Report Of The Independent Inquiry Team
Into
The Care And Treatment Of Mr M

Commissioned by
Surrey and Sussex Strategic Health Authority

July 2005

Contents

Acknowledgements

The Independent Inquiry Panel would like to extend their deepest sympathy to the family of Ms L and acknowledge the assistance given by them in meeting with the panel and providing information about the circumstances leading to Ms L's death.

We would also like to thank all of those who provided the inquiry with information and are grateful for the way in which the professionals cooperated in an open and committed manner.

We are grateful to Mr M for the assistance given in helping understand the circumstances regarding the death of Ms L.

Finally we recognise how stressful Independent Inquiries can be and appreciate the willingness of the agencies to provide us with information and to support their staff through the process, thus ensuring that the relevant information was provided.

Executive Summary

Introduction

On 21 June 2002 Mr M killed his partner Ms L. They had lived as a couple since the summer of 2000 and were both known to mental health services in East Sussex. Mr M pleaded guilty to manslaughter with diminished responsibility. He was sentenced to four years in prison with a further three years extended supervision on his release.

East Sussex County Healthcare NHS Trust, East Sussex County Council and the Hastings and St Leonard's PCT undertook a two stage internal review and reported in May 2003 with a series of recommendations and an Action Plan. The internal review was subsequently reconvened in September 2004 and findings from this were reported in December 2004. The internal review was reopened with representation from the same agencies after a number of new files relating to both Mr M and Ms L came to light that had not been known of at the time of the initial internal review's work. The internal review at both stages examined the care and treatment of Mr M and Ms L. The initial Action Plan was not amended by the findings of the second stage of the internal inquiry.

An Independent Mental Health Inquiry was formally set up in July 2004 by Surrey and Sussex Strategic Health Authority, as required by National Health Service Guidance, HSG (94) 27, and undertaken using the Terms of Reference in Section 3.

The focus of this independent inquiry has been primarily on the services relating directly to Mr M. However, the Inquiry Panel considered the services and support Ms L received in her own right and as a couple with Mr M. We have therefore focused particularly on the period from the summer of 2000 when Mr M and Ms L formed a relationship with each other to the time in June 2002 when Ms L was killed.

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.

This inquiry has been undertaken by a Inquiry Panel and Inquiry Manager independent of the local mental health services provided by the East Sussex County Healthcare NHS Trust.

The Inquiry Panel identified the written documentation it required and evidence was received from twenty four witnesses, including some written statements, over a period of eight days in October, November

and December 2004, from which a chronology of the events was compiled.

We have considered the way in which mental health services were organised in the period 2000 through to June 2002. There was high level organisational change taking place within the health services in the lead up to April 2002 with the establishment of the East Sussex County Mental Health NHS Trust. This Trust absorbed the mental health services managed by the Hastings and Rother NHS Trust, which was abolished in April 2002. On the ground the mental health services for the Rural Rother locality were provided by a number of teams.

Services are being reorganised at the time of drafting this report. The purpose is to bring together existing teams and functions under the same manager to provide a Crisis and Home Treatment Service to include a single point of referral and access to mental health services.

Chronology

A summary chronology of the events is as follows:

- Mr M was placed with foster parents until the age of 6 years when he was sent to a secure residential school for setting fire to a barn. Eight years later, on his discharge from the school, he returned to his foster home but began drinking and using illicit drugs. Over the years Mr M was involved in a number of criminal acts and spent time in both borstal and prison.

- He married in 1978 and was a stepfather to his wife's daughter. He became a father in 1979, with 2 further children in 1981 and 1983. It was during 1983 that Mr M found it difficult to hold down jobs. He would leave home for days at a time as he felt under so much pressure.

- In 1987 Mr M won £100,000 on the football pools. He went to Spain, most of the money had been spent before he returned initially to the Hertfordshire area. He did however have enough left over to purchase a bungalow St Leonards –on- Sea. In 1988 his wife stated that she wanted a divorce. Shortly after their split Mr M started a new relationship with a woman with whom he had a further 2 children. During this time Mr M had taken 2 overdoses, but it was after the second overdose in 1991 that he was admitted to a psychiatric unit in Hastings.

- During the period between 1993 to 2000 Mr M came into contact with a variety of mental health services on numerous occasions. There are recordings of several incidents of overdoses and attempted suicide. Also during this time he continued to take illicit drugs and alcohol, alongside his prescribed medication.

Additionally, there is a history of non-attendance at outpatients clinics.

- In June 2000 Mr M met and started a relationship with Ms L aged 35 years.

- Ms L was also known to the local mental health services. It was reported that there were some difficulties during her school years during which she was referred to a Child Psychologist and eventually received home tuition. She had difficulties in finding and holding jobs and had her first contact with adult mental health services in 1983.

- In 1995 Ms L had a child who lived with Ms L's mother from infancy; the social services department was involved in arrangements for the child's continuing care and occasional stays with Ms L and her partner.. However, 4 years later her partner died suddenly. This precipitated a deterioration in her mental health and resulted in an inpatient admission and spending time in a residential setting.

- In 2000 Ms L returned home and it was during this period that Mr M met Ms L. At that time and over the rest of that year they grew closer but there were also episodes when Mr M left her and the relationship could be stormy. In November they were reported to be engaged and planning to marry the following January 2001. Ms L was considering going to court to obtain custody of her child, whom she was seeing on a regular basis.

- During their relationship Mr M found it increasingly difficult to cope with Ms L as they constantly argued and had problems with some of her old acquaintances. She had become more dependent on Mr M and took to her bed, not wanting him to leave the house. At this time Ms L's mother, who had a Residency Order for her grandchild, expressed concerns about her daughter having visiting access.

- Mr M continued in his pattern of non-attendance for appointments with mental health professionals and Ms L was abusing the use of her sedatives. Additionally, Mr M had on occasions given her more sedatives so that he could leave the house without her knowledge. During this time there was intense engagement with Ms L by the Crisis Response Service (CRS) as she had been threatening suicide.

- It was during September 2001 that Mr M made threats to kill someone so he could get some peace. He later took an overdose and was sent to A&E where he was subsequently arrested for threatening and abusive behaviour. On his return home a Carer's Assessment was planned for Mr M but he refused to co-operate as he felt the assessment questions too intrusive.

- Tensions were increasing and during October 2001, after moving to their new home in Netherfield, Ms L attended A&E with a fractured wrist after falling downstairs during the night. Day Hospital was offered and due to Ms L's ambivalence a gradual programme of attendance with transport was organised.

- At the beginning of 2002 Mr M left Ms L but returned a few months later. Again the situation began to deteriorate and home visits by the Social Worker were carried out. The subsequent months saw substantial contact with the mental health services and the Social Worker.

- During March 2002 Mr M attempted to crash his car, with just himself in it, and was detained under Section 136 of the Mental Health Act 1983 (MHA). He was later admitted to hospital under Section 2 of the MHA, at that time he expressed thoughts of stabbing his girlfriend.

- In April 2002 Mr M was discharged and placed on an Standard Care Programme Approach with an outpatient appointment with the Community Alcohol Team (CAT). Once home the tensions within the household increased between Mr M and Ms L.

- During May the tensions in the house were increasing. Ms L attended an outpatient appointment with her Consultant Psychiatrist at which Mr M was also present. Later that month respite was offered at the Sanctuary which she accepted.

- There was a review of Ms L's Enhanced CPA in June, the option of a further stay at the Sanctuary and re-engaging at the day hospital were both discussed but declined. The staff involved with Ms L and Mr M responded to their increased levels of distress by putting in place a programme of home visits and telephone contacts. There were concerns about Ms L's low mood and reported misuse of her medication and Mr M's ability to cope with the situation.

- On the 18th June the Consultant Psychiatrist and Social Worker visited the house together. Ms L was referred to the day hospital as an urgent case, and a request was made for Mr M to be allocated a Community Psychiatric Nurse. During this visit Mr M was given responsibility for dispensing Ms L's medication.

- In the morning of the 21st June the Social Worker visited the household and saw both Ms L and Mr M. She later phoned Mr M in the afternoon about a possible referral to a carer support agency. Mr M informed her that everything was OK. At approximately 10.00pm that evening Mr M phoned the police to inform them that he had killed Ms L.

Findings and Recommendations

The Inquiry Panel has considered the Action Plan produced by the Internal Review in September 2002. We have taken this into account in formulating our recommendations which are intended to focus on issues not pursued in the Internal Review.

We regard the recommendations in the Internal Review as comprehensive in their scope. We comment on these in section 10 of the full report with our focus on issues either not presented in that review or where we consider the Internal Review's recommendations need to be extended.

Communication, Transferring and Sharing Information between and within Teams

Systems for capturing, sharing and using information were haphazard in this case. We have detailed specific information that was known about by individuals within the various teams that was not shared, adequately considered or used. This illustrated a combination of:

- Inadequate systems and processes in place at the time
- Poor collation or reading of available information that inhibited a fuller understanding and opportunity to use that information in planning treatment and care plans for patients
- A narrowness of perception of the relevance of statements made or behaviours that should have been considered in assessing the needs of both Ms L and Mr M separately and as a couple

The Inquiry Panel understands that since the time of this incident and the lead in to it, the plethora of teams has been rationalised with clearer responsibilities and management coordination. This is positive and should facilitate better identification of relevant information and transfer between teams and people from the different teams working within them. However in itself it will not deal with all the factors evidenced in this Inquiry. The information that was available cumulatively to different members of the local services was not recognised as significant enough to be presented to colleagues; nor was there evidence of the CPA Coordinator or responsible Medical Officer taking a lead in ensuring that decisions were made on a full consideration of what was available to the different members of the teams involved.

From the evidence gathered in this Inquiry it is clear that some practitioners worked very hard to overcome the systems problems within the services; others complied with the minimum requirements of the systems and processes required which reinforced the disconnected approach caused by this plethora of teams and processes. The

recommendations below express little more than good contemporary practice.

Recommendation 1

The Inquiry Panel recommends that the Trust ensure that within its training programme, sessions are specifically designed to promote:

- *a stronger understanding of the importance of multidisciplinary sharing of information*
- *effective ways of identifying and recording behaviours and statements that give cause for concern in the context of specific situations and the development of a care plan*
- *planning and review processes which utilise such information in their consideration of the person's needs, treatment and care options*
- *an understanding that information gained should be considered in the context of the known history, characteristics and behaviours of individual patients.*

Recommendation 2

The Inquiry Panel recommends that the Trust scrutinises its existing systems for storing, transferring and sharing information:

- *that within in-patient settings a responsible person is identified who will ensure that information contained within the patient's case file is presented to the ward's decision making forum*
- *that notes from all the disciplines are held in the same file and scrutinised for presentation in this way*
- *that the introduction of eCPA is seen as an opportunity for a clear and definite record of information, decisions and care planning.*

Use of the CPA Process

The CPA provides the cornerstone for constructive engagement with service users and the professional staff from the different disciplines in considering the factors in any particular case. This will mean identifying risk factors, agreeing clinical treatment and care management approaches, actions, responsibilities and monitoring arrangements into the future.

In the Inquiry Panel's view the guidance in place at the time of this incident did not contribute to a positive perspective and proactive usage of CPA. To some degree the use of the CPA ran in parallel to

the In-patient and Consultant Psychiatrists' decisions. Additionally, the administration of the CPA process in relation to both Mr M and to Ms L was confused in terms of the paperwork used and the level of seriousness described by the differing levels of standard and enhanced CPA.

There is no doubt that the Trust recognise the need to overhaul the use of the CPA process and this is to be encouraged. The guidance issued in March 2004 is commended, but in our view it does not give clear enough guidance in relation to the Consultant Psychiatrist's continuing responsibility for people in the community on enhanced CPA. The respective responsibilities of the Consultant Psychiatrist and the GP need to be more explicit than in the current guidance (March 2004, point 2.4) making clear the Consultant Psychiatrist's continuing responsibility. From comments made and our understanding we make the following recommendation:

Recommendation 3

The Inquiry Panel recommends that the Trust extend the CPA training programme it is currently pursuing, in the following way:

- *the provision of clear guidance on the participation of Consultant Psychiatrists in enhanced CPA meetings*
- *participation of all the disciplines working in the CMHT, In-patient and Day Hospital/treatment settings is made mandatory*
- *joint risk assessment training is incorporated in CPA training with the multidisciplinary teams*
- *the message is very strongly delivered that the CPA is the central process in care planning and that it is not acceptable to consider it an adjunct to other decision making methods*
- *CPA audit processes are used regularly and satisfy the Trust Board that day to day CPA documentation is regularly monitored to confirm that all disciplines are contributing, the adequacy of care plans, their quality and that progress from one review to the next is followed up and documented.*
- *the determinants for using standard and enhanced CPA are set out more clearly in the Trust's CPA Policy and Operational Guidelines document*
- *when a patient is on enhanced CPA greater clarity about the Consultant Psychiatrist's continuing responsibility and the responsibility of the GP*
- *we urge the Trust to consider incorporating a management plan for the person's medication as part of the CPA care plan.*

The Inquiry Panel recognise that the Internal Review report made specific recommendations about Risk Assessment and Risk Management, which we support. In addition we make a further recommendation to promote greater engagement of medical practitioners in the CPA and coherence in treatment plans:

Recommendation 4

The Inquiry Panel recommends that when a patient, subject to enhanced CPA is being transferred to another clinical team within the Trust, the Consultant Psychiatrist taking over their care is present at the CPA transfer meeting ensuring that they take a lead in the patient's care plan.

With regard to potential tensions and conflict for practitioners when they are working with people who are within a partnership or family grouping who both use local mental health services, we support the recommendation of the Internal Review, but would recommend that this is expanded as follows:

Recommendation 5

The Inquiry Panel recommends that where there is more than one patient in a relationship this needs addressing through the application of the CPA process. The focus is to promote an appreciation of the needs of each person as an individual, and also as an individual in a relationship with another person who has needs of their own.

The Local Service's Work with Mr M and Ms L

We have commented extensively about the engagement with both Mr M and Ms L as individuals and also in how they were perceived as a couple. In the light of the shortcomings detailed in this report the Inquiry Panel has considered whether Mr M's killing of Ms L was predictable to the professionals involved. Mr M made statements about harming Ms L and these were not dealt with. However, even had these statements been taken into account it is not possible to reach a conclusion that Mr M was intent on carrying out this killing based on statements made at times of stress over the previous two years or so.

The subsequent question the Inquiry Panel has considered is whether the homicide was preventable. It may be that such statements would have promoted different approaches in the treatment and care options. For example, perhaps the Sanctuary or In-patient admission would have been considered to alleviate the pressures within the household. If Ms L had gone into the Sanctuary at that time then the pressure would have lifted and Ms L would have been in a different place. However, it is possible that she might not have agreed to go, similarly she may have refused to enter hospital as an in-patient and on the face

of the information presented to us she could not have been admitted under a compulsory order of the MHA at that time. Nor is it possible to state what might have followed subsequently.

Consideration of this question is more about how the services might have responded and worked with Mr M over time, and with them as a couple, than the immediate actions at the time of the visit in June 2002. Certainly from the comments made to the Inquiry Panel by the Consultant Psychiatrist he indicated that had he known of the statements of harm made by Mr M towards Ms L he would have regarded it very seriously and sought to put in place stronger risk management arrangements. If Mr M had had more engagement and support might he have spoken about these feelings which might have been worked with and some therapeutic engagement and stronger risk management put in place? We cannot know the definitive answer to this question. It would depend on how the clinical team under the leadership of the Consultant Psychiatrist interpreted this information and used it to formulate future risk assessment and risk management strategies.

Recommendation 6

The Inquiry Panel recommends that the manager of the team responsible for the care of the patient, e.g. the In-patient ward or CMHT, is given authority to ensure adherence to quality standards set by the Board of the Trust. These would include designated time periods and quality standards for Risk Assessments, the scrutiny and incorporation of information gained into care plans and its communication to relevant professionals involved in the patient's care.

Recommendation 7

The Inquiry Panel recommends that the Trust develop processes for regularly auditing the quality and usage of information gained through risk assessments, and that this is reported within the Clinical Governance Process of the Trust.

Leadership and Clinical Accountability

The situation described at the time of this incident and in the period preceding it, indicates that there was poor leadership and accountability lines for both clinical and management arrangements.

The reorganisation and prospective future of the East Sussex County Healthcare NHS Trust at that time has been described to us and it may be the case that the anxieties about the future role and place of the Trust percolated down to the operational teams. More specifically it is evident that the clinical accountability for the then CRS was ill-defined; that the management arrangements for pulling together the activities

and processes of the various teams was in progress but not securely established in 2002.

We understand that significant steps have been taken managerially to deal with the problems described in this report. However there is more to do in this regard, for example we remain concerned that the medical clinical accountability line for the Assessment and Response Team still appears unclear.

Recommendation 8

The Inquiry Panel recommends that the Trust:

- *secures clear and sustainable lines of accountability for the practice of the Assessment and Referral Team*

- *ensures the CPA process is unequivocally adopted by the Consultant Psychiatrists and that attendance at CPA training and compliance with CPA processes is made mandatory for all relevant clinical staff*

- *utilises appraisal process to ensure all staff comply with Mandatory training and can demonstrate essential training competencies*

- *ensures appropriate professional supervision structures are in place for all clinical and non clinical staff and that this should be monitored*

Recommendation 9

The Inquiry Panel recommends that as part of the Trust's Clinical Governance Process specific guidance is drawn up as a priority to identify issues and concerns relating directly to patient care for presentation to the Trust's Senior Management Executive Team and the Trust Board.

Service Organisation

The various teams operating at the time of this incident and in the period before hand have been rationalised under more cohesive management. This is to be welcomed and the Trust is encouraged to review and refine these arrangements in the light of practice experience over the coming months. It may be helpful for the Trust to consider the internal practice of their teams in respect of procedures for caseload management, assured supervision procedures, team management and clarity in management practice.

The Inquiry Panel are aware of the significant changes taking place within the Trust and its management structure. We encourage the

management team to consider this report and its recommendations as a positive contribution to improving the Trust's services.

1. General Introduction

On 21 June 2002 Mr M killed his partner Ms L. They had lived as a couple since the summer of 2000 and were both known to mental health services in East Sussex. Mr M pleaded guilty to manslaughter with diminished responsibility. He was sentenced to four years in prison with a further three years extended supervision on his release.

Representatives of the East Sussex County Healthcare NHS Trust, East Sussex County Council and the Hastings and St Leonard's PCT undertook a two stage internal review. The initial internal review reported in May 2003 with a series of recommendations and an Action Plan. The internal review was subsequently reconvened in September 2004 and reported in December 2004. The internal review was reopened with representation from the same agencies after a number of new files relating to both Mr M and Ms L came to light that had not been known of at the time of the initial internal review's work. The internal review at both stages examined the care and treatment of Mr M and Ms L and made recommendations for action by the mental health services provided by the East Sussex County Healthcare NHS Trust; the initial Action Plan was not amended by the findings of the second stage of the internal inquiry.

An Independent Mental Health Inquiry was formally set up in July 2004 by Surrey and Sussex Strategic Health Authority, as required by National Health Service Guidance, HSG (94) 27. "Guidance on the discharge of mentally disordered people and their continuing care in the community". This requires an inquiry, independent of the service providers, to be undertaken when a person in receipt of mental health services commits a homicide.

The focus of this independent inquiry has been primarily on the services relating directly to Mr M , however gaining a full understanding required the Inquiry Panel to consider the services and support Ms L received in her own right and as a couple with Mr M. We have therefore focused particularly on the period from the summer of 2000 when Mr M and Ms L formed a relationship with each other to the time in June 2002 when Ms L was killed.

We comment on how the different teams and services operated at the time in 2002 and the systems in place at that time. Service reorganisation was underway in 2002 and since then other changes have been made in the organisation of services in East Sussex. The independent inquiry delayed taking evidence until after the reconvened internal review had been completed to maintain clarity to the processes and adherence to the Department of Health Guidance.

2. PURPOSE OF THE INQUIRY

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 job of the Inquiry Panel is to gain a full picture of what was known, or should have been known, at the time by the clinicians and to form a view of the practice and decisions made at that time with that knowledge. It would be wrong for the Inquiry Panel to form a view of what should have happened based on hindsight, and we have tried throughout this report to base our findings on information available within the local mental health services at the time.

The process is intended to be a positive one, serving both the individuals involved, and the needs of the general public. It is important that those who have been bereaved are fully informed of the individual circumstances and are assured that the case has been fully investigated by an impartial and independent inquiry panel.

The Terms of Reference for the inquiry are set out on the following page.

3. TERMS OF REFERENCE

Independent Inquiry Into The Care And Treatment Of Mr M

1. To examine all circumstances surrounding the care and treatment of Mr M, in particular:

   - The quality and scope of his health, social care and risk assessment
   - The circumstances relating to his treatment, and to comment upon:
     - The suitability of the care in view of his 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, specifically Ms L
     - Any previous psychiatric history, including drug or alcohol abuse
     - Previous Forensic History
     - How the service met his health and social care needs

   - The extent to which Mr M'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 M
     - Monitored by the relevant agency

   - The history of Mr M's treatment, care and compliance with the service provided.

   - The internal enquiry completed by East Sussex County Healthcare NHS Trust and the actions that arose from this.

   - To 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 M and the relevant competencies and supervision provided for all staff involved in his care.

3 To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr M and Ms L, or in the provision of services to them, including East Sussex County Healthcare NHS Trust and GP services.

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

4. PANEL MEMBERSHIP

This inquiry has been undertaken by the following panel of professionals who were independent of the local mental health services provided by the East Sussex County Healthcare NHS Trust.

Panel Chair

Nick Georgiou	Formerly Director of Social Services, and with experience as an NHS manager of an inner London mental health service

Panel Members

Jose Wood	Deputy Director of Nursing, Central and North West London Mental Health NHS Trust. Former CMHT Manager and Senior Practitioner
Clive Robinson	Consultant Psychiatrist in General Adult Psychiatry at West London Mental Health NHS Trust

Inquiry Manager

Lynda Winchcombe	Director of a Management Consultancy company which specialises in Serious Untoward Incident reviews.

5. METHODOLOGY

5.1 How the Inquiry was Undertaken

The inquiry was commissioned by Surrey and Sussex Strategic Health Authority and undertaken using the Terms of Reference in Section 3.

Pre-meetings were held with Mr M, and with Ms L's family who provided the Inquiry Panel with a paper containing their observations on the murder of Ms L.

The Panel identified the written documentation it required. As this was received each document was indexed and paginated. A chronology of the events was compiled and is contained within this report.

Evidence was received from twenty four witnesses, including some written statements, over a period of eight days in October, November and Dec 2004. Each interview was recorded and the individuals given the opportunity to correct the transcript for accuracy and to add any other information that might be of relevance.

This report has been drafted to include brief histories of Mr M and Ms L, detailed consideration of key periods in their care and treatment, and the panel's findings and recommendations.

5.2 Documents seen

In relation to Mr M:

a) East Sussex County Healthcare NHS Trust

- Internal Review and extracts from files
- Community Mental Health –Hastings file
- Mental Health general files, 1 & 2
- CPA policies, past and current
- Management Structure, past and current
- Annual Report 2002-3
- Integrated Supervision policy
- Risk Management System
- Internal Review Action Plan and updated version
- Crisis Response Service notes
- Woodlands file notes
- Liaison Psychiatry records
- Barnet, Enfield and Haringey mental health notes
- Consultant psychiatrist general file notes
- July 2004 Board paper

- Staff Supervision Policy
- Serious Untoward Incident Review meeting notes
- East locality structure chart
- Operational Policy for the Access and Response Team
- Individual Staff member's supervision file
- Boardman report
- Action for Change notes
- Reconvened Internal Review report

b) Social Services

- Policies for the Protection of Vulnerable Adults
- Report on Carers Assessment Case File review
- Carers Assessment

c) General Practitioner

- Medical Records

d) Police

- Records of the case

e) Solicitor

- Records of the Defence case

f) Prison

- Prison Records
- Counselling Assessment File
- Health Notes
- Psychiatric Reports

g) Court

- Transcript of Judge's summing up

In relation to Ms L:

a) From Ms L's family

- Observations on the murder of Ms L

b) East Sussex County Healthcare NHS Trust

- Bexhill Community Mental Health Team notes
- Crisis Response Team Records

- Psychology notes
- Westwood day service records
- Medical records

c) Social Services

- Case file notes
- Social care Assessment

6. PROFILE OF SERVICES

We have considered the way in which mental health services were organised in the period 2000 through to June 2002. There was high level organisational change taking place within the health services in the lead up to April 2002 with the establishment of the East Sussex County Mental Health NHS Trust. This Trust absorbed the mental health services managed by the Hastings and Rother NHS Trust which was abolished in April 2002. At the time it was envisaged that the East Sussex County Mental Health NHS Trust would itself have a short life as its services would be transferred to the relatively newly established Primary Care Trusts. In the event this ambition was changed by the local health agencies in 2003.

On the ground the mental health services for the Rural Rother locality were provided by a number of teams described below. In this presentation of the teams and services, we have also tried to summarise the way the mental health teams changed since 2000 and how they are organised at the beginning of 2005.

Community Mental Health Team, also referred to as Sector Team 2000 - 02
Function:
Provided continuing support to people with continuing mental health care needs
Key characteristics:
A small team with 2 nurses, 2 social workers and consultant psychiatrist. The team kept their own files. Weekly meetings to consider incoming work and allocations. .
Relevant changes since 2002
Development of integrated file notes
Addition of one Training Grade Psychiatrist

Inpatient ward 2000 - 02
Function:
To provide an inpatient service to people in an acute phase of mental illness
Key characteristics:
Based at Woodlands, shares its service with St Leonard's and Hastings localities. There were shared nursing and therapy files but the medical notes were separate in 2002.. Major decision making forum for patients was the weekly ward round.
Relevant changes since 2002
Medical notes are now incorporated in the multidisciplinary notes.

Day Hospital/Day Services 2000 - 2002
Function:
To provide a daytime setting at the hospital with therapeutic interventions for people who may be current inpatients preparing for discharge or as an alternative to admission . Through a partnership with a voluntary agency to provide a supportive setting for people outside the clinical setting.
Key characteristics:
A weekday service with 15 places. Intended for short/medium term attendance only. Able to accept referrals in an emergency depending on existing pressures and demand level. The Day Hospital maintained its own notes which were not transferred to the CMHT.
Relevant changes since 2002
Integrated CMHT notes

Crisis Response Service 2000 – 2002
Function:
To provide short term support to people in a crisis who were known to the local health service.
Key characteristics:
This was health service staffed: nurses and 1.5wte psychiatrists.
Referrals could be made only by mental health service professionals or GPs.
The team operated 7 days a week into the evenings, intended to be until 11pm but for significant periods at this time until 8pm because of financial pressures.
Each new contact occasioned the opening of a new case file. Files were not shared with other teams. Following visits and on closing case involvement, both the medical and nursing staff would send letters and faxes to the referrer and to other mental health teams.
In August 2001 a new manager was brought into the CRS whose task was to manage the development and operation of the Access and Response Team (see below) with the intention of bringing the nurses in the CRS into the new multidisciplinary service
Relevant changes since 2002
CRS disbanded in February 2002 when the Access and Response Team was established.

Social Services Mental Health Duty Team 2000 - 2002
Function:
To provide a Social Services out of hours emergency service
Key characteristics:
Responded to referrals from other agencies. Managed by the social services manager who took over the CRS in preparation for the opening of the Access and Response Team, and subsequently disbanded on the opening of the new team.
Relevant changes since 2002
Disbanded and its functions integrated within the Access and Response Team.

Accident & Emergency Liaison Nurse 2000 - 2002
Function:
Mental health nursing expertise available to A & E outside orthodox working hours
Key characteristics:
Offered advice to both A & E and to CMHT if other supports unavailable, but this support was not always available as there was only one Liaison Nurse in the role at that time.
Relevant changes since 2002
The function was absorbed into the Access and Response Team when it was established.

Access and Response Team 2000 - 2002
Function:
A multidisciplinary crisis support team providing a service to known people in crisis and receiving new referrals.
Key characteristics:
Took on responsibilities and functions previously carried out by the disparate services summarised here: Crisis Response Service, Mental Health Duty Team, A & E Liaison Nurse from its inception in February 2002.
Relevant changes since 2002
This service is undergoing further development at present with the integration of the Access and Response Team and the Intensive Care and Treatment Service. The same manager is now responsible, since December 2004, for a range of services: Access and Response Team, Intensive Care and Treatment Service, the Day Hospital, Liaison Psychiatry and the Approved Social Worker service.
There is now a substantive part time post for a consultant psychiatrist dedicated to the A&RT but at the time of drafting this report the post had not been recruited to and is covered on an "acting up" basis.

Psychological Services 2000 - 2002
Function:
To provide a psychological assessment and, where assessed as appropriate, a programme of psychology sessions for individual clients referred by mental health professionals or GPs
Key characteristics:
The service centralised in late 2000/early 2001, until then psychologists were based in the CMHTs. The decision to centralise was intended to provide a more equitable service as in some CMHTs had very long waiting times and others were minimal. In the event the waiting times became longer for all teams. The service took the view that they would not prioritise but see people on the basis of when they were referred only.
Relevant changes since 2002
Psychologists are now line managed within the CMHTs with their professional support and supervision from the Psychology Services, however there is no psychologist allocated to the Rural Rother team at present.

Accommodation Team 2000 - 2002
Function:
To provide practical support to people who would struggle with managing their own affairs
Key characteristics:
Part of the local social services managing the Community Support Workers.
Relevant changes since 2002
Its work subsumed into the Assertive Outreach Team in 2004 which is more closely integrated with the CMHT.

Sanctuary 2000 - 2002
Function:
To provide a safe setting for short stays on an occasional or regular basis for people needing respite.
Key characteristics:
A service provided by an independent organisation, accessed through referral by a mental health professional.
Relevant changes since 2002
Continuing its service as previously.

Services are being reorganised to bring together existing teams and functions under the same manager to provide a Crisis and Home Treatment Service to include a single point of referral and access to mental health services.

7. Chronology

This chronology is in three parts:

- **Part 1** is concerned with Mr M from his birth to the point where he met with Ms L whom he subsequently killed in June 2002;
- **Part 2** is a summary of Ms L's life to the point in June 2000 when she and Mr M met;
- **Part 3** is about the period they were together from June 2000 to June 2002.

The detail contained here is drawn from reports, contemporary records, Inquiry Panel interviews and Mr M's own account.

7.1 Chronology Part 1 - Mr M 1955 to June 2000

Childhood, from birth to 14 years old - 1955 – 1968
Mr M was born in Buckinghamshire. He was fostered at birth to the same foster parents who had brought up his mother. Mr M reports that he learned as a six year old that his foster mother was not his real mother. He also learned from his foster mum that he had a younger sister. No details are known about his father, but he is said to have left the area when he learned that Mr M's mother was pregnant.

As a 6 year old Mr M set fire to a barn, it appears that he was placed in a Children's Home and subsequently moved to a more secure residential school for disturbed young people because of his behaviour. Mr M reports that he was beaten by the superintendent and that he was always in trouble.

Adolescence, from 14 to 19 years old - 1968 – 1973
Mr M was returned to his foster family when he was 14 having been in residential care for some eight years. At about that time he is reported to have started drinking and using illicit drugs. In 1970 Mr M was placed in a Probation Hostel for the theft of wallets and of a shotgun. He was in the Probation Hostel for about a year during which time he saw a psychiatrist, it is not known if he was given any diagnosis but Mr M reports that he was prescribed valium.

After leaving the hostel Mr M returned to his foster parents and then at about 18 started to work in a pub. He subsequently robbed the pub, carried out an assault and stole a car. Mr M was placed in borstal for these offences.

The period between - 1973 – 1987

When Mr M was discharged from the borstal he made contact with his real mother. Mr M stayed with his foster family intermittently but essentially he was staying overnight with various people before he moved into a caravan.

In April of 1973 he was admitted to hospital overnight through A&E following an overdose of drugs and alcohol. He discharged himself before receiving any form of mental health assessment. When Mr M was 20 his foster father died, as described by Mr M he had given a lot of quiet support throughout his life and Mr M deeply mourned his death.

Between November 1973 and April 1977 he appeared in court in Hertfordshire eight times on numerous charges of theft, criminal damage, motoring offences, drug related and forgery. When he was 21 Mr M was imprisoned for robbery for three years.

When he left prison in 1978 he lived with an old friend and found regular work. He married in this year, obtained his driving licence and reports that he was not taking drugs. Mr M reports that he took on responsibility for his wife's child when they married and they subsequently had a first child in 1979, two other children were born in 1981 and 1983.

During these years Mr M held down driving jobs, was not in trouble with the law and lived a settled life. However he reports that at this time he had access to duty free alcohol through his job as a coach driver and that he was smoking cannabis and using LSD from 1979 after the birth of his first child. In 1980 Mr M's foster mother died.

From 1983 Mr M described how he found it harder to hold onto jobs, he reports hearing voices when he felt *"down and low".* During this period he would leave the family home for a few days at a time to run away from the pressures he felt. He saw his GP during these years and was prescribed tranquillisers, and was also using illicit drugs. Mr M appears to have maintained this pattern until 1987.

The period between 1987 – 1993)

In 1987 Mr M won £100,000 on the football pools. Over the next year or so Mr M took increasing amounts of drugs and alcohol, there was increasing family friction and reports that *"the voices were telling me to leave her".* He went to Spain, most of the money had been spent before he returned to the Hertfordshire area. Mr M describes himself as lost at this time, taking large quantities of amphetamines, cocaine and alcohol.

At this point, around 1988, Mr M visited a friend who lived in Hastings. This friend helped him through a bad phase when he reports that he attended a "sort of detox centre" and decided to spend the remainder

of his pools winnings on a bungalow in St Leonard's on Sea. Also in 1988 his wife informed Mr M that she wanted to divorce him, his response to this was that *"it was the first time I had suicidal thoughts"* and he crashed his car reportedly wanting to kill himself.

Several months later he found work, started a new relationship with a woman by whom he had two children, in 1991 and 1996. As described by Mr M this was not a good relationship although it continued for nine years with him leaving some six or seven times. Sometime in the late 1980s, early 1990s Mr M sold the bungalow in St Leonard's on Sea and moved to Bexhill on Sea.

In 1991 sometime after the birth of his one of his children Mr M reports that he again *"started to have bad thoughts"* and overdosed. He says he was admitted briefly to a psychiatric unit in Hastings and then returned to his partner at that time.

The period between 1993 – 2000

In 1993 there were several episodes with mental health services and the beginning of his engagement with support services in East Sussex.

In **March 1993** Mr M was admitted to hospital in Welwyn Garden City having taken an overdose of paracetamol with alcohol, he was also using cannabis and amphetamines at the time. He was diagnosed as having a brief depressive reaction.

In **June 1993** Mr M is reported to have been found by police at Beachy Head considering suicide, but couldn't go through with it. Mr M says this was his second visit to Beachy Head as he previously had gone with the intention of driving his car off the cliff but couldn't bring himself to do so.

In **July 1993** Mr M was prescribed an antidepressant (dothiepin) by his GP as it was felt he had early depression combined with effects of previous substance abuse and possible withdrawal, worries about money were also noted.

In **August 1993** Mr M was referred to the psychiatric services in Hastings by his GP as he complained of increasing problems with tingling all over, pressure in his head and becoming short tempered with attacks of sweatiness. It would appear that his medication was changed to fluoxetine in place of dothiepin.

In **September 1993** Mr M was seen by a Clinical Assistant in the psychiatric service who described him as *"a complex character with probably a psychopathic personality"*. He was referred for a psychological assessment by a Clinical Psychologist. Mr M's GP wrote to the Psychology Clinic advising 'that due to the side effects of fluoxetine he had put him back on dothiepin'.

In **October 1993**
Seen in outpatients, Mr M stated that he was *"not too good and was having bad nightmares"*. It appears that he increased his use of cannabis at this time.

Seen by the Principal Clinical Psychologist, the psychometric assessments carried out suggested that he was functioning with very inadequate coping skills and at a notably immature level. His scores on the Beck scales on tests taken probably in January 1994 were indicative of Moderate-Severe depression, a Moderate-Severe level of anxiety and Moderate on the feelings of Hopelessness Scale. The Clinical Psychologist reported that Mr M described a very traumatic childhood characterised by neglect, maternal rejection and abuse.

In **January 1994**
Mr M was admitted to Conquest Hospital A&E following an overdose and kept in hospital overnight. He was seen the following morning by the Community Psychiatric Nurse (CPN) who also reports that in November he had taken an impulsive overdose. As described, the January overdose had been planned and he took a combination of alcohol and sleeping tablets but as he felt himself going into sleep contacted the Samaritans and Ambulance Service. On his discharge an outpatients appointment was arranged.

Mr M was referred for further engagement in the psychology service but this did not happen as he had moved out of Rother and into the St Leonard's area. In a letter to Mr M's GP the Principal Clinical Psychologist refers to Mr M's first family in Hertfordshire and his aspirations and worries about their circumstances. She also made the following analysis of Mr M:

"*Mr M certainly is in need of psychotherapy but there are a number of problems to be considered. He has changed addresses three times recently, and this does occur impulsively and suddenly. Any therapy would therefore be subject to risk of disruption. He would really need long-term therapy and it might be difficult to retain him as a client given the chaotic nature of his life at present. It is also questionable whether psychotherapy alone would have any effect if it were not combined with medication and social care, and there is the question of whether he could abstain from taking drugs and alcohol sufficiently to make use of the treatment offered. It may be that the forensic service would be a more appropriate service to consult, as they are more likely to be able to offer him an appropriate package. Mr M, however might find this difficult to accept."*

In **February 1994** Mr M was seen in Outpatients clinic as a follow-up to the overdose in January. Dothiepin was increased and Mr M was advised to stop using alcohol and cannabis. He was referred to the Hastings team as he had moved to St Leonard's on Sea.

In **April 1994** he attended Outpatients where improvement in his mental state was noted. A further appointment was made for May with the Hastings team, it does not seem that this appointment was kept by Mr M .

In **August 1994** he was transferred to Hastings CMHT and seen by a Staff Grade Psychiatrist, who started him on thioriadazine and made a further appointment for September. Apparently Mr M thought that this was medication for schizophrenia and did not take it nor did he attend subsequent appointments.

In **October 1994** Hastings CMHT referred Mr M back to the Bexhill Team as he had moved back there.

During **November and December 1994** Outpatient appointments not kept by Mr M with the Bexhill team.

In **February 1995** Outpatient appointment not kept. Discharged from Bexhill Team due to not attending appointments.

There was no further contact with services throughout 1995 and 1996.

In **February 1997** Mr M was referred by his GP to the Crisis Response Service (CRS) after returning from a stay in Hertfordshire with a heightened level of anxiety. The CRS nurse reports that Mr M seemed quite angry and frustrated about the lack of response from previous attempts to get help. The CRS referred him for a psychiatric Outpatient appointment.

In **April 1997**
Mr M was seen in Outpatients by the Senior Clinical Medical Officer who records that she discussed with Mr M her view that his condition is primarily about his personality and that he would not benefit from clinical psychiatry but that a referral to psychology might be beneficial. It seems that Mr M was intending to return to Hertfordshire imminently as he regarded his relationship with his partner to have ended (see reference to this dated 1987 above) and therefore no referral was made. Mr M's GP was informed, and Mr M was advised to contact his GP if he did not move to Hertfordshire when she could re-refer for psychological support. It is also reported that Mr M did not feel that his intake of alcohol and drug abuse affected his mental health.

Mr M complained to the Hastings and Rother Trust that he had not had help over the years and that whoever he saw said he wasn't for them and passed him on. This was an emotional note written on the Trust's formal Complaint Leaflet stating that *"by the time you get this I will be dead".*

The Chief Executive of the Hastings and Rother Trust replied and copied the letter to the GP and advised Mr M to contact the GP.

There is no record of further contact until July.

In **July 1997** Mr M attended the GP where he was reported to have lost interest in everything again, was drinking heavily and his partner had refused to take him back. The GP referred Mr M to the Clinical Psychology services for further assessment and engagement. The GP's letter indicates that Mr M was in contact with his real mother.

In **November 1997** Psychology records indicate that after the July referral Mr M did not keep appointments that were offered to him and no further action was taken.

In **February 1998** Mr M's GP referred him to the Community Alcohol Team describing a very high level of alcohol consumption and cannabis use.

In **July 1999** Mr M sentenced to 10 days imprisonment for theft and motoring offences.

In **February 2000** Mr M was referred by his GP for a medical procedure in January, he did not attend either of the two Outpatient appointments offered in relation to this medical condition.

In **May 2000** Mr M was referred by his GP to the Bexhill CMHT as he had become depressed with symptoms of loss of sleep, appetite, extreme anxiety, depression and suicidal thoughts. His GP prescribed dothiepin.

In **June 2000**
A letter was sent to the GP from a nurse in the CMHT who had offered Mr M an immediate appointment that he did not keep. She subsequently spoke with him on the phone when he was described as "expressive and calm" that he was 'OK' and hoped to turn things round. Another appointment was made which Mr M did not keep and was discharged from her caseload.

Mr M met and started a relationship with Ms L. See Part 3 of this chronology

7.2 Chronology Part 2 - Ms L 1965 to 2000

Although Ms L is not the subject of this Inquiry we have included this brief commentary on her history and involvement with mental health services.

Early years and adolescence
Ms L was born in 1965. There were some difficulties during her school years during which she was referred to a Child Psychologist and eventually received home tuition. She had difficulties in finding and holding jobs and had her first contact with adult mental health services in 1983.

Ms L's twenties
Over these years she had periodic engagement with mental health services. Apart from a brief stay in Scotland she lived in East Sussex throughout, often in her family home. There were prolonged periods when Ms L was extremely anxious and dependent on those around her. In 1995 she and her partner had a child.

Ms L's thirties
Ms L continued to have extensive periods of depression and engagement with mental health services throughout this time. Her partner at that time was prone to violent abuse of Ms L especially when he had been drinking. Ms L's child lived with her mother from infancy; the social services department was involved in arrangements for the child's continuing care and occasional stays with Ms L and her partner.

In September 1999 Ms L's partner died suddenly. This precipitated deterioration in Ms L's mental health; during the next few months she was an inpatient and spent time in residential care after leaving hospital in November. In June 2000 she met and started a relationship with Mr M. See Part 3 of this chronology.

7.3 Chronology Part 3 - Together June 2000 to June 2002

During 2000
At the time that Ms L and Mr M met, Ms L had recently left hospital after several months as an inpatient following her admission the previous autumn when she had been subject to the Mental Health Act (MHA). Mr M had not kept the appointments arranged for him in June after his distressed request for help to his GP in May.

From the records it is apparent that Ms L was living in a rather disorganised way. A number of acquaintances would gather at her address and use cannabis and alcohol. It is during this period that Mr M met Ms L.

At that time and over the rest of that year they grew closer but there were also episodes when Mr M left her and the relationship could be stormy. In November they were reported to be engaged and planning to marry the following January 2001. Ms L was considering going to court to get custody of her child from her mother, whom she was seeing on a regular basis as agreed with her mother.

Ms L was reported to be *"consistently out for prearranged appointments"* and had little contact with her Social Worker who maintained her contact and availability to both Ms L and to Mr M over these months. Ms L's medication had been reviewed when she had been an inpatient but after discharge she was not reliable in taking this medication as it had been prescribed.

During the year 2001
In **January 2001** Ms L was seen at Outpatients by the Consultant Psychiatrist with her Social Worker where it is reported that she had decided against seeking custody of her child, that she had decided on a gradual reduction of her lithium medication and that Mr M had a job.

In **February 2001**
Mr M attended Conquest Hospital A&E department following an overdose of oxazepam and alcohol. He was kept in overnight and seen the following morning by the Mental Health Liaison Nurse who records that Mr M having taken the overdose called the Samaritans who subsequently alerted the Ambulance Service. The letter to the GP records *"that Mr M does not intent to take his own life, but that he is seeking help with his drug and alcohol use"*. He also noted his view that Mr M *"shows no commitment to work on his alcohol or drug abuse, despite the fact that that he is not using drugs upon which he can become physically dependent".*

The GP re-referred Mr M to the Bexhill CMHT immediately.

An immediate appointment was offered by the Community Psychiatric Nurse (CPN) who had spoken to Mr M on the phone the previous June 2000.

In **March 2001**
Mr M did not keep the CPN appointment offered.

During the early part of this year there were pressures between Mr M and Ms L with Mr M moving out for a spell. There were also difficulties for him and for Ms L with old acquaintances who continued to visit the house.

In **April 2001**
Mr M was seen by a Registered Mental Nurse (RMN) Graduate Student under the supervision of an experienced CPN. He discussed several aspects of Mr M's background and current prospects, noting Mr M's *"significant perception of loss regarding relationships, material wealth and future opportunities"*, he also noted that Mr M said he was currently not taking any alcohol or illicit substances. He arranged with Mr M four further sessions together. Standard Care Programme Approach (CPA) documentation completed

Ms L had an enhanced CPA Review on 6th. At this time Ms L was feeling under pressure: She had problems with her acquaintances, one of whom had smashed the front door; bills were accumulating; Mr M had left her; she did not want to be in the house. However, Ms L had sufficient awareness to agree to restart taking her lithium. Both Ms L's CPN and Social Worker were in regular contact with one another and coordinating their input to Ms L.

Ms L's mother contacted her daughter's CPN to express concern about the effect her behaviour was having on her grandchild when with visiting her at weekends. Her mother was advised that as she had a Residency Order and that she could decline Ms L's access and that she also had access to the Children and Family Team if she wanted to follow through concerns about her grandchild.

In **May 2001**
This month appears to have been particularly chaotic for Ms L with money problems, pressure from her acquaintances, and concern from her mother about her ability to have her child to visit and a specific incident outside the school about access. The mother was concerned about her daughter having people staying at her home and the impact on her child when present, and discussed these concerns with the CPN.

Mr M kept one more appointment with the CPN but did not sustain his engagement although he did make contact seeking a further session but then did not attend the appointment. Mr M was not present in the couple's home for much of this month.

During June, July and August 2001
Mr M was discharged from the CPN caseload because of his non-attendance for the appointments.

These were difficult months for both Mr M and Ms L. There were problems with Ms L's medication, which was changed, monitored and changed further. This was complicated because of Ms L's abuse of sedatives. Ms L's mental health deteriorated and she spent a lot of time in bed and is reported by Mr M to have been very demanding of him, not letting him leave the house and wanting constant reassurance that he would return.

During these months Mr M did leave the house and stayed away on a few occasions. It is reported that he drank heavily during this time.

There were times when Ms L was brighter and in early July the possibility of her attending a college course or Workability scheme was explored.

September 2001

5th Social Worker arranged to provide Community Support Worker (CSW) support to Mr M to provide respite for him as Ms L was refusing to go out and scared to let him do so without her

10th Mr M telephoned Ms L's Social Worker stating that Ms L was threatening to kill herself. The Social Worker visited that day and reports that Ms L was anxious and agitated all the time, taking zopiclone throughout the day in an attempt to calm herself. An Outpatient appointment was arranged for four days later; discussed the position with the Crisis Resolution Team (CRS) but no doctor immediately available because of illness, advised to try the Sector Team and failing that to access a Consultant Psychiatrist immediately through the A&E Liaison Psychiatry service, however Ms L refused to attend A&E. The Social Worker alerted the Emergency Duty Team (EDT) and returned to the house the first thing the next morning to monitor the situation.

11th The Social Worker sought readmission to the Sanctuary respite setting to relieve pressures within the household. The referral was unsuccessful because of difficulties the Sanctuary had experienced when Ms L had stayed there on a previous occasion and she was not admitted at this time.

The Social Worker took Ms L to the GP who changed some of her medication, oxazepam to diazepam with the intention of giving Ms L greater relief.

12/18th The CRS visited Ms L at home and the Charge Nurse carried out an assessment and completed the CPA Registration and Assessment forms. Ms L was described as having bi-polar affective disorder.

References to Mr M describe him as the carer who was finding the situation hard to handle and was feeling low. The CRS was aware from Mr M of an outline of his history they advised him to see his GP.

Nurses in the CRS were actively involved with home visits and telephone contact from the 12th to the end of the working day on the 18th September. The notes suggest that on the 17th and 18th there was increasing concern about Mr M's frame of mind and the need for him to receive an assessment and support *"in his own right"* as soon as possible. It was noted on the 16th that Mr M *"wants to have a carers assessment as feels he is only just 'hanging on'".*

These notes indicate that both Ms L and Mr M were under pressure from Ms L's previous associates who had stolen from the house, broken windows and physically threatened Mr M. The Housing Association had been contacted seeking a housing transfer and in the event this was achieved with Mr M and Ms L down to move at the beginning of October.

Throughout this episode of intense engagement by the CRS with Ms L there was regular and consistent contact with other professionals involved in her care. The CRS formally discharged Ms L from their caseload on 18th September.

14th The Bexhill sector Consultant Psychiatrist saw Ms L at an urgently arranged appointment. The outcome of this was some changes to her medication and a referral to the Day Hospital where her overall physical and mental health could be assessed and medication monitored and modified in a supportive environment.

18th Following a referral from the GP after the engagement outlined above the CRS visited the house to assess Mr M in his own right on the evening of 18th.

This visit was made by the CRS Charge Nurse and the Duty Psychiatrist. They were not well received by Mr M who had been drinking and was aggressive towards them. During this visit he made the following statements: that *he "felt like going out and killing someone, that way I'll get some peace"*, that his role in looking after Ms L is not valued and that he is stressed looking after her. The notes record that *"He revealed he had tried to sedate Ms L yesterday so he could go out and kill someone".*

The CRS team did not feel that they could assess Mr M because he was drunk and that they would return the next day. They were concerned about Ms L's safety but she told them that she would be alright. When they returned to their office the doctor informed the police of his concern who responded that they could not take any immediate action. The 1st on call Psychiatrist for the night was also alerted.

Later that evening Mr M was taken to A&E having overdosed at home with Ms L calling the ambulance. He was very abusive at the hospital resulting in the police being called, he was arrested for causing a disturbance and held overnight in the police cells. He was subsequently charged and convicted with "using threatening, abusive, insulting words with the intent to cause fear or provocation of violence, and for obstructing a Police Constable".

19th The CRS visited Mr M at home after his release from police custody.

20/28th Telephone contact by CRS with Mr M and liaison with others working with him and Ms L. During this engagement Mr M was advised to see his GP, arrangements were set in motion to undertake a Carer's Assessment with Mr M, allocation of a CPN for Mr M in his own right, and contact with the Bohemia Trust about legal representation in court following arrest.

The CRS discussed with Mr M his drinking and this indicated ambivalence on his part about engaging with the Community Alcohol Team (CAT). It is clear from the notes that Mr M was drinking heavily during this period.

A standard CPA Assessment and Care Plan Form was completed for Mr M dated 17th but with information suggesting that this should have been dated after the 19th CRS visits of the 18th and 19th. The Standard CPA Review form is dated 25th and the Further Action is *"Discharge to GP's care whilst awaiting CPN to be allocated".*

Mr M was in court on 25th September where he was given a conditional discharge following his arrest in A&E.

The CRS nurse phoned the Bexhill Sector Team (CMHT) about the CPN allocation they recommended. The CMHT did not allocate a CPN. They informed CRS that Mr M's Carer's Assessment would be undertaken by social services.

Plans were being made with the support of the Bohemia Trust for Mr M and Ms L to move into their new house in Netherfield in the first week in October.

It is evident from the CRS's notes of contact with Mr M that he was again stressed by his circumstance, by Ms L's condition, and that he was drinking heavily.

In **October 2001**

1st The Social Worker was in discussion with Ms L's GP about her medication during the previous few days and there is an entry in her social worker notes *"Ms L given one month's supply (of diazepam) on 27th September – 56 tablets. Should be taking a max of 8 per day. Query how much Ms L is abusing them"*.

2nd Mr M and Ms L moved to Netherfield

3rd Letter from the CRS to Mr M's GP informing him that *"Mr M has agreed to be discharged from our caseload"* and that they had requested a Carers Assessment and the Sector Team were considering his needs.

5th During the evening Mr M phoned CRS five times stating that he was not coping with Ms L and requested an urgent visit from them. It seems that much of this contact was with the CRS answer phone and there were sounds of argument between Mr M and Ms L in the background. When reviewing the answer phone tapes, apparently the CRS considered contacting the police but then learned on Saturday morning that Ms L was in hospital, see below.

6th Mr M phoned the CRS and informed them that Ms L had been admitted to A&E overnight. She had fallen down the stairs in their new home during the night and broken her wrist. This happened in the early hours of Saturday morning, she was discharged on the Sunday the 7th.

On the Saturday evening Mr M phoned the CRS *"saying that he thought Ms L would need psychiatric help before she is discharged from hospital"*

8th The CRS informed Ms L's Social Worker who visited that day. The Social worker probed with Ms L the cause of her falling down stairs and was satisfied that her explanation was true, ie, that she got up in the night to go to the toilet but in a new and unfamiliar house, and probably having taken an excessive quantity of diazepam, turned the wrong way out of the bedroom causing her to fall down stairs.

CRS formally discharged Mr M from their Team

11th The Social Worker visited Ms L. Tensions were running high between them and it seems that Mr M left the house for a short period. He was drinking heavily, Ms L tended to stay in bed. Getting anywhere from their new home in Netherfield was dependent on having transport and there was concern that Mr M might be driving under the influence of alcohol. The Social Worker again probed with Ms L the cause of her fall downstairs and she again stated that it was an accident.

12/31st The Social Worker alerted the EDT in readiness for the coming weekend.

Social Worker stayed in regular contact with Ms L through the rest of October. During this time the situation remained up and down. Ms L refused to be assessed for the Day Hospital but another assessment appointment was made for early November.

In **November 2001**

2nd There was phone contact from Mr M about Ms L to the Social Worker indicating that things were getting worse.

5th The Social Worker took Ms L to the Day Hospital assessment, Ms L was ambivalent about attending because of her previous engagement at the hospital. In the event a gradual programme of attendance with transport was organised.

22nd Mr M attended a new GP, having registered following his move to a village near Battle in October. He reported chest and abdomen pains, also that he had been treated previously for manic depression. GP discussed Mr M's drinking pattern and medication.

In **December 2001**

7th Mr M made an application for his own accommodation stating that he was homeless.

10th Ms L contacted the CRS by phone asking for support, she was referred to her GP.

Arrangements were being discussed to transfer continuing responsibility for Ms L to the Rural Rother Team.

In early December Mr M left Ms L and stayed away until late January.

In **January 2002**

8th A new Social Worker was introduced to Ms L at the Day Hospital.

25th An enhanced CPA Care Plan was completed at the Day Hospital and a future attendance at a YMCA scheme was arranged. Overall a positive picture of progress was made at the Day Hospital and of plans for the future: Arrangements for a transfer of Consultant Psychiatrist to the Rural Rother Team with an Outpatient appointment arranged for March with the new Consultant Psychiatrist; Rural Rother to allocate a CPN but for the GP to monitor her medication until a CPN was allocated; reduction of her diazepam planned; continuation of the practical support initiated in September 2001 through the CSW.

31st Discharge letter sent to the GP.

In **February 2002**

6th A new Social Worker, who is also the CPA Care Coordinator, visits the home for the first time. Overall Ms L is reported as making progress with next visit arranged for 25th February. Mr M had just returned to the house and was again living with Ms L after an absence of about two months.

19/20th Telephone contact was made by the Social Worker to Ms L. These indicated that the situation was deteriorating again with Mr M and Ms L rowing, Ms L giving up the activities identified in the CPA and that she had taken to her bed, was feeling depressed and lost her motivation.

25th A Home visit was carried out by the Social Worker who recorded that Ms L had attended her activity group that morning after prompting from Mr M; and that Ms L might benefit from individual counselling which she would follow up.

26th Contact with Social Worker from:

- The Consultant Psychiatrist's secretary. Mr M had contacted to say that Ms L had overdosed on prescribed medication the previous evening.

- The Access and Response Team (ART), formerly called the CRS, had been contacted by Ms L's friend – from when they were in the Day Hospital together - on the evening of the 25th asking about her support arrangements and the arrangements for a meeting scheduled for the next day.

- The A&E liaison nurse asking for background on Ms L.

- Ms L's GP to say that he had tried to refer her to CRS but she had left A&E before being assessed.

- The group Ms L attended on a weekly sessional basis to say that she had attended on the Monday morning.

- Hastings and Rother Counselling service to discuss a possible referral of Ms L.

27th Case discussed at the Rural Rother Team meeting, urgent outpatient appointment to be offered – arranged for 7th March, Consultant Psychiatrist to discuss Care Plan further, no additional input at this stage.

28th The Social Worker discussed Mr M's needs with Care for the Carers who suggested a Carers Assessment for him, and also the possibility of Relate giving him some support. Social Worker phoned and wrote to Mr M about these options.

In **March 2002**

7th Ms L was seen for the first time since transferring to Rural Rother by her Consultant Psychiatrist at an emergency outpatient appointment.

Review of enhanced CPA Care Plan also took place and was documented. Present at the Review were her Social Worker and CSW. A lack of structure in her life was identified as a major factor and Ms L was encouraged to contact Relate. At the time of this meeting it would seem that Mr M was not staying in the house and there was discussion about coping strategies should he return to the house. Ms L's chlorpromazine was increased.

8th ART contacted Ms L's Social Worker to ask that Mr M's circumstances be discussed at the Rural Rother team and for assessment as her carer.

12th Telephone contact from Ms L to Social Worker saying that she was fed-up and depressed, constantly arguing with Mr M.

13th Discharge letter from Ms L's Consultant Psychiatrist to her GP setting out her current treatment plan, engagement with Social Worker and circumstance with Mr M.

14th Social Worker spoke to Mr M who *"was angry that Ms L was trying to control him*"; Social Worker also noted that Mr M had told her that *"when they were both out in the car this am, he had tried to drive his car into a lorry as he 'has had enough'".*

Social Worker met with Ms L to rewrite her enhanced CPA Care Plan, main focus of this was on the need for Ms L to structure her time, set goals, attend groups, and that the practical support provided by the CSW was to continue.

Later on the 14th a further phone call was made by Ms L to the Social Worker to say that Mr M had cashed her giro and "stolen" her medication.

It later emerged that Mr M drove to northeast London where he crashed his car. Following this he was taken to A&E by the police. He was not physically harmed but had overdosed on a cocktail of drugs and alcohol. Mr M attempted to run away from A&E into the path of an oncoming vehicle but was restrained by the police. He was detained under Section 136 of the MHA by the police and taken to Chase Farm Hospital as a Place of Safety for a Psychiatric Assessment on the morning of the 15th March.

15th On assessment Mr M was noted to have *"violent suicidal ideation/intents"*, described as *"preoccupied with thoughts of self harm, the futility of living and his wasted life"*, and that he *"had problem with his partner who asked him to leave the house".*

Mr M was admitted to hospital under Section 2 of the MHA; on the paperwork the following is stated; *"Feels his life has gone wrong and he has nothing to live for. Thoughts of stabbing his girlfriend but did not act on them and decided to take tablets and car to kill himself".* Mr M was transferred from Chase Farm to Woodlands Unit in Hastings.

15/16 and 18th At Woodlands Mr M was seen on each of these days for separate assessments by a Charge Nurse and the Consultant Psychiatrist. Social and psychiatric histories taken and Mr M's current mood was gauged with an initial plan identified to stabilise his drinking, provide activities, relationship counselling and his physical health.

19/31st Mr M remained as an inpatient throughout the rest of March settling into the ward. There was some tension with another patient

early on, who is noted to have caused conflict with others in the ward; Ms L visited from time to time. After 10 days or so he became more settled and on 25th voiced his concerns to ward staff about Ms L's health and that he needed to return home to look after her.

22nd An Occupational Therapy assessment was made. The "Summary of Interview and Identified Needs" states that he is Ms L's *" 'main carer', doing all the cooking, shopping and housework. Mr M states that Ms L 'is all I have', he has lost his family and friends through drinking and 'gave-up' his circle of friends as they took drugs. Mr M states his only motivation is to 'get back to Ms L' although he is 'worried and frightened' that he will not cope on discharge. Mr M states that 'if I fail again' he would attempt suicide again. Mr M also stated that he did have 'horrible thoughts' about killing his partner so that 'I could return to prison' because it is 'safe and secure'."*

This information about the potential threat to Ms L was not shared with the Consultant Psychiatrist, although a copy of the assessment was placed in the notes and a reference to it was contained in the day to day "Nursing Management and Evaluation Record" dated 23rd March.

27th Mr M was seen at the Consultant Psychiatrist's Ward Round. Risk Assessment documentation was completed. The Section 2 of the MHA was rescinded. On the Becks depression inventory Mr M's score had gone down from 46 to 9, and he was considered to be confident and hopeful about the future. Ms L's Social Worker was to arrange a Carer's Assessment. Mr M was engaging with Alcoholics Anonymous with an aim at that time of achieving and maintaining total abstinence.

31st Mr M returned to Woodlands after weekend leave. He said that he would not continue to attend AA if a particular chairman of the group attended meetings. His CPA was reviewed.

In **April 2002**

1st Mr M's risk assessment was completed in full by his Consultant Psychiatrist on discharge. He was placed on Standard CPA, although Enhanced CPA paperwork was used. Outpatient appointments were made for the Community Alcohol Team (CAT) on 2nd April, and with his Consultant Psychiatrist in June.

2nd The Consultant Psychiatrist's discharge letter was sent to Mr M's GP detailing his medication in the Aftercare Plan with a diagnosis of mental and chemical disorder due to the use of alcohol, dependence syndrome, currently abstinent, ICD 110code F10.20.

6th Mr M was admitted to Conquest Hospital with a fractured fibula via police custody after having been found in a drunken state and arrested.

11th Ms L's Social Worker referred her to the Psychology service, for assessment, with personality difficulties in maintaining stable relationships, her pattern of forming dependent relationships and chronic problems with depression and disabling anxiety.

19th Letter from the Sanctuary in response to Social Worker about the possibility of Ms L gaining respite at the Sanctuary if required in the future. Sanctuary set out that this was possible and the sort of referral/assessment necessary for them. Also apologised for not attending a home visit that the Social Worker had tried to arrange for them to meet with Ms L.

29th Home visit by the Social Worker who had frequent phone contact with Ms L since she had last seen her. Throughout this time Ms L had been depressed and anxious, she had however taken a more active role in the house as Mr M had his leg in plaster following the fracture to his fibula earlier in the month.

On this visit the Social Worker talked to Mr M about the Carers Assessment he had previously declined; the notes state *"He feels that it is too 'personal' and his answers may offend Ms L if she were to read it. I reiterated that if he did not complete the form I was unable to gauge what help he needs"*

At various times throughout April there was contact from the YMCA indicating non attendance at the group; also an indication early in the month of her continuing aspiration for her son to move back with her on a permanent basis.

In May 2002

2nd Mr M contacted the Social Worker and reported that the relationship was very difficult.

9th The Psychology service wrote to Ms L asking her to confirm that she wanted to go on the waiting list as a result of a referral the Social Worker had made on the 11th April. The letter stated *"Please note that once you have responded to this letter, you may have to wait quite some time for assessment due to pressure on this service".*

13th Mr M phoned Ms L's Social Worker to cancel planned visit as Ms L was unwell.

14th Home visit by Social Worker - Ms L very low. Social Worker discussed the possibility of a few days at the Sanctuary but Ms L refused this option. Emergency Outpatient appointment arranged with Consultant Psychiatrist for 16th May.

16th Mr M was seen by his GP, notes say he was in pain associated with his broken fibula. Mr M reported that he was drinking bottled

shandy only, and that he *"still loses temper – girlfriend has major problems".*

Ms L seen by Consultant Psychiatrist at Outpatients, Mr M also present. Main focus, as documented in letter to the GP on 23rd May appears to have been on reviewing her medication and that *"since starting on a different antidepressant medication she has complained of a lot of excessive fatigue"* with an urgent thyroid function test arranged. It was later confirmed that her thyroid function was normal.

23rd Several phone calls between Mr M, Ms L, the Social Worker and other supports. The initial call from Mr M stating that things were very difficult between him and Ms L who was relying on him more and more. Mr M is noted to be *"becoming very angry and being violent towards Ms L, in turn Ms L is retaliating and is very tearful, angry/depressed and spending lots of time in bed".* Reported that Mr M was planning to present himself as homeless and that Ms L was said to be *"smashing up the house"*

Social Worker contacted CSW who was scheduled to visit that day in any event. Also contact was made with the Sanctuary who had a bed available to offer immediate respite for a few days. In the event Ms L went to the Sanctuary that same day, Thursday, and she stayed over the weekend.

27th Sanctuary reported that Ms L had calmed, was ready to return home, and that over the weekend Mr M had visited. Mr M took Ms L home that afternoon, CSW also involved in helping them.

28th Consultant Psychiatrist's letter to GP stating that Ms L's thyroid test was normal, recommending a reduction of the antidepressant. He also passed on information about Mr M and Ms L fighting occasionally.

29th Ms L's enhanced CPA Review form completed including Risk Assessment. The CPA Risk Assessment notes "*a high level of conflict +++ with partner,* and with Ms L being *at medium risk level of violence from Mr M".*

Ms L contacted the YWCA a few times during May indicating an intention to attend but that she was too unwell to do so.

In **June 2002**

10th Social Worker phoned Ms L in the morning and spoke with Mr M as she was asleep. During this call Mr M informed the Social Worker that he'd had the plaster from his ankle removed.

13th Social Worker and CSW visited together to carry out the enhanced CPA Review. Social Worker concerned about the amount of medication Ms L had taken and her drowsiness, she contacted the A&E Liaison Nurse for guidance. The notes show that Mr M felt

himself to be *"at his wits end of how to handle (Ms L's) negativity and both have been rowing and shouting at each other".*

The options of a further stay at the Sanctuary and re-engaging at the Day Hospital were discussed with Ms L but she refused both.

Mr M asked to see Ms L's Consultant Psychiatrist to discuss her condition and needs.

The Social Worker and CSW agreed a programme of visits approximately every 4 days between them until the 5th July.

Mr M told to contact Social Worker, CSW or emergency services if he fears that Ms L might be at risk of suicide.

14th Social Worker phoned and spoke with Mr M, Ms L again in bed and there had been further argument between them.

17th CSW visited. Ms L had spent most of the weekend in bed and had exceeded her medication prescription. CSW suggested to Mr M that he go out for a break while she was there to relieve pressure for him. CSW persuaded Ms L to get up from bed who expressed concern that he would not return or that he'd go out drinking.

Mr M attended A&E in the evening in a depressed state requesting help for himself.

18th Social Worker phoned and spoke to Mr M who was very stressed. *"There is more argument and Ms L's abusing diazepam."* Social Worker discussed with Consultant Psychiatrist and they decided to visit together that afternoon. Joint visit carried out on both Ms L and Mr M. Consultant Psychiatrist discussed the management of Ms L's medication, the Social Worker notes report *"M agreed to dispense Ms L's medication on a daily basis".*

Consultant Psychiatrist to refer Ms L urgently for Day Hospital/Day services with a view to bringing greater structure into Ms L's life and reducing pressure on Mr M.

Social Worker again discussed with Mr M carrying out a Carers Assessment but he remained reluctant. Social Worker to discuss further with Rethink for more specialised input on work with carers.

CSW and Social Worker to maintain their close contact. Social Worker to contact Psychology services to bring forward their assessment appointment. Noted that Mr M was due to have the pin in his ankle removed on 27th June and would have reduced mobility for a period.

The Consultant Psychiatrist's shorthand notes reflect: further outpatient appointments, for Ms L on 25th July and for Mr M on the 15th August;

"stress risk of violence"; "?CPN for Mr M essential"; "Relate once things have improved"; "zero tolerance of arguments".

19th Social Worker contacted Psychology services about bringing forward Ms L's appointment, left message as person she wanted to speak to was unavailable.

Letter from Consultant Psychiatrist to Ms L's GP updating him on his visit the previous day.

Urgent Fax from Consultant Psychiatrist to the Day Hospital seeking an urgent place in the unit.

Discussion at the Rural Rother Sector Team Meeting where it is recorded that *"Need CMHN for Mr M. Consultant Psychiatrist and Social Worker recently did a DV and feel that her partner Mr M needs help in his own right. He recently took an overdose and has been in Woodlands. He is getting stressed out, partly the problem being Ms L and partly because of his own problems. He needs to talk things through about how he handles his emotions. CPN to offer an assessment. Put on waiting list for CPN".*

21st Reply to Social Worker from Consultant Clinical Psychologist who was unable to help stating in her letter *"I appreciate the difficulties that our lengthy waiting list causes for both clients and referrers but unfortunately we are not able to offer individuals priority".*

The Social Worker visited and saw both Ms L and Mr M. Ms L still felt *"a bit doped up"* her mood was reported to have picked up and she was planning for her son to stay at the weekend. Discussed with them together the idea of drawing up a contract designed to minimise their conflicts and to respect each other's needs. Later that day, the Social Worker contacted Rethink to discuss carer's support to Mr M and updated CSW on her. At about 4.30pm Social Worker phoned Mr M about the contact with Rethink and that they'd contact him next week. *"Mr M reported that everything was OK".*

21st At approximately 10pm Mr M phoned the police through the emergency services to report that he had killed Ms L. In this phone call Mr M spoke about his contact with mental health services and his intention to overdose. Police operator persuaded Mr M to give himself up. Later that evening, shortly before 11pm Mr M presented himself to Hastings Police Station.

24th Initial appearance in court, remanded in custody.

In **February 2003**
3rd Mr M pleaded guilty to manslaughter with diminished responsibility. He was sentenced to four years in prison and then after

his release, three years of extended supervision. He has subsequently been held within the Prison Service

8. CONSIDERATION AND ANALYSIS OF CRITICAL ISSUES DURING ENGAGEMENT WITH MENTAL HEALTH SERVICES

8.1 Communication, transferring and sharing information between and within teams

It is apparent from the service profile in the late 1990s and up until the spring of 2002 that there were a number of teams and functions of the local mental health service that did not communicate adequately with one another in relation to Ms L and Mr M. There are several examples where information, which might have had a significant effect on the judgements and actions in regard to Mr M and in his relationship with Ms L, was not shared or made available between teams.

8.1.1 September 2001

When the CRS visited Mr M in September 2001, immediately following on from their engagement with Ms L, it was not possible to carry out a psychiatric assessment because he was too drunk and aggressive in his tone. The outcome of this visit was that the normal pattern of communicating information did not occur as the On-call Psychiatrist did not regard his engagement as professionally adequate to convey an opinion on Mr M and his needs to the GP as would have been the norm following a visit. He did however regard Mr M's attitude and behaviour towards him and the nurse with whom he visited as sufficiently worrying to inform the police of his concern because of what he regarded as a potential threat to Ms L.

An indication of this threat is contained in the nurse's note written after the visit: that Mr M *"felt like going out and killing someone, that way I'll get some peace"*; that his role in looking after Ms L is not valued and that he is stressed looking after her. The notes record that *"He revealed he had tried to sedate Ms L yesterday so he could go out and kill someone"*. These comments were discussed with Ms L who did not feel herself to be at risk from Mr M and she is reported to have indicated that from time to time he made such comments reflecting a state of mind he got into. The possibility of seeking to remove Ms L from the house by making an approach to the Sanctuary that evening was discussed but Ms L did not want to progress this.

The referral was made on the 18th September by the GP although it is the case that the CRS knew something of Mr M as they had been working with Ms L in the home in the days before the referral. The initial visit with the nurse and On-call Psychiatrist was on the evening of the 18th and was as described above. The substantive assessment with the CRS team Psychiatrist took place on the 19th September. However the Referral/Registration Detail and Risk Assessment CPA documentation is all dated 17th September. In discussion with the CPN

who completed this documentation at the conclusion of these and other contacts, no explanation was given for the confusion over dates.

Assessment visits are ordinarily complex and this is made especially so when the person being assessed is intoxicated, as on this occasion. The clinicians involved have to use their judgement about the significance of what is said to them, its context, tone and the mood of the person. On this occasion the Inquiry Panel notes a disjunction between the level of concern reflected in the notes of the visit, the offer of the Sanctuary, and the call to the police and the absence of this in what was conveyed to other professionals in the letter about the visit.

It is also of concern that when the CRS saw Mr M the following day (the same nurse with one of the team doctors - not the On-call Psychiatrist), although Mr M was contrite after his arrest at A&E on the previous evening, the statements he had made were not followed up when he was calm and were not incorporated in the psychiatric assessment that took place. The fact that he had also been involved in an altercation at A&E and been arrested by the police does not seem to have been probed during this assessment either.

The completed Risk Assessment tick boxes, (according to the dated paperwork completed on the 17th before the assessment visit, but more likely on the 25th which is the same date as the CPA Review form) identify that Mr M has a history (or threats) of violence; has misused alcohol and/or drugs; a history of impulsive behaviour; high levels of irritability or anger, and that there is a high level of conflict in the family/close relationships. In answer to the question on the form “Have they made threats to available ‘victims’?” the No box was ticked. A low level of violence and medium level risk about suicide was identified. The text in this CPA documentation identifies Mr M’s inability to cope with stress, however it does not make any reference to the threats Mr M had made when in a drunken state or to his arrest the previous evening.

The Inquiry Panel understands that the On-call Psychiatrist did not follow the normal practice and write to the GP because he did not feel that he had carried out a professional assessment and therefore did not want to convey his concerns. The nurse, following his assessment the next day, and subsequent contacts, did write to the GP with copies to the Bexhill Sector Team and Consultant Psychiatrist. However the letter did not contain the comments made by Mr M quoted above and nor were they referred to in the CPA Review. The CRS Psychiatrist did not follow the accepted practice and write to the GP and responsible sector psychiatrist following this assessment. As well as the confusion over dates, the failure to communicate information, and the assessment process not taking account of Mr M’s behaviour and comments, the information conveyed in the CPA paperwork did not contain relevant and available information.

8.1.2 March 2022

Mr M was detained under a Section of the MHA 1983 on 15th March 2002 when he crashed his car in north London while under the influence of drugs and alcohol. Whilst at A&E he ran from the hospital attempting to run into the path of oncoming traffic. The papers transferred with Mr M from the psychiatric unit in London to Woodlands state that he *"Feels his life has gone wrong and he has nothing to live for. Thoughts of stabbing his girlfriend but did not act on them and decided to take tablets and car to kill himself".* These comments were written in the Approved Social Worker's Report of Mental Health Assessment, under a set heading of "Details of Interview with Client". On the form under the set heading of "Assessment of Risk to Client/Others", risk to others was not described but it said that he was *"expressing suicidal ideation".* However these comments are written alongside each other on the same page of a two page summary report and should have been picked up by the receiving psychiatric team. In discussion with the Consultant Psychiatrist subsequently, he recognised that he *"didn't pick up"* this reference and that *"If I had seen that, I think I would have regarded it very seriously".*

On the previous day, 14th March 2002 the Social Worker noted that Mr M told her in a phone conversation that *"when they were both out in the car this am, he had said that he tried to drive his car into a lorry as he has had enough".* Although there was concern about the tension between the couple and the lead-in to Mr M taking the car and driving to London that same night, it does not seem that this information was made available for consideration by the ward team assessing Mr M on his admission on a Section of the MHA.

While at Woodlands Mr M attended the Occupational Therapy service based there. In his Initial Assessment Summary on 22nd March 2002 he spoke directly to the Occupational Therapist (OT) about his fears, that *"if I fail again"* he would attempt suicide again; of his closeness to Ms L saying that she *"is all I have"* and that his only motivation is to get back to her. He also described how he has run away from problems since he was a child and that he did have *"horrible thoughts about killing Ms L so that I could return to prison because its safe and secure".*

The information gathered in this assessment was not discussed with others involved in Mr M's care in the ward and most particularly was not identified as available at the ward round considering Mr M's treatment plan. A copy was placed in the ward notes and in the day to day "Nursing Management and Evaluation Record" the following day, four days prior to the Ward Round. There is no indication of any awareness of this assessment, its content or of its potential seriousness being brought to the attention of the other members of the clinical team.

These are the most significant illustrations of people failing to pick up available information; to share observations about Mr M; to pass on direct statements made by him; or for clinicians of the disciplines involved to ensure that their information was considered by the multidisciplinary team responsible for Mr M's assessment and treatment plan.

It is unclear from both the records and the recall of the Social Worker involved with the couple in 2002 whether, and if so when, she had also been told directly by Mr M that he *"in the past had put his hands round Ms L's throat and that he was frightened he may do this again, as he does not know what to do"* as is recorded in the submission to the Internal Inquiry. In any event it was not intelligence that was recorded in the case notes or passed onto anyone else.

Written information was available in March 2002 when Mr M was an inpatient in both the Approved Social Worker's report and in the OT's report. This was contained in formal documentation held in the Inpatient ward's case note file. That it was not recognised as important indicates either an inadequate read through by the responsible professionals for whatever reason, or a failure to attend to basic procedures. It does not appear that anyone in the clinical team took responsibility for collating or presenting information in the Consultant Psychiatrist's ward round. In addition there is no evidence that professionals involved in the ward round sought information contained within available case notes prior to considering Mr M's care and treatment. It is significant at this time that the Consultant Psychiatrist was the only doctor on the team. A junior doctor, as part of the team, might be expected to undertake the role of collating and presenting information.

8.1.3 Information Management

The Inquiry Panel recognises the pressure that senior staff have been working under in the East Sussex County Healthcare NHS Trust and the genuine efforts being made to improve record keeping and more reliable information exchange between teams. The difficulties experienced by both the Internal Inquiry and this Independent Inquiry in receiving records and accurate information in a timely manner might be considered to be a manifestation of the same problems reflected in this case in the handling and effective use of information about individual patients and those close to them.

8.2 Use of the CPA Process

8.2.1 General

The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 and provides a framework for the care of mentally ill people in contact with Mental Health Services in residential and community settings. The CPA requires Health Authorities and

Local Authorities Social Services Departments to have specific arrangements in place to ensure that the health and social needs of the mentally ill are addressed in a coordinated way so as to optimise the response to the persons needs and to minimise the risk that they lose contact with the services. It requires that service users and their carers be involved in all elements of the process together with other health and social care professionals involved in their care.

The Inquiry Panel were provided with two Policy documents specifically relating to the Care Programme Approach. These were dated December 2000 and therefore in operation throughout most of the period relevant to the Inquiry, and March 2004 (to be reviewed December 2004) which lays out the most current policy.

The December 2000 document states "*In Hastings and Rother since November 1995 the principles of the CPA have applied to all patients in contact with the Trust's mental health services. And since November 1997, integrated Health and Social Service Mental Health Professionals have been recording the results of integrated health and social needs assessments (including Risk Assessments), Care plans and reviews using integrated Health and Social Service CPA / Community Care Act Documentation."*

8.2.2 Mr M 1955 to June 2000

Prior to 1991 and the implementation of the CPA, Mr M had periods of contact with Child and Adolescent Services and Adult Services. Letters in the General Practice notes reflect communication between services and General Practice. Between 1991 and June 2000 there were a number of periods of engagement with psychiatric services in East Sussex (1993 - 1995, 1997, 1998 and May 2000) this included Outpatient, Emergency A&E assessments, Psychology appointments and Drug and Alcohol referrals. While there is no documentation specifically relating to CPA for this period the practitioners who saw Mr M did communicate to the GP by letter and did indicate the care plan. Letters included comprehensive assessments by a Consultant Psychiatrist and by a Psychologist. The presumption is that Mr M was subject to the standard CPA process during this time.

8.2.3 Ms L 1965 to 2000

From the late 1980s onwards Ms L had recurrent emotional, psychological and psychiatric problems bringing her into regular contact with psychiatric services. She was admitted into hospital under Section 2 of the MHA in June 1988 and had informal admissions in 1989 and 1990. Although the paperwork does not always make it clear, Ms L's care appears to have been subject to the enhanced CPA from February 1997.

The Community Mental Health Team (CMHT) notes have a copy of a discharge plan following an admission in November 1996 and subsequent CPA review documentation dated February 1997, May

1997 and May 1998. Members of the multidisciplinary team including the Consultant Psychiatrist were present at these reviews. Occurring concurrently with meetings specifically about Ms L were formal multi-agency planning meetings convened by Social Services regarding the care of Ms L's young child.

In September 1999 Ms L was admitted to hospital under Section 3 of the MHA. This was a period of complex involvement with services:

- **30th September 1999** Admitted as a Formal Patient under Section 3
- **22nd October 1999** Section 3 discharged and she continued in hospital as an Informal Patient
- **4th November 1999** Detained under Section 5/2 within the ward, this section was discharged within the 72 hour statutory framework
- **6th November 1999** Discharged herself from hospital, readmitted informally on the same day, described as in a "*confused and disorientated"* state
- **8th November 1999** Discharges herself from hospital
- Spends the night of **9th/10th November 1999** at the Sanctuary. This placement arranged at short notice by her then Social Worker. She was described as behaving in a disturbed way and was removed by the police at the request of the Sanctuary the following morning.
- **10th November 1999** Was assessed at her brother's address by her then Consultant Psychiatrist who did not consider use of the Mental Health Act appropriate at that time. The diagnosis on discharge included Bipolar Affective Disorder.

When she was admitted to hospital on 9th November a multidisciplinary meeting was held. This was attended by a full range of professionals involved, including the Consultant Psychiatrist who was responsible for her care during her admission, but had not been involved in her care prior to admission and was not involved after her discharge. The meeting was not attended by Ms L or by any member of her family. The paperwork reflecting the outcome of the meeting is headed 'Needs Assessment' and is different from previous CPA care plans but does indicate Ms L is CPA level 2 (of levels 1, 2 and 3).

The care plan from this meeting identified input from Ms L's Social Worker, the Children and Family Social Worker involved with Ms L's child, the Consultant Psychiatrist who had been involved prior to her admission, a Link Nurse and a Community Mental Health Nurse. Relapse indicators were recorded as *1. Non compliance with medication or services, 2. Elated mood and bizarre behaviour, 3. Illicit substance abuse.* All of which were recorded as problems when she presented to the Sanctuary.

8.2.4 Mr M and Ms L together from June 2000 to June 2002

The CMHT notes contain a CPA review form dated 8th June 2000. This gives no detail as to whom, if anyone, attended the review meeting but indicated the intention of transferring the Key Worker role.

In the 6th April 2001 a CPA review was held, no date for a review was set but at a subsequent Outpatient appointment in June 2001, which was not attended by Ms L, she was discharged from the clinic and subsequently discharged by the community nurse. This appears to make little sense in the light of the CPA plan made following the admission in November 1999 and suggests that CPA plans had a rather peripheral place in the medical management of Ms L.

During April and May 2001 concerns were raised by Ms L's mother about her daughter and her care of her child when visiting at weekends. The CPN and Social Worker discussed these concerns and referred the mother to the Children and Family team appropriately. There had been a considerable period of engagement with the Children and Family team previously concerning the grandchild's care; Grandmother had a Residency Order. However, it is concerning that the issues raised about Ms L's care at weekends in line with contact arrangements were not included in her CPA Care Plan, nor were they referred to in Mr M's CPA.

During September 2001, on the 5th Ms L had a CPA Review and referral to the Accommodation Team for support. On the 25th she was seen in Psychiatric Outpatients following which she was referred to the Day Hospital.

From early November 2001 to late January 2002 Ms L attended the Day Hospital and made good progress. At the 25th January CPA review, at which plans for discharge and transfer of care following Ms L's move were discussed, no Consultant Psychiatrist was present. No firm date for the next review was set but Ms L was seen in Outpatients by the new Consultant Psychiatrist and a CPA review held on the 7th March 2002. However, the care plan was written with Ms L, the Social Worker and Community Worker on the 14th March and so again there was no medical input into the care plan discussion.

Having had a review of enhanced CPA on 14th March 2002 Ms L had a further review on the 29th May with standard CPA paperwork mistakenly completed. An enhanced CPA Review took place on 13th June. These reviews were again separate from the medical review which took place on the 18th June domiciliary visit.

On the 15th March 2002 Mr M was admitted under Section 2 of the Mental Health Act, transferred from a north London hospital. The Section 2 was rescinded on the 27th March and Mr M remained in hospital as an informal patient. There are three sets of multi-professional notes relevant to the CPA process; the first dated 18th

March, is unsigned and indicates enhanced CPA, the second dated 27th March, is signed by the nurse and Consultant Psychiatrist and indicates standard CPA, and the third dated 1st April is also signed by both Consultant Psychiatrist and nurse and indicates enhanced CPA and Section 117. The Inquiry Panel heard evidence which clarified that the expectation was that a Consultant Psychiatrist would not be the Care Coordinator for a patient on enhanced CPA and that in reality Mr M was on standard CPA. There are clearly training issues which need to be considered and are covered later in this section.

8.2.5 Medication Management

During the period under consideration both Mr M and Ms L were prescribed medication as part of the medical management plan. In Ms L's case she was on a number of different drugs and there were a number of changes to her medication and to doses during periods of reassessment in hospital, in the Day Hospital, in Outpatient or home assessments. There were periods when Ms L's use of her medication was very inconsistent and at times chaotic. There were also times when Mr M misused Ms L's medication, such as when he drove to North London immediately prior to his admission under section 2 of the MHA.

General practice records for Ms L do not indicate that she was receiving repeat prescriptions more frequently than was appropriate for the doses of medicines she was taking. It is clear that on a day to day basis Ms L was sometimes taking much more than her prescribed doses of medicines, particularly of tranquillising drugs. Consequently there would have been days when she had insufficient medication to take the prescribed dose. It is also the case that medication management was not routinely part of the planning process under CPA and therefore useful information which could have been contained within the CPA care plan was not available for the different teams involved in making assessments, often at crisis points.

Both the Consultant Psychiatrist and Social Worker were agreed that Mr M appeared fully agreeable to take responsibility for dispensing Ms L's medication after their visit on the 18th June. Had there been a clear medication plan within the CPA documentation it may have been clearer that the relative risks associated with Ms L's chaotic use of her medication at periods of stress and Mr M's intermittent misuse of Ms L's medication had been considered when formulating the plan for Mr M to take on responsibility for Ms L's medicines.

8.2.6 Adequacy of CPA Process

In the case of Mr M the CPA process was probably meant to be standard CPA throughout his contact with services. There may be an argument that in view of the seriousness of the circumstances of his admission under Section 2 in March 2002 or because of the possible duel diagnosis of personality disorder and substance misuse he should have been cared for under enhanced CPA. The view of the in-patient

team at the time was that his principal diagnosis was alcohol misuse and his depressive symptoms settled very well soon after admission. Given that view, the decision to assess Mr M as requiring standard CPA is reasonable however as has been indicated in the report elsewhere, important information about risk factors was not taken into account during Mr M's assessment and the responsible Consultant Psychiatrist indicated in evidence to the Inquiry Panel, that had that evidence been considered the management plan would have been significantly more complex. Putting the last point aside the apparent confusion over which paperwork to complete and what criteria to use in determining which level of CPA is appropriate indicated a serious shortcoming in the use of the CPA process.

The Panel formed the impression that the Risk Assessment process relied too heavily on the checklist, and the written comments on the Risk Assessment form were not always followed through on the care plan. We have highlighted a number of examples where information should have been or was available but was not used to inform risk management and care planning for both Mr M and Ms L as individuals, and as a couple.

In the case of Ms L she would have been appropriately cared for by the psychiatric services under enhanced CPA procedures from their introduction in 1991. Even in her case there were times of confusion as to which level of CPA was appropriate and certainly a variety of different forms were used adding to the confusion. On several occasions at times of particular vulnerability meetings were held and a plan formulated but without Ms L's participation. Indeed in 1999 at a time of great distress and overt disturbance a plan was made in her absence which identified indicators of relapse all of which were present at the time the plan was made. It is of concern that so frequently in the subsequent months further CPA plans were made which did not include discussions with Mr M. This was partly because there were other meetings and discussions outside the CPA process.

The most concerning conclusion to be drawn from examining the CPA as practiced in relation to Ms L is what appears to be the failure to recognise CPA as the fundamental cornerstone of care planning instead it appeared to be a process which some members of the team participated in somewhat independently. In particular medical reviews were often separate from CPA meeting which had no medical input thus tending to bypass or devalue the CPA process.

8.2.7 The CPA Policies

The Policy dated December 2000 provides only the barest outline of the CPA process with inadequate guidance and may have indicated a lack of enthusiasm and leadership to the Trust's clinical staff in the CPA process. The more recent policy dated March 2004 is a much more comprehensive document and is more likely to convey the Trust Board's commitment to and enthusiasm for the process. Whilst

respecting the need to avoid too prescriptive a policy those responsible for the review of the document may wish to consider clear guidance on areas such as the participation of Consultant Psychiatrists in enhanced CPA meetings, screening for the level of CPA inpatients admitted to hospital, in particular those admitted under the MHA, dual diagnosis and patients with personality disorder.

The most important area is training and the participation of medical staff is fundamental to the success of CPA in the future. The Inquiry Panel heard evidence from a cross section of staff from many disciplines and concluded that medical staff are not committed to the CPA. Senior medical staff will need to demonstrate their commitment to the process for CPA to work. Anecdotal evidence heard by this Inquiry Panel suggests that few doctors have attended the recent Trust training on CPA and that it is not a mandatory requirement for medical staff.

8.3 The local services' work with Mr M and Ms L

Both Ms L and Mr M had been known to the services for some years before the homicide in June 2002. Ms L more consistently known and for more years, Mr M intermittently since he moved into the area, and with a history of seeking help but then not following through with the services offered. There is no doubt that in situations like these for both Ms L and Mr M as individuals, sustained engagement or adherence to a more focussed short term treatment plan can be difficult, and that engagement may be more difficult with a couple.

We have heard evidence to suggest that they were regarded as a couple with Mr M seen as the carer. But the signals that Mr M was himself vulnerable and in need of a service in his own right were not consistently picked up and acted on. There was a recommendation to the CMHT in September 2001 seeking a CPN allocation which was not acted on. The predominant view of him was as a carer which obscured both his need and the potential risks he presented to Ms L and to himself. However, the Inquiry Panel note that in our view Mr M was not consistent in what he said about his ability to cope, willingness to change his behaviour or give commitment to any agreed plan for either himself or in regard to Ms L.

While they were seen as a couple the focus of work with either one did not take significant account of the implications for the other. Certainly when they were in crisis in September 2001, May 2002 and June 2002 it was impossible to respond to the needs of one without taking account of the mental state and emotional needs of the other. It is remarkable that throughout the period from September 2001 Mr M was neither regarded as a patient in his own right nor formally recognised as a participant in the CPA process for Ms L. This is not to argue that had he been regarded as a patient in his own right he would have received

services on a sustained basis until June 2002 but the allocation of a CPN or Social Worker would have generated the opportunity for focussed consideration of Mr M and of them as a couple.

Mr M was discharged from the ward in April 2002 and put on standard CPA with follow up through a referral to the Community Alcohol Team, and an Outpatient appointment in June. Shortly after he returned to their home there were concerns about Ms L's depressed and anxious state which remained throughout the following months.

Mr M had not followed through with Alcoholics Anonymous or the Community Alcohol Team which was very much in keeping with his established pattern of disengaging from services as his need for attention diminished if he felt that they put him under pressure or did not give him the responses he expected. Where there was discussion with him and the Social Worker it tended to be about assessing him as a carer, a responsibility he evidently found difficult to shoulder and arguably increased the pressure he felt to become adequate in order to take on the mantle of carer.

A consideration of Mr M's history suggests that had there been focussed engagement with him by the professions within the CMHT his pattern of avoidance of responsibility would have generated a different line of engagement with the way the CMHT worked with both Mr M and Ms L as individuals and as a couple. They both had long term patterns of dependency: drugs and alcohol for him and of being in a dependent relationship for her. The way in which these characteristics affected their relationship, their needs as individuals and how the services might work with them was not considered even when their respective crises drew attention to the demands of the other. Essentially Mr M appears to have been perceived as able to contribute to Ms L's care most of the time and that his dependencies were something both he and she had learned to live with. Other than what was perceived by Mr M as an irrelevant referral to Relate no attempt was made to work with them as a couple or consider in depth the implications of the dynamic between them.

It was recognised in the days before the Consultant Psychiatrist and Social Worker carried out a joint visit in June 2002 that Mr M was *"at his wit's end".* However, he was considered capable of taking on the responsibility for Ms L's medication with guidance on how to administer this written down for him. There is no doubt that Ms L was unreliable in managing this responsibly herself at the time and it had been a concern for some time beforehand. The view of the Consultant Psychiatrist was that Mr M had no difficulty assuming this responsibility.

One of the outcomes of this visit was an urgent referral to the Day Hospital for Ms L. The Inquiry Panel discussed with both the Consultant Psychiatrist and the Social Worker why they had not

considered an option that would remove Ms L into a different setting, ie, hospital admission or into the Sanctuary. It appears from the notes written during May and June that there was a lot of tension between the couple and it is remarkable that a stronger step to defuse this was not offered.

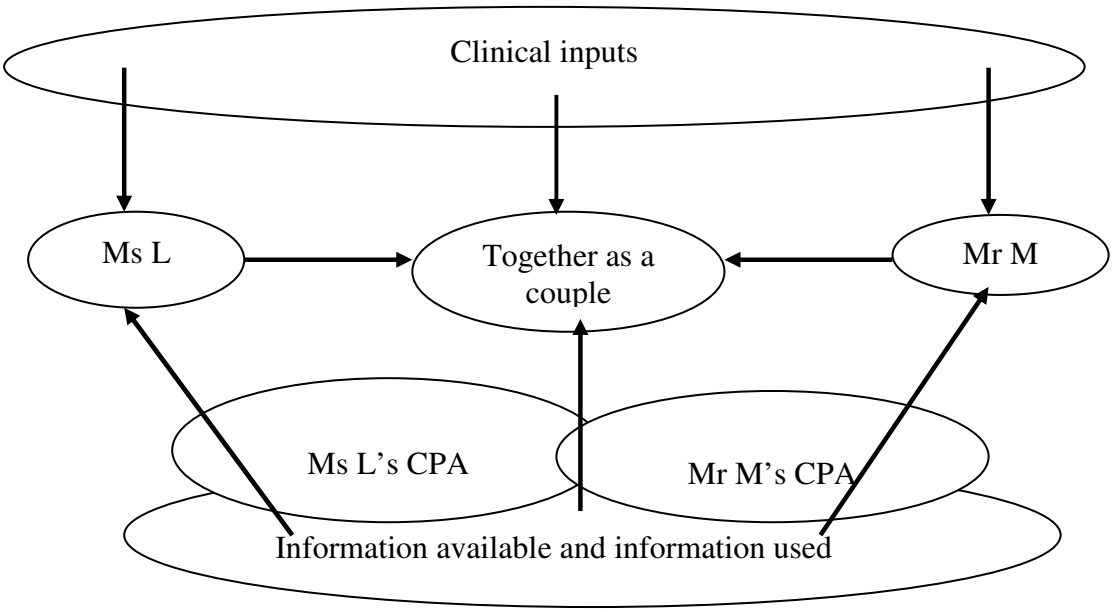
From both the notes and subsequent discussions it is evident that these options were not considered. There is no way of knowing if Ms L would have agreed to either one, she had declined both the Sanctuary and Day Hospital when suggested a few days earlier. However, the situation was substantially the same in May when she had refused the Sanctuary in mid May but then entered for a weekend in late May. The Consultant Psychiatrist is clear in his view that the Day Hospital rather than admission as an inpatient was the right option for Ms L. It is not possible to say whether she would have agreed if admission had been proposed and it is unlikely that she would have merited compulsory admission under the MHA.

A further outcome of the home visit was that the Consultant Psychiatrist wrote to the CMHT asking for a CPN to be allocated. Mr M was placed on the waiting list for allocation to the CPN on the 19th June, which at that time was for a minimum of 5 weeks.

It is relevant to note that in the period over Christmas and New Year Ms L was in a better frame of mind when Mr M had left her for a couple of months in December 2001 and January 2002. The broadly positive way she behaved during that period when she was not so directly engaged in a dependency relationship, as she had been with her former partner and with Mr M for 18 months or so, does not appear to have been considered in her treatment plan.

The focus of the work of the CMHT was with Ms L and with Mr M as two people. For Ms L there was a long history of engagement and since late 1999 a continuous contact with the CMHT. There was also contact with social services in respect of the contact with her young child which we have not considered in depth in this Inquiry, although we comment on the absence of consideration of the child in the CPA process.

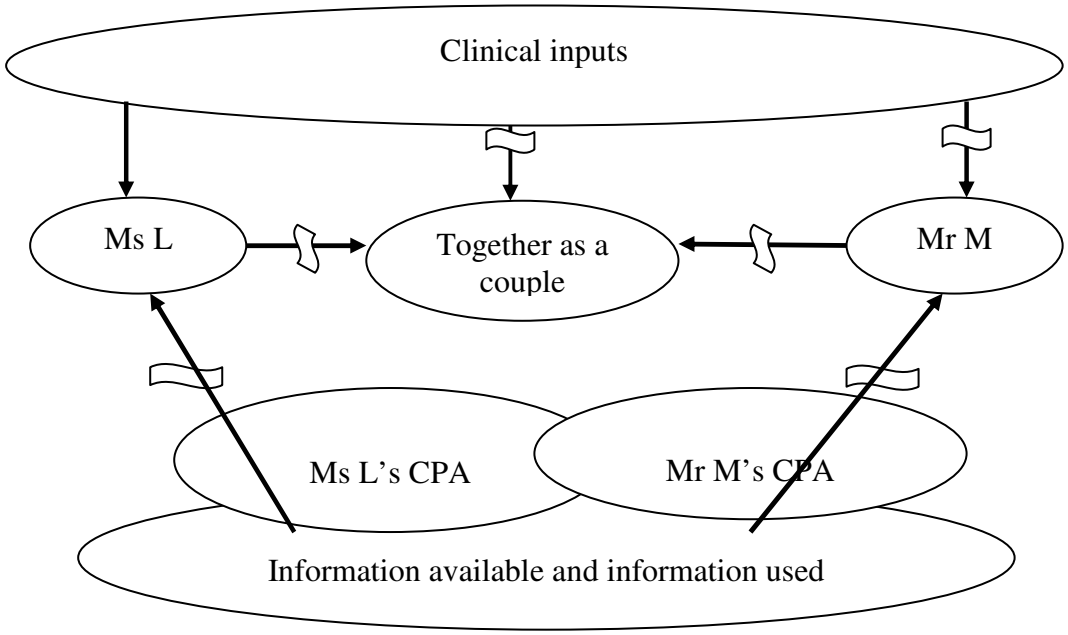
Shown diagrammatically on the following page is how local services might have been expected to work with MR M and Ms L:



There had been intermittent contact with Mr M over some years, there is a pattern evident in this contact of Mr M seeking services and support when he feels himself to be in crisis, then subsequent to the crisis Mr M proved hard to engage with for any period of time and contact was not maintained. It is difficult for services to engage effectively with people such as Mr M who have a tendency to substance misuse, have unresolved issues in their past that require longer term commitment to confront, and episodes of stress related depressive mental illness. This type of history is common with people who have an underlying personality disorder. Following the publication of "Personality Disorder, no longer a diagnosis of exclusion" in January 2003 it is now explicitly clear that local mental health services have a duty of care for such people. In Mr M's case he presented with his own needs on a number of occasions and demonstrated some vulnerability to himself and risk to others with significant variability in his coping skills.

Since the summer of 2000 they were a couple, and there were times when individually and together they needed the active engagement of crisis mental health services. However, throughout this period with the exception of the time when the CRS, in September 2001, rightly detected that Mr M had support needs in his own right and switched their attention to him, little consideration was given to them as a couple.

This diagram illustrates what actually happened in their engagement with local services:



These shapes are used to signify a broken flow of information

It is not possible to say whether the treatment options given to Mr M would have been different if they had lived apart but it may be the case that the attention that was given to him was lessened by the primary focus given to Ms L by the CMHT.

Although his involvement with Ms L was observed and considered to be, as it were, an aspect of her status as part of a couple, insufficient consideration was given within the CMHT to what the implications of that should be for the treatment and care offered to them both. It seems from the statements made by Mr M to different members of the clinical teams: the CRS nurse, the OT, the ASW's report when he was detained under the MHA, and the comments made to the Internal Inquiry by the Social Worker, that the pressures felt from within the relationship were prompting him to consider harming Ms L. The potential relevance of these statements was not identified within the team although the information was available. No cumulative picture was developed that might have caused the clinical team to act differently with either Ms L, Mr M or with them together.

There does appear to have been a reluctance to consider allocating support to Mr M in his own right. In September 2001 when Mr M was referred to the CMHT for CPN support it is unclear why this was not followed through and when in June 2002 a further referral for CPN support was identified on the joint visit of the Consultant Psychiatrist and Social Worker active engagement would not have happened for at least five weeks.

Of those who were in contact with Ms L and Mr M with any level of continuity the Inquiry Panel considered that only the CSW demonstrated a strong awareness of the way that their relationship affected the actions and behaviours of the other. The focus of the Social Worker in her contacts with Mr M was on seeking his agreement to be regarded as a carer and through that route to gain support; it seems to the Inquiry Panel that it was evident at the time that Mr M was unprepared to accept this. It may not have been so clear at the time, but this approach increased the stress that he felt given his inability to cope with responsibility for others. The respective CPA processes for them did not consider how to work with them together, and given the level of knowledge in the services this could have been achieved.

There is an issue to consider when working with a couple who might both be regarded as clients in their own right about whether they should have the same CPA Care Coordinator. This was not presented to the Inquiry Panel as a significant factor in this situation. But, particularly in smaller teams such as the Rural Rother CMHT, this is an issue that the Trust management should give guidance on in its CPA policy.

In the June 2002 domiciliary visit by the Consultant Psychiatrist and Social Worker there was recognition that the situation in the house had deteriorated. Mr M needed support and Ms L needed closer contact with services to stabilise her medication. The Inquiry Panel discussed the decision to pursue the Day Hospital option rather than a possible admission for Ms L or a referral to the Sanctuary as had happened in late May. The Consultant Psychiatrist was clear in his view that these options had not been considered and that the day Hospital was the appropriate choice. This was a judgement made at the time, as was the decision to give Mr M responsibility for Ms L's medication. A responsibility that both the Social Worker and Consultant Psychiatrist say was accepted by Mr M without questioning at the time.

8.4 Leadership and Clinical Accountability

From the information about practice evidenced in this inquiry it is apparent that the disparate teams did not work effectively together, or indeed that professions within the teams worked closely together on a consistent basis. This was indicated in the examination of the CPA process which often appeared to take place in parallel with medical reviews rather than an integrated part of a cohesive process. In the Inquiry Panel's view the clinical and management leadership at the time of this incident and in the period leading up to it was not strong. The formal management accountabilities have been described to us, and we have met practitioners and service managers diligent in their work, however it is the Inquiry Panel's impression that there does not

appear to have been clear and directive leadership within and between teams at the critical periods.

The difficulties in the workings of the CPA process, the interaction of the different clinical teams with the communication shortfalls, the problems relating to separate notes are both system issues and problems for individual patients and practitioners.

The position described to the Inquiry Panel of the Consultant Psychiatrist and their responsibility for leadership within the teams is unsatisfactory. Although there are indications that these problems are being addressed some remain as yet without evidence of remedial action. The position in the past for the CRS, and now the A&RT, without a clear Consultant Psychiatrist responsible puts the doctors and other clinicians in the team in a vulnerable position without adequate leadership, clinical direction or support.

The Trust Clinical Governance Plan should enable issues arising from the audit process to be addressed. This would include a formal process for identifying issues and concerns that will be presented to the Trust Board.

8.5 Organisation of the Trust's Services

The East Sussex County Mental Health NHS Trust acknowledge that the organisation of the mental health services in 2000/2002 was insufficiently coordinated with inadequate systems and processes for communicating information.

The Trust is very aware of the difficulties inherent in the way that teams were organised in the past where teams and different professional groups generated and held their own discrete files. This is being addressed and the arrangements just introduced in early 2002 and subsequently modified in the recent past move the service closer to a better coordinated contemporary model. For example in relation to psychological services, practitioners are now allocated to CMHTs while receiving professional supervision and support from the Psychology Department. Overall the move to more simplified management responsibilities and clinical governance accountability is to be welcomed.

9. FINDINGS AND RECOMMENDATIONS

The Inquiry Panel has considered the Action Plan produced by the Internal Review in September 2002. We have taken this into account in formulating our recommendations which are intended to focus on issues not pursued in the Internal Review.

We regard the recommendations in the Internal Review as comprehensive in their scope. We comment on these in section 10 with our focus on issues either not presented in that review or where we consider the Internal Review's recommendations need to be extended.

9.1 Communication, Transferring and Sharing Information between and within Teams

Systems for capturing, sharing and using information were haphazard in this case. We have detailed specific information that was known about by individuals within the various teams that was not shared, adequately considered or used. This illustrated a combination of:

- Inadequate systems and processes in place at the time
- Poor collation or reading of available information that inhibited a fuller understanding and opportunity to use that information in planning treatment and care plans for patients
- A narrowness of perception of the relevance of statements made or behaviours that should have been considered in assessing the needs of both Ms L and Mr M separately and as a couple

The Inquiry Panel understands that since the time of this incident and the lead in to it, the plethora of teams has been rationalised with clearer responsibilities and management coordination. This is positive and should facilitate better identification of relevant information and transfer between teams and people from the different teams working within them. However in itself it will not deal with all the factors evidenced in this Inquiry. The information that was available cumulatively to different members of the local services was not recognised as significant enough to be presented to colleagues; nor was there evidence of the CPA Coordinator or responsible Medical Officer taking a lead in ensuring that decisions were made on a full consideration of what was available to the different members of the teams involved.

From the evidence gathered in this Inquiry it is clear that some practitioners worked very hard to overcome the systems problems within the services; others complied with the systems and processes minimally required which reinforced the disconnected approach caused

by this plethora of teams and processes. The recommendations below express little more than good contemporary practice.

Recommendation 1

The Inquiry Panel recommends that the Trust ensure that within its training programme, sessions are specifically designed to promote;

- *a stronger understanding of the importance of multidisciplinary sharing of information*
- *effective ways of identifying and recording behaviours and statements that give cause for concern in the context of specific situations and the development of a care plan*
- *planning and review processes which utilise such information in their consideration of the person's needs, treatment and care options*
- *an understanding that information gained should be considered in the context of the known history, characteristics and behaviours of individual patients.*

Recommendation 2

The Inquiry Panel recommends that the Trust scrutinises its existing systems for storing, transferring and sharing information;

- *that within in-patient settings a responsible person is identified who will ensure that information contained within the patient's case file is presented to the ward's decision making forum*
- *that notes from all the disciplines are held in the same file and scrutinised for presentation in this way*
- *that the introduction of eCPA is seen as an opportunity for a clear and definite record of information, decisions and care planning.*

9.2 Use of the CPA Process

The CPA provides the cornerstone for constructive engagement with service users and the professional staff from the different disciplines in considering the factors in any particular case. This will mean identifying risk factors, agreeing clinical treatment and care management approaches, actions, responsibilities and monitoring arrangements into the future.

In the Inquiry Panel's view the guidance in place at the time of this incident did not contribute to a positive perspective and proactive usage of CPA. To some degree the use of the CPA ran in parallel to

the In-patient and Consultant Psychiatrists' decisions. Additionally, the administration of the CPA process in relation to both Mr M and to Ms L was confused in terms of the paperwork used and the level of seriousness described by the differing levels of standard and enhanced CPA.

There is no doubt that the Trust recognise the need to overhaul the use of the CPA process and this is to be encouraged. The guidance issued in March 2004 is commended, but in our view it does not give clear enough guidance in relation to the Consultant Psychiatrist's continuing responsibility for people in the community on enhanced CPA. The respective responsibilities of the Consultant Psychiatrist and the GP need to be more explicit than in the current guidance (March 2004, point 2.4) making clear the Consultant Psychiatrist's continuing responsibility. From comments made and our understanding we make the following recommendation:

Recommendation 3

The Inquiry Panel recommends that the Trust extend the CPA training programme it is currently pursuing, in the following way;

- *the provision of clear guidance on the participation of Consultant Psychiatrists in enhanced CPA meetings*
- *participation of all the disciplines working in the CMHT, In-patient and Day Hospital/treatment settings is made mandatory*
- *joint risk assessment training is incorporated in CPA training with the multidisciplinary teams*
- *the message is very strongly delivered that the CPA is the central process and that it is not acceptable to consider it an adjunct to other decision making methods*
- *CPA audit processes are used regularly and satisfy the Trust Board that day to day CPA documentation is regularly monitored to confirm that all disciplines are contributing, the adequacy of care plans, their quality and that progress from one review to the next is followed up and documented.*
- *the determinants for using standard and enhanced CPA are set out more clearly in the Trust's CPA Policy and Operational Guidelines document*
- *when a patient is on enhanced CPA greater clarity about the Consultant Psychiatrist's continuing responsibility and the responsibility of the GP*
- *we urge the Trust to consider incorporating a management plan for the person's medication as part of the CPA care plan.*

The Inquiry Panel recognise that the Internal Review report made specific recommendations about Risk Assessment and Risk Management, which we support. In addition we make a further recommendation to promote greater engagement of medical practitioners in the CPA and coherence in treatment plans:

Recommendation 4

The Inquiry Panel recommends that when a patient, subject to enhanced CPA is being transferred to another clinical team within the Trust, the Consultant Psychiatrist taking over their care is present at the CPA transfer meeting ensuring that they take a lead in the patient's care plan.

With regard to potential tensions and conflict for practitioners when they are working with people who are within a partnership or family grouping who both use local mental health services, we support the recommendation of the Internal Review, but would recommend that this is expanded as follows:

Recommendation 5

The Inquiry Panel recommends that where there is more than one patient in a relationship this needs addressing through the application of the CPA process. The focus is to promote an appreciation of the needs of each person as an individual, and also as an individual in a relationship with another person who has needs of their own.

9.3 The Local Service's Work with Mr M and Ms L

We have commented extensively about the engagement with both Mr M and Ms L as individuals and also in how they were perceived as a couple. In the light of the shortcomings detailed in this report the Inquiry Panel has considered whether Mr M's killing of Ms L was predictable to the professionals involved. Mr M made statements about harming Ms L and these were not dealt with. However, even had these statements been taken into account it is not possible to reach a conclusion that Mr M was intent on carrying out this killing based on statements made at times of stress over the previous two years or so.

The subsequent question the Inquiry Panel has considered is whether the homicide was preventable. It may be that such statements would have promoted different approaches in the treatment and care options. For example, perhaps the Sanctuary or In-patient admission would have been considered to alleviate the pressures within the household. If Ms L had gone into the Sanctuary at that time then the pressure would have lifted and Ms L would have been in a different place. However, it is possible that she might not have agreed to go, similarly she may have refused to enter hospital as an in-patient and on the face

of the information presented to us she could not have been admitted under a compulsory order of the MHA at that time. Nor is it possible to state what might have followed subsequently.

Consideration of this question is more about how the services might have responded and worked with Mr M over time, and with them as a couple, than the immediate actions at the time of the visit in June 2002. Certainly from the comments made to the Inquiry Panel by the Consultant Psychiatrist he indicated that had he known of the statements of harm made by Mr M towards Ms L he would have regarded it very seriously and sought to put in place stronger risk management arrangements. If Mr M had had more engagement and support might he have spoken about these feelings which might have been worked with and some therapeutic engagement and stronger risk management put in place? We cannot know the definitive answer to this question. It would depend on how the clinical team under the leadership of the Consultant Psychiatrist interpreted this information and used it to formulate future risk assessment and risk management strategies.

Recommendation 6

The Inquiry Panel recommends that the manager of the team responsible for the care of the patient, e.g. the In-patient ward or CMHT, is given authority to ensure adherence to quality standards set by the Board of the Trust. These would include designated time periods and quality standards for Risk Assessments, the scrutiny and incorporation of information gained into care plans and its communication to relevant professionals involved in the patient's care.

Recommendation 7

The Inquiry Panel recommends that the Trust develop processes for regularly auditing the quality and usage of information gained through risk assessments, and that this is reported within the Clinical Governance Process of the Trust.

9.4 Leadership and Clinical Accountability

The situation described at the time of this incident and in the period preceding it, indicates that there was inadequate leadership and accountability lines for both clinical and management arrangements.

The reorganisation and prospective future of the East Sussex County Healthcare NHS Trust at that time has been described to us and it may be the case that the anxieties about the future role and place of the Trust percolated down to the operational teams. More specifically it is evident that the clinical accountability for the then CRS was ill-defined; that the management arrangements for pulling together the activities

and processes of the various teams was in progress but not securely established in 2002.

We understand that significant steps have been taken managerially to deal with the problems described in this report. However there is more to do in this regard, for example we remain concerned that the medical clinical accountability line for the Assessment and Response Team still appears unclear.

Recommendation 8

The Inquiry Panel recommends that the Trust;

- *secures clear and sustainable lines of accountability for the practice of the Assessment and Referral Team*

- *ensures the CPA process is unequivocally adopted by the Consultant Psychiatrists and that attendance at CPA training and compliance with CPA processes is made mandatory for all relevant clinical staff*

- *utilises appraisal process to ensure all staff comply with Mandatory training and can demonstrate essential training competencies*

- *ensures appropriate professional supervision structures are in place for all clinical and non clinical staff and that this should be monitored*

Recommendation 9

The Inquiry Panel recommends that as part of the Trust's Clinical Governance Process specific guidance is drawn up as a priority to identify issues and concerns relating directly to patient care for presentation to the Trust's Senior Management Executive Team and the Trust Board.

9.5 Service Organisation

The various teams operating at the time of this incident and in the period before hand have been rationalised under more cohesive management. This is to be welcomed and the Trust is encouraged to review and refine these arrangements in the light of practice experience over the coming months. It may be helpful for the Trust to consider the internal practice of their teams in respect of procedures for caseload management, assured supervision procedures, team management and clarity in management practice.

The Inquiry Panel are aware of the significant changes taking place within the Trust and its management structure. We encourage the

management team to consider this report and its recommendations as a positive contribution to improving the Trust's services.

10. INTERNAL REPORT ACTION PLAN

The Internal Inquiry Report contains a good and comprehensive range of recommendations. We have taken account of these in formulating our recommendations seeking to avoid duplication although there are areas where our recommendations extend those of the Internal Inquiry.

Summary of Recommendations and Actions taken within the Trust since the internal publication of the Internal Inquiry Report

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
A. Risk Assessment and Management A1.1 A risk assessment must be done at the earliest opportunity indicating the level of risk and referencing all relevant risk assessment history.	CPA Steering Group to oversee the action and implementation of points A1.1 to A1.7 and will produce a plan to address these.	1st July 2003	Risk assessment and management training in place for all staff (Health and Social Services) as part of the CPA training programme.
A1.2 The Care Co-ordinator and other professionals involved must be informed. A CPA review may be deemed appropriate.	Service Director to issue restatement to all CMHT staff of the need to identify risk and a plan to manage that risk incorporated care plan.		CPA annual Audit carried out in 2003 and 2004 using joint CPA association/DoH tool. 2004 audit is to report in October, includes analysis at team level to allow benchmarking between teams. Also will be benchmarked against other Trusts using the CPA tool.
A1.3 CPA documentation including risk assessment should be monitored on a regular basis.		May 2003	Chronology sheets developed,

A1.4 Where risks have been identified a Risk Management Plan must be completed and shared with all involved in the provision of care. A1.5 Devise and introduce a Risk Chronology Sheet for the front of the notes. To include date and brief description of risk. Detail of the risk/incident can then be located in the body of the notes. A1.6 Review training for all staff to ensure it is available and accessible in relation to good practice when completing and communicating risk assessments A1.7 When completing risk assessments each section must be filled in and matched with the risk management plan, which is shared with all involved in the provision of care. A regular monitoring of completed risk assessment should be carried out and training given to all staff in relation to good practice when completing risk assessments.		May 2003 1st June 2003	discussed in CPA training for use with people on enhanced CPA

Risk Assessment and Management Independent Inquiry Panel Comment

These recommendations are endorsed. In the main body of our report we make further recommendations in relation to the CPA process, and to Risk Assessment and Risk Management.

We recognise that the CPA Policy and Operational Guidelines March 2004 contains actions drawn down from the recommendations of the Internal Review Report.

We are concerned that the CPA Annual Audit carried out in 2004 has still not reported.

Recommendation	Action taken by the Agencies	Timescale	Progress at April 2005
B. Carer/Client Conflict B1 Where two clients are in a relationship and both are receiving mental health services consideration should be given to undertaking joint case reviews as part of CPA. The boundaries of confidentiality will need to be agreed with each client.	The CPA Steering Group to issue Good Practice guidance taking account of the carers recognition act.	1st July 2003	
Carer/Client Conflict Independent Inquiry Panel Comment *This recommendation is endorsed. The Trust's Action Plan dated September 2004 states that this recommendation is still outstanding and no progress has been reported that this has been completed in the April 2005 update. This must be addressed urgently. In the main body of our report we make further recommendation.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
C. Care Co-ordinator C1 The particular role of Care Co-ordinator must be discussed in each case and agreed by the Team. C2 The professional taking on this role should have a clear understanding of the role and tasks involved.	CPA Steering Group to re-issue guidance of the role and responsibilities of the Care Co-ordinator	10th June 2003	Role of Care Co-ordinator addressed in CPA training.
Care Co-ordinator Independent Inquiry Panel Comment *These recommendations are endorsed. In the main body of our report we make further recommendations in relation to ensuring that there is greater clarity about the responsibilities of the Care Co-ordinator together with improved auditing arrangements within the Trust.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
D. Substance Misuse Service D1 The Substance Misuse Service and other services involved in a clients care must participate and be included in the CPA process. This is to ensure that multi-agency reviews are undertaken and all stakeholders are aware of the assessment including risk and the agreed care plan.	Service Direct (CPA lead) to circulate to staff reminding them of the need to invite all agencies to CPA meetings.	May 2003	Addressed in training.
D2 All relevant staff from other services/agencies need to be trained in the implementation of CPA and to monitor its application.	CPA Steering Group needs to establish training, in liaison with the training department, as appropriate.	January 2004	CPA training is multi-agency. It is provided by service manager, social services trainer and CPA Co-ordinator, co-ordinated by training department.
Substance Misuse Service Independent Inquiry Panel Comment *These recommendations are endorsed. Our recommendations, particularly in regard to CPA processes incorporate fuller more systematic consideration of factors relating to individuals subject to CPA and will therefore include issues such as substance misuse and dual diagnosis. This should be tackled in the CPA training and its effectiveness evaluated within the CPA audit programme.* *We strongly support the implementation of a local dual diagnosis strategy.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
E. Adult Protection Issues E1 Where there are concerns about abuse to vulnerable adults, including domestic violence, these should always be reviewed under adult protection procedures and consideration should be given to the appropriateness of involving the domestic violence unit.	Develop a joint action plan with partner agencies to set minimum standards and systems for monitoring these.	1st October 2003	Multi-agency Adult Protection policy and procedures implemented. Review of current policies underway.
E2 Clear written record to be made in the integrated notes and appropriate documentation completed in line with the adult protection policy.	Head of Social Care and Service Director of Mental Health to issue restatement to all staff of the need to follow adult protection procedures.	May 2003	Specific training provided to CMHT managers during 2003/4. Also addressed in CPA training for all staff. Restatement issued. Director of Social Care confirmed as lead.
E3 The outcome of these procedures must be documented in the CPA notes.	Identify a vulnerable adult lead for the integrated mental health service.	1st June 2003	Adult protection monitoring procedures have been set up, a multi-agency audit of adult protection practice is to be commissioned within the 2005/6 financial year.
E4 When an individual has been threatened explicit consideration should be given to informing that person and this should be documented.			Vulnerable Adults Steering Group established as part of Clinical & Social Care Governance structure.
Adult Protection Issues Independent Inquiry Panel Comment *These recommendations are endorsed. Their application should be monitored in the CPA audit programme.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
F. Child Protection F1 In all cases where there is a child involved, the child's welfare must be routinely and explicitly considered and documented at the CPA review. Where there are concerns about the risk or welfare of that child a referral should always be made to the child protection team.	Head of Social Care to develop a joint action plan with partner agencies to set minimum standards and systems to monitor these.	1st October 2003	Both child protection and adult protection are covered in the CPA training. An updated protocol for child protection is being developed by the Trust's Child Protection Steering Group in conjunction with social services adult protection department. Multi-agency training on child protection, mental health and parenting issues in place. The Trust Board agreed a Child Protection Strategy and the Safe Guarding Children Strategy Group has a work plan promoting effective work in this area.
Child Protection Independent Inquiry Panel Comment *This recommendation is endorsed. We understand that the Trust are developing a new CPA documentation and recommend that this is incorporated in that documentation.* *We welcome the "Safe Guarding Children Strategy" indicated in the April 2005 update.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
G. Personality Disorder G1 It is recommended that the Trust continue to give urgent attention to implementing the guidance within the Department of Health "Personality Disorder: no longer a diagnosis of exclusion", appropriate to local need.	Service Director to ensure the Trust Personality Disorder Working Group complete its work and circulate for service improvement plan.	March 2004	Bid rejected for development of Personality Disorder service.
Personality Disorder Independent Inquiry Panel Comment *This recommendation is endorsed. It is not clear what action is now being pursued by the Trust in relation to the development of personality disorder services given that its bid for specific funding was unsuccessful. Despite the rejection of the bid the problem remains and there is no indication as to how the Trust will address this.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
H. Record Keeping H1 The Trust and Social Services should ensure that all current files are brought up to the standards laid down in the integrated case record policy. H2 A joint system between Health and Social Services for regularly auditing case files across the Service should be put in place.	Clinical & Social Care Governance Committee to agree with Service Director case record audit and agree an ongoing audit process at a team and Trust-wide level.	1st July 2003	See A, CPA, Annual CPA and case record audit carried out. Reported at team level for benchmarking and to Records Management Group for overview.
Record Keeping Independent Inquiry Panel Comment *These recommendations are endorsed. In view of our Findings regarding the case files that came forward for consideration late, we consider that the Trust needs to satisfy itself that its file archive systems is robust. We suggest that the Trust Executive Team ask for a progress report from the Records Management Group in view of the difficulties experienced by both the Internal Review and our Independent Inquiry.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
I. Family Support I1. The Trust should monitor the recently revised Serious Untoward Incident Policy to ensure that it sets out the process to be undertaken to ensure that the family of a victim are kept informed of investigations being undertaken and provided with appropriate support.	The SUI policy has been revised to ensure families are fully informed and the changes have been implemented.		Completed.
Family Support Independent Inquiry Panel Comment *This recommendation is endorsed. Additionally in relation to Serious Untoward Incidents we recommend that specific policy guidance is issued to staff within the Trust that sets out a clear accountability line for the management and reporting of Serious Untoward Incidents through the Clinical Governance Group and the Trust Board.*			

Recommendations	Action taken by the Agencies	Timescale	Progress at April 2005
J. Psychology Service J1 People should be told when a referral is made how long the waiting list is. J2 There should be a system for prioritising referrals.	Service Director (Lead of Psychological Therapy) to ensure that a system for prioritising referrals and informing clients of waiting times is established.	1st August 2003	People are informed of the likely waiting time on referral. However, it is explained that it is difficult to be accurate as it depends on patients currently receiving a service being discharged. A new system of prioritising referrals has been implemented to reduce delays to no more than three months. In Hastings/Rother and in Eastbourne this is done by team discussion in each community team referring into a service. There is a quota system to ensure the service took referrals equally from the teams.
Psychology Service Independent Inquiry Comment *These recommendations are endorsed. Consideration should also be given to incorporating all referrals into the local Single Point of Access System already in place but which currently excludes psychology to more securely incorporate psychology services as part of the local services.*			

11. Glossary

Bipolar affective disorder
A disorder characterised by 2 or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy (depression).

Becks Depression Inventory
A questionnaire designed to help identify patients with depressive, anxious, or suicidal tendencies and the significance of these tendencies

Care Programme Approach (CPA)
Introduced in April 1991 through the Department of Health Circular (HC (90) 23/LASSL (90)11) to offer guidance on a systematic and collaborative response in the assessment, planning and review of service users' health and social care needs

CPA Standard
Will be appropriate where a person needs help from one agency, or low levels of help from a few organisations and can manage many of their mental health difficulties on their own or with the help of a carer, family or friends

CPA Enhanced
Will be appropriate where a person needs support from many different agencies, may not have a reliable support network (like family and friends) and is likely to contact with the mental health services

eCPA
An electronic information base accessible and containing all relevant data on a person subject to the CPA

Clinical Governance
"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." Taken from the NHS Modernisation Agency Clinical Governance Support Team 1998

Discharge Summary
A document prepared by the responsible clinical team and sent to the patient's GP on their discharge from hospital indicating future treatment requirements

Community Mental Health Team (CMHT)
A multi-disciplinary team working in the community

Dual Diagnosis
A person with a diagnosis of a psychiatric illness and in addition secondary psychiatric disorder relating to, for example, drug misuse or personality disorder

CPN or CMHN
A Community Psychiatric Nurse or Community Mental Health Nurse working within a CMHT with a caseload of patients living in the community

Mental Health Act 1983 (MHA)
Legislation relating to powers of compulsion for people suffering from a mental illness as defined by the act

Section 136 of MHA
A section of the MHA enabling the police to detain someone thought to be suffering from a mental illness in a designated place of safety

Section 5(2) of MHA
Specific order allowing a patient to be formally detained while in hospital as an informal patient

Section 2 of MHA
A section of the MHA that allows a person to be held in a psychiatric hospital for assessment for up to 28 days.