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Acknowledgements

The Independent Inquiry Panel would first of all like to extend their deepest sympathy to the family of Ms B.

We also acknowledge the assistance given to us by both Mr A and his solicitor who met with the Independent Panel and helped us understand the circumstances leading to Ms B's tragic death.

Independent Mental Health Inquiries can be very stressful for both individuals and organisations. We are grateful for the way in which the professionals involved in Mr A's care and treatment co-operated with us and commend their openness and commitment in providing information to the inquiry.

Finally we recognise the willingness and commitment of the Surrey Oaklands NHS Trust, Primary Care NHS Trusts, Surrey & Sussex Strategic Health Authority, the Police and the Prison Service who shared information with us and ensured that the relevant documents were provided.

Executive Summary

Introduction

Mr A, aged 35, tragically killed Ms B aged 26, at their flat in Surrey on 11th August 2001. They had been together for seven years. He was convicted of her manslaughter on the grounds of diminished responsibility in November 2002 and sentenced to life imprisonment in February 2003.

Mr A had been in receipt of mental health services from the Redhill and Reigate Community Mental Health Team (CMHT) which is part of the Surrey Oaklands NHS Trust. This Independent Inquiry was formally set up in August 2003 by Surrey and Sussex Strategic Health Authority as required by National Health Service (Health Service Guidance HSG (94)27, Department of Health, 1994).

The purpose of an inquiry is to thoroughly review the patient's care and treatment in order to establish the lessons to be learnt; to minimise the possibility of a recurrence of similar events and to make recommendations for the delivery of mental health services in the future, incorporating what can be learnt from a thorough analysis of an individual case.

Chronology

Background

Mr A first started seeing Ms B in 1994 and although he continued to rent a flat in Redhill, he spent a considerable amount of time with Ms B at her home in Oxted. Their son was born in 1996

July 1997 – June 1998

Mr A saw his GP on 24th July 1997, complaining of pressures at work and in his relationship with Ms B. His main complaint was that he was short tempered with feelings of aggression, particularly whilst he was working as a lorry driver. His GP prescribed him medication for depression and anxiety and made a referral to Primary Care Counselling in Croydon, which Mr A subsequently was unable to attend as it was difficult for him to take time off work.

He visited his GP several times during the next few months continuing to complain of anxiety, not sleeping, feelings of aggression and 'road rage'. His GP continued to prescribe medication for depression but changed it to another product.

On 5th November Mr A contacted the Redhill and Reigate Community Mental Health Team (CMHT) having visited his GP the previous evening with a 'cry for help'. He had been sacked form his driving job and wanted advice about his problems and depression. The duty worker contacted Mr A's GP and arranged for an urgent referral to be faxed through to the CMHT. An occupational therapist undertook an assessment on 10th November, following which she sent a referral to the psychology service for anger management.

Mr A was finally offered an appointment with a recently qualified psychologist on 2nd March 1998, four months after the initial referral. Nine sessions were offered but Mr A failed to attend two of these. A considerable improvement was acknowledged by Mr A and the psychologist, who wrote to the GP stating that Mr A appeared to be managing his anger.

December 2000 – August 2001

On 8th December 2000 Mr A returned to his GP following the death of his grandmother and accumulating financial difficulties after setting up his own business. He was prescribed an anti-depressant.

In April 2001 Mr A had an operation for a shoulder injury and had to stop working for a while. He became increasingly more depressed and on 21st May sought a re-referral to psychology from his GP and was prescribed further anti-depressant medication.

Mr A returned to his GP three days later. A note made in the GP file records that he was 'in a state'. Mr A was assured that a referral had been made to the CMHT and he was given their telephone number.

Four days later, at 6.30 pm Mr A rang the Rapid Response Service (RRS) for help and was asked to come to the Safe House where he was seen by a duty worker who was an approved social worker. A plan was agreed with Mr A to continue to take his medication, to contact the RRS as required and that an appointment would be arranged with the CMHT for a further assessment.

The next day Ms B rang the CMHT requesting that someone contact her in regard to Mr A. She was concerned about him as he was very sad and depressed. An appointment was made for Mr A to be fully assessed on 6th June; Mr A failed to keep this appointment.

The following contacts were made with the service during June and July 2001:-

13th June - visit to GP, medication increased. On leaving the GP Mr A and Ms B went to the CMHT offices in Redhill and were seen without an appointment by the same occupational therapist who had undertaken Mr A's assessment in November 1997.

14th June - OT referred Mr A to Redhill Counselling service, an appointment was offered which Mr A did not take up

28th June - Mr A seen in Accident and Emergency at 07.30 hours having taken an overdose of his prescribed medication. He described it as a 'cry for help' and that he found the CMHT dismissive towards him. Ms B was very concerned and wanted him admitted to hospital. Mr A was seen by a social worker from RRS with Ms B and it was agreed that he would go home.

29th June - Mr A was seen by a consultant psychiatrist at the CMHT offices. He was offered admission, either to hospital or the Safe House but declined both. He did however agree to attend the day hospital.

2nd July - Mr A did not attend the day hospital as arranged.

3rd July - Mr A and Ms B arrived at the day hospital where he was seen by the same consultant and his colleagues. His medication was increased and an outpatient appointment made for 13th July.

13th July - Mr A did not attend for his appointment.

16th July - A letter was sent from the consultant to Mr A's GP stating that he had not attended the outpatient's appointment so he would be offered another on 24th August.

30th July - Mr A visited his GP complaining of depression and feeling agitated. The GP recorded that aside from the side effects of the medication, Mr A 'seemed well'. The medication was reduced.

11th August – Ms B was due to take their five year old son to visit her mother. The couple had an argument and Mr A strangled Ms B.

Findings and Recommendations

Local service management

The former East Surrey Priority Care and Surrey Heartlands NHS Trust merged in 1998 and a further merger took place of the Lifecare NHS Trust in 1999. These three trusts then became the Surrey Oaklands NHS Trust. An internal management re-organisation took place in 2001.

As can be seen over the past few years prior to this inquiry, senior management time has been directed towards several major organisational changes, namely disagreggations and mergers. Such changes can take many months to prepare, cause significant upheaval during the change and demand continuous vigilance afterwards with the necessary integration of culture and policy. This has meant that in the area served by the Surrey Oaklands NHS Trust, senior management has been continuously distracted for some years. It also has meant that, from the point of view of the staff, culture and steer from the top has been inconsistent and constantly changing.

It was reported to us that some senior staff have had to apply for their own jobs on several occasions. This has resulted in a loss of morale, and difficulties in maintaining and developing a changing service. Such inconsistency results in difficulties in staff retention and recruitment, both for managers and clinicians

Primary–Secondary care interface

We noted that, locally, rates of GP referral were much higher than would have been expected from an area which would score relatively well on socio-economic indices. Evidence given to the inquiry panel indicated that team workers were assessing clients in high numbers who had relatively minor mental health problems. We also noted the absence of primary-secondary care protocols for referrals into mental health services at the time of the homicide. This suggests the absence of a robust dialogue between primary and secondary care and a lack of clarity for staff regarding their roles and responsibilities. We were concerned that without this dialogue future developments would be put at risk.

Support provided to families after the homicide

There was no evidence that the Trust made any attempt to contact either family after the homicide. Therefore they did not offer informal or formal support or keep the families informed of the actions being taken to review the service provided. The Trust should have appointed a senior manager to co-ordinate these actions.

Support provided to staff after the homicide

The impact of a homicide on staff, both personally and professionally can be profound. Some staff interviewed by the Independent Inquiry reported that there was little support offered and where the support of a senior manager had been offered, this was considered neither sufficiently supportive nor ongoing. The Independent Inquiry were concerned that for some staff no support had been made available.

Internal inquiry

It was considered by the Independent Inquiry that the Internal Inquiry had been promptly set up. The Internal Inquiry recommendations are largely endorsed (see Appendix 1) and we considered them consistent with their findings. However we were concerned that development of the action plan implementing the recommendations was not wholly consistent with those findings. For example:-

1. Issues around pressures on the team were narrowed into a review of medical staffing.

2. Issues relating to communication and referrals between primary and secondary care were not discussed with the local GPs.

In addition implementation of the recommendations was hampered by changes in the senior management team and we were concerned that management momentum on implementing the recommendations from the Internal Inquiry had dissipated and question whether sufficient action would have taken place without the added impetus of the establishment of the Independent Inquiry. However, in subsequent discussions with the Trust we were assured that several months prior to the Independent Inquiry the Internal Inquiry's Action plan was reviewed.

Diagnosis and implications

One of our main concerns regarding the Internal Inquiry was the premise that Mr A had "*an underlying serious mental illness*." This is normally agreed to include: schizophrenia, major mood disorder e.g. manic depression; and some severe personality and neurotic disorders. This distinction is crucial because the services which should follow are dependent upon this. The Internal Inquiry came to the conclusion that Mr A was suffering from a severe mental illness without discussing this with the consultant involved in his care. Neither did they discuss diagnosis with

other members of the team. If Mr A had had a serious mental illness, one would have expected a more assertive approach by the Trust.

Our review of the history and interviews with numerous involved parties lead us to the conclusion that it is difficult to argue that Mr A had a serious mental illness at any point during his mental health problems. There is no doubt however, that he had psychological and emotional problems with some mood disturbance which may be a consequence of environmental factors.

Psychology service

Mr A first entered the mental health service in 1997 having been seen by a duty worker. Following discussion of the assessment with the team it was agreed he would benefit from an anger management course and he was referred to the psychology service.

The Independent Inquiry, from reading the notes of these sessions, however has concerns relating to clinical practice and evidence base for intervention. For instance these included self disclosure on the part of the psychologist and encouragement to test Mr A's ability to control his road rage by driving. This clearly raises issues around training and supervision,

Issues for medical and other staff

Like many mental health services nationally, the Surrey Oaklands NHS Trust has limited resources with which to deliver a comprehensive range of services. Particularly, we noted the surprisingly high level of referrals from primary care considering the socio-economic environment. Combined with this, is the issue that the catchment population served by the psychiatrist in Redhill was almost double that recommended by the Royal College of Psychiatrists.

Care Programme Approach

Several members of the care team, including the assessing consultant psychiatrist, reported that there was a lack of clarity regarding when and how the level of CPA for Mr A was decided. We found significant differences of opinion among clinicians and managers as to whether Mr A's needs warranted '*standard*' or '*enhanced*' CPA but we took the view that on the information available, his care could have been provided within the '*standard*' level.

It is clear to us that CPA was not fully embedded in the service and at that time there was no culture for the use of CPA as a framework for service delivery.

Clinical risk assessment and management

The panel found that the Trust had a well written risk assessment policy but that there was no clear trigger point in the care pathway for ensuring an assessment was completed and that most of the staff had not been sufficiently trained. There was no mechanism for incorporating risk management into a care plan and there was no auditing mechanism for the whole process. Some of these processes were carried out on a formal basis and some on an informal basis. We were also concerned that a newly qualified psychologist was seeing a client with significant risk factors with inadequate supervision. There was also no system for a multi-disciplinary discussion which could identify the risks and then decide if any action needed to be taken in response.

Domestic violence

Mr A gave a history of domestic violence towards his current and previous partner. Ms B, some years later, had a couple of conversations with staff during Mr A's contact with the mental health services and she did not state that she personally felt at risk. This is clearly a highly complex situation which has to balance the needs of the client, confidentiality and a risk to a third party based on inevitably patchy evidence. Risk assessment is a continuous process. The prediction of risk is based on weighing any new information with what is already known.

Health and safety of staff

Health and safety was raised as an issue for the 'Safe House'. The panel was concerned to learn about the staffing arrangements which consisted of a few permanent staff who were supplemented by staff from the CMHTs. It appears this situation has now been reviewed. However, we have been informed that the alarm system which was originally included in the Internal Inquiry recommendations will not be fitted due to costs. A member of staff reported there was no means to summon help, but did not feel threatened. The Trust is advised to ensure a robust system is in place for staff to summon help to this stand alone unit, as recommended in the internal review.

Induction / Training / Supervision

Some of the staff we interviewed stated they have not had an induction to their role, sufficient training in essential issues or access to supervision to allow them to reflect upon and be guided in their day to day work. Pertinent to this case is training in clinical risk assessment and CPA, and access to regular supervision. These do

not appear to have been sufficiently available at the time of Mr A's contact with the team. Since the Independent Inquiry the Trust has reviewed their induction process and developed a comprehensive induction programme for all new staff.

The Director of Nursing informed the panel that a staffing review was taking place. This will lead to a strengthening of both the CPA and risk management departments within the Trust. The panel recommends this includes putting in place mechanisms which facilitates closer working between clinical and non clinical risk and includes training (no matter who provides it) and CPA.

Compliance by Mr A with care and treatment

We were specifically asked in the terms of reference to consider Mr A's compliance with the care and treatment that he was offered.

Mr A first recognised that he needed help in 1997, when he sought counselling, but was unable to take time off from work when it was offered. In November 1997, he attended an appointment with the Redhill and Reigate Community Mental Health Team, when he was assessed as "*high need – must have a service*".

Mr A returned to his GP in 2001 and was referred back to the CMHT. The onus was always on him to seek a service and if at any time he missed an appointment there was never any attempt to find out why. However Mr A did not always avail himself of the service on offer e.g. the Safe House or the Day Hospital and must take responsibility for not attending appointments made for him. At no time would Mr A have been found to have been detainable under the Mental Health Act 1983 nor was there any indication that he lacked capacity.

Significant discrepancy – offer of informal admission to hospital

There was one issue which was not known to the Internal Inquiry and which we were not able to resolve. Mr A told the Independent Inquiry that when he was seen on 3rd July 2001 he asked to be admitted to hospital but that it was not offered.

Audit

The quality and results from in-house audits were not as high as the Independent Inquiry would have wished to see. Training on the audit process should be a high priority for the Trust, both for corporate, as well as clinical staff, and also local managers who need to monitor the effectiveness and implementation of Trust plans.

Communication and recording

The panel did not have any concerns regarding record keeping and were largely impressed with the record keeping. Two issues that were identified by the Internal Inquiry which we consider of particular importance were the need for:-

- A clear referral process between primary and secondary care
- Availability of previous notes.

RECOMMENDATIONS

The Independent Inquiry has only a few additional recommendations to add to those already made by the Internal Inquiry (see Appendix One).

'Serious Untoward Incidents'

We recommend that Surrey Oaklands NHS Trust reviews its 'Incident Management Policy' to ensure that:-

- A senior manager is designated to provide support and information to families following a serious untoward incident and guidance is provided for anyone undertaking the role.
- Staff involved in serious untoward incidents provide written statements as soon as possible after a tragedy and receive support to do so.
- Staff are made aware of the support service offered by the Psychology Service within the Trust.
- Wherever possible, those individuals seen by internal inquiries are interviewed by professionals of the same or similar disciplines.

In order to avoid the difficulties which arose in following up some of the recommendations of the Internal Inquiry, we recommend that:-

- The person responsible for ensuring the overall implementation of inquiry recommendations is either a member of the panel and/or clearly defined on any action plan.
- Persons responsible for individual recommendations and dates for completion should be clearly stated.

Primary - Secondary Care Interface

The panel recommends a further dialogue between Surrey Oaklands NHS Trust and the Primary Care Trusts in relation to the provision of mental health services, including:

- Clarifying the roles and responsibilities of frontline staff; referral processes and access; what the Trust is able to offer (for example, anger management); and pathways of care.

- Ensuring that GPs are made aware of what mental health services are available and the procedure for making a referral. Referrals should include the essential information that is required and indicate the degree of urgency.

Care Programme Approach

The panel recommends a further review of the operation of the Care Programme Approach with particular reference to administrative support, training of staff and audit. It is essential that:-

- Clear trigger points in the CPA process require staff to discuss clients in a multi-disciplinary forum and make decisions about risk and suitable care plans.

- Systems for auditing CPA use information technology and develop a process for using CPA locally.

- Risk assessment needs to be further reinforced in the culture including specific consideration of:

    - possible domestic violence;
    - risks from driving (effect of medication; road rage etc);
    - possible child protection concerns.

Domestic violence

We recommend that the Trust should develop a domestic violence protocol, in conjunction with relevant local agencies, as part of the national agenda to aid practitioners in deciding how to respond to situations of known or suspected domestic violence.

Medical staffing

The role of the general psychiatrist has changed dramatically over the past few years; with added responsibilities and a diverse range of teams with whom they have to relate. A national debate is emerging about the role of the psychiatrist.

We recommend:-

- That the Trust initiates a debate amongst its senior clinicians to review their roles within the organisation and with clinical teams.

- Part of this review must include workload and numbers of consultants, with reference to the Royal College of Psychiatrists' guidelines.

Health and safety

An alarm system was recommended by the Internal Inquiry for the 'Safe House' but we understand that one will not be fitted due to high costs.

We recommend that the Trust ensures a robust system is in place for staff at the 'Safe House' to summon help to this stand alone unit.

Induction / Training / Supervision

We recommend the introduction of a system for reviewing all actions, (taken and proposed), at the end of the duty session with a senior clinician.

The Independent Inquiry would wish to see the Strategic Health Authority, Primary Care Trust and Surrey Oaklands NHS Trust set out a programme of actions following these recommendations, which show target dates and achievements.

1. General Introduction

Mr A, aged 35, tragically killed Ms B aged 26, at their flat in Surrey on 11th August 2001. They had been together for seven years. He was convicted of her manslaughter on the grounds of diminished responsibility in November 2002 and sentenced to life imprisonment in February 2003.

Mr A had been in receipt of mental health services from the Redhill and Reigate Community Mental Health Team (CMHT) which is part of the Surrey Oaklands NHS Trust. His first contact with the Trust's mental health services was as a result of a referral for anger management by his GP. He was treated by a psychologist over a two month period in 1998. His next contact was in May 2001 when his GP re-referred him for treatment of depression. He was seen by several professionals as an outpatient. At no time was he admitted for inpatient care.

Following the death of Ms B, the Trust held an internal inquiry which reported in January 2002.

Throughout this report the perpetrator is identified as Mr A; the victim as Ms B; Surrey Oaklands NHS Trust's Internal Inquiry as the Internal Inquiry and this Independent Mental Health Inquiry as the Independent Inquiry.

2. Inquiry Process

This Independent Inquiry was formally set up in August 2003 by Surrey and Sussex Strategic Health Authority as required by National Health Service (Health Service Guidance HSG (94)27, Department of Health, 1994). The guidance states that "*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 *Building Bridges* (Department of Health, 1995) and, as yet, has not been amended.

2.1 Panel Membership

The Inquiry panel consisted of:

Panel Chair	
Dave Sheppard	Director, The Institute of Mental Health Law, Derbyshire
Panel Members	
Dr Danny Antebi	Consultant Psychiatrist, Avon and Wiltshire Partnership NHS Trust
Sharon Dennis	Director of Nursing and Public Involvement, North East London Mental Health NHS Trust
Inquiry Manager	
Lynda Winchcombe	Management Consultant

2.2 How the inquiry was undertaken

Meetings were held with the professionals involved in Mr A's care. Unfortunately we were unable to meet any member of Mr A's or Ms B's family although they were given the opportunity to meet the panel. The panel did however interview Mr A in prison with his solicitor.

Relevant written documentation was identified and obtained for the panel to consider. Evidence was received from nineteen individual witnesses and management representatives from the Surrey Oaklands NHS Trust, the East Surrey Primary Care Trust and others early in 2004. Each interview was recorded and the individuals were given the opportunity to correct the transcript for accuracy and to add any other information that it was considered would be of further help to the inquiry.

2.3 Documents Considered

The following documentation was obtained for consideration by the inquiry panel.

Surrey Oaklands NHS Trust

- Internal Inquiry
- East Surrey Priority Care NHS Trust Case Notes
- Surrey and Oaklands Trust Care Programme Approach Policy (2002)
- A discussion and consultation document on Mental Health Services in Surrey and Northeast Hampshire
- Surrey Oaklands Trust, Internal Inquiry action plan update (12/8/03)
- Policy for Integrated Health and Social Records of care treatment and support record keeping
- Care Programme Approach Operational Policy (November 1999)
- Surrey Oaklands Trust, Risk Assessment and Management in Mental Health (12/3/03)
- Surrey Oaklands Trust, Risk Assessment and Management in Mental Health (1/4/02)
- Surrey Oaklands Trust Profile
- Structure and Annual Report
- Supervision Policy and Guidance
- Mental Health Services – Strategy in Evolution
- Notes of interview and statements – internal inquiry
- Press Releases
- Report on the Safe House Review
- Structure of Psychology services
- Locality Profile
- Audit report on Community Mental Health Team minutes/good practices
- Action Plan Review Documents
- Updated draft Action Plan (16/1/04)
- Updated Action Plan (2/2/04)
- Out of Hours Operational Policy
- BLIP Protocol
- Secondary audit of Community Mental Health Team Minutes
- Commission for Health Improvement audit of child protection arrangements for NHS Trusts
- Serious Untoward Incident Policy 2001-2003
- Journey Comparisons with the East Surrey Model of Adult Mental Health Services

General Practitioner

- Medical Notes

East Surrey Primary Care Trust

- Correspondence regarding possible PCT takeover of NHS
- Crilly Report – an analysis of expenditure within mental health services in 2001
- East Surrey PCT Presentation Documents
- Commissioners Perspective
- Progress to date
- Forums
- Expenditure
- Implementation of National Service Framework
- East Elmbridge & Mid Surrey Local Delivery Plan
- East Surrey Mental Health Promotion Strategy
- Discussion & Consultation Document
- Outcome of the Discussion & Consultation document
- Health and Social Care Governance

Lewes Crown Court

- Court Transcripts

Her Majesty's Prison Service

- Prison Health Records

Surrey Police

- Full Police Report of the Investigation
- Previous Convictions
- Police interview with Mr A

Solicitors Records

- Statements

3. Terms of Reference

The purpose of an inquiry is to thoroughly review the patient's care and treatment in order to establish the lessons to be learnt; to minimise the possibility of a recurrence of similar events and to make recommendations for the delivery of mental health services in the future incorporating what can be learnt from a thorough analysis of an individual case.

The terms of reference for the Independent Inquiry were agreed between the Health Authority and the inquiry panel and were as follows:-

1. To examine all the circumstances surrounding the care and treatment of Mr A, in particular:
   The quality and scope of his health, social care and risk assessment.

   The circumstances relating to treatment, and to comment upon:
   - The suitability of the care in view of Mr A's assessed health and social care needs, and clinical diagnosis,
   - The clinical and operational organisation, and the quality of care provided in the community,
   - Assessment of the needs of carers / family.

   The suitability of his treatment, care and supervision in respect of:
   - His assessed health and social care needs,
   - His assessed risk of potential harm to himself or others,
   - Any previous psychiatric history, including drug and alcohol abuse,
   - Previous psychiatric history,
   - How the service met his health and social care needs

   The extent to which Mr A's care corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health and local operational policies: the extent to which his prescribed care plans were:
   - Effectively delivered,
   - Complied with by Mr A,
   - Monitored by the relevant agency.

   The history of Mr A's treatment, care and compliance with the service provided

   The internal inquiry completed by Surrey Oaklands NHS Trust and the actions that arose from this.

   Consider such other matters relating to the said matter as the public interest may require.

2. To consider the adequacy of both the risk assessment procedures applicable to Mr A and the relevant competencies and supervision provided for all staff involved in Mr A's care.

3. To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr A, or in the provision of services to them, including Surrey Oaklands Trust and GP services.

4. To prepare an independent report, and make recommendations to the local health and social care communities.

4. Surrey Oaklands NHS Trust's Internal Inquiry

Following the death of Ms B an 'Internal' Inquiry was set up by the Surrey Oaklands NHS Trust with an external chairman, the Chief Executive of South Downs Health NHS Trust. Other members were a Consultant Psychiatrist, the Trust's Director of Nursing and a Non-Executive Director, a Non-Executive Director from East Surrey Health Authority and an Area Manager from Surrey County Council Social Services Department. Witnesses were usually seen by the chairman and two other members.

The Internal Inquiry completed their report in January 2002. Later that year, in November, Mr A was convicted of manslaughter.

The Internal Inquiry stated they had:-
"*evidenced both good practice and identified weaknesses in the care and management of Mr A. Our main recommendation is for the Trust to review the trigger points (i.e. once certain symptoms are presented), for the Care Programme Approach to be enacted, and to ensure through supervision, appraisal and audit that it is consistently applied by all professionals.*"

The Independent Inquiry had access to the both the notes of the Internal Inquiry and their report. The report included 19 recommendations (reproduced in Appendix One).

Our consideration of the Internal Inquiry is discussed further in section 6.6.

5. Chronology

The following chronology has been compiled from a detailed review of the documents which were provided to the Independent Inquiry, supplemented by statements and oral evidence from witnesses.

5.1 Relevant background

Mr A first started seeing Ms B in 1994. He continued to rent a studio flat in Redhill despite spending a considerable amount of time with Ms B in her property in Oxted. His sons, (from previous relationships) visited him at his Redhill home. In 1996 Ms B gave birth to their son, (Mr A's fourth child). She continued to work as a hairdresser until her death.

5.2 First contact with mental health services

24th July 1997
Mr A saw his GP complaining of pressures at work and in his relationship with Ms B. His main complaint was that he was short tempered with feelings of aggression, particularly whilst he was working as a lorry driver. His mother had died earlier in the year and he considered that he hadn't grieved properly. He felt he was not coping, was not sleeping properly, had lost weight, and was biting his nails constantly. His GP referred him to Primary Care Counselling in Croydon and prescribed him medication for depression and anxiety (*Paroxetine 20mg* daily – a months supply) and asked him to return in a month at the end of August.

11th September 1997
Mr A returned to his GP complaining that he was still anxious and not sleeping properly, despite having difficulties with some of the sedating effects of the medication. He had run out of tablets a couple of weeks before. He continued to speak of difficulties whilst driving lorries and experiencing "*road rage*." His medication was changed to another antidepressant (*Sertraline 50mg* daily – a month's supply) and he was asked to return in a month.

30th September 1997
The GP was informed by Primary Care Counselling in Croydon that Mr A was unable to attend counselling as it was difficult for him to take time off work to attend the sessions.

6th October 1997
Mr A returned to the GP practice. He was still not coping with work and was finding driving very stressful. He was given a further month's prescription (*Sertraline 50mg* daily).

5th November 1997
Mr A rang the Redhill and Reigate Community Mental Health Team (CMHT). He informed them that he had visited his new GP last night with a "*cry for help.*" He had just been sacked from his driving job and wanted to talk to somebody about counselling for his problems and depression.

A duty worker in the Community Mental Health Team contacted the surgery and left a message requesting that an urgent referral be faxed through to them. It was decided on the basis of the phone call from Mr A that they should see him urgently and arrangements were made for him to be seen in the Community Mental Health Team for assessment.

10th November 1997
Mr A was assessed by the Community Mental Health Team duty worker, an experienced Occupational Therapist. The meeting was not the easiest as she said "*he was not going to leave until he had finished. The meeting lasted 3-4 hours."*

Her report on this interview included the following (selective quotes). "*Reason for referral: complained of feeling angry and aggressive. Long-standing history of aggression in relationships. Recently worse since difficulties at work. Blows up all the time – more recently when driving his lorry – feeling like ramming other cars / lorries on road. Violent to partner. Loses his temper a lot. Sometimes has to get up in the night and go out and drive around until calmer. Does not feel safe enough to drive the lorry and has been sacked whilst off sick. Currently unemployed … unpopular with other drivers – became hostile towards him and vandalised his car and lorry. Very violent with 2nd partner, knocked her unconscious … threatened a friend of hers with a knife (convicted of GBH). Hit another with a baseball bat (premeditated), fractured skull. No charges pressed. Led to serious revenge attack on him. Violent to Ms B currently – "black eyes" etc. No prosecutions for violence to girlfriend / partners – never been charged although Police have been involved. Mr A has a history of pre-meditated violence and describes himself as always having a short fuse.*"

She scored his need in accordance with the weighting system in place at the time which equated to "*High need - must have a service*." It was agreed with Mr A that she would refer him to a psychologist for anger management.

26th November 1997
The Clinical Psychologist sent a standard letter to Mr A, with a copy to his GP, stating that he had been placed on the psychology waiting list. No time limit was given.

28th January 1998
Two months later Mr A rang the Community Mental Health Team enquiring about the delay in being seen.

5.3 Psychology treatment

24th February 1998
The clinical psychologist wrote again to Mr A, with a copy to his GP, offering an appointment for 2nd March 1998, four months after the initial referral.

Anger management from the Psychology service
Mr A saw a clinical psychologist, who had recently qualified, on seven occasions between March and May 1998. During the treatment period he was offered nine sessions but failed to attend two of these. Both the psychologist and Mr A felt that the sessions had been useful. Mr A reported a considerable improvement in his behaviour.

16th June 1998
The psychologist wrote a discharge summary to the GP which stated that Mr A "*had recently decided he was not fit to work as a lorry driver due to his experience of 'road rage' in which he had become quite fearful of what he may be capable of doing to other drivers*". He concluded that "*while Mr A did not attend his last scheduled appointment and there has been no communication from him, it is likely he has taken up one of several job offers. At our last session, he appeared to be managing his anger very adequately and therapy was expected to end very soon anyway. If for any reason Mr A finds he is experiencing further problems, you would be most welcome to re-refer him to me*."

5.4 Re-referral to mental health services

8th December 2000
Mr A returned to his GP following the death of his grandmother and his accumulating financial difficulties after setting up his own business. He was prescribed *Temazepam 10mg* daily.

April 2001
Mr A went into hospital for an operation on a shoulder injury. During the interview with him, as part of this inquiry, he told us that after the operation "*he had stopped working, suffered financially and hit rock bottom. He would sit, unwashed, in his dressing gown, all day in a darkened room".*

21st May 2001
Mr A went back to his GP complaining that he was again depressed. He was not sleeping and was stressed with his new business. He sought a re-referral to see the psychologist. The GP agreed to make the referral and restarted him on *Paroxetine 20mg* daily. He gave him a month's supply and advised him to return after one month.

24th May 2001
Mr A returned to his GP a few days later. He was still not sleeping and was "*in a state*" as was recorded in the GP notes. He was prescribed *Temazepam* 10 mg, one or two tablets at night (28 tablets) and advised that the re-referral letter had been written to the Community Mental Health Team. He was also given their phone number if he wished to contact them direct.

The referral letter stated: "*Please would you see this 34 year old man once again. He previously received counselling from you in 1998 and found this very helpful. However, more recently he has become increasingly depressed following the death of his grandmother and an operation on his shoulder. He is now not sleeping, has low self-esteem and lost interest in his new business which he has recently set up. I have started him on Paroxetine 20mg a day and Temazepam 10 – 20mg at night as required. I have also given him a contact number for the Community Mental Health Team as the situation appears to be reaching a crisis point*."

28th May 2001
At 6.30pm, Mr A rang the Rapid Response Service which provides advice and support. He gave a resume of having had help from a psychologist in 1998 and of his current anti-depressant medication. He was advised to come to the Safe House (an alternative to hospital admission in the community and staffed by trust and social services staff).

Mr A arrived at the Safe House at 7.30pm where he was seen by a duty worker who was also an Approved Social Worker. Mr A described feeling depressed and identified several symptoms including poor appetite, weight loss, poor concentration, broken sleep and listlessness. He also talked about feeling overwhelmed by the pressures involved in running his haulage business. Other life events included:

- death of mother, father and grandmother in the last four years;
- operation on shoulder two months ago;
- high level of debt from a '*mad*' spending spree at Christmas including a £35,000 Range Rover.

Mr A admitted to fleeting thoughts of suicide, but that he had no intention to take his own life.

It was agreed that;

- Mr A would take the anti-depressant medication as prescribed by GP;
- Mr A would use the Rapid Response Service as required;
- the Community Mental Health Team Duty Officer would follow up the referral made recently by the GP and contact Mr A with an assessment appointment.

Mr A left the Safe House after 45 minutes and returned to Ms B and their son.

29th May 2001
The next day Ms B rang the Community Mental Health Team and left a message asking for someone to ring her. A senior Community Psychiatric Nurse rang her back and they spoke for about 30 minutes. His entry in the duty log records: "*Telephone call with Ms B, girlfriend. Mr A has had a lot of losses recently (3 deaths), an operation (6 weeks ago). Mr A lives with Ms B even though officially he is resident in Redhill. I will arrange assessment at Shaw's Corner. Suggested they contact CRUSE and Oxted CMHT for emergency visits. Ms B did not think Mr A actively suicidal, just very sad*."

The same Community Psychiatric Nurse, when seen by the Internal Inquiry, said that "*there was a call from Mr A's girlfriend on 29th May 2001. I phoned back and spoke to her. She was very concerned about Mr A. He was depressed, so bad she feared he may need inpatient care. They were in the Oxted area so I said if Mr A needed urgent input to phone the Oxted team and they may come out to see him. I wrote a note on his notes to the psychiatrist re the need to see him urgently*."

6th June 2001
Mr A did not attend the appointment arranged for him to see the duty worker for the assessment interview at the Redhill and Reigate CMHT office.

13th June 2001
Mr A saw his GP who noted: "*Not really any better, mainly concerned about poor sleep, can't get off to sleep then wakes early morning. Has not managed to arrange counselling yet, to try to do so, increase Seroxat and see in two weeks*."

On leaving the GP Mr A and Ms B went to the Redhill and Reigate Community Mental Health office. They were seen without an appointment by the Occupational Therapist who had seen Mr A in 1997. He informed her that he had just seen his GP who had increased the *Seroxat* to 30mg daily as well as prescribing new medication to help him sleep. She recorded that Mr A's mood was "*low but variable – able to laugh at times with partner during assessment*." She noted under "*Suicidal Ideation / Self Harm*" that there "*may be some risk of impulsive act*."

Her summary of the assessment stated: *"Mr A outlined the difficulties he was currently facing, significant debts and struggling to cope with the day–to–day running of the business. In addition, the loss of family members, in particular, his grandmother, may be a contributing factor. He described feeling low in energy / motivation, tiredness, reduced appetite, some weight loss and marked sleep disturbance. Over the past 2 to 3 days, Mr A described having thoughts of taking an overdose, partly to 'make people take me seriously.' He was clear that he did not want to die and that, normally, he enjoys life. Recently, his partner has become increasing exasperated by his apparent lack of interest in trying to resolve the situation and Mr A described feeling overwhelmed by it, but his fear of losing the*

relationship had forced him to seek help. We discussed some practical strategies regarding tackling the debt and the importance of both of them communicating. The following plan was agreed:

- *Mr A to access Citizen Advice Bureaux as soon as possible for financial / business advice over the debt;*
- *Mr A to begin to document (a) debts and outgoings (b) income in preparation for the above;*
- *Mr A to plan some reward for achieving the above;*
- *To contact the CMHT for assistance if mental state changes;*
- *To refer to Redhill Counselling to explore possible loss issues."*

14th June 2001
The Occupational Therapist sent a letter (plus referral letter from GP and assessment summary) to Redhill Counselling Service referring Mr A for short-term counselling. A copy of the letter and assessment summary was also sent to his GP. (She subsequently heard that Mr A was offered an appointment which he didn't take up).

28th June 2001
Mr A arrived at the local Hospital's Accident and Emergency Department at 7.30am having taken an overdose of prescribed medication, (Ms B arrived later). He told the triage nurse that he had taken approximately 15 tablets each of *Seroxat* and *Zopiclone*, although later said it was 6 tablets of each. The Poisons Unit was contacted who advised he only needed observation. The triage nurse recorded that he felt desperate as none of the support offered so far had helped. He said he had been to the Community Mental Health Team but found them to be dismissive towards him. The nurse recorded that he reported that the view had been "*Oh well, you're not a life threatening case*."

It was recorded that Mr A said the overdose was a '*silly thing to do*' which he did not think he would repeat. He described it as a cry for help. He was happy to go home and was willing to be seen the next day. His insight was said to be good and he was talking clearly about the problems and stresses which led to overdose. Although he wanted to go home, Ms B, who was seen with Mr A, was very concerned and wanted him to be supported somewhere else that night. She thought that if he returned home that night, things may lapse back to what they were before. After discussion with the doctor as to what service was available, Ms B was keen for Mr A to be seen by the Rapid Response Service and possibly admitted to the Safe House overnight and with a follow up by the Community Mental Health Team the next day. She spoke to the doctor briefly on her own and told her that Mr A had previously taken a small overdose but that he had not told anyone apart from her. Ms B did not think he would take another in the short term.

That afternoon the hospital staff contacted the Rapid Response service and requested an overnight stay for Mr A at the Safe House. He was interviewed at the

hospital by a Senior Social Worker who recorded that Mr A "*really did not want to come. His partner (Ms B) was putting pressure on him to come as she felt very anxious about him. Ms B did most of the talking. We tried to facilitate some communication between them. She agreed to him going home*." It was agreed that they would contact the Community Mental Health Team in the morning and arrange to see the Duty Officer for further assessment and medication (including a possible outpatient appointment with a psychiatrist). The duty doctor sent a fax to the Redhill and Reigate Community Mental Health Team with a copy of her assessment and requested that Mr A "*needs an appointment as soon as possible (? tomorrow).*"

29th June 2001

On the following day Mr A was seen, on his own, by the Consultant Psychiatrist at Shaw's Corner, the office of the Redhill and Reigate Community Mental Health Team. He was seen at the end of the out-patient clinic and the consultant was able to see him for 40-45 minutes. At that time his previous notes were not available. The consultant recorded in a letter to the GP that Mr A "*was very tense and agitated but co-operative and had good eye contact. His speech was normal in form and rate. He was clearly very depressed and his low mood was associated with change in his biological functions and suicidal ideation. I did not detect any abnormal beliefs or perceptions and his cognitive functions were intact. He was offered admission to the Safe House, which he declined. However, he was willing to comply with his treatment and attend the Day Hospital at Shaw's Corner. His current medication is Venlafaxine XL, 75 mgs OD, Stematil 5 mgs and Nitrazepam 10mgs nocte. I will see him again next Tuesday*."

The consultant told the Independent Inquiry that he offered Mr A admission to hospital and when he turned that down, offered him a place at the Safe House for the weekend and during the week while he was attending the Day Hospital. The offers of hospital admission and Safe House were declined by Mr A. However he agreed to attend the Day Hospital.

3rd July 2001

Mr A did not attend the day hospital as planned on Monday 2nd July 2001. Mr A and Ms B did however go to the Day Hospital on the afternoon of Tuesday 3rd July 2001 when he was seen by the same consultant and colleagues. It was recorded that Mr A complained of "*decreasing motivation and lethargy and racing thoughts +++*". The dosage of *Venlafaxine* was increased from 75mg daily to 150mg daily. Following an overdose, because of a possibility of recurrence, prescriptions of short duration are normally given. However, due to Mr A's financial situation, he was given a prescription for six weeks and Ms B volunteered to look after the medication. She accepted Mr A's decision not to attend either the Day Hospital or stay at the Safe House. An out-patient appointment was made at the time for Mr A to attend on 13th July 2001.

13th July 2001
Mr A did not attend the out-patients appointment and there was no contact from him.

16th July 2001
The Consultant Psychiatrist wrote to the GP that Mr A had failed to attend and that "a*nother appointment will be sent to him in the near future*." A further appointment was subsequently offered for 24th August 2001, six weeks later.

30th July 2001
Mr A went to see his GP and told him that he was still depressed and agitated. He was having difficulty with the side effects of the *Venlafaxine* and so the GP agreed to the dosage being reduced by half to 75mg a day. The GP recorded that Mr A "*seemed well*" and said he would attend the out-patient appointment with the consultant on 24th August 2001.

11th August 2001
Ms B was due to take their five year old son to visit her mother in the northeast of England. The couple had an argument around travel arrangements and it was during this that Mr A strangled Ms B, at their flat.

6. Conclusions and Findings

6.1 The national context - mental health services

For the past 20 years or so, mental health services have been urged by central government to focus on those patients with severe and enduring mental illness. This policy guidance followed a drive to modernise mental health services which was associated with several high profile tragedies. Linked to this was the introduction of the *Care Programme Approach* (CPA) (1) in 1991 which offered a framework for the delivery of services particularly to those with severe mental illness, and the *National Service Framework for Mental Health* in 1999 (2).

Severe and enduring mental illness normally refers to those patients with schizophrenia, major affective disorder (manic depression and severe depression), non-psychotic disorders which severely impair functioning and some severe personality disorders though there remains debate about the ability of services to treat the latter.

Many services have risen to this challenge using the CPA as a basis for focussing resources on those with severe mental illness and complex needs. With limited resources this inevitably leads to services being directed to this particular group and an implicit rationing of the service provided for others. Those with less severe problems are left somewhere on the interface between primary and secondary care. It is well known that primary care manages at least 90% of all mental health problems, usually of the less severe nature. Services for the latter will depend on the expertise in particular GP practices, and on the negotiated care pathways with secondary care. Specialist mental health services will have developed their own local thresholds for accepting clients into specialist care. There is, as a consequence, much less clarity about who will manage clients who do not have severe and enduring mental illness.

6.2 Local service management

During the inquiry panel's discussions with senior managers from the Strategic Health Authority, the Primary Care Trusts and the Mental Health Trust, it became increasingly clear that over the past few years senior management time has been directed towards several major organisational changes, namely disagreggations and mergers. The former East Surrey Priority Care and Surrey Heartlands NHS Trust merged in 1998 and a further merger took place of the Lifecare NHS Trust in 1999. These three trusts then became the Surrey Oaklands NHS Trust. An internal management re-organisation took place in 2001.

Such changes can take many months to prepare, cause significant upheaval during the change and demand continuous vigilance afterwards with the necessary integration of culture and policy. This means that in the area served by the Surrey Oaklands NHS Trust, senior management has been continuously distracted for some years. It also means that, from the point of view of the staff, culture and steer from the top has been inconsistent and constantly changing.

It was reported to us that some senior staff have had to apply for their own jobs on several occasions. This has resulted in a loss of morale, and difficulties in maintaining and developing a changing service. Such inconsistency results in difficulties in staff retention and recruitment, both for managers and clinicians.

6.3 Primary–Secondary care interface

The relationships between primary and secondary care are some of the most important in determining the quality of care delivered and the efficiency of local health services.

We noted that, locally, rates of GP referral were much higher than would have been expected from an area which would score relatively well on socio-economic indices. Evidence given to the inquiry panel indicated that team workers were assessing clients in high numbers who had relatively minor mental health problems. We also noted the absence of primary-secondary care protocols for referrals into mental health services at the time of the homicide. This suggests the absence of a robust dialogue between primary and secondary care and a lack of clarity for staff regarding their roles and responsibilities.

We were concerned that without this dialogue future developments would be put at risk. This is particularly important for clients such as Mr A whose care needs were being managed as an outpatient and thus shared between primary and secondary care. We were advised of the planned future development of services, for example the Primary Care Liaison Team which sounded very positive. These developments involve the closer linking and co-location of mental health care staff with primary care.

More specifically, as demonstrated in this case, there should be clarity about the role of certain interventions, for example, anger management, as part of a mental health service. Such clients, by definition, pose significant risk to others and if they are to be treated there should be a careful diagnostic formulation; risk assessment; a treatability assessment and an appropriate care pathway.

6.4 Support provided to families after the homicide

There was no evidence that the Trust made any attempt to contact either family after the homicide despite the guidance given in *Building Bridges* (3) and this recommendation occurring frequently in many other inquiries following homicide. Therefore they did not offer informal or formal support or keep them informed of the actions being taken to review the service provided. The Trust should have appointed a senior manager to co-ordinate these actions.

6.5 Support provided to staff after the homicide

The impact of a homicide on staff, both personally and professionally can be profound. Some staff interviewed by the Independent Inquiry reported that there was little support offered and where the support of a senior manager had been offered, this was considered neither sufficiently supportive nor ongoing. The Independent Inquiry were concerned that for some staff no support had been made available.

The Trust's lead psychologist informed the Independent Inquiry that her department provides a support service for all staff.

6.6 Internal inquiry

> "*If a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event, action by local management must include an immediate investigation to identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach*."
> Para 33, Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community, Department of Health, May 1994

Following the death of Ms B an 'Internal' Inquiry was set up by the Surrey Oaklands NHS Trust with an external chairman, the Chief Executive of South Downs Health NHS Trust. Other members were a Consultant Psychiatrist, the Trust's Director of Nursing and a Non-Executive Director, a Non-Executive Director from East Surrey Health Authority and an Area Manager from Surrey County Council Social Services Department. Witnesses were usually seen by the chairman and two other members.

The Internal Inquiry completed their report in January 2002. Later that year, in November, Mr A was convicted of manslaughter.

It was considered by the Independent Inquiry that the Internal Inquiry had been promptly set up. In common with many other internal inquiries the panel did not meet with Mr A, nor any of the victim's family. Similarly they did not interview Mr A's GP or examine the GP notes, and of course did not see the statements obtained by the Police for the prosecution (which revealed more about the domestic violence). Inevitably this restricted the ability of an Internal Inquiry to construct a full picture of events.

In addition it would have been helpful if staff had provided statements to the Internal inquiry. This would have enabled staff to have put down their thoughts whilst the events were still clear in their memory and would have formed a framework on which to set out their evidence to both the Internal and the Independent Inquiry.

The independent panel also noted that although a member of the internal inquiry panel was a consultant psychiatrist, they did not interview the consultant psychiatrist involved in the case. He was seen instead by the chairman, a non-executive director and the director of nursing from the Trust. The panel consider that when interviewing key personnel for the purpose of inquiries, there should be careful consideration of who undertakes these interviews.

We would largely endorse the Internal Inquiry recommendations (see Appendix One) and consider that they are consistent with their findings. However we were concerned that development of the action plan implementing the recommendations was not wholly consistent with those findings. For example:-

1. Issues around pressures on the team were narrowed into a review of medical staffing.

2. Issues relating to communication and referrals between primary and secondary care were not discussed with the local GPs.

It was not clear who was responsible for ensuring the action plan was implemented and the mechanisms for reporting to the clinical and social governance sub group.

Implementation of the recommendations was hampered by changes in the senior management team and we were concerned that management momentum on implementing the recommendations from the Internal Inquiry had dissipated and question whether sufficient action would have taken place without the added impetus of the establishment of the Independent Inquiry.

The Internal Inquiry report was not widely circulated, resulting in those such as the Head of Psychology not having seen the main report, but expected to implement some of its recommendations.

6.7 Diagnosis and implications

One of our main concerns regarding the Internal Inquiry was the premise that Mr A had "*an underlying serious mental illness*." This is normally agreed to include: schizophrenia, major mood disorder e.g. manic depression; and some severe personality and neurotic disorders. This distinction is crucial because the services which should follow are dependent upon this. The Internal Inquiry came to the conclusion that Mr A was suffering from severe mental illness without discussing this with the consultant involved in his care. Neither did they discuss diagnosis with other members of the team. If Mr A had had a serious mental illness, one would have expected a more assertive approach by the Trust.

It was apparent that there was a clear problem in establishing and maintaining diagnostic consistency for Mr A. His first contact with mental health services was in November 1997 for a problem with anger control (for example - road rage) including some symptoms of depression and anxiety. The response by the Trust was to put him on a waiting list and he was seen by a newly qualified psychologist for anger management. Many trusts, then and now, do not offer a service for anger management in the absence of a mental illness. A key question we considered was that if a service is offered, what are the responsibilities of the service in terms of assessing and managing risk and assertive follow-up for such a client?

During the second referral in 2001 Mr A was diagnosed with moderate/severe depression having been seen at the end of an out-patient clinic at short notice. It is unlikely, with the time constraints, that the consultant would have had a chance to take a full assessment, especially in the absence of old notes. Mr A was reviewed subsequently by his GP on 30th July 2001, 11 days before killing Ms B, and reported to be improved following treatment. A report for the court by an independent psychiatrist gives a retrospective diagnosis of severe depression at the time of Ms B's death. The consultant psychiatrist responsible for his care in 2001 reported that he did not feel Mr A had a serious mental illness and his presentation was more likely to be personality related.

Our review of the history and interviews with numerous involved parties lead us to the conclusion that it is difficult to argue that Mr A had a serious mental illness at any point during his mental health problems. There is no doubt that he had psychological and emotional problems with some mood disturbance which may be a consequence of environmental factors.

Diagnosis in psychiatry is always potentially debatable due to the absence of externally validating tests, i.e. one can validate a clinical diagnosis of bone fracture with an x-ray. There is no equivalent test for depression.

6.8 Psychology service

Mr A first entered the mental health service in 1997 having been seen by a duty worker. Following discussion of the assessment with the team it was agreed he would benefit from an anger management course and he was referred to the psychology service. The Independent Inquiry panel were not able to interview the psychologist as he has since moved to another country and therefore the panel's views have been drawn from the Internal Inquiry interview, the psychologist's clinical notes and information from trust employees.

Mr A was complimentary about the service, and his partner apparently reported things had improved during this period. The Independent Inquiry, from reading the notes of these sessions, however has concerns relating to clinical practice and evidence base for intervention. For instance these included self disclosure on the part of the psychologist and encouragement to test Mr A's ability to control his road rage by driving. This clearly raises issues around training and supervision, which is covered in a later section.

It is clear that the psychology service at that time did not participate in the Care Programme Approach and operated largely independently of the rest of the mental health service.

The delay in contact following referral and the fact that no other service was offered in the interim were dealt with by the Internal Inquiry and it was reported to the Independent Inquiry that the process for managing referrals to the psychology service has significantly improved.

6.9 Issues for medical and other staff

Like many mental health services nationally, the Surrey Oaklands NHS Trust has limited resources with which to deliver a comprehensive range of services. Particularly, we noted the surprisingly high level of referrals from primary care considering the socio-economic environment. Combined with this is the issue that the catchment population served by the psychiatrist in Redhill was almost double that recommended by the Royal College of Psychiatrists. Whilst College figures are only guidance and need to be taken in conjunction with local morbidity, socio-economic deprivation and other local factors such as homelessness, the amount of Consultant time remains of concern. We noted that the Trust has increased junior medical support in line with the recommendations of the Internal Inquiry. The high referral rate and large catchment areas have a major impact on the work of the consultant who ultimately has to make diagnostic and risk decisions. This high workload also impacts on the whole multi-disciplinary team who are making many of these assessments.

Nationally the role of the psychiatrist is increasingly acknowledged to be problematic because of the diversity of tasks. This has been exacerbated by the creation of additional teams, as determined by the National Service Framework, with additional responsibilities for psychiatrists and other staff. The absence of clarity regarding the roles for psychiatrists prevents them from offering clear clinical leadership to teams and distances them from operational management. Surrey Oaklands NHS Trust is no different in this regard.

No action has been taken to increase the overall staffing of other professionals within the Redhill and Reigate CMHT and it would appear to be just as pressured now, as it was at the time of the homicide. Adding extra junior doctors doesn't sufficiently address the problem; bringing with it the additional issue of supervision undertaken by consultant psychiatrists.

6.10 Care Programme Approach

The Care Programme Approach (CPA) was introduced nationally to adult mental health services in 1991 (1) to provide a framework for effective mental health care. Its four main elements are:

- A systematic assessment of health and social care needs which includes a risk assessment;
- A written care plan which identifies the care required from health and social care providers;
- A care co-ordinator to keep in touch with the service user and monitor and co-ordinate care;
- Regular review and where necessary agreed changes to the care plan.

Having carried out an assessment, professionals must currently determine one of two CPA levels: '*standard*' or '*enhanced*'.

"*The characteristics of people on standard CPA will include some of the following:*

- *they require the support or intervention of one agency or discipline or they require only 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.*

People on enhanced CPA are likely to have some of the following characteristics:

- *they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;*
- *they are only willing to co-operate with one professional or agency but they have multiple care needs;*

- *they may be in contact with a number of agencies (including the Criminal Justice System);*
- *they are likely to require more frequent and intensive interventions, perhaps with medication management;*
- *they are more likely to have mental health problems co-existing with other problems such as substance misuse;*
- *they are more likely to be at risk of harming themselves or others;*
- *they are more likely to disengage with services.*" (4)

The four principles of assessment, care plan, care co-ordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Several members of the care team, including the assessing consultant psychiatrist, reported that there was a lack of clarity regarding when and how the level of CPA for Mr A was decided. The Internal Inquiry rightly placed considerable emphasis on the importance of the Care Programme Approach and contended that Mr A should have been on the '*enhanced*' level. We found significant differences of opinion among clinicians and managers as to whether Mr A's needs warranted '*standard*' or '*enhanced*' CPA but we took the view that on the information available, his care could have been provided within the '*standard*' level.

We were informed that had Mr A accepted the offer of day hospital attendance he would have been considered to be in "*high need and would have needed to have a care co-ordinator".* It is the opinion of the Independent Inquiry based on the assessments which were made that even if CPA had been implemented, this would not have materially affected the subsequent care that was offered.

Following our interviews and reflection, it is clear to us that CPA was not fully embedded in the service and at that time there was no culture for the use of CPA as a framework for service delivery. In our experience this has not been a particularly unusual situation for Mental Health Trusts.

The Independent Inquiry commended the colour coded CPA forms devised by the Trust which facilitate easy usage. They also include a '*How I see My Needs*' form for service users to complete, to ensure their views are included within the CPA process.

We considered that the Trust had inadequate administrative support to manage the CPA process and recommends this is reviewed.

6.11 Carers assessment

An understanding of carers' needs, e.g. recognition and right to support, have been slow to be established within the Health Service. Following the publication of the

National Strategy for Carers (5), carers have been defined as:- *'people who look after a relative or friend who need support because of age, physical or learning disability or illness, including mental illness.'* It is doubtful Ms B would have considered herself to be a carer of Mr A. Certainly Mr A lived on his own at times and was not dependent on Ms B in the sense of being unable to manage day to day activities without her help. It is therefore not surprising that she was not viewed as a carer nor offered a Carers' Assessment.

6.12 Clinical risk assessment and management

Risk assessment is by definition only partially predictive. The process inevitably can produce a false negative outcome, (a risk is underestimated), or a false positive outcome, (a risk is overestimated). Either of these can lead to tragic results. However good the process is, sometimes a tragedy is unavoidable. What is important is that the process of risk assessment and management is transparent, evidence based and properly managed. Responsibility lies both with the employing organisation and the individual practitioner. The organisation must ensure there is a clear policy for ensuring risk assessment is appropriate and comprehensive; that this policy is embedded in practice; that the staff using the policy are properly trained; that the process is regularly audited, and that there are clear mechanisms for incorporating risk management into care plans. The organisation must also provide the working environment within which staff can safely manage sometimes very difficult assessments. The responsibility of the clinician is to adhere to the organisation's policy, to ensure they act in a professional manner when using the policy, record their assessment in a useful format and maintain an up to date knowledge and evidence base.

The panel found that the Trust had a well written risk assessment policy but that there was no clear trigger point in the care pathway for ensuring an assessment was completed and that most of the staff had not been sufficiently trained. There was no mechanism for incorporating risk management into a care plan and there was no auditing mechanism for the whole process. Some of these processes were carried out on a formal basis and some on an informal basis. We were also concerned that a newly qualified psychologist was seeing a client with significant risk factors with inadequate supervision. There was also no system for a multi-disciplinary discussion which could identify the risks and then decide if any action needed to be taken in response.

This issue was clearly identified in the Internal Inquiry and its recommendations and we understand significant changes have been made as a consequence. During our interviews with staff they were unaware of the new training or had been unable to access it.

6.12.1 Domestic violence

> "*Domestic violence accounts for a quarter of all recorded violent crime in England and Wales. Although such violence can occur irrespective of background and circumstance, sexuality or gender, it is predominantly women who suffer. One in four women experience some form of violence from a partner in their lifetime. Every week two women die as a result of it. Domestic violence is usually a hidden crime. Victims suffer silently, afraid for themselves and for their children.*
> Foreword by the Home Secretary, The Rt Hon David Blunkett MP, June 2003, Safety and Justice: The Government's Proposals on Domestic Violence

Domestic violence has slowly begun to have an increased profile within mental health services with the Royal College of Psychiatrists issuing "*Domestic Violence*", in April 2002 (6). Research from Women's Aid, *Struggle to Survive*, (7), published in July 2004 found that between 50% and 60% of women mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse. However, mental health professionals have been found consistently to underestimate the proportion of their clients who experience domestic violence. Most recently, the *Domestic Violence, Crime and Victims Act* (8) was passed in November 2004 and all organisations will need to develop or review their domestic violence protocols and training strategy.

In the care and treatment offered to Mr A, staff correctly identified a risk of self harm and acted appropriately. However, domestic violence was an additional dimension that Mr A drew to the attention of the duty worker during his first contact with the Community Mental Health Team in 1997. She subsequently recorded that he was "*Violent to partner. Loses his temper a lot. … Very violent with 2nd partner, knocked her unconscious … threatened a friend of hers with a knife (convicted of GBH). Hit another with a baseball bat (premeditated), fractured skull. No charges pressed. Led to serious revenge attack on him. Violent to Ms B currently – "black eyes" etc. No prosecutions for violence to girlfriend / partners – never been charged although Police have been involved. Mr A has a history of pre-meditated violence and describes himself as always having a short fuse.*" This raises a fundamental issue which from our experience has not been sufficiently addressed in the national context. Namely, whose responsibility is it to address this issue, especially if the patient does not have a serious mental illness and / or the victim is not a client of the service?

Mr A gave a history of domestic violence towards his current and previous partner. Ms B, some years later, had a couple of conversations with staff during Mr A's contact with the mental health services and she did not state that she personally felt

at risk. Whether the staff should have asked Ms B directly given Mr A's professed history is a difficult issue. Should staff automatically ask all clients or their carers about domestic violence? Even if staff had discovered that Ms B was being abused, it ultimately has to be her decision to report this to the police. It must also be remembered that Ms B was not a client of the mental health services. The police evidence after the homicide indicated that family and friends were concerned for her welfare. In what circumstances, if any, should the team have spoken to them after a history of violence has been disclosed or discovered?

This is clearly a highly complex situation which has to balance the needs of the client, confidentiality and a risk to a third party based on inevitably patchy evidence. Risk assessment is a continuous process. The prediction of risk is based on weighing any new information with what is already known. This is in the context of protective factors which may mitigate or at least manage the risks that have been identified. Whilst recordings on risk assessment forms are usually a summary of risk at a given time, all clinical notes will provide an indication of the clinician's assessment of risk at the time of writing. The judgements are difficult and would have significant consequences.

We consider the Trust should develop a domestic violence protocol, in conjunction with relevant local agencies, aided by the work in other health organisations described by Women's Aid (9), and others (10) to aid practitioners in deciding how to respond to situations of known or suspected domestic violence.

6.12.2 Child protection

In the flat at the time of the death of Ms B was their son, then aged five. Child protection did not in 2001 have the profile in the NHS that it does today. The Healthcare Commission has been charged with monitoring child protection procedures within the NHS which is welcome as the recent Laming Report following the death of *Victoria Climbie* (11) indicated agencies should collaborate closely if child protection strategies are to be robust. If there had been a more robust risk assessment process in place in Mr A's care, there would have been routine consideration of whether there were risks to other members of the family, especially children. However there were no records regarding concerns in relation to their son held by Social Services nor Primary Care.

The panel understands that the Practice Development Co-ordinator has now been designated as Child Protection Lead for the Trust. Both domestic violence and child protection should feature within the Trust's risk assessment procedures.

6.12.3 Health and safety of staff

Health and safety was raised as an issue for the 'Safe House'. The panel was concerned to learn about the staffing arrangements which consisted of a few permanent staff who were supplemented by staff from the CMHTs. It appears this situation has now been reviewed. However, we have been informed that the alarm system which was originally included in the Internal Inquiry recommendations will not be fitted due to costs. A member of staff reported there was no means to summon help, but did not feel threatened. The Trust is advised to ensure a robust system is in place for staff to summon help to this stand alone unit, as recommended in the internal review.

6.13 Induction / Training / Supervision

Some of the staff we interviewed stated they have not had an induction to their role, sufficient training in essential issues or access to supervision to allow them to reflect upon and be guided in their day to day work. In order to provide a good service to users, staff need to be introduced to their role, provided with ongoing supervision and training that is appropriate to the job. Pertinent to this case is training in clinical risk assessment and CPA, and access to regular supervision. These do not appear to have been sufficiently available at the time of Mr A's contact with the team.

Since the Independent Inquiry the Trust has reviewed their induction process and developed a comprehensive induction programme for all new staff.

The approach to managing the service provision at a strategic level across the Trust appeared uncoordinated. For example, the CPA Co-ordinator was unaware of the carers assessment audit carried out by the Practice Development Co-ordinator and disputed the CPA figures contained within the report. The Risk Manager spoke of Safety Staff in another department with whom he had little contact. The Training Manager indicated an awareness of the training being offered by the practice development staff and how it aimed to address issues identified after inquiries but not whether this was successful or how it was being evaluated. There was no training for staff who train others.

The Director of Nursing informed the panel that a staffing review was taking place. This will lead to a strengthening of both the CPA and risk management departments within the Trust. The panel recommends this includes putting in place mechanisms which facilitates closer working between clinical and non clinical risk and includes training (no matter who provides it) and CPA.

The Trust is commended for including child protection and vulnerable adults in induction and notes there is a backlog of child protection training for existing staff, which the panel recommends is prioritised.

It was unclear to the panel what system is in place to allow staff working on the duty system:

- to access supervision and guidance should they be presented with an issue they don't feel equipped to deal with;
- for senior clinicians to review the contacts and satisfy themselves appropriate actions have been taken.

We recommend the introduction of a system for reviewing all actions, (taken and proposed), at the end of the duty session with a senior clinician.

The panel's interview with the Trust's lead psychologist indicated that the level of supervision available to the psychologist treating Mr A in 1998 was provided by a senior psychologist from another team who has since retired. Details of supervision were kept between the two and although the panel did not have an opportunity to clarify this with either party, it would appear that Mr A was never discussed. It does not appear (when reviewing the interventions used) to have been a satisfactory system and an improved system has now been put in place. A review two years ago led to psychologists being included in a system of general, rather than professional line management, which was in place at the time of the homicide. We were told that psychologists sometimes act as care co-ordinators but there was still some concern within the Trust about their use of CPA.

The panel were pleased to hear that CPA is now part of the consultant's appraisal which is commendable.

6.14 Compliance by Mr A with care and treatment

We were specifically asked in the terms of reference to consider Mr A's compliance with the care and treatment that he was offered.

Mr A first recognised that he needed help in 1997, when he sought counselling, but was unable to take time off from work when it was offered. A couple of months later, in November 1997, he attended an appointment with the Redhill and Reigate Community Mental Health Team, when he was assessed as "*high need – must have a service*". It must have taken Mr A quite an effort to seek help and we have no reason to believe he had experience of 'opening up' to anyone (in view of his deprived childhood), particularly strangers. After being accepted by the service, it was then 4 months before he was seen by a psychologist. Mr A was offered nine sessions and managed to attend seven of these.

Mr A returned to his GP in 2001 and was referred back to the CMHT. The onus was always on him to seek a service and if at any time he missed an appointment there was never any attempt to find out why. However Mr A did not always avail

himself of the service on offer e.g. the Safe House or the Day Hospital and must take responsibility for not attending appointments made for him.

A comment made by Mr A on 28th June 2001 when he was in Accident and Emergency following an overdose of prescribed medication, was that he had found the Redhill and Reigate Community Mental Health Team to be dismissive towards him as he was not considered "*a life threatening case*." One witness we saw felt that Mr A "*may have had unrealistic expectations which could not be met but at no point was there a dismissive attitude towards him*."

The Consultant Psychiatrist who saw Mr A on a couple of occasions believed "*the central issue was Mr A's disengagement from services*" and it is clear that in the three months before the homicide, Mr A rejected admission to the Safe House, day hospital attendance and finally turned down informal admission to hospital (although this latter point is disputed by Mr A). At no time was Mr A detainable under the Mental Health Act 1983 nor was there any indication that he lacked capacity.

6.15 Significant discrepancy – offer of informal admission to hospital

There was one issue which was not known to the Internal Inquiry and which we were not able to resolve. Mr A told the Independent Inquiry that when he was seen on 3rd July 2001 he asked to be admitted to hospital but that it was not offered.

However, the consultant did not mention it in his letter to the GP dated 3rd July 2001 (the letter was sent just prior to Mr A being seen on an unexpected visit to the day hospital) or to the Internal Inquiry when he was interviewed in September 2001.

The Consultant Psychiatrist did however write to solicitors on 11th January 2002 that Mr A "*was offered admission either to the Safe House or to hospital, which he declined.*" He repeated this to the Independent Inquiry stating *"Mr A did not ask for admission to hospital, nor were there any indications from the assessment that he required admission. Although he was clearly depressed and had suicidal ideation, the risk of self-harm seemed to be low / moderate. Also there was no indication of a risk to others. However I wanted to offer him the support he felt he may need and I recall that he was offered admission to the hospital or the Safe House".*

6.16 Audit

The quality and results from in-house audits were not as high as the Independent Inquiry would have wished to see. The Trust has completed a number of surveys, but it was unclear as to how the audit cycle is closed - including the necessary corrective action. Training on the audit process should be a high priority for the Trust, both for corporate, as well as clinical staff, and also local managers who need to monitor the effectiveness and implementation of Trust plans.

6.17 Communication and recording

One of the Internal Inquiry's recommendations was "*Discuss with local GPs information requirements to assist assessment / referral process*." The subsequent Trust action plan in March 2003 identifies the need to "*develop referral protocols with local Primary Care Trusts*" but although "*local arrangements are in place, there is no Trust wide protocol.*" However the Independent Inquiry were shown a draft document "*Process for the management of Urgent referrals and Urgent out-patient appointments,*" which seems to address routine referrals.

The panel did not have any concerns regarding record keeping and were largely impressed with the record keeping. Two issues that were identified by the Internal Inquiry which we consider of particular importance were the need for:-

- A clear referral process between primary and secondary care
- Availability of previous notes.

7. RECOMMENDATIONS

The Independent Inquiry has only a few additional recommendations to add to those already made by the Internal Inquiry.

7.1 'Serious Untoward Incidents'

We recommend that Surrey Oaklands NHS Trust reviews its 'Incident Management Policy' to ensure that:-

- A senior manager is designated to provide support and information to families following a serious untoward incident and guidance is provided for anyone undertaking the role.

- Staff involved in serious untoward incidents provide written statements as soon as possible after a tragedy and receive support to do so.

- Staff are made aware of the support service offered by the Psychology Service within the Trust.

- Wherever possible, those individuals seen by internal inquiries are interviewed by professionals of the same or similar disciplines.

In order to avoid the difficulties which arose in following up some of the recommendations of the Internal Inquiry, we recommend that:-

- The person responsible for ensuring the overall implementation of inquiry recommendations is either a member of the panel and/or clearly defined on any action plan.

- Persons responsible for individual recommendations and dates for completion should be clearly stated.

7.2 Primary - Secondary care interface

The panel recommends a further dialogue between Surrey Oaklands NHS Trust and the Primary Care Trusts in relation to the provision of mental health services, including:

- Clarifying the roles and responsibilities of frontline staff; referral processes and access; what the Trust is able to offer (for example, anger management); and pathways of care.

- Ensuring that GPs are made aware of what mental health services are available and the procedure for making a referral. Referrals should include the essential information that is required and indicate the degree of urgency.

7.3 Care Programme Approach

The panel recommends a further review of the operation of the Care Programme Approach with particular reference to administrative support, training of staff and audit. It is essential that:-

- Clear trigger points in the CPA process require staff to discuss clients in a multi-disciplinary forum and make decisions about risk and suitable care plans.

- Systems for auditing CPA use information technology and develop a process for using CPA locally.

- Risk assessment needs to be further reinforced in the culture including specific consideration of:
    - possible domestic violence;
    - risks from driving (effect of medication; road rage etc);
    - possible child protection concerns.

7.4 Domestic violence

We recommend that the Trust should develop a domestic violence protocol, in conjunction with relevant local agencies, as part of the national agenda to aid practitioners in deciding how to respond to situations of known or suspected domestic violence.

7.5 Medical staffing

The role of the general psychiatrist has changed dramatically over the past few years; with added responsibilities and a diverse range of teams with whom they have to relate. A national debate is emerging about the role of the psychiatrist.

We recommend:-

- That the Trust initiates a debate amongst its senior clinicians to review their roles within the organisation and with clinical teams.

- Part of this review must include workload and numbers of consultants, with reference to the Royal College of Psychiatrists' guidelines.

7.6 Health and safety

An alarm system was recommended by the Internal Inquiry for the 'Safe House' but we understand that one will not be fitted due to high costs.

We recommend that the Trust ensures a robust system is in place for staff at the 'Safe House' to summon help to this stand alone unit.

7.7 Induction / Training / Supervision

We recommend the introduction of a system for reviewing all actions, (taken and proposed), at the end of the duty session with a senior clinician.

Appendix One

RECOMMENDATIONS OF THE INTERNAL INQUIRY – JANUARY 2002

1. Discuss with local GP's information requirements to assist assessment / referral process

2. Review risk assessment process

3. Where waiting lists are considered excessive, review the process for an initial assessment to ensure patients can be prioritised

4. Ensure supervision policy (including consultants and for bank staff) is consistently applied

5. Ensure induction policy is consistently applied

6. Review the Safe House to ensure the safety of staff (and vulnerable patients) e.g. to consider buying alarms, layout, staffing levels etc

7. Regularly audit records to ensure good practice is promoted

8. Review DNA policy for patients at risk

9. Review the trigger points for CPA to be enacted (i.e. once certain symptoms are presented) and ensure through supervision, appraisal and audit, and that it is consistently applied by all professionals

10. Encourage regular discussion and review of cases via CMHT meetings

11. Review access to health records at all locations (24hours/7days) to ensure professionals have as full information as possible to make decisions

12. Review outpatient management to ensure urgent appointments can be seen within the planned core time allocated

13. Review the practice for use of the GP letter to substitute for a formal written CPA, including consideration of a standard set of headings within the letter

14. Review application of carer assessments to ensure appropriate support is available

15. Review Consultant cover during annual leave and prioritising 'at risk' patients

16. Review Consultant workloads and patch size along with the general workload of the Redhill and Reigate Community Mental Health Team

17. Review Consultant support to junior medical staff in crisis situations
18. Review Consultant on call arrangements
19. Review Care Management problems identified in interviews with staff

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(3) *Building bridges: arrangements for inter-agency working for the care and protection of severely mentally ill people (HSG(95)56)*, Department of Health, 1995

(4) *Modernising the Care Programme Approach*, Department of Health / CPA Association, October 1999, *http://www.cpaa.co.uk/docs/cc_pol.pdf*

(5) *The National Strategy for Carers,* Department of Health, 1999
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