.

23 July 2001

P attended a Court hearing in response to breach letter in April. He was fined £25.

2 August 2001

Ms Jill Narin, Probation Support officer, wrote to Dr James introducing herself as P's new case manager. She wished to know if he could provide her with an update of P's current mental health status, and if he had been allocated a CPN.

Comment

We could find no evidence that this letter was answered, despite the fact that Mr Read had now met with P and was responsible for his depot injections.

9 August 2001

P did not attend for an appointment with Ms Narin. However, the following week she received a letter from P's GP. There is an entry in the GP notes, which confirmed this.

14 August 2001

Ms Narin wrote to P requesting that he attend on 21 August 2001, stating that if he did not attend he would be in 'breach' of his Order.

Mr Read wrote a letter, undated, to P inviting him to attend the Nuffield Clinic on 17 August 2001 to see both himself and Dr Doyle.

16 August 2001

P told Ms Narin he had not had an injection since May, and he should have it every two weeks. She advised him to see the CPN the following day, and that taking amphetamines would have an adverse effect on his prescribed medication. He had a further appointment for 21 August 2001. Ms Narin also wrote to Mr Read requesting information about P's appointments and treatment, and reminding him that P was subject of a Probation Order with a Condition of Treatment.

17 August 2001

P attended the doctor's clinic, which had been cancelled. Mr Read saw him but did not give him the depot injection as there was no doctor present.

Comment

This was an ideal opportunity to carry out and document a nursing assessment, as well as commence the depot injections. It was also an opportunity to arrange to see P at home to complete a full assessment. Mr Read asserted that it was his practice, and that of other nurses, that before commencing the regime of ongoing depot medication, patients were reviewed by a doctor.

Mr Read insisted to us on more than one occasion that some of his documentation was missing. This aspect of his practice and these specific claims were investigated during the internal investigation, and were not part of the terms of reference of this Inquiry. We comment elsewhere on the conduct of the internal investigation.

Recommendation

We recommend that the Trust reviews its policy on the administration of depot injections following test doses and gaps between doses.

21 August 2001

P saw Ms Narin and told her he had seen the CPN and the doctor the week before. His supervision plan was explained to him, and he signed it.

22 August 2001

Dr James replied to Ms Narin's letter of 2 August 2001. He said he had heard that she was concerned about P's rather elusive nature. He said

> *"... despite our best attempts to contact him we have not always been successful ...*
>
> *... As to his depot neuroleptic medication he had a test dose on the 25th May and the plan is he will to have to have another test dose before proceeding with this medication. As you know Ted Read is the CPN in this case and he has arranged to see P tomorrow".*

24 August 2001

P did not keep his appointment with Dr Doyle who wrote (5 September) to Ms Narin and copied it to Mr Read, who he was expected to be in contact with P.

> *"...this gentleman did not turn up today. Ted Read, his CPN will be in contact with him again to arrange a further date".*

4 September 2001

P kept his appointment with Ms Narin who recorded

> *"Agitated as he had been washing his clothes in the bath and left the tap running. Was not aware of appointment with Ted Read on 23 gave him telephone number to call and arrange further appointment, said would write*
> *Says he has now sorted out post box*
> *Medication not fully sorted yet and he is still taking amphetamines…".*

6 September 2001

Ms Narin also wrote to Mr Read

> *"I received a letter from Dr James stating that the above had an appointment with you on the 23rd of August. I interviewed P on the 4th September and he claims he was not aware of that appointment. I have advised him to contact Nuffield Clinic for another appointment. Perhaps you could write and advise the current situation".*

12 September 2001

Mr Read wrote, by hand, to P asking him to attend an appointment on 5 October 2001 to see himself and Dr James. He also wrote to Ms Narin informing her of the appointment and the others that P had not kept. He hoped to give P his injection on this day.

27 September 2001

Ms Narin wrote a further letter to Mr Read after seeing P. P was not aware of the appointment for 5 October to see Dr James, and she gave him an appointment slip to remind him. Ms Narin recorded that P seemed very down and that he said he was depressed, which he attributed to having been single for three years. He did not want to talk much and did not want to get into trouble again. She made another appointment for 25 October 2001.

5 October 2001

P did not keep his appointment with Dr James, who wrote to Mr Read that day, but dated 17 October 2001, copying it to Dr Pollard and Ms Narin:

> *"I see that he (P) failed to keep an appointment with Dr Doyle previously in August. Obviously there must be concern that he does keep an appointment and I wondered if you in fact were seeing him regularly and whether he needs receiving his depot neuroleptic as planned. I gather Dr Pollard might well be issuing prescriptions for his oral medication and I will send him a copy of this letter to verify".*

25 October 2001

Dr Pollard replied to Dr James' letter of 17 October 2001. He confirmed that P was collecting supplies for Sertraline 100mgs and Olanzapine 7.5 x2 nightly. The last supply was 18 September. He went on to say that P had not been supplied with Clopixol (Zuclopenthixol) since March 2001, and that there was no indication that it was being administered in the surgery. P attended the Probation Service office, saw the Duty Officer and was given another appointment for 22 November 2001.

14 November 2001

Ms Pauline Nichols, Probation Support Officer, wrote to P informing him that she was taking over his care whilst Ms Narin was on sick leave. She confirmed his next appointment for 22 November 2001, changing the time to 3pm. He did not keep this appointment and was sent a letter explaining that he was in 'breach' of his Probation Order. He was requested to attend the office 6 December 2001, but again he did not attend.

23 November 2001

Mr Read wrote to Dr James, in reply to his letter dated 17 October 2001, copying it to Dr Pollard but not the Probation Officer. He told Dr James that he had not seen P since 17 August and finished the letter *"please let me know if you want me to do anything further"*.

Comment

Dr James did not reply to this letter, but told us that he spoke to Mr Read and asked him to *"keep on trying and give the depot and to let the Probation Service know what was happening with P being difficult to see"*. His assumption had been that Mr Read was visiting frequently and regularly.

We were surprised that this did this not prompt a case conference, as P had not received any Zuclopenthixol depot injections, other than test doses, since coming out of prison in March of that year. We were also surprised that there was no discussion with the PCLT manager to decide on a further strategy, or more constructive advice to Mr Read from Dr James.

This appears to be the last entry in the records for 2001. We are not clear as to why Mr Read felt that he needed further instruction when he had never achieved his first objective of giving the depot injection. Mr Read told us that, in his view, he was not the Care Co-ordinator for P. He said that he was assessing P to see whether he should be taken on to his caseload, or whether Assertive Outreach was more suitable. No evidence of an assessment has come to light. Mr Read told us that he attempted to visit P at approximately weekly intervals for months on end. We find it hard to understand this and consider that the following questions should have been asked:

- **If P was difficult to follow-up why was he not referred to Assertive Outreach?**
- **At what point should Mr Read have considered his assessment complete or alternatively impossible to complete?**

CHAPTER 6

P'S CONTACT WITH ANY OF THE STATUTORY SERVICES IN 2002

2 January 2002

A 'breach' letter was sent to P as he failed to keep his Probation Service appointment on 22 November, however this letter was withdrawn and Ms Nichols wrote again asking him to attend the office on the 7 January 2002. He did not attend and was sent a 'breach' letter with another appointment for 11 January 2002, but he failed to keep this one as well.

5 February 2002

P failed to appear in Court and a Warrant was issued for his arrest. He was duly arrested on 22 February and appeared in Court. The Probation Order was revoked and he was given a Conditional Discharge for the original offence of driving whilst disqualified.

25 April 2002

Mr McGarry, the Housing Estate Manager, telephoned Ms Callus – he knew that she had previously been P's keyworker - to inform her of concerns about P. P had been seen outside his flat in his dressing gown 'flashing' at young girls passing by, and lighting fires in the courtyard. She agreed to telephone the mental health services to arrange for a Mental Health Act assessment. As P was not shown as an active case on the electronic system, Ms Callus was directed to the Gateway Service, which was the part of the mental health service responsible for organising assessments. Ms Callus was aware that P was not open on the electronic register to Mr Read, and that he had not succeeded in maintaining contact.

The Gateway duty officer took the view that the mental health service was not in a position to make an assessment as she was not requesting a MHA 1983 assessment, and so Ms Callus contacted Dr Pollard, P's GP, who agreed to visit P. He agreed with Ms Callus that it was acceptable to go the following day. Ms Callus decided not to visit herself as she had other commitments and because she had been advised to go through the route of contacting the GP.

She informed Ms Rose Hoyle, PCLT CPN, of the situation. Dr Pollard visited P but was unable to make contact. Mr Read subsequently told the police that he was aware of these

concerns at this time, but took the view that Ms Hoyle would deal with the matter as she saw fit.

Comment

The Trust medical/PCLT notes do not contain any reference to either of these contacts.

Dr Pollard telephoned the Gateway co-ordinator to inform the service about the outcome of his visit, which led to the Gateway co-ordinator recording that P was either not at home or not answering the door when the GP called to see him.

29 April 2002

Mr McGarry again telephoned Ms Callus to inform her of an incident the previous evening, when the Police and Fire services were called. She informed Mr McGarry about the possible route of action that may have to be taken either using section 136 MHA 1983 or through the Court, and she agreed to keep him informed of any further action. Following this she telephoned the Gateway Service, from which she learned that the Police had not made any contact with the mental health services.

1 May 2002

Dr Pollard wrote to Dr James

"Just to update you on this patient. I was contacted by Jeannette Callus ASW, yesterday because of concerns that had been expressed by neighbours of P's. Apparently he was 'flashing' in the courtyard and also setting fires. I see from the notes that in fact there has been no contact with P since August last year and he has not collected any medication since October 1st 2001.

I went around to his flat today but unfortunately I was unable to make any contact but I put a note though the door asking him to attend surgery, although I expect it is highly unlikely that he will.

I understand he was under a treatment order it sounds as if things are beginning to fall apart and I expect your CPN will need to make contact".

Comment

Dr Pollard told us that he unable to understand why his letter was not 'perceived' as urgent, and he was sure that there was an implicit sense of urgency in his letter. This was borne out by the fact that he stated that P had had no contact with anyone since August 2001 despite the treatment order, that things were beginning to fall apart, that P was setting fires, and that he had not collected any medication since October 2001.

3 May 2002

Ms Callus informed Dr James about P's recent behaviour. Dr James also received the letter from Dr Pollard making a note to discuss it with the team.

P's ex girlfriend telephoned Gateway Service seeking some advice, as P wanted contact with their daughter.

7 May 2002

Dr James told us he discussed the GP letter at the team meeting held that day, as the day before had been a Bank Holiday, and therefore the regular allocation meeting did not take place. Mr Read was present, as was Ms Murphy, but he had no recollection of any discussion about P.

Comment

The team's practice was to document only new referrals and not to detail other ongoing patients, as Dr James considered there was not enough time. We were pleased to learn that this practice has now changed and all patients discussed are recorded.

The notes of the meeting that day do not record P being discussed, either because he was not a new referral as Dr James has indicated, or because he was not mentioned as Mr Read maintains. We do know, however, that both Mr Read and Dr James were aware of concerns regarding P by this stage.

Dr James told Mrs Howard in the internal investigation proceedings:

"My intention was to have a full PCLT discussion given the previous difficulties with engagement and wanted to use this to overcome any possible reluctance to take P on. I wanted a proper discussion about him and wanted Jeanette Callus involved again, I wanted some commitment. I was aware of events the previous year and lack of contact. I felt it would be reasonable to keep it for another week. I did not see excessive urgency in the GP's letter. If the GP had felt it to be urgent I felt he would have phoned me, he didn't and I did not view the letter as urgent. My main concern was to get commitment from the team to do a full review. It would have allowed a proper informed discussion and try yet again and reinstate some team involvement. It is my impression that the team did not want to work with him. They felt pressured and there was reluctance to get involved. I didn't give them difficult cases because I am aware of how they felt – I was trying to be supportive. Anyone complex immediately went to medical staff in the first instance. This was about the reluctance of the team to be involved. I tried to work with this situation in the best way I could ...".

Comment

Dr James wished Ms Callus to become involved again, but she was on holiday until the next week and so it is possible that P was not discussed. Dr James told Ms Howard that he was unable to understand why neither Mr Read nor anyone else from the team tried to make further contact with P.

Nonetheless Dr James was now aware that he had not seen P since June 2001, and that there had been no contact with the CPN or with the GP since August 2001. It was most unfortunate that he did not consider Dr Pollard's letter to be urgent.

We do not understand why this letter did not prompt a joint visit with Dr James and Mr Read, bearing in mind that P lived only 150 yards away.

12 May 2002

Another tenant who lived at the same house as P went downstairs at about 07.30hrs and saw that the panes of glass from the inner hall doors were broken, and found Mr Warnes dead in the vestibule. He telephoned the police who attended the scene.

P was charged with murder.

P pleaded guilty to manslaughter with diminished responsibility. He was made subject to a Hospital Order with an accompanying Restrictions Order (section 37/41).

CHAPTER 7

P'S PRESENTATION AND MANAGEMENT

Care and Treatment

In order to provide satisfactory care and treatment for P, an accurate appraisal of his mental health problems was required. In fact by May 1998, when P was discharged from Hartford Ward after his admission there under Section 2 of the Mental Health Act 1983, a fairly clear picture of P's mental health problems was already available to the local service. He was noted to have a psychotic mental illness, to have history of substance abuse (particularly amphetamines) which had been long-standing, he already showed signs of poor engagement with mental health services, and he had a forensic history, which was exacerbated by his mental illness and his misuse of substances. When unwell he was noted to be impulsive and at times to act dangerously. Furthermore, information was available about his relapse pattern. Subsequent contacts with mental health services only served to underline the accuracy of this initial assessment. As time passed it became clear that he had a schizophrenic illness, in other words he was likely to suffer relapses in the future, the likelihood of which could be reduced by a comprehensive package of care and treatment.

From the above we can see that P had complex needs. He clearly needed, therefore, a detailed needs assessment, and also a detailed risk assessment. Detailed assessment of needs and risk are characteristically part of proper care planning. However, no formal written care plan was ever recorded for P. A social care assessment was completed in May 1998, and P's social care needs were reviewed by his social worker in April 2001 when she reviewed P with his community psychiatric nurse. No formal risk assessment was ever recorded for P, although information concerning risk was collated to some extent in the various court reports prepared by Dr James. The failure to examine in detail the alleged offence against a fellow patient is a cause for concern.

What was required was a comprehensive assessment of P, which could then lead on to a comprehensive plan of care. Whilst it is somewhat arbitrary to separate out various facets of care and treatment because of the significant overlaps, we can, for the sake of convenience, consider P's care and treatment needs in terms of the medical and nursing needs, the need for psychological interventions, and the need for social interventions.

Since P was known to have a severe and enduring mental illness with a likelihood of further relapses, it was essential that he should receive regular treatment for his mental illness in the form of antipsychotic medication, and that his progress should be regularly monitored and reviewed. In addition people with severe and enduring mental illnesses have a higher rate of physical health problems than the general population, and also P had a history of drug misuse including using drugs intravenously. Regular monitoring and review of his physical health care needs was also required, with close liaison with primary care. The issue of Dual Diagnosis is discussed elsewhere in this report.

As the chronology of care makes clear, P did not receive regular antipsychotic medication from mental health services, and he was not regularly seen and reviewed. It was well established that he could not be relied upon to take oral medication consistently, and so it was essential that he receive regular injections of depot antipsychotic medication. In addition liaison with primary care was poor, and his physical health care needs were not identified.

The minimum psychological interventions required by P included work to attempt to improve his engagement with mental health services, education regarding substance misuse, and assistance with strategies in order to try to reduce the use of substances and the harm that might arise from them. P also had intermittent low mood, which might have prompted additional psychological support.

Despite the fact that P had six GCSEs, he was known to have limited independent living skills. There had been problems with his housing, he was known to be estranged from his family and relatively socially isolated. Persistent attempts were made by P's social worker to attempt to address his social care needs. At the time that his episode of care with his social worker was closed in April 2001 P did not wish to receive any further assistance with respect to those needs. He had, however, formed a relationship with his social worker by this stage, and one could argue that her continuing input might have helped the client for that very reason. However, this comment does not imply a criticism for the social worker at that point.

We have thus far discussed aspects of care and treatment that might have been delivered to P. An equally important requirement was a way of working with P.

Firstly, it was clear that a range of interventions was required, which would necessitate the involvement of a multi-disciplinary team. For that team to deliver care appropriately, effective relationships between different practitioners, clarity regarding their roles, and good and regular communication were all required. The team should have regularly discussed P's progress, because his needs were complex, and such needs characteristically change with the passage of time and in response to changing circumstances. As is discussed elsewhere in this report, multi-disciplinary team working in this service with respect to P left much to be desired. For example, when the CPN appeared to be out of his depth help from colleagues should have been forthcoming.

Secondly, effective working between different agencies was required. The various agencies involved included mental health services, primary care, housing, and probation. We have identified deficiencies elsewhere with respect to communication and liaison between these agencies, failure to come together to devise and implement packages of care under the care programme approach, and the lack of a shared understanding of the different roles and responsibilities of the different practitioners. We have noted the absence of effective care co-ordination in this case.

As has been indicated earlier P was poorly engaged with mental health services, had a history of poor compliance with medication, and a history of repeated relapse associated with substance misuse and impulsive and potentially dangerous behaviour. P clearly required assertive follow-up and the effective promotion of engagement with mental health services. P had previously required assessment and treatment under the Mental Health Act 1983. Dropping in hand written notes regarding appointments and knocking at P's front door was not sufficiently assertive. Active collaboration with other agencies was required; regular and persistent visits to his accommodation, and attempts to speak to his neighbours (he lived in a house in multiple occupation) and family would all have been wise. Expressions of concern from neighbours, in the light of his previous history, should have prompted a home visit by his consultant and CPN, and when that failed steps should have been taken to undertake an assessment under the Mental Health Act 1983. In addition to the unsatisfactory response by Mental Health practitioners in May 2002, we have also identified the insistence on a referral by the GP by the Gateway Service as a barrier to care for a seriously ill man, ie a system failure.

Dual Diagnosis and substance misuse

We were told on a number of occasions by staff who interviewed P, and by P himself, that substance misuse (his use of non-prescribed drugs/stimulants) was a frequent and regular problem. They stated, and there was evidence, that it interfered with his functioning and his ability to maintain contact with agencies involved in his care and treatment. P acknowledged this to the Inquiry.

It was noted that he had presented at numerous times during various care spells as affected by the use of cannabis, stimulants and crack cocaine.

There is no doubt that many mental health practitioners in hospital or community services over the last 10 years would offer experiences of the dramatic increase in the use by mental health service users of recreational drugs. This has been caused by the increasing availability of these drugs and to falling prices charged for them, even in illegal markets. This has also been caused by the development of so-called 'designer drugs', and the complex and rapid development of new lines or products, which provide challenges for consumers and their advisors in terms of impact of use, side effects, safety and impact upon prescribed psychiatric medication.

P himself was said, in the latter stages of his involvement with Plymouth Primary Care Trust prior to the incident in May 2002, to be regularly using stimulants. He had reported this to a number of professionals, his method of injecting and the frequency of his habit were known. It was recorded that drug use and erratic mood swings were a feature of his involvement with the Police and his criminal behaviour.

The Inquiry was told by P's allocated CPN that he knew P had been taking Amphetamines, and there had been a pattern of him doing this over years. He said he did this to help with low mood. It was written in his case notes that his use of amphetamines could lead to a relapse in his mental state and that his used them to self-treat low mood. It was recorded by his GP that when Dr Unwin assessed P in 1996/7 he was using a variety of illicit drugs and suffering from a psychotic state induced partly by drug use. When assessed in 1998 by Dr Taye, SHO to Dr H James, P was found to screen positive for amphetamines and a continuing drug use of speed, amphetamines, ecstasy and LSD.

Stimulants

These include caffeine and tobacco as well as amphetamines, anabolic steroids, 'poppers', hallucinogenic amphetamines (ecstasy), cocaine and crack. They act on the central nervous system and increase brain activity. Users generally feel more confident and alert, are able to stay awake for longer or perform physical tasks for a long period of time. With all except tobacco, high doses can cause nervousness and anxiety. Apart from tobacco and caffeine, stimulants can cause temporary feelings of paranoia. (Mental Health Foundation *Fact Sheet* 2002)

There is an added dimension that should be recognised. There is evidence that the consumption of certain types of recreational drugs can lead to the development of mental health problems and the experience of the symptoms of mental illness. In mental health services this has led to a recognition of the cause of some psychiatric episodes as a drug induced psychosis, and defining ongoing work with people with mental health problems who also use non prescribed, street or recreational drugs as 'Dual Diagnosis'.

In the evidence we heard about P's frequent presentations as a substance user, we did not find any significant or concerted attempt to address his substance use. This could have been done by either offering him a referral to an appropriate specialist agency, or to conduct an assessment of his needs for detoxification and treatment or rehabilitation services, dependant upon his motivation to accept such help and intervention by a substance misuse worker.

A number of mental health service users report substance misuse of drugs and the effects of this on their mental well being or contraindications to their prescribed psychiatric medication. For this reason there should be identified drug and alcohol practitioners available in or to community mental health teams, to work with identified patients with Dual Diagnosis.

As P was never established on the medication regime thought necessary, concerns about contra-indication were redundant. However, promoting his engagement with services to prevent relapse or further illness developing was critical. There was a failure to recognise the significance of his substance misuse and its likely impact upon his ability to maintain contact with services. When taking evidence we were told by the allocated CPN and two of

his managers that they could not recall any training or information being given to the team in which P's case was held about drug or alcohol use and guidance to promote working with Dual Diagnosis.

Additionally, faced with this presentation, there was a failure to offer appropriate follow up assessment, treatment or rehabilitation services by substance misuse practitioners allied to mental health services, or to refer this to a local voluntary sector provider, or to Commissioners to look to develop such a service.

Research is available and examples of best practice were being developed in 1998. In Kingston (CDAT), North Birmingham (Compass) and mid Cheshire (Dual Diagnosis Team) services were being established to develop mental health services that respond to the *"growing gap between substance misuse and mental health services"* and to provide a response to service users with enduring mental health problems who exhibited little motivation to drug or alcohol treatments, *Dual Diagnosis Good Practice Guide* (Department Of Health 2002).

Whilst wholesale reorganisation is not always possible, the elements and understandings of new developments can be cascaded to practitioners, to develop responses to particular service users needs in their locality.

CHAPTER 8

THE USE OF THE CARE PROGRAMME APPROACH

The Care Programme Approach (CPA) was first introduced in the UK by the Department of Health in 1991. It is the framework for providing care for all service users accepted by the specialist mental health services of a Trust/PCT, or otherwise configured mental health service. It includes care management - the care planning process of the Local Authority - with whom mental health services are often delivered through partnership arrangements.

Despite CPA being introduced in April 1991, with a view to improving the delivery of care to individuals with severe mental health problems, many services around the United Kingdom are still striving to achieve more effective processes in this respect.

In October 1999, the NHS Executive published a policy booklet entitled *Effective Care Co-ordination in Mental Health Services ~ Modernising the Care Programme Approach,* and this introduced the various changes of the CPA, which included the establishment of the Care Co-ordinator role.

In 2002, at the time of the incident that is the subject of this Inquiry, the Plymouth PCT and Devon County Council did not have an agreed CPA/Care Management framework operational across the services providing care and treatment to P. We were shown documents that represented the CPA policy then in force.

We identified the following deficits in the arrangements that should have been in place for 2002 as:

- No adequate integration of roles and tasks of health, social care, criminal justice and voluntary service staff in relation to CPA operation.
- No guidance about allocation of Care Co-ordinator.
- No common or standardised statutory CPA paperwork.
- No guidance for staff about review time scales and service users who do not attend (DNA) or do not respond to follow up.
- No risk assessment format used to draw up necessary risk management plan by a care team.

The case recordings kept on P showed that each professional involved, even those from the same agency in the same office, kept an individual file on P. Therefore there was not a common document, which was an expectation of a CPA system, in place in 2002. There were a number of findings in the internal investigation about the deficits in the care co-ordination in this case, which concluded that there was no system that ensured a Care Co-ordinator was allocated, and no alerts of this to advise those who might have sought a remedy.

There are four key elements that make up the CPA process:

1. The assessment of an individual's health and social care needs.
2. The development of a Care Plan which meets those needs.
3. The need to identify a professional within the mental health service who is responsible for co-ordinating the Care Plan.
4. A regular review of progress and the effectiveness of the Care Plan.

In 2004, we concluded that these basic requirements were being met and that, furthermore, an ongoing CPA and MHA staff training and development programme was in place. Nevertheless, in the documents available to us, there was no assessment tool or format that assesses or is a summary of needs. There was a failure to state the needs in the assessment and for it to say simply what services are needed. There is evidence that a CPA care plan was considered and how this might be operated, but no agreement was understood about how, when, and by whom this was to be reviewed.

CPA is the underpinning structure for providing care that runs through every clinical team, whether they are based within the Community or Inpatient Services. It applies to every service user accepted by any of the mental health services, such as those for Adults of Working Age, mental health services for Older People, Learning Disability Services and Adolescent mental health services.

Following referral and initial assessment, each service user, if accepted as needing the service, is allocated to a level of CPA. In 2001, Dept of Health guidance was issued requiring there to be two levels of CPA, which are intended to meet the different levels of need a service user may have. The CPA level reflects the complexity of the mental health needs an

individual has and the range of services required to meet those needs. The following indicate some of the typical differences between the needs of people on either level.

The characteristics of people on Standard CPA are:

- They require the support and intervention of one agency or discipline or low key support from more than one agency or discipline.
- They are more able to self-manage their mental health problems.
- They have an active informal support network.
- They pose little danger to themselves or others.
- They are more likely to maintain appropriate contact with services.

The characteristics of people on Enhanced CPA are:

- They have multiple care needs that require inter-agency co-ordination.
- They may be in contact with a number of different agencies and have multiple care needs.
- They are likely to require more frequent and intensive interventions.
- They are more likely to have mental health problems co-existing with other problems such as substance (eg drugs, alcohol) misuse.
- They are more likely to present a significant risk to themselves or others because of their mental health problems.
- They are more likely to disengage from services in an unplanned way.

P clearly had both needs and sufficient history in mental health services prior to 2002 to be considered appropriate for Enhanced CPA. There is little doubt that all the above characteristics were present in his case. Even if the health and social care staff were properly integrated into a cohesive community mental health service, the need for them to communicate effectively with staff in the Probation Service was critical.

Comment

On a number of occasions, just prior to the incident, crucial observations of P's relapsing mental state were not effectively communicated and acted on by those responsible for mental health treatment in the care team.

As a service user's needs change from time to time, they may transfer from one level of CPA to another, based upon assessment of needs and review of progress. Every service user, whether allocated to Standard or Enhanced levels of CPA, will have a named Care Co-ordinator. The Care Co-ordinator is the member of the mental health team who is responsible and best placed to oversee the Care Plan and for ensuring contact with the service user is maintained. Care Co-ordinators can come from a variety of professions including medical, nursing, social work, occupational therapy and psychology.

For service users on Standard CPA, the Care Co-ordinator may be the only member of the mental health team that the service user sees, whereas for Enhanced CPA, the Care Co-ordinator may be one of a number of services or individuals who help make the Care Plan work. The Care Co-ordinator's name and contact details will always be clearly notified to the service user, and is the first port of call in the event of any difficulties or queries arising.

Comment

There was a lack of clarity as to who was the Care Co-ordinator. Dr James thought it was Mr Read and he thought it was Dr James. In fact Dr James wanted Ms Callus to become involved in May 2002, which would have led to P being considered as Enhanced CPA.

Although the principles of CPA apply to both Standard and Enhanced levels, it works slightly differently at each level. For service users on Enhanced CPA, the forum for agreeing the Care Plan and how an individual's needs are to be met is through a formally arranged meeting of all the relevant parties. The most important person at this meeting is the service user whose views and wishes will help inform the development of the Care Plan. These meetings can be quite daunting for some service users and therefore they can choose to be accompanied by a friend, relative or carer.

The mental health charities such as MIND or similar local voluntary organisations can provide advocacy services to service users and may be commissioned specifically to provide advocates to support service users in these meetings. Staff can assist in making these arrangements. Other people who may be present at the meeting include the Consultant Psychiatrist, nursing staff, social workers or other members of the multi-disciplinary team

involved in providing care. Based upon individual requirements as determined by the Care Co-ordinator, other agencies with a professional interest in the service users well-being will also attend the meeting. This helps to ensure there are no misunderstandings and services are properly co-ordinated

Recommendation
We recommend that the Trust reviews the CPA policy and its best practice guidance to include who should chair the meeting, where it should and should not be held, and how confidentiality is maintained.

Once everyone has had an opportunity to contribute, a Care Plan is agreed that summarises actions to meet the service user's needs and how support will be provided for them. A risk assessment should be discussed and agreed for service users on Enhanced CPA.

The meeting should be recorded and a copy of the written Care Plan with the outcomes of the meeting provided to everyone who was present, plus anyone else who needs to be aware of the agreements reached. The service user should have a final opportunity to comment on the written Care Plan, and amendments made based on those comments.

At the end of each Enhanced CPA meeting there should be an agreement as to when the review meeting should be held. The process for review meetings continues along the same lines. The review meeting should consider how effective the Care Plan has been and how well and supported the service user feels. If necessary the Care Plan can be amended or, if it is still working well, continue along similar lines.

Recommendation
We recommend that the Trust regularly reviews the outcome of CPA meetings to ensure that the actions are carried out and that a nominated person is accountable for the follow up of any interventions.

Advocacy

Service user empowerment and involvement.

The provision of CPA can be augmented by service user involvement and Advocacy, so that service users can be assisted to engage in this process through the use of advocacy services. Advocates often occupy a position between service users and professionals. In this position they are frequently able to promote the relationship necessary between the service user and professionals where it is subject to compromise and/or breakdown.

Advocacy services are frequently provided by independent voluntary sector organisations, which may in themselves be seen to be service user led. As a result, commissioning mental health services often involves setting up and maintaining funded advocacy services. The Inquiry received evidence from staff responsible for commissioning services, as well as senior managers and clinicians who had responsibility for promoting service development. This was not considered prior to and at the time of this incident.

It was evident to the Inquiry team that the mental health services provided to P at the time of the incident in May 2002 did not have provision to offer him the services of an Advocate. There were a number of points in his contact with Primary Care Trust, Local Authority and Probation services during 2001 and 2002 where he demonstrated willingness and ability to engage with services. It was a major issue for the Internal Investigation and this Inquiry that little attempt was made to co-ordinate the care being given to P. It has been found that there were individual failings that led to this. The clinical staff operated within a structure of clinical and management supervision, which should have ensured that there was at the time an adequate range and diversity of service provision that included user involvement, empowerment and advocacy.

The range of services available to P was insufficiently diverse relative to what should have been expected at that time of a National Service Framework, Local Implementation Team.

Recommendation

We recommend that the PCT, through the Local Implementation Team (LIT), should ensure the provision of a community and inpatient mental health advocate service that is able to represent service users where appropriate at care and treatment forums in the service.

CHAPTER 9

TENSIONS BETWEEN STAFF AND MANAGEMENT, AND THE CONSEQUENCES

Sequence of events

In 1998 mental health services were managed as part of the Plymouth Community Services NHS Trust, and became part of the Primary Care NHS Trust in 2001, following the merger of the Plymouth Community Services NHS Trust and the Plymouth Primary Care group. The Trust has a population of approximately 550,000, with 125,000 people living within the environs of the city.

Following the closure of Moorhaven Hospital, the delivery of adult mental health services for Plymouth had evolved towards an increased community focus. The services were configured as:

- Acute inpatient services
- Rehabilitation inpatient services
- Community mental health teams services
- Primary care counselling services
- Psychiatric advisory services
- Emergency psychiatric services
- Day services and work projects
- Assertive rehabilitation community team
- In patient drugs treatment service.

In 1997 a consultation process was undertaken to 'reconfigure' the adult mental health services away from the traditional generic secondary care Community Mental Health Teams (CMHT) towards the provision of a range of specialist teams within each of the identified localities, these being:

- Primary care liaison teams
- Assertive outreach
- Psychiatric emergency/home treatment/ emergency service
- Access to acute inpatient beds.

January 1998

The then Chief Executive, Mr Paul Roberts, changed the Trust management structure and introduced a new post, Director of Mental Health and Learning Disability Services. The person acting into the position was unsuccessful at interview, and Mr Phil Confue was appointed to implement the reconfigured service. The unsuccessful person, Mr Memo Musa, the Deputy Director of Mental Health, became the Inner City Manager but did not stay for much longer in the Trust.

May 1998

An implementation team was appointed and met weekly to monitor the implementation plan and deal with issues as they arose. Between June and September 1998 new job descriptions were agreed with a series of 'slotting in' interviews taking place. A draft Operational Policy was circulated to all staff, GPs and staff working in the Glenbourne Inpatient Unit.

From 1 September 1998 the Plymouth Community Services, including mental health services, were divided into three localities. Within each of the localities the core services were seen as Primary Care Liaison teams (PCLT) and accompanying inpatient facility. Access to emergency assessment was via the developing home treatment/psychiatric emergency services for the inner city locality. Staff expressed concerns that there were insufficient numbers in some of the teams, and that there was a lack of clarity in the new roles. Staff complained to us that they had increased caseloads, as it was difficult to refer some clients on whilst taking on new ones. They were unclear whether they were working to a 'GP attachment' or a 'GP liaison' model. Other contributory factors included staff sickness, reluctance to take clinical risks with patients not previously known, and having to respond to GP referrals.

The Trust population in Plymouth City is seen as mixed deprivation - some areas on the edges of the city being of low deprivation while others, particularly those situated closer to the 'waterfront', being of significantly higher level. We were told that on the whole the staff working in the Inner City teams (population approximately 100,000) were the only ones who had difficulties settling into this new way of working.

January 1999

The Inner City manager left and the Inner City PCLT manager was absent, which led to staff feeling there was no one to lead them through this time of transition and change. In the meantime Mr Sean Swaffield-Conlon, Locality Manager – Outer City Locality, also became the manager for the Inner City Locality, as the Trust had not made an appointment to this post despite holding a series of interviews.

March 1999

Ms Rayna McDonald-Birch, a NHS management trainee, was appointed as acting assistant Locality Manager to cover the Inner City PCLT. As a NHS management trainee, she would have had a variety of middle management roles without any particular expertise, and was directly accountable to the Chief Executive, who had previously managed an acute Trust. As a way of resolving day to day issues an 'away day' was arranged to discuss clerical support, absence cover arrangements, staffing levels and caseload audit. A further meeting was arranged for June.

July 1999

Mr Mike Hall was appointed as the manager for the Inner City PCLT. At the same time GPs were unhappy with the lack of identified CPN time and so extra CPN support was provided to them.

September 1999

Ms McDonald-Birch left the Trust and Mr David Furze, who had been the Senior Human Resources (HR) Manager supporting the management team through the reconfiguration process, was appointed Assistant Locality Manager. His previous experience was in mental health services for the elderly.

October 1999

Mr Paul Sanford, CPA and Mental Health Act Administrator, wrote to David Furze about concerns over the lack of clients registered on electronic system recording (ePEX), neither were there details of who was the Care Co-ordinator and what contingency plan was in place.

Two of the Consultants changed roles, resulting in Dr Tomlinson moving from the Rural PCLT to take over the Home Treatment Team. He wished to follow the Birmingham Model, which had implications for the Psychiatric Assessment Service (PAS), and the Emergency Psychiatric Service (EPS). PCLT Staff were expected to participate in PAS on a rota basis, including some weekends.

A development programme was arranged for PCLT G grade staff, including supervision skills and managing a budget. This latter subject was seen as irrelevant by some of the staff, who wanted to change the programme. For whatever reason, senior managers felt that the programme was sabotaged and perceived that some staff were critical of any management.

November 1999

There was still a lack of clarity of how emergency referrals were handled, and an away day with medical and nursing staff was arranged to clarify how referrals should be made. The operational policy for the PCLT was still not finalised.

December 1999

Mr Swaffield-Conlon wrote to Mrs P Robinson, CPN and the chair of the Nurse Forum, reminding her that it was not set up to consider management issues and that its future was under consideration. The CPN Forum was developed to provide peer support and to discuss service developments, but was later disbanded as managers felt that it became nothing more than a ‘talking shop’ and trade union forum.

Mr Swaffield-Conlon invited Mr Martin Ringrose, Director of Human Resources, to a staff meeting to discuss the behaviour of the CPNs over the previous months, because they had been bypassing him as their line manger and going straight to Mr Ringrose. The staff had approached him about the new arrangements for the ‘out of hours’ service, which left Mr Swaffield-Conlon feeling that his instructions were being undermined. The meeting did not go well and Mr Swaffield-Conlon was left feeling that he was the ‘problem’ and unsupported by Mr Ringrose.

Comment

Mr Ringrose had anticipated that about 10 or so staff would attend, but in the event many more staff members attended and this would have changed the nature of the meeting. Nonetheless it did not help with Mr Swaffield-Conlon's feeling of helplessness and lack of support from the Director of human resources.

Mr Swaffield-Conlon told us that he found the next few months quite difficult and at the end of March 2000 he commenced a long period of sick leave, after which he did not return to work in Plymouth and left the health service.

Mrs Karen Howard had joined the Trust the previous year and managed the CPNs in the Assertive Outreach Service (AOS). She undertook an audit of the AOS CPN's notes that demonstrated that at least six members of staff had not kept appropriate records. Those staff were accordingly disciplined.

Mr Furze was absent on sick leave from April 2000 until July 2000, and in June Mrs Howard was asked to take on more responsibility and became the acting Assistant Locality Manager. This role provided advice and support to Ms Longbottom, Acute Day Services Manager, who also became the acting manager of East and West Waterfront PCLT.

November 2000

Mr Mike Hall had a period of 'family leave' and Ms Elaine Longbottom, was asked to be manager of the Waterfront PCLT in an 'acting' capacity.

Comment

Initially Ms Longbottom was intended to take on this extra responsibility for two months but she remained in this situation for two years.

Dr S Rideout, the Occupational Health Consultant, had a conversation with Mr Confue, Director of Mental Health and Learning Disability Services, as two consultations with nurses from the Waterfront PCLT had raised issues of poor record keeping. An audit was undertaken of the notes kept by CPNs working in the Inner City (Waterfront east and west)

PCLT. The result of this audit was described to us as *"appalling"* with only about three CPNs keeping reasonable records. These notes should have been a 'running' record about the care, interventions, crisis, progress, medications, support, etc provided to patients who were on individual nurses' caseloads. This situation was discussed with Mr Confue and on the advice of Mr Ringrose no disciplinary action was taken because of the number of nurses involved.

December 2000

Mr Confue undertook a caseload review, following which each member of staff had a caseload of approximately 35. There was also a meeting between managers and trade union representatives to discuss the findings of the recent audit. Following the meeting a way forward was agreed to deal with the staff within the team, and for Mrs Howard to meet with individual staff who had not documented written information as required, to provide advice and support on correcting the situation. A training session on record keeping and CPA was also arranged.

February 2001

Mr Confue reported his findings of the caseload review. Ways to rectify the missing records, clinical supervision, and the interface between the PCLT and the HTT (Home Treatment Team) were discussed regularly at staff meetings.

Mr Hall returned to work as a Clinical Nurse Specialist, a post without line management responsibility.

June 2001

Ms Ann James, Chief Executive, joined the Trust. The latest draft Operational Policy was issued and staff expressed concerns about the transfer of patients to and from home treatment, and attachment versus linked methods of working with GPs.

August 2001

In preparation for the Partnership arrangements due to take place in April 2002, Mr Ian Jane, who was already seconded from Social Services as the lead manager for social care, was appointed to take over management responsibility for the PCLTs. Mr Hall was asked to manage the pilot 'Gateway' service.

September 2001

Some staff still had not reconciled their missing records 'by way of an alert' in the electronic system.

October 2001

Five CPNs working in the Waterfront PCLT each received an anonymous letter questioning their behaviour and attitude.

November 2001

Mr Patrick Canavan, Regional Officer MSF (Managerial and Scientific Federation – now known as Amicus), met with a large number of nurses to discuss the ongoing issues with Inner City PCLT. He advised the CPNs to formally request an investigation of the anonymous letters. Despite the Trust policy of not investigating anonymous letters, Mr Colin Shrewry, Acting Deputy Director of Community Services, was appointed to carry out an investigation into the source of the anonymous letters, but the author was never identified.

March 2002

Mr Confue decided to increase the staff complement of the Inner City PCLT to support staff, as they still had concerns about sickness levels and the 'cover' arrangements which, they perceived, gave them increased workload. Ms Emily Spick was appointed. Mr Furze was moved to another senior post, not in line management. Ms Longbottom decided to move back to her previous post as soon as a new manager could be appointed.

May 2002

The appointment process of the manager was further delayed as staff were invited to comment on the job description, which they failed to do. The outcome of Mr Shrewry's investigation was implemented. Positive attempts to engage staff, using an external facilitator, were thwarted as staff could not agree any of the three people put forward. Three members of staff were deployed to increase the existing resources. A full time G grade, and part time G grade and H grade nurses were allocated to the Inner City Team. On 12 May 2002 the homicide occurred. Mr Confue, with Ms Longbottom in attendance, collected the notes for P from the Nuffield Clinic.

June 2002

Ms Kim Smith, Clinical Risk manager, was appointed to undertake the review of P's care, but before it could be commenced she left the Trust for another appointment.

July 2002

Mr Nick Pennell, now Head of Mental Health Services, moved from being the manager for the Rural Locality to the Plymouth City Locality, which included the Waterfront PCLTs.

October 2002

A Critical Incident Analysis was conducted, which demonstrated serious concerns about care provided to P, communications, and lack of follow up. The CPN, Mr Read, was suspended awaiting the outcome of the internal investigation. Ms Longbottom informed Mr Confue that she could no longer manage the Inner City PCLT and returned to her previous role. Mr Jane took over the day to day management of the team while the appointment of a substantive manager was made.

November 2002

Mrs Howard began the process of the internal investigation. The staff sickness level in the Inner City PCLT increased.

December 2002

Dr James, P's Consultant retired.

January 2003

The newly appointed manager of the Inner City PCLT only stayed a short time. We were told that although she left for personal reasons, she felt that the scale and scope of the job was too large, and she also recognised that there were problems within the team. Mr Jane continued to manage the team on a day to day basis.

April 2003

Mr Steve Meredew, interviewed prior to the appointment made in January 2003, became the Inner City PCLT manager.

May and June 2003

Mr Read's disciplinary procedure was postponed and eventually heard in July 2003, following which he was dismissed.

During our interviews it was clear to us that during the last few years there were overarching tensions between some staff, who were identified as a 'handful' in the Inner City PCLT, and the senior managers in the Trust. We have chosen to raise these issues in this report to illustrate the importance of strong management to support and supervise staff in the delivery of health care, as staff need to feel both included and listened to and managers need to be consistent in their approach.

We were also well aware that we only looked at one service, namely the Adult Mental Health Service, and therefore our comments reflect on that service rather than any other, but we would hope that there are lessons which can be learnt by other managers.

Management support

The Inquiry Team heard a lot about the 'Reconfiguration' of the service with a certain bias depending on the informer's position in the Trust's hierarchy. The consultation was seen as going on for a long time, and the implementation was perceived as 'quick'. Almost everyone we spoke with said that the implementation time was too short. It has to be remembered that just because a consultation process has taken place not all staff will be 'signed up' to it. Some individuals will always find change difficult and require extra help and support though the implementation of change. It might also be said that a gradual approach is more likely to bring about change, but by the very nature of a regularly changing NHS this is not always possible.

Comment

It seemed to us that managers felt that there was a small group of staff who, having worked together for some time, were seen as seen as extremely resistant to change and to management interventions in the way they wished to work.

There have been various problems with respect to the culture within the Adult Mental Health service, which in our opinion have made effective management problematic. Most prominent amongst these problems is the culture of clinical staff regularly and persistently bypassing their managers and going direct to more senior managers in the Trust to query or overturn decisions taken by their line managers.

In addition there was an approach to staff/management relations, which was variously described as "*hands-off*" in the need to be more "*empathetic*". Rather than being helpful in improving relationships, this policy had the effect of undermining managers and perhaps conveying to staff the wrong impression - namely that effective and appropriate clinical care by staff could be negotiated, and was not seen as the core, and therefore an unavoidable feature, of their employment.

Comment

Whilst we are concerned that staff relations might have suffered as a consequence of this approach, we are even more concerned about the impact it appears to have had on clinical care of patients. We also wonder whether the extensive consultation period prior to the implementation of changes, as previously discussed, inadvertently gave staff the impression that everything was up for discussion, whereas of course some things clearly are not.

From 1998 there developed a pattern of staff in the Adult Mental Health services either going to their trade union representative or going to a more senior manager, such as the Director or the Chief Executive. This was further compounded by an adopted style of management wishing to be more accessible and visible to staff. Mr Confue held regular 'surgeries', when any member of staff could go to see him without an appointment. Ms James regularly met with staff informally. As a consequence, staff played one manager off against another and 'bypassed' line managers when they chose, resulting in team managers feeling undermined. Consequently, several managers 'passed through' the Inner City PCLT, each giving their reason for leaving as an inability to manage because of the few members of staff seen as trouble makers, and their own sense of being undermined. In all, six managers left their posts between 1999 and 2003 as a direct consequence of the difficulties in this team.

Comment

The Director of Human Resources should have identified this as a management issue and should have provided a more supportive approach to both middle and senior managers struggling to provide leadership.

We were told that a deliberate strategy of adopting a 'hands off' approach was taken in order to resolve the apparent 'conflict'. This approach was seen as not taking a tough line of action with staff because it might have led to conflict. Managers at all levels felt unsupported. In particular, when managers tried to implement decisions the Human Resources directorate did not support them but always, in their view, appeared to take the side of staff and their trade union representatives.

We identified that there was not a consistent management strategy for dealing with major human resource issues as they occurred. We have listed some examples that came to our attention:

1. When staff working in the Assertive Outreach team brought their lack of record keeping to the attention of their manager, they were disciplined when their records were found to be of a poor standard. Whereas, when the Inner City CPNs' records were found to be in a worse state, an 'amnesty' was granted for an agreed time period. We have been told that this approach was agreed because there were at least 30 staff involved.
2. Staff were 'slotted into' short term posts, such as producing the mental health resource handbook, or 'acting' positions rather than advertising these positions, giving rise to a perception of favouritism and lack of opportunity for others. We were told that this was part of a 'return to work' programme following maternity leave. Nonetheless there was a need for all staff to know about this.
3. The prolonged delay and over-involvement of frontline staff in appointing the permanent manager of the Inner City PCLT.
4. The decision taken to investigate the set of five anonymous letters when the policy adopted to a previous anonymous letter was not to investigate.
5. The issuing of draft documents and not finalising them, eg operational policy and job descriptions. The reason given for them not being signed off was that staff did not

return comments, in which case an assumption should have been made they had no comments.

6. The use of ‘compromise’ agreements in dealing with situations which senior staff perceived as difficult to handle. This kind of agreement, though legal and quite widely used in the NHS and with the support of the Trust Board, does not alter the fact that other staff may well see its use as a way of not confronting management issues.

During our Inquiry much was said about ‘bullying’, with some staff accusing some managers of doing just that. Bullying (*Bullying and Harassment at Work*, Royal College of Nursing 2000) is described as

- verbal abuse such as leaving anonymous answerphone messages, offensive language or innuendo, name calling or spreading malicious rumours,
- written abuse such as letters, emails (which may be anonymous),
- explicit behaviour such as mimicking,
- incidents associated with work such as stalking.

However, we received no evidence of any particular incidents which could be defined by the above definition. When staff described the behaviour of managers as ‘bullying’ it tended to coincide with managers trying to change or influence practice and therefore improve patient care. In contrast, we were given copies of a series of anonymous emails sent to the Chief Executive by a previous employee, and staff told us that they still felt threatened by this same individual. Some staff told us that they felt they would be ‘dealt with’ if they approached us during our inquiry, but still attended at their own request. It was difficult for us to come to a definite view about ‘bullying’, as managers were tasked to improve standards and implement new ways of working which some staff may have found threatening. Some members of staff were fundamentally offended by managers, interpreting their instructions as bullying and harassment. We know that the ‘hands off’ approach was adopted for some considerable time and a more ‘direct’ management approach discouraged. As said before, this approach did not lead to a more conducive culture in the Inner City team and so a stronger approach has now been taken to address the deficits identified in the internal investigation, which in turn has led to some staff discontentment.

Comment

Much was said to us about different styles of management that did or did not engage staff, particularly those staff who were not able to embrace change. Leaders need to be 'product champions', in other words see that patients receive the care they need. CPNs, as the deliverers of that care, require supportive management direction, and managers need to be more objective and consistent in their approach with staff if they are to achieve the same aims and improve services to patients.

In the absence of leadership staff work in a vacuum and, if not carefully managed, can be distracted from the core business of delivering healthcare to members of the public who, because of their poor health, are already disadvantaged.

Recommendation

We recommend that the Trust reviews the human resource support to the mental health services Directorate

CHAPTER 10

MANAGEMENT ISSUES WITH REGARD TO THE INNER CITY PCLT

General Context within the Organisation

Management of the Inner City PCLT was made more problematic by the fact that there were frequent changes amongst managers within the mental health services. The lack of continuity of managers appears to have increased uncertainty, lead to a certain loss of authority, and raised questions about how exactly managers were appointed or moved from one post to another. This gave the impression of a lack of transparency and openness with regard to appointment procedures.

There are, in our opinion, a large number of PCLT teams within the Trust and we wondered whether the teams were so small that they experienced more difficulty in absorbing occasional sickness or holiday absence. Small teams have more difficulty in coping with peaks and troughs of work, and also have more difficulty in providing a sufficiently varied range of skills and disciplines working with the same client group.

There were also, in our opinion, limitations with regard to some of the policies and procedures that had a bearing on the workings of the PCLT. In particular, we note the absence of any referral protocols for primary care, and any explicit criteria with regard to referrals. We have previously noted some difficulties with respect to interfaces between the different teams, and would suggest that there be an explicit procedure for arbitrating disputes between different teams, for example between Home Treatment and PCLT.

Management of the Inner City PCLT took place within a particular context which, in some respects at least, was problematic. Firstly, we would suggest that the manager of the Inner City PCLT would benefit from regular meetings with peers who occupy similar positions in other teams. This is particularly important given the number of specialist teams within the Trust, and the ever-present danger that interfaces between teams can prove to be a source of conflict and difficulty. Such meetings for peers would assist in discussing, and hopefully resolving, any difficulties with such interfaces.

Secondly, we are of the opinion that the PCLT manager would benefit from regular meetings with the Locality manager. It is essential that such meetings have a clear agenda, and occur in a regular and predictable fashion.

The Thursday morning business meetings within the PCLT have been described to us as a 'flashpoint'. It seems clear that the meetings require robust and effective management with explicit and predictable agenda. The greatest difficulty in these meetings appears to have been in the context of the cultural problems, to which we have referred above.

Management Tasks within the PCLT

Management of staff and staffing levels

We reviewed a considerable amount of evidence with regard to the issues of staffing and staffing levels within the Inner City PCLT. We were aware of the suggestion that the staff within the team had excessive workloads. We will discuss this issue later in this section but for the present we would record the fact that one of the continuing problems within the team arose from frequent sickness absence, absences due to performing work on duty rotas elsewhere in the system, and absence through holidays. Understandably the most problematic absence to cope with was that due to sickness, because of its unpredictability, and in the case of the particular team the often extensive duration of such absence. It is clear that the Trust needs a robust policy for dealing with sickness absence.

> **Comment**
>
> **We were assured that such a policy does exist and is used, but we were not entirely convinced by this line of argument.**

Efforts were often made to address the staffing shortfalls by allocating CPNs to the team for short periods of time. However, this in itself may have caused problems in that new staff may be viewed with some suspicion and may be seen as 'manager's spies'. Staff who had been in the team for some time were possibly threatened by more recently trained nurses, who were keen and enthusiastic and not distracted by any existing 'cultural baggage'.

Clearly the team manager also has a significant role to play in ensuring that there is an adequate skills mix within the team. Given the complaints that we received about managing

the interface with primary care, we are not sure that all members of the team had the appropriate skills for working in primary care liaison. These comments obviously relate to the need for regular appraisal of staff, ensuring that staff members' training needs are identified, and where appropriate further training and supervision is provided.

Workload management

As previously noted concerns have been expressed about excessive workloads within the PCLT. We were not persuaded by this argument other than perhaps for a short time following 'reconfiguration'. However workloads can be perceived as high when there are colleagues on leave or away for other reasons and, from everything we heard, sickness levels were high for this team. Their view of the reason for high sickness levels was poor morale and 'burn-out'. Working at the interface with primary care does mean that the 'door' is always open whereas the Home Treatment Team and the Assertive Outreach Service can limit their referrals.

There were difficulties in the allocation of cases within the team. We noted some evidence for the assertion that the more senior members of the team had the most continuing care cases and also fewer overall numbers on their caseloads. Allocation of clients in the past has not always been equable, as demonstrated by P. P was clearly a complex and difficult case to manage and in our opinion should have been managed by a more senior and experienced CPN. Senior team members should also have had greater experience in the assessment of new cases and should, as a consequence, have seen a significant proportion of new referrals from primary care. In our opinion staff had manageable workloads both with respect to overall patient numbers, and the complexity of cases managed.

We heard evidence of tensions at referral meetings. The suggestion has been made that considerable amounts of time would be spent before new referrals could be allocated to team members. Whilst it is desirable that team members volunteer to do new referrals, if there is a shared reluctance within the team then ultimately the manager will have to allocate new referrals in a transparent and fair manner.

Given our reservations about the skills within the team it seems likely that the team manager could have both enhanced his or her standing within the team, and improved patient care, by

means of doing some joint work with team members around the care of complex and or difficult cases.

Management responsibility for records and record keeping

We have discussed elsewhere in this report the poor quality of some nursing case notes. A key task for the team manager is to ensure that all patients have up-to-date and comprehensive case notes. Whilst this issue can be regularly addressed in supervision, it is also the case that regular and systematic audit of case notes is desirable and appropriate. Whilst there might be some room for discussion about the mechanisms of audit, professional responsibility of nurses to maintain adequate case notes is not a matter for negotiation or voluntary agreement. These comments apply equally to electronic patient records.

Management of the Care Programme Approach

Our comments with respect to case notes in general apply in particular to the question of Care Programme Approach documentation. It is essential that each patient has a documented Care Plan and identified key worker, and that there are regular reviews of the Care Plan. Again, these matters can be regularly reviewed within the supervision arrangements, and also by systematic audit.

Management supervision

Clarity is required with respect to the Trust's policies with regard to clinical supervision. It needs to be clear how frequently supervision takes place, what areas are covered in supervision, how supervision is recorded, and what the various responsibilities are within the supervision arrangements. Supervision of G grade nursing staff by the team manager should, in our opinion, include the issue of whether they are fulfilling all of their own responsibilities, including the appropriate supervision of more junior nursing staff.

Management support to improve the staff environment - office space, administrative and technical support

We were aware of considerable disquiet expressed by staff with regard to the suitability of the facilities, and the lack of administrative support for the team. Clinical staff should be enabled to perform their tasks satisfactorily. It is the responsibility of managers to enable them to perform those tasks. Clearly, therefore, any deficiencies with regard to

administrative support and accommodation need to be actively addressed. At the time of our Inquiry the team had just moved to a new building, which should relieve some of the problems they experienced while based at the Nuffield Clinic.

Mechanisms to improve communication and staff involvement in clinical decision making

In October 1998 a group of CPNs held an informal meeting to set up a CPN Forum, chaired by Ms Patricia Robinson. The meeting was used to express various concerns about the implementation of the new services, which ranged from lack of clarity about the key worker, poor staff mix, increase in staff sickness, lack of cover for planned absences and inequalities in service provision. Lack of working space was recorded as a reason for not being able to keep records up-to-date.

A further meeting of senior CPNs was held, and in early 2000 Ms Robinson wrote to Mr Confue of their concerns, some of which were similar to those expressed some time in 1998. In addition, there was a lack of clarity in the role of the G grade CPNs in the new teams - especially management of junior staff, their perceived overlapping role with the PCLT manager, and the interface between the PCLT and the HTT.

Comment

It seemed to us that some staff held the same views despite the record keeping audits, the caseload review and the move to Avon House. It has to be noted that when the steering group was set up to implement the 'reconfiguration' of services it did not include a CPN. As a consequence the issues that they had at the time had been allowed to fester, and manifested in mistrust and a perception of not being listened to. Attempts were made to resolve the recurring issues by external facilitation, but this did not happen as we were told that staff could not agree on the appropriate facilitator.

Recommendation

We recommend that the Trust implements a development programme for the Inner City PCLT, facilitated by an impartial trainer, which takes account of the changes in personnel and the outcome of the internal investigation. The outcome of this programme should

i) Establish ground rules for acceptable behaviour in the working environment, eg responsibility to each other, and working with other teams

ii) Develop operational policies into agreed practical procedures

iii) Identify opportunities if staff wish to work in other teams

iv) Develop working arrangements at the interface with other services in order to achieve 'conflict resolution'.

Recommendation

We recommend that the Trust carries out an audit of the workload of the CPNs working in the Inner City PCLT on an annual basis.

Recommendation

We recommend that the CPNs working in the Inner City should meet regularly with other CPNs providing primary care liaison in order to develop a better understanding of their workload pressures and provide peer support.

CHAPTER 11

AUDITING RECORDS AND RECORD KEEPING

The UKCC, now The Nursing and Midwifery Council, document '*Guidelines for Records and Record-keeping'* (1988 updated 2002) sets out the profession's expectations of how nurses should document their interaction with clients and patients.

The guidelines state that record keeping is an integral part of nursing practice and as such is a tool that helps the care process. Good record keeping protects the welfare of patients by providing:

a) accurate, current, comprehensive and concise information including a chronology of events, reasons for decisions and any other problems;
b) evidence of care;
c) a baseline against which improvement or deterioration may be judged.

Managers should expect records to be factual, consistent and to reflect accurately the intervention carried out by the individual writing the notes. In present day services there is an understanding that Care Plans are written with the involvement of the patient. Therefore records should be constructive and provide clear evidence of planned care and its delivery, whilst including any decisions made and a note of all professionals involved in the process. Any member of the multi-disciplinary team who has contact with clients has a responsibility to document that contact in the notes.

In 2000, six CPNs working in the AOS team informed Mrs Howard that they had not been keeping records for the past year, which shocked her as all nurses have a responsibility to record their contact with patients. Mrs Howard contacted Ms Karen Grimshaw, the Deputy Director of Nursing at that time, and she in turn contacted the Trust's solicitor. The time period covering the incomplete nursing records for the CPNs' clients was documented on the electronic system, ePEX.

Managers and staff agreed a system which ensured written confirmation that records were incomplete within an agreed time span, and that from this date onwards the records were contemporaneous. Mrs Howard developed a simple CPA audit process to identify consistency in the team and used the following three simple questions as the standard:

- Is there a care plan?
- Has a risk assessment been completed?
- Was there an index?

Six months later Mrs Howard re-audited the records and found them to be of a better standard than before, although there was room for improvement.

In 1999 when Mr Hall joined the team, he learnt through supervision of the 'G' grade CPNs that some people were not completing the appropriate paperwork. At that time there were eight G grades in post in five PCLTs as part of the Inner City workforce. Staff also told us that there was confusion at the time as to how to record their work, as the paperwork was constantly changing and being updated whilst the composition of the Trust was changing.

In May of 2000, to ensure conformity, he produced one 'file' with all the appropriate paperwork and instructed staff to use this paperwork for new referrals.

In November 2000 during a consultation with Dr S Rideout, Occupational Health Consultant, a CPN from the Waterfront PCLT raised concerns about record-keeping in that records were not being kept. Dr Rideout wrote to Mr Confue informing him and as a consequence the team were told that an audit was to be carried out.

Mrs Howard was asked to undertake an audit of the CPNs' records because of her recent experience with the CPNs in the AOS. She arranged to carry out the audit with Mr Hall, the manager at the time, and Mr Furze. Before the audit was completed Ms Longbottom replaced Mr Hall as the PCLT manager, as he had an extended period of absence for family reasons. Five case files for each of the CPNs, going back over a period of 12 months, were selected. The audit was undertaken in the evenings over a couple of days after the staff had left. The results for the majority were less than satisfactory, with three where the standard was acceptable - three out of approximately 15 or 16 staff. Entries had not been written for a significant period of time.

The files were poorly organised and were not kept in accordance with the Trust CPA policy, even though it had been in use for quite some time. Some staff used ordinary lined sheets of

paper to write nursing records, whilst others used older style record-keeping notes. It was difficult for someone else to determine the care plan, whether a 'risk' history had been taken, and if relapse factors were documented. Even when there were care plans, some were two or three years out of date. This audit was considered to be worse than the one completed in the AOS team. Advice was taken from the Director of Human Resources at the time, and when we interviewed him about the audit he told us

> *"There was a big problem with record-keeping within the Mental Health Directorate and the scale of the problem was such that we took the view – rightly or wrongly – that it would be inappropriate simply to discipline everybody. I mean, you cannot discipline every single member of staff! We took the view to take an amnesty. What that meant was that the individual staff had to go back over their records and make those records correct, prior to the amnesty. So the amnesty was only in terms of not taking disciplinary action as a result of the lack of record-keeping".*

Mr Hall told us that he took personal responsibility for the poor audit results, and felt it appropriate to relinquish his post as team manager. He felt he had to go, although he agreed that this was only one of many reasons. He found managing the team very problematic as there was a good deal of absence due to sickness, and he spent his time 'fire fighting' on a daily basis, trying to provide a service to the patients and appropriate care.

> **Comment**
>
> **The basis for his decision was not made public and therefore staff were never aware why he did not return the team.**

The audit uncovered serious concerns about record keeping by some staff, dealt with in a lenient way by way of the perceived 'amnesty'. However, instead of seeing this as a 'wake-up call' some staff failed to recognise, or perhaps accept, the seriousness of their omission.

In response to the outcome of the audit, in December 2000 Mrs Howard delivered a training programme that included a 'handout' about record keeping and the extant CPA policy dated July 2000.

Following a Dept of Health Directive, in March 2002 a further audit of all CPA records was commenced. Ms Longbottom, as the manager, informed the team that their records were going to be audited and a random selection of records was chosen. Some of the records were much improved, although there were some discrepancies between the written record and the electronic system. Generally the entries corresponded. There were a significant number of records still missing for some staff, going as far back as 1998, which meant that qualified staff were in breach of their professional Code of Conduct.

One of the nurses made a complaint to her union representative and the Human Resources Department that records were being audited again. A decision was taken by Mr Confue that Ms Longbottom should not continue with the audit, but that Mr Graham Burton, Clinical Governance advisor for mental health, would complete it in conjunction with the CPNs. The audit process continued over many months, as some of the CPNs had failed to meet with him despite the audit being requested by the Dept of Health. The outcome of the second audit demonstrated similar shortcomings as the first had done two years previously.

Comment

There was a contradictory view as to whether the nurses were informed about the audit, but they must have been because at a different time it was said that they were 'violently upset' by the tone of the letter. This was yet another example of some nurses not accepting the seriousness of their lack of record keeping. We were also told by some staff that insufficient guidance was given. A chronology of the events relating to the rectifying record exercise is detailed in Appendix 8.

Recommendation

We recommend that:

a) The Trust invites its Solicitors to deliver a training programme which covers the legal obligation to keep appropriate records, especially as more records are being kept electronically

b) Staff from all the teams are trained to 'peer review' their written records in addition to the audits required by the Dept of Health.

CHAPTER 12

NURSING LEADERSHIP

The NMC code of professional conduct (April 2002) states that *'as a registered nurse or midwife you must maintain your professional knowledge and competence'*. The purpose of the code is to inform the professions and the public of the standard of professional conduct expected by a practitioner and, therefore, justify the trust and confidence the public can expect.

In the Trust a CPN Forum was established with the agreement of Mr Confue and supported by Ms Karen Grimshaw, Deputy Director of Nursing, in line with others in the Trust, such as the Health Visitors, and seen by the managers as the appropriate place to discuss nursing matters. Unfortunately this did not continue as envisaged, as managers perceived that the Forum became a further platform for trade union activities, with full time officials in attendance. From what we have understood, there was little in the way of senior nurse leadership. Mental health nursing was not truly represented at a senior level. There were senior managers with a nursing qualification, in fact the Director of mental health had a nursing background but was much more operationally focussed, and at one time one of the locality managers also had a nursing background. However, when we asked the question 'who is the senior nurse in the directorate?' we received a variety of answers, but in the main staff thought it was any of the functional managers who had a nursing background.

Mrs Howard told us that she had been approached to provide Learning Disability and Mental Health Nursing advice to the Trust Board, as the current lead nurse in the Trust did not have a background in mental health. Mr Confue told us that there was not a current Mental Health Nursing forum. He shared his despair with us about some local mental health nurses' lack of professionalism, which had become apparent through the auditing of their records.

We were pleased to learn that the Trust has appointed a Nurse Consultant, based in the inpatient unit, and concerned with practice for inpatient nurses in the first instance.

Comment

It was most unfortunate that the previous CPN Forum had not been more pro-actively managed with input from a senior nurse. Organisations have become more 'matrix' in their structures, and ways need to be found to ensure that clinical advice and leadership, both uni- and multi-professional, is available to inform decision making at every management level, and can contribute to the development and delivery of services.

Recommendation

We recommend that the Trust appoints a further Nurse Consultant in the Mental Health and Learning Disability Directorate to take a lead on community based practice in order to:

i) Identify opportunities for ongoing professional development for all nursing staff and support nurses in new areas of working.

ii) Advise the Director on these as they impact on patient care.

iii) Work with members of the multi-disciplinary healthcare team in furthering the Trust's Clinical Governance programme.

Recommendation

We recommend that:

The Director of Mental Health and Learning Disability services establishes a nursing forum, jointly chaired by the Nurse Consultants, which will be the focus for professional and clinical practice development, and advise the Trust Board through him.

The Nursing Forum membership should include the identified Lead Nurses representing Adult Mental Health, Older People, Learning Disabilities, Child and Adolescent Mental Health Services, Rehabilitation Services and Substance Misuse Services.

This Nursing Forum should link with the other nursing networks in the Trust on issues relating to the provision of services to mentally ill people, including changes to service delivery, the practice of nursing and its quality.

CHAPTER 13

CLINICAL SUPERVISION

The notion of clinical supervision, in addition to managerial supervision, was introduced into the nursing profession in the early 1990s and enshrined in the UKCC Code of Conduct 1992:

> *"Nurses, midwives and health visitors must act in a manner as to promote and safeguard the interests and wellbeing of the patients and clients, maintain and improve professional knowledge and competence"*.

A working definition of clinical supervision can simply be described as *'an exchange between practising professionals to enable the development of professional skills'* (Butterworth, 1992). Another is *'the interactive process between providers of health care, which enables the development of professional knowledge and skills'* (Butterfield and Faugier 1993). Either way, clinical supervision provides an opportunity to look at all aspects of care given in individual cases, which takes account of personal professional development and changing needs in service delivery. Clinical supervision is perceived by nurses to be a 'sounding board', which gives practitioners the opportunity to clarify thinking, question established practice, seek new approaches to care and participate in 'reflective' practice.

We believe that clinical supervision is essential for the development of professional competence, to improve the quality of service delivery, and to benefit the organisation by providing a skilled and supported workforce. If clinical supervision is to provide a contribution to improving patient care, supervisors and those they supervise need to agree a set of objectives for the supervision of individual nurses and the care provided by them to individual patients, by which they can measure change. The person being supervised has a responsibility to inform their supervisor of all relevant details of each case. The supervisor has a responsibility to ask specific questions, which will lead to a change or continuation of the nursing plan. In the entries documented in this case it is not clear how the supervisee moved on in the journey of care.

Comment

We understand that the Trust makes a clear distinction between clinical supervision, reflective practice and case management. However, previous experience has demonstrated that a strict demarcation is, in effect,

superficial because both volume of work and the quality of proposed interventions by a practitioner can adversely affect the quality of patient care.

The Inquiry Team recognises the difference between clinical supervision and caseload management, but has to agree that there will always be situations when there is overlap. This needs to be discussed with both supervisors and managers if patients are to receive optimum care and some practitioners are not over loaded.

We do know that Mr Read had at least two supervisors, Mr Hall from May 2001 until August 2001, and Mrs Murphy from November 2001 to December 2001, whose notes we were able to read. In all Mr Read discussed his caseload with Mr Hall on four occasions, and with Mrs Murphy twice before May 2002. Both supervisors kept notes to which we have had access. In Mr Hall's notes he wrote:

8 May 01 P ?Jeannette Callus – Care co-ordinator. On probation on depot. ?
drug problem ? joint assessment meeting CAS

8 June 01 N/P P – probation order for treatment
doing own ……..
referral from Dr J. for depot
no Care Co-ordinator

11 July 01 P – not responding to letters
to contact probation re treatment
not…
focus strategy with action
self admin for….

Comment

Mr Hall did not check with Mr Read to confirm that he had contacted the Probation Officer. He assumed that as he (Mr Read) was asked to do so and also being a qualified nurse he would have done so. Mr Hall identified the need to clarify who was the Care Co-ordinator.

6 August 01 P –probation order for treatment
not keeping appointments
letter to GP and probation

Ms Murphy wrote in her notes

13 November 01 P not on caseload
not engaging with service

14 December 01 ? *F*(ollow) *U*(p)

Comment

Mrs Murphy was of the opinion that she was not responsible for Mr Read's clinical supervision but only caseload management, which gave rise to the entries when she advised about not taking on more patients because he had to complete the record keeping exercise already identified in the records audit.

It became clear to the Inquiry that Mr Read received caseload supervision, rather than supervision of his clinical practice, on a regular basis. It was suggested to us that such supervision should include a clear enquiry about what he was doing with each patient, ie what precisely the care plan was; what outcomes were expected for the case; what risks were associated with the case; what the risk management plan was for that case; and the role and responsibilities of any other agencies. The question of who the key worker was for a particular case would always be clarified. These comments, in our opinion, exactly encapsulated some of the concerns that we have had in regard to the care and treatment that P received. It has been suggested to us that an hour-long session in which at least 20 patients were due for discussion was insufficient for this to happen. This surely begs for a need to

prioritise patients requiring discussion, and detailed notes to be kept which outline the continuing care plan and personal interventions of the practitioner.

We do know that in November Ms Murphy advised Mr Read not to take on any more clients and that he should bring his CPA paperwork up-to-date. On 14 December, she again advised him not to take more clients onto his caseload. In respect of P there was no evidence that advice proffered was actually documented. In neither set of supervision notes was a plan of action documented. The supervision notes were not passed from Mr Hall to Ms Murphy.

Comment

In the internal investigation there was a debate as to when Ms Murphy knew P was on a Probation Order with a condition of treatment, but this would have been irrelevant if the notes had been passed on to her.

Mr Read held a Diploma in Mental Health Nursing, qualifying as an RMN in 1997. He commenced work at the Nuffield clinic as a community based mental health nurse, D grade. He was re-graded to E some two years later. In 2000 he completed a degree in Community Mental Health Nursing. According to the *Nursing and Midwifery Staffs Grading Structure*, a guide to grading definitions published in the late 1980s and still relevant, an E grade nurse is responsible for the assessment and evaluation of programmes of care and is expected to carry out all relevant forms of care, and is designated to take charge regularly of a ward or equivalent sphere of nursing in the absence of the person who has continuing responsibility.

An E grade nurse is required to take responsibility as the prime care provider for one or a defined group of patients. This is the minimum grade in nursing, which can be classed as a 'key-worker'. The next grade, F, differs from an E grade in as much as the post holder has 'continuing responsibility' and can be a team leader for a group of E grade nurses. G grade nurses carry the continuing responsibility for the assessment of care needs, the development, implementation and evaluation of programmes of care, and the setting of standards of that care. Another definition is described as *"the management of a defined caseload, including liaison with other agencies and where appropriate the supervision deployment and teaching*

of staff. This scale is the minimum level for district nurses, community psychiatric nurses with the appropriate qualifications".

Although Mr Read had the appropriate qualifications for a G grade post and five year's experience, he was not employed in this capacity. As a first level nurse the expectations of him in P's care were to make an assessment, to plan care, to implement that care, and to evaluate the care provided – involving the client where possible, to record, communicate and feed back to colleagues. This was the basic competency expected of first level nurses and was not an unreasonable expectation of Mr Read. However his assessment of P's on-going mental health or, as it turned out, the lack of it, should have led to a much more vigorous approach to his clinical supervision by his senior nurse colleagues than demonstrated in this set of notes.

When problems arose in engagement, it was not an unreasonable expectation for these issues to be raised by the CPN with the G grade and team to gain support. The supervising G grade should have supported the CPN from the outset of referral, but what was being asked of the CPN in terms of skills was appropriate.

Comment

We are concerned that as P did not engage with the service, Mr Read did not request support from one of the more experienced G grade nurses. However, we learnt that there were several occasions when G grade nurses were not available, leaving him in a difficult situation. It was unfortunate that he either did not or was not able to bring this to the attention of a more senior nurse, even if he fully appreciated the implications of dealing with a patient on a Probation Order with a condition of treatment.

We were given very little evidence of the Trust's policy on Clinical Supervision other than a policy dated 1995 and some correspondence about training days in 2000/1. We were informed that the Trust policy was an "Enabling Excellence Project" in June 2003, which is currently being developed into a working policy.

Recommendation

We recommend that the Trust revises its Clinical Supervision Policy and implements a more structured approach to supervision in order that

- **Aims and objectives are agreed for each case.**
- **Supervision notes are passed on to new supervisors.**
- **Notes are agreed and countersigned by both supervisor and supervisee.**
- **The Care Co-ordinator is identified.**

Recommendation

We recommend that the Trust implements a programme of evaluation to ensure that clinical supervision fits into the clinical governance framework.

CHAPTER 14

THE TRUST'S RESPONSE TO THE RECEIPT OF ANONYMOUS LETTERS BY FIVE STAFF MEMBERS

In October 2001 five CPNs working in the Inner City team each received an anonymous letter signed 'a very fed up colleague'. The letters were typed on Plymouth Community Services NHS Trust notepaper but each envelope was handwritten. We only saw one letter, dated 18 October 01, but were told that the others were very similar and followed the same pattern.

> *"... following another unpleasant working week, my frustration has got the better of me and I need to reflect to you my thoughts. I need to tell you how I feel to get it off my chest, but don't feel to safely in any other way. You and some of your colleagues spoil my every day at work. I have written to them also with my views. You are rude abrasive negative destructive and poisonous. You do not have a good word to say about anyone, particularly management whether past or present. The views you express are unhelpful and I do not need to know your views about managers when they were students. It's just not relevant. You are supposed to be a G grade, and I am supposed to respect you and receive advice and guidance. That in my opinion is unreal. You are just tiresome. ....*
> *...you even have the gall to complain about being overworked. That's a joke, we all know how "flexible the hours are at work to suit some individuals' own needs" I think its called taking advantage. Times have changed. You need to wake up. I am personally sick and tired of listening your views. I am embarrassed to be associated with you. Comments from other teams of exasperation about you are frequent. Please, please wake up and behave like a professional. You have so much experience and in my opinion you throwing it away along with every ones else's reputation for the sake of being 'bloody minded' and trying to score points management.*
> *I don't feel able to stand up to you, it feels like a form of oppression and intimidation. I go home from work angry, humiliated and exhausted. When others and me have commented we were shouted. You are not the only one I am so tired of, but in my book that does not excuse you behaviour..."*

Ms Longbottom (and Mr Ringrose) received original copies of all the letters with a covering letter saying that the other letters had been sent. Unsure of what to do, and feeling intimidated, Ms Longbottom sought advice from senior colleagues. One of the staff members who received the letter was particularly upset and Ms Longbottom advised her to go to a 'bullying and harassment' counsellor in the Trust. The policy at the time was to ignore such anonymous letters, which delayed the time before staff were offered support and counselling.

Mr Patrick Canavan, Regional officer MSF, met with the staff 31 October 2001. They appraised him of their ongoing issues and he agreed with the people present at the meeting that he would seek a meeting with the Chief Executive. Following this meeting, the five recipients sought his advice. Mr Canavan wrote to Mr Ringrose, who had also received copies of the letters:

> *"...I have been alerted to a very sinister development. Five members of the team have apparently all received similar anonymous letters which are felt to be both threatening and abusive advised the five to formally request that their line manager investigates the receipt of these letters. The letters have apparently been copied to management and I am suspicious that its being sent is connected to the very clear view at the meeting I held with the team at which it was agreed to seek a meeting with the Chief Executive. I believe the letters are meant to deliberately undermine the other staff. What the author does seem to be unaware of is the large number of staff that I met on 31 October and the unanimity of view ...*
>
> *I am therefore calling on the trust to mount an immediate investigation in to the receipt of these letters and to arrange a meeting between the inner city team and the Chief Executive. I have to say that I regard today's development very seriously and must advise you that I am asking the staff concerned if they wish to formally register a collective dispute ..."*

Two days later the five recipients also wrote to Mr Ringrose requesting that an investigation be carried out as it seemed likely that the author was someone from in the Inner City team. There had been a previous incident of an anonymous letter but on that occasion the Trust policy was to ignore it, as such complaints were difficult to prove or disprove. However, on

this occasion a decision was taken to investigate. We were told that the decision to investigate was in line with the new *"empathetic style and a relatively hands off approach and going the extra mile"*. It was felt appropriate as, by not supporting local managers in the past, situations had flared up and managers had *"shot themselves in the foot"*.

Mr Colin Shewry, Director of Primary Care and Rehabilitation, was appointed to carry out the investigation into the anonymous letters received by the five nurses in the Inner City PCLT.

The terms of reference were as follows:

a) To establish the nature of the complaint.
b) The initial assumption of the investigation was that the recipients of the anonymous letters:
    i) are distressed by the threatening and abusive nature of the letters,
    ii) reject the allegations made within the letters, and
    iii) are distressed at the apparent loss of trust within the team that had led to the author writing anonymously.
c) Interview all immediate and associated persons to establish as fully as possible the facts relating to their complaints.
d) If possible identify the author of the anonymous letters.
e) Produce a report to the Human Resources Director containing all established facts relating to this complaint and make recommendations for the actions to be taken by Plymouth Primary Care Trust.

In all Mr Shewry conducted 43 interviews over a couple of months. Notes of the interviews were taken by a representative from Human Resource Directorate and sent to each recipient to check and sign.

The outcome of the investigation was as below:

a) It did not reveal the author.
b) The content was largely or wholly untrue.
c) Relationships between management had remained compromised since the organisation changed three years ago.

The investigation identified a number of contributory concerns that lead to a working environment that could have increased the possibility of such an event.

Comment

It was always going to be difficult to identify the author. It risked being seen as another occasion when managers did not give the staff the answers they wanted. We believe that if the Trust wished to take this kind of behaviour seriously it would have been more appropriate to seek Police advice, and possibly to send the letters to a handwriting expert. Once management 'failed' to find the author, the incident became yet another source of bitterness and distrust for some members of the Inner City PCLT

The outcome of the investigation and its recommendations was reported to the Trust Board in March 2002. The investigation 'exonerated' all recipients from any criticism made by the author. A recovery plan was drawn up to include team building for the team and management, to agree a protocol for communications within the team and with management, including 'fast tracking' back from the director to the line manager, and a review of the team's meetings.

Comment

The main focus of the investigation was never achieved, and one could argue that without specialist expertise no one was going to own up. During our inquiry we heard various opinions as to who the person might have been, but speculation does not help an already poor relationship between staff and their managers. Whilst we acknowledge that the receipt of such letters was distressing, a line should have been drawn following the report; instead this was yet another opportunity for management to be seen as failing.

Other recommendations were in line with management procedures. These would have been better addressed by an external review if staff were going to have any confidence in the procedure.

It is sad to reflect that it has taken this tragedy for there to be an external scrutiny of the Adult Mental Health Directorate. The issues between some of the staff in the Inner City team have required much management time, with a variety of management styles since reconfiguration. It is a truism that one cannot please everyone all the time. Perhaps both managers and staff just forgot what their prime function was.

CHAPTER 15

THE INTERNAL INVESTIGATIONS INTO THE CARE OF P

In our terms of reference we were invited to review the structure of the internal investigations into the care of P. In response to the serious incident there was a multi-disciplinary critical incident review completed fairly quickly, which led to a further internal investigation, and a more in-depth series of interviews completed by Mrs Howard.

The critical incident review

Dr L Behennah, previously the deputy Medical Director and Consultant Psychiatrist, told us that shortly before this incident a Critical Incident Panel was set up to investigate serious incidents. She hoped that incidents could be reviewed in a clinically orientated and non-threatening way, but it remains to be seen how realistic this desire is.

Since this incident there have been several reviews carried out, now chaired by Dr Simon Payne, the deputy Medical Director, and assisted by a 'core team' acting as a standing committee. The *Incident Reporting and Investigation Policy* (working draft 03), states that the team will consist of two senior clinicians, and that a representative from the Clinical Governance Department will conduct the preliminary investigation. We understand that the review into the care of P was the only time that the treating team did not carry out their review; it was not felt appropriate due to the concerns being raised, and the internal investigation.

Comment

We are aware that the Trust has a Serious Incident Review Policy, which includes detailed information regarding the procedures for the reporting of serious untoward incidents. The policy documents also include information on the Critical Incident Debriefing Policy. However, it is also important that the Trust develops policies that encourage the facilitation and monitoring of "near misses", ie those incidents in which nothing adverse happens but, had circumstances been slightly different, then something undesirable might indeed have happened. We were told that it was expected that well functioning teams would discuss such incidents and moreover that the staff

involved would want that to happen. However, dysfunctional teams might not initiate such discussions, although such teams might be in obvious need of such review of their actions.

The critical incident review was completed in line with the Clinical Governance Framework incident investigation protocol. We were told that this was the first such incident reviewed in this way. The review team comprised:

Dr L Behennah, Consultant Psychiatrist (chair),
Mr D Furze, Clinical Governance,
Mr P Wilson, Child Protection Lead Adult Mental Health Services,
Mrs K Howard, Adult Protection Lead Adult Mental Health Services,
Mr G Burton, Clinical Governance Advisor for Mental Health.

Using the Root Cause Analysis approach the group concluded that there were concerns covering

- individual failures,
- poor individual practice,
- failure to use existing systems to support the care of P,
- breakdown of systems and processes,
- breakdown of communication within the Mental Health Partnership,
- breakdown in communication between agencies, and
- lack of managerial control and direction.

The recommendations can be found at Appendix 5.

Comment

In this case there was a suggestion that some notes went missing, fuelling a conspiracy theory. Mr Read told us on more than one occasion that some of his documentation was missing. This aspect of his practice, both in this case and generally, was discussed during the internal investigation and was not part of the terms of reference of this Inquiry.

Recommendation

We recommend that all notes are photocopied and a complete set given to the relevant practitioners involved in the case.

As the initial review exposed so many concerns, Mrs Howard became the investigating manager and commenced a more in-depth investigation into the care and treatment given to P, and another investigation into the specific issues in the Inner City PCLT culminating in the disciplinary hearings of some staff. This process was completed in late 2003 and the findings reported to the Trust Board. The summary became a public document and was shared with both staff and Mr Warnes' family. The recommendations are documented at Appendix 4.

From our interviews, we concluded that much of the work was completed by Mrs Howard with help from Mr P Wilson, Clinical Nurse Specialist/Coroner Liaison Community - Forensic team. We were told that a 'reference group', chaired by a Non-Executive Director, was set up with specialist input from the Director of Nursing, Cornwall Partnership NHS Trust and senior staff within the directorate. In reality this group never met and, as findings unfolded, it became more operational as specific actions had to be taken. Mrs Howard told us that she completed much of the work in her own time, as she had no one else to cover her day-to-day managerial responsibilities.

We have already commented on how helpful we have found this report and we wish to commend Mrs Howard for detailed analysis and thoughtful recommendations. We therefore do not wish to imply any criticism of her with the comments we make about the process.

We were surprised that the senior managers thought it was acceptable for a middle ranking manager to carry out this comprehensive investigation on their own and in addition to their existing work. The outcome of the original review of the case led to two further investigations, finally being completed well over 12 months later.

As there was a climate of mistrust of staff and managers alike in the directorate, to expect one person to carry out this investigation was wrong. Although we know that a psychiatrist chaired the critical incident review, we were surprised that the subsequent investigation did not include a psychiatrist and an independent chairperson. This was made even more

difficult because Mrs Howard, in her managerial role, was responsible as the investigating manager in the concurrent disciplinary hearings.

Recommendation

We recommend that the Trust reviews the management of serious incidents and ensures that:

a) Any serious investigation is carried out by a team of senior staff, including an independent chairperson.

b) In any investigation which necessitates interviewing staff, the notes of the meeting are taken by a confidential transcriber.

We know that the CPN in this case was suspended in November 2002 and subject to a disciplinary hearing in July 2003. The chronology outlined in this report will enable the reader to understand the concerns regarding a potential failure in the responsibilities of a qualified nurse in the following areas:

- Level of care provided – there was no care plan
- Timeliness of interventions – the last contact was August 2001 by the CPN
- Record keeping – in his police statement dated 24.6.02 Mr Read said *" because of P's inconsistency in failing to meet appointments I did not place him onto my caseload and kept his records separate as I knew there was going to be problems engaging with him and didn't want to place him onto my caseload until a reasonable rapport had been established"*.

Comment

This Inquiry was not asked to consider the disciplinary action taken. It is debatable whether an E grade nurse should have been asked to continue with this young man who was difficult to engage, as there were more experienced G grade staff in the team who, by their very grade, should have taken more responsibility for the care of P. We know that Mr Read was supervised by more senior nursing colleagues, but the question remains as to why he, as a qualified nurse and a person of some maturity, did not articulate to his supervisors any concerns he may have had about his

inability to see this man, and whether they should they have been more probing in their questioning of him.

Recommendation

We recommend that the Trust reviews the roles and responsibilities of all qualified nurses in the PCLTs so that more junior nurses are not working beyond the expectation of their grade.

During the course of our inquiry we learnt that another senior nurse was asked to read the transcript and statement made by one of Mr Read's supervising colleagues. Apparently there was a discrepancy between what she told the disciplinary hearing and what she had written, with an inference that she had lied. Again she was suspended, but chose to leave the Trust's employment prior to a disciplinary hearing.

We interviewed Ms J Wilson, Assistant Director Mental Health – Commissioning, who told us that she was asked to perform this task by Mr Pennell in the absence of her manager, Mr Confue, who was on leave. She told us she thought it unusual and assumed she was asked as a senior manager and a clinician with an understanding of the way in which community teams work. She picked up an inconsistency in that the interviewee was unaware of a 'community order', she called it, within the verbal tapes, and this contradicted what was actually written in her statement. Ms Wilson took notes and gave them to Mrs Howard and gave verbal feedback to Ms S Elliot, chair of Mr Read's disciplinary hearing and Director of Service Excellence, Mr Pennell and Mr Jane. She was then asked to interview the nurse but refused, as she was no longer in clinical practice. Another senior nurse interviewed her.

Comment

We found this action quite worrying, as Ms Wilson was not in line management in the Mental Health Directorate. If any one had to decide about the discrepancy then perhaps Mrs Howard was in a better position to do so, as she was present in the interviews, which on this occasion were transcribed. We considered this to be poor practice and mixed the roles of commissioning with line management.

Recommendation

We recommend that The Trust clearly demonstrates that the role of commissioning is separated from that of providing services.

We have already commented that the various internal investigations were thorough and competently carried out. A further investigation was undertaken to explore the difficulties experienced in the Inner City teams. Staff were only given the summary of all the findings at the time of publication, which did not include discussion of the difficulties in the Inner City team as uncovered by Mrs Howard, and senior staff had to ask for the full copy when attending this Inquiry. We heard much about an open and honest approach taken by the organisation. Unfortunately, if staff only have access to summaries of important documents it will possibly lead to unbalanced interpretation of the facts. We were told that the full document was not released as a 'duty of care' to those staff who had given evidence, and which might be used by others to victimise them at a later date. If this was indeed the case then consideration should be given to the outcome of this report.

Another feature of this investigation was the length of time the whole process actually took to complete, finishing shortly before this external inquiry commenced work, which meant that staff had little opportunity to digest the internal investigation before preparing for the external inquiry.

Recommendation

We recommend that in the event of future serious incident investigations all reports are shared in full with the clinicians who were responsible for providing care.

The recommendations of the internal investigations, which we fully endorse, should enable the directorate to move on, although we do not underestimate the difficulties ahead given the climate of mistrust.

Recommendation

We recommend that the findings, conclusions and recommendations of the internal investigation report and this report, with their action plans, are used to debrief staff and are the focus for an in-depth training programme for all staff in the Adult Mental Health Directorate.

CHAPTER 16

INTER-AGENCY WORKING BETWEEN HEALTH AND PROBATION SERVICES

Probation Orders

The statutory purpose of supervision under a Probation Order is defined in Section 2(1) of the Powers of Criminal Courts Act 1973 (as substituted by Section 8(1) of the 1991 Criminal Justice Act as

- securing the rehabilitation of the offender,
- protecting the public from harm from the offender, or
- preventing the offender from committing further offences.

To achieve this, supervising officers should address the following objectives:

- Confronting offending behaviour, challenging the offender to accept responsibility for his or her crime and its consequences.
- Making offenders aware of the impact of the crimes they have committed, the community and themselves.
- Motivating and assisting the offender towards a greater sense of personal responsibility and discipline, and to aid his or her re-integration as a law-abiding member of the community.
- Intervene to remedy practical obstacles preventing rehabilitation eg skills for employment, action to counter drug/alcohol abuse, homelessness, and to help the offender acquire relevant new skills.
- Ensuring that the supervision programme for the offender is demanding and effective.

National Standards for the Supervision of Offenders in the Community, a guidance document aimed at promoting effective working between Health and Probation Services (Dept of Health/Home Office 1995), provided a measurable framework to strengthen the supervision of offenders in the community, providing punishment and a disciplined programme. Local Probation Services were expected to agree local practice guidelines to enable the standards to be delivered. The guidance, *Mentally Disordered Offenders: Inter-agency Working* (Home Office circular 12/95, published in 1995) followed on from a Home Office Circular 66/90,

which set out the existing powers available for dealing with mentally disordered offenders. It encouraged inter-agency co-operation so as to make the most effective use of resources and so ensure that those suffering mental disorder receive care and treatment from health and social services.

In the 1995 guidance, Chief Probation Officers were asked to review arrangements for co-operation and joint planning services with local health authorities and social services departments and other agencies:

> *"To ensure where defendants who might benefit from psychiatric assessment are identified that the court receives appropriate information about the person's condition and the available treatment services".*

When the Probation Order (now known as Community Rehabilitation Order) includes a Condition for Treatment of the offender's mental condition, the supervising officer should liaise with the relevant services and agencies.

The purpose is to ensure that the offender co-operates with any treatment ordered by the court, proposed in the Pre Sentence Report (PSR) or considered appropriate by the supervising officer after assessment. Ms Stewart quite rightly wrote to Dr James when she commenced her role as case manager requesting a three way meeting. Both Dr James and Mr Read were informed of each case manager as they changed.

> **Comment**
>
> **Communications could have been improved, although it must be noted that each change of Probation Service worker with P was notified to the mental health staff.**

None of the Probation staff we interviewed were aware of any guidelines for joint working; neither was Dr James. Nonetheless, the local CPA procedure should have prompted both Dr James and Mr Read to arrange a meeting, which could have included the Probation Service. Evidence presented to the Inquiry suggested that the lack of practice guidelines hampered the supervising Probation Officers' attempts to engage with other local agencies. We believe that there is a need to develop and effectively implement a policy for the supervision of

people with experience of mental distress. Such people form a significant and growing proportion of the workload that any probation service has to deal with. We were pleased to hear that a protocol has been developed between Plymouth Primary Care Trust and the Plymouth Probation Service (Appendix 7).

Comment

We recognised that P was supported within the framework of supervision. However, none of the Probation staff responsible for his supervision had any specific knowledge of mental health. It should not be acceptable for practitioners with little or no experience and, more particularly, little or no training, to be allocated Probation Orders with psychiatric conditions.

We were told that the team was under pressure at that time, with three new officers and two experienced officers in a newly formed team with a new manager not long in post. At that time probation support officers were taking on work that probation officers would normally carry out. A probation officer would be assigned, a case administrator and a probation support officer. It was left to the probation officer to make the assessment to decide what needed to be done with the individual and how much input was required by them, otherwise it was be left to the probation support officer who would be directed to work with the offender. At the time caseloads were in excess of 100, possibly up to 120, which was considered too high. Their current case management model requires that each cluster, a probation officer, a probation support officer and a case administrator, should carry a caseload in the region of 75.

Pressure of work was given as a reason why there was no expectation that the probation officer would chase up the lack of meeting as requested by Ms Stewart, but that staff were very much reliant on receiving more information from their health service colleagues.

Comment

It was most unfortunate that such a meeting never took place. We were at a loss to understand why the meeting did not take place, but at the time there were no formal agreements between Probation and Health Services.

Recommendation

We recommend that the Devon and Cornwall Probation Area Service, as part of the multi-agency Public Protection arrangements, should participate in a mental health awareness training programme which takes account of the findings and recommendations of this report for practitioners and their managers.

Recommendation

We recommend that the Devon and Cornwall Probation Area Service and their constituent Health and Social Services should introduce a protocol and an agreed 'template' to improve communication and the sharing of information, leading to a better understanding of the role played by each agency

CHAPTER 17

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In reaching our conclusions we have been helped by the findings and conclusions of the internal investigations. We have reiterated some of those findings and enlarged upon them when we have felt it necessary to make a specific point. We recognise that we have had access to more documentation and that we completed our report some months after a good deal of activity resulting from the internal investigation. We also know that disciplinary action has been taken in respect of some of the front line workers, and that some staff members have felt intimidated by the process adopted by the Trust in response to its own findings.

Key Findings

Our key findings and conclusions are as follows:

1. The death of Mr Warnes could not have been predicted but may have been prevented if more assertive action had been taken by the mental health professionals responsible for his care.
2. P was mentally unwell at the time of the incident.
3. There were lost opportunities for passing on detailed information about P's previous mental health history and convictions.
4. The Consultant Psychiatrist should have adopted a more rigorous approach in managing P's care once he was released from prison and living in the community.
5. The CPN had a poor understanding of the Probation Order with a Condition of Treatment.
6. The CPN did not fulfil his responsibility in the continuing need to supervise P and provide ongoing care whilst the Probation Order was extant.
7. There was little shared understanding of the different roles and responsibilities of primary care staff, members of the PCLT and the Probation Service
8. Consideration of risk to himself and/or others did not appear to be sufficiently taken into account during the 15 months that P was in the care of the Inner City PCLT.
9. Management of CPA was confused, especially with respect to the role and responsibility of the Care Co-ordinator.

10. P's lack of engagement with services should have led to a case conference and possibly a referral to the Assertive Outreach team.
11. We were concerned by the way in which a few nurses in one part of the Adult Mental Health service appeared to work outside the management framework. They appeared to hold managers in contempt, and at the same time were able to circumvent proper lines of management when it suited them.
12. Nurses are both professionally and managerially accountable for their actions in completing their work and should document their interventions with patients in appropriate record keeping.
13. For a variety of reasons much attention has focussed on the nurses in this case but in our view managers at all levels in the organisation must take some responsibility for the poor functioning of the team in question.
14. Senior managers were poorly advised to adopt a 'hands off' approach when breaches in nurses 'code of practice' occurred, notably in the management of the outcome following the audit of record keeping in 2000.
15. Both clinicians and managers have a shared responsibility to provide services that protect patients and the public through appropriate care plans. Unless there is good communication and a mutual understanding of how this can be achieved services will fall short of what should be expected, as in this case.
16. Multi-disciplinary discussions would have allowed for more critical appraisal of the management of this case and the desired outcomes.

Recommendations

The Inquiry team fully endorses the recommendations from the internal investigations and in addition make the following recommendations:

1. We recommend that the Trust reviews it policy on the administration of depot injections.

2. We recommend that the Trust reviews the CPA policy and its best practice guidance to include who should chair the meeting, where they should and should not be held, and how confidentiality is maintained.

3. We recommend that the Trust regularly reviews the outcome of CPA meetings to ensure that the actions are carried out and that a nominated person is accountable for the follow up of any interventions.

4. We recommend that the PCT, through the Local Implementation Team (LIT), should ensure the provision of an inpatient and community mental health advocate service, which is able to represent service users where appropriate at care and treatment forums in the service.

5. We recommend that the Trust reviews the human resource support to the mental health services Directorate

6. We recommend that the Trust implements a development programme for the Inner City PCLT, facilitated by an impartial trainer, which takes account of the changes in personnel and the outcome of the internal investigation. The outcome of this programme should
   a) establish ground rules for acceptable behaviour in the working environment, eg responsibility to each other and working with other teams,
   b) develop operational policies into agreed practical procedures,
   c) identify opportunities if staff wish to work in other teams, and
   d) develop working arrangements at the interface with other services in order to achieve ‘conflict resolution’.

7. We recommend that the Trust carries out an audit of the workload of the CPNs working in the Inner City PCLT on an annual basis.

8. We recommend that the CPNs working in the Inner City should meet regularly with other CPNs providing primary care liaison in order to develop a better understanding of their workload pressures and provide peer support.

9. We recommend that the Trust invites its Solicitors to deliver a training programme that covers the legal obligation to keep appropriate records, especially as more records are being kept electronically.

10. We recommend that Staff from all the teams are trained to ‘peer review’ their written records in addition to the audits required by the Dept of Health.

11. We recommend that the Trust appoints a further Nurse Consultant in the Mental Health and Learning Disability Directorate to take a lead on community based practice in order to:
    a) Identify opportunities for ongoing professional development for all nursing staff and support nurses in new areas of working.
    b) Advise the Director on these as they impact on patient care.
    c) Work with members of the multi-disciplinary healthcare team in furthering the Trust’s Clinical Governance programme.

12. We recommend that the Director of Mental Health and Learning Disability services establishes a nursing forum, jointly chaired by the Nurse Consultants, which will be the focus for professional and clinical practice development and advise the Trust Board through him.

13. We recommend that the Trust revises its Clinical Supervision Policy and implements a more structured approach to supervision in order that
    - aims and objectives are agreed for each case,
    - supervision notes are passed on to new supervisors,
    - notes are agreed and countersigned by both supervisor and supervisee, and
    - the Care Co-ordinator is identified.

14. We recommend that the Trust implements a programme of evaluation to ensure that clinical supervision fits into the clinical governance framework.

15. We recommend that when a serious incident is being investigated all notes are photocopied and a complete set given to the relevant practitioners involved in the case.

16. We recommend that any serious investigation is carried out by a team of senior staff, including an independent chairperson.

17. We recommend that the Trust reviews the roles and responsibilities of all qualified nurses in the PCLTs so that more junior nurses are not working beyond the expectation of their grade.

18. We recommend that in any investigation which necessitates interviewing staff the notes of the meeting are taken by a confidential transcriber.

19. We recommend that the Trust clearly demonstrates that the role of commissioning is separated from that of providing services.

20. We recommend that in the event of all future serious incident investigations all reports are shared in full with the clinicians who were responsible for providing care.

21. We recommend that the findings, conclusions and recommendations of internal investigation reports and this report, with their action plans, are used to debrief staff and are the focus for an in-depth training programme for all staff in the Adult Mental Health Directorate.

22. We recommend that the Devon and Cornwall Probation Area Service, as part of the multi-agency Public Protection arrangements, should participate in a mental health awareness training programme which takes account of the findings and recommendations of this report for practitioners and their managers.

23. We recommend that the Devon and Cornwall Probation Area Service and their constituent Health and Social Services should introduce a protocol and an agreed 'template' to improve communication and the sharing of information, leading to a better understanding of the role played by each agency.

APPENDIX 1

PROCEDURE ADOPTED BY THE INQUIRY

An inquiry is a learning tool and its purpose is to learn any lessons that may minimise the possibility of a recurrence of the tragic event. The report is made available to those bodies that have power to change the service provision. The outcome should be that feasible improvements can be made to secure the safety of mental health users, the public and staff.

The independent panel should do all they can to reduce apprehension on the part of those taking part.

1. Every witness of fact will receive a letter in advance of appearing to give evidence. They will be asked to provide a written statement as the basis of their evidence to the inquiry and inform them of the following:
   - The terms of reference and the procedure adopted by the inquiry.
   - The areas and matters to be covered with them.
   - When giving oral evidence they may raise any matter they wish which they feel might be relevant to the inquiry.
   - They may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another inquiry witness, as a support.
   - The witness will be asked questions and will be expected to answer, but in some circumstances their supporter may be able to help.
   - Their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Any points of potential criticism will be put to witnesses of fact, either verbally when they first give evidence, or in writing at a later time, and they will be give a full opportunity to respond.

3. Anyone else who feels they may have something useful to contribute to the inquiry may make written submissions for the inquiry's consideration and, at the chairman of the panel's discretion, be called to give oral evidence.

4. All sittings of the inquiry will be held in private.

5. The draft report will be made available to the Health Authority, Social Services and the NHS Trust for any comments as to points of fact.

6. The findings of the inquiry and any recommendations will be made public.

7. The evidence that is submitted to the inquiry, either orally or in writing, will not be made public by the inquiry, except insofar as it is disclosed within the body of the inquiry's report.

8. Findings of fact will be made on the basis of the evidence received by the inquiry. Comments, which appear within the narrative of the report, and any recommendations will be based on those findings.

APPENDIX 2

WITNESS LIST

Ms J Barker	Friend of Mr Warnes
Dr L Behennah	Consultant Psychiatrist
Mrs S Bellamy	Mr Warnes' daughter
Mr L Bellamy	Mr Warnes' son in law
Ms T Coleman	CPN
Mr P Confue	Director, Mental Health & Learning Disability Services
Mr A Cookson	Probation Service Team Manager
Mr M Cooper	Community Psychiatric Nurse
Dr J Copper	Trust Medical Director
Ms M Demeranville	Former CPN
Ms S Elliot	Former Director Service Excellence
Mr D Furze	Head of Clinical Governance, Mental Health & Learning Disability Services
Mr M Hall	Manager, Gateway Service
Mrs K Howard	Deputy Head of Mental Health Service
Ms A James	Trust Chief Executive
Dr A James	Consultant Forensic Psychiatrist
Dr H James	Consultant Psychiatrist
Mr I Jane	Locality Manager, Mental Health Services
Ms C Jenkins	Community Psychiatric Nurse
Ms E Longbottom	Acting PCLT manager at the time of the incident
Mr C May	Police Liaison Officer
Ms C Murphy	Former Community Psychiatric Nurse
Ms J Narin	Probation Support Officer
P	Subject of the inquiry
Dr S Payne	Consultant Psychiatrist
Mr N Pennell	Head of Mental Health Service
Dr B Pollard	General Practitioner
Ms G Pridmore	Probation Officer
Mr E Read	Former Community Psychiatric Nurse
Mr M Ringrose	Director of Human Resources
Ms P Robinson	Community Psychiatric Nurse
Mr P Sanford	CPA and MHA Manager
Ms E Spick	Community Psychiatric Nurse
Ms V Stewart	Probation Officer
Dr G Tomlinson	Consultant Psychiatrist
Ms J Wilson	Assistant Director Mental Health (commissioning)

Written information

Mr I Clewlow	Director of Operations, Devon and Cornwall Probation Area
Mr T Harris	Court Diversion Community Psychiatric Nurse
Ms A Mylles	Clinical Psychologist
Mr J Nason	Assistant Chief Officer, Devon and Cornwall Probation Area
Mr S Swaffield-Conlon	Former Locality Manager

APPENDIX 3

DOCUMENTS RECEIVED BY THE INQUIRY

P's Medical Case notes

Cornwall Partnership

Devon Partnership NHS Trust

GP case notes

HMP medical records

Plymouth Teaching Primary Care NHS Trust Inpatient and Community case notes

Plymouth Teaching Primary Care NHS Trust

Internal Investigation into the Homicide of May 2002

P Inquiry chronology

Meeting with P 10.7.03

Interview with Terry Gregory, Care Taker

Notes of meeting with Dr Pollard

Staff interviews

Papers prepared for disciplinary hearings

Mental Health Partnership Strategy consultation draft August 2003-

12-30 specifications and performance schedules

Sainsbury Centre

Evaluation of impact of integrated mental health and social services 2002

Service evaluation 2001

Audit of mental health services 1998

Devon & Cornwall Probation Service

Case Records including electronic entries

Pre-sentence Reports 1999 and 2000

Devon & Cornwall Constabulary

Case Summary

Complete Police files on the case

Department of Health

The Care Programme Approach HSG(90)23/LASSL(90)11, 1990

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community, HSG (94) 27, 1994

Building Bridges, a guide to arrangements for inter agency working for the care and protection of severely mentally ill people, 1995

A National Service Framework for Mental Health, 1999

Code of Practice Mental Health Act 1983 HMSO, 1994 and 1999

Effective Care Co-ordination in Mental Health Services A Policy Booklet, 1999

Still Building Bridges. The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management, 1999

An Organisation with a Memory, report of an expert group on learning from adverse events in the NHS, 2000

Building a Safer NHS for Patients – Implementing An Organisation with a Memory, 2001

Safety First, Five-Year Report of the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness, 2001

The Journey to Recovery – The Government's vision for mental health care, 2002

Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision, 2002

Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide, 2002

APPENDIX 4

INTERNAL INVESTIGATION TERMS OF REFERENCE, OUTCOMES AND RECOMMENDATIONS

Terms of reference

To provide an Internal Investigation, running concurrent to the Critical Incident Review, to examine circumstances of treatment and care by the Mental Health Partnership, in particular:

1. Quality and scope of Health, Social Care and risk assessment at the time of the incident.
2. Appropriateness of treatment, care and supervision, with regard to client's history and assessments.
3. Extent of how much the client's prescribed treatment and care plans were communicated, co-ordinated, delivered, documented and complied with by the client.
4. Adequacy of care and monitoring by the Care Co-ordinator.
5. Exercise of professional judgement by those involved in the care delivered.
6. Examine appropriateness of training and development of those involved in the care of the client.
7. Review of inter-agency working and communication between health authority, housing, social services and other agencies, which were, or might appropriately have been, involved in the care of the client.
8. Existing systems available for use.
9. Consider other issues arising in the course of the Internal Investigation.

How the internal inquiry was undertaken

The course of the investigation was steered by issues raised through the research of notes, allowing evolvement of the questions to be asked of all parties. Systems and process found wanting in the organisation were identified.

The critical analysis and internal investigation included research of available notes, interviewing probation, housing, and Trust staff who had contact with the client. Admin and medical staff from Waterfront East Primary care Liaison Team (PCLT) were also interviewed.

The client himself was spoken to at the appropriate time, following his improved mental state and sentencing. Notes were taken of his recall of events and his suggestions as to how the service could have been improved.

Notes of the interviews with specific questions to the staff working within the team caring for the client were taken and formally signed by staff.

Outcome of the internal investigation

The internal investigation concluded that the care provided to the client was inadequate, with a number of systems, communications and individual practitioner failures. These are detailed below.

Quality and scope of Health, Social Care and risk assessment at the time of the incident

The client was diagnosed with an identified mental illness and a history of substance misuse. He was prescribed medication for treatment of the condition.

The internal investigation has established that no services or care were being offered to the client by the mental health partnership at the time of the incident.

The quality and scope of social care and related documentation was considered to be good.

There were no formal risk assessments available for this client. The consultant psychiatrist, in his court report January 2001, documented details of risks as the use of illicit substances and offending behaviours..

The client was on a Probation Order with Condition of Treatment from February 2001 to February 2002.

The suitability of care and the effort made to maintain contact with the client was not adequate.

Appropriateness of treatment, care and supervision

The care and treatment for the assessed health care needs were not adequate or appropriate. The mental health partnership provided no care, treatment or supervision to the client from May 2001.

Extent to which the client's prescribed treatment and care plans were communicated, co-ordinated, delivered, documented and complied with.

The internal investigation established that the client had no formal written care plan using care programme approach (CPA) paperwork for the episode of care from February 2001 to May 2002, although the consultant psychiatrist outlined the care and treatment required in the court report of January 2001.

Additionally, the CPN failed to document nursing/care programme approach (CPA) progress notes for each client contact made.

The last documented assessment was that of May 1998 – a detailed social care assessment.

The last care plan documented was that of the ASW, written on formal social care paperwork and dated June 1998. (Social Care and Mental Health Trust staff did not start using Trust Care Programme Approach (CPA) paperwork until April 2002).

The prescribed treatment and care was discussed with the client in an outpatient appointment (January 2001) prior to preparation of the court report, and discussed again with the client at a joint appointment with the CPN and ASW (10 April 2002), when the client was informed who his CPN was. The depot neuroleptic medication was also discussed and the client agreed.

The client's prescribed medication and outline of the care plan were shared with the GP (June 2001 and August 2001) and Probation Service (June 2001 and August 2001) in letters from the consultant psychiatrist. However, updates were not regular or consistent. There was no medical review during this episode of care, due to the client failing to attend when appointments were made.

The client was not reliable regarding attending appointments, however the lack of effort made to engage the client was a significant problem.

Adequacy of care and monitoring by the Care Co-ordinator

There was no care co-ordination for the client for the period of April 2001 to May 2002.

This role was not undertaken by any member of the care team following the closure of this client to the caseload of the ASW. His care was not co-ordinated as directed by Care Programme Approach (CPA).

Exercise of professional judgement by those involved in the care delivered

The exercise of professional judgement in the care of this client falls below what would be expected of nursing and medical staff from May 2001 onwards.

Appropriateness of training and development of those involved in the care of the client

All staff from the Trust involved in the care of this client had adequate experience and training to provide the care required. The care team had a significant number of years experience behind them and further training in addition to this.

Inter-agency working and communication

The internal investigation shows that inter-agency working did take place regarding this client, but was not effectively managed by the Trust.

Housing and Probation did communicate concerns about the client's mental health and behaviour to the relevant staff in the Mental Partnership immediately, in a timely response, but follow up was not timely or actioned appropriately.

Both verbal and written communications from the Trust were ambiguous and allowed for individual interpretation. The absence of appropriately documented care on the electronic and manual records system, and lack of clarity of accountability, compounded this.

One team that might have been able to respond to the criteria of the client was the Assertive Outreach Service, which was well staffed and operated over extended hours to enable contact with 'difficult to engage' clients. A referral to this team was not made.

Existing systems available for use

When reviewing the care of this client, the concerns raised cover individual failings, as well as systems and process failures.

The following systems were available for use:

- Care Programme Approach (CPA) paperwork policy and system was in place.
- Multi disciplinary team meetings where client issues could be discussed.
- Line management/case load supervision.
- Clinical supervision – supervisor allocated.
- Record-keeping training undertaken.
- Care Programme Approach courses and training were regularly available.
- Professional NMC.
- Assertive Outreach Service available to work with clients with severe and enduring mental illness who are difficult to engage could be accessed by any staff involved in the client's care.

Other concerns relating to this matter

During the course of the investigation it was highlighted that there was a lack of trust between staff and their managers, which lead to a culture that was not best conducive to patient care. This was not helped by changes in the team managers and a reluctance to agree and accept operational policies and procedures. Much of this stems from the change process that the service undertook in order to deliver the National Service Framework for mental health. These issues had been discussed at the highest level and a plan had been put into place to begin to address the lack of trust.

Conclusion

In summary, the concerns surrounding the care of this client span over these main areas:

- Individual failings/poor practice.
- Breakdown of systems and processes in place to support the care of the client.

- Breakdown of communications within Mental Health Partnership.
- Breakdown in communication between agencies.

Through the analysis of events leading to the tragedy the review panel/investigating officer applied the standard of reasonable practice of practitioners in their relevant field. Where there have been failings the Trust has taken direct action

Way forward/Recommendations

1. Continue with the agreements made by the Chief Executive with staff and Staff Side representative, ensuring that this is done with timeliness. (See Appendix 4).

2. Continue with the team building process already started with the outside facilitator.

3. Circulate the line of communication to all staff within the Trust, and outline through a flow chart the up and down movement of communication through the organisation. This may be different for different directorates.

4. Agree with Human Resources and Staff Sides a process to meet with each individual in the Waterfront Primary Care Liaison Team (PCLT) (Inner City) to discuss any individual concerns they may have; address these if appropriate, and if not give the reason why to staff, personally and in writing.

5. Agree a protocol between managers and staff of expectations of conduct and how each will treat the other.

6. Address issues of concern relating to staff conduct, and the issues of poor practice, individually at the time that they occur, using the Trust's policies and procedure in a fair and open manner.

7. Appoint a Deputy Manager, who is a clinician, for support to the Waterfront Primary Care Liaison Team (PCLT) (Inner City) team Manager.

8. Review the management structure to ensure that it is ‘fit for purpose’ as required by the Mental Health Partnership within the Primary Care Trust.

9. Provide training for issues of poor practice to ensure there is every opportunity for poor practice to be understood and changed.

10. Review sickness/stress levels; consider moving affected staff to other areas as discussed with the Occupational Health Doctor to meet the organisation’s duty of care.

11. Review the administration resources for the Waterfront Primary Care Liaison Team (PCLT) (Inner City) team.

12. Develop and ensure all administration staff follow the same procedure for recording Consultant’s clinical contact, caseloads, clinics etc.

13. Develop a process for change within the organisation, which is in line with staff involvement policy and also outlines the consequences and the ramifications of any change. Circulate this to staff.

    This process must have:
    The vision, mission statement, rationale (supported by evidence based practice/ research where appropriate), time scales, description of new roles and Operational Policy.

    This information to be circulated to managers and the staff in the team. Representatives on the planning group must include team members; senior and junior, with agreed rules for communicating information to other staff.

14. Develop region-wide clinical networks for clinicians and managers of clinicians. If the managers are not signed up to high clinical standards, then implementing them is more difficult.

15. Ensure issues raised in Directors ‘slots’ are discussed and actioned by Team Managers, supported by Trust policy and procedure and good documentation.

16. Agree with Staff Sides the process of how an individual moves from one post to another, addressing work/life balance and equal opportunities. This process to be circulated to all staff.

APPENDIX 5

ROOT CAUSE ANALYSIS (RCA) RECOMMENDATIONS

Provide feedback from the critical incident review panel.

Address inadequate, incomplete record keeping and other issues surrounding records.

Address the dysfunctional MDT within the Waterfront PCLT (inner-city).

Review the administration resources and processes with Waterfront PCLT (Inner city).

Protocol to be developed for Community Rehabilitation Orders with Condition of Treatment.

Develop a Trust-wide ePEX Policy.

Develop and introduce Multi Professional notes for the mental Health Partnership.

Develop new Trust Policies and update existing ones that require review.

Provide further Education and Training.

Review and amend Gateway Service operational policy.

Reinforce and uphold required professional responsibilities for qualified practitioners.

APPENDIX 6

P'S FORENSIC HISTORY

Date	Offence	Outcome
December 1985	Theft of vehicle x 2 3 other offences taken into consideration	Disqualification from driving for 12 months. Compensation £150
December 1986	Burglary and theft – Non dwelling	Fined £250 Costs £35
January 1992	Grievous Bodily harm against the persons act 1861 Victim was punched in the face and knocked to the ground where P then kicked victim in the face, breaking the victim's jaw, which required surgery.	Community service Order 200 hrs. Compensation to victim £1000 Costs £270
January 1993	Theft	Probation Order 9 months.
November 1996	Possession of a class B drug - Cannabis resin Misuse of drugs act 1971	Fine £50 Costs £25 Forfeiture/confiscation Order for destruction of drugs
November 1998	Possession of a class B drug - Cannabis resin Misuse of drugs act 1971	Fine £50 Forfeiture/confiscation Order for destruction of drugs.
November 1998	Failure to surrender to custody at appointed time Bail act 1976	Conditional discharge 12 months.
August 1999	Dangerous driving Road traffic act 1988 s.2 Using vehicle while uninsured Road traffic act 1988 s.143 (2)	Hospital Order to be detained in Glenbourne Unit, Derriford Hospital. Disqualification from driving for 5 years and licence endorsed.

Date	Offence	Outcome
September 1999	Accused of ‘administering a noxious substance with the intent to cause harm’ Rape x 1 Charge was originally attempted murder	Acquitted due to victim being unable to give evidence. NOT CONVICTED
February 2001	Driving whilst disqualified Using vehicle while uninsured Road traffic act 1988 s.143 (2)	Probation Order with a Condition of Psychiatric Treatment to run for 12 months.
July 2001	Breach of Probation Order	Fined £25 and ordered to continue with the Order as previously.
February 2002	Breach of Probation Order	Conditional discharge.
2003	Manslaughter on grounds of diminished responsibility	Hospital Order Section 37 of 1983 MHA to be detained in Butler Clinic Medium Secure Unit - indefinitely.

APPENDIX 7

PLYMOUTH PRIMARY CARE TRUST AND PLYMOUTH PROBATION - PROTOCOL FOR COMMUNITY REHABILITATION ORDERS WITH A PSYCHIATRIC CONDITION

INTRODUCTION

Following a homicide a case review was recently held. One of the learning outcomes was the need for agreed joint working arrangements between the two services for the better management of these orders. A working party was established with representatives from both services and consultation with relevant staff has taken place. The protocol, information sheet and algorithms explain the process and procedures for these cases.

At the time of a Court request for a Psychiatric Report allocation will be to a Plymouth Psychiatrist whether or not the offender is in custody. If the case is an open case then the request should go to the current, named Psychiatrist. If it is a closed or new case then it should go to Dr Reddy.

Liaison (which can be mainly by telephone) to take place between the two report writers (PSR Writer and Consultant Psychiatrist or Psychologist) prior to the court date in order to discuss and agree the recommendation of a treatment condition where considered suitable. Both the Probation Officer and Psychiatrist may need to be available to be questioned at court.

When a treatment condition is to be proposed, the Psychiatric Service to formulate an Outline Care Plan including the allocation of the necessary resources. These cases to be considered a priority and to include the allocation of a Care Co-ordinator.
Within 10 working days of the order being made Probation to notify the Psychiatrist the name of the Case Manager, and the Psychiatrist to confirm the name of the Care Co-ordinator.

Liaison to take place between the Case Manager and Care Co-ordinator within 15 days of the Order being made. This would set dates for future such liaison to fit in with the Supervision

Planning and Review cycle. If RAMP/MAPP Meetings are convened a representative of the Mental Health Partnership (normally the Care Co-ordinator) to attend.

Joint Agreement of the Care/Supervision Plan to include the frequency and type of contact expected from each agency.

The agreement to include a requirement to inform the Probation Case Manager of all appointments kept/missed, plus an agreement on which appointments are enforceable and count for National Standards.

To communicate all failures to attend, whatever the reason, by the end of the next working day, by telephone to be followed up by letter or email (can be by CPN or Medical Secretary).

Evidence of failure to attend to be provided; a written statement may be required which can be used as evidence in court. This could involve attendance at court and the giving of sworn evidence in not guilty breach cases.

Both agencies to share copies of letters relevant to enforcement (appointment letters, warning and breach letters).

All significant changes/developments to be notified to each other in between Case Conferences.

The Case Manager or Care Co-ordinator is entitled to convene a meeting with the other at any stage. These meetings can also include the offender and/or others. This may be part of the normal review process for Supervision and Care Plans.

APPENDIX 8

CHRONOLOGY ASSOCIATED WITH RECTIFYING THE CASE RECORDS FOLLOWING THE AUDIT, AS WRITTEN BY MRS K HOWARD

Nov 2000

Phil Confue had general verbal discussion in specific meeting to discuss the concerns from the audit to identify time period, clients affected and gaps in electronic data and written records

Dec 2000

A letter was sent from Phil Confue to each staff member individually working in Waterfront PCLT outlining the following:

Trust would not pursue disciplinary action against staff based on full co-operation from all staff in identifying gaps in their patient records.

This was necessary to enable the organisation to cover the legal position of both the Trust and each individual practitioner.

Each CPN was required to meet with a designated manager and systematically note each of the gaps between electronic data and their written records - based on advice received from Trust solicitors.

Staff were to return to the office one hour before finishing time to write up records. This included allowances for individual staff - some to start at 08.00 to write up notes an hour before normal work commenced.

As initial staff in the community teams manage their own work loads and their own time management - time to complete this work would have been agreed locally with the team managers - but within their usual working hours.

Where staff were working in other teams, managers were made aware of the issue via the business and briefing meetings and the need to complete this task. Some managers specifically discussed this at this meeting.

Following no response from Waterfront PCLT, staff were to meet with Mrs Howard as the identified manager to systematically note each of the gaps between electronic data and their written records between 11th Dec 00 and Feb 01 KH met and asked E Longbottom as the team manager to follow this up and remind staff this needed to be done.

Jan/Feb 2001

Elaine Longbottom gave specific verbal instruction in one to one meetings about: identifying time period, clients affected, and gaps in electronic data and written records, the need to put an alert into the electronic records and written records inserting the period when records became incomplete and when they became contemporaneous again.

July 2001

Elaine Longbottom sent letter to all staff with copy of insert to go into written notes

To ask staff to identify clients with missing records.

To inform staff that a written and computerised note needed to be made for each client identifying when the problem started and when the notes became contemporaneous again.

To remind staff of the importance of this to protect themselves as professionals and the Trust in the event of any litigation / other issue.

To ask staff to identify all the clients that this problem applied to.

KH discussed again with EL and another copy of the process as advised by the solicitors sent in writing with attachments of the form identifying the start and end of incomplete/missing records that needed to go in the written notes. Attached to this was a copy of the forms which needed to go in the written notes identifying the start and end of incomplete/missing records that needed to go in the written notes. The letter specifically stated: establish

– with each professional the names of the clients that there are missing records for

– the dates for each client this relates to i.e. when the records started not be contemporaneous / incomplete and when they became contemporaneous

There is a need to STRESS to all staff the need to be honest in order to protect themselves and the organisation

On ePEX (electronic records) each CPN/OT needs to enter in the warning screen notes

"incomplete nursing / occupational therapy notes (apply what ever title is appropriate) are held for the period (install date from and date to). The documentation available does not contain full details of care and treatment undertaken."

Create a form using Trust headed note paper as follows (form attached). These forms need to go in each clients nursing notes at the start of the notes when the problem began and at the point in the records when it ended.

Clients moved to another service outside of the Trust – identify manager of area, contact, explain situation, explain what to do with the forms and send on forms to be inserted in the notes.
The forms to go in the notes were attached to the letter.

September 2001

Elaine Longbottom met with one individual and verbally explained in detail the process.

How to identify case load from ePEX
Time period identified was that of going back to 1998

Explained need to enter a warning screen on electronic record for incomplete including date when records became incomplete and when they became contemporaneous again.
Explained the need to do the same in paper format in the written records.

Aug 2002

Letter from S Meredew to specific staff whose records were of concern following a CPA audit requested by the Department of health in March 2002

letter advised for the need to re-audit this time period of the records which were a concern.

Letter asked staff to contact S Meredew to either book an appointment with G Burton (person doing audit) 5 dates were given in letter if they wished to be present
or To inform him that they did not wish to be present. The letter acknowledged that the records may now be in order but there was a need to establish this. The Letter asked the specific staff who were written to that: if they were aware of other client CPA records which were deficient to bring them to G Burtons attention so they could be rectified - to protect the staff and the Trust.

The process to rectify the records was included in the letter as:

entering onto ePEX (electronic records) a warning that records are incomplete
a written acknowledgment of this in the patient record.

S Meredew stated in the letter he would assist them with this if necessary

G Burton would be advising S Meredew of his findings, these would be discussed with staff.

If the staff had need of any assistance or had any concerns to let S Meredew know. Staff were given 'ring fenced' time to do this.

Aug / September 2003

S Meredew - provided a number of verbal confirmation of the process to individual staff following letters with the process identified in them verbal reassurance was also provided to some staff who were concerned about how to identify the time period. A verbal reminder were given about the Nov 2000 audit looking back over the previous 12 months to help them to focus on identifying time periods Steve Meredew wrote a letter to each individual staff

member affected by the Nov. 2000 audit those in post and those who have left. Letter gave precise details of:

The need to identify the time period when staff did not keep contemporaneous records for what ever reason for any client on their case load , or seen regularly by them.

the staff case load could be accessed from electronic records system

Staff to inform S Meredew which clients were affected

Process adopted:

Staff to open a warning screen on ePEX for each client to note in the warning date of entry

In the ‘event box’ incomplete nursing / occupational therapy notes held for the period (install date from and date to). The documentation available does not contain full details of care and treatment undertaken

Complete the form attached to the letter to go into the client notes one at the point records became incomplete and one at the point in the records when they became contemporaneous again.

Any clients who have now left the service - establish where the records are now, and insert the forms as appropriate.

If they have gone to other service areas outside of the Trust then staff need to establish who the manager is for that area and make contact with them to explain what has happened and send the forms onto them to be entered into the notes.

Staff were advised should they have any questions not to hesitate to contact S Meredew.