Report of the Independent Inquiry
Into the Care and Treatment of Ms X

Commissioned by Surrey and Sussex Strategic Health Authority

2003

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Inquiry Members

Mrs Jane Mackay (chairman), former NHS General Manager and Regional Nurse.

Dr Robert Higgo, Consultant Psychiatrist.

Mr Ian Milne, previous Assistant Director Social Services and now Director of HAGAM (Hillingdon Action Group for Addiction Management)

Acknowledgements

We would like to thank everyone who gave up time to give evidence to the Inquiry Team and who spoke so freely to us. All of the witnesses who gave evidence to the Inquiry Team are listed in Appendix 1.

Any Inquiry such as this, requires good management and organisation and in this respect we are indebted to Mrs Lynda Winchcombe who carried out these duties with a great deal of professionalism. We received much of the written material long after we commenced our Inquiry and were greatly helped by having them prepared into working documents by her. Because of the initial delay in acquiring these documents, the Inquiry Team apologise for the resultant delay in concluding this work.

In addition to taking verbal evidence we read a great deal of written material including six volumes of medical case notes and two volumes of GP records. In all we read some 5570 pages of documentation. A full list of documents can be found at Appendix 2.

We would also like to thank Mrs K Latimer for looking after all of our needs whilst we took evidence at the Health Authority offices at West Park Hospital, Epsom.

Lastly our task was made easier by the efficient manner that the Fiona Shipley Transcription Service promptly provided us with the transcriptions of all our interviews.

Preface

Following the Inquiry into the Care and Treatment of Christopher Clunis the Department of Health published "*Guidance on the discharge of mentally disordered people and their continuing care in the community EL(94)27"*. Although this document was primarily about discharge arrangements, risk assessment, and the Care Programme Approach, there was a Section on what to do in the event of a homicide stating "*that in cases of homicide it will always be necessary to hold an Inquiry independent of the providers involved*". The purpose of such an Inquiry is to establish whether there are lessons to be learnt from the tragic incident and to make recommendations for the delivery of mental health services in the future.

In the years following the publication of this guidance there have been some 130 independent inquiries into the care and treatment of patients who commit a homicide and have been in receipt of mental health services. It has been said that this process is the only way in which families of both the perpetrator and the victim find out the truth despite an inquest and the subsequent trial. However over the past few years Trusts have been required to have in place robust systems which examine services and staff actions when things are deemed to have 'gone wrong'. Clinical Governance had been introduced and following the outcome of four pilot investigations using a *Root Cause Analysis* approach these inquiries will in the future be conducted by the National Patient's safety Agency.

There has been much said about the blame culture as a result of these inquiries and that staff feel bruised and demoralised. We hope that the process we adopted helped alleviate any anxieties that the people we interviewed may have had and we were encouraged by and grateful for their frank and open discussion.

In completing our report we have chosen not to dwell on the Child Protection aspects, which were undoubtedly a major contribution to the way in which Ms X reacted to, and sought mental health services, as we wished to further protect and thereby safeguard the children involved.

As part of our Inquiry we endeavoured to make contact with both families but regrettably we were unable to do so. When we have referred to family members or friends we have used initials to protect their anonymity and hope, therefore, that we cause no offence by anything we may have said about any of them.

The West Surrey Health Authority had an obligation to commission an independent Inquiry, following a homicide by a person in receipt of mental health services, under the Department of Health guidance HSG (94)27. On 1 April 2002 the West Surrey Health Authority was subsumed into a new organisation Surrey and Sussex Strategic Health Authority, which assumed responsibility for commissioning this Inquiry and it is to this organisation that we present our report.

Terms of Reference

The West Surrey Health Authority, Surrey Social Services and the NHS Executive agreed the terms of reference for this inquiry which are as follows:

1. To examine all the circumstances surrounding the treatment and care of Ms X and in particular:

    1.1 The quality and scope of her health care, social care and any assessment of risk

    1.2 The appropriateness and quality of any assessment, care plan, treatment or supervision provided, having regard to:

        (i) Her past history
        (ii) Her assessed health care and social care needs;
        (iii) Her use of illegal substances and alcohol abuse;
        (iv) The care of her children.

2. The extent to which her care and treatment corresponded to statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach, HSG (90)23/LASSL(90)11; and the Discharge Guidance HSG(94)27; the Mental Health Act 1983 including Section 136 and any local operational policies.

3. The extent to which her care and treatment plans :

        (i) Reflected an element of risk
        (ii) Were effectively drawn up, communicated and monitored

4. To examine the adequacy of the co-ordination, collaboration, communication and organisational understanding between and within the various agencies, who were involved in the care of Ms X or in the provision of services to her, in particular whether all relevant information was effectively passed between the agencies involved and other relevant agencies, and whether such information was communicated and acted upon adequately.

5. To examine the adequacy of the communication and collaboration between the statutory agencies and any family or informal carers of Ms X.

6. To prepare an independent report and make such recommendations as may be appropriate to West Surrey Health Authority and Surrey Social Services.

Procedure adopted by the Inquiry

A) Witnesses received a letter in advance of appearing to give evidence. This letter asked them to provide a written statement as the basis of their evidence to the Inquiry and informed them of the terms of reference and the procedure adopted by the Inquiry. It also covered the areas and matters that were to be discussed with them, and they were

assured that they could raise any matter they wish which they felt might be relevant to the Inquiry.

B) Witnesses were invited to bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wished to accompany them, with the exception of another Inquiry witness. It was explained to the witnesses that although there was an expectation that the questioning would be directed towards themselves, there might be occasions when the person accompanying him/her could be asked to clarify a particular point.

C) Witnesses were not asked to affirm their evidence, but the seriousness of the proceedings was pointed out to them and we were assured that all the witnesses we saw would answer our questions in their own truthful manner.

D) Evidence was recorded and a written transcription sent to witnesses afterwards for them to sign.

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

F) All sittings of the Inquiry were held in private. The draft report was made available to the Health Authority, for any comments as to points of fact.

G) The findings of the Inquiry and any recommendations are usually made public.

H) The evidence which was submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, except insofar as it is disclosed within the body of the Inquiry's report.

I) Findings of fact were made on the basis of the evidence received by the Inquiry.

J) Comments, which appear within the narrative of the report and any recommendations, were based on those findings of fact.

Introduction

Ms X had lived in the Woking area with her two daughters since 1996 and had a history of mental health problems associated with excessive drinking and low mood. Ms X had frequent admissions to both the adult inpatient unit, Blake Ward, Abraham Cowley Unit and the drug and alcohol service based at Windmill House.

Prior to this she lived in the north of England, and for a time with her partner who was the father of two of her children. She later married and had a third daughter but this relationship was short lived and he had custody of the child. Following the birth of her first child in 1984 she had numerous admissions to psychiatric hospitals.

Ms X was well known to various agencies in the Woking area, mainly because of her volatile behaviour, that was exacerbated and fuelled by her use of alcohol. She was frequently brought to the hospital by using Section 136 Mental Health Act 1983 (MHA) with the police in attendance, and on four occasions she was detained under the Mental Health Act 1983. Ms X was in fact admitted on 29 occasions but rarely stayed longer than a few days on any admission.

She formed a relationship with a fellow patient, by whom she had another child in 1999. This child was removed on an Emergency Protection Order when she was two days old. Although various attempts were made to help Ms X keep in touch with her, she was finally placed for adoption and Ms X saw her for the last time on 14 June 2001.

Over some months in 2001 she formed a relationship with Mr S, a friend of her earlier partner, who she described also as a "friend". He appeared to be supportive to her and concerned about her welfare.

In June 2001 Ms X was seen quite frequently on the ward, as she was unable to cope without support from the staff. As Blake Ward was full a bed was made available for her on Clare Ward but she declined this offer. It was agreed that she should be seen on the Ward round on 11 June, but she failed to attend. She returned to the Ward, 14 June with Mr S and was given more medication as she said she didn't have any. She stayed the night and the next day left with Mr S on 16 June. Later that evening Mr S telephoned the ward.

On 17 June Ms X telephoned the ward wanting to speak to a nurse but he was busy and she telephoned again speaking to another patient. Later that morning, at 12.30hours, the Surrey Ambulance Service informed the Surrey Police that they had received a 999 emergency telephone call from a female saying that a man was dying, having been stabbed at her address (Ms X's flat). The Police attended the property and found a man with multiple stab wounds, including a fatal wound penetrating his chest severing a rib, through into the aorta and the heart. In addition he had another stab wound through the lip and several others thought to have been caused during a struggle.

Other police officers arrived at the Abraham Cowley Unit (ACU) looking for Ms X. Ms X arrived not long after them. She was dishevelled, agitated and smelt of alcohol. She asked to use the toilet and the police arrested her on suspicion of murder. The man who had been found stabbed in her flat was identified as her friend, Mr S.

She was convicted of murdering her friend Mr S on 27 February 2002 and sentenced to life imprisonment.

Chapter 1

Early Events in Ms X's life

Ms X at some time, as a baby, was adopted into a family with two sons. She described her childhood both as 'good' and 'unhappy'. Ms X enjoyed school and obtained four GCSEs and two 'O' levels before leaving at 15 years when she also left home to live in London.

Although she passed secretarial examinations and held various secretarial posts, at 18 years Ms X elected to join the Army and served in the Military Police. After three years she bought herself out, wishing to join the civilian police force. Formal proceeding took some time during which Ms X took jobs as a store detective in Lancashire and working as a disc jockey at night. In the end Ms X elected not to join the Police force and continued to work as a disc jockey, some times abroad.

1984

On returning to England Ms X met and lived with a man described as an American singer (JH) by whom she became pregnant. She returned to her adoptive parents to await the birth of the baby. At this time her stepfather died of a heart attack and she was blamed for causing him a degree of stress. She returned to Lancashire to live with (JH) following which baby (J) was born. Ms X suffered post natal depression and was admitted to a mother and baby unit for a period of three weeks. (JH) had a new girlfriend but saw no reason why the three could not live together. It was about this time that Ms X started drinking heavily, several cans of strong lager daily.

1985

Ms X was pregnant again, took an overdose and because of the unstable relationship she had with JH, she decided to have this pregnancy terminated. In the following year she had a further termination and was referred for a psychiatric opinion as she had noticed her mood was low and she was unable to work. In this mood she was apt to disappear and have short episodes of amnesia. She admitted to needing to have a drink every evening until "*quite legless*". Her depression was thought to be as a result of the termination and at times she was "*hysterical with sudden changes of mood and poorly controlled behaviour*" believed to be rooted in her background and sense of insecurity. To cope she had developed a secondary problem with using alcohol and although this required no treatment she would benefit from long-term formal psychotherapy.

1988

She was seen in the Accident and Emergency Department (AED) by the liaison psychiatrist. She was still seeing (JH) although he was now married. Ms X was made subject to a two year Probation Order for a driving offence. She disliked the house she was living in preferring to be in bed and breakfast places or staying with a friend. Although not depressed she had severe mood swings and felt miserable at times. As a consequence of her past psychiatric history and previous overdoses she was referred to the community psychiatric nursing service.

Chapter 2

Ms X's Contact with Mental Health Services before moving to Surrey

1990

Ms X was referred for a termination of her pregnancy but did not go ahead with it. (S) was born on 18 August 1990 and Ms X continued to bring the children up as a single parent. From the notes it was difficult to ascertain exactly what services she was receiving.

1992

Ms X had a serious road traffic accident, which, despite many operations, eventually resulted in the loss of her right eye. During the admission to hospital, as a result of this accident, it was discovered that she had a diseased kidney and later in the same year she had to undergo a right nephrectomy. During this year she was drinking heavily and took a further two overdoses and was admitted on both occasions. She met and married (DS) during this year and became pregnant.

1993

Ms X apparently suffered from agoraphobia and required the ambulance service to take her for GP and hospital appointments. In November 1993 (T) was born. Ms X was treated with Dothiepin as she was having panic attacks. She was admitted 26 December 1993 having taken an overdose and stated, "*having overwhelming feelings of wanting to die or not be around*". She had been panicky because (T) had been admitted to hospital with bronchitis and she felt guilty. She had also agued with her husband about her use of alcohol.

1994

In January Ms X was involved in another road traffic accident in which she suffered a 'whiplash' injury as did her eldest daughter who was in the car with her. At some time after this she left (DS) with her daughter (T) in his care. During 1994 she received psychotherapy, during which she discussed her problems as being the result of her own lack of care as a child and therefore not having a good model upon which to base her child rearing skills.

1995

In May Ms X was admitted to hospital following a panic attack when her car and another collided. She was taken to the police station because she was so upset but did not co-operate. She spent the night in a cell prior to her admission to hospital. She described feelings of becoming more depressed, having no appetite, lacking motivation and unable to take the children to school and feeling guilty about not being able to manage the house or her life. She was discharged after eight days.

Two weeks later she was admitted again having taken an overdose as she couldn't cope with the children and had had a row with her brother. She was drinking three cans of lager and up to a bottle of vodka as drinking made life easier despite her main concern that she would lose her children. She spent her days gardening but could not motivate herself to

ensure that the children went to school. Ms X was placed 'on contract' but within three days of the admission had broken it by leaving the Ward and drinking whilst away. Her excuse was that one of the children, placed with foster parents, was unwell, though she did not go to see her. Because she had broken the contract she was discharged.

Over the next few months Ms X was not drinking, kept her outpatient appointments and even took her older two daughters for a holiday on the east coast. She was having problems with access to (T) who was with her father.

1996

May 10, Ms X was admitted to hospital for 10 days because when the GP visited her she was aggressive, disturbed, unable to answer simple questions and wanted to kill herself. She was thought to be suffering from 'chronic fatigue syndrome'. She was very dishevelled on admission and took a few days to settle down. She complained of feeling anxious about the responsibility she had at home. She blamed that on the fact, that had she not lost custody of her child then life would be so much better. Her older children were cared for by a male friend who was also concerned about her well-being. Without any warning, Ms X suddenly left the Ward and subsequently discharged being followed up by the Home Treatment Team for one month. This service, providing intensive practical support, was available 24 hours per day and staffed with doctors, nurses and social workers. She also started a course of Cognitive Therapy, but Ms X cancelled her appointment in August and moved to the Woking area sometime before November.

Chapter 3

Contact with Mental Health Services in Surrey

1996 Ms X and her two daughters moved to Surrey, allegedly to be nearer to her adoptive mother and were housed in a refuge in Woking. Ms X told staff that she was escaping from a violent and abusive marital relationship. She registered with a local GP, who, on 5 November, referred her to the Consultant Ophalmologist at St Peter's Hospital Chertsey as she was complaining of visual disturbances. However before this appointment could be kept Ms X was seen in the Accident and Emergency Department (AED) because she had taken an overdose of Dihydrocodeine. "*She did not want to kill herself and doesn't think she will try again*". An urgent request was made to the psychiatric service for her to be seen the following week and the GP was urged to make another appointment if this did not occur.

30 November 1996 Ms X was admitted to Blake Ward at the Abraham Cowley Unit (ACU), in the care of a Consultant Psychiatrist, under Section 136 Mental Health Act, regraded to Section 2, and rescinded on 9 December. She had been found wandering about with a knife in her hand threatening to kill herself. She was discharged three weeks later and during this time Woking Borough Council gave her a flat. She was allocated a social worker (SW1) and a community psychiatric nurse (CPN1) and follow up arrangements made for her to been seen at Bridgewell House. She was given medication, Fluoxetine 20mgs, Thioridazine 10mgs and Dihydrocodeine as required.

1997

9 January 1997 Ms X did not keep her first appointment at Bridgewell House but on 11 January the Crisis Response Team admitted Ms X to Blake Ward as an informal patient. She had stopped taking the antidepressants but was discharged later the same day. On 20 January SW1 referred her to the Windmill Drug and Alcohol Team for an assessment and treatment. Ms X had admitted to drinking in excess of two litres of cider or strong lager whilst in the Women's Refuge. During her time there, the children's names were placed on the Child Protection Register under the category of Emotional Abuse.

11 February 1997 Ms X kept her appointment with the Drug and Alcohol (DAT) Team. During this interview she expressed guilt at the impact her behaviour had on her children and agreed that her drinking was about 150 units per week. She admitted to having some withdrawal features and felt she was seriously dependent on alcohol. She was described as:"*a loving mother and even a very capable woman who has been unable to cope as a result of impossible stresses in her life"* she was seen as motivated to seek help for her own and her children's sake. As she was visiting her other daughter in Yorkshire she was added to the waiting list for an inpatient appointment and a further outpatient appointment given for 26 February. Ms X did not keep this appointment but was seen the following day and on 28 February and admitted to the Abraham Cowley Unit to undergo a detoxification programme. Again she admitted to drinking up to 150 units a week, drinking after the children had gone to bed and consuming anything up to half a bottle of whisky and/or four or five cans of extra strength lager. She completed the medical detoxification successfully, but was unable to cope with the emotional confrontational aspect of her care and required sedation to manage her hysteria. When told that she could complete the course as an outpatient she retaliated by cutting her arms but was still discharged on 14 March 1997.

18 March 1997 The case manager for the children, wrote urgently to the Consultant Psychiatrist

> *"… I am becoming increasingly concerned about her emotional well-being and stability. On 15 March at 6.00 hours Ms X was admitted to Blake Ward from AED having taken an overdose and spent the weekend there. …..Ms X has become increasingly reliant upon myself to support her emotionally and to advocate on her behalf. My contacts have become almost daily and I am becoming increasingly concerned about her reliance and potential for manipulating the boundaries of my role……. I am concerned that Ms X will up the stakes of her self harming behaviour until such time that she receives adequate support from the mental health services and treatment in the form of post traumatic psychological counselling. I am concerned that Ms X requires an environment that can offer her the safety to make progress and that her needs are unable to be met at the ACU. Ms X 's children are currently being looked after by the local authority and will not be returned until such time that she stops exhibiting self harming behaviours, which I believe will not cease until she receives an appropriate service. I am of course concerned that Ms X 's threats will be acted upon and that if the pressure becomes too great that she will commit suicide….."*

24 March 1997 Ms X was re-admitted under Section 136 Mental Health Act 1983 following a violent fracas with a male lodger, whom she had taken hostage, threatening murder and suicide with three knives. She was forcibly restrained by the police and attempted to cut her throat. Ms X had been in bed for three days with the curtains drawn, not answering the door or telephone and not eating or sleeping. She described "going out of control" on four cans of lager and wanting to kill herself or someone else and had smashed most of the windows before taking her lodger hostage. Ms X agreed to stay as an informal patient and settled quickly, discharging herself the following morning. Later the same day she was again in police custody, she spent time in the police cells, went to court and was bailed for a couple of days. Again she agreed to stay informally but powers under the Mental Health Act 1983 would be used if she threatened to leave. During this admission Ms X locked herself in the toilet and cut her wrists with broken glass requiring suturing. Ms X was drinking whilst on home leave and refused to have a breath test on her return. She was discharged on 7 April and re-referred to the day hospital.

15 April 1997 Ms X took an overdose of her medication with alcohol and was brought to AED by police under Section 136 Mental Health Act 1983, though she was not admitted. She had attended the day hospital on one occasion.

8 May 1997 The Crisis Response Team(CRT) admitted Ms X to Blake Ward in an agitated state with superficial lacerations to both her arms. On this occasion she talked about being God and her children being her disciples and wanting to become the blood of Christ. She was highly aroused and agitated, making signs of the cross and smelt of drink. She was angry because she was not allowed to see her children unsupervised. Ms X had no insight into her behaviour and so she was detained using Section 4 MHA 1983 as no other Section 12 doctor was available, but as she did not appear psychotic the Section was discharged the following day. She left the ward four days later without permission, but reluctantly returned the next day not showing any sign of psychosis.

19 May 1997 = Ms X's solicitor's wrote to her Consultant psychiatrist about her impending impending Court case and stated that she was intending to deny the charge of affray and that the proceedings had been adjourned until 8 July. A condition of the bail conditions was that she resided somewhere directed by her Consultant Psychiatrist, either the ACU, at her home address or other accommodation

She was advised to stay, but left, and on 24 May the police again brought Ms X to the ward as she had been creating a disturbance at her mother's house, who had called the police. She was aggressive, smelling of alcohol and therefore difficult to assess. This time she was described as being admitted under Section 5(2) MHA 1983, but only four days later, on 28 May, Ms X was discharged - to be followed up as an outpatient.

5 June 1997 The senior social worker children and families wrote to her Consultant Psychiatrist:

> *"I am writing to inform you of the Local Authority's proposed plan to rehabilitate J… and S… in the care of their mother……I would be grateful if you would contact me as soon as possible if you have any concerns about Ms X resuming full-time care of her children, as planned, or there are comments you would like to make about the plan. I would also welcome your comments concerning any support you feel would be appropriate and available in the community, to support Ms X and……I feel it would also be very important for the Local Authority, at this stage to be fully aware of any proposed treatment that Ms X will be undertaking both in the short and longer term and any additional information that you may feel to be relevant concerning Ms X 's mental health and the possible impact on J… and S…"*

24 July 1997 The independent chairman of Child Protection Conferences wrote to Senior Clinical Medical Officer in the Drug and Alcohol Team, copying the letter to her Consultant Psychiatrist and said*:*

> *".... I am writing to express our concern that no representative of Adult Services attended the conference, sent in a report or apologies, despite the fact over the past 6 months Ms X, the children's mother, has had at least 16 crises including overdoses and self harming requiring hospitalisation and Sectioning under the Mental Health Act. Also admission for de-tox regarding her alcohol abuse which is still not under control. Ms X reported to the conference that she felt badly let down by your services as no co-ordinated approach appeared to have been made to tackle her psychiatric and alcohol problems…… I would strongly recommend that you meet with* her Consultant Psychiatrist *(who is receiving a copy of this letter, the)* senior social worker children and families *and Ms X to plan a strategy on how best to provide services or minimise Ms X's having to resort to life threatening behaviour in order to obtain attention/treatment. I would appreciate being informed on progress..."*

25 July 1997 The Senior Clinical Medical Officer, Windmill Drug and Alcohol Team, wrote to the GP:

> *" Ms X told me that she was drinking at least 9 cans of extra strong lager daily, plus half a bottle of Vodka twice weekly since the last two months. She accepted that she had a dependence on alcohol and she desperately wanted to sort herself out. She told me that she was feeling much better, she last attempted to harm herself about two*

months ago. She was insistent that she feels strong in herself and that she would be able to cope with the six week inpatient programme at Windmill House…. I have asked her not to stop drinking but to curtail the amount of alcohol that she is consuming"

28 July 1997 Ms X was in hospital overnight because of a knee injury as a result of intervening in an argument between her friend (MB) and another male.

31 July 1997 The Senior House officer (SHO) in Opthalmology at the Royal Surrey County Hospital wrote to the GP:

"This lady has a past history of ocular trauma following an RTA and now has only light perception on the right. She had become aware of pain and blurring on the left over the past three days and on examination has inferior epithelial oedema. I am not sure what the cause of this is but have prescribed G. Betnesol q.d.s.and Oc. Chloramphenicol q.d.s. in that eye. We shall review her in five days time."

Ms X was informed that her eyesight was further significantly impaired.

6 August 1997 The orthopaedic SHO, St Peter's Hospital Chertsey, wrote to Ms X's GP informing him that she had been admitted overnight as she had been hit on the head and collapsed.

19 August 1997 Her Consultant Psychiatrist replied to the letter from the independent chairman of the Child protection conference bringing him up to date with Ms X 's progress. He went on to say:

"... she was also receiving support from the Drug and Alcohol team and awaiting therapy for her post traumatic stress syndrome. I pointed out that her present stress has included a period of failure when she was not looking after her children and that she cannot do without alcohol, she said, when she had them at the weekends. I do not think that Ms X has a right to feel let down as we are pouring an enormous resources into her care. Whether she is fit at this stage to look after her children, I personally an unwilling to say and I leave that decision entirely to yourselves…..… Ms X cancelled her appointment on 15 July as she felt too unwell physically. I spoke to her on the telephone and she said otherwise she was doing well and pleased to have her children. At that time she seemed calm and sober to me…."

26 August 1997 Ms X was admitted to hospital with a history of vomiting blood and kept in for 48 hours. A neighbour looked after the children during the day and Ms X's friend (MB) stayed overnight.

3 September 1997 The community social worker with the DAT team, visited Ms X at home to discuss her pending admission to Windmill House. She was quite tearful and was drinking from a can of Tennants Super lager. She described the need to "*let it all out"* and was fearful that she would be thrown out of Windmill House as she said had happened before. She was also unhappy about the proposed care of her daughters, although later these plans were changed.

17 September 1997 Ms X contacted the Children and families' office because she thought she was unsupported. She smashed a coffee cup and caused injuries to herself with the debris. She was seen in outpatients by the senior clinical medical officer, DAT, and was very distressed by the alleged sexual abuse of her daughter (S). She was anxious about her forthcoming six week programme as she felt she wouldn't do well because she was very emotional and tearful.

22 September 1997 Ms X was admitted to Windmill House for a further detoxification programme. She participated well in the group although preoccupied with issues relating to her children. Ms X took her own discharge on 2 October against medical advice only to be readmitted on 3 October. Ms X was eventually discharged from the programme on 21 October as she had left the unit on 15 October, and although she telephoned the Ward a couple of days later, she refused to return. She felt she was unable to cope with her feelings about the recent allegations her daughter (S) had made, and that they were not being followed up by the police, as well as being concerned about her impending Court case for causing an 'affray'.

2 October 1997 A solicitor's letter sent to senior clinical medical officer, DAT, but dealt with by her Consultant Psychiatrist, suggested that a medical report to the Crown Prosecution Service might persuade them to drop the charges against Ms X. It also stated that following a meeting with her key worker, a specialist nurse in the drug and alcohol service, Ms X was not fit enough to attend court.

20 October 1997 Ms X was readmitted to Blake Ward after a medical assessment in the AED having been taken there under Section 136 Mental Health Act 1983, by the police she had taken an overdose of medication and had been abusing alcohol. The notes state that she drank a bottle of brandy and ingested a combination of Paracetamol, Diazepam, Thioridazine, Asprin, Paroxetine and Co-codamol. When the ambulance arrived she refused to get in it and the police were called because she was running down the street. She left the Ward on 25 October, returning in the early hours intoxicated and aggressive. She was detained using Section 5(2) MHA 1983 which was later rescinded. She left the Ward again the following evening and on her return she had facial injuries from a fall. She was found collapsed drunk. Ms X agreed to a weekly contract with the staff on Blake Ward not to drink, leave the Ward or behave violently or else she would be discharged. Ms X did leave the Ward on 30 October and was discharged on 3 November. Her Consultant Psychiatrist wrote

> *"….as I understand it not too badly but remains unstable. The intention is for to her resume the Drug and Alcohol programme as soon as she is motivated……"*

5 November 1997A female neighbour complained about difficulties with Ms X. Ms X was banging on her door and threatening to 'get' her, which made her concerned for herself and her son. Apparently Ms X, having collapsed in an off license, was brought home by the police following which, they completed an incident report.

17 November 1997 Ms X was referred to the mental health services by GP and seen as an outpatient. As she was not depressed or suicidal and the impression gained was one of personality problems complicated by alcohol misuse, she was discharged home to be assessed by the team. The night before when the out of hours doctor was called to the house he wrote:

" contacted ACU-said they'd assess tomorrow. Patient not happy. Held knife to own throat and then moved towards me saying 'I'm going to kill myself and I'm going to take you with me"!

An ambulance and the Police were called. Ms X refused to go voluntarily and so she was arrested and taken to the ACU in a police van.

21 November 1997 Ms X was due in Court but the GP wrote a report to say she was too unwell to attend.

27 November 1997 The, team leader DAT team, interviewed Ms X during which Ms X admitted to drinking up to one and half bottles vodka daily. She also expressed suicidal ideation and seemed depressed and down. Because of her low mood the duty doctor assessed her, but no further action taken. In sharp contrast when the team leader, DAT saw her again on 4 December Ms X said she had stopped drinking and felt she no longer needed the six week programme whilst acknowledging she required help with her physical health and the after effects of the car accident.

1 December 1997 The criminal charges, against Ms X of causing an affray, were dropped because of lack of evidence.

10 December 1997 Ms X failed to keep her appointment with her Consultant Psychiatrist as she had started a night shift job and she had overslept. She had stopped drinking and was feeling well. He concluded another "*flight into health*".

18 December 1997 Ms X failed to keep an appointment with the team leader, DAT. She wrote to Ms X saying that if they hadn't heard within 21 days they would assume that she no longer wanted any help.

22 December 1997 Ms X 's two older daughters returned home from Yorkshire. Ms X had new boyfriend (SG).

1998

8 January 1998 The team leader, DAT, saw Ms X as an outpatient however Ms X cancelled her next appointment as she was rehoused out of the area because her house had been flooded.

15 January 1998 A Child Protection case conference was held during which it was agreed that the children should remain on the register.

2 February 1998 Ms X was reassessed for the six-week de-toxification programme and placed on the waiting list. Ms X was also seen by her Consultant Psychiatrist on 5 February and said she had not taken any medication for three weeks but was drinking four lagers at night. The Consultant Psychiatrist discharged her to the care of the DAT team.

2 March 1998 Ms X was admitted to Windmill House for the de-tox programme. Breathalysed at 16.30 hours and was found to have 175 mmols of alcohol, at 18.00hours the level was 105 mmols and at 20.20 hours the level was down to 35 mmols. At this point she

was feeling very uncomfortable and was given 10mgs Diazepam. Ms X was discharged on 22 March as it was decided that she could complete the programme as a day patient. All seemed well, but after a couple of days Ms X was phoning the Ward saying she was unwell and not able to attend the day programme. There were problems with the fostering arrangements for the children and Ms X required a lot of reassurance from the staff, ringing two or three times during the night as she was unable to sleep. Ms X, concerned about her children, did not attend as regularly as she should have done and so was discharged from the programme.

17 April 1998 Ms X took an overdose in an effort to readmitted to Windmill House and was seen in.

8 May 1998 Ms X was referred by the GP as she was feeling "suicidal" and had superficial cuts to her arms. She had stopped taking medication three weeks previously. She had seen the CPN, called the GP out twice and spoken to staff on Blake Ward. Admitted to Clare Ward as in "crisis" over the weekend to provide place of safety, as she *"feels safer in hospital and wants help"*. She complained of withdrawal symptoms the following day and recommenced Venlafaxine 75mgs twice daily. Ms X 's progress was reviewed on 13 May and the following day she did not return from day leave.

16 May 1998 Ms X was feeling suicidal and was referred by the Children and Families Team for an emergency assessment. She was admitted as an informal patient. Her daughters went into foster care and were told that Ms X was too ill to look after them.

19 May 1998 Ms X was arrested and charged with harassment and threatening the life of her neighbour.

26 May 1998 The Co-ordinator, Woking Victim Support, wrote to the Housing Officer informing her that a neighbour of Ms X 's had been referred to them for support as a result of criminal damage caused by Ms X when she had tried to hammer down a door. She said

> *"…..…We are very concerned for K… and her son as being very vulnerable. They are both very frightened. Her neighbour Ms X has been causing great distress over the last few months. I believe K…has been in touch with your office and sent a diary of incidents which have occurred recently .We and K… feel she is at risk. This situation should not be allowed to go on. Is there any way you are able to resolve this problem"*

This letter was also copied to the staff at the Abraham Cowley Unit.

In the meantime on 1 June Ms X went on home leave and as she had not returned by 3 June, which had been agreed as part of her contract, she was discharged. Ms X spoke to the 'out of hours' duty worker saying she was frightened that she would be discharged as she had not returned. She had mixed up the days and remained at home to obtain her benefit money. Ms X was taken to Blake Ward on 5 June, escorted by a policeman as earlier in the day an 'out of hours' doctor was called to the house by the Police and Ambulance Service. Ms X was self-mutilating with a knife, threatening suicide and had been drinking. Ms X had no rapport with admitting doctor and refused to be breathalysed. The notes recorded:

Impression "alcoholic problems, intoxicated at the moment, with anti social behaviour, possible personality disorder. No features of mental illness noted during this interview. Plan to stay on the Ward to sober up and to be assessed tomorrow. To keep appointment to see psychologist as planned tomorrow. Avoid arguments with this patient please".

6 June 1998 Ms X telephoned the Crisis Response Team (CRT) because she was feeling unwell and complaining that she had been unfairly discharged from Blake Ward.

12 June 1998 Ms X was served with an injunction not to go near her neighbour and her son.

13 June 1998 Ms X was in AED as she had taken an overdose but left before seeing a psychiatrist.

17 June 1998 A Care Programme Approach (CPA) meeting was held at Bridgewell House at which Ms X was present and a future plan agreed with her. Ms X was to abstain from alcohol, receive weekly support from the DAT team, have fortnightly meetings with CPN 1 and the team leader, DAT, and keep monthly outpatient appointment. A family friend who was an ex-patient was looking after her daughter (S) and (J) was to remain with her childminder.

19 June 1998 A senior housing officer, wrote to the Community Mental Health Team (CMHT) informing them of the number of incidents which had led to an injunction against Ms X being obtained by a neighbour. He also informed them that a 'Notice of Seeking Possession' was due to be served on Ms X on 25 June. He was aware of Ms X 's previous history of self-harm and wanted to give the team advance warning of the action the housing department intended to take.

Later that day Ms X did not keep her appointment with the team leader, DAT, and was referred by the CRT for an assessment as she was threatening self-harm and drinking heavily. She stopped taking her medication four days previously. She was admitted as an informal patient but the following day she left the Ward without telling anyone. On this occasion a bed was kept for her, she returned at 18.00 hours the following day, but as many times before, left the Ward because she was worried about her children.

22 June 1998 Ms X contacted the CRT many times during the day and they referred her for a further assessment. When seen, she said that when she was at home she should be in hospital and when in hospital she should be at home. Earlier in the evening her eldest daughter told her that she wanted to live with her father and Ms X was concerned that the children would be taken from her, and that on this occasion she would stay in hospital *"this time"*. Ms X stayed in hospital for two days

25 June 1998 Woking Housing Department wrote to her Consultant Psychiatrist, the team leader, DAT, and Senior Social Worker, Children and Families, informing them that Ms X was to be evicted possibly in September. Ms X telephoned Bridgewell House to say that as she was going on holiday for two weeks she needed to get some money and as a consequence she was attending her outpatient appointment.

26 June 1998 Ms X left the Ward without permission and, therefore, was discharged only to be re-referred by the CRT later that day. The notes stated:

> *" discussed with her Consultant Psychiatrist. …. If requesting admission she should be put on an informal contract stating that she has to stay in hospital, and stay on the Ward.…… not drink alcohol or abuse illicit substances. Going off the Ward briefly can be negotiated with nursing staff but can not come and go as she pleases. If she leaves and does not come back or breaks the contract in any other way then the plan of crisis admission as necessary is to be negated and she will not be admitted unless under exceptional circumstances. To be reassessed by her Consultant Psychiatrist on the Ward round".*

Several telephone calls were made to her but there was no reply.

5 July1998 Ms X went on holiday with her children for a week. Her friend was unable to go at the last minute. She telephoned to say that she and the children were having a good time.

14 July1998 Her Consultant Psychiatrist wrote to the manager of the family support team outlining his assessment of Ms X. He said:

> *" my assessment of Ms X 's condition is that she suffers a personality disorder characterised by panicky states, depressive moods with occasional suicidal ideation, and a tendency to abuse alcohol. In addition, since the 2 road traffic accidents she had several years ago, she has suffered from symptoms of post traumatic stress disorder, as well as the social consequences. She would seem always to have had a somewhat unstable mood, but over the past 2 years this has become increasingly unstable for a variety of reasons, not least of which has been her tendency to abuse alcohol.……she has had several admissions over the past few years when she has been desperate and on occasion she has settled down within a matter of days. Currently she remains somewhat unpredictable, but her latest admission, as usual, has resulted in the stabilisation of her mental state. The current plan (she has managed to sabotage all for very good reasons mostly pertaining to child care…) is that she continue on leave from the Ward for the following week, and if all goes well she will be discharged. In the medium to long term, however, I am considering referring her to the Henderson Hospital or possibly the Cassel Hospital. This has not been a possibility before because I have thought it essential that she stay in close touch to her children, and indeed she has always wished to do so. She accepted the idea of minimum of 6 months in a therapeutic community, however with some equanimity so I think this may be a good option . She has tremendous qualities of perseverance and toughness…*
>
> *…..I believe she has the intelligence and insight and flexibility to respond to psychotherapeutic intervention, if she will give a chance to minimising her alcohol intake…. If she continued the treatment that we are able to offer here only the(n) I suspect she will remain unpredictable, but there is a trend for gradual improvement in that I do not believe she is drinking quite as much or intensively as she used to.*
>
> *Like wise she is not acting out quite so dramatically, but there is no guarantee that she will not continue to do this for the foreseeable future"….*

Later that day Ms X, having made contact with CRT, was seen by the duty psychiatrist on admission to Blake Ward for respite care. She spoke of being unable to cope with life any

longer, and of killing herself and her children, had they been with her. She was very agitated, shouting and kicking doors. She had been drinking over the weekend, and felt everyone was against her and wanted help. She was currently distressed by her thoughts of the car crashes which had been precipitated by the solicitor contacting her about them, and the impending compensation, the threatened eviction and possible loss of her children.

15 July 1998 Ms X was absent from the Ward, returning home where the duty worker CRT saw her in the earlier evening. She was threatening to kill the children rather than they go into foster care. Ms X also threatened to throw herself out of the first floor window, which upset the children. Ms X made a dash for the window and had to be restrained from hurting herself in front of the children. A neighbour agreed to look after the children and the police took Ms X back to the Abraham Cowley Unit in handcuffs at 21.45hours. She calmed down and later, whilst the staff were dealing with another disturbed patient, she left the unit. She returned about 00.45 hours claiming to have taken an overdose of Paracetamol, Zopiclone, Venlafaxine, Diazepam, Acamprosate and Thioridizine with vodka and wine. Although at first she refused she was taken to the AED, where it was established that her blood level of Paracetamol did not require treatment, and so she returned to the Ward.

16 July 1998 Her Consultant Psychiatrist, when he saw Ms X , recorded that she was not psychotic and wrote:

> *"If she tries to leave the Ward she should be assessed and then placed under Section 5/4 or 5/2".*

18 July 1998 Ms X was given overnight leave and went home to collect some clothes. She telephoned the Ward the next day saying that a car had knocked down her daughter causing her to have a twisted ankle. Two friends brought her back to the Ward where she became disruptive, throwing rubbish bins, shouting and swearing at staff. She was visibly drunk. Ms X was found in the day room with two lacerations on her forearms which were cleaned and dressed. She later threatened to cut her throat. Eventually she settled and was apologetic for her behaviour. Her Consultant Psychiatrist was contacted and advised the staff that if she attempted to leave she was to be placed on Section 5/2 MHA 1983 due to diminished responsibility from alcohol intoxification.

20 July 1998 Ms X telephoned the Ward from home, declining to return and said she would come back the following day to collect her money. She and her friend made several contacts with CRT. Ms X told them that she would not return to the ward and that she had a hammer to attack anyone who tried to enter her home. Later that day a worker from MIND rang to say that Ms X was shaking and wanted some medication. She was advised to return which she did and having been given her medication went to sleep.

22 July 1998 Ms X signed various papers relating to the children and their future care. In effect, the Local Authority were 'taking over' their care and Ms X was to attend court on 28 July. Later that night she went left the ward to try and locate the children. The emergency duty team were informed as she refused to return to the Ward. There was some confusion about her status, as according to the medical notes she was due for discharge. It was decided that she could remain as an inpatient in view of the impending court case. Ms X was very agitated, kicking doors and walls- threatening violence. She was told that if her behaviour continued the police would be called. She eventually settled.

23 July 1998 Ms X went off the ward again without permission, only to return at 22.30 hours. The following day Drs 1 & 2 reviewed her care and decided to place her on Section 3 MHA 1983 for her own safety and health. Ms X left the ward by climbing through the window, and when she telephoned, she stated she was scared at being on Section 5/2 MHA 1983. She was reassured and returned to the Ward the following day. She attempted to abscond the following day, but was apprehended by staff.

24 July 1998 An approved social worker, asked to complete the mental health assessment, wrote to the Emergency Duty Team requesting that they complete the assessment as she had difficulty in contacting a doctor to make their assessment. Both GPs, who knew Ms X, were on holiday, as was the Section 12 (MHA 1983) doctor based at the Abraham Cowley Unit.

26 July 1998 Ms X cut her right arm which later became infected. She was treated with antibiotics. The following day, a second approved social worker, and a general practitioner, completed the papers for the mental health assessment. At 22.00 hours Ms X was missing. A telephone call to her home established that she was there. She did not want to return, saying *"Blake Ward is like a prison to me"* and so stayed at home with a friend who felt she was alright.

She returned 28 July at 09.45 hours. Ms X was asked why she continually absconded. She said that she had paperwork to collect for the court proceedings. She was visited by the Mental Health Act Manager and decided to appeal against being detained.

30 July 1998 The Missing Person's Procedure was implemented at 16.30 hours as Ms X could not be found. The police brought her back by at 20.45 hours. She found being on the Section exasperating, but said she would stay over the weekend.

3 August 1998 Ms X had attended Alcoholics Anonymous and stated on the Ward round with her Consultant Psychiatrist that she did not have a drink problem. She also said that the problems with the neighbours were of their making, not hers. She wanted the chance to fight the impending care proceedings. The medical notes stated:

" plan - would like s(ocial) w(ork) input
- *feels that CPN1 will help by giving her regular support*
- *to continue with MIND and AA*
    - *discharge from Section as symptom free and willing and able to take responsibility*

Not to use CRT
NOT TO BE ADMITTED UNDER ANY CIRCUMSTANCES
If DISTRESSED in the community & presents….. call for an ambulance and go to A&E
Duty doctor to assess regarding….. but <u>NOT</u> to be admitted
CPN1 to see by appt. only
Continue to be seen by team leader DAT
Section 3 is hereby rescinded."

Later that day the CRT received a telephone call from a friend of Ms X 's informing them that she had gone to her mother's house, having been drinking, and causing a disturbance by banging on the windows. As the address was out of the area no action could be taken and that caller was advised to telephone the police.

6 August 1998 Her Consultant Psychiatrist spoke to Ms X 's GP and said that the service was not keen to react to her attention seeking behaviour, and was trying to avoid admission, and so asked him to prescribe Venlafaxine 75mgs twice daily, Paroxitine 10mgs and Thioridazine 25mgs as necessary. He also sent a detailed letter outlining the future plan.

> *" This is to let you know that I reviewed the above (Ms X) on Blake Ward 3 August with the multidisciplinary team. We found her to be entirely free of psychiatric symptoms and requesting discharge. We discussed her recent history of instability. She was strongly of the opinion that the situation had changed. She had discovered a supportive network in the form of MIND and Alcoholics Anonymous. Her symptoms of post–traumatic stress had diminished. She was more determined than ever now to remain stable in order to fight for the care of the custody of her children. It was agreed that admission has not been helpful. With Ms X 's agreement therefore the following package is tentatively agreed, and indeed requested by Ms X*
>
> 1. *To attend CPN1 at Bridgewell House by appointment for supportive counselling.*
> 2. *To attend team leader,DAT, regularly for psychological and alcohol counselling.*
> 3. *To derive emergency support through AA and MIND.*
> 4. *Outpatient appointment with myself in about 4 to 6 weeks.*
> 5. *She is **not to be admitted <u>except under Section</u>** as, in a crisis she is willing to be admitted but behaves erratically and uncontrollably if not under Section. I recommend **that the Crisis Response Team is <u>not to be used</u>** to visit her when there is a crisis, but that she be seen at the Accident & Emergency Dept. should she indulge in any self-harm, and be allowed to settle there.*
> 6. *She should continue her medication and be given **a week at a time.***
> 7. *A CPA will be called within the next 3 weeks and to be held at Bridgewell House".*

7 August 1998 At 00.30 hours the Police and a friend took Ms X to the hospital. She had drank a bottle and a half of vodka, but denied taking an overdose of medication. She was anxious about losing her children. Her CPN had visited her during the day. The plan not to admit her was followed on this occasion.

9 August 1998 In the evening Ms X was taken to the hospital under Section 136 MHA 1983. Earlier she telephoned the foster parents telling them that she was going to kill herself. In fact she went to the top of Toys R Us building (a local high landmark in Woking). She sat on the edge, refusing to let anyone near her and was given a mobile telephone with which she rang a boyfriend to say goodbye. She was there for about one and half hours before being grabbed by an ambulance man. The police were sure she had intended to jump and as she attempted to run away, they took her to the hospital. Although smelling of alcohol she was not drunk, was very pleased to see Dr 2 and was laughing, maintaining that she had gone to buy a present for her daughter and had '*got lost'*. She denied having any ideas of self-harm and when explaining the events she *said "every time I tell you something you put it in letter against me. I can't tell you the truth"*.

Ms X was admitted to Laureate Ward (a locked facility) because of the dramatic nature of the incident and her desire to abscond. The following day Dr 1, Consultant Psychiatrist, saw her during his Ward round. She complained of having very little support since she had been previously discharged. She was referred to an approved social worker (ASW) for a mental health assessment.

10 August 1998 The senior housing officer wrote to the CMHT informing them of Ms X 's impending Court Case set for Monday 5 October.

14 August 1998 A, general practitioner, referred Ms X to the DAT team for a further detoxification programme. He said in his referral letter:

> *" we have had a chat about the appropriate use of health care services and I hope that she will be more appropriate in future".*

26 August 1998 SW2 carried out an assessment in which she noted that Ms X had ME, spending time in bed and exhibiting bizarre behaviour when she had been drinking. She also noted that Ms X had held people hostage and that she had depressive episodes without a defined diagnosis.

7 September 1998 Ms X stated that she did not have a drink problem and so was discharged from DAT.

5 October 1998 Her Consultant Psychiatrist wrote to Ms X's, solicitor, in answer to the complaints made by her neighbour about Ms X damaging her car. He wrote:

> *"Opinion Ms X has had an extremely volatile existence up until her last discharge. Admissions have been precipitated by episodes of acute distress with suicidal ideas, and often the involvement of excessive quantities of alcohol, which have allowed these feelings to bubble to the surface. She has had numerous social problems to deal with, not the least of which is her concern over her children with whom she has to cope, and in my view has done her level best to do……*
> *she has been admitted under Section on several occasions, **on admission**, she accepts medication readily and settles down quickly….. She has been full of good intentions, but up until recently had been unable to persist in sustaining an alcohol free existence. However, since her last discharge she had accepted responsibility for her actions, and she tells me that she hasn't had any drink. As a result she feels in much positive and free of depressive symptoms, and indeed post traumatic stress disorder at this point as far as I can judge…… **Regarding the incidents** for which she has been charged she said " I can understand when I was ill her not liking my behaviour, with the police and the ambulance coming round, and the commotion." However she felt that Ms D had either made up or exaggerated the incidents concerned……..she feels that the situation had now changed and her psychological condition is much improved. I would concur with wholeheartedly. She continues to derive support from voluntary agencies as well as from myself in outpatients and Bridgewell House Mental Health Centre personnel".*

14 October 1998 The GP wrote to Ms X requesting that she find another doctor because of an unpleasant scene at the surgery, when Ms X had attended the week before for a vitamin B injection. He said:

> *" I am sorry that is has come to this, but we have had discussions about you needing to control your attention seeking behaviour. As usual alcohol seems to be implicated in your loss of control and perhaps you could learn from this".*

17 December 1998 Her Consultant Psychiatrist saw Ms X in the outpatient clinic. Her eldest daughter, who had elected to live at home, accompanied her. She was no longer drinking as much and was deriving a good deal of support from her boyfriend. She was receiving regular social worker support and seeing her other children on supervised visits. He felt she should continue with taking antidepressants and sleeping tablets.

1999

7 January 1999 Her Consultant Psychiatrist was asked to see Ms X at home. SW2 also attended. The ambulance service was called earlier in the day because she was so distressed. They in turn called the police, who arrived in protective clothing along with a hostage negotiator and they set up an incident room in the local school because Ms X was seen with a knife, threatening self harm and had thrown a cup of hot water out of the window. After about four hours, she let (DM), her fiancé, back into the house, the police entered, overpowered Ms X and she was arrested, taken to the police station and charged with a breach of the peace.

Her Consultant Psychiatrist went along to the police station to see Ms X, who told him that she had woken up feeling low, and failing to obtain a response from the GP or child-care social worker, she telephoned (DM). She had been drinking and so he called the ambulance service. Ms X was admitted to Blake Ward where a mental health assessment was completed. She was first seen in AED because she had taken a number of Paracetamol, but her blood level was satisfactory and so was sent to the Ward.

8 January1999 The Primary Care Agency allocated Ms X to another general practitioner, GP 3. DM telephoned the surgery demanding medication for Ms X.

12 January1999 Social Services held a 'network meeting' in which various professional staff discussed their contact with Ms X over the last few weeks. Ms X had been making threatening telephone calls to (JH), her previous partner, and his wife. The police were reported as saying that when Ms X was drunk, she was very dangerous.

25 January 1999 Ms X attended her new GP and her pregnancy was confirmed. The expected date of delivery was 6 October 1999. Ms X requested that none of her medical information be disclosed to Social Services. Ms X had stopped taking her medication and the GP referred her to her Consultant Psychiatrist for an urgent appointment.

26 January 1999 A Child Protection Case Conference was held, which both Ms X and her partner, (DM), attended. SW 2 expressed her concern about the incident on the 7 January. CPN 1 who had seen Ms X after the incident on 7 January discussed Ms X 's alcohol abuse.

1 February 1999 GP 3 wrote to her Consultant Psychiatrist informing him that Ms X had joined his list. He also informed him of Ms X 's pregnancy, as a result of which she was no longer taking medication and was becoming slightly volatile. GP 3 was reluctant to prescribe anything in particular because of her previous history and requested an urgent assessment. He said:

> *"I understand that you know this lady well. She has joined our list having left that of GP 2 in rather unhappy circumstances."*

At the end of the letter he wrote:

> ***"SHE IS VERY CONCERNED THAT SOCIAL SERVICES MAY BE REQUESTING INFORMATION CONCERNING HER MEDICAL CARE IN VIEW OF HER FORTHCOMING CASE CONCERNING LONG TERM CUSTODY OF HER TWO DAUGHTERS. SHE HAS SPECIFICALLY ASKED THAT THIS INFORMATION SHOULD NOT BE RELEASED WITHOUT DIRECT LEGAL REQUEST FROM THE COURT. I EMPHASISED THAT I WOULD ENDEAVOUR TO UNDERTAKE BUT WOULD ASK THAT ALL MEMBERS OF YOUR TEAM ARE AWARE OF THESE STIPULATIONS"***

3 February 1999 Her Consultant Psychiatrist replied to GP 3 confirming that he had been seeing Ms X as crises constantly recur. He said:

> **"….. her boyfriend who lives with her is doing his best to stop her drinking etc. but sometimes rings in a panic when she becomes histrionic. I am sure that her stopping her medication has made her more unstable, but on the other hand she was wise to do so because of her pregnancy. I saw her at home in response to one of these calls. By the time I arrived she had settled down. She had taken some vodka to help her. She was quite rational…….**
> **……regarding her request for confidentiality, I believe that the Children's Act overrides this in the interest of children. In any event the Social Services already have acquired a lot of information."**

Comment

Her Consultant Psychiatrist was quite correct in his view that in the interest of protecting children there were occasions when patient confidentiality had to be breached. This is endorsed in paragraphs 36 and 37 of the General Medical Council guidance, *Confidentiality: Protecting and Providing Information.*

Her Consultant Psychiatrist also wrote to the staff in the DAT team. Ms X was at crisis point again and the only way she could calm herself when dealing with social services was by drinking. When she was drunk she had gross histrionic outbursts. Although she was contrite she wished to resume her contact with the team and seek their help. Her Consultant Psychiatrist also replied to GP 3. He agreed that as Ms X had stopped her medication she would be more unstable but on the other hand it was probably wise because of the pregnancy. Her Consultant Psychiatrist had visited Ms X at home in response to one of these crises but she had settled before he arrived as she had calmed herself by drinking some vodka. He recommended Flupenthixol 1mgs, twice daily, Zopiclone 15mgs at night and for only week's medication at a time. Her Consultant Psychiatrist also reminded GP 3 that in respect of confidentiality the Children Act took precedence.

10 February 1999 A CPA meeting was held and present were CPN 1, her Consultant Psychiatrist , SW 2 and Ms X with her boyfriend DM. The agreed plan was for Ms X to attend the DAT, joint appointments with CPN 1 and SW 2, and the senior social worker children and families team, to provide support to Ms X . Next appointment arranged for 18 February.

11 February 1999 Ms X presented at the AED with (DM), who was described as 'highly manipulative', as she was having difficulty in coping at home, despite seeing her Consultant Psychiatrist the day before. She was tearful and described her mood as ' up and down' and had thoughts of self-harm. She was admitted to Blake Ward and her Consultant Psychiatrist was duly informed, although Ms X had wanted to be admitted to Windmill House in the care of the DAT team. She was prescribed Diazepam to be taken whenever necessary to relieve any withdrawal symptoms because of her pregnancy.

15 February1999 Ms X was transferred from Blake Ward to Windmill House for the detoxification programme and on 19 February her Consultant Psychiatrist wrote to Ms X 's solicitor stating that the immediate prognosis was good and that her mood swings would improve if she abstained from drinking. As yet, she had not managed to complete a course of treatment for her alcohol difficulties, but was now motivated. Ms X was settled in her mood and behaviour, attempted to participate in the six week programme and deal with other agencies. She had not had a drink since her admission.

5 March1999 A Court Hearing to do with the children's care did not go in Ms X 's favour which caused some difficulties for her and she was unable to cope with the programme and so she was discharged from it.

5 April 1999 The police were called to Ms X 's flat and she showed them how she had intended to hang herself. The Emergency Duty team, social services were called and at 23:20 hours, the duty ASW, a, Consultant Psychiatrist and a deputy GP attended Ms X at home to carry out mental health assessment. Her partner,(DM), objected to the assessment as it could have resulted in a compulsory admission. The notes stated:

> *"Ms X was actually and constantly threatening violence especially to s/w's and SSD. She is unpredictably violent and should not be seen alone- in current mood".*

(DM)'s mother contacted the police because she had had telephone calls from Ms X in which she threatened suicide. Mrs (M) had also telephoned Clare Ward earlier in the evening. Ms X refused to be interviewed by the doctors, saying that *"people were coming from behind the curtains and the devil might arrive if the doctors insisted on sitting cross legged"*. When the duty ASW, arrived her behaviour changed and she started punching (DM) and verbally abusing him, despite the police being present. The two doctors and the social worker thought she was exhibiting bad behaviour rather than suffering from a mental disorder. Everyone left at 02:15 hours and (DM) agreed to take Ms X to Bridgewell House in the morning.

6 April 1999 At 22:00 hours third ASW and Dr 1 visited Ms X at home. The notes stated *"**DO NOT GO** WITHOUT POLICE BACK-UP. Both have been drinking this evening and were extremely aggressive and volatile"*. Ms X had telephoned her daughters earlier to say "goodbye" as she and (DM) were going to kill themselves by fixing a hosepipe to their car. Ms X 's daughter J was used to telephone calls like this and said they usually occurred when they were due to see their father. (DM) went to friends and Ms X telephoned the CRT saying they were going to commit suicide. She was very distressed and had cut her hands. The ASW and Dr 1 met with the police outside the house and in view of the previous night's scene, the police called for 'back-up, who arrived in riot gear. Ms X, obviously inebriated, spoke to the police, anxious that as she was pregnant she was not 'jumped on'.

Both the ASW and Dr 1 concluded that neither Ms X not her partner were mentally ill, although they were angry, volatile and totally unpredictable. The police decided to withdraw, thus de-escalating the situation. They would only take action if members of the public were threatened, for example, if (DM) carried out his threat to cut the gas pipe and torch the flat with petrol.

Comment

The subsequent police evidence demonstrated that DM had broken the gas mains and was arrested.

SW 2 wrote a letter to Ms X informing her that she was leaving Bridgewell House but she did not know at this point in time who Ms X 's new social worker would be.

7 April 1999 The police, reported that Ms X was consistently disorganised, disinhibited and abusive took her to the hospital. She was seen as an emergency admission threatening self harm and whilst in the AED she looked for a scalpel, she said, to kill herself.

8 April 1999 Ms X left the Ward against medical advice and without medication as she left before being seen by the junior doctor. She was concerned that (DM) was in custody charged with "intent to kill". As Ms X 's problems centred mainly around alcohol, when her behaviour became unpredictable, and as she was angry with Social Services, staff were advised not to visit her at home but she was encouraged to attend Bridgewell House.

15 April 1999 GP 3, wrote to her Consultant Psychiatrist and the obstetric Consultant to say that, in light of the events of the 6 April when Ms X was agitated and extremely violent, the practice could no longer maintain her on the practice list because of previous threats to all who saw her.

18 April 1999 Her Consultant Psychiatrist wrote to GP 3. Ms X was due to see him on 14 April but did not keep the appointment. Her latest crisis was caused by (DM)'s remand. Her Consultant Psychiatrist went on to say:

> *"….. She has been calling the crisis response team I think in an appropriate way. It is extremely difficult to help Ms X, mostly I think because she continues to respond to her crises with alcohol. I promised her I would discuss her follow up with the drug and alcohol team……Meanwhile she is well aware that she can attend at Bridgewell House anytime to see the duty professional, and the crisis team are available out of hours"*
>
> .

29 April 1999 Her Consultant Psychiatrist wrote again to GP 3 as Ms X had not kept her appointment. He went on to say that he had not sent her another appointment but would see her if she so wished. He also said that she claimed to be agoraphobic but as she had visited her boyfriend in prison he had his doubts.

Comment

Ms X was reallocated to yet another new GP 4 21 April.

12 May 1999 Ms X was admitted to the labour Ward at St Peter's Hospital in the evening. She reported that she had been assaulted, dragged along the floor, pushed against a wall and hit in the lower abdomen and complained that she had not felt the baby moving. Ms X had been involved in a fight between one of her friends and a neighbour, which caused her injuries. When seen by the SHO, she was reported as being 'drunk'.

22 June 1999 The community midwife saw Ms X for the first time despite various previous attempts. Ms X had telephoned her saying she had lots of social problems and was depressed. Ms X had visited DM despite being 'agoraphobic.

28 July 1999 Her Consultant Psychiatrist wrote to GP 4 having seen Ms X on 15 July. She was well and had distanced herself from (DM) who was still in prison. Her Consultant Psychiatrist did not arrange to see her again and the CPN was asked to keep in contact with her.

29 July 1999 Ms X admitted to the antenatal Ward for rest and to have a renal (kidney) scan and was discharged on 2 August.

6 August 1999 GP 4 wrote to the allocations officer at the Primary Care Agency requesting to be relieved of having to carry out home visits to Ms X because of her previous violent behaviour. He went on to write that if this request was not granted, then he would seek to have her removed from his list. The Operations Manager, Primary Care Agency, replied on 10 August to say that police escort arrangements for home visits were in hand so that Ms X could remain on his list. At about this time (DM) was discharged from prison.

11 August 1999 A meeting, with social workers in the children and families team, midwifery staff and the health visitor, was held to discuss the arrangements when Ms X delivered her baby. The decisions reached at this meeting were as follows:

1. A decision was reached that the baby should be removed at birth without notice or contact - Police Protection Order
2. Following birth – Emergency Protection Order
3. At the meeting there was a need for the strictest confidentiality….
4. The police will be present in the unit to effect this order in conjunction with Social Services
5. A detailed plan of action is to follow
6. Should Ms X be admitted to St Peter's Hospital earlier than the planned date of delivery, Social Services are to be contacted.

Comment

It should be noted here that no one from the mental health services was present at this meeting.

11 August 1999 The Patient's Charter and Complaints Manager, West Surrey Health Authority, wrote to GP 4. It was regretted that the Health Authority had no power to vary national terms of service. It went to say:

> *" Our view is that, if a patient's life is at risk, then a doctor should visit. If, by making that visit, the doctor's own life could be at risk, then there should be a police*

escort. Our understanding is that, in circumstances such as these, the police do not need a warrant before entering the patient's home. if the patient's life is not at risk then the doctor can make a judgement about whether a visit is necessary or not (as s/he would in the case of any other request for a home visit)".

13 August 1999 GP 4 wrote to the Secretary for State, requesting help and advice about a patient (Ms X) who had been allocated to his list and her partner who was not his patient. He went on to say

" …there is a long history of violent behaviour, both in general and health professionals in particular. Her partner was recently convicted of actual bodily harm with an offensive weapon and false imprisonment. Her last GP had to visit her at home and such was the level of violent behaviour two police officers were needed to restrain her. The GP feared for his future safety and had no alternative but to remove this patient from his list….. I fear for my safety, that of my family and that of my partners and practice staff. One of my biggest concerns is that I will have to visit this patient at home if she requests it and that I shall be in breach of my terms of service…. I have been told to get a police escort…. But I find this situation far from satisfactory, as actual bodily harm has previously taken place even with a full police presence. Other professionals including Social Services, health visitors and the mental health team have been relieved of their duty to visit but no similar change in terms of service has been offered to me…… This patient is clearly in need of medical help. It is in everyone's interest, including my patients, that my terms of service be altered such that I was relieved of my duty to visit her at home. if this was granted then I would consider keeping her on my list and building on the relationship that already exists between us".

This letter was copied to the Local Medical Committee, British Medical Association and the local Member of Parliament.

Comment

From the records there was no evidence that this letter was answered by any of the recipients.

23 August 1999 Ms X was admitted to the antenatal Ward for rest and discharged two days later.

2 September 1999 Ms X was admitted to the antenatal unit, accompanied by (DM), having gone into labour. Baby (L) was born later that night and the following day four social workers and Child Protection police officers removed the baby using an Emergency Protection Order, with armed police available in the unit. As (DM) was present and known to be unpredictable, a decision was taken to have 'back up', which consisted of six officers from the Police Support Unit and two Sergeants in what was possibly a violent situation. (DM) stayed with Ms X until she was discharged sometime on 4 September.

Comment

This seemed an extreme decision to take as other mothers may well have been upset by this activity. She had considered a termination but as she had no idea that Social

Services would remove her daughter she went ahead with the pregnancy. She did not know of their decision to remove (L) until after the baby was born. Whilst we appreciate that the decision was taken in the best interest of and perhaps safeguarding the child, the effect of removing baby (L) in this manner must have had a detrimental effect on Ms X .

16 September 1999 A Child Protection conference was held, at which Ms X 's eldest daughter's name was removed from the register as she was now the subject of a Full Care Order. (S) was subject to a Final Hearing in October and would remain on the register. (DM) was no longer living with Ms X and she had a new man in her life providing support to her, Mr S who was a friend of (DM).

20 September 1999 Ms X informed the CMHT that over the weekend (DM) had cut himself and set fire to the bathroom and smashed up the flat, including her computer which contained all her legal matters. He was duly arrested, charged with Arson with intent to endanger life and criminal damage and held in custody.

24 September 1999 CPN) 1 and SW 3, who had taken over from SW 2, visited Ms X at home. Ms X, with support from her friends, was willing to comply with any treatment and seeing her baby with social worker supervision.

4 October 1999 The Court proceedings in respect of Ms X 's daughter (S) took place. Her Consultant Psychiatrist attended but was not asked to give evidence. The Consultant Psychiatrist who completed a court report following discussion with her Consultant Psychiatrist in which he confirmed that Ms X was suffering from a personality disorder, the precise subdivision somewhat difficult to define. He also stated that in his view it would be safe to reunite Ms X with (L) in a residential unit with staff on hand. However in a letter to a social worker, he stated

> *" there remains doubt in my mind whether Ms X is really abstinent or not. This would affect her motivation to comply with her treatment. It is a matter for the court to decide whether she is abstinent or not. Her Consultant Psychiatrist agrees with me that the prognosis is poor if she really is drinking despite her denials. Bearing in mind her past tendency to discharge herself or to be discharged shortly after being admitted to hospital this suggests that she is unlikely to remain in a therapeutic institution very long especially one that requires individual to take personal responsibility for themselves. Personally I doubt that she will stay the course at the therapeutic institution long enough for any therapeutic benefit to be obtained let alone a "cure". …. For cognitive therapy to work the patient has to define certain problems which they hope to work on and find solutions to. If no problems can be defined then therapy is unlikely to move forwards. ……*
>
> .
>
> *Conclusions*
>
> *I personally believe the prognosis to be poor. I doubt she will get as far as being admitted to a therapeutic community and if she does I think she won't stay there long enough to change significantly. Change is hard to measure, but one would need to sustain long term abstinence and acknowledgement of the problems (insight) and to demonstrate consistent work on changing the personality. I personally doubt any of these goals will be achieved within a realistic time frame. If DM resumes his relationship with Ms X then matters can only get worse and the chaos will*

> *continue….. I hope I have represented the views of her Consultant Psychiatrist fairly, he retains a greater degree of therapeutic optimism than I. He knows Ms X better than me, but maybe does not have the advantage of distance in looking at the stark realities."*

Ms X came to the view that *"he is in league with social services"* when she discussed this report with CPN 1 and SW 3, who were visiting weekly.

8 October 1999 CPN 1 and SW 3, saw Ms X at home when Mr S, Ms X 's friend, was present. Ms X was offered a one bedroom flat but turned it down because there was not enough room both for her and the children. She wanted a house with four bedrooms and a garden.

14 October 1999 Ms X was reported as making abusive telephone calls to her ex-husband's partner and their children. Ms X was reported to look tired and frail, not taking any medication and because of her behaviour there were doubts about her drinking.

20 October 1999 A CPA meeting was held when CPN 3, SW 3, her Consultant Psychiatrist a third SW, and Ms X with her solicitor were all present. The agreed plan was for her to see CPN 1 and SW 3 every two weeks, to see her Consultant Psychiatrist as required and to attend a psychology session with a Clinical Psychologist. A further CPA meeting was arranged for 15 December.

1 November 1999 The Court psychiatrist had had the opportunity to read more papers and wrote to the Local Authority:

> *"..an inconsistency over what Ms X told me, that her last drink was apparently in April 1999. Her Consultant Psychiatrist said it was in July and according to the papers on a home visit 25 October 1999 there is a suggestion that Ms X is indeed drinking more than she admits to and that she does indeed continue to drink to the point of drunkenness and her drinking is apparently not under control, as Ms X suggests…. I think she would need to attend a residential establishment for a period of six months in order to begin to achieve the lifestyle changes necessary. She would need to be there on her own and without baby (L), at least for the first few months so that she could concentrate on her own needs and difficulties, which is where the problem lies rather than splitting her attention between her own therapy and childcare which would prove a distraction to the work that needs to be done……. I think she needs to be in a therapeutic community because frankly seeing a therapist once a week for a few weeks or months is unlikely to create the necessary change in her deep rooted personality disturbance"*

The clinical psychologist also assessed Ms X and concluded that psychological therapy would be inappropriate and unlikely to benefit Ms X at that time. She also said

> *"however it is quite possible that her problems are long standing ones rooted in her personality and emotional functioning, and that with different life events, she may continue to experience dramatic fluctuations in her ability to cope with life. Should you feel that under changed circumstances she would be more likely to benefit from and engage in therapy, then please feel free to discuss….."*

15 November 1999 Ms X received a letter from the Housing Department explaining that she could participate in a mutual exchange of property.

18 November 1999 Her Consultant Psychiatrist wrote to GP 4, Ms X 's GP stating that Ms X was a:

> *"model patient now, professing to be entirely normal and free from alcohol. She is of course desperate to get her baby back and will do anything to achieve this end. The court case was postponed whilst further assessments took place as to her 'stickability' of her road to Damascus conversion. The social services might return her child to her if she completed successfully a period in a therapeutic community at least part of which would be with her baby if it were possible to arrange this. Social services would not readily help fund the Cassel which is a shame but would do so if ordered to by the judge".*

19 November 1999 A Consultant Psychotherapist, assessed Ms X and reported that Ms X could be the sole carer of her daughter only if she went into a residential unit such as the Cassel, where she would be observed under supervised conditions as well as allowing for psychotherapeutic treatment to take place.

26 November 1999 Her Consultant Psychiatrist referred Ms X to a second Consultant Psychotherapist at the Cassel Hospital. The reason given for the admission was pressure from the Court for a decision as to whether Ms X was a fit mother, and her ability to care for her baby. He sent various reports and informed this second psychotherapist about Ms X 's presentation since 1996, when he first saw her with PTSD (post traumatic stress disorder). He painted a picture of chaos until April 1999 when Ms X changed for the better and curtailed her drinking. She was on her own as she was no longer with (DM) and her other daughters were in care. She had kept appointments and was believed to living a more stable existence. Her Consultant Psychiatrist finished by saying:

> *"There is no doubt that she minimises the trouble she had before her road traffic accident but nevertheless her behaviour has changed, I find her rather a engaging personality with a degree of warmth who even according to the Social Services is a good mother and whom I think does deserve some inpatient assessment before deciding on the issue as to whether she should be allowed to resume full time care of her baby".*

15 December 1999 A CPA meeting was held and present were CPN 1, her Consultant Psychiatrist and Ms X with Mr S . Apologies were received from a SW. Home visits from CPN 1 and SW 3 were to continue and a further meeting arranged for 17 January 2000

2000

2 February 2000 A CPA meeting was held with SW 3, her Consultant Psychiatrist and Ms X. CPN 1 and a SW gave their apologies. A very comprehensive plan was agreed, noting problems under specific headings and all the agencies responsible for taking any action. These were, the CMHT, Cassel Hospital, Woking Housing Department and the other professionals not at the meeting. Following this meeting, Ms X was so keen to attend the Cassel Hospital that she tried to borrow £500 to pay for the assessment. She was supported by home visiting and was not thought to be drinking. Ms X was concerned about her safety as (DM), had threatened suicide and she was also appearing as a defence witness. It was at this time that Ms X and Mr S became friends, and he was thought to have moved in as a lodger taking some responsibility for Ms X 's care.

13 March 2000 The second Consultant Psychotherapist at the Cassel Hospital, assessed Ms X . He offered a 6-8 week initial assessment with twice weekly individual therapy sessions as well as a group weekly meeting. The assessment would cover both her personality difficulties and her mothering skills. In addition he wrote a detailed report to Ms X 's solicitors.

30 March 2000 A guardian ad litem, completed her Court report and concluded that this was not a case in which returning parental responsibility to Ms X , with either no order or a supervision order, was in the baby's interest.

18 April 2000 The Court psychiatrist wrote to the second psychotherapist in support of Ms X 's assessment at the Cassel Hospital with reservation that a further assessment would delay a decision about baby (L)'s future. He acknowledged that since his original involvement there had been an improvement in Ms X 's drinking and behaviour, which had altered his original position quite considerably.

27 April 2000 The Director Mental Health and Specialist Services, wrote to the directorate manager, at the Cassel Hospital, confirming that the Trust would fund Ms X 's and her baby's treatment and care for the 42 days of her stay as the West Surrey Health Authority was not prepared to pay for the treatment costs.

9 May 2000 Ms X was admitted to the Cassel hospital in the care of the second psychotherapist. Ms X settled well making relationships with other patients. She found it difficult to become involved with some of the groups discussions, possibly because she unlike other patients did not have her baby with her. Staff were concerned that as Ms X did not experience the usual day to day demands she would present more positively and wished that (L) could spend more time with her mother.

10 June 2000 Ms X went home on home leave. Ms X and Mr S had been drinking. She alleged that Mr S, with whom she thought she had a platonic relationship, made sexual advances towards her. She called the police and he was arrested. He was later bailed not to go anywhere near Ms X 's flat. Ms X went to hospital and was treated for bruising to her face and a painful wrist as her arm had been twisted behind her back.

Comment

This matter was still outstanding at the time of his death

16 June 2000 The second psychotherapist wrote a detailed report for the Court in which he said he and the staff at the Cassel Hospital felt that it was important to admit baby (L) with her mother for a further six weeks assessment. Although there were positive indications about Ms X 's capacity to look after (L) in the long term, it was felt that these needed to be tested out. He also commented on the incident involving Mr S :

*"**……..** it would be quite wrong to make too much of it because the evidence is that the man who beat her up was known to Social Services and other people and it is a great shock to them he did this. At the same time it would be wrong to make too little of it because, after all, it had been in the past a pattern for Ms X to get involved in violent episodes. What we can say from the assessment so far is that there has been a shift from her initial denial of difficulties to want to look more at issues and to want to face her ambivalent feelings more openly, rather than deny them. ….My overall opinion is that there is a better than 50/50 chance of rehabilitation succeeding. However we have to have L in hospital for us to come up with a firm recommendation."*

The court psychiatrist commented in his report dated 16 June 2000: *" we therefore have to assume that either Ms X associated with a potentially violent man again as is the pattern in the past without being aware of it, or that she had the ability to turn a meek and mild man into a seriously violent person".*

21 June 2000 Ms X was discharged from the Cassel Hospital. Initially Ms X was keen to participate but as time moved on she claimed to be concerned about the level of aggression displayed by the other mothers and the effect on her baby. Staff concluded that this was probably a defensive response to her own level of aggression, although Ms X denied this. A referral to the Henderson Hospital was discounted as Ms X could not have her baby with her. Ms X had stated in Court that although she was frightened to return to the Cassel Hospital she would return if necessary. However this was no longer an option. There were serious doubts about Ms X 's drinking behaviour.

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6 August 2000 (DM) broke into Ms X 's flat. A neighbour stated that they heard a lot of shouting and noise including: *"help me she's stabbed me after all the support I have given "*. Other neighbours said that when they went to help him, Ms X stepped over him and went to catch a bus saying: *"He got what he deserved this time. You must have heard him beating me up"*. The police were called and (DM) was found at the bottom of the staircase, bleeding with his arm wrapped in a shirt. Ms X apparently telephoned Mr S who advised her to go out. Ms X 's version was quite different. (DM) was supposed to have said: "*if I can't have (L) no one else will*", produced a knife, cut himself in the stomach and fell down the stairs. She said she had gone to buy cigarettes and found him on her return.

A couple of days later the senior housing officer, wrote to Ms X informing her that legal action could be taken against her for breaching her tenancy agreement. He also wrote to the

CMHT co-ordinator, stating that the residents wanted Ms X *'out'* and there was a possible vigilante and siege situation. The Housing Department obtained an injunction against (DM) restricting him from entering Ms X 's property.

7 August 2000 Court proceedings took place, which completed the Local Authority Care proceedings that (L) would be adopted.

8 August 2000 Ms X was admitted to Blake Ward using Section 5(2) MHA 1983 to prevent her from leaving the Ward. She was very angry, unco-operative, refusing to remain in hospital and feeling hopeless. Later that evening Ms X was transferred to Laureate Ward, a locked low secure facility, for closer supervision.

10 August 2000 Ms X was seen by her Consultant Psychiatrist and Section 5(2) MHA 1983 was rescinded. He also agreed that Ms X could go home on weekend leave. She was to return to the Ward on 14 August to see the doctor, but failed to arrive. She was staying with Mr S and did not see the need to attend the ward round on 16 August as her Consultant Psychiatrist was away, and so Ms X was discharged but was later allowed to spend the evening on the ward.

4 September 2000 Ms X attended AED with superficial laceration to her arm. She felt frustrated because Social Services kept changing the arrangements for her to see her children. Two days later, Ms X telephoned the police as Mr S was causing a disturbance at her home. She sounded intoxicated.
Her Consultant Psychiatrist returned from holiday. 8 September.

20 September 2000 SW 3 saw Ms X at home visit following a telephone call from her as she had been drinking. During the visit, Ms X spoke in a child's voice and said *"She wanted to die*". She appeared to hear things that were not there and threatened to take all her medication as well as Paracetamol. Ms X agreed to an admission to Blake Ward. Once on the Ward she was angry, swearing, hysterical and physically aggressive to staff. She was upset because she had said goodbye to (L). For the last two weeks Ms X had been drinking a bottle of vodka daily. Ms X stayed a couple of days.

Comment

Ms X could not be considered for an assessment at the Henderson Hospital because (DM) was an inpatient there.

25 September 2000 Ms X took an overdose of Propranolol and was assessed by her Consultant Psychiatrist in AED. She was discharged to attend the day hospital on 28 September, but she did not go as she did not feel well enough.

11 October 2000 Ms X fell over and broke her nose.

2 November 2000 Ms X was distressed and threatened to jump off Toys R Us.

17 November 2000 Ms X was admitted to Windmill House. She had started drinking again, a bottle of brandy a day to '*kill the pain'*. Ms X attended Cognitive Behavioural Therapy (CBT) sessions but was not allowed to join the other groups which upset her. She also

thought she was staying in the unit until Christmas and as she was unhappy with this decision decided to leave that evening.

2001

11 January 2001 Her Consultant Psychiatrist wrote to GP 4 informing him that Ms X , although she had said she would attend, did not keep her appointment with him. He said:

> *" I fear she is drinking again and behaving unreliably. She obviously continues to be at risk but attempts to help her get to the root cause of her problems unfortunately she has undermined repeatedly".*

17 January 2001 Since leaving Windmill house, Ms X had not been in contact with anyone and admitted she was drinking a bottle of vodka daily. A new key worker, CPN 2, was allocated and Ms X agreed to see Consultant Psychotherapist.

Comment

CPN 2 never saw Ms X. Ms X did not keep any appointments and the following month CPN 2 was transferred to another department in the mental health directorate.

28 January 2001 Ms X and Mr S had an argument resulting in her locking herself in the bedroom. He damaged the door with a hammer and broke a window.

12 March 2001 Her Consultant Psychiatrist went on annual leave and a locum consultant psychiatrist, was appointed in his absence. Her Consultant Psychiatrist 's secretary rang the CMHT to say that Ms X had telephoned and was threatening to take an overdose. Mr S confirmed that she was unhappy because (DM) had a new girlfriend. He also telephoned the police saying he was worried about Ms X .

13 March 2001 CPN) 4 and an HV visited Ms X and referred her to Blake Ward for an assessment and admission. Ms X had no interest in herself or her environment. Three days after her admission she was given leave to see her daughter. As there was a possibility that Ms X was pregnant, the DAT were contacted to give advice about a detoxification programme. Ms X attended two sessions with clinical psychologist 1 but cancelled three more.

19 March 2001 During the ward round Ms X was found standing on a window ledge with a noose around her neck complaining of feeling anxious and depressed. She was put on 15 minute observations. She also asked to have a female CPN.

21 March 2001 Ms X left the ward against medical advice and on 23 March at 17.00 hours Mr S telephoned to say that Ms X would not return. She was discharged from the ward to be reviewed by the CMHT the following day.

28 March 2001 Ms X was seen at AED having taken an overdose of 10 tablets of Venlaflaxine 75mgs, eight Paracetamol tablets with alcohol and lacerated her left wrist. She apparently was interrupted by a telephone call and was not sure whether she had taken enough to kill herself. She said: *"I just wanted to sleep and if I go home I shall do it again"*. Ms X gave (DM) as her next of kin. On examination she was very agitated and aggressive

and thought to be suffering from post natal depression. She was very thin and unkempt and appeared timid. Ms X blamed this latest episode on the fact that her relationship with (DM) had broken up a month previously. He had been making threatening phone calls regarding his intention to gain custody of their daughter. She expressed no regrets about taking the overdose. Ms X wanted to be in hospital and agreed to an informal admission on Blake Ward.

30 March 2001 Ms X left the ward with a friend. When she telephoned she was told that if she did not return she would be discharged. She had gone out to pay some bills, but learnt that one of her daughters had had a hockey accident and she could not get back from the other hospital. She telephoned again making threats because she was going to be discharged and said "*In that case I shall take another 10 Paracetamol and you will have to admit me through AED"*

31 March 2001 Ms X was discharged as she did not return after her leave as agreed.

4 April 2001 Ms X attended the GP surgery having had a miscarriage. The GP telephoned a senior house officer who said he would not accept her back as it was pointless as she would discharge herself. Ms X was told to telephone the emergency 999 if she had any problems.

11 April 2001 The locum consultant psychiatrist visited Ms X at home along with an ASW. She agreed to an informal admission with a contract and a detox regime, to Blake Ward the following day. A Staff nurse was allocated as the named nurse and completed the risk assessment on which she noted '*amber'* against '*severity, immediacy and Volatility to self*' and wrote '*never been risk to other'*

16 April 2001 Ms X left the ward with a friend, who telephoned later that evening to say she was upset and did want to return. She was advised that she would be in breach of her contract. Ms X was granted daily leave, which went well. On 20 April she was due to see her daughter (S).

29 April 2001 The police were called to a disturbance in the street outside Ms X 's house between her and Mr S . He was in breach of his bail conditions and was arrested. Ms X did not return to the ward and so, following a discussion with the locum consultant psychiatrist, she was discharged.

24 May 2001 Ms X telephoned the police saying she had been raped.

Comment
When the police interviewed her about this, she refused to give a name or any other information, which made it difficult for them to pursue the matter, but neither did they arrange for her to have a medical examination to collect evidence.

Ms X had earlier called a taxi driver who dropped her off at the car park of the Toys R Us building and threatened to throw herself off. Ms X was taken to Blake Ward by the police using Section 136 MHA 1983 and admitted as an informal patient. The police informed her that if she wished to make a complaint about the alleged rape then she should contact the police.

Ms X was placed on 15 minute observations, with an agreed contract for her behaviour, was prescribed Diazepam as required to deal with any withdrawal symptoms and was told that if she discharged herself it would be against medical advice. The staff nurse was her allocated named nurse, who on completing the risk assessment, recorded Ms X as being '*medium'* risk of suicide and that she should be managed as 'Enhanced CPA'.

As often happened, Ms X soon wanted to go home as she was bored in hospital. It was agreed that she could have home leave on 26 and 29 May but during the day only. Her Consultant Psychiatrist referred her to a work-based programme for the mentally ill trying to gain employment, known as 'Project 18'.

28 May 2001 Ms X went on leave and spent the day with her daughters at Thorpe Park. Her Consultant Psychiatrist saw Ms X on 4 June at the ward round. She said she was feeling much better, although the ongoing court case, the adoption of her youngest daughter and harassment from (DM) were all contributing to her possible inability to cope. The plan was for Ms X to go home on leave for one week and return for the Ward round. She went home on leave as planned, but later rang the Ward to say that she was anxious about being on her own. She was advised that she could return to the Ward. She did not, and the following night rang again still anxious about being on her own, although on this occasion she told staff about her engagement to Mr S. Again, she was advised to return but did not.

8 June 2001 Ms X telephoned the Ward at 04.00 hours. She was very depressed, was not drinking but needed help. During the following night the Police telephoned the Ward at 02.30 hours to say she needed admission and a bed on Clare Ward was prepared for her. Ms X telephoned at 05.00 hours to say that she did not want to be admitted to Clare Ward and so she did not return. She did not attend the ward round as arranged on 11 June. She was contacted on 12 June and she said she was unwell and not looking forward to the meeting on 14 June when she was meeting (L)'s adoptive mother and would have to say goodbye to (L). She requested admission, but as she would have to sleep on Clare Ward she, declined to be admitted.

14 June 2001 Ms X contacted the Ward at 18.00 hours. She was very tearful, requesting medication, and agreed to return to the Ward that evening. Mr S took her back to the Ward at 22.00 hours. Ms X spent the next day mostly sleeping. Two days later Ms X went out with Mr S in the morning and was due to return for the Ward round on 18 June.

At 17.00 hours on 16 June Mr S rang the Ward and spoke to a healthcare assistant, and said that Ms X was unwell. He was advised to bring her back and he said he would arrange transport. Ms X telephoned at 19.00 hours and spoke to the healthcare assistant. She wished to speak to the staff nurse, who was not on duty.

17 June 2001 Ms X telephoned the Ward at 09.00hours and spoke to the healthcare assistant telling him that she had bought some tablets and he advised her to return to the unit. She telephoned again at 10.30 hours and spoke to an, enrolled nurse, but in fact wished to speak to the charge nurse. He was busy at the time and he advised the enrolled nurse to explain this to Ms X and encourage her to return to the Ward. During Ms X 's conversation with the enrolled nurse she said, *" this is serious, this is murder, I've done something"* She was advised to return, but Ms X said she could not as she was with the police. Ms X telephoned again wanting to speak to the staff nurse who was not on duty. She also spoke to a fellow patient, on the ward payphone, telling her that she had done something awful and was going

to take an overdose. This same patient some time later telephoned Ms X 's home and spoke to a police officer.

12.26 hours Ms X telephoned the Surrey Ambulance Service and reported that she had gone home and found a man dying in her flat. She said he had been stabbed lots of times, was not breathing and was unconscious.

At about 12.30 hours five police officers arrived at the Abraham Cowley Unit. The acting Detective Sergeant indicated that there had been a stabbing and that they believed it involved Ms X and that they were looking for her as they were concerned for her safety. Whilst the charge nurse and the police were viewing the CCTV video tape from the day before to identify the car registration number of Mr S, Ms X arrived in the reception area of the Abraham Cowley Unit. The charge nurse spoke to her as she walked towards the smoking room of Blake Ward. She was dishevelled and smelt of alcohol. She said *"I've done something awful, J… is dead I am going to prison for twenty years"*. A female patient went up to Ms X and spoke to Ms X for a few minutes before returning to the Ward. Ms X continued to walk down the corridor and asked if she could use the toilet. She went on to say "*he tried to rape me, look"*. She pulled up her sleeve and showed the charge nurse her right wrist, which was bruised and another bruise on her right knee. She said: *"I got a knife, I stabbed him, I don't know if he is dead. I'm not going to prison. I've got lots of tablets in the car. I am going to leave. I'm going to kill myself*". The charge nurse accompanied Ms X to the first toilet on the Ward. Ms X asked the charge nurse not to call the police.

The police moved to the toilet area, and as Ms X came out she was arrested, handcuffed and escorted from the unit at 14.15hours. The charge nurse telephoned the oncall manager, nurse manager and the clinical nurse specialist. Her Consultant Psychiatrist could not be contacted.

Chapter 4

Ms X's Mental Health and Physical Health Presentation

By the time Ms X moved to Surrey the key elements of her mental health problems were well established, as was her pattern of involvement with services. There was already a history of heavy misuse of alcohol, problems with unstable mood, repeated overdoses, a suggestion of other problems, including chronic fatigue, and underpinning it all, evidence of personality dysfunction. The most obvious features of personality dysfunction at that stage included a history of intense unstable relationships, impulsivity, instability of mood, and uncertainty about her self-image. She already had a pattern of self-discharging from inpatient care, readmission, and repeated disengagement from services.

There were significant difficulties in providing care and treatment for Ms X. The complex mix of problems that she had would severely test any mental health and social care services. In addition there were other factors, including her skill in controlling the passage of information between agencies, partly due to her concerns about childcare issues. She was able to draw on concerns regarding confidentiality to this end. There were no available and reliable sources of collateral information regarding her background and past and present conduct. Previous partners (JH and DS) were in the North of England, and current partners in Surrey (DM and JS) had their own agendas or were unreliable. Ms X had little contact with her adoptive family. She herself was not a reliable source of information regarding her use of alcohol, her relationship with (DM), and most importantly her use of violence. These difficulties were compounded by systems of parallel care, intra- and inter-service communication, and a plethora of different case-notes, as discussed elsewhere in this report.

Although there are limits to the value of mental health diagnoses, they are an essential guide to understanding, managing and treating patients. In the case of Ms X the value of a multi-axial approach cannot be over-estimated as it helps to avoid focusing on one problem to the exclusion of others, and may help in understanding the interactions of several problems. In other words, one needs to consider the nature of her mental illness, important personality factors, the misuse of substances, the nature of her medical and social problems, and the interplay of all of these. As previously noted Ms X has an emotionally unstable personality disorder. The International Classification of Diseases (ICD- Version 10) defines this condition as follows:

> *"A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control. In the Borderline sub-type several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense*

> *and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).”*

Unstable moods are a key feature of the disorder and are frequently unresponsive to drugs such as anti-depressants. In addition, and importantly, such individuals are known to be very changeable, manipulative, inconsistent, and liable to involvement in intense and unstable relationships. They may be found to be charming by some staff but they are often found to generate tensions and misunderstandings between members of staff groups and/or different organisations. There is good evidence of Ms X conducting herself in this way, and of organisations responding. Such individuals have a fluctuating capacity to cope with ordinary life situations. To add to this Ms X was ambivalent about accepting care, possibly due to her early experience of adoption and her unsatisfactory relationship with her adoptive family. At one end of the scale therefore she would want inpatient care and then without any real resolution of her deeper problems she would insist on her capacity to cope and leave the Ward.

Some of the features of an emotionally unstable personality would tend to predict the risk of violence including the intensity of relationships, their characteristic instability, and intense anger associated with poor impulse control. Whilst professional staff did consider Ms X to have a personality disorder their conceptualisation of her problems, and response to them did not always take full account of that disorder. Some at least of the problems between different organisations may be attributed to Ms X’s capacity for “splitting”. Some of the staff we interviewed indicated to us that they did not really understand the nature of emotionally unstable personalities. That lack of knowledge made their task more difficult.

Since changeability and inconsistency is at the heart of an emotionally unstable personality, each apparent change or improvement should be seen as a temporary shift and not necessarily as the beginning of a sustained improvement until there really has been one. There is a recurring theme of unfounded optimism to be found in the case-notes. At times Ms X is described as “*a model patient*” or even according to Social Services “*a good mother*.” There is a reference to a “recent history of instability” when in reality the history of instability was enduring, and the pattern of stability and instability was **the** continuing pattern, and was in itself a problem. Rather than seek to understand and predict how Ms X might in part create her own circumstances she was seen by services as a victim of circumstances, with a suggestion that if only those circumstances were less adverse all would be well. For example there was a history of relationships with violent and abusive men. If one man left or one particular relationship ended it did not mean that the abiding problem had been resolved. Given this history greater curiosity about her relationship with Mr S might have been advisable.

Ms X also had longstanding problems with alcohol. These were persistent, although her use of alcohol possibly decreased during her pregnancy with (L). Such use of alcohol exacerbated and interacted with her personality difficulties and low mood (alcohol is a depressant drug). Attempting to regard any one of these as primary was probably unhelpful, and trying to treat them separately was also unlikely to succeed. Parallel services for substance misuse and other mental health problems are discouraged by the recent Department of Health Dual Diagnosis Good Practice Guide which states:

" The parallel model (of service delivery) implies the concurrent but separate treatment of both conditions. This approach can also be problematic since it may require the individual to attend different services and engage with different therapeutic structures and approaches."

The Guide goes on to support an integrated model in preference, by which is meant the same staff member or clinical team, working in a single setting, providing relevant psychiatric and substance misuse interventions in a co-ordinated fashion.

Ms X's other mental health problems including references to chronic fatigue, PTSD and agoraphobia were not persistently complained of by her, and probably only served to complicate and confuse the picture. On two occasions the case notes refer to possible episodes of psychosis although these were probably due to acute intoxication with alcohol. Ms X also suffered from several medical conditions including damage to one eye in a road traffic accident, anaemia due to Vitamin B12 deficiency, and the removal of one kidney, which was discovered after, but not caused by the accident. These problems were significant and added extra burdens to her, and further complexity to her care.

Ms X had particularly difficult and persistent problems. Services responded with remarkable patience and support, and determination in the face of little improvement. An extensive range of interventions was offered although this was not always well co-ordinated or effective at addressing issues of risk. Many mental health services, faced with a similarly complex and difficult set of problems, would have adopted a more dismissive or rejecting stance.

The care offered was however geared towards the management of crises, with less focus on a longer-term strategy. There was an implied goal of long term 'recovery' rather than a focus on providing forms of care to compensate for Ms X 's own abiding difficulties. These points will be discussed further below in the Section dealing with CPA and Risk.

Childcare services, however, were detached from the question of care for Ms X, and hence saw her difficulties from the perspective of the children. They were better able to make hard headed assessments of the consequences of her problems.

In the absence of a longer-term strategy a pattern developed of Ms X using the service as she pleased, for example coming and going from the Ward seemingly at will.

Chapter 5

West Surrey Mental Health Services

The mental health specific services available to Ms X were extensive and included:

- Mental health services based in the In-patient Abraham Cowley Unit, on the St Peters Hospital site in Chertsey. The main Ward accessed by Ms X was Blake Ward
- The Community Mental Health Team at Bridgewell House, Woking. The CPNs who were her keyworkers were based here.
- Drug and alcohol services from the Windmill Drug and Alcohol Team, on the St Peters Hospital site in Chertsey. This service had been commissioned since 1998.
- The Day Hospital on the St Peters Hospital site in Chertsey
- GP practices based in Woking, some offering a patch based mental health service.
- The Crisis Response Team based at Bridgewell House
- Psychotherapy Service based at St Peters Hospital, Chertsey
- Psychology Services based at St Peters Hospital, Chertsey
- Project 18 - a mental health employment service.
- The Cassel Hospital.
- The Surrey Emergency Duty Team (out of hours ASW service)

Services

The mental health service philosophy, at the time, was that of a developing community mental health service with the majority of social workers and community nurses being based in the community team. There was however a strong cultural element of a focus on in-patient services and developing patch based services in a few GP practices. Mental health services in West Surrey had derived and developed from the now closed Brookwood Hospital.

Drug and Alcohol services were a recent development from 1998 and were based on an in-patient facility with a community team. Both psychology and psychotherapy are separate services from the mental health services.

In December 1998 in a report entitled 'Explaining Mental Health Spend in West Surrey' Edward Peck and Tessa Crilly, concluded that the high comparative spend on mental health services locally was due mainly to the legacy of high cost solutions for the resettlement of long term patients from the now closed Brookwood Hospital, whose needs were being more than met.

This report also noted local suggestions that drug and alcohol misuse represented a disproportionate problem for mental health services. The findings of the report however was that only 18 percent of all episodes were attributed to substance misuse as compared to 15 percent in another report prepared by the Sainsbury Centre covering comparable areas.

The Inquiry Team were informed that at that time, the inpatient unit at the Abraham Cowley Unit experienced management problems in relation to drugs and alcohol on the Wards and did not have a Ward alcohol policy. Staff also identified 5 areas of concern. These were:

- Lack of definition of the needs to be addressed by the crisis/out of hour services and, therefore, lack of consensus about the appropriate service response
- Lack of effective assessment (gate-keeping) prior to admission
- Lack of integration and of communication between entry points into services (especially for patients with dual diagnosis)
- Lack of spectrum of care (e.g. crisis intervention, housing)
- Lack of resources to respond to crises outside hospital

Some progress has been made in the intervening years as demonstrated by the range of services available to Ms X but even so, the services offered to her did not appear to be always integrated or co-ordinated.

Progress to integrate and co-ordinate the service appears to have been further delayed by management changes despite some staff having an emerging vision for a 'whole service'. This has continued following the merger of the Ashford service and local mental health services finally into the North West Surrey Mental Health Partnership NHS Trust.

Comment

There are still some services that are not yet developed with a degree of service fragmentation. The Inquiry Team noted a lack of a coherent and overall vision for the mental health services.

The Inquiry Team was informed of the work going on in relation to the 'Corporate Objectives 2002/3 for Adult Mental Health Services'. This document includes several actions relevant in this case, including for example:

> *"Ensuring that people with drug and alcohol problems and mental health problems are properly targeted and supported…."*
>
> *"Ensure that all services work to a model of crisis resolution/home treatment… ."*

The Inquiry Team supports the work in the development of these corporate objectives and acknowledges the workload implied in the action resulting from them. Work in this area will no doubt include the development of relevant care pathways as discussed in the National Service Framework, the Dual Diagnosis Good Practice Guide and the National Treatment Agency for Substance Misuse Models of Care.

Comment

The Inquiry Team was not given, and there does not appear to be, any overarching strategic document that describes the totality of local mental health services including its philosophy. Such a document would be useful to those using the service, the staff within services and for planners in the development of future services.

The Inquiry Team has concluded that special consideration is required for those who have multiple needs with a co-morbidity of personality disorders, mental health problems and alcohol and/or drug problems. In such cases there are often other complex and complicating factors, such as income, childcare needs, relationship and family problems, all of which require conflicting attention at times.

Case Records

The organisation of the case records in the mental health services exemplifies the separateness of parts of the service from others. The main clinical notes were and are kept in the Abraham Cowley Unit with separate notes kept by the nurses on Blake Ward. The Community Mental Health Team kept a completely separate set of case files. The DAT workers used to record on separate notes but practice for the last few years is to record on the main set of notes.

Due to Ms X 's frequent contact with services a mass of recording had built up in a very short time but held in separate locations.

Comment

Four things may have helped in relation to the records.

- **A single integrated set of case notes separated in simple agreed Sections for ease of consultation.**
- **Electronic records containing details of admissions and risk factors which were accessible to all staff involved.**
- **Detailed case summaries on complex cases with frequent admissions.**
- **A method of flagging up risks within the case in an easily accessible format in either a paper or electronic format.**

An aggregation of the significant factors may have helped the mental health professionals see the wood from the trees. This could have been in the form of a summary social and clinical history containing detail of family history including significant childcare events, admissions, diagnoses, violent incidents, other crisis factors, and risk assessments including other patient management issues including her pattern of absconding or not returning from leave. More significantly such a summary might also have led to a longer-term therapeutic plan rather than that of crisis management and demonstrated the greater need to work more closely with those responsible for making decisions about child protection.

An electronic record system was described to the Inquiry Team – although the evidence we received is that reliance on these alone might be difficult.

Had there been an appeal or Mental Health Review Tribunal then a social circumstance report may have been required. Such a report would have been prepared using the Mental Health Act Commission guidelines. Even so it would not have been expected under those guidelines for the full case history to be summarised and so the total picture of admissions and violent incidents may not have been known even then.

Comment

The Inquiry Team is of the view that a case summary would have been helpful to those involved in the case. This is because the case was volatile, involved several agencies, several admissions, a high degree of violence and threats of self-harm, and with dual diagnosis to the fore. Such a case summary/history would have enumerated the totality of admissions and the level of disturbance accompanying some of these. In addition the elements and impact of different agencies in relation to the whole family may have emerged as issues requiring more and better liaison with childcare services.

Whilst acknowledging that such case summaries take more time than is often available the Inquiry Team considers that at minimum there should be a summary of previous admissions and detail of any violent or other serious incidents including self-harm. This would help admitting doctors and social workers responsible for making key decisions such as detention, risk, protection of self and others, and home leave to make an assessment against the history. In accepting that there are time constraints, a scheme to select only those complex cases to which guidelines on case summaries apply, could be developed.

Admissions and Discharge

The case notes contained many admission/discharge letters informing the GP's involved and the fax transmission records demonstrated good practice.

Psychiatric Workload

Her Consultant Psychiatrist, at the time, was managing a mix of Old Age and General Adult Psychiatry (adults of working age) workload beyond the Royal College of Psychiatrist norms which undoubtedly had different pressures of work, styles of working and types of problem that must have had frequent competing demands from him. There were examples when her Consultant Psychiatrist could not, and probably understandably, commit his time, but if he had, he would have been more able to provide a better standard of care. Examples of this were, his non-attendance at case conferences which was critical, and less critically, an occasion when an approved social worker was left for four hours before the Consultant Psychiatrist could join her for an ASW urgent assessment. In both of these examples, pressure of work and the need to attend to other patients was the reason advanced.

Blake Ward

The Inquiry Team visited Blake Ward to see the improved facilities since Ms X had been a patient and discussed with the staff one of Ms X's observations that with the previous layout staff were often inaccessible. We found that the layout of the Ward, although much improved, could lead to a situation that staff could be less available to patients if they congregated in the nurse's station. The bedroom areas could be made less stark and League of Friends or other such body could be invited, to provide a more homely setting with pictures, improved and brighter decoration with activities involving patients and volunteers thus bringing the wider community into the unit. We were pleased to learn that plans were already in hand for some of these improvements and we mean no disrespect to staff for commenting further in this report.

Home Leave

The murder of Mr S happened when Ms X was on home leave. The relevant policy covering informal leave was the Bournewood Community and Mental Health NHS Trust *"Informal Leave Procedure"*. This was a draft undated document (reference MP2) relevant to all informal patients who were being treated as inpatients within the mental health services. Its stated purpose is to ensure that leave from inpatient care is co-ordinated, monitored and appropriate as agreed by the clinical team involved in that patient care.

Responsibility lay with the "named nurse" or deputy:

> *".. to ensure that the clinical team considers leave from the Ward as part of the agreed individual's care plan".*
> *Where it has been agreed with the patient and team that leave is appropriate, the named nurse will work with the patient and others to ensure the leave process has taken place is* (sic*) a timely and therapeutic manner"*

The policy continues with the procedure. In Section 2.4 the policy states:

> *"A plan of what to do in an emergency is discussed with a patient (or carer if appropriate) and is reflected in the "Crisis Card" given to the patient"*

There is nothing on record to show that Ms X or Mr S was given a crisis card, or that there was a crisis plan, although both she and Mr S did contact the Ward and spoke to staff. Ms X in fact asked for her named nurse, who was off duty on the day of the murder. Both Mr S and Ms X were advised that she should return to the Ward, but in the event no further action was taken to ensure this advice was followed up. The staff's actions were in line with the stated policy.

Comment

The draft policy was insufficient as it did not give enough weight to the needs of the carer, in this case Mr S, who raised concerns about Ms X 's mental health before the murder. The policy does not outline sufficiently what staff should do if concerns are raised by either a carer, a patient, another agency or a member of the public or if the patient refuses to return on being given advice to do so. The policy does not specify who should be informed when concerns are raised or patients do not return from leave. Had her Consultant psychiatrist been informed at the time he may have asked for a mental health assessment or other follow-up action.

Drug and Alcohol Service

The Drug and Alcohol Team's (DAT) services accessed by Ms X were those of detoxification and relapse prevention. There is a good range of services available as described in a handbook, given to patients.

Ms X appeared to have good relationships with the staff she was in contact with in drugs and alcohol services, however she continued in her pattern of being in charge of the times of attendance. The DAT, in common with many other similar services, has a policy of mainly

dealing with patients when they are motivated. Those with mental health problems and/or personality problems often demonstrate little motivation. Motivational interviewing techniques are available and practised by DAT members.

We noted that there was one occasion when Ms X wanted to remain on the Ward and attend the various groups in the longer programme but as her admission was just for detoxification she was not allowed to stay. This may have been a missed opportunity to harness her motivation. However despite this admission, there was evidence of both serial and some parallel planning. There was at the beginning of her treatment a period when she could only be treated for alcohol problems if her mental health problems were sorted out and vice versa. When she was seen concurrently by both the mental health and drug services the DAT worker attended care programme approach meetings. Even so there was no evidence of integrated planning.

Clearly people with mental health and drug and/or alcohol are often less motivated and their lifestyles are often more chaotic. Special consideration is required to ensure that their needs are meet and that they achieve a sufficient priority for receiving services and do not fall between services.

In 1998 two senior staff in the Trust, made a study of seventeen reports of inquiries into homicides by mentally ill people, supported by the Alcohol Concern and Standing Conference on Drug Abuse (Now DrugScope) and published their findings as 'The Unlearned Lesson'. The report highlighted the contribution of drugs and alcohol to investigated homicides and recommended that, at both national and local level, mental health and drug and alcohol services should collaborate to develop better services for dually diagnosed clients. They however warned that this should not be at the expense of the wider drug and alcohol problem group who also faced shortages of provision.

Comment

There is no protocol, guideline or service plan to bring about an integrated approach between the two services, mental health and drug and alcohol.

Recent Government guidance on dual diagnosis includes the need to give dual diagnosis patients priority due to the predominant evidence of the effects of alcohol and drugs on effective treatment and the evidence of the part that drug and alcohol plays in homicides. The separate strands of planning in the Drug Action Team and the Multi-Agency Mental Health Partnership Group (MAP) should jointly consider the priority of these patients.

Housing issues

The Inquiry Team was impressed with the support and professionalism of the Housing Service offered to Ms X . Of necessity because of the problems of Ms X, her partners and her neighbours, this included both care and control elements. The Housing Oficer, who is now Area Housing Manager (East) and his staff, were extensively involved in Ms X 's case. He communicated well both verbally and in written form in a timely way with Ms X, the mental health and children's services and attended relevant meetings.

GP services as part of mental health services.

The Inquiry Team was made aware that one of the GP practices providing Ms X 's care was involved with the CMHT as part of the 'patch based' system. The importance of this system was differentially valued by staff and it appeared to have very little effect on the provision of services overall. It was unclear to us where exactly the 'patches' fitted in with the emerging vision of mental health services locally.

Recommendation

We recommend that the North West Surrey Mental Health Partnership NHS Trust, together with the Surrey Drug Action Team, ensures that a protocol and service model are developed between the drug and alcohol services and the mental health services in line with the Department of Health's Dual Diagnosis Good Practice Guide to develop an integrated model of service rather than the serial and parallel models as evidenced in this Inquiry.

We recommend that the North West Surrey Mental Health Partnership NHS Trust develops a protocol for the production of case summaries in selected cases to include criteria for the selection of relevant cases where there are several complex interrelating factors or agencies involved and an agreed proforma for the summary.

We recommend that the North West Surrey Mental Health Partnership NHS Trust together with the relevant Primary Care Trusts should review the activity, range and balance of provision, together with the roles and function of services including the 'patch based' system. The review should be integrated with the work of the NSF Local Implementation Team for Mental Health and integrated with the Corporate Objectives.

We recommend that the North West Surrey Mental Health Partnership NHS Trust review the Informal Leave Policy.

Chapter 6

Care Planning and the Assessment and Management of Risk

The assessment and management of risk is an integral part of care planning. This point is amplified by two recent publications. In the Department of Health document Modernising the CPA (D.O.H. 1999) it is stated *"risk assessment and risk management is at the heart of effective mental health practice and needs to be central to any training developed around the CPA"*. The National Service Framework for Mental Health states that local health and social care communities *"should focus on ensuring that staff are competent to assess the risk of violence or self-harm, to manage individuals who may become violent, and to know how to assess and manage risk and ensure safety"*. Care planning and risk are therefore discussed together.

The following comments relate to the situation at the time of Ms X's care and with respect to Ms X. There have been many changes since, some of which were in the process of being implemented at the time of the homicide.

In common with many Mental Health Trusts, the Trust was somewhat slow to develop and implement robust policies for CPA and Risk Management/Assessment. In our view the absence of nationally agreed procedures and assessment instruments has delayed the effective introduction of what are national policies to no discernible benefit.

There were problems with regard to training in the Trust. Not all staff received appropriate training with respect to CPA and Risk Management/Assessment policies, and we encountered some uncertainty as to the relevant policies and their implementations, as well as how to carry out a detailed and accurate risk assessment. Different professionals had different perspectives on the question of risk and risk assessment. There are benefits to be had by training staff from different disciplines together so as to share expertise and develop shared understanding of key issues.

There were problems with regard to the processes involved in the implementation of CPA and Risk management. It is noteworthy that members of the Inquiry Team had considerable difficulty in locating and collating the various care plan and risk assessment documents. We could not find any documented CPA meeting in the last six months before the homicide.

Keyworkers were relied upon to call meetings with no backup system to ensure that these were at regular intervals (e.g. a database of all patients for a particular keyworker or team). There was no system in place to monitor the quality of care plans or risk assessments. We encountered forms that were poorly completed, undated, and unsigned. There was too, no system for ensuring that completed plans were sent to all interested parties.

There were deficiencies with respect to the access to care plans. Care plans were not available out of hours e.g. via access to a computerised patient administration system which could for example include care plans and plans for the management of crises.

Ward rounds for inpatients were often used as CPA meetings. With care this approach can work, but there is a risk that such meetings will not fully include other agencies and other interested parties and therefore not result in truly multi-disciplinary multi-agency plans.

Ms X had been detained under Section 3 of the MHA (1983). She was discharged from this Section, but should have remained subject to Section 117 after-care, with regular reviews under Section 117 unless it was decided that she no longer required after-care. We did not find evidence of adherence to this policy.

There were inadequacies with regard to the documentation involved in CPA/Risk management. Risk forms need to capture information predating the last six or twelve months, unless there is a robust system for collating previous forms, and having them available to clinical staff. The forms currently in use in the trust are an improvement but it would be helpful if they included an item for recording the date of the last CPA meeting as well as the next one.

A more robust Information System is required for the Trust. Specifically a method of flagging up risks within a particular case in an easily accessible format would be helpful. Electronic records should be accessible to all relevant staff and they should contain details of admissions and risk factors. Such a system would have identified the many recorded violent incidents as detailed later in this report.

Ms X was an exceptionally difficult patient and the provision of her care and treatment was discussed in Chapter 4 'Presentation'.
A number of agencies were involved including different aspects of the mental health services. These agencies did not have the same responsibilities and priorities as one another. For all of these reasons it was important that there should have been regular meetings involving all interested parties. Ideally, these meetings should have provided a strategic overview and plan for the management of the 'whole' case, i.e. for Ms X, her children and/or her pregnancy, and her various related problems, including housing and substance abuse. Such meetings could have also served as 'network' meetings – i.e. to allow professionals to share information about their involvement and recent developments, not least of which would involve information about risk. Instead, meetings often involved only a small group of mental health workers. At times Ms X appears to have been allowed to dictate who would be present at meetings, and she would at times cancel such meetings. Discussions about care with the service user seem to have precluded other types of meetings taking place.

Ms X frequently discharged herself from inpatient care before any pre-discharge meeting could be called. The Trust does have a policy for arranging CPA meetings in these circumstances although it would be fair to point out that Ms X had often been readmitted before any such meeting could have been called.

Some of the key professionals dealing with Ms X told the Inquiry Team that they had a limited understanding of the nature of her mental health problems and how they could interact with, and impact on considerations of risk. Professionals working with Ms X should have provided more explanation and supervision to other colleagues as appropriate in order to facilitate better assessment and management of the case.

Clinical risk factors can interact with each other; several adverse developments may not only be cumulative. Risk in other words may be a dynamic process. In the case of Ms X, in the final months of her care prior to the homicide, she had a final meeting with her daughter and a miscarriage, she claimed to have finished her relationship with (DM), there was alleged violence and rape against Mr S, and she also claimed to have become engaged to him. Having

an understanding of the meanings, inter-relationships and possible consequences of these developments is crucial. There were in fact several other important events including repeated changes in keyworkers, having a locum consultant, and having four admissions to the Ward in the last 3 months. Staff appear to have failed to see the significance of these developments.

Professional staff in the mental health service did not consider all of the relevant risks.

There was a focus on Ms X's capacity for self-harm, with insufficient recognition of her capacity for violence to others. We have found in her case notes extensive information regarding her risk of such violence. There were some incidents that were ambiguous at the time and we are perhaps seeing them more clearly with hindsight. However, at the time of those incidents staff were too inclined to accept uncertainty. A concerted effort to clarify such incidents would have been preferable. Instead there is a sense in which staff can be seen to minimise such incidents and to neglect to consider alternative explanations. An example here is the alleged stabbing of (DM) and the remarks Ms X made to neighbours at the time. Community and inpatient Ward staff did not see the clinical risks in the same way due it seems to, inadequate sharing of information.

Mental health staff greatly under-estimated the negative consequences of Ms X's mental health problems and conduct on her capacity to provide adequate parenting to her children. A number of statements about her parenting simply fly in the face of what was clearly the view of the Child Protection Services.

There were limitations to the care plan offered to Ms X. This is not to deny the fact that she would often fail to take up the offers of help, would seek to control the involvement of various agencies, and not follow through an agreed plan.

Overall, the care plans offered seem to have focused on the management of crises, with less clarity regarding a longer-term overall strategy or plan to manage her out of hospital at times of crisis. As discussed elsewhere in this report, the care offered by some services was too inflexible, for example the limited range of psychotherapies available (e.g. DAT, and local psychotherapy services). From our reading of the records, we concluded that, the admission to the Cassel Hospital was arranged without a clear understanding by the relevant parties of the ultimate use of a scarce resource.

Also, as mentioned elsewhere in this report, the care offered was orientated to episodic dysfunction, rather than to compensate for Ms X 's abiding problems.

Care plans lacked detail with regard to potential risks, and what developments or changes would trigger a review of care.

In terms of the Carers Act (1995) the provisions of which apply to the CPA, Mr S should have been offered a carer's assessment by Ms X's care team but as far as we can tell this was not done. The National Service Framework has also emphasised the importance of carer's assessments.

Recommendation

We recommend that the Commissioners and the North West Surrey Mental Health Partnership NHS Trust discuss with the Department of Health the benefits of having nationally agreed procedures for CPA including Section 117 and risk assessment.

We recommend that the North West Surrey Mental Health Partnership NHS Trust ensure that there is a comprehensive multi-disciplinary training programme for all aspects of effective care co-ordination including the assessment and management of risk so that staff can fully share their expertise and understanding.

We recommend that senior mental health staff introduce network meetings in complex cases to stress the importance of and ensure close working with the Family Support team, child protection services and when relevant, other agencies.

We recommend that when mental health managers ensure a summary of the case together with copies of CPA and risk forms be provided to the next professional when there is a change of care co-ordinator or keyworker.

We recommend that the North West Surrey Mental Health Partnership NHS Trust develop and maintain an effective and robust information system which as a minimum allows for the collation of all CPA and risk forms, provides access to such information at all hours, and facilitates regular CPA meetings.

We recommend that the North West Surrey Mental Health Partnership NHS Trust carefully review its plans for a specialist day service taking account of evidence based practice and acknowledging the difficulty of engaging and treating people with severe personality disorders in such units.

Chapter 7

Ms X and the use of Mental Health Legislation

Ms X had twenty-nine admissions during the period of November 1996 to May 2001.

Of these, twenty-three were informal admissions, five were admissions using Section 136 MHA 1983 and one admission was using Section 4 MHA 1983.

The details of the admissions for Ms X were difficult to identify from the files as some of the information was contained in the CMHT files whilst other information was located in the main case file kept at the Abraham Cowley Unit.

The table below details these admissions.

No.		Dates	Status
1	1996	30/11 – 20/12	**Section 136** and **Section 2** rescinded 9/12/96
2	1997	11/1/97- 1 day	**Informal** from Crisis Response Team (CRT)
3	1997	28/2 - 14/3	**Informal** to Abraham Cowley Unit for Detox
4	1997	15/3 - 17/3	**Informal** to Blake Ward ACU from Accident and Emergency Department (AED)
5	1997	24/3 - 25/3	**Section 136**. Became Informal and discharged herself the next day.
6	1997	March - 7/4	**Informa**l after police bail. Home leave drinking and discharged.
7	1997	8/5 - 19/5	CRT admission. **Section 4** completed as no other Section 12 or acquainted Dr was available in the short term. Ms Xsuffering from severe religious ideation, had cut herself and wanting to go home. Became informal the following day. Discharged herself by leaving the Ward.
8	1997	24/5 - 28/5	Police admission **Informal** became **Section 5(2).** Discharged 4 days later
9 & 10	1997	22/9 - 2/10	**Informally** admitted to Windmill House for Detoxification. Took own discharge 2/10. Re-admitted 3/10 finally discharged on 19/10 as had left the Ward 15/10
11	1997	20/10 - 3/11	**Section 136** from AED to Blake after overdose. Assumed expired or rescinded. **Section 5(2)** after aggression and intoxication, rescinded.
12	1998	2/3 -1/4	**Informally** admitted to Windmill House for Detoxification. Could not sustain attendance at day programme so discharged.
13	1998	8/5 -13/5	Admitted **informally** to Clare Ward for crisis respite as not coping and suicidal
14	1998	16/5 - 3/6	**Informal.** Referred by Children and Families Team.

			Suicidal feelings
15	1998	5/6 - 6/6	Brought in escorted by a policeman. Admitted **informally,** discharged next day
16	1998	20/6 - 26/6	**Informal admission** - self harm. Left Ward 20/6. Discharged therefore.
17	1998	14/7 - 3/8	CRT referral to Blake Ward. **Informal** admission. Left Ward on several occasions leading to **Section 3** 27/7. Revoked 3/8 by her Consultant Psychiatrist
18	1998	9/8 -7/9	**Section 136** to Laureate Ward. ASW assessment 26/8. No outcome. Referred to DAT for Detoxification but was discharged from DAT
19	1999	7/1 - ?	**Informally** admitted to Blake Ward after aggression and threats of self-harm. Police breach of the peace. Mental health assessment.
20	1999	11/2 - 5/3	**Informal**. Admitted from AED. Depressed and requested DAT. Children's issues meant she was unable to cope with the programme so discharged.
21	1999	7/4 - 8/4	Police admitted via AED. **Informal**. Discharged self against medical advice
22	2000	9/5 - 21/6	Admitted **Informally** to the Cassel Hospital.
23	2000	8/8 - 16/8	Admitted to Blake Ward. **Informal. Sec 5(2) Invoked**. 10/8/2000 Section revoked by her Consultant Psychiatrist . Weekend leave granted. She did not return, so was discharged.
24	2000	20/9 – 22/9	Admitted **informally**. Angry aggressive. Drinking. Children's issues. Discharged after 2 days.
25	2000	17/11	**Informally** admitted to Windmill House DAT). Ms X left as she was not allowed to join the full programme.
26	2001	13/3 - 27/3	**Informal** admission. Lost interest, anxious, depressed. Left against medical advice 21/3 and discharged.
27	2001	28/3 - 31/3	Admitted **informally** from AED following overdose. Discharged after not returning to Ward.
28	2001	12/4- 20/4	Admitted **informally** after ASW and Dr assessment. Contract agreed which she broke therefore discharged.
29	2001	24/5 – 17/6	**Section 136.** Brought to Blake Ward by Police**. Informal** admission on contract. Said she had been raped. Threatened to jump off high building. Enhanced CPA. Home leave agreed. Did not return to Ward when advised. 9/6 police tried to get her admitted but she declined available bed on Clare Ward. 14/6 she returned to the Ward. 15/6 on Ward. 16/6 agreed home leave, due back 18/6. 17/6 Killed Mr S .

Many of the staff interviewed did not know the extent of her numerous admissions. The dates and circumstances of admissions were not recorded in any one single place but were filed in differently located case records. There was no summary of admissions easily available. Whilst we hope that the new computer system for case records will overcome this problem the system in place at the time could not do so.

Most of the informal admissions were at crisis points for Ms X and had she not agreed to informal admission, and in some cases to a contract as well in respect of her behaviour, many of these may have resulted in formal admission.

The Police were the main instigators of the Mental Health Act 1983 in this case. There were five admissions as a result of using Section 136 MHA 1983 and one when she was not admitted.

On the first admission using Section 136 MHA 1983 on 30 November 1996, she was placed under Section 2 MHA 1983 as a result of an ASW assessment following which she was in hospital for a considerable period.

23- 24 March 1997 Ms X was admitted using Section 136 MHA 1983. The public place being the road where she lived in Woking. There was some question in the Emergency Duty Team social worker's mind as to whether the Section was actually from a public place or from her own home (which would have been illegal) but this was not apparently followed up. There was a referral to the Emergency Duty Team, from staff on Blake Ward, who then referred her to the CMHT for follow-up. An ASW assessment was apparently made as the Section was rescinded. She calmed down considerably and so was discharged from Blake Ward a day later.

On 15 April 1997 Ms X was taken to the AED on a Section 136 MHA 1983 after taking an overdose but was not admitted. She smelt of alcohol. The Duty Doctor who examined her said she could go home after her bloods were checked. There is no record of an ASW assessment having been made.

On 20 October 1997 she was taken to ACU on a Section 136 MHA 1983 and transferred to AED. The Emergency Duty Social Worker was informed and awaited information as to whether she was admitted to Blake Ward. There is no record of an ASW assessment having been made. She was admitted to Blake Ward including a period of detention under Section 5(2) and then transferred to the Drug and Alcohol Team at Windmill House, but she discharged herself after 14 days

On 9 August 1998 she was admitted under Section 136 MHA 1983 and assessed by an Approved Social Worker the following day. There appears to be no record of this assessment on file although there is a note on the community mental health team file, which stated on the 10 August 1998 that she was to be seen by Dr 1 and an approved social worker with a view to rescinding the Section 136 as she was discharged the same day. On reading the files she was both in hospital and at home assumedly on leave from in-patient care. She was discharged after 29 days which included a period of admission to the Drug and Alcohol Team for a detox programme.

On her last admission 24 May 2001 Ms X was brought to the hospital under Section 136 MHA 1983, when she was admitted informally. The admission assumedly did not require an assessment under the Mental Health Act 1983.

The purpose of removing a person to a place of safety, under Section 136 (2) of the Mental Health Act 1983, is to enable him or her to be examined by a doctor and interviewed by an ASW and for any necessary arrangements for his care and treatment to be made and not for

an **emergency** admission. The doctor and the ASW have 72 hours to complete the assessment following which time the authority to detain the patient ceases.

The local policy should ensure that these assessments are conducted effectively and quickly and the assessment by both the doctor and social workers should begin as soon as possible after the arrival of the individual at the place of safety.

If the doctor sees the person first and concludes that admission to hospital is unnecessary, or the person agrees to informal admission, the individual **must** still be seen by an ASW, who must consult with the doctor about any other arrangements that might need to be made for his or her treatment and care.

The role of the ASW should include interviewing the person, contacting any relevant relatives/friends, ascertaining whether there is a psychiatric history, considering any possible alternatives to admission to hospital, making arrangements for compulsory admission to hospital, making any other necessary arrangements.

Both the doctor and the ASW **must** see the person unless the circumstances are and as described under Section 10.8 of the code of practice that states: -

> *"Ordinarily, neither a hospital nor the police should discharge an individual detained under Section 136 before the end of the 72 hour period without assessments having been made by a doctor and the ASW within that period. Where the doctor, having examined the individual, concludes he or she is not mentally disordered within the meaning of the Act then the individual can no longer be detained under the Section and should be immediately discharge from detention."*

The Mental Health Act 1983 Code of Practice also recommends as good practice that
The policy should include provisions for the use of the Section to be monitored so that:

a. A check can be made of how and in what circumstances it is being used including its use in relation to ethnic minorities;
b. The parties to the policy can consider any changes in the mental health services that might result in the reduction of its use.

Any implementation policy should also set target times for the commencement of the assessment and the Health Authority, Trust and Local Social Services Authority should review local practices against these targets.

The Mental Health Act Commission commented on the use of Section 136 and the lack of review of the joint Section 136 policy.

The Commissioners had specifically noted in their visit of 4 October 1999 that:

> *".. the last audit of Section 136 was apparently undertaken in 1996. Commissioners suggest that this is undertaken annually and that a joint forum is established with the police for discussion of any difficulties arising with the implementation of this provision. The police told Commissioners of their concern for patients with drug and alcohol problems who, they felt, or often refused admission. Commissioners wonder whether this might be related to the revision in subparagraph 10.8 a of the Code of Practice…."*

The Inquiry Team examined the Bournewood Community & Mental Health NHS Trust *"Section 136- Mental Health Act 1983. Procedure Number MH007"* issued in June 2000, with an anticipated review date of June 2001. The Inquiry Team assumed that this policy was updated at the review date to take account of the changes in both the place of safety, now Laureate Ward, and the organisation of services. The policy as it stood at the time was in accord with the spirit of the Mental Health Act Code of Practice and did set a timescale of 6 hours for the MHA 1983 assessment to be undertaken.

Comment

The Section 136 procedure could be potentially improved by adding more detailed guidance on alternatives available to the police service for the disposal of cases where it is suspected that drugs and/or alcohol is the sole reason for their coming to the attention of the police and Section 136 is not appropriate.

In addition the circumstances as outlined in paragraph 10.8a of the Code of Practice neither appears in the text or flowchart. Including this will make clear the exception to the requirement for a mental health assessment being where the doctor, after examination, concludes that the person is not suffering from mental disorder within the meaning of the Mental Health Act and that the patient should be immediately discharged from detention.

In relation to the use of Section 136 the Inquiry Team were informed by in-patient staff that the approved social workers were in short supply especially, at weekends and evenings, although this was contested by those who are responsible for the service. In any case her Consultant Psychiatrist told us that Ms X would present differently when in a secure environment and would be agitating to leave to sort out her practical or childcare problems very soon after admission. She would present as settled and well and he would discharge her.

The Doctors were the second most frequent users of the Mental Health Act 1983 in the use of the powers under Section 5(2). There were two occasions where Section 5(2) was invoked to prevent her leaving after admission. In both of these cases the action appeared appropriate to detain but the approved social workers were apparently not called assumedly because the doctor decided within a short time that no assessment for possible detention under Section 2 or 3 needed to be carried out.

Lastly, approved social workers were used to undertake assessments on some of the admissions and their decision making, and that of the doctors involved, appeared appropriate for circumstances with which they were presented. Much of the action taken by the approved social workers was to defuse and de-escalate crisis situations stirred up by Ms X's inappropriate behaviour due to her excessive drinking.

There was one Section 2 MHA 1983 application after admission, one Section 4 application upon admission and one Section 3 after admission which was discharged soon after completion and before the appeal that Ms X had requested was called.

The Section 2 MHA 1983 was appropriately used on her first admission.

The Section 4 on 8 May 1997 was explained in terms of the lack of an available doctor who either knew her or was Section 12 approved and the urgent necessity to detain her. Her Consultant Psychiatrist said in a letter of the 13 May 1997 that on this admission:

> *"she had peculiar symptoms at that time and admitted to having drunk a considerable amount of alcohol, which properly accounted for them. She was placed under Section 4 of the Mental Health Act and was admitted to Blake Ward. When seen the next day, she had slept well and was free of all symptoms. I saw her briefly and she appeared to me to be calm, rational and sober if rather sleepy. I therefore decided not to convert the Section 4 to Section 2 and she was therefore made informal. My plan was that she should stay in hospital but that if she wished to leave, she should be assessed medically and made to sign her own discharge. If found to be free of psychotic symptoms and not Sectionable. All was apparently reasonably well until the 11th of May, Sunday, when she left the hospital by agreement, and failed to return"*

The order under Section 3 MHA 1983 on 27 July1998 appeared appropriate and significantly different to other admissions as Ms X was a known patient who would either abscond, not return from planned leave, absent herself otherwise or manipulate her inpatient treatment to the extent she would be discharged and frequently re-admitted yet again in another crisis. Significantly her children had only just returned to her care as from the beginning of the month.

She was detained on Section 3 MHA 1983 on 27 July 1998 following an informal admission on 14 July 1998. This was presumably to give those responsible for her care the ability to detain her for a sufficient period for treatment. Her Consultant Psychiatrist discharged her some six days later on 3 August 1998, again within a very short period but on this occasion with no evidence that Section 117 aftercare arrangements were in place. Only six days later she was readmitted on 9 August 1998 on Section 136 MHA 1983.

Whether she was discharged because she was either considered no longer in need of it, or because she had given notice of appeal is open to conjecture. This was a continuation of the established pattern when Ms X was effectively in charge of her own treatment, a situation that her Consultant Psychiatrist agreed was therapeutic.

The Inquiry Team examined how both the present Mental Health Act Administrator and her predecessor monitored the Mental Health Act. We observed that record keeping had substantially improved since the present post holder had taken up her post. Neither the record keeping system nor the auditing had been satisfactory prior to her taking up her post. For example there were no records of Ms X being detained in July 1998. The recording system was now on detailed timed ledgers with separate files and on a computer system.

The Inquiry Team was concerned that Mental Health Act Administrator post had developed and expanded over time without regular review. The post is an important one and the role, task, status, reporting lines and function all need to be clear in order for the role to be both effective and efficient.

Comment

The detailed information from the Mental Health Act monitoring system is a very important resource for professionals who wish to improve their practice and for

managers who wish to ensure their services are within the legal framework. This could be markedly improved with computerisation, statistical packages and a colour printer, backed up by proper training and IT software support.

The role, function and scope of the Mental Health Act Administration post, and the additional post from Ashford, could benefit from a review. This should consider the development of an operational policy that draws together, in an integrated way, the responsibilities of the post holder and the obligations of the professionals involved in the use of the MHA 1983.

Finally the Inquiry Team was impressed by the joint training available to the police and operational staff in the mental health and drug and alcohol teams on all aspects of mental health policy. We were also impressed with the co-operation between the police and mental health personnel in relation to their joint meetings.

Recommendations

We recommend that the Commissioners, the North West Surrey Mental Health Partnership Trust and Surrey Social Services review and updates the Section 136 policy and reinforces the legal requirement of the ASW to interview the patient.

We recommend that the North West Surrey Mental Health Partnership Trust develops a training programme to ensure that all staff, particularly junior doctors, are fully aware of their obligations in the use of the Mental Health Act and included in induction, supervision and appraisal arrangements.

We recommend that the North West Surrey Mental Health Partnership Trust develops an operational policy to take account of the role, function, resources, management arrangements and scope of the Mental Health Act Administration Service.

Chapter 8

The organisation of Parallel Childcare and Mental Health Support

This Section covers the parallel childcare and mental health support services available to Ms X and her family whilst they were living in the Woking area.

The totality of services available to Ms X was extensive and included:

- Mental health in-patient unit, Abraham Cowley Unit, St Peters Hospital Chertsey.
- The Community Mental Health Team at Bridgewell House, Woking.
- Drug and alcohol services from the Windmill Drug and Alcohol Team, St Peters Hospital, Chertsey.
- The Day Hospital, St Peters Hospital, Chertsey
- GP practices based in Woking.
- Health visiting service based at Goldsworth Park Health Centre.
- Woking Family Support Team, Surrey Children's Services based in Trizancia House in Woking.
- Allocated social worker, for eldest two daughters.
- The Crisis Response Team based at Bridgewell House.
- Psychotherapy Service St Peters Hospital, Chertsey
- Psychology Service St Peters Hospital, Chertsey
- Project 18, an employment service.
- The Cassel Hospital
- Woking Housing Department.
- Surrey Emergency Duty Team (out of hours)

The Inquiry Team found good evidence that professionals communicated both by letter and telephone and recorded in the case file although unfortunately this communication was not always productive, and records at times were incomplete. Contact with Ms X was very frequent as at least one of the services was often in at least weekly contact with her.

Her four main contacts were the in-patient unit, the community mental health team, the drug and alcohol team and the children's services available through the Woking Family Support team. After a while all home visiting personnel were aware that they should not visit Ms X's home alone in view of the history of her and or her male associates' potential for violence. Social workers from the CMHT visited together with the CPN who was Ms X's keyworker. Ms X also had frequent contact with the Crisis Response Team and many of her admissions were preceded by contact with this team.

Contact with the Drug and Alcohol Team was mainly for in-patient detoxification, often terminated by Ms X. This pattern was repeated when she was an in-patient in the Abraham Cowley Unit. Invariably she discharged herself before any progress could be evaluated.

In relation to parallel childcare and mental health support the picture is of professionals developing their own views of the case, sometimes in isolation, and sometimes together. There were very different views of Ms X's ability to sustain care or a caring environment for her children and prevent the emotional abuse the children were experiencing. Her

discussions with members of the mental health teams were focussed on supporting her mental health needs and conversations about the children included Ms X's regret that the children were not with her anymore, the unfairness of it and her dissatisfaction with the foster parents. Mental health professionals were not that concerned as to whether she was a fit mother as their role bordered on advocacy for her as their patient.

Children's Services social workers however were concerned more for the whole family, but their major concern became the safety of the children.

These professional views changed over time and in different contexts and added to the confusion that emerged over the resulting professional goals for the family. There were also different or varying views of her mental health condition and treatability that also affected the decisions made in relation to the family and childcare.

Whilst the mental health professionals were aware of Ms X's several crises and her alcohol problems they were only partially aware of her potential for violence and her difficult relationships with violent men. They appeared even less aware of the disruption or potential for disruption that the combined effect of these factors would mean for her childcare ability and accompanying emotional abuse.

Ms X presented to most of the staff in the mental health services as a caring mother when not drinking, with the notable exception of the Consultant Psychotherapist 1. She appeared to have a more realistic view of the potential effects of Ms X 's situation and her relationships on her children.

In her evidence to the Inquiry in relation to Ms X 's daughter (L) born in August 1999 said: -

> *"My view at the time, as I wrote in my report, is that she could only have custody of the child (L) if she went into an inpatient therapeutic community, because I felt that she was not being open about all the difficulties she had had. I believe I made the point in my report that she said she had a bit of depression and, having looked at the psychiatric files, I knew she had several bundles of notes. The other point was that she had a bare awareness of the effect on her other children of the continuous separation and moving across the country from one place to another. She was leaving them, they went into care, came back with her and went into care again. She had no awareness whatsoever of the effect on her children. She did have an awareness of the effect on her of having been adopted and of not having had a satisfactory upbringing. She obviously had a lot of warm feelings towards her children and she seemed to be very pleased that her children loved her but very few thoughts about how her lifestyle and her problems were affecting her children. I felt that there was too much risk of her being alone with the new baby."*

She recommended the Cassel Hospital as a possible place for treatment and continuous assessment on Ms X 's ability to care for her child (L). It would have been helpful if there had been face to face communication with the social workers responsible for making decisions about the future care of (L).

Social Services children's services saw Ms X from a family and childcare perspective. Through case conferences and other observations they built a picture of her situation that led them to believe that she could not sustain a good and risk free environment in which to bring

up her new born child or have care of her other children without them suffering emotional abuse.

They were thus ready to respond to the children's needs when required. Ms X was admitted to hospital on 17 occasions between May 1996 and July 1998 when (J) and (S) were accommodated by the Local Authority. There were also eight separate moves for the children during this period, including nine months between November 1996 and July 1997 when they were returned home in a rehabilitation plan supported by her Consultant Psychiatrist .

There were 5 Child Protection case conferences on (J) and (S), the daughters of Ms X using the category of emotional abuse. The initial case conference was held on 14 January 1997 and the review conferences were 16 July 1997, 15 January 1998, 14 July 1998, 26 January 1999 and 16 September 1999.

All of the case conferences were communicated to mental health professionals, however mental health or drug and alcohol specialists attended only some of them.

The initial case conference on 14 January 1997 was as a result of Ms X 's admission to hospital following a mental health and family crisis involving information about her child (S). A pattern emerged in that Ms X was frequently unable to cope. An ASW, was present and agreed with the conference that, the children's names should be placed on the Child Protection Register because of the likelihood of the children suffering emotional abuse caused by the circumstances they were in rather than deliberate harm by their mother.

The first review case conference held on 16 July 1997 noted that the Independent Chairperson:

> *"… expresses concern and disappointment at the lack of attendance of mental health professionals and their lack of reports to this conference as a key component of concern is for the psychiatric health of the parent"*

As a consequence, on 24 July 1997 he wrote to her Consultant Psychiatrist at the ACU and the at the DAT to note that

> *" … no representative of adult services sent in a report, or apologies despite the fact that over the last 6 months Ms X, the children's mother, has had at least 16 crises including overdoses and self harm requiring hospitalisation and Sectioning under the Mental health Act. Also admission for de-tox for her alcohol abuse which is still not under control"*

Her Consultant Psychiatrist replied and apologised for not speaking to the ASW personally and not being able to attend. Her Consultant Psychiatrist wrote,

> *"… Perhaps in future, if you think that my presence is essential at these meeting, could someone be good enough to telephone me and speak to me personally. I am sure that you are aware that I have very few spare moments to attend Social Services conferences as I have huge numbers of patients to see. …"*

At this time Ms X reported that she was '*stuck*' between the Drug and Alcohol Team (DAT) and the mental health services, as the DAT were saying that they can't help her until her depression was cured, and the mental health services saying her alcohol problem was a priority.

The ASW noted he found it "*extraordinary*" that there were two adult teams involved with Ms X and they were unable to achieve a co-ordinated approach.

In addition to case conferences, core group meetings were held. There was a core group meeting on 24 November1997, which stated in a Section entitled "Close liaison necessary between relevant professionals":

> "*.. both Doctors had responded positively to the ASW's letter and that Dr (DAT) had attended the last core group meeting.*"

By the time of the second review case conference, 22 January 1998, a more co-ordinated plan emerged with five of the 13 actions relating to Ms X 's mental health. These were to be followed up in the core group that was to meet twice before the third review. However neither the keyworker CPN 1, or her Consultant Psychiatrist was present at this case conference although they did receive the minutes. The team leader from the DAT was present.

The third case review was held 14 July 1998 and neither her Consultant Psychiatrist, the team leader nor CPN 1 attended although all apologised and both her Consultant Psychiatrist and team leader presented reports. The case conference notes again reported the ASW as saying:

> *"... today there are two reports for conference from the adult teams so that is an improvement on previous conference but it would have been helpful if there had been attendance here today from one of them. …"*

This was a significant review in that the police reported that they had six reports of Ms X saying she was going to kill herself, and that the Housing Department was taking action to obtain a 'Possession Order'. Her daughters (J&S) were suffering the effects of emotional abuse and so their names were kept on the Child Protection register. Ms X 's personal crises and resultant hospitalisation meant that only unsatisfactory short term arrangements being agreed by her which in turn caused disruption for her children and their schooling. At the same time Ms X attempted to have her other daughter (T),aged 4, to live with her.

The social worker for the family, states in her report to the conference: -

> *" A contingency plan and further child care plans will need to be informed by the report requested from her Consultant Psychiatrist. His attendance at the conference has been stressed."*

During this conference there was some discussion about her Consultant Psychiatrist's recommendation in his report of 3 June 98 to refer Ms X in the medium to long term to the Henderson Hospital or the Cassel Hospital. The differences between the two hospitals were noted in that the Henderson only admitted adults and the Cassel specialised in family work. The social worker for the family reported that her Consultant Psychiatrist did not address the Cassel Hospital as an option at that time.

Ms X would have to be alcohol free to go to the Henderson Hospital and told the team leader that she had no intention of going into therapy because she did not need it and did not accept any sort of therapy would be helpful and therefore had little motivation for this plan.

The Independent Chairperson of the Child Protection Conferences raised the non-attendance of significant mental health professionals at the various conferences with the Audit Group.

From the Minutes of the Audit Group it was clear that the group agreed with the concerns raised by the Independent Chair and noted that the lack of adult psychiatric information was significant. Children's Service Manager wrote to the Consultant Community Paediatrician and named Child Protection doctor for the Trust, with copies of letters sent by the Chairperson to her Consultant Psychiatrist. He outlined his concerns about inter-agency work and a proper contribution from the adult psychiatric services.

In her reply, the community paediatrician detailed the difficulties of dual diagnosis, missed appointments, different management structures, professional communication, training, and the difficulty for psychiatrists in attending child protection case conferences. Following this correspondence an agreement was reached that somebody, most probably the CPN, from the mental health team, should attend in future.

Comment

The children's services had taken up the issue of non-attendance of mental health professionals at child protection conferences in an appropriate manner and the Inquiry Team heard that attendance by mental health professionals throughout Surrey was 'patchy' and that there was a need to re-launch the principles and practice as described in "Working Together".

Three days after this case conference the Local Authority accommodated Ms X 's older daughters (J&S) and care proceedings were instigated with interim care orders being granted on 28 July 1998.

The fourth case review was on 26 January 1999 and was attended by SW 2, mental health social worker, and CPN 2 and key worker for Ms X from the mental health services. Her Consultant Psychiatrist significantly was not on the list of attendees/non attendees and would not necessarily be sent a copy of the case conference notes.

The social worker for the family noted that:

> *" liaison has continued, however due to the need to prioritise tasks and complex legal proceedings liaison has not been as frequent with health and mental health. The drug and alcohol services are not currently involved and have not been since the previous Review Conference"*

Significantly it was also noted that the final hearing for the legal proceeding concerning the care of her daughters (J&S) was to be on the 1 March 1999. The Consultant Child and Adolescent Psychiatrist, had been asked to make an assessment of the children's needs and a Consultant Psychiatrist, was asked to provide an assessment offering his opinion of Ms X 's mental health difficulties and the impact of these on her parenting ability. Other reports had

also been requested including one on Ms X and her then partner (DM) assessing the relationship and the impact of this on the care that would be potentially provided to (J&S)

On 4 March 1999 a full care order was granted for Ms X 's daughter (J) and she was placed with foster parents. The case conference removed her from the Child Protection Register. Ms X 's daughter (S) renewed supervised contact with her mother as from 9 February 1999, and moved to her new foster carers in July 1999. On 16 September 1999 the fifth and final case review was held and attended by CPN 1 and to which SW 3, sent her apologies.

In October 1999 a full Care Order was granted on (S) and she was removed from Surrey's Child Protection Register. Her youngest daughter (L) was subject to an interim care order and her case was being dealt with separately.

At this time (DM), Ms X 's ex-partner, was off the scene and Mr S was present at the case conference. He was described as Ms X's '*supporter*' and participated fully on Ms X 's behalf at the meeting.

The Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection was formulated. It was written because of concerns raised in several Case Reviews in Surrey, following the death of a child, which highlighted the mental health problems of the parents involved and that professionals in these cases had problems of working together and communication. The protocol is addressed in particular to the Social Services internal relationship between the Mental Health Service and Children's Services, whose teams are separately managed and located.

Whilst the protocol's principles are generally applicable to all professionals in mental health the focus on Social Services in particular may mean that the dissemination of good practice as outlined in the protocol is limited. The protocol suggests one social worker in each team should be identified as having experience in child protection and that this social worker is to receive additional training and be available to other professionals in the team.

Comment

The Protocol should be reviewed as it only reflects a social services perspective and needs to include a multi-agency approach. The organisation of services has changed markedly with the reliance on old social services affiliations now being outdated. We learnt that numbers of staff attending the current training were low. Joint training has been proven to be an effective way for different professionals to have a better understanding of their respective roles and responsibilities. The link people defined within the protocol, from the children's services and adult mental health services, require training in the opposite discipline. The training will then need to be audited by the Surrey Area Child Protection Committee through the five smaller area child protection committees and taking account of the fact that the ACPC areas are not co-terminous with the PCT areas.

As in this instance, it was anticipated in the protocol that not all cases involving children were held by a social worker working in the mental health services.

The protocol in its eligibility Section says:

> "*Care should be taken to ensure that situations which might appear moderate need in relation to the mental health of the adult and moderate need in relation to the children are considered holistically, i.e. taking the cumulative effects of both mental health problems plus child care may bring the case into high need*".

Thus there is a need to focus additional attention on all cases where both mental health and children's services are working on the same case. Ms X and her family were such a case.

The protocol states in relation to care plans, that the CPA Care Co-ordinator for the case should normally be part of the Core Group responsible for implementing the Child Protection Plan.

In this case the key person was a community psychiatric nurse. No mental health professional was invited to the meeting held prior to (L)'s birth to discuss planned action following this event. Ms X 's new-born daughter (L) had been removed the day after her birth under an emergency protection order on 4 September 1999. It appears that the children's services had excluded the mental health professionals from the decision to remove (L) from Ms X and her partner (DM).

In relation to care plans the protocol states that any dispute should be referred to the Senior ASW and the Family Support Team Manager who should attempt to resolve it. In this case there was a dispute in relation to whether referral to the Cassel Hospital was appropriate. There was no apparent attempt to resolve that dispute at a senior or managerial level, but just more evidence that the two services were travelling in different directions. In the event an uncomfortable compromise was reached with the Trust paying for the Cassel Hospital as the Health Authority and the Local Authority had refused funding.

Clearly by this stage any joint approach to the family was much lower priority for both mental health and children's services. This could have reflected distrust or different beliefs between the teams and had several consequences.

For example, mental health professionals could not consider and plan how to manage/ support Ms X and thus the "respond to crisis" approach was perpetuated. There was no network meeting and no assessment of what Ms X needed. There was also no clarity as to what Mr S could realistically have provided in caring for Ms X. The decision of mental health professionals to fully support Ms X in her plan to be admitted to the Cassel Hospital so as to resume care of her daughter (L), may have been effected by this.

The separate views and the referral to the Cassel Hospital exemplifies the lack of any process to bring different specialists to the same view in relation to the best plan for the whole family, including Ms X's mental health care and the future of her children.

The Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection also covers financial arrangements and it would appear that the agencies did not follow their own guideline. The lack of management resolution to the dispute over funding for the Cassel Hospital left her Consultant Psychiatrist in a position where he was seen by Ms X as her 'saviour'.

The final resolution of the dispute was largely left to the three Psychiatrists involved, to resolve after Ms X had been admitted to the Cassel Hospital, funded by the Trust without the support of Social Services.

In the event Ms X largely resolved the dispute herself by withdrawing from the Cassel stating it was not appropriate for her or her daughter's needs.

Comment

A holistic view of both the needs of the whole family and the separate individuals within it did not exist. Neither did an integrated plan exist for the whole family.

There were five local possibilities where such a professional dispute could have been discussed before matters were left to the Court to decide. These were:

- The Care Programme Approach Meetings to which the children's services social worker sometimes attended
- The Child Protection Core Group and
- The Child Protection Case Conference, both of which were poorly attended by mental health professionals
- With the child protection trained social worker within the Community Mental Health Team
- Using the procedures within the '*Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection'*.

None of these possibilities appeared to call on sufficient authority across the several professional agencies, to resolve and discuss cross professional and service issues in a way that avoided being partisan. This would have ensured that areas of agreement and disagreement could be aired to a point of sufficient resolution for the whole family taking into account all the complexities, legal restraints and the separate and disparate views of the professionals involved and family members.

The increasing specialisation of services demands that separate structures need to be put in place to overcome the communication and perspective difficulties that arise between different services with very different cultures.

The Inquiry Team is of the view that with modification '*The Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection***'** could include the possibility of disputes being raised with Heads of Services. Three things have brought about local changes recently - **firstly**, "Working Together" has strengthened the role and responsibility of the core group in that it has the power to amend the child protection plan within 10 days of the initial case conference and to hold the first review of the child protection conference in three not six months. – **secondly**, the "Framework Assessment Document" (Departments of Health and Education and the Home Office) strongly recommends and requires all agencies to contribute to an assessment of each child in the family, which takes account of the parenting abilities and includes the importance of involving adult psychiatric services. - **thirdly** the preparatory work that was underway following the publication of the Climbie Report.

The care for Ms X and her daughters was divided at this point and so The mental health services and Mr S, as her carer, were left to support Ms X as the children's were only concerned with the future of the children. There appeared to be no recognition of the effect that this would have on Ms X. There was no re-assessment of her needs, or a plan for her support. There was no assessment of Mr S's capacity to care and provide for her or of his needs as a carer.

There was a significant lack of admissions to mental health inpatient care during her pregnancy between 7 April 1999 and the baby's birth on 3 September 1999 and until Ms X 's admission to the Cassel on 9 May 2000. This gave some hope to mental health professionals who observed changed behaviour in that Ms X appeared motivated to secure care of her youngest daughter and appeared able to contain herself.

There was a resumption of the pattern of frequent crisis admissions in the period from the time that the Cassel assessment was completed (26 June 2000), after which time there was little hope of her resuming care for her daughter (L), until (L) was finally separated from her on the 14 June 2001.

There were a total of 7 admissions and ongoing support from the CMHT workers in this period. Her admissions followed the previous pattern of crisis admissions with her discharging herself soon after admission and followed by out patient appointments with her Consultant Psychiatrist.

The CMHT social worker, SW 3 was in contact with Ms X or attempting contact appropriately every few days. She was aware of incidents relating to Ms X, (DM) and (JS), and liaised with the housing department about accommodation. She was monitoring Ms X in relation to contact with her daughter (L) and liaising with the Children and Families team social worker. SW 3 was also appropriately liaising with her Consultant Psychiatrist regarding Ms X who was unsettled and under extreme stress and in need for psychotherapy and a possible change of medication.

Ms X was also referred to the day hospital for support and frequent arrangements were made with the crisis response team for contact with Ms X overnight. Ms X was also referred to the Windmill House (DAT) for detox as she thought she was becoming more reliant on alcohol. SW 3 last saw Ms X on the 15 November 2000 and left a useful transfer summary of her contact on the CMHT file for her successor. Her case file was handed over to CPN 2 who did not see her and then transferred to CPN 3, a fellow community psychiatric nurse.

The standard of care offered at this point by the CMHT workers was good and CPN 3 continued the same pattern of weekly contacts. Ms X was often not in when workers called to see her and did not answer phone messages. There were significant interventions in relation to admissions and notes from the approved social worker, who was also acting team leader, and assessed her under the MHA 1983 on 11 April 2001 resulting in an informal admission. Contact with the social worker from children and families was not apparent at this stage and there appeared to be very little planning for the whole family.

On 31 May 2001 there was an entry from CPN 3 saying that Ms X reiterated the fact that she would like SW 3 to be her key-worker and not him. CPN 3 appropriately took this up with both SW 3 and their team leader, but no further action was taken.

The next entry on the CMHT file by CPN 3 on 18 June 2001 was a report from the Abraham Cowley Unit that Ms X had killed her male friend.

In the course of the Inquiry, the Inquiry Team heard evidence that senior managers wanted to improve working relationships between the children's services, the Community Mental Health Teams, the Drug and Alcohol Team and Inpatient Services at the Abraham Cowley Unit. We are of the view that senior managers need to develop a more strategic view of the problems facing mental health and childcare professionals.

Recommendations

We recommend that Social Services and the North West Surrey Mental Health Partnership NHS Trust, review the way in which they interact in complex family situations and develop a family plan ensuring that agency and cultural differences are minimised.

We recommend that the Surrey Area Child Protection Committee review the '*Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection*', to ensure that procedures are in place when communication is required at a more senior level to resolve different views on case management.

We recommend that the Surrey Area Child Protection Committee agree how to ensure attendance by relevant mental health professional staff at child protection case conferences and core groups and the need for a co-ordinated whole family plan.

We recommend that North West Surrey Mental Health Partnership NHS Trust ensures that an evaluation is carried out of the role and capacity of carers in CPA reviews and that a separate assessment of carer's needs is undertaken when necessary.

Chapter 9

The events of 17 June 2001

On 17 June 2001 Ms X's neighbours were woken by sounds of a very loud argument coming from her flat. Ms X was seen standing at an open first floor window and then leaving her flat at about 07.00 hours returning some time later.

At 09.30hours she drove off from her flat in her car and went to a local shop and bought a quantity of painkillers, Paracetamol, Disprin and neurophen along with a bottle of vodka and cola. Ms X telephoned Blake Ward again at 10.30 hours and this time she spoke to enrolled nurse, but really wanted to speak to the charge nurse who was busy checking equipment. He told the enrolled nurse to try and encourage Ms X to return to the Ward. Ms X again told her she needed to speak to the charge nurse and said "*This is serious, this is murder. This is serious.*" The enrolled nurse knew Ms X quite well and felt that she could make situations out to be quite dramatic, especially when she had been drinking, but usually there was no foundation to the drama. Ms X said she couldn't return to the Ward as she was with the police, which again was not unusual and frequently Ms X was admitted with the police being present.

Ms X was told to ask the police to contact the Ward but Ms X became angry and slammed the telephone down. The enrolled nurse thought it was a '*ruse*' to make the charge nurse speak to her because Ms X was frequently dramatic, creating scenes to gain attention from the people she wanted to respond to her.

Sometime later in the morning Ms X telephoned Blake Ward and spoke to the healthcare assistant. She told him she had some problems and that she had purchased a quantity of pain killers and she intended to take them. The healthcare assistant suggested she return to the Ward but she refused to do so as she thought he would call the police. She said *" you're going to hear something soon or today and that will surprise you and will probably be the biggest thing you will ever hear."* On this occasion Ms X wanted to speak to the named nurse who was not due on duty until the afternoon. The charge nurse thought this telephone call was shortly before two female police officers arrived on the ward, which appeared to be about 12.30 hours.

Comment

By now the police service knew that Mr S had been found dead in Ms X's flat. They had received a telephone call from a female thought to be Ms X saying that a man had been stabbed and gave them the address as hers.

The officers told the staff that they were concerned about Ms X 's safety because they believed she had been involved in a stabbing incident. They also wanted to know if she was on leave and where and with whom she had left. They were told that Ms X had gone with Mr S.

The healthcare assistant thought it would make sense to look at the CCTV film footage from the day before so that they could ascertain the number-plate of the car she had left in. The police officers, charge nurse and healthcare assistant went to the reception area of the

Abraham Cowley Unit to look at the film. The healthcare assistant was in the entrance area and saw Ms X arrive in the car park in front of the reception entrance whilst the police officers and the charge nurse were behind the reception desk. The healthcare assistant told them that she was coming into the building and the police suggested that the charge nurse speak to Ms X, which he did. Ms X would not have seen the police officers as they were in the reception area, which at the weekend, had shutters in front of it. Ms X wanted to use the Ward toilet, which was some 75 yards down a corridor and on the left well out of view from the reception area. The charge nurse accompanied her to the toilet during which time she punched the wall and kicked the door.

He told us that staff carried personal alarms and if he had set the alarm off in the corridor someone from the Ward carrying the pager would have come running. He, therefore, decided not to use the alarm because if Ms X heard it and still had a knife she was likely to use it. He thought that it would be safer with fewer people present and so became concerned when he saw another patient in the corridor. Another member of staff saw him wave to her and took the patient back into the ward area.

Comment

At that point the charge nurse did not know about the conversation Ms X had had earlier in the morning with this patient telling her what she had done. The two police officers were always in close proximity to Ms X should she do anything reckless but nobody knew whether she had a knife with her.

One of the police officers, Acting Detective telephoned the Detective Sergeant who was in charge of the police investigation. She told him that Ms X was at the hospital and it was arranged for as many officers to attend as possible as they did not know what her state of mind was like or whether she still had the weapon. He was concerned that Ms X was at the hospital and that there were two female officers without any protection and so he arranged for the dog unit, an armed officer and other available officers to go to the Abraham Cowley Unit. He estimated that it was only about six minutes from the call until the extra police personnel arrived.

Ms X went straight into the toilet. The toilet door was ajar and the charge nurse could just see her knees and was concerned that if she had a knife she might use it on herself. When the additional police officers arrived they asked where she was. They identified themselves to her through the toilet door and as she came out from the toilet they explained that as they were worried for her safety and that of the other people they needed to search her and needed to handcuff her. She was arrested by the uniformed police officers and taken to Staines police station.

At no time did any of the police say to the charge nurse that they would take over from him. The charge nurse told us that he remained on duty until midnight that evening and that the police returned to take a statement as well as take his handwritten jottings he used to complete the notes in the clinical record. The charge nurse contacted the duty medical officer and the duty manager, – a manager in the learning disability directorate. He made contact with the duty consultant sometime in the evening and as it was such a serious incident he also informed other senior managers.

There was no 'debriefing' session afterwards with the staff involved with Ms X 's care and who were on duty that day. The only professional to attend the Ward that evening was the duty medical officer who made an entry in the medical notes and left.

Comment

When we discussed this action with the charge nurse he was very clear that, although with hindsight it might have been foolhardy and he could have been in danger as suggested by some of his colleagues, he was the right person to apprehend her as he knew her well, she was his patient and he was in charge of the Ward. The police officers did not know her and if they had approached her it may have led to another incident.

He did not know of her previous violent behaviour in the community until her Consultant Psychiatrist discussed the events later.

He did know that she could be volatile as when on the Ward if she did not get her own way she would throw ashtrays around. We were told that it was a tough decision to leave the charge nurse in control of the situation as Ms X was strongly suspected of killing Mr S but in the event nothing untoward happened.

We commend the charge nures for the way in which he handled this very unusual and difficult situation.

The only person who attended the ward that evening was the duty medical officer, not knowing either the staff or patients, wrote in Ms X's clinical records and left. The Inquiry Team was surprised to learn that no senior manager visited the unit that evening. The situation that the charge nurse found himself in, of managing the ward, managing the police and managing a serious incident, which, hopefully, will never happen again, was unacceptable. We understand that both senior managers were very supportive to the staff when they appeared as witnesses in the trial and in preparation for this Inquiry.

Support for Families

'Safer Services' (National Confidential Inquiry into Homicides and Suicides by people with Mental Illness Department of Health 1999) demonstrated that extreme crimes of violence such as murder or manslaughter were more likely to be committed by a family member than a stranger and this was no different when a person deemed to be mentally ill committed the offence. For this reason Carers need help with dealing with the crisis they find themselves in and reassurance about future action to be taken.

We have already indicated that we have been unable to make contact with either family who we consider to be victims of this incident. Neither did the Trust make contact as part of their internal investigations. From our experience of other inquiries such as these, families often receive the support required from police liaison officers but this should not negate the Trust from its own responsibility in this matter. An offer of appropriate counselling and support services, if required, should have been made. Health Services may not always have all the details of families concerned in these matters, but in this case the family was well-known.

We consider that more effort should have been made to keep families involved in this incident informed about the various Inquiry processes. The Home Office in 1995 published a folder

'Information for Families of Homicide Victims' which includes 'The Work of the Coroner', 'Going to Court', 'Coping when someone has been killed', leaflets about the criminal justice system as well as information about voluntary organisations which can provide ongoing help and support. This documentation does not appear to be widely distributed although a folder with the relevant information could easily be produced locally, particularly in conjunction with the appropriate local agencies.

Recommendation

We recommend that the North West Surrey Mental Health Partnership NHS Trust reviews the serious incident policy to

a) Include the attendance of the call senior manager at the scene of the incident to take immediate action in supporting staff and patients and securing the notes to make a contemporaneous record.

b) Make sure that the internal inquiry involves all agencies and the need to appoint panel members who have an objective, but informed view of the service

c) Ensure that the terms of reference cover the breadth, depth and scope of the care provided

d) Implement a training programme for all staff working in mental health services.

We recommend that the North West Surrey Mental Health Partnership NHS Trust keep copies of all notes and statements which may be used as evidence in criminal or other proceedings and that managers undertake training to assist staff in the preparation of these.

We recommend that the North West Surrey Mental Health Partnership NHS Trust should make contact with families who are the victims of serious incidents and implement a staff training programme which takes account of the sensitive nature of support required seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme.

We recommend that the North West Surrey Mental Health Partnership NHS Trust, when the need for an external independent inquiry, appoints a senior person to make and maintain contact with the family until that independent inquiry has been appointed. This person will be responsible for:

- **a) Offering to keep the family up to date of all proceedings including, internal investigations, court hearings and the possibility of an external inquiry**

- **b) Arranging for the family to have appropriate care, support and counselling services if they wish it.**

Chapter 10

The Bournewood Community and Mental Health NHS Trust Internal Inquiry

As mentioned at the outset of this report, this Independent Inquiry was commissioned firstly by the West Surrey Health Authority and following the changes in the NHS in April 2002, the Surrey and Sussex Strategic Health Authority, pursuant to HSG(94)27 which requires that where there has been a homicide by a patient of the mental health services, it is always necessary to hold an Inquiry independent of the providers involved. In the event of a violent incident the Health Circular, '*Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* HSG(94)27', states that '*an immediate investigation should be carried out to "identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach*'.

NHS Trusts have a responsibility to firstly, carry out a review and secondly, conduct an internal Inquiry following any serious incident involving a patient. It is usual practice for the Trust to report the findings and any action taken to the Health Authority. In many inquiries such as this the terms of reference include a review of the internal Inquiry previously carried out. This was not the case for this Inquiry but we felt that there were some aspects of the internal process which needed highlighting and that the resultant action plan merited discussion.

At the time of this incident the Trust policy, '*Incidents and Near Miss Reporting'* (dated November 1999 and due to be reviewed in November 2001), was to provide the Health Authority with a formal report within eight weeks of a serious incident. In fact the eight week deadline was extended and the panel had 15 weeks to complete their work.

The Trust Board appointed a non-executive director to chair the Inquiry The other members of the panel were, the Clinical Director Mental Health Services Bournewood Community and Mental Health NHS Trust, Director of Mental Health and Specialist Services Bournewood Community and Mental Health NHS Trust, who also acted as the panel administrator, Director of Mental Health Services Surrey/Hampshire Borders NHS Trust, but who at the time of the internal Inquiry was on secondment to the West Surrey Health Authority, Senior Operational Manager Surrey (West Surrey) Social Services and Consultant in Public Health West Surrey Health Authority. The terms of reference of the internal inquiry were discussed with the West Surrey Health Authority and a decision was made to examine Ms X's care and support along with communication and relationships from the Trust's perspective but including social care because of the integrated community mental health team. (Appendix 3).

The Chair of the Inquiry had not performed this kind of investigation before and told us that she relied very heavily on the skills and expertise of the director of mental health services who had conducted the initial staff interviews following the events of 17 June 2001.

The panel reviewed the inpatient records for Ms X 's admissions to the acute Ward and Windmill House and the records held by the Community Mental Health Team and focussed on the last 14 months of Ms X 's care and treatment. They were not able to glean much prior history during the time Ms X lived in the North of England nor did they see the GP records. Various chronologies of events were completed by each of the panel members, and one from an external consultant who had assisted the Complaints Convenor. These chronologies were

used to assist the panel in agreeing the areas of questioning they wished to pursue. They decided to focus on the following specific areas:

1. Assessment of Ms X's need and the local response
2. Risk assessment /risk management processes applied in both hospital and community settings
3. Care planning/CPA processes and the interface between hospital and community mental health team services
4. Relationships and joint working between local mental health services and specialist drug and alcohol services
5. Collaboration and communications between health and social care and other agencies involved with Ms X

In establishing our Inquiry we had the benefit of previous experience of homicide inquiries both internal and external. We were therefore surprised to learn that two of the internal Inquiry members were directly involved in the management of mental health services. We acknowledge that incidents of this nature happen rarely and that there may well have been few senior staff members with expertise. However the process could have been more objective if the membership had included a senior manager and or clinician from a similar service and not staff involved in the service under review.

During the course of their Inquiry the panel met only three members of staff and these were , Consultant psychiatrist, the co-ordinator leader Woking CMHT and the team leader of the Drug and Alcohol team.

The panel decided not to interview the Ward based staff, we were told that perhaps they needed protecting from sitting in the "*hot seat*", which given that Ms X had over 20 admissions, seemed to be a missed opportunity especially to formulate a fuller view of the communications between the various aspects of the mental health service. As events like this are rare it should have been an opportunity for staff to put forward their point of view and have the opportunity to influence future practice. In a different kind of culture staff do not need to be 'protected' but to be fully engaged in aspects of care especially if things go wrong.

The internal Inquiry Team did not interview or seek information from Ms X's GP. If they done so then they would have a clearer picture of her violent behaviour and the concerns of her GP as previously noted in this report, so much so that he wrote to the Primary Care Agency and the Secretary of State for Health to be relieved of his house visiting obligations.

The other aspect of the internal review, which caused us some concern, was the absence of reviewing the communication between the mental health services and the children and family team, despite personnel from both services being invited to each team's care planning meetings on several occasions. The information held by other agencies involved with Ms X was not always shared with others and therefore neither the mental health nor children and families services had a complete picture of the situation.

The internal inquiry did not discuss the events of 17 June and how the situation, that staff found themselves in, unfolded during the day and not least of all the effect that the events may have had on the patient who received the telephone call from Ms X.

The internal inquiry concluded that they carried out a thorough and comprehensive review of the care provided to Ms X in the five years since she came into contact with the specialist mental health services. They also concluded that the service had tried everything possible to respond to her needs, although largely in a reactive manner. They identified shortcomings on risk assessment and management, which at the time of writing the internal Inquiry report, were already in hand.

The policy was reviewed in April 2002 and provides more comprehensive guidance setting out the different kinds of review processes, support to staff, the panel membership and terms of reference for each kind of review. We were pleased to read in the updated policy that staff involved in serious untoward incidents would receive face to face support and have access to a counselling service.

Though this Inquiry does not find fault with the conclusions we believe that the benefits of the investigation would have been enhanced if:

a) A more objective Inquiry team had been appointed
b) There had been interviews with more staff who were involved in Ms X's care
c) There had been more discussion about the relationships between the various teams involved in Ms X and her family's care
d) The events of 17 June 2001 had been thoroughly explored
e) All staff had been supported through the process and given time to prepare

Some of the recommendations (appendix 4) were acted upon straightaway, for example, a risk management procedure was implemented, CPA training took place and a protocol between the CMHT and the drug and alcohol services was developed. No person was nominated to take the recommendations forward despite there being two senior managers on the panel and as a result, no formal action plan was formulated and circulated. There was a view that the findings should not be circulated until after the trial, as Ms X was accused of murder rather than manslaughter due to diminished responsibility and it could have been concluded that the incident had no bearing on the services she had received.

In April 2002 the Chief Executive of the newly created organisation, North West Surrey Mental Health Partnership NHS Trust, drafted an action plan which identified responsible senior managers and work to be completed in an agreed time frame. The action plan was initially received with suspicion and some staff considered it punitive as it was a year after the incident, which may have resulted in staff not being 'connected' to the action plan through the actual incident, which had necessitated the plan. This was a lost opportunity for staff to learn lessons in a more open learning culture and as a result the chief executive put in place a series of briefing sessions alongside training in serious untoward incidents and risk management.

We recommend that the North West Surrey Mental Health Partnership NHS Trust Clinical Governance group uses this report to debrief all involved staff and in the wider context as a training tool.

Chapter 11

Sharing of Information about Individuals Assessed as Presenting a Risk of Serious Harm

In other parts of the country, Inquiry Team members have encountered Multi Agency Risk Panels (MARP) which, initially, were set up between Probation and Police Services to deal with dangerous people when released from prison. The purpose of the panel is to focus on the small number of offenders who pose a major risk to public safety. However this notion has since been extended to include other agencies as appropriate to 'best manage' the risk posed by some people living in the community. The Consultant Psychiatrist Drug and Alcohol Team, told us about the Community Incident Action Group (CIAG) based in Woking, which discusses people who behave in an antisocial manner, following the Crime and Disorder Act 1998. The Community Safety Officer and a Police Inspector jointly chair the group which was started in January 2001 and included representatives from CMHTs, the DAT, Education, Housing, Probation and the Youth Justice Service.

We also heard about another forum for disseminating information to 'alert' agencies about certain people who posed a risk. The Woking BLIP (Blue Light Information Process) was in operation having been based on an earlier pilot project instigated in November 1997 based in the Guildford area. The BLIP project was defined as:

> *The Blue Light Initiative is a multi-agency process to assess, monitor and assist in the management of a dangerous or potentially dangerous individual who presents a threat to themselves or the community which is life taking, life violating or life threatening, thereby to increase the public safety within Guildford Borough.*

Information is sent to a confidential fax machine located in Windmill House (DAT) and then distributed to all participating agencies through an automatic dial capacity. The group includes police, probation, mental health services and the children and families team. These agencies did meet for other purposes such as CPA and Child Protection case conferences to which GPs and representatives from the Housing department were also invited. The BLIP project was intended only to inform all agencies of heightened risk situations which might have led to serious adverse outcomes.

From experience we know that some professionals are reluctant to pass on information to others and time is required to encourage staff to overcome mistrust and share information. We were not given any information as to whether this system was used to share information about Ms X and therefore concluded that neither of the CIAG or BLIP processes, appear to have triggered a special meeting to discuss Ms X's 'risk', possibly because they were still in their infancy. Indeed the locality manager, said *" I have on a number of occasions reflected whether the Woking BLIP could have assisted with swift multi agency alerts in Ms X 's case"*. It may well have been because she was never perceived as being high risk.

It is fair to say that most professionals considered Ms X's risk was mainly self directed and whilst episodes of her risk associated behaviour to others were known to individual agencies a full history was not known by all. It is also fair to say that different agencies had a different approach to her care and sometimes what information could and should be shared. For

example a GP was reminded that in the case of child protection there was a need to override patient confidentiality.

During the course of our Inquiry we counted many more than the three episodes of violence, (although mainly against herself) that her Consultant Psychiatrist told us about. We also know that there were about nine supporting police crime reports. The table below lists some of the violent incidents, which were a threat to Ms X and others. It was of some concern that on several occasions no further action was taken as a result of Ms X 's behaviour. Even the threat to move or evict her came to nothing, although we understand that the legal process to carry this action out normally took a long time.

Table of 21 violent events as described in documents sent to us

10 May 1996 - Ms X exhibited aggression and wanted to kill herself and her children.
30 November 1996 - Ms X was found wandering with a knife threatening to kill anyone.
23March 1997 - Ms X had taken a male lodger as a hostage and threatened murder and suicide. When restrained by the police she attempted to cut her own throat. Police completed a crime report, " she must be treated with extreme caution if police attend the address".
16 November 1997 - Ms X held knife to own throat and then told the visiting doctor 'I'm going to kill myself and I'm going to take you with me"!
19 May 1998 - Police crime report. Ms X 's neighbour was extremely distressed and frightened because Ms X was threatening her. Ms X had kicked her front door.
5 June 1998 - Ms X taken to hospital by the police and admitted as she had been self mutilating.
15 July 1998 - Ms X was threatening to kill her children rather than allow them to go into foster care.
27 July 1998 - Ms X opened up an old wound and it became infected. Ms X admitted to hospital under Section 3 MHA 1983, for the protection of others.
9 August 1998- Ms X telephoned the children's foster parents saying she was intending to kill herself. She went to the Toys R Us building and threatened to jump off.
5 October 1998 - Complaint by neighbour about Ms X 's threatening behaviour to her and her son. Report by Dr Kidd, Ms X has extremely volatile existence.
8 October 1998 - Ms X 's GP asked her to find another doctor as she had caused an unpleasant incident in the surgery and she needed to control her attention seeking behaviour.
7 January 1999 - Ms X had a knife, threw hot water at the police officers who

attended in protective clothing and with a hostage negotiator.
6 April 1999 - Police called to the flat as Ms X threatened to hang herself. The loft cover was down and an iron flex was hanging from the loft with a chair underneath it. According to the GP notes she had assaulted DM, seen by GP and psychiatrist but not Sectioned because diagnosed as having a personality disorder rather than a mental illness. Later that day Ms X and DM decided on a joint suicide pact. Police arrived in riot gear. DM threatening to cut the gas supply and the gas supply had been cut.
15 April 1999 – GP 1 was no longer prepared to see her because of her threats to others.
12 May 1999 - Police crime report Ms X was involved in a fight between two men. She then was involved in an argument with one of the men's wives and threatened to kill her.
10 June 2000 - Police crime report. Ms X and Mr S involved in a disagreement. Ms X was assaulted by Mr S.
8 August 2000 - Police crime report. DM was stabbed in the arm. Ms X was arrested for Grievous Bodily harm (GBH). DM refused to co-operate with the police.
20 September 2000 - Ms X physically aggressive to staff having taken an overdose.
28 January 2001 - Police crime report. Ms X and Mr S had violent argument and he smashed the door with a hammer.
23 May 2001 - Ms X telephoned the police saying that she had been raped. She went to the Toys R Us building. She was Sectioned under the mental health act and taken to the Abraham Cowley Unit.
17 June 2001 - Mr S found stabbed in Ms X 's flat.

The bringing together of the various agencies involved in this kind of case would adopt a 'case management approach', which ensures discussion about assessment and level of risk, formulates an individual plan which can be monitored, implemented and reviewed, as well as ensure formal communication. Often communication is left to the CPA process or the formal Child Protection Conferences, when children are included on the Child Protection register, but inevitably not everyone who has something to contribute is invited. Knowledge about any potential risk, which Ms X may have posed to the general public, was known to individual services and possibly played down because once she was sober her behaviour changed. The word 'risk' is understood but defined differently and perhaps had her risk been the focus for a multi-disciplinary meeting then GP 4 would have had a forum to share the various general practitioners' anxieties.

It is considered good practice to have such a forum, which gives all agencies the opportunity to learn from past experience and improve public safety and not intended to take away the

need for individual agencies to act in accordance to their own guidance. Such a forum should be seen as a way of enhancing their collective knowledge and understanding.

Recommendation

We recommend that the agencies concerned with public protection in Surrey review the criteria for referral to the CIAG and the BLIP system and that its membership agrees and implements a sharing of information protocol. This protocol should complement the existing arrangements for *'Inter Agency Child Protection Guidelines and the Policy for 'Managing Potentially Dangerous Offenders'*.

Chapter 12

Key Findings and Summary of Recommendations

Based on all the evidence available to us we do not consider it appropriate to lay blame for what occurred upon individual professionals. We note that Ms X was convicted of murder. It is our opinion that most professionals who came into contact with Ms X provided her with the care that she would allow. Nevertheless there were some shortcomings and these are listed below

1. We were unable to find any specific clinical factors which led to Ms X's fatal assault upon Mr S. We learnt that her last contact with her youngest daughter (L) was only on 14 June 2001 and we can only assume that that must have had a psychological effect. Ms X had been admitted on 24 May 2001, using Section 136 MHA 1983, saying that Mr S had raped her. This allegation does not appear to have been investigated.

2. There were, however, clear risk factors indicating that Ms X might act violently in the event of any relapse or in an episode of heavy drinking. These should have been recognised by the professionals caring for her. It is true to say that she may have led staff to think that she was more in danger of harming herself than others. On the other hand, the degree of violence she finally exhibited could not have been predicted.

3. The quality of care provided to Ms X was somewhat inconsistent and sometimes inadequate. In all Ms X was admitted on 29 occasions of which eight used Sections of the Mental Health Act 1983 although she frequently became an informal patient shortly after admission.

4. The combined effects of poor co-ordination of care, inadequate communication and repeated changes of personnel, led to a superficial approach to risk assessment and management.

5. The Consultant psychiatrist's responsibility for both acute adult and elderly mentally ill populations was excessive. These two groups have very different needs. At the time of the incident his general catchment area was a total population of 34,479 for five sessions and was significantly above the Royal College of Psychiatrists' recommended level (3.3whole time consultants for 110,000 population). The Inquiry Team were please to learn that funding was agreed for an additional consultant and at the time of our Inquiry he had decided to restrict his workload to adult general psychiatry.

6. The Bournewood NHS Trust and Surrey Social Services did not meet the needs of people with a similar diagnosis of borderline personality disorder. The recommendation of the internal inquiry, to implement plans for a day service for people with severe personality disorder, should be reviewed in the light of our findings.

7. Although there were frequent communications between all the agencies involved with Ms X, there was no overall multi-disciplinary plan either in the short or long term.

8. The parallel planning, as proposed by Social Services Children and Families team, for the future of Ms X's youngest daughter, was not fully understood by other key professionals working with Ms X.

9. Support mechanisms, following serious untoward incidents, for both staff and families were inadequate. Fortunately an event of this nature does not happen often. Staff involved in the incident were left to cope with not only dealing with the actual situation, but to carry on the working day without senior management support. Whilst the police supported the families there was no contact made from the senior staff in the Trust or from the Health Authority to inform them that an external Inquiry would be implemented.

10. Whilst the Department of Health issues guidance on agreed procedures for CPA, risk assessment and Section 117 they are interpreted differently within different local organisations and perhaps the time has come for nationally agreed policies. The implementation of CPA was inadequate. Many meetings called 'CPA' meetings were often called at short notice because Ms X was being discharged from hospital. It was hard to ascertain who had been invited, whether written reports were sent and whether the outcome of these meetings was shared with other professionals.

11. The recommendations of the internal inquiry were primarily about organisational issues and as such were adequate. However there were some shortcomings in the breadth and scope of the Inquiry, which led to staff not necessarily becoming 'connected' to the outcome. We were pleased to learn that an action plan, although sometime after the Inquiry reported, had been drafted and was in the process of being implemented.

Summary of recommendations

1. We recommend that the North West Surrey Mental Health Partnership NHS Trust, together with the Surrey Drug Action Team, ensures that a protocol and service model are developed between the drug and alcohol services and the mental health services in line with the Department of Health's Dual Diagnosis Good Practice Guide to develop an integrated model of service rather than the serial and parallel models as evidenced in this Inquiry.

2. We recommend that the North West Surrey Mental Health Partnership NHS Trust develops a protocol for the production of case summaries in selected cases to include criteria for the selection of relevant cases where there are several complex interrelating factors or agencies involved and an agreed proforma for the summary.

3. We recommend that the North West Surrey Mental Health Partnership NHS Trust together with the relevant Primary Care Trusts should review the activity, range and balance of provision, together with the roles and function of services including the 'patch based' system. The review should be integrated with the work of the NSF

Local Implementation Team for Mental Health and integrated with the Corporate Objectives.

4. We recommend that the North West Surrey Mental Health Partnership NHS Trust review the Informal Leave Policy.

5. We recommend that the Commissioners and the North West Surrey Mental Health Partnership NHS Trust discuss with the Department of Health the benefits of having nationally agreed procedures for CPA including Section 117 arrangements and risk assessment.

6. We recommend that the North West Surrey Mental Health Partnership NHS Trust ensure that there is a comprehensive multi-disciplinary training programme for all aspects of effective care co-ordination including the assessment and management of risk so that staff can fully share their expertise and understanding.

7. We recommend that senior mental health staff introduce network meetings in complex cases to stress the importance of and ensure close working with the Family Support team, child protection services, and when relevant, other agencies.

8. We recommend that mental health managers ensure a summary of the case together with copies of CPA and risk forms are provided to the next professional when there is a change of care co-ordinator or keyworker.

9. We recommend that the North West Surrey Mental Health Partnership NHS Trust develop and maintain an effective and robust information system, which as a minimum, allows for the collation of all CPA and risk forms, provides access to such information at all hours, and facilitates regular CPA meetings.

10. We recommend that the North West Surrey Mental Health Partnership NHS Trust review its plans for a specialist day service, taking account of evidence based practice and acknowledging the difficulty of engaging and treating people with severe personality disorders in such units.

11. We recommend that the Commissioners, the North West Surrey Mental Health Partnership Trust and Surrey Social Services review and updates the Section 136 policy and reinforces the legal requirement of the ASW to interview the patient.

12. We recommend that the North West Surrey Mental Health Partnership Trust develops a training programme to ensure that all staff, particularly junior doctors, are fully aware of their obligations in the use of the Mental Health Act and included in induction, supervision and appraisal arrangements.

13. We recommend that the North West Surrey Mental Health Partnership Trust develops an operational policy to take account of the role, function, resource allocation, management arrangements and scope of the Mental Health Act Administration Service.

14. We recommend that Social Services and North West Surrey Mental Health Partnership Trust review the way in which they interact in complex family situations

and develop a family plan ensuring that agency and cultural differences are minimised.

15. We recommend that the Surrey Area Child Protection Committee review the *'Surrey Protocol for Links and Communication between Adult Mental Health and Childcare/ Protection'*, to ensure, that procedures are in place communication at a more senior level to resolve different views on case management.

16. We recommend that the Surrey Area Child Protection Committee agree how to ensure attendance by relevant mental health staff at child protection case conferences and core groups, and the need for a co-ordinated whole family plan.

17. We recommend that North West Surrey Mental Health Partnership Trust, ensures that an evaluation is carried out of the role and capacity of carers in CPA reviews and that a separate assessment of carers' needs is undertaken when necessary.

18. We recommend that the North West Surrey Mental Health Partnership Trust reviews the serious incident policy to

    a) Include the attendance of the oncall senior manager at the scene of the incident as soon as possible to take immediate action in supporting staff and patients and securing the notes to make a contemporaneous record.

    b) Make sure that the internal inquiry involves all agencies and the need to appoint panel members who have an objective, but informed view of the service

    c) Ensure that the terms of reference cover the breadth, depth and scope of the care provided

    d) Implement a training programme for all staff working in mental health services

19. We recommend that North West Surrey Mental Health Partnership Trust keep copies of all notes and statements which may be used as evidence in criminal or other proceedings and that managers undertake training to assist staff in the preparation of these.

20. We recommend that the North West Surrey Mental Health Partnership Trust should make contact with families who are the victims of serious incidents and implement a staff training programme which takes account of the sensitive nature of support required seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme.

21. We recommend that the North West Surrey Mental Health Partnership Trust, when the need for an external independent inquiry arises, should appoint a senior person to make and maintain contact with the family until that independent inquiry has been appointed. This person will be responsible for: -

    a. Offering to keep the family up to date of all proceedings including, internal investigations, court hearings and the possibility of an external Inquiry

b. Arranging for the family to have appropriate care, support and counselling services if they wish it.

22. We recommend that North West Surrey Mental Health Partnership NHS Trust clinical governance group uses this report to debrief all involved staff and in a wider context as a training tool.

23. We recommend that the agencies concerned with public protection in Surrey review the criteria for referral to the CIAG and the BLIP system and that its membership agrees and implements a sharing of information protocol. This protocol should complement the existing arrangements for *'Inter Agency Child Protection Guidelines and the Policy for 'Managing Potentially Dangerous Offenders'*.

Appendix 1

Witness list

Woking Locality Manager
Non- Executive Bournewood NHS Trust
Social Worker CMHT
Ward manager Abraham Cowley Unit
Staff Nurse Abraham Cowley Unit
Team Leader Drug and alcohol service Windmill House
Community Psychiatric Nurse
Director of Mental Health learning Disability Services
Area Housing Manager
Consultant Psychiatrist Drug and alcohol service
Independent Chair Child Protection Conferences
Charge nurse Blake Ward
Drug and alcohol specialist ~Windmill House
Senior Social Worker
Approved Social Worker
Subject of Inquiry

Written information

Assistant Team Leader Surrey County Council until June 2000
Chief Executive North West Surrey Mental health Partnership

Appendix 2

Documents received and considered

Documents relating to Ms X

GP case notes
Inpatient case notes Abraham Cowley Unit
CMHT records Woking Locality mental health services
Maternity records St Peters Hospital
Health visiting records
HMP medical records
Inpatient records Cassel Hospital

Department of Health

The Care Programme Approach HSG(90)23/LASSL(90)11 1990
Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community HSG (94) 27 1994
Building Bridges a guide to arrangements for inter agency working for the care and protection of severely mentally ill people 1995
A National Service Framework for Mental Health 1999
Code of Practice Mental Health Act 1983 HMSO 1994 and 1999
Effective Care Co-ordination in Mental Health Services A Policy Booklet 1999
Still Building Bridges. The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management 1999
Modernising the Care Programme Approach 1999
Framework for the Assessment of Children in Need and their Families Referral and Initial Information Record, Initial Assessment Record and Core Assessment Records 2000
An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS 2000
Building a Safer NHS for Patients – implementing An Organisation with a Memory 2001
Safety First Five-Year Report of the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness 2001
The Journey to Recovery – The Government's vision for mental health care 2002
Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision 2002
Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide 2002
on Serious Untoward Incidents Guidance South East Regional Office August 2000

Bournewood Community & Mental Health NHS Trust

Service Level Agreement
Complaints and Compliments Procedure
Suicide or Other Unexpected Death of a Patient
Overarching policy for the care programme approach.
Informal Leave Policy

North West Surrey Mental Health Partnership MHS Trust

Management and Board Structure 2002
CPA policy
InterHealth printout
Woking BLIP protocol and Corporate Objectives
Action Plan following RS internal Inquiry
Serious Untoward Incident Policy
Roles and Responsibilities of a clinical director
Corporate Objectives 2002/3 for Adult Mental Health Services

West Surrey Health Authority

Complaints and Disciplinary Procedures
Procedure for Reporting Serious Untoward Incidents

Surrey Police Service

Report and Summary of Evidence

Community Health Council

Reports of visits 18 May 2000 and 28 February 2001

Mental Health Act Commission

Reports of visits and responses Feb 1997 March 1998 October 1999 June 2000 June2001

Surrey Social Services

Community care plan
Adult Mental Health and Child Care/Protection Protocol for links and communication
Child protection case conference notes

General Medical Council

Confidentiality: Protecting and Providing Information

Other Documents

Peck and Crilly Explaining Mental Health Spend in West Surrey December 1998
Ward and Applin The Unlearned Lesson The Role of Alcohol and Drug Misuse in Homicides Perpetrated by People with Mental Health Problems Wynne Howard Books 1998

Appendix 3

Terms of Reference of internal Inquiry

1.The investigation will review and report on the following:

a) Whether the plan of care Ms X was receiving from the specialist mental health services provided by the Bournewood NHS Trust and Surrey Social Services.
b) Whether the current plan of care had taken into consideration any known or foreseen risks regarding her behaviour.
c) To consider and report on the adequacy of the Risk Assessment Procedure as applied to Ms X and the related staff issues regarding the application of the procedure.
d) To examine the adequacy of the collaboration and communication between all the agencies involved in the care of RS or in the provision of services to her, including, Bournewood NHS Trust, Primary Care Services, Surrey Social Services, Police, local Borough Council and Child Protection Services.
e) To report on the adequacy of service provision to meet the assessed needs of Ms X
f) To highlight any service specific issues which need to be addressed and to make recommendations for service improvements consequent to this review

2. The panel will use the NHS Executive Guidance of August 2000 on Serious Incidents and Bournewood's agreed Action Plan on Safer Services, the National Confidential Inquiry into Suicides and Homicides by People with mental Illness in assessing the effectiveness on the local service response in this case.

3. The Panel will report to the Bournewood Trust Board, Surrey Social Services and West Surrey Health Authority by 14 September 2001.

4. The Panel will need to take into consideration legal advice and not to jeopardise any future legal investigations or proceedings that may be taken against Ms X.

Appendix 4

Internal Inquiry recommendations

1. The Trust should implement its plans for a specialist day service for people with severe personality disorder. This could be done on a limited basis within the existing resources, possibly in partnership with other providers in West Surrey; resource parameters need to be agreed with local commissioners of mental health services.

2. The Trust should implement as a matter of priority its training programme on risk assessment and risk management in mental health services. The training should be mandatory for all professionals who are involved in the risk assessment process.

3. Robust risk assessment including good documentation for people with complex needs remains a high priority for specialist mental health services and professional workloads need to reflect this. The Trust and Social Services management should ensure that the caseloads of individual clinicians are containable within the requirements to ensure that proper and effective risk assessment can be delivered.

4. The risk assessment process must take account of the person's behaviour in both the acute setting and the environment in which they normally live. This will enable the risk assessment to be used to help make a more appropriate effective determination of a client's suitability for home leave.

5. The review of mental health policies and procedures should be completed to link with the establishment of the new Mental Health Partnership Trust in April 2002. In particular a procedure on day leave should finalised to give suitable guidance to nursing staff on the Wards.

6. The Trust and Social Services should ensure in implementing its revised CPA policy that the role of the care co-ordinator is clearly defined and that full training is put in place to enable both health and social services care practitioners to take on its role.

7. The Trust should review its current documentation with a view to implementing a single clinical record for both hospital and community mental health services. Given that this is likely to take time to implement, the Trust should consider a summary sheet (reviewed on a regular basis) for key clients with key facts, trigger points and service responses that can be held by both the hospital and the community team.

8. The Trust should ensure that care Co-ordinators/keyworkers in the CMHT attend all care planning meetings in hospital relating to their clients.

9. We recommend that planned locum consultant appointments allow for a suitable handover period of a minimum of 3 days.

10. Carer's assessments should be introduced as an integral part of the care planning process in cases where a carer is identified.

11. A link worker from the Windmill Team should always attend Ward rounds and CPA reviews and other care planning meetings for people being co-worked, and ensure regular face to face communication between these key service providers for this group of clients.

12. The Trust should maintain a register of all people with dual diagnosis within its care for circulation to all parts of the specialist mental health service. CMHT's should be responsible for compiling and updating the register for the localities on a monthly basis with the other specialist services involved.

13. We recommend that, for every client on an enhanced CPA there is a single person identified for each client, in each agency involved to ensure communications of key points are communicated effectively between the services.

Appendix 5

Glossary

ACU Abraham Cowley Unit
AED Accident and emergency department
ASW Approved social worker
CBT Cognitive behavioural therapy
CMHT Community mental health team
CPN Community psychiatric nurse
CPA Care progamme approach
CRT Crisis response team
DAT Drug and alcohol team
GP General practitioner
PTSD post traumatic stress disorder
SHO Senior house officer