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REPORT OF THE PANEL APPOINTED BY THE ESSEX STRATEGIC HEALTH AUTHORITY TO REVIEW THE CARE AND TREATMENT PROVIDED FOR MR GARY ROBERTS

May 2008

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A. Introduction

1. This is a report made to the East of England Strategic Health Authority as successors to the Essex Strategic Health Authority by Dr John Bradley, Fellow of the Royal College of Physicians, Fellow of the Royal College of Psychiatrists, Emeritus Consultant Psychiatrist and Chair of our Panel; Mrs Dee Fagin, Registered Mental Nurse, formerly a Psychiatric Nurse Manager and now a Forensic Mental Health Nurse; and Mr Colin Brown, a Solicitor now retired from active legal practice but with experience of medico-legal practice both inside the National Health Service and in private practice . We are, of course, the members of the independent panel appointed by the Essex Strategic Health Authority to review the psychiatric care and treatment provided for Mr Gary Roberts of Leigh-on-Sea. The review has been carried out following Mr Roberts' conviction, on grounds of diminished responsibility, of the manslaughter of Miss Jane Poppy, his girlfriend, on the 25 December 2002. Mr Brown has also acted as the Secretary to the Panel.

2. Mr Roberts has convictions for previous criminal offences. These offences are variously described in his psychiatric records, but include a conviction related to the stabbing of another person in 1992, for which he was sentenced to 15 months imprisonment, and a further conviction for possessing an offensive weapon and/or affray in November 1997, for which he was placed on probation for two years.

3. The limitations to the scope of this report are due to the circumstances set out in paragraph 36 below.

B. Definitions

4. In this report the words and expressions listed below shall have the meanings given to them below:

"Mr Roberts" shall mean Mr Gary Roberts of Leigh-on-Sea, Essex

"Mr J Roberts" shall mean Mr Gary Roberts' father.

"Mrs Roberts" shall mean Mr Gary Roberts' mother.

"the Authority" shall mean the Essex Strategic Health Authority but shall include the East of England Strategic Health Authority where the context permits or requires.

"the Trust" shall mean the South Essex Partnership NHS Trust, the National Health Service body responsible for the provision of psychiatric care and treatment to Mr Gary Roberts at the times relevant to this report, and including (where the context permits or requires) its predecessor or successor NHS and Social Services bodies.

"the 1983 Act" shall mean the Mental Health Act 1983 (including all subsequent, relevant amendments).

"CPA" shall mean the Care Programme Approach, being an administrative measure introduced in April 1991. It is applicable to all persons under the care of specialist mental health services. Its aims are to ensure good clinical practice and the provision to every individual client of all the facilities and services which he or she may require for the proper care and treatment of his or her mental health problems. It consists of four parts, namely the assessment of a client's health and social care needs, a written care plan, the appointment of a Care Co-ordinator with the prime responsibility for ensuring the delivery of that care plan, and regular reviews.

"Client" shall mean a person receiving care and treatment for mental illness, including Mr Roberts, whether or not that person might also otherwise be described as "a patient".

"CMHT" shall mean a Community Mental Health Team.

C. Our Terms of Reference

5. Our terms of reference from the Authority are:-

1. To examine and review the report of any Internal Review by the Trust including:

i) The quality and scope of Mr Roberts' health and risk assessment.

ii) The appropriateness of his care, treatment and supervision having regard to:

(a) his assessed health and social care needs,

(b) his risk assessment of potential harm to others,

(c) any previous psychiatric history, and

(d) the nature, extent and relevance of any previous criminal involvement or convictions known.

iii) The extent to which his care corresponded with statutory obligations, in particular the Mental Health Act 1983 and the relevant guidance from the Department of Health (including CPA HC(90)23, LASSL (90)11, Discharge Guidance HSG (94)27 and local operational policies).

2. *To examine the inter-agency relationships in the case, including the links between the General Practitioner and the secondary psychiatric services.*
3. *To consider any other facts that appear to be relevant.*
4. *To produce a report and to make recommendations to Essex Strategic Health Authority."*

D. Executive summary

- Mr Gary Roberts was convicted, on grounds of diminished responsibility, of the manslaughter of Miss Jane Poppy on the 25 December 2002.

- Mr Roberts, now aged 41, was first in contact with the psychiatric services on the 12 February 1994. Between that date and November 1999 Mr Roberts underwent two periods of in-patient treatment. During the first period he was a voluntary patient and in the second period he was first detained as formal patient, that is to say he was detained compulsorily under the Mental Health Act, and then when the authority for his detention ended, he remained in hospital for a time as a voluntary patient. Outside those two periods as an in-patient, he received care and treatment in the community. During the second stay in hospital, he was put on probation for two years on the 26 November 1997 on a charge of having been in possession of an offensive weapon. Mr Roberts' records also refer to an earlier conviction for wounding, for which he had served a prison sentence of 15 months. By October 1997 the diagnosis for Mr Roberts was one of paranoid schizophrenia.

- In November 1999 Mr Roberts required hospital admission again for a serious, self-inflicted injury to his throat and for his psychiatric condition. His admission for his psychiatric illness was again formal under the Mental Health Act. After the necessary, immediate treatment for his throat injury had been given, Mr Roberts was transferred to Runwell Hospital, Wickford, Essex, where he remained until the 20 February 2000, when he was discharged for further care in the community under the supervision of his Consultant Psychiatrist and the Southend Community Mental Health Team under the Mental Health Act 1983 (as amended). The period of supervision came to an end on the 18 January 2001. Mr Roberts then continued to be treated in the community as a voluntary patient. From discharge from in-patient care on the 20 February 2000 until the 8 August 2002 Mr Roberts was seen with acceptable regularity by Community Psychiatric Nurse (CPN)1, his Care Co-ordinator and psychiatric care was provided by Consultant Psychiatrist 5, until the 29 October 2000, when Consultant Psychiatrist 5 left the Trust, and then by locum Consultants until CP6, a new Consultant, joined the Trust on the 5 November 2001.

- Consultant Psychiatrist 6 did not actually see Mr Roberts until the 18 September 2002 and Community Psychiatric Nurse (CPN)1's successor as Care Co-ordinator, CPN2, only saw him on one occasion, namely the 19 November 2002, though it should be noted that during his relatively short time as Mr Roberts' Care Co-ordinator there were appointments for him to see Mr Roberts, which Mr Roberts did not keep, or calls to Mr Roberts' home, together totalling seven. On the 18 September 2002 Mr Roberts asked that he should be allowed to give up his maintenance injections of depot medication and Consultant Psychiatrist 6 reluctantly decided that he had no grounds to refuse that request. On the 19 November 2002 CPN2 was of the view that Mr Roberts did not present with any overt, psychotic symptomatology; that there was no evidence of any perceptual abnormalities; and that there was no suicidal/self-harming ideation or risk to others. Mr Roberts did not keep an Out-patient's appointment to see Consultant Psychiatrist 6's Clinical Assistant on the 18 November 2002.

- The Independent Panel decided to concentrate on the period from March 1999 to December 2002, as that period included both the care and treatment preceding the self-inflicted injury to Mr Roberts' throat in November 1999 – a serious incident in itself – and his care and treatment during the three years leading up to the sad events of the 25 December 2002.

- Between the Independent Panel commending its task in April 2005 and reporting to the East of England Strategic Health Authority on the 14 July 2007, the Trust had carried out its own internal review of the case and its review body (referred to in this summary as "the Internal Panel") had made numerous recommendations, many of which either had been implemented or were in the course of implementation by the time the Independent Panel was undertaking its work. It should also be stated that the Trust's ratings by the Healthcare Commission in its Annual Performance Ratings for 2005/06 were "Excellent" for its use of resources and "Good" for the quality of its services, and in January 2007 it achieved Level 2 in the NHS Litigation Authority's Clinical Negligence Scheme for NHS Trusts, which is an indicator of the Trust's competence broadly in the field of risk management achieved by only eight mental health trusts. These more recent developments provided grounds to believe that the Trust has resolved several of the service problems, which the Independent Panel identified in this case.

- The Independent Panel invited GP1, Mr Roberts' General Practitioner, the Probation Service and Social Services' Child Protection Service to contribute to the review, if they wished to do so. GP1 accepted that invitation. The Independent Panel also met Mr Roberts' parents when they took advantage in late-2006 of an offer of a meeting first made to them some time previously.

- The Independent Panel decided that there were fifteen matters arising from their enquiries which required their further consideration. The leading one was the position of CPN2 when he took over as Mr Roberts' Care Co-ordinator in August 2002. He took over from CPN1, who had been Mr Roberts' Co-ordinator for a considerable time; who was more experienced; and who had built up a good relationship with Mr Roberts and his parents. CPN2 was concerned about his personal safety, if he had to visit Mr Roberts on his own. The Community Mental Health Team was never able to provide CPN2 with a colleague actually to accompany him on visits, and generally there seemed to have been a lack of supervision, advice and training to help CPN2. It was also relevant that CPN2 became Mr Roberts' Care Co-ordinator some time after a comparatively new Consultant Psychiatrist had taken over Mr Roberts' case but without having yet seen him or even being aware of Mr Roberts' existence. In any event, it appeared to the Independent Panel that requisite support, supervision and training were not available to CPN2, when he took over as Mr Roberts' Care Co-ordinator. However, it has been borne in mind that the Independent Panel had no opportunity of discussing the matter with a member of the Community Mental Health Team's immediate management at the material time. Accordingly, the Independent Panel saw the problems which affected CPN2's conduct of Mr Roberts' case as being problems of the whole service at that time, rather than problems resulting from any individual acts or omissions.

- The Independent Panel's other conclusions included:

    a. a finding that they had not been able to establish that Mr Roberts' medication had been continued right up to the time when he injured his own throat. It may have been, but the records did not show it;
    b. the inability of the Trust, perhaps through recruitment difficulties, to provide treatment at times by Consultant Psychiatrists holding permanent posts rather than locum ones;
    c. the view that the CPA, a process broadly aimed at achieving good clinical practice and delivering required facilities and services to a patient, had not been fully

implemented in Southend in 1999-2002, and doubts whether that process had actually facilitated the delivery of care and treatment to Mr Roberts;

d. the lack of any system for informing a new Consultant Psychiatrist of the identities of his patients, so that he could decide which of them he might need to see as a matter of priority; and

e. in response to Mr Roberts' parents' concerns, stressing the need for professionals involved in care and treatment to communicate fully and accurately with near relatives involved in a patient's care and to ensure that they have all the information they need to play their full part in that care.

The other matters addressed by the Panel are matters which had already been addressed by the Internal Panel and/or which do not need to be highlighted in this summary.

- The Independent panel makes certain recommendations. A number of them are recommendations that the Strategic Health Authority seeks assurances from the Trust on specific matters of concerns arising in this case. Others address the present state of the implementation of the CPA, a contractual matter regarding Community Psychiatric Nurses of CPN2's grade and confirmation that emergency assistance is now available to relatives and lay carers through telephone numbers local to the patient's place of residence.

E. Summary of Mr Roberts' psychiatric history and treatment

6. In order that this report can be seen in its proper context, we now set out a summary of Mr Roberts' psychiatric history and his care and treatment.

7. Mr Roberts was born on 29 October 1965.

8. His first contact with the psychiatric services was on the 12 February 1994, when he was admitted to Runwell Hospital, Wickford, Essex as an informal (i.e. voluntary) patient on a referral from the North Middlesex Hospital after taking an overdose of haloperidol. The diagnosis was that of amphetamine-induced psychosis, though alcohol abuse and paranoid schizophrenia were also considered as possibilities. He was discharged on the 1 March 1994. From that date until September 1997 he was treated at psychiatric out-patient clinics and by his General Practitioner, GP1, who was actively involved in his psychiatric care on three occasions. On the first of them (14 November 1994) GP1 was concerned with Mr Roberts' increasing paranoia and the fact that he had stopped taking his medication. On the second (15 December 1995) GP1 recorded that Mr Roberts was expressing numerous paranoid beliefs, and on the third (29 August 1997) GP1 asked for him to be sent another out-patient appointment because he was overtly paranoid again and had barricaded himself in his room.

9. Indeed, on the 30 August 1997 Mr Roberts was compulsorily admitted to Runwell Hospital under Section 2 of the 1983 Act. The first medical recommendation - by Consultant Psychiatrist 1 at Runwell Hospital - found that Mr Roberts was suffering from persecutory delusions; that he had barricaded his room and slept with a knife under his pillow; that he lacked insight and refused voluntary hospitalisation; and that *"For the sake of his own safety and of others he should be hospitalised"*. The second recommendation was provided by GP1, who concluded that Mr Roberts had paranoid delusions with no insight into his condition. Social Worker 1, a social worker appointed by the local Social Services Authority for the purposes of the 1983 Act (including making application for the compulsory admission of clients to hospital), interviewed Mr Roberts on the 29 August 1997 and completed the application for his admission to hospital under Section 2 of the 1983 Act that

same day. While the necessary procedural steps were being taken, Mr Roberts absconded but was detained by the Police on the following day and taken to Runwell Hospital.

10. At Runwell Hospital the previous criminal conviction for wounding, for which he had been sentenced to 15 months imprisonment, was noted, as was the further charge relating to the possession of an offensive weapon, which was due to be heard in Southend-on-Sea Magistrates' Court on the 20 October 1997. Mr Roberts was said to have *"potential for aggression"*, to be *"full of paranoia"* and to have *"a total lack of insight into his mental health problems".* The initial diagnosis was one of brief psychosis and query schizophrenic type of psychosis.

11. In Runwell Hospital Mr Roberts' condition improved until on the 27 September 1997 Consultant Psychiatrist 1 allowed the authority for his detention under Section 2 of the 1983 Act to lapse. After that date Mr Roberts remained an informal patient in the Hospital.

12. On the 19 September 1997 a CPA meeting was held and the action plan for Mr Roberts was agreed as follows:

    a. That he would be given Out-Patient appointments with Consultant Psychiatrist 1 or his successor .

    b. That he should be referred to a Forensic Psychiatrist.

    c. That intra-muscular injections of depot medication would be considered for him, with

    CPN1 [the Community Psychiatric Nurse allocated to him] administering these injections at the Community Mental Health Team Clinic, if necessary.

13. A case conference was held on the 7 October 1997, attended (amongst others) by the Consultant Forensic Psychiatrist, Consultant Psychiatrist 1 and Mr Roberts. Those present were told of Mr Roberts' criminal record. After a review of, and discussion about, Mr Roberts' mental state, the Consultant Forensic Psychiatrist is noted as having said that according to the discussions at the conference it was clear that Mr Roberts suffered from mental illness, namely paranoid schizophrenia. The Consultant Forensic Psychiatrist apparently added that from the history there were clear indications that there were times when Mr Roberts exhibited these paranoid symptoms even when he was not taking any

illicit drugs. The Consultant Forensic Psychiatrist is said to have further explained to Mr Roberts that although he seemed to function well when taking his medication, it was difficult to predict his future compliance.

14. The recommendations for treatment made as a result of this conference were as follows:

    a. *It was sufficiently clear from the above discussion that Gary* [Mr Roberts] *still lacked insight into his mental illness and there was high risk of future non-compliance with medication and subsequent relapse. It would be advisable to start him on depot anti-psychotic medication as soon as possible.*
    b. *As there was also a high risk to himself by non-compliance and also to others in view of his past history of violence it was recommended that he should be placed on the supervision register. This process was explained to him.*
    c. *As he is attending a court hearing on 20.10.97 with the charge of possession of an offensive weapon it was recommended that if the court asked for a report, treatment should be mentioned as a condition of probation on the approval of Mr Roberts."*

15. On the 4 November 1997 another CPA meeting was held in which the following plan for his continuing care and treatment was evolved:

    a. To attend a monthly psychiatric out-patient appointment with Consultant Psychiatrist 2 or his successor;
    b. To commence depot medication to be administered by CPN1, if Mr Roberts was willing to attend the Queensway Community Mental Health Team Clinic;
    c. To attend the Henry Hayes Centre, if requested; and
    d. There should be input from the Probation Officer.

16. Mr Roberts' outstanding court case was dealt with on the 26 November 1997, when he was placed on probation for two years with a condition that he should undergo treatment. He was then discharged from Runwell Hospital on the 2 December 1997.

17. His discharge from hospital was followed by care in the community for nearly two years until the 14 November 1999, in the course of which CPN1, his Care Co-ordinator, made

regular visits to him to administer his fortnightly depot injections and to monitor his mental state. Mr Roberts was also seen on four occasions in the Out-patient Department in addition to telephone contact between CPN1 and Mr Roberts' Probation Officer.

18. From the 1 October 1998 onwards some longer intervals occurred between contacts with Mr Roberts, though up to March 1999 Mr Roberts generally gave no cause for concern to CPN1 or to the Probation Officer.

19. On the 30 March 1999 the Probation Officer passed on to CPN1 the information that recently Mrs Roberts had been concerned about her son's behaviour in a restaurant, when he was said to have been paranoid and shouting at other diners. He was also said not to have been taking his medication. After he had failed to keep an appointment with the Probation Officer and CPN1 on the 31 March 1999, they did see him on the 6 April 1999 and arranged an appointment for him to see Consultant Psychiatrist 3, on the 12 April 1999. CPN1 set out the position in a letter dated the 12 April 1999 to Consultant Psychiatrist 3. In that letter he advised that Mr Roberts had become paranoid and suspicious about another diner, leading to a verbal confrontation, and also that Mr Roberts had expressed some paranoid thoughts about his girl-friend at the time, who was pregnant. Moreover, when the Probation Officer and CPN1 spoke to Mr Roberts about the incident, he was very angry about their intrusion and, although never aggressive physically, he had been very much on edge. He was still convinced that the IRA or the Mafia were after him and would eventually get him. CPN1 also reported that Mr Roberts had absolutely no insight into his current state and presented a significant risk to the general public.

20. However, on the 12 April 1999 Consultant Psychiatrist 3 assessed him as being placid and pleasant and found no evidence of change in his speech or mood. Mr Roberts was said to have been drinking twenty pints of lager a week. Because he would not accept a depot injection, Consultant Psychiatrist 3 changed his medication to *Olanzepine*, *10mg,* at night.

21. Mr Roberts was seen again at a clinic on the 11 May 1999, this time by Consultant Psychiatrist 4, a Locum Consultant, when he was said to have been doing very well, to have been complying with his medication and when there was no evidence of suicidal or homicidal ideas. Indeed, Mr Roberts' improvement seems to have been maintained at a

meeting with CPN1 on the 28 June 1999 and a further meeting with CPN1 and the Probation Officer on the 4 August 1999. Thereafter, in spite of attempts to meet him, CPN1 and/or the Probation Officer were unable to do so, and on the 15 November 1999 a message was received from Mr J Roberts [Mr Roberts' father] about the incident mentioned in the next paragraph, which led to Mr Roberts' further hospitalisation.

22. On 14 November 1999 Mr Roberts was admitted to Southend General Hospital for the treatment of wounds sustained when he had stabbed himself in the throat with a broken bottle. On the 17 November 1999 he was compulsorily detained for treatment of his psychiatric condition under Section 3 of the 1983 Act. The application for that detention was made by Social Worker 2, a social worker approved for that purpose, who recorded the view ascribed to Mr J Roberts that if his son was not treated, he was in danger of killing himself or other people. Social Worker 2 also concluded that Mr Roberts' parents were unable to manage his behaviour and were likely to have been at risk of violence from their son because of his paranoid beliefs. GP2 and Consultant Psychiatrist 5, the two doctors providing the medical recommendations in support of Mr Roberts' compulsory detention, also concluded that Mr Roberts was a paranoid schizophrenic, who had caused severe harm to himself and might do likewise to his close family (GP2) and that he might be very difficult to contain as he was very violent (Consultant Psychiatrist 5).

23. The need for treatment of Mr Roberts' throat injury necessitated his stay at Southend General Hospital until 23 November 1999, when he was transferred to Runwell Hospital. In the early stages of his treatment in Southend General Hospital he was agitated and incidents of violence directed against the hospital staff by him are recorded, but his condition began to improve from about the 20 November 1999. Consultant Psychiatrist 5 visited Southend General Hospital during this period to advise on Mr Roberts' medication. When Mr Roberts was transferred to Runwell Hospital, he was admitted initially to the intensive care unit. He exhibited paranoid ideas and other psychotic symptoms attributed to the recent birth of his daughter. Also he was said not to have taken his *Olanzepine*, but to have been taking large amounts of alcohol and possibly illicit drugs.

24. His psychiatric condition began to improve, but he felt uneasy there at night because of the disturbed atmosphere of the ward and the fear that he might be attacked. To relieve this

unease, the staff planned his transfer to an acute ward, and arranged for him to attend that ward for day care until a bed became available for him there. In the meantime Mr Roberts continued to sleep on the intensive care unit. He was then transferred to the acute unit on the 3 December 1999 and generally he did not present any management problem to the ward staff. A CPA review followed on the 14 December 1999 in which Mr Roberts' parents and girl-friend were told of the staff's concerns (his lack of insight, his poor compliance with his medication regime and his drinking to excess) and of the fact that those concerns made his relapse a high possibility. It was then emphasised to them that they must inform his professional carers immediately, if his condition began to deteriorate. Mr Roberts' parents and girl-friend were told of the plan for a supervised discharge under Sections 25A to 25H of the 1983 Act, and Consultant Psychiatrist 5 explained that depot medication would be necessary for the foreseeable future, with only the dose being variable according to Mr Roberts' mental state from time to time.

25. Mr Roberts was then granted various periods of leave with his parents, and generally no difficulties occurred, save for one apparently minor altercation with another patient on the 24 December 1999. Further CPA reviews took place on the 11 and 18 January 2000, when the proposal for Mr Roberts' supervised discharge was pursued, agreed and apparently authorised. The agreed arrangements included:

a. depot medication of *Depixol* (*40mg* according to the ward nursing note, but 60*mg* according to the Discharge Summaries) with CPN1 to give Mr Roberts his first injection on the Monday after the meeting on the 11 January 2000;
b. a case conference to be arranged to safeguard the children close to him, namely his girlfriend's elder child, of which he was not the father, and his daughter by her;
c. an agreement that no practitioner/community staff should visit him on his or her own;
d. Mr Roberts' family being reassured that they could telephone any member of the team associated with his care at any time if there were any concerns about him, with the relevant telephone numbers being given to family members; and
e. the family also being advised that if Mr Roberts required admission at any time, he should be taken to Heron ward.

26. The order for Mr Roberts' formal detention under the Act was discharged on 20 January 2000 and a supervision order was substituted in accordance with Sections 25A to 25H of the 1983 Act. GP1, his General Practitioner, the Social Services' First Contact Team and the Child Protection Team were advised by telephone of Mr Roberts' change of status.

27. Before Mr Roberts was discharged, Consultant Psychiatrist 5 wrote to him on the 13 January 2000 about his new status as a patient on supervised discharge under Sections 25A to 25H of the 1983 Act. In his letter Consultant Psychiatrist 5 set out the agreed care plan, which was in the following terms:

a. The Team would help Mr Roberts and his girl-friend to obtain suitable accommodation so that they could live together;
b. Mr Roberts should not return to work until the Team felt that he was mentally stable;
c. Mr Roberts would not abuse illicit substances and would avoid abusing alcohol. Mr Roberts' attendance at the Roche Unit might be considered, if he did not comply;
d. Mr Roberts' girl-friend and his family would provide the Team with feedback regarding his mental state;
e. Mr Roberts would comply with his depot medication and any other medication that Consultant Psychiatrist 5 may prescribe; and
f. CPN1 would visit Mr Roberts initially on a weekly basis and would administer the depot medication of *Depixol 40 mg* fortnightly.

28. At the same time as Mr Roberts was discharged, his relationship with his girl-friend broke up, but fortunately, and with the benefit of close contacts between Health and Social Services personnel and the active involvement of Consultant Psychiatrist 5 and CPN1, this did not precipitate any significant or lasting deterioration in Mr Roberts' mental state. The only other comment which has to be made in this connection is that one of the factors which featured in this break-up was the suggestion that Mr Roberts had struck his girl-friend's elder child, of whom he was not the father. However, the records, although suggesting that there *"would appear to be some credence"* in this claim, do not contain any proof that this had actually happened. Mr Roberts subsequently confirmed that he at no time intentionally struck his then girl friend's eldest child and that any contact was accidental in the course of play.

29. After discharge and until the 8 August 2002, Mr Roberts was seen with acceptable regularity by CPN1 (by our calculations forty-seven attendances in approximately two years and seven months) in addition to nine consultations at outpatient clinics. During that period Mr Roberts missed a number of appointments with CPN1 - perhaps it would have been unreasonable to have expected otherwise - but in these instances CPN1 promptly rearranged further meetings to maintain contact with Mr Roberts if he missed an appointment. During this period Mr Roberts' depot medication was reduced from *40mg of Depixol fortnightly to 30 mg* on the 14 July 2000 and then to *20 mg* on the 28 February 2001.

30. The supervised discharge arrangements were renewed on the 18 July 2000 and then brought to an end on the 18 January 2001. Care plans for Mr Roberts were drawn up on the 17 April 2000 and eight months later on the 4 December 2000. There is no record of further CPA steps until twelve months later when a further care plan was drawn up, though CPN1 made his routine visits regularly throughout that period. A further review followed two months later on the 3 April 2002. It is not clear whether the April review was prompted by Mr Roberts' mental state at that time, as a contingency plan was drawn up to address the risks which he posed, or whether it was prompted by the anticipated departure of CPN1 to pursue post-graduate training.

31. Consultant Psychiatrist 5 left the Trust's employment on the 29 October 2000 and psychiatric care was then provided by locum consultants again until Consultant Psychiatrist 6 joined the Trust's staff as a substantive Consultant Psychiatrist on the 5 November 2001. He did not see Mr Roberts until the 18 September 2002 and, indeed, did not know of Mr Roberts' existence until that date. Moreover, on the 8 August 2002, CPN2 took over from CPN1 as Mr Roberts' Care Co-ordinator. CPN2 felt unable to visit Mr Roberts on his own because of his concerns about his own personal safety and as no colleague was available to accompany him, CPN2's only home visit to Mr Roberts was on the 19 November 2002 and it took place on the doorstep. CPN2 did, however, tell us that he had known Mr Roberts for twelve to eighteen months.

32. At the Out-patient clinic on the 18 September 2002, Consultant Psychiatrist 6 found that Mr Roberts had no psychotic symptoms at that time and had not had any for the last three years. Consultant Psychiatrist 6 recorded that Mr Roberts wanted to stop his injections of depot medication. Consultant Psychiatrist 6 thought that this was unwise but that there was nothing he could do about it. He did, however, advise Mr Roberts' parents, who were attending that appointment, to give early warnings to CPN2 when necessary. When CPN2 saw Mr Roberts on the 19 November 2002 on the doorstep of his home, Mr Roberts told him that he was feeling fine and was not experiencing any problems, and CPN2 concluded that Mr Roberts did not present with any overt psychotic symptomatology; that there was no evidence of any perceptual abnormalities; and that there was no suicidal/self-harming ideation or risk to others.

33. An assessment of the risk presented by Mr Roberts was completed by CPN2 nine days later on the 28 November 2002, which indicated a severe risk of violence or aggression to others. Such an assessment should normally be made in the course of a face-to-face contact with the client, whereas the dates in this case, taken alone, may suggest that the assessment was made nine days after the last face-to-face meeting. However, CPN2 has told us that in this instance the reason for the apparent discrepancy in the dates was simply that it took him several days to complete the form based on his face-to-face meeting with Mr Roberts on the 19 November 2002. It must also be noted that during CPN2's time as Mr Roberts' Care Co-ordinator appointments for CPN2 to see Mr Roberts, which Mr Roberts did not keep, or fruitless calls at Mr Roberts' home, totalled seven.

34. Mr Roberts then failed to attend an Out-patients' clinic appointment with, Consultant Psychiatrist 6's Clinical Assistant, on the 18 November 2002. Mr Roberts subsequently confirmed he did not attend this appointment, he believed this was due to a change in his postal address which meant that a number of letters did not reach him during that period.

35. The sad events which have given rise to our review then occurred on the 25 December 2002.

F. Our approach to our task

36. As stated in paragraph 3, the limitations to the scope of this report are for the following reasons:

a. The lapse of time between the unfortunate events of the 25 December 2002 and the date on which we were in a position to start our review. In that respect Dr Bradley and Mr Brown were appointed as members of our panel in March 2004 but two problems caused delay in the commencement of the work of this review. First, the difficulty of identifying an appropriate, senior nurse to be a member of the panel was not resolved until Mrs Fagin was approached to act in that capacity in April 2005 and kindly agreed to do so in that same month. Second, Mr Roberts' consent to our having access to his psychiatric records was not forthcoming until that same month (April 2005). The result has been that two years and four months had elapsed since December 2002 before we were able even to start the initial work of considering the records and papers in the case in order to decide who were the people whom we would have to meet in order to obtain a full understanding of the nature of Mr Roberts' care and treatment and the reasons why it had taken the form which it did take.

b. The Summary of Mr Roberts' Psychiatric History and Treatment set out above shows that his first contact with the Psychiatric Services occurred on the 12 February 1994, with the consequence that the earlier aspects of his care and treatment were already 11 years old by the time we started our work. For that reason we considered whether it was really necessary, and likely to be fruitful, for us to carry out a full review from February 1994, including trying to trace witnesses from that time. We recognised that, if we were not to do so, we might not fulfil our terms of reference exhaustively; nevertheless we concluded that it would be counter-productive for us to undertake the full review, because (i) we were reluctant to see further time pass by while we tried to trace earlier witnesses; (ii) even if we managed to trace some of the earlier witnesses, it seemed to us to be unlikely that they would be able to recall much more about Mr Roberts than was already apparent from the contemporaneous records; and (iii) the care and treatment afforded to him in more recent times were likely to be of far greater significance to our work than his earlier history and treatment. We had regard

to the fact that the underlying purpose of our review is to try to find out if everything that could or should reasonably have been done by way of care and treatment for Mr Roberts with the ultimate view to preventing Miss Poppy's death, had been done or whether there were gaps or improvements to be filled or made in future cases in an endeavour to prevent a similar tragedy occurring. We, therefore, decided to concentrate mainly on the care and treatment provided for Mr Roberts from March 1999 to the 25 December 2002.

c. The Trust has informed us that no member of the management of the Southend Community Mental Health Team still remains in its employment, with the result that we have not been able to discuss the case first-hand with anyone involved directly in the management of the Community Mental Health Team at the material times. This is unfortunate as a number of management issues arise in the case. These issues were canvassed to some extent in the Trust's internal review and the report from that review and the transcripts of the internal review panel's meetings with witnesses have been made available to us. However, it would have been far more satisfactory for us to have had an opportunity to discuss matters with the Community Mental Health Team's immediate managers directly rather than having to rely on these transcripts.

d. The Trust's internal review panel has, as one would expect, made various recommendations for action following its consideration of the case. It may well be that the implementation of those recommendations has already resolved several of the points which are concerning us in the case, but we cannot tell whether or not that is actually so without making further enquiries of the Trust. To do so may be outside the scope of our terms of reference and/ or unacceptable to the Trust and/or would increase the cost of our review.

37. Because of the matters appearing in paragraph 36, particularly sub-paragraph d, we consider it right to submit this report now, so that the Authority may appreciate the limitations on the work which we have been able to do and decide whether they wish to enquire more deeply into the matters of concern which we raise in the following part of this report.

38. What we have been able to do is as follows. We first considered all of Mr Roberts' psychiatric records produced to us (including those prior to 1999). Having read the records,

we agreed that we would meet the leading people involved in Mr Roberts' care and treatment from 1999 to 2002, who were still available. The two Consultant Psychiatrists primarily responsible for Mr Roberts' psychiatric care during that period were Consultant Psychiatrist 5 and Consultant Psychiatrist 6, and we have met both of them for a discussion about his case. During the same period Mr Roberts had two Care Co-ordinators, CPN1 and then CPN2, and again, after resolving some reservations on CPN2's part about meeting us, we have met both of them. Indeed, tracing Consultant Psychiatrist 5 and CPN2 initially through the Trust, whose service they had both left by the time we were able to begin our work, also added to the passage of time since the material events. However, we were ultimately able to meet Consultant Psychiatrist 5 on 22 November 2005, CPN1 and Consultant Psychiatrist 6 on the 20 January 2006 and CPN2 on 27 March 2006.

39. We took an early decision that the interviews of "witnesses" would be as informal as the proper discharge of our duties allowed and would not involve cross-examination in a legal sense. Witnesses were, however, informed that they were entirely at liberty to seek advice and to attend meetings with us accompanied by a representative (professional or trade union) or a friend. Two of our members (Dr Bradley and Mr Brown) have adopted that approach in previous cases and are satisfied that it is more conducive to an open dialogue with a witness rather than having any formal, legal structure to such meetings. We believe that in this way we obtain a more complete and open account of the relevant events and understanding of the part played by each witness in the relevant care and treatment. However, this approach need not, and does not, prevent adverse findings being made by us where they are justified. Witnesses were also advised that if the Panel finds it necessary to criticise any of them, then an extract from our draft report setting out the criticisms would be sent to the witness concerned, who would then be given a further opportunity to comment on the criticisms either in writing or at another meeting, before the report is finalised. This approach to witnesses is generally helpful in overcoming reservations about meeting us, particularly in a case like this one where the material events occurred some years ago. In this regard it is important to remember that we are entirely reliant on the goodwill of witnesses agreeing to meet us, as we have no legal powers to insist that they do so.

40. Experience has also shown us that the reorganisation of NHS bodies can give rise to problems when, for example, a newly-constituted trust or authority has to co-ordinate pre-existing policies or protocols on matters affecting service delivery, such as the CPA and Risk Assessment. In that regard we were told by the Trust's Director of Inpatient and Rehabilitation Services, in another review broadly covering the same period as we are concentrating on in this case, that the Trust came into being on the 1 January 2000 when it assumed the functions of two predecessor trusts, one of which was the Southend Community Care Trust. Then, on the 1 April 2002 the Trust took over the mental health responsibilities of certain local authorities, including Southend Borough Council.

41. We wrote to GP1 (Mr Roberts' General Practitioner), the Probation Service and Southend-on-Sea Social Services' Child Protection Service, inviting them to contact Colin Brown if they wanted to meet us to discuss any concerns about Mr Roberts' care and treatment which they had, or to write to Mr Brown about those concerns, if they preferred that method of communication. Only GP1 replied and the points which he raised are considered in paragraphs 84 and 85 below. We have also met Mr J Roberts and Mrs Roberts (Mr Roberts' parents), and summarise our contacts with them in paragraphs 86 to 88 below.

G. The legal position

42. The relevant legislation is still to be found in the 1983 Act. A wide-ranging review of that Act was announced by the then Secretary of State for Health in July 1998. An expert committee was appointed to consider the changes needed to the 1983 Act and in due course it formulated proposals, which were submitted to consultation.

43. However, on the 23 March 2006 the Health Minister, Rosie Winterton, announced "...a fresh approach to overhaul mental health law..." and that announcement has now been followed by the introduction of a new Mental Health bill into Parliament in November 2006.

44. Therefore, both at the time of the events which have given rise to our review and currently, the 1983 Act is the principal act governing the compulsory admission to, and detention in, hospital of someone requiring compulsory in-patient assessment or care for mental disorder.

45. We think it appropriate briefly to consider the material provisions of the 1983 Act, because on two occasions in the course of Mr Roberts' care and treatment the Consultant Psychiatrists with responsibility for him felt that those provisions did not permit them compulsorily to admit him to hospital.

46. Section 2 of the 1983 Act authorises the admission of a person to hospital and his detention there for a period of up to 28 days, if that person is suffering from mental disorder of a nature or degree which warrants his detention there for assessment, or assessment followed by treatment, for at least a limited period, and the person ought to be so detained in the interests of his own health or safety or with a view to the protection of others. Section 3 provides for the admission of a person to hospital and his detention there for an initial period of up to six months, renewable, if he is suffering from certain specified mental conditions and if other requirements set out in the Section are fulfilled. For our purposes the main one of these requirements is that the client should receive the treatment for his own health or safety or for the protection of other persons and that it cannot be provided unless he is detained under Section 3.

47. Over the years the 1983 Act has been the subject of considerable litigation aimed at defining its precise effect, and earlier decisions demonstrate the point that a client has to meet the precise requirements of the Act before it is available as a basis for his compulsory detention in hospital.

48. Consultant Psychiatrist 5 told us that he considered recalling Mr Roberts from supervised discharge to the hospital as an in-patient because he was failing to take his medication, but that there was never a case for recalling him simply on that ground. The problem there was that a patient's recall from supervised discharge requires that, unless Mr Roberts had agreed to return to hospital on a voluntary basis, all the conditions attached to compulsory detention under Section 3 would have to be have been satisfied afresh before he could have been legally recalled to hospital on a compulsory basis, and it was not thought to be possible to satisfy that requirement.

49. When Consultant Psychiatrist 6 saw Mr Roberts for the first (and only) time on the 18 September 2002 he found no psychotic symptoms present, and when Mr Roberts was adamant that he wished to stop his depot medication, having warned him in the presence of his parents that it was very unwise to do so, Consultant Psychiatrist 6 decided that there was nothing further that he could do in that regard as, to use Consultant Psychiatrist 6's words to us when we met him, "there were no signs of illness which meant that there was no way of enforcing medication or treatment or anything else." Consultant Psychiatrist 6 added that "So we had to stick to the second best which, in this situation was to try to monitor and try to engage the parents to get in touch if something went wrong of if something peculiar happened or if they had any concerns or saw any signs of illness."

50. Accordingly, it has always to be borne in mind that the present legislation does not necessarily provide the public with a complete means of protection against the risk of injury from another person, even though that other person may have a history of mental disorder and at times be a recognised danger to others.

H. Questions and issues which arise in this case and our consideration of them

51. The questions and issues arising from our enquiries, which in our view require further consideration, are as follows:

- Mr Roberts' care and treatment in the period leading up to the November 1999 incident, when he injured his own throat;
- Consultant care;
- The method of selection of a Care Co-ordinator for a client;
- The handover procedure from CPN1 to CPN2;
- CPN2's concerns about visiting Mr Roberts unless accompanied by a colleague;
- Compliance with the protocols governing the operation of the CPA;
- The experience, qualifications and training of CPN1 and CPN2 respectively; their performance of the role of Mr Roberts' Care Co-ordinator and the effectiveness of management supervision and assistance available to them in that role.
- In-service training for Care Co-ordinators
- Record-keeping and communications generally
- The fact that Mr Roberts was not seen by a Psychiatrist from the 26 September 2001 until the 18 September 2002;
- GP1's comments in his response to our invitation to let us have his views on the case;
- Relationships with Mr J Roberts and Mrs Roberts, Mr Roberts' parents;
- Risk Assessment;
- Services available to CPN2 to help him in the provision of care and treatment to Mr Roberts; and
- CPN2's position as Mr Roberts' Care Co-ordinator.

We now consider each of these topics separately.

Mr Roberts' care and treatment in the period preceding the November 1999 incident, when he injured his own throat

52. Mr Roberts' injury to his own throat on the 14 November 1999 was a serious matter and, no doubt, one of great concern to his parents. We, therefore, decided to include Mr Roberts' treatment in the period leading up to it in our deliberations. On the 12 April 1999 Consultant Psychiatrist 3 had changed Mr Roberts' medication to *Olanzepine, 10mg*, taken orally at night, and had given him a supply of *Olanzepine* for one month. Mr Roberts was then seen on the 11 May 1999 by Consultant Psychiatrist 4, a Locum Consultant, who wrote to Mr Roberts' General Practitioner on the same day confirming that Mr Roberts showed no evidence of any psychotic features and saying that Mr Roberts had told him that he was complying with his medication regime. Locum Consultant Psychiatrist 4 does not say in his letter that any further prescription for *Olanzepine* was given to Mr Roberts and we have not seen any other record to confirm that a further prescription was given to him, though CPN1 noted on the 28 June 1999 that Mr Roberts had told him that he was continuing with his medication. Mr Roberts then did not attend out-patient clinic appointments on the 2 August 1999 and 3 November 1999. This would suggest that at best he was unlikely to have been given prescriptions for anti-psychotic medication for three months before he injured his own throat on the 14 November 1999 and may not have been given such medication for up to six months prior to that injury. Indeed, when admitted to hospital, he was said not to have been taking his *Olanzepine* recently - the periods recorded in the notes vary - but to have been taking large amounts of alcohol and possibly illicit drugs. As indicated in paragraph 21 above, this period coincided with a time of limited contact between CPN1 and Mr Roberts, though the contacts which did take place between them at about that time indicated that Mr Roberts was well. It would, therefore, be no more than conjecture for us now to question whether a reduction in Mr Roberts' medication in the period leading up to the events of November 1999 was a contributory factor to his injuring his own throat. It is unfortunate in a case such as this that we are unable to point to evidence which positively establishes that prescriptions continued after the 11 May 1999.

Consultant care

53. Although they occurred before the 1999/2002 period on which we have concentrated, the following circumstances exemplify the difficulties which can arise from a lack of consistency in Consultant care. Mr Roberts was discharged from Runwell Hospital on the 2 December 1997 by Consultant Psychiatrist 7, Locum Consultant Psychiatrist, on medication which included depot injections of *Clopixol 300mg* intra-muscularly every two weeks. At an Out-patients clinic on the 11 February 1998 Consultant Psychiatrist 8, another Locum Consultant, rejected a request from Mr Roberts for a reduction in his depot medication because of the seriousness of his illness with the potential for violence and his high potential for dangerousness, adding that "it should be possible in a few months time to initiate a small reduction in the medication under regular supervision." Then, on the 6 May 1998 Locum Consultant Psychiatrist 7 agreed to discontinue the depot medication because of its extra-pyramidal side-effects and restart Mr Roberts on *Trifluoperazine*, *5mg bd and Procyclidine, 5mg tds*. This change was linked to monthly reviews in the clinic while Mr Roberts was coming off depot medication. Consultant Psychiatrist 3, then saw Mr Roberts on the 10 June 1998 and while keeping him on the same medication, said that he would review him in eight weeks' time. Thus, a plan for monthly reviews only lasted for one month.

54. During certain periods in Mr Roberts' care and treatment he was seen by different Locum Consultants. One example has already been given in paragraph 53 above, and earlier in 1994/96 Mr Roberts seems to have been seen mainly by locum Consultants and junior staff, being seen by a substantive Consultant on only one occasion. It is self-evident that there is a considerable risk that the quality of psychiatric care and treatment will be adversely affected if the same Consultant Psychiatrist does not consistently and personally provide, or oversee, a client's psychiatric care and treatment. Moreover, in this case Mr Roberts' probation officer between November 1997 and November 1999, wrote to CPN1 on the 6 February 1998 on this very point. In her letter she referred to "*...the serious nature of Gary's current and previous offences ....*", the importance of there being *"...a measure of consistency in his supervision..."* and her hope that as *"...the Psychiatrist performs a very important role in this particular type of Probation Order.....perhaps Gary could see a permanent Consultant Psychiatrist, if one is available, as opposed to a series of locum*

Psychiatrists on short term contracts." At the time of Mr Roberts' Out-patient appointment on the 11 February 1998, Locum Consultant Psychiatrist 8 noted that Mr Roberts' care needed to be undertaken by a permanent Consultant and he wrote to Consultant Psychiatrist 9 on the 18 February 1998 asking if he would consider taking over Mr Roberts' care. There is no reply in the papers which we have seen, but Consultant Psychiatrist 3, who describes himself in his letters as a Consultant Psychiatrist rather than a locum, did see Mr Roberts for three successive Out-patient appointments on the 10 June 1998, the 5 August 1998 and the 3 March 1999, so we assume that Consultant Psychiatrist 3's involvement in the case as a substantive Consultant constituted the practical response to the concerns expressed by the probation officer and Locum Consultant Psychiatrist 8. It then appears that at some time in mid-1999 Consultant Psychiatrist 5 was appointed by the Trust, perhaps directly or indirectly in succession to Consultant Psychiatrist 3, because he became closely involved in Mr Roberts' care from November 1999, when Mr Roberts injured his own throat and was admitted first to Southend General Hospital and then to Runwell Hospital under Section 3 of the 1983 Act for treatment of the mental illness associated with this incident of self-harm.

55. We do, of course, appreciate that an NHS body may have difficulty from time to time in recruiting a sufficient number of substantive Consultants in a given specialty, and that situation may be caused by a variety of factors, some of which may well be beyond the Authority's control. The problem was canvassed briefly in the report of the Trust's internal review but no specific recommendations were made by that panel for dealing with the problem of a shortage of substantive Consultants or of suitable candidates for vacant, substantive posts. Recommendation 31 of the internal review panel advocated a further investigation into the robustness of medical care at the time of the December 2002 incident and that investigation was completed, but it is not clear to us that it covered the point which we are now raising.

56. If it is the Authority's wish that we enquire further into this point, then of course we shall be happy to do so, but it does occur to us that it is a point which can equally easily be resolved by the respective managements of the Authority and the Trust, now that we have identified it as a factor in Mr Roberts' case, which may not have been avoidable but which would have been better avoided, had that been possible.

The method of selection of a Care Co-ordinator for a client

57. Our understanding is that the procedure which was generally in operation when CPN1 was appointed as Mr Roberts' Care Co-ordinator, provided for the appointment of the new Care Co-ordinator to be made at the weekly meeting of the Community Mental Health Team, perhaps after a member of the Team had attended a CPA review on the ward in the case of a client who had been an in-patient, and it then depended on which Team member had the capacity, experience and willingness to take on the new client. CPN1 told us that he was probably the second longest-serving team member when he was appointed as Mr Roberts' Care Co-ordinator and that in accordance with good practice he was asked to attend the ward to meet Mr Roberts and to give Mr Roberts the opportunity of meeting him, before he was appointed as Care Co-ordinator.

58. However, when CPN2 took over as Mr Roberts' Care Co-ordinator in August 2002, we have seen no evidence to confirm that his appointment was made or approved at a Team meeting or was made within the CPA framework. Indeed, CPN2 recalls CPN1 asking him to take on Mr Roberts, but he does not recall the appointment being discussed at a Team meeting. There was a discussion about Mr Roberts' case around the time when CPN2 took over as his Care Co-ordinator, but according to CPN2 it was related more to his concerns for his own safety when visiting Mr Roberts and he accepts that it occurred after he had taken over as Care Co-ordinator, as is borne out by entries in Mr Roberts' records.

59. In this regard, we have not seen any minutes of Team meetings. Moreover, as mentioned above, we understand that the immediate managers of the Community Mental Health Team at the material times have all now left the Trust's employment and we feel that it is unlikely that any further, useful information will be forthcoming from them at this time. However, the fact that CPN1 and CPN2 may well have come to their own agreement that the latter would take over as Mr Roberts' Care Co-ordinator would seem to be explained by an extract from page 17 of the report of the Trust's internal review panel, which reads *"Prior to the introduction of cluster leaders the responsibility for reallocating cases when a member of staff left the team was left with the member of staff leaving.....There is no evidence to suggest the team leader or cluster manager oversaw the process."* As to the

reference to the introduction of cluster leaders in the above quotation, the evidence given to the Trust's internal review panel about the timing of the introduction of cluster leaders was not consistent, though the evidence of Cluster Leader Trainer, herself a cluster leader appointee, and the Assistant Director of Mental Health, was that the cluster leader system was not in operation until January 2003. Accordingly, the probability seems to us to be not only that CPN2's appointment as Mr Roberts' Care Co-ordinator came about simply as the result of an agreement between him and CPN1 but also that the method of his appointment was in accordance with normal practice in the Community Mental Health Team at the time. In that event, the appointment process would not have been in accordance with best management practice nor would it have been consistent with the principles of the CPA. The wording of the internal review panel's report (the latter part of the second paragraph on page 17) implies that the responsibility for appointing a care co-ordinator now rests with the cluster leader and, if that is right and if paragraph 3.3 of the Trust's policy paper, MH Policy 07, is still in force *("Keyworkers* [now Care Co-ordinators] *must only be appointed with their consent....")* that arrangement seem to us to be acceptable.

The handover procedure from CPN1 to CPN2

60. Linked with the selection of CPN2 as CPN1's successor as Care Co-ordinator is the procedure for the hand-over of responsibility between them. CPN1 told us that there was certainly a meeting or two between him, CPN2 and Mr Roberts regarding the handover and a CPA review was carried out, and the records confirm that CPN1 and CPN2 visited Mr Roberts on the 8 August 2002 (the hand-over date) to carry out the CPA review. We also note that four months before the hand-over CPN2 was named in a CPA Contingency Plan dated the 3 April 2002 as a Team member who, with the Duty Officer, could substitute for CPN1, which seems to support the proposition that CPN2 had some knowledge of, or involvement in, Mr Roberts' case some months before he actually took it over.

61. CPN2 also confirmed to us that he felt that he had a good grasp of the case and the risk that Mr Roberts could pose and that although he had some concerns, they were not major concerns. He told us that if his concerns had been major ones, he would have voiced them, but he then added that he *"personally felt uncomfortable visiting him* (Mr Roberts) *on his own, particularly now that he was not taking medication"*, which seems to us to be a

concern of considerable importance. We put to him the point that since he actually performed the job of Care Co-ordinator, presumably he had been happy to take on Mr Roberts or had been prepared to do so. His answer was that he had been prepared to take him on, though he had not relished the thought of doing so. CPN2 also had concerns about the services available to support him in dealing with Mr Roberts - an issue which we consider later in this report.

62. Accordingly, the evidence before us suggests that the hand-over process between CPN1 and CPN2 was satisfactory in that it did give the latter knowledge of Mr Roberts' case and its potential problems, with which he was satisfied at the time of the hand-over of Care Co-ordinator's responsibility.

CPN2's concerns about visiting Mr Roberts unless accompanied by a colleague

63. Certain entries in Mr Roberts' records by CPN2 referred to the need for him to be accompanied by a co-worker when visiting the client at home. For example, an entry dated the 18 September 2002 included the sentence reading *"Will need to request a co-worker for home visits to protect personal safety"* and a note in Mr Roberts' records of a discussion at a Team meeting on the 20 September 2002 stated that the main purpose of the discussion had been to make the Team aware that CPN2 *"would not be visiting client alone due to possible issues around personal safety....."*and that *"....whilst client appears to be symptom free on a small amount of anti-psychotic over quite a long time, I still need to insist on another working* (sic) *visiting with me* (if/when) *he is no longer accepting medication."*

64. This approach by CPN2 contrasted with that of CPN1, who frequently visited Mr Roberts alone. It is, however, fair to CPN2 to remember that CPN1 was considerably more experienced than him; that CPN1 had built up a good relationship with Mr Roberts over a long period of time; and that, in CPN1's own words to us, *"Gary, whenever I saw him, whether I was with somebody or not, certainly between 1997 and 1999.....did not pose too many problems and was not, at any time, floridly, consistently unwell."* It is also right to bear in mind that throughout the period from January 2000 to August 2002 Mr Roberts had taken his depot medication with reasonable regularity, whereas from about the time when

CPN2 took over as Care Co-ordinator, Mr Roberts showed a desire to discontinue his depot medication.

65. We asked CPN2 about the response of his managers or supervisors to his "insistence" on another worker accompanying him on visits to Mr Roberts, when he raised the point at the Team meeting on the 20 September 2002. He told us that he believed that they felt that his concern was justified and that the Team Leader felt that it was appropriate to take another member of staff with him and not to visit on his own. However, it was apparent from the records that CPN2 experienced difficulty in actually getting a colleague to visit with him and when we asked him whether anything was done by management to ease the problem, his reply was "*Not really. I brought it up at supervision, clinical supervision, management or caseload supervision purely from the point of view that I had not been able to get hold of* (Mr Roberts)*. I had not been able to see him....."* In our view the question of CPN2's performance as Care Co-ordinator is linked with certain aspects of the management of the Community Mental Health Team and in view of that fact we shall set out our overall conclusions on CPN2's position later in this report (see paragraphs 92 to 97 below).

Compliance with the protocols governing the operation of the CPA

66. We enquired about the Trust's policy documents governing the implementation of the CPA in the period 1999-2002 and two such documents have been made available to us. One had been produced by the Trust's predecessor, the South Essex Mental Health and Community Care NHS Trust and Essex Social Services' Directorate of Mental Health jointly and was entitled "The Integrated CPA". It had originally been brought into operation on the 1 October 1996 and had since been reviewed on the 1 April 1997 and the 3 October 2001. The second was produced by the Trust, entitled "CPA", and its implementation date was the 1 April 2001. The relevance of this second document to Mr Roberts is not entirely clear to us, as the version which has been produced to us is, as we understand it, the version which includes certain amendments which result from the consideration of this very case by the Trust's own internal review panel. Indeed, it appears from the Trust's Summary of Recommendations resulting from the internal review that paragraphs 6.0 to 6.8, 10.0 to 10.7, 16.0 to 16.7, 12.4 and Appendix 1 were new additions following that review. We

assume that the other provisions of this document were operative at the relevant times of Mr Roberts' care and treatment.

67. Before we consider these two documents in any detail, and in the absence of any evidence from a member of the Community Mental Health Team's management at the material time, it is helpful for us to turn to some of the evidence given to the Trust's internal review panel. The Community Mental Health Team Manager, who we understand to have been the Community Mental Health Team manager at the material times, was asked about the CPA framework and he replied as follows:

> *"..... CPA is a working tool and document. We were using it 95% and because of various events that had happened within Social Services and the team, when we had just gone through an SSI review, so we had just spent an awful lot of time changing all the paperwork, bringing it all up to date, to the point that the new CPA policy that's recently come out has incorporated an awful lot of stuff that we did for SSI.....I think there's always an issue around the amount of paperwork that CPA produces and the amount of workload that all the staff are under, which means that compliance of all the bits of paper isn't always as much as you would like it to be."*

The Director of Mental Health Services, was asked for his views of the then existing policy of CPA in Southend and he replied:

> *"Around about the spring of last year, I was asked to chair a CPA review meeting where we looked at all aspects of the CPA across South Essex and what we found within South Essex is that there were pockets of excellent practice, areas which developed practice that had not been introduced by the Trust and areas of weakness. Some of the areas of weakness were around risk assessment processes, care planning process, frequency of reviews and there was no one particular area in South Essex that was either any better or any worse. There were pockets of excellent practice in all areas and pockets of weaknesses in all areas. What we did as a group we completely reviewed the CPA process to try to bring some standardisation within the process because the process had an absence of standards and there was no explicit standard in place in December 2002.... There*

were no actual explicit standards in place within the CPA policy; most of it was aspirational; most of it was not measurable in terms of the standards whereas what we did do we standardised the documentation and the training.... but we also created a series of standards which we expected to achieve."

He further commented that "*... In fact, the CPA policy to which I refer was only drawn up in 1996 there was a real slowness in implementing the CPA process within the NHS our Trust was no different to any other part of the NHS ..."*

A further question was put to the Director: of Mental Health Services *..." what you seem to be saying ... is that you felt that systems were in place for a successful risk assessment and management but there were issues maybe or maybe some concerns around the application of those systems in terms of individuals' practice, possibly "* to which he replied: *"Yes, and certainly in the review of the CPA process, actually I was saying earlier that there were some examples of excellent practice but also some examples of pockets where it needed to be improved ... The risk assessment and the care planning part of the CPA process were two areas where there were pockets of weakness across the board....."*

In the course of the internal review, CPN1 was also asked about the operation of the CPA in Southend and he replied: *"Southend.....did get a lot of criticism over a period of time because it was perceived that CPA documentation wasn't what it should be and there were a number of audits where it was perceived that certain things weren't in place with certain people.....that would have been a year or two prior to this all happening.....the structure of (CPA) will work if you've got the time to allow it to work. Personally with a case load of forty it's very difficult to make sure that all your notes are always up to date, that every little bit of paper is in place, that it's relevant, that there's a risk assessment....."*

68. Whilst we have some reservations about relying on evidence which we have not received first-hand, the views quoted above appear to provide support for the proposition that the implementation of CPA in Southend had been a slow process and that, for whatever reason, there may still have been on-going problems in the years 1999-2002.

69. We do not think it necessary to set out in this report the contents of the two policy documents, but we have identified from Mr Roberts' records certain instances where CPA

procedures have not been fully complied with. For example, there was no specific CPA review of Mr Roberts between the 17 April 2000, when a care plan was prepared for him, and the 4 December 2000, whereas the prescribed interval for such reviews in the case of a client on Mr Roberts' CPA level was six months. However, during that period, on the 14 July 2000 Mr Roberts was reviewed for the purposes of the renewal of his supervised discharge under section 25 of the 1983 Act. Also, during that period Mr Roberts was visited regularly by CPN1 and his condition gave no particular cause for concern. We should add that we have no specific evidence of any causal link between non-compliance, or mere partial compliance, with the CPA and the events of late-December 2002.

70. The CPA has dedicated record forms but they were not used consistently in Mr Roberts' case. Some CPA events were recorded on general record forms. For example, where a CPA review was carried out in the course of a ward round, a specific CPA form may not have been used, and even then the occasion was sometimes described as a "review" and at other times as an "update". This confusion over records at least had the potential for causing significant information to be missed. Even where the dedicated CPA forms were used, their layout and completion left something to be desired. Certain forms made no provision for the entry of the particular client's CPA level and someone coming to Mr Roberts' case afresh would not have easily seen which level he was on. In addition, it was difficult to see what had happened to certain earlier proposals for his care and treatment. For example, one CPA Form 3 contains entries of meetings on 19 September 1997, 4 November 1997 and 2 December 1997 and in relation to the third of those meetings, the decision that Mr Roberts was to be placed on the supervision register was recorded. However, that proposal ceases to play any part in the plan for his care and treatment in early 1998 without any reason being given for its abandonment. Mr Roberts had, of course, been placed on probation for two years on 26 November 1997 and it may have been that probation order which led to the abandonment of the proposal to put him on the supervision register, but there was no indication that that was so.

71. It seems clear from the extracts from the internal review papers which we quote in paragraph 67 above, that the CPA had not been fully implemented in Southend in 1999-2002. Also, we are doubtful whether the CPA, as practiced in Mr Roberts' case, actually facilitated the delivery of care to him. The Trust's internal review panel made various

recommendations aimed at improving implementation of the CPA and the first step in considering whether such compliance has now been materially improved would be a discussion with the relevant Trust managers. Whether that is something which the Authority would wish us to carry out or whether it is something to be pursued along normal management lines are questions for the Authority to decide. We would, however, recommend that if there is any continuing doubt about the full implementation of the CPA, then the Trust be asked to carry out a further audit, covering not only the simple observance of CPA procedures but also the quality of the work done in observing them. This is included in our recommendations in paragraph 101.

The experience, qualifications and training of CPN1 and CPN2 respectively; their performance of the role of Mr Roberts' Care Co-ordinator and the effectiveness of management supervision and assistance available to them in that role

72. CPN1 has been a Community Psychiatric Nurse since 1993, having qualified as a Registered Mental Nurse in 1985. Prior to working as a Community Psychiatric Nurse, he had experience in a variety of other Mental Health settings, including that of Ward Manager on an Acute Team. The need for someone else to take over from him as Mr Roberts' Care Co-ordinator arose because he was returning to study for a BSc (Hons) degree in Community Specialist Practice, which he duly obtained. He confirmed that he had received in-service training in risk assessment and the operation of the CPA. He told us that at the time of these events the Worthing risk assessment tool was in use in the Trust, but that it was not nearly as comprehensive as the FACE tool now in use. He also suggested to us that every visit to a client is, in effect, a risk assessment, although you might not describe it as such, because the Care Co-ordinator or Community Psychiatric Nurse is still observing and assessing the client. CPN1 also told us that he had a good relationship with Mr Roberts and that he got on well with Mr Roberts' parents, both of which statements we accept.

73. CPN2 is a Community Psychiatric Nurse, having qualified as a Registered Mental Nurse in 1997. After working initially at Westcliff Day Hospital, he had four-and-a-half to five years' experience on the Southend Community Mental Health Team at the time of his appointment as Mr Roberts' Care Co-ordinator. He told us that at the time of the events in

question he held a "G" grade appointment, a level at which a Community Psychiatric Nurse is expected, both generally and expressly under CPN2's job description, to be capable of working autonomously. Nevertheless, it seems to us that an employer retains an obligation to provide an employee with the training and supervision reasonably necessary to enable him to perform his duties properly. Having considered the evidence given to the internal review panel, we do not think that proposition would be contested by the Trust. As to in-service training, after some initial uncertainty, CPN2 confirmed that he had received two separate days' training on the CPA and risk assessment. He confirmed that as a result of that training he felt competent to assess risk. We asked CPN2 about the support available to him in the form of supervision from his managers/supervisors. He started his answer by telling us that there were two areas of supervision: clinical and management. Whilst we appreciate that there may well be some overlap between clinical supervision and management supervision, "clinical supervision", as we understand the term, relates to the care and management of clinical work, including the relationship with the client, medication, health and social care needs, and "management supervision" concentrates more on the practitioner, his/her workload, professional development, training, time-keeping, sickness, annual leave, his/her place in the Team and the Mental Health Service, and performance. CPN2's clinical supervision apparently came from an experienced CPN in the Team, whom he himself selected as his clinical supervisor, and his management supervision came from the Team Manager.

74. We asked CPN2 if he had ever had an opportunity to seek advice from his clinical supervisor about the problems he was experiencing in September/December 2002 in getting Mr Roberts to engage with him, to which he answered that he did not recall whether he had clinical supervision around that time or not.. That led to a series of comments by him to the effect that *"The Team was very chaotic all the time"*; about the difficulties of structuring one's day; and the fact that if one brought up issues about doing one's job exactly as it was supposed to be done, one would be doing that every day, with the result that one would not feel oneself to be a productive member of the team.

75. The transcripts of the evidence given to the Trust's internal review panel also deal with the supervision question, though in some respects the precise nature of some of the statements is not entirely clear. However, it seems to have been common ground between

the Director of Mental Health Services, the Assistant Director of Mental Health Services and CPN1 that the aim was for management to provide supervision on a monthly basis but that this was not always achieved. Indeed, the Cluster Leader Trainer, who took over as a cluster manager in January 2003 provided some detailed information about the extent of CPN2's supervision. She said that the first supervision session she had with him was on the 23 January 2003, which was of course after the events giving rise to this review. She also said that from Community Mental Health Team Manager's (the Team Leader's) notes, there had been one supervision session between him and CPN2 in October 2002; that a session in November 2002 had been cancelled by CPN2; and that the Community Mental Health Team Manager had then seen CPN2 two or three times at the end of December/ beginning of January after the incident, by which we assume that she meant the events of the 25 December 2002. If that is right, it appears likely that CPN2 had one effective session between the 8 August 2002, when he took over as Mr Roberts' Care Co-ordinator, and the 25 December 2002. From those same transcripts it appears that supervision primarily took the form of checking on-going files for compliance with the CPA and the Assistant Director of Mental Health Services told the internal review panel that she *"never went down the route of qualitative audit because I just did not have time in that period when I was conducting all the audits."* She also said that she did not think that she audited Mr Roberts' file.

76. We are mindful that we have not been able to discuss management within the Team directly with any of the managers in post in the Team during the period from 1999 to 2002 and that we are now considering the perspective of only one Team member (CPN2), but our provisional conclusion in this case is that there was a low level of supervision, both clinical and management, in the Team at the times in question and we recommend the Authority to satisfy itself that this position has been rectified by the Trust since December 2002.

In-service training for Care Co-ordinators

77. As already stated, both CPN1 and CPN2 told us that they had received in-service training in the operation of the CPA and risk assessment during their time with the Trust, though CPN2 was a little hesitant on this question.

78. Nevertheless, we are in some doubt about the precise nature and effect of that training, because of the terms of the evidence given to the Trust's internal review panel by the CPA and Risk Assessment Trainer. We understand from the transcript of her evidence to that panel that she was the CPA and Risk Assessment trainer from May 2000. The CPA and Risk Assessment Trainer described an "....*initial rollout of training [of] 12 sessions specifically for adult mental health services and they were configured on a locality basis."* Again according to the transcript, there was considerable debate between CPA and Risk Assessment Trainer and the Trust's panel as to whether or not the training was based on Mental Health Policy 07 originally formulated by the South Essex Mental Health and Community Care NHS Trust and adopted, as we understand it, by the Trust. The CPA and Risk Assessment Trainer then seems to have distinguished between a "policy" and a "framework" and at one stage she appears to have suggested that Mental Health Policy 07 had not been ratified when she did the training, a statement which surprises us as the copy of the Policy provided to us gives its implementation date as the 1 October 1996. The CPA and Risk Assessment Trainer then added that *".....the training didn't centre around the documentation because the documentation hadn't been standardised and even when the new documentation came in 2001 it wasn't being implemented consistently."* We assume that the "new documentation", which came in 2001, was the amended version of Mental Health Policy 07. These matters arising from the transcript of the CPA and Risk Assessment Trainer's interview illustrate the reasons why we feel doubtful about the precise nature and effect of the training provided for Community mental health staff (including Care Co-ordinators).

79. Whilst the Trust's internal review panel made certain recommendations about in-service training, without further inquiries we are presently unable to confirm to the Authority that the apparent confusion surrounding training arrangements in about 2000/01 has been resolved and replaced by a comprehensive system related directly to the policies and practices which the Trust now has, or should have, in place throughout its area.

Record - keeping and communications generally

80. There are examples in Mr Roberts' records of inaccurate record-keeping and gaps in communications between members of the Trust's staff involved in his care. Some of these seem to be trivial at first glance, but the problem is that even an ostensibly trivial inaccuracy or omission may cause or contribute to an unexpectedly serious consequence in a client's treatment at a later date. An example was an omission to copy to the Care Co-ordinator a material letter which was being sent to the General Practitioner when, for whatever reason, the letter quoted the intended frequency of the Care Co-ordinator's visits to Mr Roberts as being weekly when they were intended to be two-weekly. In this respect we should add that the author of the letter has confirmed to us that it is now routine practice to ensure that copies of such letters are sent to General Practitioners, Care Co-ordinators and anyone else with a significant involvement in the care and treatment of the client in question. Again, the Trust's internal review panel have made some recommendations on these subjects, the effect of which we have not sought to check at this stage. We would, however, make the general comment that the most effective way for any organisation to tackle these problems is for senior management to foster a culture throughout the organisation of attention to detail in these fields and for all members of staff to know that such attention to detail is one of senior management's cardinal principles.

The fact that Mr Roberts was not seen by a Psychiatrist from the 26 September 2001 until the 18 September 2002

81. Mr Roberts was seen by Locum Consultant Psychiatrist 10 on the 26 September 2001. Locum Consultant Psychiatrist 10 found him to be well and said that Mr Roberts would be seen again in four months. He did not attend an Out-patients appointment on the 16 January 2002. On the 3 April 2002 CPN1 made provision in Mr Roberts' Care Plan for him to be seen "six-monthly" by Consultant Psychiatrist 6, who had joined the Trust as a substantive Consultant Psychiatrist on the 5 November 2001. Mr Roberts again did not attend an Out-patients appointment on the 16 June 2002 and, in fact, did not see Consultant Psychiatrist 6 until the 18 September 2002.

82. Fortunately, it appears that Mr Roberts was well for the major part of the period between the 26 September 2001 and the 8 August 2002, when CPN2 took over as his Care Co-ordinator. However, on the evidence given to us it does not seem as though any system

was in place at the material times either for a Care Co-ordinator to brief a new Consultant about the clients for whom the Consultant was to be responsible or for the Consultant to review the records of "his" clients. This may have been due, at least in part, to the pressures which the Service faced at the times in question, but we would hope that it is not now possible for a new Consultant to go for nine months, without being briefed about all his clients and seeing all of them who need to be seen. That would at least enable the new Consultant, as a very minimum, to make a conscious decision as to which of his clients should be seen by a psychiatrist. That the position in this case went, as it were, by default is borne out by Consultant Psychiatrist 6's evidence to us that until he saw Mr Roberts on the 18 September 2002, he did not know of Mr Roberts' existence.

83. Evidence given to the Trust's internal review panel revealed that at times material to this case the electronic information systems operating in the Southend locality were poor in recording a client's failure to attend an outpatient appointment and in bringing such a failure to a Consultant's attention. The internal review panel made two recommendations which have resulted in a client's records being better integrated on the intranet and in the provision of an Alert system for a client who may be disengaging from services. Only a practical test of the improved systems would show whether they have fully resolved the problems identified in our review in this respect.

GP1's comments in his response to our invitation to let us have his views on the case

84. As stated in paragraph 41 above, we invited GP1, Mr Roberts' General Practitioner, to let us know if there had been any aspects of Mr Roberts' care, which had caused him any concerns. He accepted that invitation and brought the following matters to our attention:

- The effect on the continuity of care of a client being seen by a series of locum psychiatrists; and
- Whether Mr Roberts' supervised discharge on the 18 January 2000 had been renewed and, if so, whether the proper process for renewal had been adopted.

85. The first of these two matters has already been canvassed in paragraphs 53 to 56 above. As to the second of them, Mr Roberts' supervised discharge originally took effect on the 18 January 2000. The initial period permitted under Section 25G of the 1983 Act is six

months, so the supervised discharge had to be renewed, if (as was the case) renewal was thought to be appropriate, on the 18 July 2000. It was duly renewed on that date for a further six months in accordance with Section 25G and accordingly it terminated on 17 January 2001. The copies of Mr Roberts' psychiatric records provided to us do not include a full set of copies of the forms and documents required for a valid application for a supervised discharge or a valid renewal. That is not necessarily to say that such documents were not properly prepared; in the normal course of events they would have been sent to the body to which the application was made and may well have been kept separately from the psychiatric records. Indeed, Mr Roberts' records do at least contain copies of certain letters dated 18 January 2000 from the Service Manager of the Southend Community Care Services NHS Trust, to whom the initial application in respect of Mr Roberts was apparently made, confirming that Consultant Psychiatrist 5's application for Mr Roberts to be placed on supervised discharge had been accepted, and the 19 July 2000 confirming the renewal.

Relationships with Mr J Roberts and Mrs Roberts, Mr Roberts' parents

86. Mr Brown wrote to Mr J Roberts and Mrs Roberts individually on the 24 January 2006, explaining our part in relation to their son's treatment and inviting them to contact us if they had any concerns or questions about their son's care. They did not reply at that time. However, when we were preparing our draft report, Mr Brown wrote to them again on the 20 November 2006 and they then replied that they would welcome a meeting with us after all. Consequently, Mr Brown and Mrs Fagin met them on the 19 December 2006. Dr Bradley was prevented from attending the meeting because he was unwell on the day in question, but he has had the opportunity of subsequently reading the transcript of the discussions at the meeting.

87. Understandably Mr J Roberts and Mrs Roberts had several concerns about their son's care and treatment. For example, they were concerned - as we have been - about the lack of continuity in Mr Roberts' Consultant care, something which we have considered earlier in this report. Their other concerns included not being told that Mr Roberts' diagnosis was schizophrenia and a lack of information about the way in which schizophrenia manifested itself. We do not feel that it would be helpful at this stage for us to approach these matters in an adversarial way. Memories of the material events on both sides inevitably become blurred with the passage of time and although Mr Roberts' psychiatric records may, and indeed do, provide some information on the matters in question, in themselves they are unlikely to provide conclusive answers to any questions raised by Mr J Roberts and Mrs Roberts in our meeting with them.

88. Accordingly, we think it better at this stage to treat their concerns as a compelling reason for us generally to stress the importance of every professional involved in the care and treatment of a client like Mr Roberts communicating fully and accurately with near relatives involved in the client's care in the community and ensuring through those communications that the relatives have all the information which they need to play their full part in that care. We recognise that issues of the client's right to confidentiality may hinder full and accurate communications, but it is to be hoped that the client's consent to disclosure can be obtained, failing which the Trust or Authority concerned may need to obtain legal advice. Mr J Roberts and Mrs Roberts also complained that the telephone numbers given to them

for use in an emergency were of carelines in Chelmsford or even London. If that is right - and we have no reason to doubt them - then we are surprised that assistance was not available more locally.

Risk assessment

89. During the period on which we are concentrating formal risk assessments were carried out on the 17 April 2000 by CPN1 and on the 28 November 2002 by CPN2. CPN1 used the Worthing Risk Indicator, on the basis of which Mr Roberts was found to be a severe risk of violence or aggression towards others. Using the same tool, CPN2 reached the same conclusion. CPN1 told us that risk assessment was an on-going function and when he carried out a CPA assessment on the 3 April 2002 he noted that Mr Roberts represented a risk of violence when unwell. Consultant Psychiatrist 5, too, told us in our meeting with him of the risks posed by Mr Roberts, though in relation to all these assessments it is worth repeating the point made in paragraph 50 above that the 1983 Act does not always provide an advance or preventative solution, even when such a risk is recognised.

90. Indeed, in some ways Mr Roberts' care and treatment during the period from January 2000 to August 2002 illustrates the problem often presented by a patient with schizophrenia, in that considerable success was achieved in controlling Mr Roberts' illness for considerable periods, but without necessarily being able to eliminate risk.

Services available to CPN2 to help him in the provision of care and treatment of Mr Roberts

91. CPN2 had concerns about the availability of services to have supported him in the provision of Mr Roberts' care and treatment. An Assertive Outreach Team, a Crisis Intervention Team and an Emergency Duty Team were mentioned in this context at our meeting with him and his Union representative, but it seems doubtful whether Mr Roberts' signs and symptoms in the period from the 8 August 2002 (when CPN2 took over as Care Co-ordinator) to the 19 November 2002 (when Mr Roberts was last seen prior to the events of the 25 December 2002) would have justified the intervention of any such team, even if they had been available at that time.

CPN2's position

92. We stated in paragraph 65 that we would consider CPN2's position in later paragraphs and we now do so. The reason for dealing with that matter in this way is that in our opinion the way in which CPN2 carried out his responsibilities as Mr Roberts' Care Co-ordinator depended to a considerable extent on the management and resource circumstances in the Community Mental Health Team in late-2002.

93. We note that the Trust's internal review panel made recommendations on this topic, identifying the need for more robust line management/clinical supervision in relation to high-risk clients on CPN2's case-load, the need for further training in risk management and risk assessment, advice on the keeping of records of the reasons for his clinical decisions and further investigation into his practice skills and competence. He was redeployed while these matters were addressed. In our view these recommendations clearly cast doubt, not least in CPN2's own mind, upon the adequacy of his performance of his duties as Mr Roberts' Care Co-ordinator. Indeed, CPN2 subsequently resigned voluntarily from the Trust's service.

94. With respect to the internal review panel, we would be less critical of CPN2's individual part in this case. We start from perhaps the same standpoint as the internal review panel, namely that there could have been improvements in the way in which CPN2 handled Mr Roberts' case, but we feel that more recognition then needs to be given to the general circumstances of the case, as they existed in the last four months or so of 2002, and to what seems to us to have been the management position within the CMHT at that time. In reaching that view, we do not lose sight of the fact that the evidence on which it is based was not given directly to us but to the internal review panel, nor can we now attempt to define the reasons for the management position, be they staff shortages, lack of other resources, difficulties in drawing together the working practices of the Trust's predecessor bodies or otherwise. However, the general circumstances of the case, to which we refer above, were:

- The difficulties inherent in the fact that CPN2 was having to take over from CPN1, who had been Mr Roberts' Care Co-ordinator for a long time; who had established a

good rapport with Mr Roberts and his parents; and who had considerably more experience in dealing with such a client as Mr Roberts;

- The fact that CPN2 took over Mr Roberts' case at a time when the latter had a Consultant Psychiatrist, who had been in post for nine months but who had never actually seen him, or even knew of his existence;
- The fact that CPN2's assumption of responsibility occurred contemporaneously with Mr Roberts' desire to come off depot medication and, indeed, his ultimate refusal to continue on it; and
- The absence of effective support, when CPN2 expressed the view that he would not visit Mr Roberts alone.

As far as management within the CMHT at the time is concerned, the primary problem seems to us to have been that an effective supervision system was not available to CPN2. If it had been, then he probably would have been able to obtain advice in dealing with Mr Roberts' desire to disengage and more effective assistance in ensuring that a colleague was available to accompany him on home visits to Mr Roberts.

95. It might be suggested that CPN2 should have been more persistent in seeking help and advice from his superiors, but it is not unknown for a relatively inexperienced employee to be diffident about so doing, in case he might be seen as being unable to make his proper contribution to the apparently heavy work-load of the team, and the primary responsibility for ensuring that such help and advice is available surely rests with management.

96. Put another way, we see the problems in this case as being problems of the whole service at that time, rather than problems resulting from individual acts or omissions.

97. As a follow-up to this last topic, we feel it fair to record that CPN2 very frankly confirmed to us a point made by him to the Trust's internal review panel to the effect that he regretted not having telephoned Mr Roberts' parents to obtain a view of what was happening to Mr Roberts from them, when he had been unable to see Mr Roberts for himself, and that he was sorry that he had not had more contact with them. He added that it was something he always meant to do but never got round to doing, except on one occasion. He also said that he would have felt happier if he had written to Consultant Psychiatrist 6 at some point

to say that he had been unable to assess Mr Roberts since the CPA meeting, presumably on the 8 August 2002.

I. The Trust's internal review

98. As already mentioned, a panel of officers of the Trust were nominated to carry out their own internal review of Mr Roberts' care and treatment. Their terms of reference expressly directed them to focus on the period of three months prior to the 25 December 2002, whereas we have looked at a longer period. They made a considerable number of recommendations which, together with a summary of the action taken on those recommendations as at August 2005 have been copied to us. In some respects, we have commented on those recommendations in the body of this report. Apart from those comments, at this stage we can but make the general observation that without involving ourselves in the business of the Trust to a much greater extent, we simply do not have first-hand evidence of the effect of the internal review panel's recommendations and the action taken in consequence of them. However, it should be noted that the Healthcare Commission has rated the Trust as "Excellent" for its use of resources and as "Good" for the quality of its services in its Annual Performance Ratings for 2005/06. Additionally, we are advised that in January 2007 the Trust achieved Level 2 in the NHS Litigation Authority's Clinical Negligence Scheme for NHS Trusts. We understand that this is an indicator of the Trust's competence broadly in the field of risk management and that Level 2 is attained by only eight mental health trusts.

J. Our recommendations

99. In making recommendations in this case, we have had to bear in mind that the Trust has carried out its own internal review of the case; that its own review panel made numerous recommendations; and that those recommendations have been the subject of further action over the intervening four years. Accordingly, our recommendations fall into two groups, namely a general recommendation, which follows on from the internal review panel's recommendations, and some specific recommendations, which relate to some particular points.

100. **The general recommendation** is that, unless the Authority wishes us to pursue with the Trust on the Authority's behalf the effect of the internal review panel's recommendations, the Authority should seek from the Trust an assurance that the internal review panel's recommendations have been implemented and have effectively improved performance compared to the period 1999 to 2002 in the following respects:

a. The keeping of full and accurate patient records;
b. That reliance on locum Consultant Psychiatrists has been substantially reduced, to the extent that the majority of clients are now under the care of Consultants holding substantive posts;
c. That appointments of Care Co-ordinators are now made by cluster leaders or other appropriate managers, with the consent of the appointee in each case and consistently with CPA Principles;
d. That when a member of a CMHT is reasonably concerned about visiting a client at the client's home because of fears for his or her own safety, effective measures are implemented by the Team's management to provide the Team member with the requisite support. In this regard, management must be consistently alert to the fact that the failure or inability to provide such support may well adversely affect the number and/or pattern of contacts with the client, which may in turn provide the client with a greater opportunity to disengage from the Mental Health Service.
e. That the doubts about the availability and take-up of in-service training in areas such as the CPA and risk assessment, which have appeared in the course of our review,

have now been addressed; that CMHT members now receive the necessary training; and that records exist to confirm that they have received training in these areas.

f. That systems of management supervision and clinical supervision are in place and that those systems now provide the supervisor with the opportunity actively to intervene, wherever necessary or desirable, to ensure that an individual client is receiving a proper level of care and treatment.

g. That across the whole spectrum of a client's care and treatment communications between **all** staff are full and accurate, particularly to ensure that every member of staff involved in a particular client's case is informed of **all** matters which **might** affect that staff member's part in the case.

h. Following on from the last point, that all members of staff involved in a client's care and treatment are kept informed, by efficient electronic or manual means, of a client's failure to attend out-patient clinic appointments, meetings with the Care Co-ordinator or other appointments bearing upon the safety of others including members of the Public, relatives of the Client or NHS employees, as any such failure may be an indication of disengagement from the Mental Health Service and/or a risk to third parties.

i. That where national or local policies provide that a particular step be taken by or within a specific date or period, available resources permit front-line staff to have time to comply. Non-compliance with any such policy is potentially an indication of excessive pressure of work on front-line staff, requiring prompt attention by senior management, if risk to the client or to third parties is to be avoided.

101. **Our specific recommendations** are as follows:

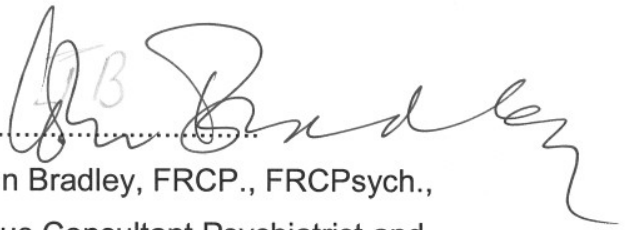
a. That if there is any continuing doubt about the full implementation of the CPA, then the Trust be asked to carry out a further audit, covering not only the simple observance of the mechanics of the CPA procedures, but also the quality of the work done in observing them.

b. That if the contract for the post of a Community Psychiatric Nurse on Grade G is still in the same form as the contract produced to us in respect of CPN2, the Trust give consideration to the inclusion in the contract of provisions, which make it clear that the employee is subject to both managerial and clinical supervision and is expected to comply with Management's reasonable requirements in that regard. The contract

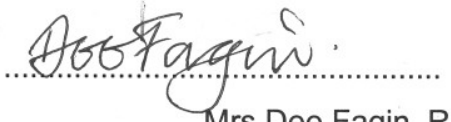
produced to us stresses the autonomous nature of a Grade G post, without containing any reference to supervision.

c. That the Trust be asked to confirm that a system is in place whereby a newly-appointed Consultant Psychiatrist and all members of the Community Team(s), with whom he will be working, know the clients, for whom he will be responsible, and that the Consultant, in conjunction with Care Co-ordinators, draws up a programme of clinic appointments for any clients who may need to be seen before their next routine appointments.

d. That the Trust be asked to confirm that emergency assistance is now available to a client's family or lay carers through telephone numbers local to the particular client's place of residence (see paragraph 88 above)



Dr John Bradley, FRCP., FRCPsych.,
Emeritus Consultant Psychiatrist and
Chairman of the Independent Review
Panel



Mrs Dee Fagin, RMN
Member of the Independent Review Panel

Colin Brown
Solicitor (Non-practisng), Member
of the Independent Review Panel and
its secretary