South East Coast Strategic Health Authority
And Surrey County Council

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF MR S.

JULY 2007

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1. Acknowledgements

As with so many independent inquiries this one is tasked with examining a set of circumstances that are associated with a tragedy and the loss of an innocent life. The conduct of such inquiries and the objectives with which it is tasked make significant demands of many but in particular those involved directly and family and relatives of the victim.

The inquiry's methodology necessarily revisits all of the circumstances and events in great deal. This does much to cause all of those involved to go back and experience difficult and often disturbing processes and brings to the fore all of the feelings that prevailed at the time of the events. The panel wishes to acknowledge this, as well as the discomfort caused by the process. Nevertheless the inquiry underlines the importance of ensuring that such processes are properly conducted.

Public bodies have an obligation to protect the general population and to ensure that all adverse and tragic events are forensically investigated. In this way we can learn from them and so continue to operate services with minimum risk. The overriding impetus for the panel and the commissioning body is to ensure that there is a comprehensive effort to support the delivery of this objective.

In the course of this inquiry those called to give evidence, account for their roles, and supply information, have all done so in accordance with expectations and with frank openness for which they must be acknowledged. We are grateful to all of those who have given evidence directly, who have supported those giving evidence, and who granted access to facilities and individuals throughout this process. This has allowed the panel to reach an informed position on which to progress actions and improvements.

1.2. Condolences to the family of victim

The panel would like to take this opportunity -at the outset of this report- to publicly acknowledge the contribution made by the victim's family, and we convey to them our most sincere thanks. We recognise the profound nature of the demands made upon them in contributing to this inquiry. We also recognise that this has been a traumatic time for them and extend our deepest condolences for their tragic loss.

2. Executive Summary

On the night of 11th January 2004 Mr S –the subject of this investigation- attacked a man with a rock near his home in Sunbury. The victim sustained fatal injuries and died later that night.

Mr S had been in receipt of learning disability and mental health services provided by the North West Surrey Mental Health Partnership NHS Trust or predecessor organisations for a number of years.

The North West Surrey Mental Health Partnership NHS Trust established an internal review to investigate this case and the review reported its findings and recommendations to the Trust's Board.

Further investigation was deemed necessary by the then Strategic Health Authority. An Independent Mental Health Inquiry was initially set up in November 2005 by Surrey and Sussex Strategic Health Authority together with Surrey County Council as required by National Health Service Guidance HSG (94) 27 and the 2005 Addendum. The guidance requires that an independent inquiry is undertaken when a person, who has committed a homicide or caused serious untoward harm to others, has been in receipt of mental health services during the six months prior to the incident. Due to Mr S's initial inability to enter a plead to the charge of murder, the Independent Mental Health Inquiry was deferred for six months until after Mr S's conviction in court. The inquiry recommenced in May 2006.

During the period of the Independent Mental Health Inquiry the Surrey and Sussex Strategic Health Authority has been merged with Kent and Medway Strategic Health Authority. On 1st July 2006 these two authorities were replaced with the South East Coast Strategic Health Authority.

It is important to note that since the tragic circumstances under review occurred, the local mental health and learning disability services have also undergone a period of reorganisation and extensive change. The local services are now provided by a Surrey- wide organisation, the Surrey Borders Partnership NHS Trust.

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

The independent inquiry has been undertaken by a panel of professional people each of whom are completely independent of the organisations that contributed to the care systems subject to investigation.

The inquiry panel identified the written documentation it required and evidence was received from 20 individual witnesses both orally and in writing over a period of six days during August and September 2006. Families of both the victim and Mr S were also seen.

A summary chronology of events is as follows;

Family History

Mr S was born on 20th October 1983 and is the youngest of four male full siblings. Mr S's brothers are older than him. One sibling had an extensive criminal record (allegedly for offences including theft, burglary and stealing cars), and spent some periods in prison, and was suspected of supplying Mr S with illegal drugs.

Mr S has two younger half-sisters from a subsequent marriage.

Mr S's parents married, divorced and remarried. They separated and divorced for the second time when Mr S was aged approximately two years.

When Mr S was aged approximately ten years, he and a brother are reported to have spent a short period in the care of their father in Kettering. It appears to have been during this period that Mr S alleged to have been sexually assaulted by one of his father's friends.

During Mr S's childhood, relationships within the family appear to have been volatile. His reaction on one occasion was to steal and deliberately damage his stepfather's car. On a separate occasion Mr S stole and crashed his stepfather's car when his stepfather allegedly refused to take his mother to hospital where she needed emergency treatment for a perforated peptic ulcer.

It is of note that in the period immediately prior to the homicide, Mr S was reported to have continued to be subject to physical and verbal abuse from family members including an assault by a brother resulting in facial bruising. A further assault was reported to have occurred prior to Mr S leaving the family home on the night of the homicide.

Developmental History

It was reported that Mr S displayed unremarkable developmental milestones. Little is known of the quality of his social communication or social interaction during early childhood.

Educational History - 1988-2001

By the age of six years Mr S is reported to have been recognised as experiencing learning difficulties, and was transferred to a special school in Ashford. At 11 years he attended a special boarding school in Dorking for approximately one month. Reports suggest that this was as a result of behavioural difficulties rather than as a result of intellectual difficulties per se. He was removed by his mother following an allegation that he had been sexually assaulted by another pupil (see psychosexual history). His mother is reported to have stated that as a child Mr S was severely traumatised by this and that his academic progress suffered as a result.

Between the ages of 11 and 12 Mr S is reported to have received home tuition for several months prior to transfer to another school Molesey, Surrey, (a school for children with emotional and behavioural difficulties).

The following year it is reported Mr S was expelled from a further special school having been accused of causing damage to a car, and having climbed on to the roof of a school building with other students. Mr S's mother reported that he was easily led and frequently in trouble with other pupils, and frequently truant from school. Mr S received home tuition from this point onward.

He obtained no formal qualifications, but is able to read to a *"reasonable"* degree. He is reported to have difficulty in managing money.

Employment History - 1999-2001

At the age of 16 years Mr S is reported to have worked in a building supplies store for approximately three months where apparently he was ridiculed by staff for slowness during this period and lost his job as a result, although the mechanism of this is not clear.

He then apparently worked intermittently for his stepfather in his removal business. He left his stepfather's employ after an incident in which he left the handbrake off a removal lorry, causing the lorry to be damaged. It has been reported that Mr S had been drinking with other employees at the time. Finally he was employed on an ad hoc basis for his uncle's building firm. Mr S appears to have been continually unemployed from age 18 years and prior to the index offence.

Forensic and Challenging Behaviour History

During the period 1996 to 2003 Mr S was convicted several times for criminal activities. He frequently failed to attend probation sessions without explanation, and appeared in court on a number of occasions as a result of breaches of the conditions of supervision orders.

it is alleged that in August 2002 Mr S had a disagreement with his sister, then aged fourteen years, in which she sustained a fractured finger. A second alleged assault on the same sister was followed by the involvement of the Child Protection Team in October 2002, and Mr S's first referral to adult psychiatric services at age 18 years.

Mr S was barred from a local public house subsequent to an argument (date unknown), and was barred from a second establishment, the pub involved in the index offence as a result of *"helping himself"* to other peoples' drinks (date unknown).

Substance Misuse History

At the age of 15 Mr S was reported to have abused butane gas and admitted to using cannabis, sometimes on a daily basis. In addition he is reported to have used alcohol and that his mother gave him money to buy this. Family members also reported that he stole money from them in order to purchase alcohol. Mr S informed the inquiry panel that he had drunk approximately eight cans of Stella Artois immediately prior to the index offence.

Past Psychiatric History

In August 2002 Mr S was referred to community adult mental health services in close temporal proximity to the assaults on his neighbours and sister. Mr S was assessed by a general adult psychiatrist. A history was obtained from his mother that suggested that Mr S was hearing voices, believed that his neighbours were talking of past sexual abuse, was *"going off into a world of his own" and was "flying off the handle"*. Mr S admitted to using cannabis. It was considered likely that Mr S was suffering from a psychotic illness (the context of illegal drug misuse was noted),

As there was a history of educational difficulties, it was suggested that Mr S be referred to learning disability services. On receipt of the referral letter the acting consultant psychiatrist in learning disability (ACPLD) referred Mr S on for a psychological assessment. (ACPLD) did not assess Mr S at this stage.

Mr S was seen by a trainee clinical psychologist in November 2002. and was discharged back to the ACPLD's care. He then failed to attend two follow up appointments and was in breach of his Community Rehabilitation Order. His probation officer offered to take him to his psychology appointments but this offer was declined by the consultant psychology. She stated that this would be an abuse of Mr S's Human Rights.

In July 2003 the ACPLD assessed Mr S who was accompanied by his mother. She contributed to the assessment. The ACLD considered that he did not believe that Mr S's mental disorder was of a degree of severity that required the use of the 1983 Mental Health Act.

In August 2003 the ACPLD made an internal Specialist Community Assessment Team (SCATS) referral to the Nursing Team. In October of that year an Advisory Officer saw Mr S and his mother at home and completed the FACS. In October that same year an Enhanced CPA meeting was convened and chaired by the ACPLD to discuss Mr S's care. At this meeting it was agreed that a Carer's assessment would be undertaken on Mr S's mother.

In November a 'Mapping' meeting for Mr S was held, this was attended by Mr S and his mother, it was agreed at this meeting that Geesemere Day Services (a Specialist Health Service provision) was not an appropriate option for his care. By December 2003 the Community Care Services file was closed, this decision was reached following a discussion between the Senior Care Manager and the Locum Community Services Manager. It was concluded that Mr S was not eligible for Social Care Services.

Mr S did not attend for his appointment with the community nurse on 17 December who then phoned Mr S who said he had been unwell with flu and that he was going away with the family for three weeks. It was agreed that the community nurse would contact Mr S or his mother in the second week of January 2004 to make another appointment.

Finally Mr S left the family home at 10.35 pm on 11 January 2004 it was on this date that the assault on Mr P took place. Following the incident he returned home where the police later arrested him

Conclusions and Recommendations

The Investigation panel have worked hard to ensure that the inquiry focused on systems and not individuals. The analysis, findings and recommendations are therefore clearly focused on this analysis and the processes involved. Specific areas of investigation and the relevant recommendations are outlined below in summary form.

Mother's ability to care

Mr S's mother's difficulties were well known as the principal carer in this case. She went to some lengths to express her anxiety on several occasions and she was making it clear that she could not cope. The evidence clearly demonstrates that several practitioners picked up her distress but she was never offered support in her own right. The evidence gathered suggests that the decision to allow this situation to continue should not have been allowed to stand

A number of recommendations within this report suggest changes to the way carers are treated, to be mindful of their needs independently of the principal focus of care and to ensure that they are fully engaged within the ongoing process of assessment, care and review.

Criminality

This reports concludes that there were many characteristics of this case which might –if viewed objectively- have given good reason for the services to take a very different approach to managing this case. There are many formerly cited characteristics which have come to light in independent inquiries that might have served as reminders of the need to think through behavioural patterns which previously led to very serious consequences.

The existence of significant criminal behaviour as part of a clinical presentation should serve as a reminder to practitioners to take expert advice and seek referral to specialist agencies when such presentations arise. This was not the path followed in this case despite mounting evidence of criminality and a tendency to abusive behaviours.

In light of the evidence found the inquiry panel have made two recommendations regarding the need to seek specialist advice and to take a view of the overall community safety mechanisms in place and the involvement of appropriate agencies.

Diagnosis and Treatment Options

Mr S presents a very complicated set of symptoms and behaviour. There is no reference to a differential diagnosis although evidence to hand might indicate the need for some thought to this arena and possible assessment or investigation.

At various times there is reference to a variety of symptoms and possible psychotic illness but there is no definitive assessment material to hand in the records. He is prescribed anti-psychotic medication but his compliance is variable although this too seems not to have been closely monitored at any point in the care process

The presence of a possible personality disorder is never assessed despite the complicated presentation and behaviours consistent with such diagnoses as well as a reference to autistic spectrum disorder but it was never assessed and seems to have prompted no further action or specialist assessment.

The level of learning disability is never fully assessed and this is borne out in the decision by the psychology department to discharge him for failing appointments. He is described as vulnerable and chaotic. It is clear he cannot organise himself and it is known that his literacy and numeracy skills are poor. However, there is no formal assessment of his functional skills and how this may have impacted on need and risk.

There is overwhelming evidence within this case that non-compliance was a recurrent theme. Despite the evidence those involved in the care of Mr S did not act decisively to gain control and establish a regime in which confidence of medication compliance could be achieved.

Whilst the use of the Mental Health Act was considered, there is no convincing evidence in the records that an admission to hospital was really given serious consideration. Moreover it is clear that it was considered that an admission to an acute mental health hospital bed might be detrimental. There is no evidence in the records that this risk was balanced against ongoing risk of non compliance even though evidence of the implications of the latter might have been predicted.

In addition there is no evidence that any real alternative strategy to establish compliance was ever considered. In the final analysis Mr S was left with his mother as the principal policing influence of his medication compliance even though this had already proved itself to be an inadequate strategy. Her own capacity was significantly hindered by her ill health and the added stress of responsibility for further family members experiencing their own problems at the time.

In light of the highlighted circumstances the panel have made a number of recommendations regarding care pathways, governance systems, protocols for clinical assessment and training programmes related to the use of the Mental Health Act in complex case management.

Lack of integration between services

Several areas of policy application clearly lack understanding of responsibilities in evidence given by witnesses throughout the inquiry. Chief amongst these was the question of eligibility criteria for several elements of service but primarily Social Services and the SCATS team. This is one of many examples. Witnesses consistently expressed a shortfall in clarity around their understanding of access criteria and an absence of clear guidance or policy available at the time.

Services were clearly operating in isolation from each other and the evidence taken from witnesses does not convey a picture in which the culture had progressed beyond discussion and verbal recognition of contemporary models of care where real integration of thinking, practice and assessment had occurred.

The commonly expressed view was an awareness of other service components with little evidence for example of what role they fulfilled, what resources were available or what services might be offered. Perhaps one of the worrying features of this presentation is that the culture of defensive practice failed to acknowledge the need or benefits of understanding alternative agency contributions in delivering solutions to wide ranging problems such as those presented by the case of Mr S.

Services were not operating in a co-operative way at the time and there is evidence of active efforts to avoid agency or individual department involvement

In light of the evidence outlined above the panel have made a number of recommendations designed to ensure that existing policies and procedures are more widely known and utilised in appropriate circumstances, that oversight systems are established and embedded in services and that the overall systems of policy development are reviewed and monitored.

Further recommendations address the need to ensure that all staff have access to systems in which policies and procedures are maintained and that further urgent work is needed to clarify access points for services, protocols for engagement and eligibility criteria.

Record Keeping

Throughout this inquiry clinical records and their scrutiny has been a source of concern for panel members. Supervision of practitioners has not been demonstrated to meet acceptable standards and auditable

accountability was found to be weak. These factors have clearly led to lost opportunity.

Record keeping was a prominent feature amongst witness interviews wherein it was often not possible for witnesses to answer questions even in circumstances where they had their own contemporary records to hand.

Records were sometimes inadequate and it was not possible to audit decision making trails. Much of the treatment programme information gained from witnesses could not even be cross referenced from alternative notes of practitioners who had concurrent involvement with the care of Mr S and following a trail of events or establishing a chronology.

These tasks proved to be very challenging and much more so than might be expected from reasonable records. It is not clear what systems were in place at the time to assess or scrutinise the records of professional practitioners involved but it is evident that some of them fell short of reasonable expectations.

In an effort to strengthen these systems a number of recommendations have been proposed by the panel. These include proposals for auditing and active case management systems, performance management and a specific and targeted training programme for effective case management

Social Services Referral

Much of the evidence gathered from professional practitioners in the course of this investigation suggests a tendency towards a reactionary approach to managing the case of Mr S and their work in general. Practice did not appear to support more innovative or proactive case management which one might expect from truly integrated multi-professional teams. It must be said however that for the most part those involved in the care of Mr S worked hard and struggled to make the best of what appears to have been inadequate systems of support, policy development and practice support such as continuing education and supervision.

It is clear from the evidence that more should have been done by Social Services in recognising areas of responsibility and acting to ensure support was made available in this case

Social Services were advised that Mr S was a vulnerable adult in October 2002 following the investigation into assaults against his sister under Child Protection Procedures. Nevertheless there were no proceedings instituted under the department's Vulnerable Adults Policy. This would have prompted a multi-agency case conference, formalised care planning and

identification of roles and responsibilities and provided a mandate for the provision of services.

It is clear that Mr S was eligible for a community care assessment under the Community Care and NHS Act which he did not receive. One of the key responsibilities for Social Services Authorities under this Act is to carry out an appropriate assessment for social care, in collaboration as necessary with medical, nursing and other caring agencies, before deciding what services should be provided. In addition one of the key objectives in the Act for service delivery is to ensure that service providers make practical support for cares a priority.

In light of the issues raised above the panel has recommended that more should be done by Social Services and that they should work with other relevant agencies to review the policy support mechanisms which facilitate access to assessments under the NHS and Community Care Act and the Carers Act

Learning Disability and Mental Health Services

It has become clear from available evidence that there is a tendency to avoid acceptance of lead responsibility in the face of referral between these two services and the scenario lacks any clear sense of eagerness to work collaboratively. Clearly this is a case which has a tendency to straddle at least two specialist areas of care but insufficient success was achieved in gaining collaborative working.

Evidence available supports the proposition that services lacked the necessary policies and procedures to support strong collaborative practices but professional standards would have expected a more robust effort from all concerned in delivering services at the time.

Having carefully scrutinised the evidence and the implications which arise from it the panel have put forward a set of recommendations to bring both specialties together in learning opportunities which focus on a more proactive programme designed to identify opportunity rather than avoid accountability. It is further recommended that this case presents a unique opportunity from which all agencies can learn and develop more successful approaches to care in challenging cases.

Substance misuse

It is of note that despite the presence of significant evidence of need this case did not to give rise to any focused demand for a formal assessment of the degree of problems associated with substance misuse. It is clear that the decision to seek an assessment should have been taken and that

there was overwhelming evidence of need which does not appear to have prompted appropriate actions.

In order to establish a uniformed and safer approach to managing challenging cases such as this the panel have made recommendations to ensure that evidence of need is properly assessed in the case of substance misuse –especially where there is a mixed diagnosis- and appropriate expert help is secured at an early stage.

Communications

In each of the areas scrutinised throughout this process communication has come to the fore as an issue which impacts across policy, planning, change management and professional practice.

The overwhelming sense that is conveyed in the gathering of evidence is that there is a lack of sufficient awareness in integration, joint working, policy development, agency or individual roles and information about resources, services or agency responsibilities. It is clear that whatever systems have been put in place they were not effective in maintaining confidence to work in a contemporary way amongst those involved in the care of Mr S.

The panel recognise the challenges facing services and the need for effective communication. In order to support the achievement of a successful system of communication a number of recommendations have been proposed. These recommendations propose that all agencies need to ensure that there is a coherent strategy for communication and simplified annual plans in place to deliver it. Key amongst these recommendations is the need to ensure clear communication of service plans and systems for all personnel involved in order to ensure and test communication.

Understanding of agency roles

The expressed views of witnesses involved across agencies reflects a common pattern in a lack of understanding of their respective roles and responsibilities and this is played out in a number of scenarios including understanding of effective routes into the various aspects of service provision

What becomes most evident is the recurrent failure of various aspects of services to confirm and accept responsibility for ongoing or even transient responsibility within this case. Whilst any level of negligence within the systems is a hard concept to evidence this case does raise some real

concerns about competence within the system and roles and responsibilities both at a service and individual practice level.

The panel are very clear that there is a need to define roles and responsibilities so that there is open clarity of role in both service and agency terms. The panel has attempted to ensure that the recommendations include a specific responsibility for training on this initiative so that there can be no doubt arising in future cases**.**

Knowledge and Understanding

Any judgements made by the inquiry panel should be measured against expectations based on the knowledge and expertise held by the individuals involved in the care of Mr S. The question which has been addressed by the inquiry is whether or not incompetence was a factor in the outcome of this case and what underlies that incompetence.

The evidence gained in the course of the inquiry is that those involved acted within a knowledge base which might at times have been below the expectations of a reasonable well informed and reasonably educated system.

There is no reliable indication of negligence in so far as no individual generated evidence to lead the panel to decide that they failed to apply what knowledge that they held or knowingly failed to act with good faith. What the evidence does imply is that overall those involved in the care of Mr S failed to individually or collectively stand back and appraise the situation with an informed overview. This has raised significant concerns regarding their overall supervision and ongoing education.

In order to ensure that risks related to knowledge and or competence are minimised in the future the panel have made a number of recommendations which cover support to posts where substantive appointments are delayed or difficult, robust systems of governance and clinical case review .

Recommendations made by the panel also seek to ensure that operational policies and job descriptions or person specifications clearly outline the competencies required for the tasks demanded across all services and that this becomes an embedded part of corporate behaviour.

Planning and Strategy

It must be acknowledged that many of the characteristics of services in operation at the time are not without precedent. Local services and public

organisations have been subject to major organisational change and it is often the case that corporate restructuring achieves its objectives of resource alignment, accountability and authority whilst allowing awareness of policy, procedure and other governance systems to fall behind.

Evidence put forward by witnesses interviewed in this inquiry support this as a case in point

The experience of planning across the county for service integration and co-location of health and social services in both Learning Disability and Mental Health was consistently reported to be disparate and vague. Whilst there are clear high level strategic commitments to achieve integration this was perceived to be piecemeal and without widespread operational understanding or ownership.

The panel recognises much of the difficulty described within major agency change programmes and has made some recommendations to minimise the sense of distance between corporate plans and the day to day experiences of practitioners. The recommendations seek to ensure effective involvement and therefore communication consistency across all affected services. The recommendations seek to ensure that individual management systems of communication accurately reflect the corporate requirements.

Risk Management

This is a complex and challenging concept even in the most coherent of circumstances and it must be acknowledged that risk management is dependent on a high level of analysis which must be informed by a detailed data and subsequent information and intelligence gathering process.

Predictability of outcome is a significant factor in determining risk and it is only through the most able and detailed intelligence gathering and information sharing that predictability can be established for risk management purposes in services such as those being scrutinised for this inquiry.

On the basis of evidence gathered in the course of this investigation it is evident that there are clinical risk management processes in place. Their effectiveness has not been established for services that were operating at the time but more importantly it has proved difficult to identify a shared process or system of risk management operating between the services who took some part in supporting –or providing care to- Mr S and or his family.

Past Independent inquiries relating to Mental Health and Learning Disability services have demonstrated a tendency to identify areas of background risk which imply an underlying indicator from which planning of services, risk management, care and treatment might be informed. These indicators have included risks around major service change such as those in train in the course of this case.

Many of the adverse indicators previously cited in local politics, planning and inter-agency systems appear to be present in this case and might – with some careful reflective thought- have heightened the perceived level of risk in this case.

Given the evidence available from past inquiries and the similarities within this case the panel has made a number of recommendations to ensure that risk management systems are reviewed and fully embedded within the respective organisations.

The panel further recommends that practitioners are seen to be receiving sufficient training to effectively utilise the systems of risk management and –more importantly- the concept in their day to day work.

Capacity Assessment

Whilst it is appropriate to presume capacity there was much in Mr S's presentation which suggested that he did not have the capacity to make certain decisions and where a formal assessment of his capacity was indicated. However, the panel did not elicit any evidence that this was carried out by any of the professionals involved with him.

Where a person does not have the capacity to make a particular decision it is then a matter for the professionals to decide what would be in his best interests and act accordingly.

The fact that Mr S's mother was made responsible for his medication suggests that he was deemed unable to understand the reason for its prescription and unable to organise himself to take it. His inability to keep his appointments with the psychologist may have been due to a lack of capacity to understand the nature and purpose of such an appointment and an inability to get himself there. Rather than making him personally responsible for that and closing the case it could have been concluded that it would have been in his best interests to be brought by the Probation Officer. Instead it was concluded that this would have been against his human rights.

The courts deemed Mr S to be responsible for his actions and to be able to comply with Community Rehabilitation Orders despite the Probation

service providing evidence that he was unable to do this and requesting a mental health disposal. It is significant however that, following the homicide, he was deemed unfit to plead. Clearly there were differing views on capacity in this case which were used as the basis for decision making which ultimately do not stand up to scrutiny and remain as clear indicators that multiple agency systems were not being used to achieve consensus and effectively manage this case.

Whilst it is acknowledged that the Bournewood judgement has generated some reservations regarding the detention of individuals suffering from conditions which include impaired capacity, actions taken in this case do not imply that this was a case which presented challenges in that context.

The panel have considered the available evidence and sought to make recommendations which will serve to strengthen future practices. It is clear that more thought needs to be given to the issues of capacity and the recommendations address this need through both training and practice,

Systems CPA Leadership

Whilst there was evidence from testimony and the records available for scrutiny that CPA was being used in this case there is a lack of consistency and little evidence that those using it understood the requirements. Evidence of its application is limited and there is further evidence that there was a general reluctance to take on responsibility for doing it or gaining compliance from the various contributors in effectively managing this case. The rigorous application of the CPA systems would have created a much stronger and robust approach in the ongoing management of this case.

Both the training programme and CPA practice are targeted in the recommendations with a view to improving knowledge, awareness and day to day application of the process

Policy and Procedures

Several questions have been raised relating to joint working across disciplines and functions within the NHS. Professionals operating within functions clearly do have information systems and processes which are recognised as being joint but these too lack ownership outside or across functional groups such as Mental Health or Learning Disability services

It has not been possible to identify a shared risk management process or tool operating within the health related elements of service. Whilst there was involvement from doctors, nurses, psychologists and occupational therapists within the NHS services there is no evidence to support the

existence of a single system of risk management operated across these professional groups. When scrutiny is extended beyond NHS involvement the picture becomes still more difficult to assess in terms of shared risk management or information gathering systems. No conclusive evidence has been presented to support the proposition that there were shared interagency systems of risk management operating across the involved agencies at the time of the incident under investigation.

This case does exhibit many of the composite indicators of high risk such as chaotic family, mixed diagnosis, poor employment and educational history, substance misuse, criminal activity and past offending behaviour. These indicators should have given rise to more assertive action by professionals involved but the discipline of risk assessment systems does not appear to have been in evidence at the time. together with the dissemination of learning from past Independent Inquiries and the embedding of learning from those inquiries

Internal Review

Contemporary systems of inquiry are clearly based on root cause analysis, they are designed to be open and non blaming. This was not the case in this instance.

Evidence from those involved in the internal review process did not present a view that it was either helpful or effective. More needs to be done to ensure that this is a process, which effectively helps those involved to be open, feel supported and to learn from the process. Most importantly such processes must inform the task of service improvement and public confidence in the services.

In order to ensure that services gain maximum benefit from the finding of this inquiry the recommendations include changes to the management and application of process in future internal inquiries. Recommendations propose much closer conformity to established good practice and the auditing of their outcome to give assurances that positive change is offering positive gains to services.

Resources

The panel have not found that resources played a part in any of the failures apparent in this case nor can it take the view that the marginal provision of additional resources would have changed the events or outcome.

Despite the findings it is clear that most of the clinical staff involved in this case thought resources were an issue. Contrastingly managers did not

have the same view. The evidence supports the proposition that there was insufficient interaction and discourse between practitioners and managers of the services and that this allowed opposing but subjective views to prevail.

There is an evident need for a more uniformed programme of knowledge building to be established in resource management and recommendations include the need to ensure that practitioners are fully involved in budget building and general resource allocation and management.

Commissioner, Provider Issues

This case was being managed within a time of major strategic change for all agencies. It is clear from available evidence that little was known on the ground of these changes or the longer term intentions. Major corporate and strategic agency changes do impact on the services on the ground and this must be effectively managed and communicated to all staff involved. The evidence suggests that this was not effective within provider agencies and there is little evidence that this was being overseen by commissioners.

The panel has made recommendations designed to ensure that oversight of major change programmes becomes integrated into the commissioners key performance management framework. In addition service changes are proposed for provider organisation so that assurances are available of full stakeholder involvement. Finally recommendations suggest that commissioners should look at systems that offer assurances that their contracted providers are implementing recommendations from past independent inquiries.

Final Comment

Compliance with a prescribed regime -be it probationary or medication- is a clear area where discipline was absent for Mr S and there is evidence throughout the process of the inquiry that this was an enduring concern for many individuals involved in his life and care. The unpredictable and unreliable nature of his own testimony has been an underlying concern at many junctures in the process of this inquiry but it has often been the case that he has been unwisely given the benefit of the doubt.

When gathered together the evidence in this case begins to present with a familiar picture which expertly viewed might be seen to bear all of the predictors of a potentially high risk scenario. In this instance that was not the case.

It is the opinion of the inquiry panel that systems and practices operating within services at the time of the incident did not reach the high standards expected from reasonable services. However the panel also recognise that it is system weaknesses which have been identified as causative and not individual professional practice.

Given the period of time that has elapsed since the incident it is accepted that many changes have already been made to service and practices and much has already been learned. It is nonetheless important to ensure that services are assessed against all of the recommendations contained within this report even if that is only for the purpose of confirming positive change

The panel commend these recommendations to the authorities concerned and trust they are perceived to be a progressive set of recommendations upon which significant service improvement can be achieved and maintained.

3. Introduction

On the night of 11th January 2004 Mr S attacked a man (Mr F) with a rock near Mr F's home in Sunbury. Mr F sustained fatal injuries and died later that night.

Earlier in the evening Mr S had had an altercation with his brother and had left his home at approximately 10.35 pm. On entering a local public house he then had an argument with Mr F and Mr F's friend after allegedly trying to steal their drinks.

Mr S had been in receipt of learning disability and mental health services provided by the North West Surrey Mental Health Partnership NHS Trust or predecessor organisations for a number of years.

Mr S was initially deemed unfit to plead but was declared fit to plead early in 2006. He pleaded guilty to and was subsequently convicted of manslaughter on the grounds of diminished responsibility and sentenced to a Hospital Order with restriction (37/41 under the Mental Health Act 1983). He is currently being treated in a learning disability medium secure unit.

The North West Surrey Mental Health Partnership NHS Trust established an internal review which reported its findings and recommendations to the Trust's Board.

An Independent Mental Health Inquiry was initially set up in November 2005 by Surrey and Sussex Strategic Health Authority together with Surrey County Council as required by National Health Service Guidance HSG (94) 27 and the 2005 Addendum. The guidance requires that an independent inquiry is undertaken when a person, who has committed a homicide or caused serious untoward harm to others, has been in receipt of mental health services during the six months prior to the incident. Due to Mr S's initial inability to enter a plead to the charge of murder the Independent Mental Health Inquiry was deferred for six months until after Mr S's conviction in court. The inquiry recommenced in May 2006.

During the period of the Independent Mental Health Inquiry the Surrey and Sussex Strategic Health Authority has been merged with Kent and Medway Strategic Health Authority. On 1st July 2006 these two authorities were replaced with the South East Coast Strategic Health Authority.

It is important to note that since the tragic circumstances under review occurred, the local mental health and learning disability services have also undergone a period of reorganisation. The local services are now

provided by a Surrey- wide organisation, the Surrey Borders Partnership NHS Trust.

4. Purpose of the Inquiry

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

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

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

5. Terms of Reference

The agreed Terms of Reference for the Inquiry is as follows:

The independent inquiry is commissioned by South East Coast Strategic Health Authority and Surrey County Council. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27, "The Discharge of Mentally Disordered People and their Continuing Care in the Community."

The detailed brief was:

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

    - The quality and scope of his health, social care and risk assessment:
    - The circumstances relating to treatment, and to comment upon:

        - The suitability of the care in view of Mr S's assessed health and social care needs, and clinical diagnosis.
        - The clinical and operational organisation, and the quality of care provided in the community.
        - Assessment of the needs of carers/family

    - The suitability of his treatment, care and supervision in respect of:

        - His assessed health and social care needs.
        - His assessed risk of potential harm to themselves or others.
        - Any previous psychiatric history, including drug and alcohol abuse.
        - Previous Forensic History.
        - How the service met his health and social care needs.

    - The extent to which Mr S's care corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health and local operational policies: the extent to which his prescribed care plans were:

        - Effectively delivered
        - Complied with by Mr S

- Monitored by the relevant agency

- The history of Mr S's treatment, care and compliance with the service provided
- The internal investigation completed by Surrey and Borders Partnership NHS Trust and the actions that arose from this.
- Consider such other matters relating to the said matter as the public interest may require.

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

3. To examine the adequacy of the collaboration and communication between all the agencies involved in the care of Mr S, or in the provision of services to him, including Surrey and Borders Partnership NHS Trust and GP services.

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

6. Panel Membership

The independent inquiry has been undertaken a panel of professionals independent of the services provided by Surrey Borders Partnership NHS Trust and its preceding bodies.

Panel Chair		
John Brouder	–	Currently Executive Director of Corporate Affairs and Nursing with Berkshire Healthcare. A registered Nurse with 30 years experience of specialist services. A business graduate with extensive experience of public scrutiny, analysis and investigation.
Panel Members		
Dene Robertson	- -	Consultant psychiatrist at the South London and Maudsley NHS Foundation Trust. He has worked on a national specialist forensic learning disability psychiatry unit for the past 10 years. Has extensive experience of other aspects of general and developmental psychiatry.
Jane Barnes		Senior social worker and ASW with the London Borough of Southwark. Based on a national forensic learning disability unit. Mental Health Act Commissioner. Accredited Practice Teacher and Lecturer in Mental Health and Learning Disabilities.
Inquiry Manager Lynda Winchcombe	–	Former Director, GW Management Consultants Ltd, a company specialising in undertaking Inquiries and investigations. Currently working independently as a management consultant.

7. Methodology

7.1 How the Independent Inquiry was undertaken

Surrey and Sussex Strategic Health Authority in conjunction with Surrey County Council commissioned the Independent Inquiry under the Terms of Reference in Section 5.

The inquiry panel identified the written documentation it required. As each document was received it was indexed and paginated. A chronology of critical events was compiled and is contained within this report (section 8). A full list of the documentation considered by the inquiry panel can be found in Appendix One.

A presentation was received from senior managers in the Surrey Borders Partnership NHS Trust. The purpose of this was so that the inquiry panel could gain an understanding of the services provided by the Trust and their partners, learn about the plans for future service developments, provide an opportunity to meet the Trust's senior managers and discuss the inquiry process.

An informal staff meeting was arranged to discuss how the inquiry would proceed and to provide an opportunity for staff members involved in the inquiry to ask questions of the inquiry panel.

Evidence was received from 20 individual witnesses both orally and in writing over a period of six days during August and September 2006. Efforts were made by the inquiry panel to contact the Consultant Psychologist involved in Mr S's case and invite her to be interviewed but we were unable to do so. Those identified for interview either had direct contact with Mr S or held managerial responsibility for some aspect of the services engaged with this case. Representatives from related agencies such as the Local Authority, the Probation Service and Police were also interviewed.

Each interview was recorded and the individuals were given an opportunity to correct the transcript and add any other information that might be of further help to the inquiry.

The families of both the perpetrator and the victim were interviewed by the members of the inquiry panel in order that their viewpoint could be understood and also that any concerns they had regarding Mr S's care could be investigated.

8. Chronology

8.1 Background

8.1.1 Family History

Mr S was born on 20th October 1983 and is the youngest of four male full siblings. Mr S's brothers are older than him by approximately seven, six, and three years. One sibling (second in birth order) had an extensive criminal record (allegedly for offences including theft, burglary and stealing cars), spent some periods in prison, and was suspected of supplying Mr S with illegal drugs.

Mr S has two younger half-sisters from a subsequent marriage. His half-sisters are approximately seven and five years younger than Mr S.

Mr S's parents married, divorced and remarried. The first marriage is reported to have failed because of Mr S's father's history of alcohol abuse and gambling, and the family's consequent financial hardship. The second marriage is reported to have occurred as a result of Mr S's mother being pregnant with him.

His parents separated and divorced for the second time when Mr S was aged approximately two years. It was reported that his father continued to physically abuse his wife and that his abuse of illegal drugs contributed to the marriage breakdown.

When Mr S was aged approximately ten years, he and a brother are reported to have spent a short period in the care of their father in Kettering. This was supposedly to have been prompted by his brother's involvement in criminal activities. Whilst they were in Kettering Mr S's mother was reported to have stated that Mr S would be left alone in his father's house whilst his brother and father went out drinking. In addition, it appears to have been during this period that Mr S alleged to have been sexually assaulted by one of his father's friends. Other than during this period, Mr S is reported to have had little contact with his father between his parents' divorce and the homicide, though his father has made irregular contact subsequently.

Mr S's mother's third marriage was to her stepfather's son who had a removals business. It was reported that she initially invited him to be her lodger when he was homeless and it was alleged that he had a history of alcohol abuse. Mr S's mother was reported to have stated that she considered herself to be, in essence, a single parent as her partner did little more than provide an income.

During Mr S's childhood, relationships within the family appear to have been volatile. His reaction on one occasion was to steal and deliberately damage his stepfather's car. On a separate occasion Mr S stole and crashed his stepfather's car when his stepfather allegedly refused to take his mother to hospital where she needed emergency treatment for a perforated peptic ulcer.

There are indications that Mr S was vulnerable to verbal and physical abuse from his elder brothers. His mother reported that his brother and stepfather would refer to him as a *"spastic"* and would resort to physical violence against him. A possible precipitant to this behaviour may have been Mr S's propensity to *"pick up anything lying around"* including money that did not belong to him.

Mr S's mother was employed as a home help. However, she had to give up this work as a result of poor health and this added to the pressure of caring for Mr S. In 2002 she had a stroke (there are reported to have been two or three similar events within a relatively short period) and had emergency treatment for a perforated peptic ulcer. Following the onset of her poor physical health, Mr S's mother developed a history of anxiety and depression. She died in June 2005 after driving her car at high speed into the Thames at Walton Bridge.

The panel is not aware of any other family history of psychiatric disorder.

8.2 Developmental and Educational History

8.2.1 Developmental History

It was reported that Mr S's mother spent one week in hospital when seven months pregnant with *'labour pains'*. As far as is known, Mr S was born in hospital at full term; there are no reported birth-related complications.

It was reported that Mr S displayed unremarkable developmental milestones apart from a possible delay in toilet training. Little is known of the quality of his social communication or social interaction during early childhood. Mr S's mother described him as clumsy, different from her other sons, and as *"a problem child"*. She is reported to have indicated that his sleep was poor and that he would panic if he could not see her (the age at which this is reported to have occurred is not known). His mother is reported to have described Mr S as *"resentful"* when his two half-sisters were born.

8.2.2 Educational History - 1988-1998

Age 5 years: Mr S entered mainstream education.

Age 6 years: Mr S is reported to have been recognised as experiencing learning difficulties, and was transferred to a special school in Ashford. His mother reported that he made *"good progress"* at this school.

Age 10 years Last statement of Educational Needs recorded.

Age 11 years: Mr S attended a special boarding school in Dorking for approximately one month. Reports suggest that this was as a result of behavioural difficulties rather than as a result of intellectual difficulties per se. He was removed by his mother following an allegation that he had been sexually assaulted by another pupil (see psychosexual history). His mother is reported to have stated that as a child Mr S was severely traumatised by this and that his academic progress suffered as a result.

Age 11-12 years: Mr S is reported to have received home tuition for several months prior to transfer to another school at Molesey, Surrey, (a school for children with emotional and behavioural difficulties).

Age 13 years: It is reported Mr S was expelled from a further special school having been accused of causing damage to a car, and having climbed on to the roof of a school building with other students. Mr S's mother reported that he was easily led and frequently in trouble with other pupils, and frequently truant from school. In addition, she reported that 'the council' complained about Mr S's behaviour outside school, which included fighting with other children on the estate in which the family lived.

Age 14 years: Mr S received home tuition from this point onward. In addition, it was recorded that he attended a special needs group in Epsom twice a week.

Age 14 years: Mr S is alleged to have been assaulted by the father of a local child (reason unknown). The assault was not reported to the police.

Age 15 years: It is reported that Mr S had been assaulted by a neighbour and his son (reason unknown). The police were contacted but no action was ultimately taken.

Mr S obtained no formal qualifications, but is able to read to a *"reasonable"* degree. He is reported to have difficulty in managing money.

8.3 Employment History - 1999-2001

Age 16 years: Mr S is reported to have worked in a building supplies store for approximately three months where apparently he was ridiculed by staff for slowness during this period and lost his job as a result, although the mechanism of this is not clear.

Age 16-18 years: He then apparently worked intermittently for his stepfather in his removal business. He left his stepfather's employ after an incident in which he left the handbrake off a removal lorry, causing the lorry to be damaged. It has been reported that Mr S had been drinking with other employees at the time.

Age 16-18 years: He then appears to have worked intermittently with his brothers for his uncle's building firm.

Mr S appears to have been continually unemployed from age 18 years and prior to the index offence, Mr S was receiving jobseeker's allowance and *'signed on'* at the jobcentre fortnightly.

8.4 Forensic and Challenging Behaviour History

From 1996 to 2003 Mr S was convicted for criminal activities several times as follows:

17.05.96: Cautioned for causing actual bodily harm. Circumstances unknown.

24.05.99: Cautioned for the theft of a bicycle.

07.12.01: Possession of a controlled drug - Class B -(amphetamine). Sentence: 12 months Conditional Discharge, subsequently revoked 05.06.02, Community Rehabilitation Order 12 months concurrent.

07.12.01: Being carried in a motor vehicle taken without consent. Fine £100 and a Community Rehabilitation Order to be monitored by the Probation Service

05.06.02: Possession of a controlled drug - Class A (Heroin). Sentence: Community Rehabilitation Order 12 months concurrent.

05.06.02: Possession of a controlled drug - Class A (crack cocaine). Sentence: Community Rehabilitation Order 12 months concurrent.

10.09.02 Mr S appeared before the Magistrates Court in breach of the Community Rehabilitation Order.

12.01.03: Common assault. Sentence: Community Rehabilitation Order 2 years supervised by North Surrey Magistrates Court.

12.01.03: Common assault. Sentence: Community Rehabilitation Order 2 years supervised by North Surrey Magistrates Court. These convictions for common assault relate to assaults on his neighbours whom he is reported to have believed were talking and writing about his past experience of sexual abuse (see past psychiatric history and chronology of events for further details).

Mr S pleaded guilty to all charges.

He frequently failed to attend probation sessions without explanation, and appeared in court on a number of occasions as a result of breaches of the conditions of supervision orders. The view was expressed that Mr S did not benefit from supervision sessions when he did attend, having *"little grasp of what was being said to him in general and was unable to engage in discussion of the issues related to his offending behaviour".*

In addition to the formal forensic history given above, it is alleged that in August 2002 Mr S had a disagreement with his sister, then aged fourteen years, in which she sustained a fractured finger. A second alleged assault on the same sister (in which she is reported to have sustained bruising to her face) was followed by the involvement of the Child Protection Team in October 2002, and Mr S's first referral to adult psychiatric services at age 18 years. The sister also alleged other assaults by Mr S.

He is also reported to have:

1) been stopped by neighbours from tying a length of rope across the road and waiting for a motorbike to come by (age unknown)
2) driven off in his stepfather's car and crashed it into a lamppost – allegedly in response to his stepfather's threat to smother his mother with a pillow
3) taken and written off his stepfather's car in response to his stepfather's alleged disinterest in his mother when she was ill with a perforated peptic ulcer.

Mr S was barred from a local public house subsequent to an argument (date unknown), and was barred from a second establishment, the pub involved in the index offence as a result of *"helping himself"* to other peoples' drinks (date unknown).

Mr S killed Mr P on 11th January 2004.

8.5 Substance Misuse History

Age 15 years Mr S was reported to have abused butane gas and admitted to using cannabis, sometimes on a daily basis. In addition he is reported to have used alcohol and that his mother gave him money to buy this. Family members also reported that he stole money from them in order to purchase alcohol and that he drunk excessively on a regular basis

Mr S's forensic history indicates that he has used cannabis, heroin, amphetamine and cocaine. It is reported that he may have obtained drugs from his older brother and also that he stole from his mother and other family members in order to finance his drug and alcohol use as cited above. It is reported that his mother restricted his money in order that it would be more difficult for Mr S to buy drugs.

Mr S informed the inquiry panel that he had drunk approximately eight cans of Stella Artois immediately prior to the index offence

A number of previous psychiatric reports indicated that it had been difficult to establish the extent and frequency of Mr S's alcohol and illegal drug use.

Mr S's mother reported that in her view Mr S was vulnerable to exploitation and tended to associate with local youths who made use of

illicit drugs. It is recorded that Mr S smoked approximately ten cigarettes a day.

There is no evidence consistent with pharmacological dependence on any legal or illegal substance other than tobacco.

8.6 Medical History

There is no known history of a head injury leading to altered level of consciousness nor a history of systemic medical disorder associated with abnormality in brain function. These observations are relevant in so far as they might give rise to behaviours consistent with Mr S's presentation.

Other than intermittently having taken antipsychotic medication (Olanzapine 10mg daily), Mr S was not taking any regular medication prior to the index offence.

Mr S had an operation to correct a squint during childhood. The operation is reported not to have been completely successful, and Mr S is reported to retain some degree of strabismus. Mr S inconsistently wears glasses despite advice to the contrary.

Mr S was also investigated for dizziness during childhood by his general practitioner; no particular pathology was found.

8.7 Psychosexual History

Mr S is alleged to have been subject to two alleged episodes of sexual abuse, aged 10 and 11 years. Although Child Protection investigations were initiated, they did not progress to court.

The first alleged episode occurred whilst Mr S was living in Kettering with his father: Mr S alleged that a friend of his father's touched him in the genital area. His father's friend is reported to have been a *"known paedophile"*. Mr S's father reported the incident to the police.

The second alleged episode occurred approximately one year later when Mr S was age eleven years and was a pupil at a boarding school. Mr S's allegation was regarded as justified on the basis of physical examination, which suggested that he had been seriously sexually assaulted. However the case did not progress to court due to lack of evidence.

Mr S is reported to have stated on a number of occasions that he is heterosexual and has had a number of girlfriends.

8.8 Past Psychiatric History

General Practitioner records indicate that Mr S was referred to the child and adolescent psychiatric services. The reasons for this referral are not contained within any of the material available to the inquiry panel.

21.08.02 Mr S was referred to community adult mental health services in close temporal proximity to the assaults on his neighbours and sister.

23.09.02 Mr S was assessed by a general adult psychiatrist. A history was obtained from his mother that suggested that Mr S was hearing voices, believed that his neighbours were talking of past sexual abuse, was *"going off into a world of his own" and was "flying off the handle"*. Mr S admitted to using cannabis. It was considered likely that Mr S was suffering from a psychotic illness (the context of illegal drug misuse was noted), and he was prescribed olanzapine (an atypical antipsychotic drug) 10mg daily. As there was a history of educational difficulties, it was suggested that Mr S be referred to learning disability services. He was placed on Standard CPA and a low risk rating.

Oct 02 On receipt of a referral letter the acting consultant psychiatrist in learning disability (ACPLD) referred Mr S on for a psychological assessment. (ACPLD) did not assess Mr S at this stage.

28.10.02 A consultant psychologist requested that Mr S's GP complete the internal Risk/CPA summary tool.

12.11.02 Mr S was seen by a trainee clinical psychologist. and was discharged back to the ACPLD's care.

28.02.03 Mr S failed to attend two follow up appointments and was in breach of his Community Rehabilitation Order. His probation officer offered to take him to his psychology appointments but this offer was declined by the consultant psychology. She stated that this would be an abuse of Mr S's Human Rights.

March 03 After several more failed appointments Mr S was in breach of his Community Order again. The Probation service considered a revocation of the Order and requested a pre-sentence Medical report.

23.04.03 Mr S appeared before the Magistrates Court and pleaded guilty to breaching his Community Rehabilitation Order

May 2003 Mr S's mother informed the Probation services that he had not been taking his medication for some time. She reported that she had herself stopped him from taking medication as she had been of the opinion that he should be able to cope without it. Subsequently, Mr S's mother is reported to have attempted to supervise her son in taking medication.

June 03 The ACPLD received a request from Probation services for a medical report

08.07.03 The ACPLD assessed Mr S who was accompanied by his mother. She contributed to the assessment

02.08.03 The ACLD considered that he did not believe that Mr S's mental disorder was of a degree of severity that required the use of the 1983 Mental Health Act.

04.08.03 The ACPLD made an internal Specialist Community Assessment Team (SCATS) referral to the Nursing Team.

11.08.03 In the Team Meeting the SCATS referral was discussed and it was agreed that Mr S should be placed on enhanced CPA. No contemporary Risk Assessment Form nor minutes of the meeting were completed.

14.08.03 Mr S was referred to the North Surrey Adults and Community Care Team.

20.08.03 The Community Care Team wrote to the ACPLD asking for a copy of the Court Report and seeking further clarification on the type of input required.

9.09.03 The Court Report (Medical report for probation) was received from the ACPLD. The referral letter requested that issues of sheltered employment and day care be considered and a Fair Access to Contact Services Assessment (FACS) was requested.

22.09.03 The Advisory Officer involved in completing the FACS assessment returned to work from leave and made contact with the family on 24th September 2003. During this period a Community Nurse from the Community Team for people with a Learning Disability (CTPLD), began assessing Mr S.

23.09.03 It is stated that a nursing assessment was started on this date, but a completed assessment was not found

01.10.03 The Advisory Officer saw Mr S and his mother at home and completed the FACS.

14.10.03 An Enhanced CPA meeting was convened and chaired by the ACPLD to discuss Mr S's care. At this meeting it was agreed that a Carer's assessment would be undertaken on Mr S's mother.

22.10.03 Mr S failed to attend an appointment with the community nurse, but attended his scheduled appointment with the ACPLD.

28.10.03 The community nurse wrote to Mr S to arrange another appointment.

20.11.03 A 'Mapping' meeting for Mr S was held, this was attended by Mr S and his mother, it was agreed at this meeting that Geesemere Day Services (a Specialist Health Service provision) was not an appropriate option for his care.

24.11.03 The community nurse took Mr S to a Supported Living Service, with a view to getting Mr S involved in this Service.

01.12.03 The Community Care Services file was closed, this decision was reached following a discussion between the Senior Care Manager and the Locum Community Services Manager. It was concluded that Mr S was not eligible for Social Care Services. Mr S did not attend his appointment with the community nurse.

09.12.03 The community nurse contacted Mr S by telephone regarding the failed appointment. Mr S claimed that he had forgotten his appointment on 1st December

17.12.03 Mr S did not attend for his appointment with the community nurse who then phoned Mr S who said he had been unwell with flu and that he was going away with the family for three weeks. It was agreed that the community nurse would contact Mr S or his mother in the second week of January 2004 to make another appointment. It was also agreed that a further CPA meeting was to be organised in the New Year, although no specific date was arranged.

No further contact was established with Mr S prior to the incident.

11.01.04 Mr S left the family home at 10.35 pm. The assault on Mr P took place near his home following which Mr S went home where the police later arrested him.

9. Profile of the Services

North West Surrey Mental Health Partnership NHS Trust (the Trust) was established in April 2002 pending further reconfiguration of the mental health and learning disabilities services in Surrey, as a transitional organisation -which was not at this stage – fully integrated with social services.

When the Trust was created, it brought together staff groups from two former healthcare organisations; Hounslow and Spelthorne Community and Mental Health NHS Trust and the Bournewood Community and Mental Health NHS Trust, and absorbed adult mental health; older adult mental health; substance misuse; eating disorder services; forensic services, and specialist learning disability services.

The Trust served a population of approximately 344,000 in the boroughs of Woking, West Elmbridge, Runnymeade and Spelthorne covering an area of 90 square miles. The area is relatively affluent, mainly suburban and densely populated; the Black and minority ethnic groups account for 9 % of the population. In addition North West Surrey has three of the most deprived regions in Surrey, and Woking, in particular, has a diverse population with Indian, Chinese, Italian and Spanish communities.

During the time that Mr S was in receipt of Mental Health and Learning Disability services these were provided by the North West Surrey Mental Health Partnership Trust. In April 2005 a new NHS Trust was formed combining the North West Surrey Mental Health Partnership, North Hampshire and Surrey Borders Partnership and Surrey Oaklands. This new Trust is called the Surrey and Borders Partnership NHS Trust (S&BPT), which has partnership agreements in place with Surrey and Hampshire County Councils in relation to integration with their Social Services departments.

S&BPT provides mental health services for adults, older adults, children and adolescent together with learning disability services.

The benefits of the merger have been by identified S&BPT as: -

- A service user and carer focused, inclusive and accessible organisational culture
- Strong and effective managerial and clinical leadership and accountability
- Systems and working practices that ensure probity, quality assurance, quality improvement and patient safety are central to the organisation
- Sound financial management

These are part of the new Trust's Governance arrangements and will incorporate assurance, monitoring mechanism and service delivery.

9.1 Relevant Current Mental Health Services

The following is a summary of services that are available at the time of writing and most were operating at key points during Mr S's engagement with services although managed by a different organisation.

9.1.1 Acute Inpatient Units

S&BPT has four inpatient units across Surrey providing a total of 138 beds as below: -

- 106 mixed sex units
- 15 male only beds
- 17 female only beds

9.1.2 Psychiatric Intensive Care Units (PICU)

There are three PICU units situated in Epsom, Chertsey and Frimley with a total of 25 beds.

9.1.3 Rehabilitation Units/Continuing Care Beds

There are six units across Surrey divided into:

- 54 Rehabilitation beds in 4 units
- 31 Continuing Care beds in 2 units

9.1.4 Community/Primary Mental Health Teams

Community Mental Health Teams (CMHT) are multi-disciplinary and consist of a team manager and one or more of the following: Psychiatrists, Psychologists, Community Mental Health Nurses, Approved Social Workers, Occupational Therapists and Community Support Workers. Each team operates from a single address with referrals coming from a variety of sources.

Primary Community Mental Health Teams (PCMHT) are an extension of the CMHTs but are based with and work in close proximity to the Primary Care Teams such as General Practitioners.

There are five PCMHTs operating as follows: -

- East Elmbridge and Mid Surrey – 3 teams
- East Surrey – 2 teams

The twelve CMHTs are in the following areas: -

- North Surrey – 3 teams
- Guildford and Waverley – 6 teams
- Surrey Health, Woking and North East Hampshire – 4 teams

9.2 Learning Disability Services

At the time of the Independent Inquiry the Learning Disability services were undergoing a review to restructure the service profile. Health and Social Care Services staff although working to some degree in teams, are not integrated within a single management structure. A draft model has been proposed for integrated Community Teams for People with a Learning Disabilities (CTPLD), which would provide a single point of entry to the services for those individuals. The CTPLD would provide expert specialist health and social care assessment, support and intervention, treatment and consultation.

Close working with the mental health services would be established to include access to:-

- General psychiatry
- Forensic psychiatry
- Children and Adolescent Mental Health Services
- Intensive support
- Primary care
- Physical disability care and support

9.2.1 Service Provision

The Learning Disability services available in North West Surrey at the time of Mr S's contact were as follows:-

Community Homes

- One male six bedded residential home for people with a learning disability and associated enduring mental health problems
- One seventeen bedded residential home for older adults with a learning disability and associated physical health needs

- One seven bedded inpatient unit for individuals with challenging needs
- Two respite units proving six and four short break places respectively

Day Services

One specialist day service provided for individuals with specialist and complex health care needs based in Chertsey.

Specialist Community Assessment and Treatment Service (SCATS)

SCATS is a community based multi disciplinary service comprising of the following professionals:-

- Consultant Psychiatrist
- Nurses
- Psychologists
- Speech and Language Therapists
- Occupational Therapists

It should be noted that this summary of services is not intended to be Inclusive of all of the services provided by the Trust during the time of Mr S's care and treatment.

Local Authority Service Provision

The Learning Disability Services provided by Surrey County Council was separated into five sections. The Boroughs of Spelthorne, Runnymeade and West Elmbridge were covered by the North Surrey service, which was an assessment and care planning service provided by care managers. Eligibility for the service was determined by 'Fair Access to Service' (FAC) criteria after which there was ongoing reviews of individual care plans and annual reviews of all cases.

10. Findings and Analysis

10.1 Case Outline

In early 2002 Mr S's mother had a stroke and suffered a perforated peptic ulcer. Although she had taken primary responsibility for his care up to this point the records clearly show that her health impacted heavily in diminishing her ability to care for Mr S. Whilst records show Mr S was living at home with his mother and stepfather it was clear that he did not easily relate to the latter and that they did not get along.

During 2002 a number of incidents were reported including an alleged assault by Mr S on his sister. A further incident relates to an assault on a neighbour in addition to other events, which attract the attention of the police and the law courts. In summary he became subject to a community rehabilitation order, which was breached leading to a further appearance before the courts in September 2002. Proceedings were adjourned pending a medical report requested through a consultant psychiatrist at Spelthorne Hospital. The consultation was undertaken on 23 September 2002.

The outcome of this assessment and subsequent report concluded that Mr S was suffering from psychotic symptoms related to his use of illegal drugs and exacerbated by his mother's illness. It was suggested that Mr S's GP prescribe Olanzapine or Risperadone and refer him on to the Specialist Community Assessment and Treatment team (SCATS), Learning Disability services (health) and further suggested that some psychology intervention might help with exploring his past sexual abuse. At this time the records show he was placed on standard CPA and assessed as a low risk. This information remained on the record file and did not accompany the subsequent referral to SCATS.

Subsequent to the consultant psychiatrist's conclusion that Mr S suffered from a learning disability and a paranoid psychosis, Mr S's GP appropriately referred Mr S to the SCATS team. However, the consultant psychiatrist considered that her involvement in the case had ended without establishing that the SCATS team had taken the case on, and the recipient psychiatrist (ACPLD) did not establish that Mr S remained under the care of the referring doctor whilst he established eligibility for his service.

On receipt of the referral from the consultant psychiatrist the ACPLD referred Mr S to his clinical consultant psychology colleague in order that she could determine his intellectual function and therefore, eligibility for his service. The consultant psychologist asked Mr S's GP, to complete a risk

assessment. The GP considered that Mr S was a medium to high risk in all areas except suicide. To the best of the inquiry panel's knowledge, the consultant psychologist did not share this information.

In November 2002 Mr S was seen by a trainee psychologist operating under the supervision of the consultant psychologist. There is no evidence of any risk assessment being referred to or being undertaken at this stage. Mr S failed to appear for two subsequent scheduled appointments and was subsequently discharged under the care of ACPLD.

In January 2003 Mr S was placed on a further Community Rehabilitation order having returned to court to answer to charges initially made in 2002 which had resulted in the initial referral to services. This order was the result of two offences of common assault. Probation services saw Mr S weekly following these events and offered to accompany him back to psychology to ensure that he received the necessary support and treatment but this was declined by the psychology department on the basis that it contravened his human rights.

By March 2003 Mr S had failed to attend for several appointments with the Probation services and went back to court to answer a charge of breaching the Community Order. At this time the Probation services were considering revoking the Order and seeking a pre-sentence medical report. In April Mr S was in court again, found guilty of breaching his order and the request for a medical report was progressed to the ACPLD. This assessment was carried out in July 2003 when Mr S was seen and on this occasion accompanied by his mother.

The ACPLD reported in his assessment of 8th July 2003: *"When Mr S's mother mentioned that Mr S assaulted the neighbours last year Mr S said that the neighbour was talking about his sexual abuse. Mr S's mother mentioned that Mr S was getting worse. He ripped up a letter, shaved his eyebrows, and lit a bonfire in her back garden a few days previously. He changes his clothes several times a day"*. She mentioned that his comprehension was poor and he was *"lost in space' most of the time".*

The ACPLD considers (in his report of 2nd August 2003) that:

"He will pose a medium to high risk to the general public and his family if he did not take his medication and other treatments regularly".

However, the ACPLD previously noted that Mr S's mother *"finds it difficult to look after him and give him sufficient attention and supervision"* and that Mr S was not taking his antipsychotic medication regularly because it made him dizzy.

In August 2003 the ACPLD reported *"At present his mental disorder and mental illness are not of a degree of severity that would warrant compulsory treatment on a hospital order under Section 37 of the Mental Health Act 1983. If his condition deteriorated he would be considered for compulsory treatment under the Mental Health Act in the future".*

The ACPLD reported to the inquiry panel that the use of the Mental Health Act was considered but did not consider that this was necessary at this time. He made an internal referral to the nursing team. On receipt of the referral the SCATS team concluded that Mr S should be on enhanced CPA and met to discuss it. The records do not include minutes or indeed any other record of the meeting and reasoning behind the decision was not reported. On 14 August Mr S was referred to the North Surrey Adult and Community Care Team in Social Services. One week later a reply was received seeking clarification of the request. In November it was concluded that Mr S was not eligible for care. This like other elements of the process was protracted and the evidence clearly suggests that there is little understanding between the agencies of their respective eligibility systems. The process that facilitated the decisions is not clear.

In September 2003 the courts received the Medical Report from the ACPLD and this contained a referral request for sheltered employment and day care within Social Services which was received by them on 9th September 2003. The Advisory Officer was on leave at the time and the family were not contacted until 22nd September 2003.

During September 2003 a nursing assessment was reported to have been started. This is reputed to have been the focus of a good relationship but this was not found in records available to the inquiry. During October Mr S and his mother were seen at home to be assessed for Fair Access to Care Services and the Contact Assessment was completed. On 14 October a CPA meeting was convened, this was chaired by the ACPLD. It is not clear why two months had elapsed between Mr S being put on enhanced CPA and the first meeting being scheduled. The CPA documentation was not complete. The action plan from the meeting only assesses adequate supervision of Mr S to minimise risk to others with his mother identified as the lead. It was also agreed at this meeting that a Carers Assessment would be carried out but there is no evidence that this was done.

Mr S failed to attend his meeting with the community nurse on 22nd October 2003 but did maintain his schedule with the ACPLD. The community nurse wrote to Mr S on 28th October 2003 to arrange a further meeting.

On November 20th 2003 a mapping meeting was held. At this stage the referral to Geesemere NHS day service was deemed not to be appropriate

and turned down by Mr S's mother and it was at this time that Mr S was discharged from the Social Services community team.

On the 24th November 2003 the community nurse escorted Mr S to Shepperton to see a supported living scheme with a view to involving him in the service. They scheduled a further meeting for 1st December 2003. Mr S did not turn up for this meeting. At this meeting the community care file was closed as a result of a joint agreement between the Interim Community Services Manager and the Senior Care Manager. The meeting concluded that Mr S's needs were primarily arising from offending behaviour and substance misuse and that his assessed risks did not fit their service category. Mr S was again contacted by phone on 9th December 2003 by the community nurse and claimed to have forgotten the meeting on 1st December 2003. The record suggests his mother was looking after his medication. When the next contact was initiated –again by phone- on 17th December 2003 Mr S claimed he had been unwell with the flu and was going away with his family for three weeks. He said he was taking his medication and had no problems.

In January 2004 a further CPA meeting was to be arranged. The community nurse contacted Mr S's mother again by phone leaving Mr S's mother to get back to him. This was the final contact with services prior to the incident on 11th January 2004.

On 12th January 2004 the incident was initially reported to the services but this did not effectively identify Mr S to them. On the 13th January 2004 Guildford police contacted the community services seeking information regarding their contact with Mr S. By 14th January 2004 the community nurse became aware of the involvement of Mr S in the incident through an unrelated meeting with community services but this was not acted upon until the following day.

10.2 Totality of Services

Throughout the gathering of evidence there are a number of recurrent themes, one of which is substance misuse. There is clear evidence of concerns and actions taken by the courts. There is evidence of a family problem in some degree and expressed concerns by several of the practitioners involved in this case. Despite the available information and the concerns expressed there is no clear evidence that any opportunity was taken to seek advice or make a referral to specialist substance misuse services.

Professional people seen by the inquiry panel all acknowledged that this was a difficult, complex and challenging case with all of the attendant risks

of a borderline case falling between professional and agency responsibilities.

Assessment of need was difficult and therefore achieving a consensus around diagnosis (diagnosis may not be a problem so much as risk), preoccupation with diagnosis, and a care package was a real challenge in efforts to meet this man's need.

It is clear that there were numerous needs both directly on the part of Mr S and indirectly in supporting his family and all those involved in his support. The responsibility of those professional practitioners continuously involved with Mr S weighed heavily on them and witnesses clearly suggest there were insufficient coherent policies and procedures to support them in securing enduring input from additional support services, agencies or individuals.

Further complications arising from practices at the time, offer testament to the difficulty that was experienced by practitioners having more enduring responsibility for the care of Mr S.

The absence of consistent responses following referral within agencies provides evidence of these difficulties. One case in point is the difficulty in securing support from psychological services where a referral failed to produce a requested assessment despite repeated efforts by the Psychiatrist involved.

Here the panel encountered a confused picture in which a referral was made, the initial referral was referred on in the department, relegated to a trainee and ultimately did not generate a product consistent with the original request. In fact the failure of Mr S to comply with appointment requests resulted in discharge from the psychology service without him ever being seen.

Further attempts by the probation services to secure access to the service by actually accompanying Mr S to the appointment were interpreted by the psychology service as a potential breach of his human rights.

This scenario implies a highly defensive practice which may not have served the best interest of the patient and may not survive the professional peer test of reason.

Throughout the investigation patterns of consistency failure have emerged.

Amongst these is the perception of a lack of responsiveness of agencies to each other, a lack of clarity of policies and procedures between them

and the low level and quality of interagency communication, support and agreements.

Almost without exception these are cited as areas in need of attention at the time of the incident and throughout the period in which Mr S was being cared for. The general reputation of agencies expressed by those interviewed was poor and this was a consistent view across health, social services, probation services and the police.

There is something of a mixed view regarding the level of improvement in this arena since the incident, with Health and Social Services having a more positive perception than for example the police or probation services. It should be stressed that this perception is more positive amongst some senior managers in the respective agencies with many practitioners at operational level expressing a more pessimistic view.

There was a consistent sense of a lack of clarity of agency roles and real difficulty for those involved to define the roles of their partner organisations.

There is no reference to a differential diagnosis. At various times there was reference to a variety of symptoms and possible psychotic illness. He was prescribed anti-psychotic medication but his compliance was variable.

There are a number of factors which were only acknowledged or given passing comment without follow up action. For example the impact of illicit drugs is referred to but never evaluated. The presence of a possible personality disorder was never assessed although it is clearly at the fore of thinking. The community nurse referred to a recollection of a reference to autistic spectrum disorder but it was never assessed.

The level of his learning disability was never fully assessed and when the option availed itself he was discharged by the psychologist for failing appointments. Mr S is described as vulnerable and chaotic. It is clear he cannot organise himself and it was known he cannot read or write. However, there was no formal assessment of his functional skills and how this may impact on need and risk.

There is little evidence of integrated thinking between services.

There were no multi-agency meetings which would have enabled a holistic review of his difficulties. This position prevailed throughout his care despite the involvement of the police, probation, mental health, learning disability, Social Care and primary care services.

Even when professionals were making referrals and flagging up concern the information was often lost or not acted upon, examples of this were evident in information flows from the GP and reports from the Probation service.

Assumptions were made about who was doing what. Nobody was checking or taking a lead responsibility in co-ordinating information and activity, services were preoccupied with their own eligibility criteria. Mr S's difficulties were seen in isolation, for example his problems with illicit drugs, and there is no reliable evidence that any view was taken which covered the totality of presenting problems followed by appropriate actions.

At no time in the sequence of care did all agencies achieve a meeting where all appropriate interests were present or served.

10.3 Surrey Council Adult and Community Care Services

The evidence suggests that Mr S's health and social care needs were never adequately addressed in the community. Social Services took months to consider a referral then it was declined. A Senior Care Manager attended the CPA meeting and agreed to a Carers Assessment but later withdrew that agreement. To complicate this further there is no evidence of this meeting being recorded.

Services were often very clear about what they were not going to do but agencies and individuals were often less clear about how they could contribute to the overall care of Mr S and his family. Very little consideration appears to have been given to meeting needs.

Despite evident needs Mr S was deemed unsuitable for the day care service to which he was referred without having apparently been assessed by that service.

Social Services were advised that Mr S was a vulnerable adult albeit following the investigation into the fracturing of his sister's finger under Child Protection procedures. Nevertheless there were no proceedings instituted under the departments' Vulnerable Adults Policy.

It is clear from the information seen that Mr S was eligible for a community care assessment under the Community Care and NHS Act which he did not receive. In addition Mr S's mother was also eligible for a carers' assessment under the Carers Act which she did not receive.

10.4 Criminal Justice Services

Criminal Justice Services are a prevalent feature in this case and it is clear that Probation services struggled to gain support and collaboration from other agencies and carried a strong sense that their efforts were being thwarted rather than assisted by other agencies.

The sense of frustration felt by the probation services was very significant. Various attempts at contact with services are reported but no collaborative work practices emerged. Attempts by probation services are recorded and the pattern suggests that each inquiry was passed on to another office within the health services and no formal response was achieved.

The probation services –as with other agencies- clearly cited this case as a medium to high risk of threat to the general public but again this did not spur any action on the part of the services

General relationships between services was cited as being poor and even concerted efforts to bring Mr S into services for appointments were thwarted.

Comments made by the probation services regarding other agencies and their relationships suggest that inter agency relationships were very poor at the time.

10.5 Liaison Between Services

The central concept in contemporary care is a collaborative individual and agency approach which brings together all of the necessary facilities and resources which make up a comprehensive solution –within a seamless package- to address the needs in an individual case.

The concept of integrated care does not appear to have been in evidence within this particular case and a great deal of systemic change will be required to establish the necessary standards of practice. Countless inquiries have established the need for agencies to work together within shared policies to ensure that all aspects of demand are considered when assessing the needs of individuals such as Mr S.

Whilst there is evidence of mental health need in this case there is equal prominence of evidence in learning disability with poor social functioning.

At the same time there was extensive evidence of substance misuse by Mr S, his siblings and others in their family and or social circle. Other active considerations include criminal activity, court appearances,

charges, sentences not complied with and involvement of probation. In the background there is abuse both within and from outside the family with at least some evidence of Child Protection Agency involvement.

Whilst this case presents itself as a model for collaborative multi-agency working it is clear that this did not happen. Those key individuals involved throughout the case struggled to gain any additional agency support in their endeavours. From evidence taken during this inquiry it is clear that there was little more than an awareness of other agencies between many of the professionals involved.

Whilst steps had been taken to integrate thinking and practices it seems that these changes were paid lip service at practice level but there is little evidence that practice had been elevated beyond the rhetoric for many practitioners and some managers.

10.6 Roles and Responsibilities

Defining roles and responsibilities of services and individual practitioners appears to have been an area in which services struggled. The definition of the roles of the various elements of Learning Disability services across health and social services clearly generated a challenge for those involved.

The evidence presented to the inquiry panel clearly acknowledges that there were problems in determining which element of service in each agency had what responsibility or role, or indeed, to whom or what client group. Again, presented evidence from witnesses suggests that practice was defensive and role or agency boundaries were used to exclude individuals from agency care.

Given the absence of collaborative protocols and supporting policy this is understandable but has clearly contributed significantly to what was already a very difficult and challenging case.

Role definition has been a recurrent factor and manifests itself in a number of ways in this inquiry. Further evidence of confusion has emerged with regard to several areas of practice including the application of the Care Programme Approach and the allocation of the care manager role as well as other lead responsibilities.

It is clear that training and guidance throughout the implementation period did not succeed in supporting services to achieve a clarity of decision making and left practitioners unclear about who might take on lead

responsibilities, how such decisions might be made and what factors might be considered in coming to a decision.

The question of the position of the principal or lead professional should be considered in this case. It was reported that the acting consultant psychiatrist in learning disability services had been left with lead responsibility for some considerable time and must have felt very isolated. He had been acting up for a very considerable time and despite efforts to recruit to this post he effectively carried the lead responsibility with little support.

The inquiry is clear that the professionals' understanding of the referral process was confused, and that this led to a significant hiatus in the care of Mr S. This is likely to have significantly affected his compliance with medication, his mental health and prognosis. Moreover it may have played a part in exposing others to continued risk and rendered Mr S vulnerable.

10.7. Carers Assessment

There are numerous references to Mr S's mother in the evidence available and the pressure she was under: As already stated Mr S's mother's health was poor. Despite these serious problems Mr S continued to live at home but clearly he did not get on with his stepfather who presents as the only other responsible adult in the household.

In August 2002 Mr S is reported to have fractured his sister's finger. Later that month his mother took him to see his GP and claimed that she was unable to cope with him any longer. She informed the GP about Mr S's experience of sexual abuse at school, his abuse of his sister and the possibility of him experiencing abuse from his older brother.

In an urgent letter to the consultant psychiatrist the GP describes the family composition, mother's concerns, the offending behaviour, the assault on the sister and the criminality of the brothers. The GP remarks on the pressure on mother and her distress. The GP considered that Mr S had been lost to services and raises concerns about his illicit drug usage.

In an appointment with the consultant psychiatrist on 23rd September 2002 Mr S tells her that he does not get on with his stepfather and *"broke his car"*. (In his mother's evidence to court on 25th February 2004 she says that Mr S took the car and crashed it into a tree because he was upset about his stepfather's treatment of his mother). His mother is described by the consultant psychiatrist as obviously very worried about Mr S's behaviour and vulnerability and was trying to keep him off drugs. The

consultant psychiatrist makes reference in her notes to the fact that Mr S's mother had had a stroke, a perforated ulcer and periods in hospital. She had become depressed and suicidal and lost her job. It was also noted that she had a lot on her plate with six children, Mr S, his relationship with his stepfather and the fact that one of her other son's was associated with both drugs and crime. There is a consistent picture of a highly burdened person with serious health care problems who is expected to take the lead carer role for a very complex and challenging individual.

Mr S's admission to hospital was considered but the violence was not seen as significant and he was being managed by his mother. Despite all of the above it is clear from events that the professionals involved in delivering care took the view that Mr S's mother was able to carry on taking the lead in caring for her son.

This was reinforced when in July 2003 Mr S and his mother are seen by the ACPLD. He impressed on her the need to ensure Mr S took his medication or face the prospect of him ending up in a secure setting in which care could be delivered.

By October 2003 when there was still no response from the referral to Social Services, the ACPLD, who was not familiar with CPA, reluctantly took on the role of care co-ordinator and arranged a CPA meeting. It was attended by a senior care manager and the ACPLD assumed a community care assessment and carers assessment would be done. It was not. Mr S's mother was made responsible for his supervision and care because there was nobody else. There was no consideration of whether it was acceptable or appropriate. The community nurse picked up the case at this stage and reputedly started a nursing assessment with a view to organising respite care. Records show one meeting with Mr S and his mother at the Outpatient's clinic and one at home in September 2003 but there was no additional recorded discussion with Mr S's mother or reference to assessment of the carers needs or discussion with her.

10.8 Duties and Responsibilities

10.8.1 Use of Section 2 of the Mental Health Act 1983

According to available information, the use of the Mental Health Act 1983 (MHA) in the care of Mr S was deemed to be inappropriate by the ACPLD. The absence of evidence to support this conclusion raises questions as to how this decision could have been reached.

Given Mr S's presentation and prevailing conditions it is the opinion of the inquiry panel that an assessment under Section 2 of the MHA would have

been appropriate particularly as there were considerable difficulties in engaging him in assessment in the community. His criminal offending history demonstrated the need for the protection of others. His experience of abuse and exploitation demonstrated the risk to himself.

The MHA states that: -

“An application for admission for assessment may be made in respect of a patient on the grounds that: –

a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment followed by medical treatment) for a least a limited period; and
b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons."

The questions about diagnosis, intellectual functioning and the possibility of a psychotic illness could have been properly addressed if Mr S had been admitted to hospital for an assessment of his mental health.

10.8.2 Use of Section 3 of the Mental Health Act 1983

Under Section 3 of the MHA, a treatment order, there is a requirement that the patient fulfils the criteria for one or more of the four classifications of mental disorder.

These are: -

- Mental illness
- Mental impairment
- Severe mental impairment
- Psychopathic disorder

and

" it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section."

There is evidence that Mr S would have fulfilled the criteria for detention under a classification of mental illness. Attempts to treat him in the community were ad hoc and met with numerous difficulties including his lack of insight, his poor compliance with medication and his inability to keep appointments. The use of the Criminal Justice System was not succeeding as he was unable to comply with the Community

Rehabilitation Orders which were made and the Probation Service was reporting that he needed the intervention of Mental Health Services.

There is also evidence that he would have fulfilled the criteria for detention under a classification of mental impairment.

Under the MHA mental impairment is defined as " a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned." In the case of mental impairment it has to be demonstrated that "such treatment is likely to alleviate or prevent a deterioration of his condition." This has been interpreted widely by Mental Health Review Tribunals which have accepted containment as evidence of treatability.

It is significant that Mr S responded extremely well when detained under the Mental Health Act in a Special Hospital after the incident. He received a comprehensive assessment of his difficulties so that appropriate care and treatment could be provided. His mental state improved, he engaged in structured activities, he did not demonstrate any aggressive behaviour.

Detention in hospital under Section 3 of the MHA would have entitled Mr S to after-care under Section 117 which places a duty on the Health Authority and local Social Services Authority to provide, in co-operation with relevant voluntary agencies, after-care services based on an assessment of health and social care needs. This would have ensured a robust discharge plan.

Detention under section 3 of the MHA would also have enabled Mr S to have been considered for After -Care under Supervision (supervised discharge) under section 25A if it was considered that " there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons or of the patient being seriously exploited, if he were not to receive the after-care services to be provided for him under section 117 after he leaves hospital."

Even without the use of a hospital admission, whether informal or detained, Mr S could have been considered for Guardianship under Section 7 of the MHA. Both orders would also have ensured that there was an identified Community Responsible Medical Officer and Care Co-ordinator as well as regular reviews.

10.9 Policies and Procedures

All agencies and services acknowledge that the Care Programme Approach (CPA) (Introduced in the early nineties and embraced by all mental health organisations) has been implemented within the services in some degree but the extent to which it might have applied to Learning Disability services up to the point of the incident being investigated is unclear.

There is evidence to support the proposition that it was applied to the care of Mr S by the NHS element of services supporting him at the time but only partially, and evidence does not support full compliance with CPA by all of those involved in his care. Some evidence put forward to the inquiry panel from the doctors and nurses involved at the time is strong in that it provides contemporary proof that it was being applied but only in the most cursory terms with little supportive evidence that it was being used for assessment or risk management purposes but rather to comply with a policy requirement.

CPA provides a system of review which is familiar to Mental Health Services but appeared not to be so to local Learning Disability Teams. Given Mr S's profile he should have been covered by enhanced CPA which involves multi-disciplinary input and it would have provided a framework for care planning, risk management which would include contingency planning and crisis management. In the event the GP's recommendation about CPA in August 2002 was not taken up and when a meeting was eventually convened in October 2003 it was by a learning disability consultant who had to take on the role of care co-ordinator with little support or follow up.

It has been very difficult for the inquiry panel to gain a consistent understanding of the application of the CPA policies across the agencies involved in the care of Mr S. This issue was not limited to a single agency and evidence presented by witnesses suggests that this was equally applicable across professional groups or functions providing care, advice or services to Mr S. Equally troubling to many of the witnesses interviewed was the absence of evidence for professional or functional groups of protocols supporting work being carried out across these boundaries, transfers of care, dealing with referrals, the application of the CPA and clear operational policies.

10.10 Internal Review

Throughout the conduct of this inquiry staff involved in the initial internal review have presented with two conflicting perceptions of the process.

More senior managers internal to the Trust felt it was thorough and appropriate. This is in stark contrast to the impressions gained by the panel in the course of the inquiry

Those involved directly in the care of Mr S have a contrasting perception of the process and overall experience which does accord with the panels view.

The general feelings expressed by those interviewed by the internal panel expressed high levels of anxiety. The evidence presented by witnesses suggest that they felt uncomfortable and experienced a high level of pressure through the tone of questioning; that they felt unsupported and intimidated. Those asked to present their evidence to the internal inquiry panel felt that the whole set up and size of the panel was intimidating and not conducive to openness but rather expressed a need to be defensive.

The inquiry panel were informed by those interviewed that they were never given sight of the internal report nor were they given the opportunity to scrutinise their transcripts prior to them being submitted as evidence.

10.11 Resources

Efficiency in the system was clearly compromised by cumbersome and rather outdated approaches. There is strong evidence throughout the testimony of witnesses that services operated in silos without the benefit of integrating policies and procedures that might have much more easily and effectively gained the co-operation, collaboration and support of additional professional and agency support.

The perception gained from the evidence is that efficiency and effectiveness of individuals was severely compromised by the absence of systems which might have served to significantly enhance and reward their efforts.

Resources have featured strongly in the evidence presented to the panel and the overwhelming balance of opinion suggests that there are not adequate resources available across any of the agencies to honour their responsibilities.

In contrast it is not always easy to see how a marginal addition of resources would have had a major impact on this case. Any judgement made by an inquiry must sit within the bounds of reason. Limitless resources cannot be a reasonable expectation and any judgement therefore about resources must be made on the basis that there might be

a case to consider as to what the impact of minor additional resources might have been.

However in this case it is difficult to see what outcome changes would have been forthcoming with minimal resource uplift. In contrast it might be reasonable to assume that if systems were more efficient and practices more compliant with contemporary expectations, different decisions might have been reached and they in turn might have influenced a different outcome.

10.12 Culture

The evidence gathered for the inquiry seems to support a situation in which defensive practices either emerged during this time or that they became evident during this time. Whichever is the case, the position which emerges is one in which services failed Mr S and his family.

There is very little evidence of a willingness on the part of the various teams, professional groups or agencies to work together. The overwhelming sense portrayed by evidence gathered in the course of this inquiry was one of resistance to collaborative working and an unwillingness to engage with complex presentations

Defensive practice is a mechanism which will fail individuals and families. Both commissioners and providers need to work together across the agency boundaries to establish a much more proactive corporate governance approach in cases such as these. This culture needs to ensure that all of those involved in caring for individuals and families such as those in this inquiry are the beneficiaries of a much more coherent professional and proactive care programme approach. The culture overall needs to be one which goes one step further in delivering care and not one step less as appears to be the case in this incident.

10.13 Commissioning and Providing Considerations

There can be no case for overt negative criticism of practice within an economy that is being subject to major corporate and agency change unless there are coherent systems in place that comprehensively address objectives and policies or procedures during transition and that reasonably link existing systems through transition to future expectations. In support of such programmes there must be an expectation of highly effective communication systems addressing change at every level.

The three tiers of agency or corporate requirement for planning were clearly not coherent to those interviewed at the time of the incident and they were unable to identify strategy, operational systems or coherent practice policies and procedures. No one giving evidence to the panel were able to clearly articulate expectations or understanding of the wider economy at the time.

Major agency change programmes were in place throughout the care and treatment of Mr S and it is easy to understand why there might have been areas where clarity of relationships between agencies could become a factor of concern and lead to confusion.

Despite these prevailing conditions it would be reasonable to expect good professional practice to be consistent and guided by up to date and robust policies and procedures. Of particular concern would be assurances of these requirements acknowledging that services such as those subject to scrutiny are at a higher level of risk in transition and major change management programmes.

The integration of existing services into a larger more coherent organisation and the establishment of co-terminous relationships between agencies clearly follow a sound strategic path. The benefits of this are well founded, researched and published.

It would be reasonable to expect professional practitioners to be aware of this, acknowledge the practice implications of such change and work accordingly. In order to defend a statement of this kind one must assume that the attendant communication systems are in place to support such change and that this is effectively implemented and audited right down through organisations and services concerned, to professionals on the ground.

In short provided that effective communication systems have been planned and implemented there is no sound reason for corporate change programmes to play any part in system failure at practice level. The expressed perceptions cannot be easily dismissed and both provider and commissioner organisations must accept that they have clearly defined roles in ensuring that change management plans are well thought through, effective and well communicated.

The evidence gathered during the course of interviews does not clearly demonstrate that staff involved in the care of Mr S, were fully aware of the rationale behind the change, or the sequencing of events leading to completion of that change programme.

The change process is however highlighted as a factor in their thinking often in reference to changing roles for service managers which detract from experience of continuity for some practitioners.

The evidence gathered by the inquiry panel rather leads to a conclusion that professionals and some managers were conscious of a lack of clarity in the change management process and experienced this as incoherent at times and somewhat unsettling.

The higher level strategy does appear to have been put in place, consulted on and implemented consistent with planning. The level of operational planning and implementation within each element of the organisations involved is less clear.

10.14 Intelligence Sharing

The prevailing culture of defensive and reactive practice lends itself to a minimalist approach to practice. There is little evidence of intelligence sharing between agencies.

One example from many encountered suggest it is clear that Mr S's GP and his probation officer have either a view or an overt weighting of risk rated as high but this does not appear to have come to the notice of his psychiatrist or community nurse. Neither of whom considered his case to present risks rated as high.

More importantly the assessment completed by the GP was initiated by the psychology department who acted in the final analysis to discharge Mr S without ever seeing him.

If all of the intelligence now available was pooled at an earlier time it is difficult to see that no more assertive action would have been taken. What the evidence does suggest is that there was little in place at the time to indicate that intelligence was shared and, perhaps more importantly, if and when it was shared, appropriate action did not necessarily follow.

There does appear to have been a culture in place which resisted action in response to the intelligence available; resisted involvement which made transfer between services –whether in terms of information or care responsibility- at best very difficult.

It must be accepted therefore that individuals involved in an ongoing pattern with this case would have felt isolated, frustrated and unsupported. This in turn could conceivably create a culture in which their performance might fall below expected standards.

The key consideration here is that even in the face of clear evidence of need, the likelihood of achieving support from additional departments or agencies is extremely low. The evidence supports this proposition and leaves established practitioners, working with Mr S in a very precarious, isolated and high risk position.

11. Conclusions and Recommendations

11.1 Mother's ability to care

Mr S's mother's difficulties were well known as the principal carer in this case. She went to some lengths to express her anxiety on several occasions and she was making it clear that she could not cope. Under the circumstances –given her expressed feelings- it was not reasonable to make her solely responsible for her son's management and supervision. The evidence clearly demonstrates that several practitioners picked up her distress but she was never offered support in her own right. The evidence gathered suggests that the decision to allow this situation to continue should not have been allowed to stand

The inquiry panel were informed by Mr S's social worker in the special hospital that his mother was not contacted by the local services following the incident. However the Trust dispute this view as they reported that contact was made following the incident and team members spoke with them at the court. It was however reported that Mr S's mother felt very isolated and unsure in relation to the events taking place. Although her eventual death could not have been foreseen valuable information regarding her son was lost to the services as well as an opportunity to immediately explore whether there were any lessons to be learnt and actions put into place.

Recommendation 1

It is recommended that:

All agencies should review their approach to carers' assessments and establish clear policies that support carers and effectively assess their capacity and effectiveness prior to accepting their nomination for tangible roles in supporting care. In addition:

- **Monitoring systems must be introduced to highlight carer's capacity to carry out their role and form an explicit part of risk management**

- **The Trust should designate a senior manager to support the victim and patient's families following a serious untoward incident thus ensuring that they are:**

    - **Kept informed of the investigation process being undertaken**
    - **Invited to participate in the internal review**

- **Be given an opportunity to examine the actions taken by the Trust and Local Authority following their internal review**
- **Be kept informed of other investigations that might take place such as an Independent Mental Health Inquiry**

11.2 Criminality

Given the past offending behaviours there should have been a case made of active risks of escalation.

There were a number of known facts:

- Mr S was known to have assaulted his neighbour.
- caused his neighbour's fence to be burned.
- assaulted his sister and believed to have broken her finger.
- abusing illicit substances and it is these circumstances in which his offending behaviour is known to escalate.

These circumstances together with evidence of non compliance with medication should have increased the urgency in securing a more rigorous treatment programme. The question of further more assertive action remains

The level of threat to others, damage to property and assaults within the family does suggest a scenario in which more action might have been taken.

Recommendations 2 and 3

It is recommended that: -

All future cases where there is significant evidence of criminal activity should be considered for specialist assessment. Where there are indicators to warrant it services should consider a specialist forensic assessment.

Organisations should undertake a review of community safety and support systems and determine what can be done to more usefully link agencies such as the police, probation services, health and social services.

11.3 Diagnosis and Treatment Options

Mr S presents a very complicated set of symptoms and behaviour. There is no reference to a differential diagnosis although evidence to hand might indicate the need for some thought to this arena and possible assessment or investigation.

At various times there is reference to a variety of symptoms and possible psychotic illness but there is no definitive assessment material to hand in the records. He is prescribed anti-psychotic medication but his compliance is variable although this too seems not to have been closely monitored at any point in the care process

The presence of a possible personality disorder is never assessed despite the complicated presentation and behaviours consistent with such diagnoses. The community nurse remembers a reference to autistic spectrum disorder but it was never assessed and seems to have prompted no further action or specialist assessment.

The level of learning disability is never fully assessed and this is borne out in the decision by the psychology department to discharge him for failing appointments. He is described as vulnerable and chaotic. It is clear he cannot organise himself and it is known that his literacy and numeracy skills are poor. However, there is no formal assessment of his functional skills and how this may have impacted on need and risk.

Mr S suffers from an illness or set of problems, which have clearly proved very difficult to diagnose and treat resulting in a situation where the multiple agency involvement has struggled to determine what level of involvement is called for. They have further struggled to know what form that involvement should take and indeed how Mr S and his family might best be engaged to deliver those services or needs.

There is overwhelming evidence within this case that non-compliance was a recurrent theme. Despite the evidence those involved in the care of Mr S did not act decisively to gain control and establish a regime in which confidence of medication compliance could be achieved.

Whilst the use of the Mental Health Act was considered there is no convincing evidence in the records that an admission to hospital was really given serious consideration. Moreover it is clear that it was considered that an admission to an acute mental health hospital bed might be detrimental. There is no evidence in the records that this risk was balanced against ongoing risk of non compliance even though evidence of the implications of the latter might have been predicted.

In addition there is no evidence that any real alternative strategy to establish compliance was ever considered. In the final analysis Mr S was left with his mother as the principal policing influence of his medication compliance even though this had already proved itself to be an inadequate strategy. Her own capacity was significantly hindered by her ill health and the added stress of responsibility for further family members experiencing their own problems at the time.

It is significant that Mr S responded extremely well when detained in a Special Hospital after the incident. He received a comprehensive assessment of his difficulties so that appropriate care and treatment could be provided. His mental state improved, he engaged in structured activities and he did not demonstrate any aggressive behaviour.

Recommendations 4, 5 and 6

It is recommended that:

Services should as a matter of urgency, establish agreements for a comprehensive care pathway for dealing with complex cases of this kind which includes all agencies involved in the individual's care ensuring that cases of this kind should be subject to special scrutiny in the future and that:

- **Systems are implemented to achieve this until such time as governance systems are satisfied that all of the necessary competence is in place.**

- **a protocol and specification of service options is established over and above standard local services that are available for specialist assessment or referral.**

Compliance and the patient's capacity for compliance should become an explicit element in clinical risk assessment.

A training programme should be established to ensure that staff understand the application of the MHA in complex and mixed diagnosis cases.

11.4 Lack of integration between services

Several areas of policy application clearly lack understanding of responsibilities in evidence given by witnesses throughout the inquiry. Chief amongst these was the question of eligibility criteria for several elements of service but primarily Social Services and the SCATS team.

This is one of many examples. Witnesses consistently expressed a shortfall in clarity around their understanding of access criteria and an absence of clear guidance or policy available at the time.

Services were clearly operating in isolation from each other and the evidence taken from witnesses does not convey a picture in which the culture had progressed beyond discussion and verbal recognition of contemporary models of care where real integration of thinking, practice and assessment had occurred.

The commonly expressed view was an awareness of other service components with little evidence for example of what role they fulfilled, what resources were available or what services might be offered. Perhaps one of the worrying features of this presentation is that the culture of defensive practice failed to acknowledge the need or benefits of understanding alternative agency contributions in delivering solutions to wide ranging problems such as those presented by the case of Mr S.

Services were not operating in a co-operative way at the time and there is evidence of active efforts to avoid agency or individual department involvement

Recommendation 7

It is recommended that: -

Services must be aware of the opportunities that already exist for multi-agency meetings and use them accordingly, for example, Vulnerable Adults' Policies, Multi- Agency Public protection panels and Care Programme Approach and that:

- **Services should establish an agency wide oversight panel or partnership board that ensures that services are working together effectively.**

- **Policy development, implementation and distribution should be reviewed to ensure that staff are able to have access to them and that they are read and understood.**

- **All agencies involved in this case should ensure that there are clearly published access points, protocols for engagement, available operational policies and clearly defined eligibility policies**

11.5 Record Keeping

The system of records review is reported to have been weak in some areas at least. Some clinical records were not scrutinised by a third party, some practitioners were not subject to supervision or proper accountability and later scrutiny of records implies clear evidence that an intervention of scrutiny would have changed some clinical decision making.

Record keeping was a prominent feature amongst witness interviews wherein it was often not possible for witnesses to answer questions even in circumstances where they had their own contemporary records to hand.

Records were sometimes inadequate and it was not possible to audit decision making trails. Much of the treatment programme information gained from witnesses could not even be cross referenced from alternative notes of practitioners who had concurrent involvement with the care of Mr S and following a trail of events or establishing a chronology.

These tasks proved to be very challenging and much more so than might be expected from reasonable records. It is not clear what systems were in place at the time to assess or scrutinise the records of professional practitioners involved but it is evident that some of them fell short of reasonable expectations.

Recommendation 8

It is recommended that: -

Audits should be undertaken of case management recording. Case management must be established as part of the individual and team performance management systems across all services. In addition:

- **Records should be subject to random audit and specific training initiatives on case recording should be put in place.**

11.6 Social Services Referral

Much of the evidence gathered from professional practitioners in the course of this investigation suggests a tendency towards a reactionary approach to managing the case of Mr S and their work in general. Practice did not appear to support more innovative or proactive case management which one might expect from truly integrated multi-professional teams. It must be said however that for the most part those

involved in the care of Mr S worked hard and struggled to make the best of what appears to have been inadequate systems of support, policy development and practice support such as continuing education and supervision.

It is clear from the evidence that more should have been done by Social Services in recognising areas of responsibility and acting to ensure support was made available in this case

Social Services were advised that Mr S was a vulnerable adult in October 2002 following the investigation into assaults against his sister under Child Protection Procedures. Nevertheless there were no proceedings instituted under the department's Vulnerable Adults Policy. This would have prompted a multi-agency case conference, formalised care planning and identification of roles and responsibilities and provided a mandate for the provision of services.

It is clear that Mr S was eligible for a community care assessment under the Community Care and NHS Act which he did not receive. One of the key responsibilities for Social Services Authorities under this Act is to carry out an appropriate assessment for social care, in collaboration as necessary with medical, nursing and other caring agencies, before deciding what services should be provided. In addition one of the key objectives in the Act for service delivery is to ensure that service providers make practical support for cares a priority.

Recommendation 9

It is recommended that:

Social Services should work with other agencies to review the policy support mechanisms which facilitate access to assessments under the NHS and Community Care Act and the Carers Act

11.7 Learning Disability and Mental Health Services

It is clear from available evidence that there is a tendency to avoid acceptance of lead responsibility in the face of referral between these two services and the scenario lacks any clear sense of eagerness to work collaboratively. Clearly this is a case, which has a tendency to straddle at least two specialist areas of care, but insufficient success was achieved in gaining collaborative working.

Evidence available supports the proposition that services lacked the necessary policies and procedures to support strong collaborative

practices but professional standards would have expected a more robust effort from all concerned in delivering services at the time.

Recommendation 10

It is recommended that: -

Joint learning opportunities is developed between Learning Disability and Mental Health services focused on methods of joint working in order to prepare them for understanding their respective skills and potential contributions to joint case management to include:

- **Programmes of education which focus on the need to predict and act proactively in the management of casework and to ensure that the approach is one that seeks collaborative opportunity.**

- **The use of this case study as a basis for development of a mixed diagnosis strategy which incorporates people with a mental health and learning disability problems.**

11.8 Substance misuse

Despite the presence of significant evidence of need this case did not to give rise to any focused demand for a formal assessment of the degree of problems associated with substance misuse. It is clear that the decision to seek an assessment should have been taken and that there was overwhelming evidence of need which does not appear to have prompted appropriate actions.

Recommendation 11

It is recommended that: -

In situations where there is a mixed diagnosis and a lack of clarity over diagnosis, but where there is a background of substance misuse services, policies should automatically demand a specialist assessment from appropriate service providers

11.9 Communications

In each of the areas scrutinised throughout this process communication has come to the fore as an issue which impacts across policy, planning, change management and professional practice.

The overwhelming sense that is conveyed in the gathering of evidence is that there is a lack of sufficient awareness in integration, joint working, policy development, agency or individual roles and information about resources, services or agency responsibilities. It is clear that whatever systems have been put in place they were not effective in maintaining confidence to work in a contemporary way amongst those involved in the care of Mr S.

Recommendation 12

It is recommended that:-

All agencies should work together to address communication systems and the need to ensure that corporate change is effectively communicated within and across organisations, including the development of clear communication strategies in place against ongoing and development plans.

- **Annual communication plans should be in place to test progress of strategies and these should be effectively monitored within the respective organisations**

11.10 Understanding of agency roles

The expressed views of witnesses involved across agencies reflects a common pattern in a lack of understanding of their respective roles and responsibilities and this is played out in a number of scenarios including understanding of effective routes into the various aspects of service provision

Whilst any level of negligence within the systems is a hard concept to evidence this case does raise some real concerns about competence within the system.

Recommendation 13

It is recommended that: -

All agencies and services involved in this case should ensure that multi-agency training programmes are put in place and that joint agency approaches to care, respective agency roles and responsibilities are understood and effective

11.11 Knowledge and Understanding

Any judgements made by the inquiry panel should be measured against expectations based on the knowledge and expertise held by the individuals involved in the care of Mr S. The question, which has been addressed by the inquiry, is whether or not incompetence was a factor in the outcome of this case and what underlies that incompetence.

The evidence gained in the course of the inquiry is that those involved acted within a knowledge base which might at times have been below the expectations of a reasonable well informed and reasonably educated system.

There is no reliable indication of negligence in so far as no individual generated evidence to lead the panel to decide that they failed to apply what knowledge that they held or knowingly failed to act with good faith. What the evidence does imply is that overall those involved in the care of Mr S failed to individually or collectively stand back and appraise the situation with an informed overview. This has raised significant concerns regarding their overall supervision and ongoing education.

Recommendation 14

It is recommended that: -

Practitioners operating in positions where their appointment is not substantial should be supported with robust governance systems, a supervised work plan and regular review. In addition:

- **Operational policies for all services need to be reviewed. They must clearly define the services and the competencies required. This should be reflected in individual job descriptions to allow effective competency assessments and a training needs development plan to be implemented**

- **All services should be required to be able to demonstrate knowledge and competency assessments for all staff against an agreed set of objectives.**

- **Formal systems of supervision should be reviewed to ensure that no practitioners are operating without reasonable scrutiny of their practice**

11.12 Planning and Strategy

It must be acknowledged that many of the characteristics of services in operation at the time are not without precedent. Local services and public organisations have been subject to major organisational change and it is often the case that corporate restructuring achieves its objectives of resource alignment, accountability and authority whilst allowing awareness of policy, procedure and other governance systems to fall behind.

Evidence put forward by witnesses interviewed in this inquiry support this as a case in point

The experience of planning across the county for service integration and co-location of health and social services in both Learning Disability and Mental Health was consistently reported to be disparate and vague. Whilst there are clear high level strategic commitments to achieve integration this was perceived to be piecemeal and without widespread operational understanding or ownership.

Witnesses claimed there was no clear understanding of planning systems where individual practitioner or teams could contribute to integration and development plans or indeed an understanding about the shape, location or nature of future services.

Recommendation 15

It is recommended that: -

Planning systems should be reviewed to ensure that there is involvement of stakeholders, including staff at all levels, and that they have a clear understanding of planned services changes.

11.13 Risk Management

This is a complex and challenging concept even in the most coherent of circumstances and it must be acknowledged that risk management is dependent on a high level of analysis which must be informed by a detailed data and subsequent information and intelligence gathering process.

Predictability of outcome is a significant factor in determining risk and it is only through the most able and detailed intelligence gathering and information sharing that predictability can be established for risk management purposes in services such as those being scrutinised for this inquiry.

On the basis of evidence gathered in the course of this investigation it is evident that there are clinical risk management processes in place. Their effectiveness has not been established for services that were operating at the time but more importantly it has proved difficult to identify a shared process or system of risk management operating between the services who took some part in supporting –or providing care to- Mr S and or his family.

Past Independent inquiries relating to Mental Health and Learning Disability services have demonstrated a tendency to identify areas of background risk which imply an underlying indicator from which planning of services, risk management, care and treatment might be informed. These indicators have included risks around major service change such as those in train in the course of this case.

Many of the adverse indicators previously cited in local politics, planning and inter-agency systems appear to be present in this case and might – with some careful reflective thought- have heightened the perceived level of risk in this case.

Recommendation 16

It is recommended that: -

More work is undertaken to ensure that practitioners understand the risk management process both clinically and corporately

11.14 Capacity Assessment

Whilst it is appropriate to presume capacity there was much in Mr S's presentation which suggested that he did not have the capacity to make certain decisions and where a formal assessment of his capacity was

indicated. However, the panel did not elicit any evidence that this was carried out by any of the professionals involved with him.

An assessment of capacity would have formally taken a view on his ability to comprehend and retain the information given about a particular matter and weigh it in the balance to reach an informed decision based on risks, benefits and alternatives. Where a person does not have the capacity to make a particular decision it is then a matter for the professionals to decide what would be in his best interests and act accordingly.

The fact that Mr S's mother was made responsible for his medication suggests that he was deemed unable to understand the reason for its prescription and unable to organise himself to take it. His inability to keep his appointments with the psychologist may have been due to a lack of capacity to understand the nature and purpose of such an appointment and an inability to get himself there. Rather than making him personally responsible for that and closing the case it could have been concluded that it would have been in his best interests to be brought by the Probation Officer. Instead it was concluded that this would have been against his human rights.

The courts deemed Mr S to be responsible for his actions and to be able to comply with Community Rehabilitation Orders despite the Probation service providing evidence that he was unable to do this and requesting a mental health disposal. It is significant however that, following the homicide, he was deemed unfit to plead. The trial and this inquiry, therefore, were delayed until he was deemed to have regained the capacity to stand trial.

If it was deemed that Mr S lacked capacity to consent to informal admission and was objecting, or he was deemed to have capacity but was refusing admission, then an assessment under the Mental Health Act 1983 would have been appropriate taking into account the criteria for admission as detailed above.

It must be remembered that the European Court of Human Rights subsequently ruled on the Bournewood case in October 2004 and said that the common law is not robust enough where a person is deprived of his liberty. However, at the time of the homicide, the legal position was as described above.

Whilst it is acknowledged that the Bournewood judgement has generated some reservations regarding the detention of individuals suffering from conditions which include impaired capacity, actions taken in this case do not imply that this was a case which presented challenges in that context.

Mr S was clearly regarded by the courts, probation services and those caring for him to have capacity in several contexts. His commitment to compliance is accepted by the professionals working with him. The courts assumed capacity on several occasions by convicting him of offences and making him subject to a community rehabilitation order.

Recommendation 17

It is recommended that: -

Health and Social Care services staff should receive training in the assessment of capacity and consent. It is important that they develop an understanding of these issues and how they can be used to inform decision-making processes. In particular in the future it will be important to have an understanding of the Mental Capacity Act 2005; the changes to the Mental Health Act when they are introduced; the proposed Bournewood provisions, and how these interface.

11.15 Systems; CPA and Leadership

Whilst there was evidence from testimony and the records available for scrutiny that CPA was being used in this case there is a lack of consistency and little evidence that those using it understood the requirements. Evidence of its application is limited and there is further evidence that there was a general reluctance to take on responsibility for doing it or gaining compliance from the various contributors in effectively managing this case. The panel were informed at the meeting with the Trust that they were working on a training programme in the use of CPA with the Learning Disability service. The rigorous application of the CPA systems would have created a much stronger and robust approach in the ongoing management of this case.

Recommendation 18

It is recommended that: -

CPA must be applied across all services and audited as prescribed in national policy implementation guidelines. Where there are complications of diagnosis with multiple agency demands steps should be taken to ensure there is a multiple agency meeting and a comprehensive action plan put in place.

11.16 Policy and Procedures

Professionals operating within functions clearly do have information systems and processes which are recognised as being joint but these too lack ownership outside or across functional groups such as Mental Health or Learning Disability services

11.17 Internal Review

Contemporary systems of inquiry are clearly based on root cause analysis, they are designed to be open and non blaming. This was not the case in this instance.

Evidence from those involved in the internal review process did not present a view that it was either helpful or effective. More needs to be done to ensure that this is a process which effectively helps those involved to be open, feel supported and to learn from the process. Most importantly such processes must inform the task of service improvement and public confidence in the services.

Recommendation 19

It is recommended that: -

The systems and procedures for carrying out internal reviews must be reviewed and redefined in a way which reflects the recommendations set out within NHS guidance. New procedures should be put in place so that those giving evidence are supported, do not feel intimidated and experience the process as one which promotes openness and most importantly is seen as a learning experience which supports positive change. In addition;

- **Future internal reviews should be audited to ensure that they adopt a systemic approach which supports staff and the organisation in gaining insight into incidents without generating defensive reactions and gaining honest analysis followed by positive change**

A full analysis of the internal reviews recommendations and actions to be taken can be found in section 14.

11.18 Resources

The panel have not found that resources played a part in any of the failures apparent in this case nor can it take the view that the marginal

provision of additional resources would have changed the events or outcome.

Despite the findings it is clear that most of the clinical staff involved in this case thought resources were an issue. Contrastingly managers did not have the same view. The evidence supports the proposition that there was insufficient interaction and discourse between practitioners and managers of the services and that this allowed uninformed views to prevail.

Recommendation 20

It is recommended that: -

Planning and support systems, including budget building, must be reviewed to ensure that clinicians are involved and understand the processes for investment decisions and the process through which additional resource requests operate and that:

- **Service managers ensure that all practitioners have access into systems or discussion fora in which their knowledge of resources and planning can be brought up to date and maintained**

11.19 Commissioner, Provider Issues

This case was being managed within a time of major strategic change for all agencies. It is clear from available evidence that little was known on the ground of these changes or the longer term intentions. Major corporate and strategic agency changes do impact on the services on the ground and this must be effectively managed. The evidence suggests that this was not effective within provider agencies and there is little evidence that this was being overseen by commissioners.

Recommendation 21 and 22

It is recommended that: -

Commissioners should develop a system of robust Key Performance Indicators which effectively monitor planned change within their provider services to include:

- **The review of Corporate systems to ensure that all stakeholders are fully informed about all major change processes**

- **The monitoring of the implementation and effectiveness of output from Independent Inquiries and these should be built into the Commissioners' performance management systems for provider organisations**

Services should review the culture within the organisations, understand prevailing attitude, identify potential problem areas and seek to address positive change by instituting training programmes with measurable outputs.

12. Final Comment

Compliance with a prescribed regime -be it probationary or medication- is a clear area where discipline was absent for Mr S and there is evidence throughout the process of the inquiry that this was an enduring concern for many individuals involved in his life and care. The unpredictable and unreliable nature of his own testimony has been an underlying concern at many junctures in the process of this inquiry but it has often been the case that he has been unwisely given the benefit of the doubt.

When gathered together the evidence in this case begins to present with a familiar picture which expertly viewed might be seen to bear all of the predictors of a potentially high risk scenario. In this instance that was not the case.

It is the opinion of the inquiry panel that systems and practices operating within services at the time of the incident did not reach the high standards expected from reasonable services. However the panel also recognise that it is system weaknesses which have been identified as causative and not individual professional practice.

Given the period of time that has elapsed since the incident it is accepted that many changes have already been made to service and practices and much has already been learned. It is nonetheless important to ensure that services are assessed against all of the recommendations contained within this report even if that is only for the purpose of confirming positive change

The panel commend these recommendations to the authorities concerned and trust they are perceived to be a progressive set of recommendations upon which significant service improvement can be made.

13. Internal Review Action Plan

The following tables show the recommendations and actions taken within the Trust since the internal review took place. The inquiry panel comments regarding these areas can be found at the bottom of each table.

Recommendations	Action taken by the Agencies	Timescale	Progress
1. Procedures for monitoring the implementation of care plans and case reviews should be reviewed to ensure that agreed actions are carried out fully and within a reasonable timescale.	The SCATS Nursing Team has developed a PSR audit tool to measure compliance with the record keeping and CPA policy (attached). It is presently being used within the Nursing Team and Geesemere Day Service. • The tool needs to be reviewed to ensure that it incorporates recommendations 1. • All SCATS disciplines to be audited using the PSR tool. • Lead practitioners to be identified within SCATS to implement a rolling programme of PSR audit across Specialist Learning Disability Services. • Evidence of audit outcome and follow up action plans to be produced.	September 05 October 05	1a) PSR Audit Tool recording compliance with record keeping and CPA Policy. 1b) Achieved. New PSR Audit developed and currently in use. 1c) Achieved. Lead Practitioners identified and Audit Rota established. Audit reviewed every month at SCATS and in individual services. 1d) Evidence of audit outcome produced and held.
Inquiry Panel Comment **The inquiry panel strongly endorse this recommendation and note that it has been achieved.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
2. The Learning Disability team should be considered for co-location and joint management of team members.	At present all the SCATS Team (health) are co-located within Villa 23 (St. Francis House/Mayford Lodge) on the old Botley's Park site. It is proposed that the SCATS Nursing Team and the Psychiatry service are relocated to Bourne House in Ottershaw – this will disperse the health team although, provision will be made for a number of hot desks to support continued joint working with members of the health team. Bourne House does however have the facilities and potentially the space to accommodate the LD Adult and Community Care Team. • Implement an Integrated Care Pathway for access to specialist health and social care services which includes a shared eligibility criteria and supports a single care/treatment plan. • Identify a single management structure that is accountable for health and social care practitioners working within specialist learning disability services.	December 06 April 07	2a) Due to move to Bourne House Nov/Dec 06. Capital bid submitted. 2b) Project group formed with membership from A&CCT, Health providers and commissioners – mapping exercise and option appraisal undertaken – Recommendations made regarding future model. 2c) County Council and NHS Trust organisational restructuring has led to a delay in the progress of this action.
Inquiry Panel Comment **The inquiry panel were disappointed to note that the organisational restructuring has delayed the achievement of this recommendation**			

Recommendations	Action taken by the Agencies	Timescale	Progress
3. In the meantime there should be more systematic contact between professions. A team identity needs to be fostered: closer working between professionals established and clear leadership provided.	• A representative from each health discipline and A&CCT to attend the weekly SCATS case discussion and allocation meeting and monthly SCATS management meetings. • A representative from SCATS team to participate in the A&CCT 'Best Practice' panels. • Identify a single management structure that is accountable for health and social care practitioners working within specialist learning disability services.	April 04	3a) Partly achieved. Case Managers from one area attends SCATS allocation every week. 3b) Achieved. Representative from SCATS team attends A&CCT Best Practice panels. 3c) See action from 2.
Inquiry Panel Comment **The inquiry panel recognise this recommendation as crucial and again are disappointed to note that only partial achievement can be evidenced.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
4. The SCATS team should be developed into a joint health and social care service for people with a learning disability.	Refer to actions within recommendation 2.		
Inquiry Panel Comment **Please refer to comments on recommendation 3.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
5. The SCATS team should be considered for development as the single point of access for services.	The SCATS Team is the single point of access for all Specialist Health Learning Disability Services (across North West Surrey). There is a clear referral process, eligibility criteria, a weekly multi-disciplinary case discussion and allocation meeting which includes representatives from the Day Service and Respite Care. Referrals are accepted for treatment following the allocation meeting without the need for a further initial allocation meeting without the need for a further initial assessment. The LD Adult & Community Care Team sends a representative to the weekly meeting to support discussions. • Agree and implement a shared eligibility and access criteria, with the Learning Disability Adult and Community Care Team, based on the FACS assessment.	December 06	
Inquiry Panel Comment **Please note Section 11.4 in the main body of the report.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
6. A system of case recording should be established which is available to each team member. The content of the record should be jointly agreed by team members and record case management decisions, case plans and who is carrying them out. These should be monitored and reviewed.	Achieved – SCATS now have a weekly case discussion and allocation meeting. Discussion outcomes are recorded and made available to all team members. Eligibility evidence, risk assessment outcome, CPA status and key worker are agreed and recorded at the meeting.		6a) Central file held by Service Coordinator – each discipline receives a copy for discussion at professional/departmental meetings.
Inquiry Panel Comment **The recommendation is supported by the Inquiry panel but further reference should be made to the recommendations in Section 11.4.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
7. The responsibilities of the care coordinator should be made explicit.	Following the SUI, The SCATS Team have provided a number of training sessions to health and social care colleagues on the CPA process and the role of the Care Coordinator. • Learning Disability Service representative to participate in the S&BPT CPA steering group to ensure that the specific care planning needs of individuals with a dual diagnosis are addressed. • A system for ensuring communication of decisions and issues regarding CPA, needs to be established between the steering group and the Learning Disability A&CCT. • Following the ratification of the CPA Policy, a rolling programme of joint training on the role of the Care Coordinator to be provided. •	November 06	7a) Training programme and attendance list available. 7b) Achieved
Inquiry Panel Comment **The Inquiry panel support this recommendation in conjunction with further detailed recommendations in Sec 11.16 and 11.17.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
8. Assessments should take account of the needs of carers and other agencies who are involved.	Achieved – The SCATS initial screening assessment includes an opportunity for carers to raise concerns, as they perceive them, and assesses the family's functioning and capacity. The identified needs now routinely include a referral to the LD Adult and Community Care Team for a formal carers assessment Achieved – Adults and Community Care have agreed the publication of working protocols between the Mental Health and Learning Disability service to ensure that the first team receiving a referral meeting the authority's eligibility criteria takes action. Such a case can only be transferred once a joint agreement on responsibility is reached. Achieved – Adults and Community Care has developed a generic risk assessment tool to enhance initial risk assessments carried out as part of a FACS or Community Care Assessment. Achieved – Carer assessments are routinely carried out as part of all new assessments. The local manager then signs off the assessment.		8a) SCATS screening document available for use by all disciplines. 8b) Service Interface protocol forms part of procedures database. 8c) The Tool, together with associated Practitioner Guidance forms part of the procedures database.
Inquiry Panel Comment **This recommendation is supported in conjunction with additional recommendations in Sec11.1, Sec 11.11 and 11.21.**			

Recommendations	Action taken by the Agencies	Timescale	Progress
9. The Probation Service should have a closer working relationship with health and social care services and SCATS over mental health/learning disability issues.	Achieved – The SCATS Nursing Team presently seconds a nurse (0.2 wte) to work in the MDO service. Their role is to; develop the capacity of the MDO service, to support individuals with a Learning Disability and to develop networks with the Criminal Justice System, Probation Service and the Police. • Joint protocol to be developed to govern relationships between services. • 'Green Lights' target 21.	April 07	9a) Update report available. 9b) Information Sharing Protocol The management of with a dual diagnosis of mental health and learning disabilities policy.
Inquiry Panel Comment **Health and Social services should both take steps to ensure that this recommendation is fully implemented but the onus should be upon them and not the probation services who were the only agency able to table evidence of their efforts to work collaboratively on this case.**			

Appendix One

List of Documentation

Surrey and Borders Partnership NHS Trust

Internal Review
CPA Policy 2003
CPA Policy Review of 2003
Current CPA Policy
Carers Assessment Form
Risk management strategy December 2003
Risk Management Training Plan
Specialist Community Assessment and Treatment services for adult with Learning Disabilities (SCATS)
Service Structures
Press Cutting
Mentally Disordered Offender Service Operational Protocol
Clinical Governance Structure
LD Service Plan 2004-5
SUI Policy and Procedure September 2003
SUI Policy November 2005
Initial Multi-agency Action from internal review
Draft Action Plan August/September 2005
SCATS notes
Medical records
Nursing notes
Ashford Hospital Records
Abraham Cowley Unit records
Geesemere – SCATS notes
Psychology notes
Amended Internal Review – Joint Action Plan
Annual Report for The Learning Disability Partnership Board in Surrey
Trust information pack

Cornwall report action plan

Special Hospital

General Records
Social Care Records
Criminal Records
CPA Review
Home Office
Reports
Depositions

GP

Records

Probation Service

Probation Records

Social Services

Records
Child family Records
Family Records
Eligibility Criteria

Court

Sentencing
Summing Up

Other

Cornwall Report