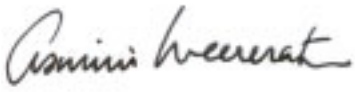
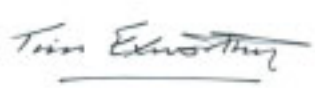
We were commissioned in May 2002 by the South West Peninsula Health Authority to undertake this inquiry into the circumstances surrounding the treatment and care of H.

We have now completed our report.



ASWINI WEERERATNE
Barrister
Doughty Street Chambers



DR TIM EXWORTHY
Consultant Forensic Psychiatrist
Redford Lodge Hospital

CHARLES FLYNN
Director of Secure Services/Deputy Chief Executive
Mersey Care NHS Trust

Contents

EXECUTIVE SUMMARY

This Inquiry was commissioned by the South West Peninsula Health Authority. The main aspects of its remit were to review the care and treatment afforded to H during the period of his contact with NHS mental health services from May 1999 until 14 November 2000, when he killed M, his previous partner and the mother of their two children; and to make recommendations, which would lead to improvements in mental health services and minimise the risk of future similar deaths.

In undertaking this remit, it was also the Inquiry Panel's task to consider any issues in the interests of the public in general. The Panel was appointed in May 2002 and in the course of its work the Panel heard evidence from a wide range of professional witnesses and from the families, friends and acquaintances of both M and H and also sought advice from a number of expert witnesses. The Panel was supported by a local part time Inquiry manager.

The Inquiry report falls into seven chapters, supported by a number of Appendices. The first chapter is in the form of a Preface. This and the next two chapters (1 and 2) deal respectively with an introduction to the Inquiry process; a factual summary and overview of the events prior to M's death; and management and practice issues. Chapters 3 and 4 deal with the two compulsory admissions of H to hospital under the Mental Health Act 1983 (MHA) in 1999, and his follow up care by the Community Mental Health Team on discharge after each period of detention as an inpatient. Chapter 5 considers the assessment of H undertaken by an approved social worker (ASW) and a police surgeon on 13 November 2000, following his arrest outside M's house on that day, and their decision that he should not be compulsorily detained under the Mental Health Act 1983. Chapter 6 addresses the subsequent assessment of H's needs by his community psychiatric nurse (CPN), following H's release from custody, and the homicide itself.

The preface chapter sets out the Inquiry process, procedure and approach and explains the processes of obtaining relevant documentation and for the formal hearings with witnesses.

Chapter 1 sets out brief biographies of M and H, including reference to what may have been periodic signs of mental illness in H since his adolescence. It sets out the main concerns identified by both the family of M and the Panel itself and the Panel's view that these should be reviewed in two contexts. Firstly, from the context of managerial practice and, secondly, by looking at the standards of practice of individual practitioners.

Chapter 2 considers management and practice issues in relation to Cornwall Healthcare Trust (now Cornwall Partnership Trust) and Cornwall Social Services, identifying a number of areas of systemic and organisational inadequacy. There are five key findings: i. a "hands off" style of senior management whereby local CMHT managers and practitioners were left insufficiently supported through procedure, policy and training, ii. CMHT operational and care programme approach (CPA) policies were poorly drafted and not implemented even as drafted. Importantly, there was no sound structure for regular review of patients subject to the "simple" level of CPA, iii. the supervision and training available for CMHT practitioners was poor and the process of care planning for H in 2000 was significantly affected by the lack of appropriate qualifications and inadequate training of the CPN appointed to co-

ordinate his care, iv. there were problems in inter-agency communication between the CHT and social services in relation to ASW co-location and v. the internal review following the homicide was inadequate.

Chapters 3 and 4 deal with the detail of H's presentation in hospital, discharge from hospital and follow up in the community associated respectively with his two compulsory admissions to hospital in 1999. The Panel identified failings in relation to H's discharge from Trengweath in January 2000 and in the subsequent support to H. In relation to the discharge, concerns identify the lack of a proper discharge meeting; the failure to review whether the complex CPA level should apply; and the lack of a formal system for reviewing patients in the community.

H's second admission to Trengweath in December 1999 followed a report by M to the Community Mental Health Team that H was not taking his medication and had become increasingly paranoid. The Mental Health Act assessment relating to that admission involved the ASW, who was to undertake the same role in the subsequent assessment on 13 November 2000, following H's arrest outside M's house. On admission H was: i. paranoid and psychotic, ii. unable to see the need for medication, iii. likely to deterioration in his mental state if he remained untreated and iv. was assessed as a risk to M who had been identified in his paranoid beliefs and H had threatened to make her "black and blue", and v. reluctant to be admitted to hospital.

Whilst H was an inpatient, the Responsible Medical Officer (RMO) identified M as being at risk from H. This chapter highlights the Panel's concerns regarding the process and planning of H's discharge and its view that H's discharge and subsequent supervision in the community were an example of how care can be allowed to drift in the absence of clear procedures and their implementation. For example the lack of any reviews of H's progress by the RMO and CPN. Other concerns include the lack of contingency planning in the event that H defaulted on outpatient appointments after discharge; the failure to act on H reporting that he had ceased taking his medication in early August; the effective withdrawal of supervision of H by the CPN thereafter; and the latter's failure to share with H's RMO the safety plan he had drawn up for M at the time of her impending departure from the family home with the children. The Panel criticise the CPN's practice and competence.

Chapter 5 of the report reviews the assessment of H at the local custody centre on 13 November 2000 following his arrest for a breach of the peace outside M's home. He was noted to be expressing delusions and anger towards M by the arresting officers. This assessment was carried out under section 136 of the Mental Health Act 1983 by an ASW and a police surgeon. The Panel find that this assessment fell below an acceptable standard in that it failed to comply with the requirements of the Mental Health Act Code of Practice and local policy. The ASW and police surgeon conducted an initial screening assessment of H prior to obtaining any of the information available to them about H. They formed the view that H did not present as being sufficiently mentally ill to warrant a compulsory admission to hospital. For that reason the attendance of a section 12 MHA doctor was not pursued, nor was the information readily available about H obtained. The Panel find that, if accessed, this information is likely to have indicated the need for an assessment by a section 12 MHA approved doctor and changed the outcome of the assessment with H being compulsorily detained in hospital. The information available to the ASW and the police surgeon (but not accessed) included the record of the previous assessment of H by the ASW. The Panel also find the arrangements made for H's care, in the absence of admission to hospital, to be inadequate.

Chapter 6 of the report focuses on the response of the mental health services after H's release from custody following the Mental Health Act assessment on 13

November 2000. The concerns of the arresting officers were such that they took the unusual step of installing a panic alarm in M's home the following day. An appointment with the RMO was arranged for H on 13 November, but without any contingency plan in the event of his non-attendance. In the afternoon, the CPN visited H, who refused the outpatient appointment offered. The Panel's view was that, on the basis of the CPN's record of H's mental state during that visit, he should have sought an assessment of H by a section 12 doctor. This was not done and no follow up action was taken concerning H's refusal to attend the outpatient appointment with the RMO. H was noted to be experiencing significant delusions regarding M. The Panel has criticised the treatment plan devised for H by the CPN. The Panel found that if subject to an assessment by a section 12 doctor, the recommendation is likely to have been that H be detained in hospital.

On the afternoon of 14 November, M met with H in the local park to inform him that she was restricting his previously unlimited access to the children. That evening, H went to M's house where he killed her.

H was charged with murder and pleaded guilty to manslaughter on the basis that his responsibility for the killing of M was substantially impaired by reason of chronic paranoid schizophrenia. On July 6th 2001, at Exeter Crown Court, he was made the subject of a Hospital Order with a Restriction Order unlimited in time under sections 37 and 41 of the Mental Health Act 1983.

In summary, the Inquiry Panel found that there had been a number of serious failings in the care and treatment of H, in relation to the practices of individual staff employed by the then Cornwall Healthcare Trust and by Cornwall Social Services. It found also that there had been organisational failings in relation to systems; the supervision, support and development of staff; and managerial approaches to the management of services. The last aspect included the quality of the internal review undertaken by the Trust immediately following the homicide. The Panel formed the view that there was sufficient evidence available to those engaged in the care of H on 13 November to indicate that his mental health was deteriorating in the absence of medication as before; H was expressing clear delusions focusing on M and a risk to her had been identified previously; that a serious incident between him and M was likely on the balance of probability, even in the absence of any history of violence between them, and that had the assessments on this day been carried out to an acceptable standard H's compulsory admission to hospital was the most likely outcome. M's death might therefore have been avoided.

The Panel developed a set of nineteen recommendations for improvements in the provision and management of services. These recommendations are listed in Appendix F of the report and relate to the following key areas:-

- The Cornwall Partnership Trust's Care Programme (CPA) policy and implementation and the role of staff engaged in CPA
- The quality and implementation of clinical and operational policies by the Cornwall Partnership Trust (including clinical record keeping; the investigation of serious untoward incidents; and the writing of patient discharge summaries) and the alignment of these with national guidance and requirements
- The systems within the Cornwall Partnership Trust for the supervision, appraisal and training of its staff
- The securing of key documentation by all agencies following a serious adverse event

- The joint working of the Cornwall Partnership Trust and Cornwall County Council Social Services, including the co-location of social workers in the West of Cornwall and the supervision arrangements for this group of staff
- The management of assessments under Section 136 of the Mental Health Act 1983, including the respective roles of social workers and police surgeons; an increase in the number of doctors trained to undertake responsibilities under Section 12 of the Mental Health Act 1983; and the provision of training for all involved in Section 136 assessments
- The requirement for the Cornwall Partnership Trust to disseminate the findings and recommendations of past and future Independent Inquiries and to ensure that practice and policies are informed thereby

These recommendations provide the foundation for the development of a joint agency action plan to address the failings identified by the report. The key agencies involved will include the Cornwall Partnership Trust, Cornwall County Social Services, the Devon and Cornwall Constabulary and the South West Peninsula Health Authority.

Whilst every Inquiry involves a personal tragedy to the family and friends of the deceased and the perpetrator and is also a tragedy to the professionals, this Inquiry findings and recommendations, to a large extent, mirror the findings and recommendations of other homicide Inquiries with common themes emerging.

Abbreviations

ACI	-	Acting Chief Inspector (police)
ASW	-	Approved Social Worker
CBT	-	Cognitive behavioural therapy
CHT	-	Cornwall Healthcare Trust (now Cornwall Partnership Trust)
CMHT	-	Community Mental Health Team
CPA	-	Care Programme Approach
CPN	-	Community Psychiatric Nurse
CPT	-	Cornwall Partnership Trust
DC	-	Derek Condon
DVU	-	Domestic Violence Unit
ECHR	-	European Convention on Human Rights
ETA	-	Expected time of arrival
F grade	-	Grading within A – I grading structure for clinical nurses
G grade	-	Grading within A – I grading structure for clinical nurses
GP	-	General Practitioner
H	-	Subject of the Inquiry
H/O	-	History of
HSG	-	Health Service Guidance
IPR	-	Individual performance review (staff appraisal process)
LSD	-	Hallucinatory drug
M	-	Homicide victim
MDT	-	Multidisciplinary (care) team
MHA	-	Mental Health Act 1983
NMC	-	Nursing and Midwifery Council
NVQ	-	National Vocational Qualification
O/N	-	Overnight
OPA	-	Outpatient appointment
PACE	-	Police and Criminal Evidence Act 1984
PAMs	-	Practice and mentoring sessions (Cornwall Social Services)
PC	-	Police constable
PREP	-	Post Registration, Education and Practice
RMO	-	Responsible Medical Officer
Sgt	-	Sergeant (police)
SHO	-	Senior House Officer (doctor)
SWPHA	-	South West Peninsula Health Authority
TADs	-	Training all day sessions (Cornwall Social Services)
T/G	-	Trengweath
UKCC	-	United Kingdom Central Council (for nursing)

PREFACE

THE INQUIRY PROCESS

Introduction

1. This report sets out the findings and recommendations of an Inquiry into the care and treatment of H. The Inquiry was commissioned by the South West Peninsula Health Authority (formerly the Cornwall and Isles of Scilly Health Authority) and established under NHS Executive Guidance (HSG (94)27) following the homicide of M by H on 14 November 2000. The terms of reference are at Appendix A.

2. At the time of the homicide H was subject to monitoring in the community by a community psychiatric nurse from the West of Cornwall community mental health team (CMHT) part of the Cornwall Healthcare Trust (Cornwall Partnership Trust (CPT) since April 2002).

3. Membership of the Inquiry Panel comprised Ms Aswini Weereratne, barrister in independent practice, Mr Charles Flynn, Director of Secure Services and Deputy Chief Executive of Mersey Care NHS Trust (formerly Nurse Executive, acting Chief Executive and Director of Clinical Services of the Guild Community Healthcare NHS Trust) and Dr Tim Exworthy, consultant forensic psychiatrist, Redford Lodge Hospital, London.

4. In order to promote the treatment and rehabilitation of H, insofar as possible, without the glare of publicity surrounding the publication of this Inquiry report, and at the request of solicitors acting for him, it was agreed that all references to him would be anonymised. We have adopted the expedient of a single capital letter "H". To make this as effective as possible the identity of the deceased has been similarly reduced to the use of the capital letter "M". However, the need for the accountability of the services involved in providing care to H prior to the homicide requires that references to the services and professionals involved in his care be open and full. This approach was discussed with and approved by the family of M.

5. There have now been close to one hundred inquiries after a homicide by a person under the care of mental health services and, as here, the majority have been commissioned in compliance with HSG (94)27. Even so, there are no prescribed procedures to be followed by such inquiries which have no

statutory powers or status[1]. Until recently the sole guiding principle has been the concept of "fairness", recognised by the common law of England and Wales.

6. Since October 2000 it has also been necessary to consider the requirements of the European Convention on Human Rights (ECHR) as applied in the UK courts pursuant to the Human Rights Act 1998. Of particular relevance to homicide inquiries is article 2, the right to life, and the associated investigative process that is required when a death has occurred to protect and promote the right to life in the future.

7. The Panel is mindful of criticisms in the process often adopted by inquiries into homicides and the inherent difficulties in the methodology adopted[2]. We have striven to overcome these where possible and to adopt procedures which are in accordance with the law as it stands today. The written procedure is at Appendix B.

8. This chapter deals with the procedures followed by the Inquiry and the terms of reference within which it operated. It hopes to explain the aims of the Inquiry and the way in which it discharged its obligations to investigate the death of M, and the care and treatment received by H from the mental health services.

9. This is the second Panel appointed to investigate the death of M and the care and treatment received by H from the mental health services. The first was appointed in early 2001, regrettably the Chair was taken ill early in 2002 and a new chair was appointed in April 2002. Thereafter, it also became necessary to replace the medical member as the first had taken up a post in the USA. At the time the second panel was appointed no medical or other records had been secured or copied from the relevant agencies. It was necessary to obtain a fresh written consent from H for disclosure of his records because the first was specific to the previous Chair. This took some months to achieve through H's solicitor.

10. In the light of these initial delays, the Inquiry Panel has endeavoured to place a particular emphasis on timing and to deal with matters as expeditiously as

[1] In the future the process is to be streamlined by the National Patient Safety Agency.
[2] See *Reforming inquiries following homicide* by Anselm Eldergill (1999) Journal of Mental Health Law.

possible, but inevitably delays have been incurred, most of which have been completely outside the Panel's control.

Inquiry Procedure

11. The panel was guided by the principle of fairness and the objectives underlying an article 2 ECHR investigation in setting its procedures. The Court of Appeal[3] has held that the procedural requirements of an investigation under article 2 are flexible and dependent on the type of case.

12. In May 2001 the European Court enunciated principles for an article 2 investigation. These were:

    a. Independence

    b. Effectiveness

    c. Reasonable promptness

    d. A sufficient element of public scrutiny

    e. Involvement by the deceased's next of kin to a necessary extent[4]

13. The Court of Appeal has stated that the elements of public scrutiny and family involvement are not necessarily compulsory. However, we do consider these to be important features of a homicide inquiry, which we have sought to incorporate in the procedures adopted. We also considered it important to see H and discuss with him his experience of the services offered to him. He consented to a meeting with panel medical member, Dr Exworthy, and this took place prior to the commencement of hearings.

14. As with the majority of homicide inquiries, this Inquiry heard evidence in private. The procedures were designed to mitigate any unfairness that may result, for example where witnesses could not hear the evidence of others, which was relevant to them. All witnesses had the opportunity to be accompanied by a legal representative or other person and to comment on conflicts in evidence which emerged through the course of the hearings that were relevant to findings of fact and comments likely to be made by the Inquiry in the final report. The element of public scrutiny has also been preserved by the publication of the final report in its entirety.

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[3] *R(Amin); R(Middleton) V Secretary of State for the Home Department [2002] EWCA Civ 390 para 31*

[4] *Jordan v UK*

15. In our view, our procedures ensured that the Inquiry was undertaken with expedition and allowed for candour in evidence which a public hearing is likely to have inhibited.

16. The independence of the process has firstly been guaranteed by the Panel membership. Secondly, the Inquiry had separate office and postal facilities and thirdly, we were able to rely on the extreme professionalism of our inquiry manager Rae Wallin, whose experience and seniority were such that she was able to maintain the need for independence.

Approach of the Inquiry

17. The Inquiry has been guided by its obligations under HSG (94)27 and article 2 ECHR. A thorough examination of the events leading up to and surrounding a serious incident such as a homicide is essential in promoting the accountability of public services and professionals to those in their care and the public at large. This is in the public interest.

18. The aim of an Inquiry as set out in the guidance in HSG (94)27 is to minimise the risk to the public or to patients themselves in the future by investigating the care received by the patient, his assessed social care needs and the exercise of professional judgment. These are reinforced and extended by the requirements of an article 2 investigation to include assuaging the anxieties of the public and systemic failures.

19. At the request of the Inquiry Panel an additional term was added to the Terms of Reference that allowed the Inquiry to fulfil its obligations fully. This stated "To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require".

20. We also requested that a term be included to allow the Inquiry to look into the adequacy of the internal reviews undertaken.

21. The Inquiry Panel's opinion was that these additional terms were necessary to ensure its ability to fulfil the aims of its investigation as described under paragraph 17 (above), which expressly articulates the public interest.

22. When evaluating the evidence of witnesses the Inquiry had to take cognisance of the lapse of time of over two years between the events being inquired into and the hearings. It was clear in some cases that knowledge

gained after the homicide from the press and reflection on events, had confused recollections of the real facts.

23. The Inquiry Panel was acutely aware of the stress that is experienced by individuals and agencies while an Inquiry is under way and the perception of a "climate of blame" that an Inquiry creates. It is clear from the tension in the relationship between an Inquiry and those being inquired into, which is apparent in the course of hearings and the correspondence generated by the process, that feelings of fear and mistrust are aroused.

24. The Inquiry is firm in its view that attaching "blame" or finding "scapegoats" is not a positive way forward. We have found, however, that it is difficult to adopt an approach or procedure that removes stress altogether. In an attempt to address this problem, a readily accessible point of contact with the Inquiry for all witnesses was available in the form of the inquiry manager Rae Wallin who also met with the Chair of the CPT, and key Trust personnel in September 2002 to advise on the remit of the Inquiry and its processes and to respond to any questions and anxieties. This was at the request of the CPT. Written procedures and terms of reference were provided to every witness written to and witnesses and agencies were kept informed of changes in the Inquiry's timetable.

25. In finalising our report we have tried to be constructive in our criticisms and offer praise where in our opinion it is due. It has not been our mission to find individuals to blame. For that reason the first substantive section at chapter 2 of this report focuses on managerial and practice issues which in our opinion are relevant to the systemic framework within which individual practitioners perform their roles.

26. We are also only too aware that some tragic incidents are unavoidable and we do not wish to perpetuate a culture which thinks otherwise. As a society we must learn to understand that serious adverse incidents will sometimes happen and it is not always necessary or productive to find someone to blame as long as lessons are learnt along the way.

27. Although mental health professionals must be accountable for good practice, they cannot ultimately be expected to carry complete responsibility for the actions of their patients. There is a limit to the control and influence which it

is possible for them to achieve over any individual. It would also be wrong to overlook the right of a patient to refuse interventions by the services.

28. The Inquiry has considered the care and treatment received by H throughout his time in contact with the mental health services, a period of approximately eighteen months between 1999 and 2000, and focused particularly on the period December 1999 to November 2000. We have endeavoured during our deliberations to come to conclusions without the benefit of hindsight and to consider the standards of practice that would have prevailed at the relevant time. However, some degree of hindsight is both an acceptable and unavoidable aspect of any inquiry.

29. The practice of individual practitioners has been judged by reference to that of a reasonable and responsible body of practitioners in the relevant field. To assist in that process, additional expert evidence was sought, where it was considered necessary. We have throughout applied the standard of proof used in civil law, namely, a balance of probabilities.

30. This inquiry is not and cannot operate as a court of law. We believe that it has fulfilled its aims and obligations as fully and properly as possible, taking account of the flexibility allowed by the courts in terms of procedures and the need to act fairly and expeditiously.

31. It is crucial that employees are fully supported by those employing them at the time of the relevant incident through to the conclusion of legal proceedings and any Inquiry. Legal services are only one form of support. A full debriefing, counselling and a timely internal review are also relevant.

32. The Inquiry has treated all evidence, written and oral, including H's records, as being received in confidence. We have considered its relevance to the terms of reference and in using and disclosing information within the report the Inquiry has weighed the public interest and whether disclosing confidential information is proportionate to the legitimate aims of the Inquiry. The evidence provided to the Inquiry will remain confidential save to the extent that it is set out or referred to in the text of the report. We consider that the agreement to anonymise references to H and M is consistent with this approach.

33. This report contains the unanimous findings and comments of the Inquiry Panel.

Documentation

34. We received the written consent of H for disclosure of his medical and other relevant records to the Inquiry. He was advised by his solicitors on this issue. The Inquiry required information relating to his past history relevant to his mental illness, conduct and behaviour. The chronology of key events (Appendix C) shows which agencies H was in contact with and had records relevant to the Inquiry.

35. The Inquiry, with H's consent, also had access to the statements and material gathered by the police during their investigation into the homicide. This was of particular importance in identifying the names of friends and family who could enlarge on H's activities and behaviour in the community, information that might additionally have been helpful to those caring for him and offered the Inquiry a point of balance to evidence otherwise solely provided by the practitioners and agencies.

36. Documents which we sought but did not receive were H's school records, which had been destroyed in accordance with policy by the Local Education Authority. Additionally, we were not provided with and there was some confusion over the existence or whereabouts of the supervision and training records of Derrick Condon the CPN responsible for H's care in 2000 and attached to the West Cornwall/Penwith community mental health team. We have made a recommendation with regard to the securing of records (Chapter 2, Recommendation 8).

Hearings

37. Save where indicated (see witnesses marked # in appendix D), meetings with witnesses were held at the Crossroads Hotel in Redruth and the offices of Harry Counsell Limited who provided our transcription service, in London, between January and May 2003. The evidence was recorded and transcripts provided to the Inquiry and the witnesses who were asked to check them for accuracy.

38. A list of all witnesses is at Appendix D.

Administration

39. The Inquiry was skilfully and cheerfully managed by Mrs Wallin, a former health service manager, but who was never employed by any healthcare organisations in Cornwall. This was an onerous task not least because the Inquiry Panel was investigating two homicides simultaneously. Managing an inquiry requires high level skills of organisation, investigation, sensitivity and diplomacy all of which Mrs Wallin has in abundance. The work is intensive and ideally benefits from a dedicated and independent manager such as her. This also assists in complying with time tables and minimising cost.

40. Mrs Wallin was the main point of contact between witnesses, agencies, families and the Inquiry Panel. She tirelessly pursued lines of investigation and ensured that everyone was kept informed of any changes to the time table.

Acknowledgements

41. We would like to offer our sympathies to the family and friends of M.

42. We would like to thank the following individuals and agencies for their co-operation and patience: H, the families of M and H, all witnesses, the Cornwall Partnership Trust, Cornwall Social Services, Devon and Cornwall Constabulary and ACI Simon Selley and DC Mark Rowe, who were of particular assistance in gathering information at the request of the inquiry.

43. We must also thank and praise staff at Harry Counsell Limited for their excellent service and patience when hearings were longer than anticipated. The Panel were comfortably accommodated at the Crossroads Hotel, Redruth for the duration of the hearings in Cornwall. We thank them for their flexibility in catering to the needs of the Inquiry. Of course enormous thanks and gratitude to Mrs Wallin.

CHAPTER 1

FACTUAL SUMMARY AND OVERVIEW

Introduction

1. H killed M his ex partner on 14 November 2000. He was charged with murder and pleaded guilty to manslaughter on the basis that his responsibility for the killing of M was substantially impaired by reason of chronic paranoid schizophrenia. As a result, on 6 July 2001 at Exeter Crown Court, he was made the subject of a Hospital Order with a Restriction Order unlimited in time under sections 37 and 41 of the Mental Health Act 1983 (MHA). He is currently detained by virtue of those orders in a medium secure unit where he is receiving treatment for his mental illness. His discharge from hospital falls to be decided by the Home Secretary or the Mental Health Review Tribunal.

2. H and M had cohabited for a period of about ten years and had two children, a girl born in 1993 and a boy born in 1998 who were aged seven and two respectively at the time of the homicide.

3. In this chapter we provide brief biographies of H and M in an attempt to present a broad impression of what they were like as people. These are intentionally not complete but aim to pick out what the Inquiry considers to be relevant and useful in understanding the personal context within which the events investigated took place. We also summarise the events leading to the homicide and the issues arising for the consideration of the Inquiry Panel. See also the chronology at Appendix C.

4. In compiling this section we are indebted to the assistance of the friends and family of M, H and his sister, and thank them also for their patience and co-operation during the whole Inquiry process.

M: brief biography

5. M was born on 9 April 1964 in Sussex. She was the eldest of three and had a younger brother and sister. Her mother and father, now retired, have taken on the role of parents to M's two young children, a

role they are pursuing with enormous sensitivity and vigour. The family has always been close and supportive of each other.

6. M grew up in Kent and is described as a bright, vivacious girl with a gentle nature. Her interests were of a sporting nature, especially swimming. She worked at Sealink Ferries after leaving school and lived at home until she was aged nineteen. Then she shared a flat with a female colleague and later moved in with a boyfriend to a house she had purchased. In around 1988 M started a relationship with H and about 12 months later she moved in to his mobile home. The family got on well the H and M seemed really happy with H.

7. They left Kent to travel around the UK at the end of 1991 (see below). She and H were thrilled at the news of her pregnancy in 1993. By August 1999, after H's first period of inpatient treatment, the family travelled to Kent to stay with M's parents where it was noticed that their relationship was strained and they spent the week in separate bedrooms. M always remained fiercely loyal to H and did not tell her parents about any problems.

8. Her parents noticed that things were even more strained when they visited Cornwall in the Easter of 2000. They identified a property for M to purchase and her father helped her to finance it. In early August M moved into the new property with the two children and took a month off work around this time because H's behaviour was upsetting her. H was visiting the house a lot and M found it difficult to get him to leave. H wanted to get back together with her and was angry and jealous at the thought of her having another man. There is no evidence at all that she had met or was seeing anyone else.

9. M made friends easily and had formed a network of female friends with whom she socialised or shared child care. M had said that she thought H had been discharged home from hospital when he was not ready, but that she thought she could cope and wanted to do everything in her power to get him well. M had also expressed her frustration at the time it took to make contact with H's community psychiatric nurse (CPN); on occasions she said this had taken one or two weeks to achieve. As will be seen later in the report, the CPN Derrick Condon, refutes that this was the case.

10. M did not like to dwell on her problems with her friends, but she started running as a way of getting out of the house. At other times she would go to her friend who lived a few doors away and whom she regarded as her "safe house".

11. When she moved to her own home M relaxed into a calm, happy person. She loved her new home and spent time decorating it.

12. Everyone agreed that H was a good father and loved his children. One of M's friends who knew H and had observed his attentiveness to his daughter when they had all gone swimming together, said that in her opinion when well H was a gentle person who was incapable of harming anyone.

H: a brief biography

13. H was born on 12 May 1963 in Liverpool. At the time that H was born his father was a seaman and later took a factory job in Liverpool. The family consisted of four children, including H who was the third in age. The eldest was a half brother, born to his mother before she met his father. H has two sisters. His parents separated in around 1982 or 1983 and his mother died in 1987.

14. His early schooling and childhood were normal and from secondary school he was accepted for entry to the Royal Air Force as a technician, but a physical injury prevented him from being able to take this up. This upset H and he joined the Merchant Navy as a seaman instead.

15. For just over a year H worked on two ships, firstly between England and Panama and then on to Japan. H would drink and get into trouble on shore. Once he was banned from entering Japan when, as he described to his father, he had stolen a motor scooter and ended up in jail. Another account of this episode is that he had taken a drug and reacted badly, becoming aggressive and necessitating him being locked in a cabin for some time until he calmed down.

16. His behaviour was noticed to have altered at around this time and on his visits home from sea he displayed what has been described as

chauvinistic behaviour towards his sisters and mother which resulted in heated arguments. He had started to expect the women in the family to wait upon him which they resisted, considering instead that he should do things for himself. He also became physically aggressive to the women in the family and once held one of his sisters by the throat. He was noted to have frequent outbursts of temper.

17. In around 1980, aged seventeen, after being sacked from the Merchant Navy because of his behaviour in Japan, he went to work on the ferries in Dover, Kent. H said he experienced his first episode of mental illness at around this time and shortly before the Herald of Free Enterprise, a P&O ferry, capsized off the coast of Belgium in 1986. He said he developed a feeling of being a messenger from God and started to attend bible meetings. He was given time off work and had started to recover without medication when he was sacked from his job. He recalled his next period of illness as occurring when he was travelling to work on ferries in Southampton from Cornwall and he was again sacked from his job.

18. It was here in about 1989 that he met M who was also working for the same company, Sealink Ferries Limited. M's father had been a captain for Sealink until his retirement.

19. Towards the end of 1991 H and M took advantage of a voluntary redundancy scheme being offered by the company and set off in a caravan to travel around the whole of the UK. When they got to Cornwall, however, they stayed put and were based on a caravan site where they both also worked. Later they bought a small house where their two children were born.

20. H had little contact with his family in Liverpool after leaving for Kent. He, M and the children had been to visit no more than two or three times.

21. H enjoyed wind surfing and paragliding in his spare time. Later he worked on the Scillonian, a ferry between Penzance and the Isles of Scilly, during the summer season only. After about four years he left this job because the hours were too long and planned to go up to the North Sea oil rigs to work on a supply vessel. M's father had advised

against it because of the mundane nature of the work, but H was attracted by the idea of it being one month on and one month off which would give him more time to indulge his sporting interests and be with the children. It was around this time that difficulties in the relationship between H and M came to the fore.

22. After about eight months in the North Sea in 1999, H suffered his first significant episode of mental illness resulting in compulsory hospitalisation. H experienced delusions focused on and involving M. M had noticed a change in H's behaviour over the ten years that they were together and had mentioned this to his sister at around the time that H was first detained in hospital in 1999. After the homicide it emerged that H may have shown periodic signs of mental illness since adolescence, but never been treated for it. There are no recorded details of these periods and recollections are now hazy. The possible relevance of this history to H's care and treatment in Cornwall is discussed further in chapter 3.

23. After his admission to hospital in Aberdeen he was transferred to Cornwall to Trengweath Hospital, Truro on 10 June 1999 under the care of Dr Margaret Hand, consultant psychiatrist. He was detained under section 2 Mental Health Act 1983 (MHA). He was then discharged back to the family home and subject to monitoring by Hilary Oates (now Mansell), a community psychiatric nurse attached to the Penwith CMHT. Again he lost his job but found a variety of other short term jobs locally. These included an iron foundry, a factory and the plumbing trade. He did an NVQ in carpentry and worked for a company that built conservatories. H described how keeping in work was very important to him.

24. Later in the year and following a period of about two months in which he failed to take his medication, H was readmitted to Trengweath Hospital under Dr Hand on 30 December 1999 under section 2 MHA once again. His mental health had deteriorated and a potential risk to M was identified. He thought M was talking about him and that people were referring to him as a pervert. His care in the community had transferred to Derek Condon, CPN, in October.

25. H was discharged from hospital on 17 January 2000 to be followed up by Mr Condon. H and M were planning to separate and M had identified a property she liked and negotiated to buy it with the help of her parents. M was concerned to support H through his illness and do what she could to help him, but their relationship had by this point deteriorated beyond repair.

26. M moved out of the family home in August 2000. H recalled frequent arguments between them prior to this happening. He was "devastated" at not having his children living with him and was scared that they might be brought up by someone else if M formed a new relationship. H never physically assaulted M during these times, but they did have heated arguments when he would threaten her and intimidate her by placing his face close to hers.

27. H was angry with her for taking the children away. He did help her to move out and there was a part of him that just got on with the situation he was faced with. M placed no restrictions on H's access to the children and he went round every evening, he said for approximately one hour each evening. Other friends of M's have said that he would often spend the whole evening at M's.

28. The CPN Mr Condon was concerned for M's safety in the period leading up to her moving out to her own home and drew up a "safety plan" for her. Almost as soon as she moved out, however, he ceased to have any contact with H who had said to him that he had stopped taking his medication on 2 August 2000.

29. At this time H was working in a plumbing shop in Penzance and on Friday, Saturday and Sunday evenings delivering take away meals for an Indian restaurant (later mistakenly referred to as a Chinese take away). These jobs gave him approximately the same amount of money as when he was working at sea.

30. H said he had no particular friendships except some acquaintances through windsurfing or paragliding. He drank one or two bottles of beer with his evening meal and did not use any illicit drugs. He was not taking his medication (Risperidone) at this time and thought that his life was progressing. He did not think that the mental health

services could have behaved any differently towards him. He blames himself entirely for the death of M.

31. He was very upset by his split from M. He was concerned to rebuild his relationship with her for the sake of the children. He said that two or three days before the index offence his feelings of being persecuted became considerably worse. He perceived words used on the television or radio as having direct significance for him. He believed M was ringing his place of work and spreading rumours about him which led to a fall off in the number of customers visiting the Indian restaurant.

32. H recalled that he said that M was the cause of all his problems and in particular had caused him to lose his job in Aberdeen and was doing it to him again in late 2000. The morning of 13 November 2000 he went round to ask her why she was doing these things. She called the police who arrested him and took him to the police station where he was assessed by an approved social worker and a police surgeon. He was released back to his home.

33. He recalls feeling in despair over the loss of his children and his job. The next day he telephoned M and asked to see the children. She asked him to meet them in the local park rather than her home. This was the first time she had put restrictions on him seeing the children and this made him angry. They met at 4 p.m. and he played with his daughter for about half an hour before returning to the car where his son had been asleep.

34. By his account M got upset and left with the children. H returned to his house but then wanted to see the children again. He went round to M's house and another argument ensued. She threatened to telephone the police, but he wanted to "sort things out", meaning that he wanted to try and understand why she was ruining his life. He started to walk away but then turned and kicked the door down. He said he was on "automatic pilot" and did not know what he was doing. He strangled M and then he said that he pushed the alarm button and waited for the police to arrive.

Mental illness and services

35. H's mental illness at the time of the homicide may be categorised as follows:

- Diagnosis was paranoid schizophrenia.
- He became symptom free on small doses of Risperidone (2-4 mg).
- Stopping medication led to a predictable relapse with the re-emergence of psychotic symptoms and a loss of insight into his illness.
- He did not have an adequate understanding of his illness.
- He associated illness with the loss of his various jobs.
- As his illness progressed he became more and more focused on M as the source of rumours about him and came to see her as ruining his life.
- He became non compliant with medication within a few months of becoming asymptomatic on it.

36. He had contact with mental health services in Aberdeen and in Cornwall where he was assessed as an inpatient under MHA at Trengweath Hospital on two occasions in June 1999 and December 1999 to January 2000. He was monitored in the community by CPNs attached to the Penwith CMHT. These services were provided by the Cornwall Healthcare Trust (CHT), later to become the Cornwall Partnership Trust (CPT) in April 2002. In November 2000 he was seen and assessed at Camborne custody centre under section 136 of the MHA 1983, by an approved social worker attached to the Kerrier CMHT, which by that time had merged with the Penwith CMHT. He was also assessed by a police surgeon and his CPN from the Penwith CMHT.

Issues

37. The main issues which arose for investigation by the Inquiry Panel coincided with those of concern to the family of M:

a. What was known to services about H's mental illness? How had he been assessed?

b. Were the discharge arrangements from hospital in June 1999 and January 2000 adequate?

c. Was H effectively monitored in the community in 1999 and 2000?

d. Was his mental state adequately assessed on 13 November 2000 in the police station and later by his CPN?

e. Was it reasonable to release him from police custody on 13 November and were the arrangements made adequate to support him?

f. How did the system of management and practice in place impact on the above.

38. While there is some suggestion from his history that H used illicit drugs in the past, the Panel has not received any evidence to suggest that such drug use or abuse played a part in the emergence of his mental illness in 1999 or later. This has not, therefore, been an issue before the Panel.

39. We have considered these issues firstly from the perspective of managerial and practice issues, and secondly by looking at the standards of practice of individual practitioners.

CHAPTER 2

MANAGEMENT AND PRACTICE ISSUES

- **Introduction**
- **Community mental health team (CMHT) operational policy and structure**
- **Care programme approach (CPA) level and documentation**
- **Care planning**
- **Clinical supervision and training**
- **Social worker co-location**
- **Internal review**

Introduction

1. This chapter explores the managerial and policy context of the events related to the homicide. It does not purport to provide a review of the whole management structure of the Cornwall Healthcare Trust (CHT) but to elucidate the management of the West of Cornwall CMHT. H's psychiatric history and responses of individual practitioners are considered in detail in chapters 3 to 6.

2. At the time under consideration H was primarily under the care of the CHT, now the Cornwall Partnership Trust (CPT). He had less contact with Cornwall Social Services but, importantly, was assessed under the Mental Health Act 1983 (MHA) by an approved social worker (ASW) on 30 December 1999 and again on 13 November 2000 at Camborne custody centre (Chapter 5).

3. Following a brief period of inpatient care in Trengweath Hospital in June 1999, H was discharged to the care of the West of Cornwall Community Mental Health Team (CMHT) (Chapter 3). He remained under the care of this team until he was readmitted under MHA to Trengweath Hospital on 30 December 1999. He was again transferred to the care of the CMHT following his discharge on 17 January 2000 and remained under its care until the date of the homicide, 14 November 2000 (Chapter 4). One of the consultants for the CMHT was Dr Margaret Hand who was also the responsible medical officer (RMO) during H's inpatient care. This provided a degree of continuity in the community. When he was discharged on 17 June 1999 the community psychiatric nurse (CPN) to whom his care was allocated was Hilary Oates,

now Mansell. On 22 October 1999 Ms Mansell transferred responsibility for H's care to Derrick Condon, a CPN, as she was leaving the CMHT to undertake further professional training.

4. Mr Condon was responsible for the co-ordination of care arrangements for H and for providing psychiatric community nursing input to H's care from 22 October 1999 until his admission to hospital on 30 December 1999 and again from his discharge on 17 January 2000 until the date of the homicide, that is 14 November 2000. At the time they had responsibility for H both Ms Mansell and Mr Condon were employed as 'F' Grade CPNs.

5. The West of Cornwall Community Mental Health Team (CMHT) had recently been formed by the merger of two previous CMHTs (Penwith and Kerrier) and was under severe pressure, particularly from January 1999. Social worker co-location had additionally recently been introduced whereby approved social workers (ASWs) were located within CMHTs. In the Kerrier District this had given rise to problems of appropriate professional supervision for the ASWs. The CHT and Social Services agreed a programme of managerial and professional supervision for ASWs in August 2001.

6. The Panel found that Juliette Hostick, the clinical manager, and Victor Bridges the team leader, of the CMHT had excessive workloads. They did however make strenuous efforts to address the management challenges identified above.

7. We have been told that the senior management culture at the time of this homicide was not supportive of local managers, in particular implementation of Trust policy was not monitored or supported. The expectation seems to have been that staff would get on with it. This culture no doubt contributed to a lack of meaningful supervision of Mr Condon's work and the failure to identify the inadequacy of his training for the post to which he had been appointed. These organisational failings, however, do not mitigate Mr Condon's own failure to fulfil his professional obligations by accessing appropriate training. These failings expressed themselves in inadequate care planning, risk assessment and monitoring of H's mental illness.

8. Additionally there was no cohesive county wide management of mental health services, a situation that was changed on the appointment of Michael

Donnelly as general manager for mental health services in September 2000. This appeared to be the result of the CHT's recognition that there were problems which needed addressing.

9. The failure of ASW co-location in the Kerrier CMHT, particularly with regard to the professional supervision of ASWs, which persists to this day apparently, stands in stark contrast to the situation in the rest of Cornwall. The Panel could find no justification for this situation and criticises both agencies (CHT and Social Services) for their inability to resolve what seems to be a fairly straight forward issue. Michael du Feu, Approved Social Worker (ASW), placed heavy emphasis on the problems of co-location by way of explanation for the circumstances he found himself facing on 13 November 2000. Our expert advice is that the 'lack of informed supervision and support' may mitigate the standard of Mr du Feu's practice on that day. We are critical of the standard of his assessment on that day (Chapter 5), and do not consider these co-location problems to provide sufficient mitigation.

10. In summary the Inquiry has found evidence that:

- There was a "top down" style of management within the CHT whereby local CMHT managers and practitioners were left to do their jobs as best as they could, resulting in insufficiently supported, autonomous working.
- The clinical manager and team leader of the West of Cornwall CMHT had excessive workloads.
- The CMHT operational and care programme approach (CPA) policies were poorly drafted.
- The above policies were not implemented, even as drafted.
- Practice was inconsistent between practitioners in the same team.
- There was poor supervision and training available for practitioners.
- There was insufficient audit by the CHT of CPA implementation.
- There were problems of inter-agency communication between the CHT and Social Services in relation to ASW co-location.
- The internal review was inadequate.

11. In our view, proper systems of CPA, supervision, training and audit within the CPT are likely to avoid the deficiencies in practice that we have identified in individual practitioners. These include: discharge planning, CPA reviews, record keeping, care planning, withdrawal of contact. It must also be said that

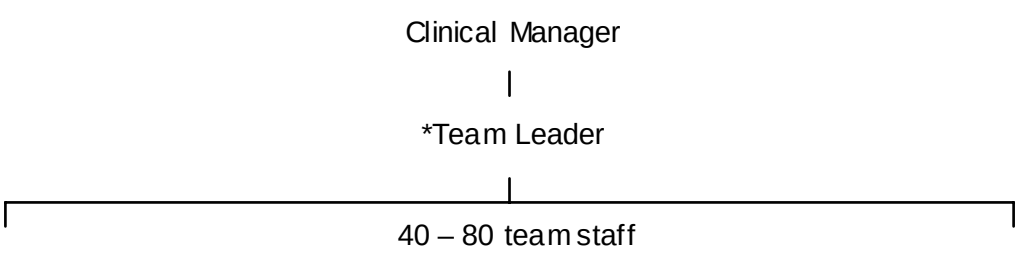
Cornwall has been extremely slow to implement these measures, and especially CPA which became a requirement in 1991.

12. We have identified issues of competency around the CPN Mr Condon. He returned to practice after a significant break in clinical work and with no specific CPN qualifications. He has not been offered or sought appropriate training to remedy this situation.

CMHT Structure

13. The following organisational diagrams were provided by Mr Donnelly, CHT general manager for mental health services. Mr Donnelly was appointed to this post in mid September 2000 and was answerable to the Chief Executive of the CHT. The Panel felt that Mr Donnelly was well placed to provide evidence of the structures he inherited and the changes instituted by him. Diagram 1 describes the arrangement within the CMHT when Mr. Donnelly took up post. At that time each had a single clinical manager and a single team leader. For the West of Cornwall CMHT they were respectively Ms Hostick and Mr Bridges. Mr Bridges had direct responsibility for all team staff, the team provided care for adults and older people.

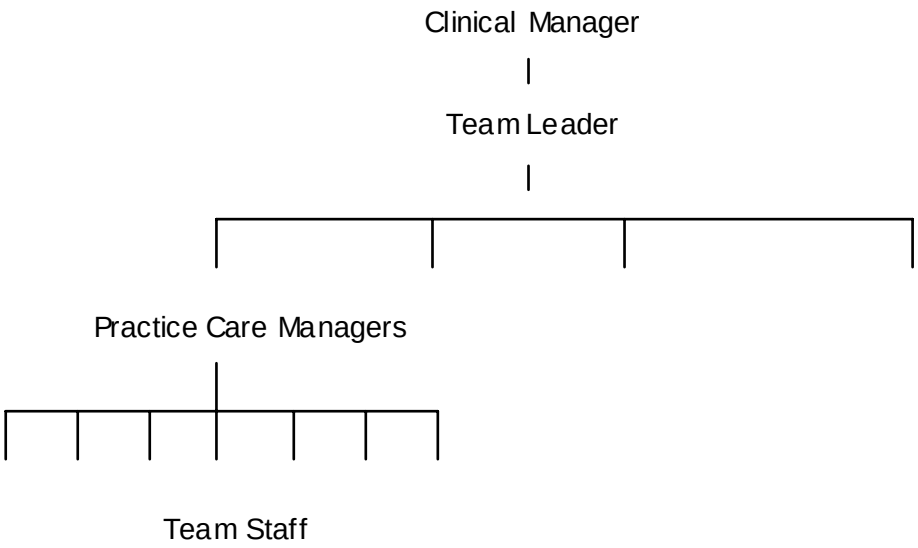
CMHT Structure – September 2000 (Diagram 1)



* the team at that time provided care for adults and elderly people

14. By April 2001 the Trust had reorganised the CMHT and separated care for adults from that provided for older people, diagram 2. The same clinical manager and team leader were in post for West of Cornwall, but by this time new posts of practice care managers, who were either G Grade CPNs or the equivalent in other professions had been created. These posts had line management responsibility for a smaller group of team staff.

CMHT Structure August, 2001 (Diagram 2)

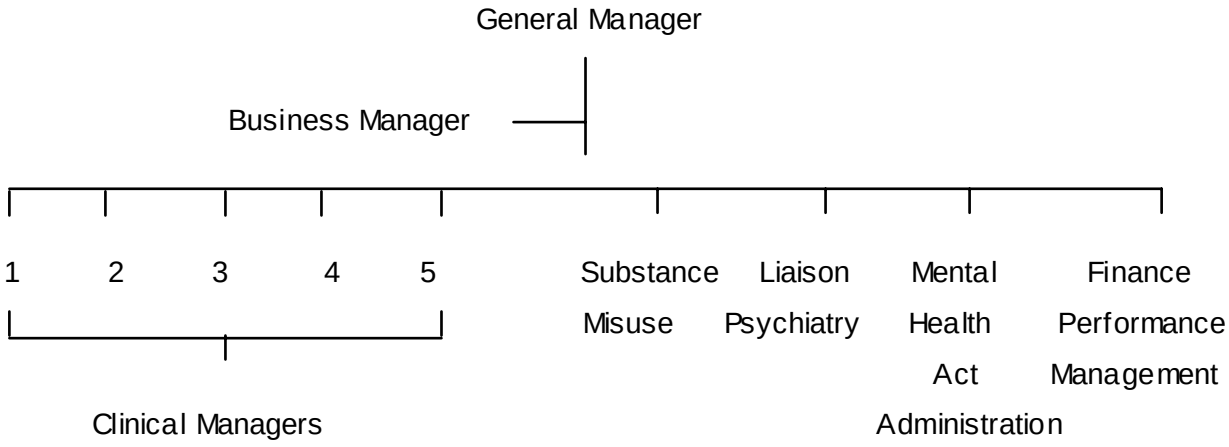


The above arrangement refers to adults

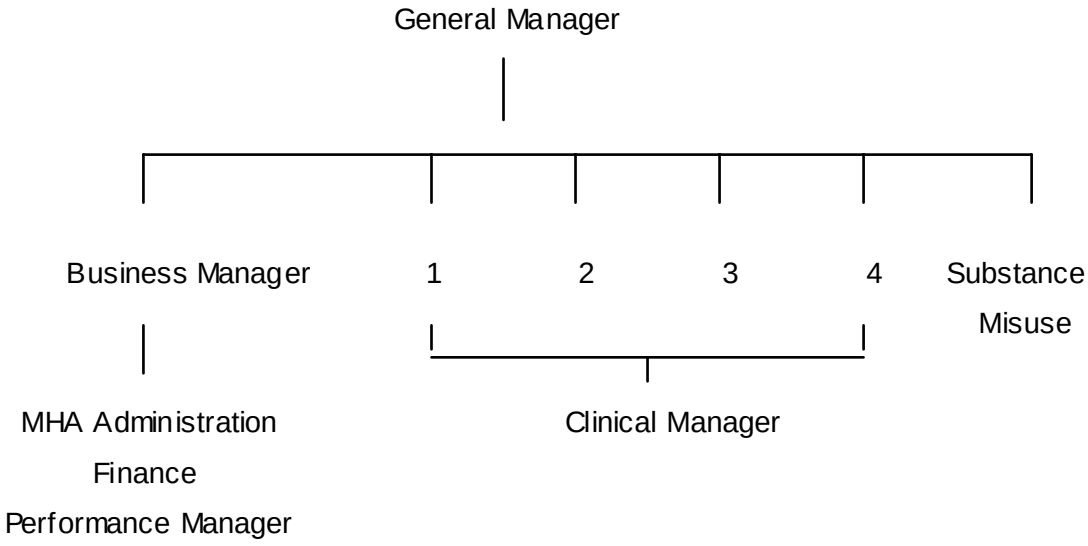
15. Mr Donnelly estimated that the number of team staff directly managed by Mr Bridges before this change was probably nearer 80 than 40.

16. Mr Donnelly also described the distribution of his own management responsibilities within mental health services. On appointment Mr Donnelly had 10 people who reported directly to him, 5 clinical managers, a business manager and 4 other managers covering separate aspects of the mental health service, this is shown in diagram 3 below. By April 2001 the Trust had reorganised this arrangement so that he had 6 people directly reporting to him as described in diagram 4 (a) below. Diagram 4 (b) which follows demonstrates the revised responsibilities of the 4 clinical managers. In essence Mr Donnelly created a new post of clinical manager for county wide older people services, he retained the manager for substance misuse, delegated the non direct clinical management responsibilities to his business manager and reorganised the workload of the three clinical managers for adult services to ensure a more balanced workload and range of responsibilities.

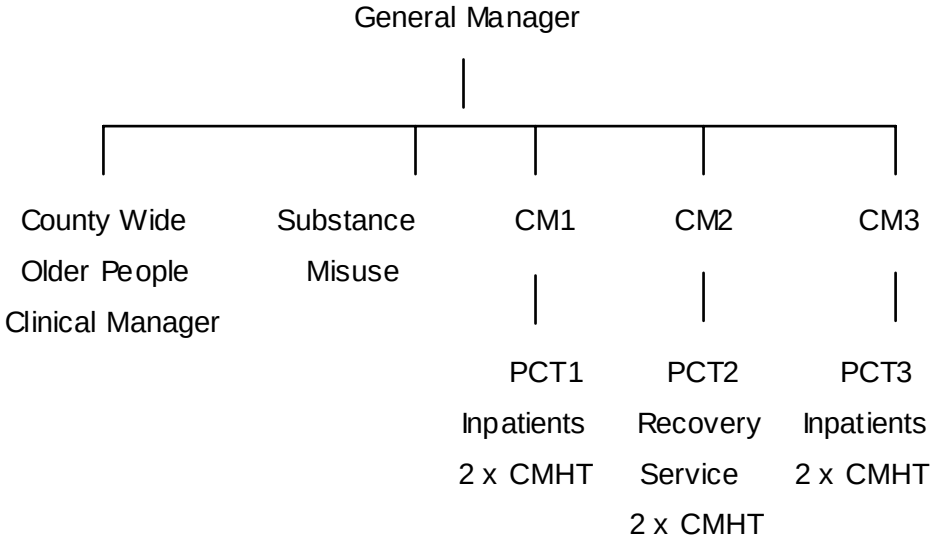
September 2000 (Diagram 3)



April, 2001 (Diagram 4a)



(Diagram 4b)



17. The changes above are particularly significant for Ms Hostick and the West of Cornwall CMHT. Prior to the reorganisation and throughout the material time of this incident Ms Hostick was responsible for the following.

i. Trengweath Mental Health Unit – 26 bedded Adult Acute Admission Unit
ii. Charles Andrews Clinic – 25 bedded Older Adult Assessment and Continuing Treatment Unit.
iii. Lower Cardrew House – 10 bedded Adult Continuing Treatment Unit.
iv. Bolitho House – 16 bedded Older Adult Unit for Assessment and Continuing Treatment.
v. Pentire House and Porthminster House – Each a 5 bedded supported domestic home.
The above services had a total of four team leaders.
vi. 2 CMHTs in four separate bases, each Community Health team provided for adults and older adults and each had a single team leader.
vii. A G.P. based Primary Care Mental Health Service covering Kerrier and Penwith with a single team leader.
viii. Mental health services for the Scilly Isles.

18. The service listed above was undergoing significant reorganisation at this time including the closure of Bolitho House inpatient unit, the co-location of Approved Social Workers (ASWs) into CMHTs and the integration of the Penwith and Kerrier CMHTs to form new West Cornwall CMHT. In addition to this Ms Hostick was responsible for site and security management, and investigation of serious and untoward incidents and complaints. During his interview Mr Donnelly described this span of control as unacceptable, hence his reorganisation and redistribution of responsibilities.

19. Mr Donnelly summarised the responsibilities of the CMHT team leaders when he was appointed as follows. Team Leaders had:

> A large span of control, meaning a lot of fire-fighting not much more team leadership or team management. The staff appeared overwhelmed, overstretched, there was poor or limited formal case load management. Team Leaders very rarely met. In fact I subsequently found out they had been discouraged from meeting by the previous arrangements and that the

> real tensions in the teams, what they were struggling with was the plan versus emergency dilemma, which seemed to be a constant problem and we are really still wrestling with that at the moment. So my perception of the Community Mental Health Team was that there were really good, well motivated and positive people in them. I really have to say that quite loud. There were some really very imaginative pieces of work being done, but the structures within which they were working seemed designed not to assist them in that process of delivering good quality care.

20. Ms Hostick in her evidence to the panel described her responsibilities as onerous. While she had 4 team leaders to cover inpatient services her time was largely taken up managing crises in these services. She did visit CMHT bases regularly, but such visits tended to be brief.

21. Following the reorganisation Ms Hostick managed a more limited range of services i.e. she managed acute inpatient services for adults at Trengweath Hospital and two CMHTs. These responsibilities are coherent and logical, and both Ms Hostick and Mr Donnelly consider this workload to be manageable and equitable.

Comment

22. At the time material to this inquiry, the 80 or so staff of the West of Cornwall CMHT were managed by a single team leader, Mr Bridges, who reported to Ms Hostick, the clinical manager, who in turn had an excessive workload in which the demands of inpatient care took priority. The unreasonableness of these management arrangements was recognised by Mr Donnelly, the general manager for mental health services, appointed in September 2000. Mr Donnelly redistributed and reorganised services producing more equitable and manageable arrangements by April 2001. At the time of the homicide, and for a significant period before it, it would be difficult to argue that sufficient management resource was available to supervise, in a clinical or managerial sense, the workload or quality of work of the CMHT staff.

23. The structural problems above were compounded by what was described to the panel as a disempowering command and control, very ''top down'' senior management system which encouraged competition rather than co-operation between clinical managers. The Panel heard

evidence that the management approach of the Trust (CHT) at the material time was quite destructive.

24. Mark Steer, now director of nursing, repeatedly described to the Inquiry the management arrangements at the time of the homicide as being the responsibility of local managers or individual clinicians.

25. We have seen evidence that the result was that practitioners worked autonomously within the CMHT and that multi-disciplinary work was limited. The problem, as will be apparent from the sections below, was exacerbated by insufficient support from meaningful Trust wide procedures, for example, to guide practice and access to or provision of appropriate training, supervision, or policy implementation. We have been told that these deficits have subsequently been addressed partly in response to this homicide, partly in response to changing senior personnel and partly as a consequence of organisational change. However, problems regarding access to appropriate training persist.

26. It would appear, therefore, that the many crucial organisational mechanisms required to ensure effective delivery of clinical care were either absent or organised in such away as to make them ineffective at the time material to this inquiry.

27. Ms Hostick and Mr Bridges made every effort to support and lead the staff of the CMHT in delivering appropriate care. However, as will be seen below, the effect on CMHT practice of poorly developed policies, supervision arrangements and training provision combined with the absence of appropriate higher management support prior to the appointment of Mr Donnelly, created circumstances where patient review systems, risk assessments and multi-disciplinary working were inconsistent.

28. The panel considers the degree of unsupported autonomy, in this case, to be unacceptable and detrimental to practice and patient care. We believe the Trust could and should have been aware of these circumstances and consequently they should also have intervened to prevent these failings.

CMHT Operational Policy and the Care Programme Approach (CPA Level and Documentation)

29. The Care Programme Approach (CPA) was introduced in the joint Health and Social Services Circular LASSL(90)11 titled "Health and Social Services Development (Caring for People) A Care Programme Approach for People with a Mental Illness referred to the Specialist Psychiatric Services". This circular required District Health Authorities by 1 April 1991 to "have drawn up and implemented in consultation and agreement with Social Services Authorities, Local Care Programme Policies to apply to all inpatients considered for discharge and all new patients accepted by the specialist psychiatric services". Also "by 30th April, 1991 Regional Health Authorities must confirm to the NHS Management Executive (via their Regional Liaison Principal) that all District Health Authorities in their area have introduced a Care Programme Approach".

30. Throughout the time of his care in the community the CMHT providing care for H had its operational mechanisms described in an operational policy. At least two different versions of this policy exist. The first described the structure and operational mechanisms of the Penwith CMHT, the second described the same features and mechanisms for the newly formed West of Cornwall CMHT following the merger of the Penwith and Kerrier CMHTs.

31. Only draft versions of the Penwith CMHT Operational Policy dated 1995 were produced for the panel; it was not possible to locate a copy of the approved version of this operational policy. The panel were provided with a memorandum describing the production of parts of the West of Cornwall CMHT in which the existing operational policy is referred to. This memo was dated 15 August 2000.

32. The West of Cornwall CMHT Operational Policy is a more extensive document produced during 2000 which describes the operational procedures of the CMHT and the roles of individual CMHT members. It also describes the operation of the CPA and the role of supervision for CMHT members. In evidence Mr Condon said that he did not recognise this document. He was, however, familiar with the role of the CPN as described in that document.

33. Within the copy of the Penwith Mental Health Team Operational Policy provided to the panel, which is a draft and dated September 1995, no reference is made to the CPA in the introduction, aim, objectives of the service, philosophy, referral criteria, referral process, screening, allocation of cases or priority sections. The first and only mention of the CPA is under the responsibilities of Care Managers/Key Worker Section which states "'meet the person and/or carer(s) advocate to explain the CPA giving the appropriate people, "what you need to know about your Care Programme". Gains agreement and seeks their views.'" This section on the responsibilities of the care manager/key worker seems to be lifted directly from page 4 of the CPA Procedure Guide provided in the general documentation requested by the Panel; this guide however is not dated. It contains significantly more information than that available in the Operational Policy for the CMHT and there is no reference in the Operational Policy to the CPA Procedure Guide.

34. The CPA Procedure Guide does not define the levels of care programme approach in the terms used by clinical staff interviewed by the panel, that is 'simple and complex', which later changed to 'standard and enhanced'. Within the initial system there was a third level which covered patients on the supervision register. The CPA Guide describes three levels of needs within a needs-led approach to CPA. These are:

- High need "Will the person's health and/or safety or that of others be at risk. Will there be a significant reduction in the person's quality of life".
- Moderate need "Will there be a moderate reduction in the person's quality of life".
- Low need "Will there be a prevention of a significant improvement in the person's quality of life".

35. None of the clinical staff interviewed by the panel could describe how these definitions had been translated into simple, complex or supervision register categorisations. Nor could they explain the difference between the definitions of moderate or low need. Whilst it is not stated within the CPA procedure guide, it would appear that the documentation within this guide was only used for patients who were on complex care programmes. For those on simple CPA, their clinical record was considered to be sufficient to qualify as CPA documentation. This did, however, preclude those patients on simple CPA

being given a copy of their care programme since no separate identifiable documentation existed.

36. This deficiency is recognised in the Cornwall and Isles of Scilly Mental Health National Service Framework Initial Delivery Plan, Chapter 4, Section 4.2. In the section on current position and perceived gaps it states: "those on complex CPA are provided with a copy of their care plan (703), those on simple CPA do not receive copies". In the comments section it states "provision of care plan information to those on simple CPA planned, held during run up to NSF provision".

37. It proved impossible to secure a definitive version of the West of Cornwall Operational Policy which applied at the material time of this inquiry. None of the versions provided had a date indicating when it had been produced. In each version the CPA was a more prominent feature than in the Penwith Operational Policy. In the section Treatment Planning and Care Programme Approach, two kinds of care programme are described "a care programme will be implemented which may be (a) complex/enhanced or (b) simple/standard". This terminology is used throughout the documentation, and while there is a section titled "Responsibilities of Key Worker under complex CPA" there is no equivalent section for simple CPA. It is also noteworthy that the term used here is complex and not complex/enhanced, similarly the responsibilities are almost identical to those described earlier in the 1995 document titled "Responsibilities of Care Manager/Key Worker"

38. LASSL (90) 11 Joint Health/Social Services circular "The Care Programme Approach for people with mental illness referred to specialist psychiatric services" describes how the CPA works. This includes sections which describe inter-professional working, involving patients, involving carers and the role of key workers. Within this last section four requirements have particular resonance in this case:

    - "The key worker can come from any discipline but should be sufficiently experienced to command the confidence of colleagues from other disciplines".

- "A particular responsibility of the key worker is to maintain sufficient contact with the patient to advise professional colleagues of changes in circumstances which might require review and modification of the care programme".

- "Every reasonable effort should be made to maintain contact with the patient and where appropriate his/her carers to find out what is happening, to seek to sustain the therapeutic relationship.

- "Often patients only wish to withdraw from part of a care programme and the programme should be sufficiently flexible to accept such a partial rather than a complete withdrawal."

39. H.S.G (94) 5 " Introduction of Supervision Registers for Mentally Ill People from 1 April, 1994" described not only arrangements for the supervision register but its relationship to the CPA. While the CHT produced a document titled "The Supervision Register System Policy and Procedures", the Penwith Operational Policy makes no reference to that document and scant reference to the CPA or supervision register. Under the title Responsibilities of Key Workers in Response to Supervision Register this states:
"The role is essential to the success of monitoring the [care] plan. The named Nurse should ensure that decisions/actions and amendments are systematically recorded and that regular updating and reviews take place, and arrangements are made for the dissemination of that information to the Care Team".

40. The West of Cornwall Operational Policy expands the title of its equivalent section to include responsibilities for a patient protection plan. However only slight elaborations are made to the Penwith CMHT entry, whilst still making no reference to the specific Trust Policy. It states:
"1) The role is essential to the success of monitoring the plan
2) The key worker and R.M.O. should ensure the decisions, actions and amendments are systematically recorded (organised at minimum of 3 months intervals).
3) Reviews take place, organised by key worker and R.M.O.
4) Arrangements are made for the dissemination of that information to the Care Team".

41. Ms Mansell was able to describe the process of allocating a CPA level as being determined by the patient's need and dependent on their level of risk and the complexity of their needs. The more general convention used and described by Mr Condon and Dr Hand seems to be based on the number of people providing care to the patient, that is, a provision led model rather than a needs led model. For example, we were told that the difference between a simple CPA and a complex CPA "revolves around the number of people that are actually actively involved with a client, the general mental health status and the risk or potential risk that that could involve". This is reflected in the CMHT operational policy.

42. It was also clear that CPA documentation was only used for those patients on enhanced CPA. When asked if a formal decision had ever been taken about the level of CPA appropriate to H, Mr Condon stated that he did not think that decision was ever taken and there is no documentary evidence of any such decision.

43. Following further discussion about H's clinical presentation and level of need, Mr Condon stated that H had a high need for monitoring. He went on to say that in his current opinion H would have qualified for enhanced CPA.

Comment

44. Throughout his care by the CMHT H was considered to fulfil the criteria for simple CPA. There is no evidence which demonstrates a formal consideration of his level of need resulting in the application of simple CPA standards. The appropriate level of CPA never seems to have been reviewed throughout his care.

45. The introduction of the CPA and later Supervision Registers has been a fundamental building block of mental health services for 12 years (9 years at the material time). The existence of a Trust wide CPA policy is poorly reflected in CMHT operational policies from 1995 up to and beyond the time of the homicide. The different categories of CPA seem poorly defined and difficult to relate to rather confusing definitions of levels of need.

46. The practical application of CPA guidance in the CMHT led to a situation where only those patients defined as requiring complex CPA had any formal mechanisms of receiving a copy of their care programmes and

perhaps being involved in the formulation of the same. Of added importance and relevance is that there were no systems for discharge planning, formal multi-disciplinary CPA review meetings or risk assessment.

47. It is of particular concern to read the rather superficial reference to the CPA in the West of Cornwall Operational Policy which was formulated during 2000, simultaneously to the introduction of the National Service Framework for adult mental health services. These managerial failings may provide some explanation for the apparent lack of any demonstrable consideration of CPA or risk assessment displayed in the clinical care of H.

48. Key aspects of the responsibilities of key workers under the CPA are described in paragraph 38 above. The Panel believe none of the four particular requirements were satisfied in this case:

- **Mr Condon may have been experienced in terms of years of service since qualifying as a Registered Mental Nurse, but he had no relevant experience prior to being appointed as a CPN, and received no in-service training from his appointment in 1995 up to and beyond the date of the homicide. Mr Condon was out of clinical practice for 15 years before he was appointed to the Penwith CMHT as a CPN. He did not have a CPN qualification. This is not sufficient experience to command the confidence his colleagues appear to have had in him.**

- **H's circumstances changed significantly during the time Mr Condon was his key worker. These changes included fluctuating job prospects, consistent deterioration in his relationship with M, increasing and repeated non-compliance with medication and defaulting on outpatient appointments. The panel believes this catalogue of change should at least have led to a review of the CPA category from simple to complex, combined with the development of appropriate care interventions, none of which seem to have taken place.**

- **It would be impossible to state that Mr Condon made a reasonable effort to maintain contact with H or to seek to sustain**

the therapeutic relationship. This is particularly so from August 2000 until the time of the homicide. He did not maintain contact with H.

- **Mr Condon did not reformulate H's care after August 2000 as a consequence of the partial withdrawal of H from his care programme. This would have been one of a range of possible outcomes had Mr Condon reviewed H's care programme in the light of the separation from M. Unfortunately no such consideration took place and H was effectively abandoned between August and the homicide. (See paragraph 69 to 75 below and Chapter 4 for more detail).**

49. **There appears never to have been a formal decision that simple CPA was continuously the appropriate level for H. Albeit with an element of hindsight, Mr Condon now suggests that complex CPA may have been more appropriate. The major obstacle to such a decision seems to have been the informal, provision-led approach to categorisation rather than a genuine needs-led approach. This is poor implementation of the Trust's own policy.**

50. **H should at least have been considered for complex CPA in response to problems which became apparent particularly in the period leading up to his last period of inpatient care, that is, compliance problems with medication, non attendance at outpatient appointments, the presence of children in the family home, marital disharmony and uncertain employment prospects. None of the above factors was considered in any formal sense by anyone other than Mr Condon. He and Dr Hand both report some informal discussion of these problems, but there is no formal record of any evaluation of these risks, or appropriate action being planned or delivered.**

51. **Dr Hand described a system of weekly "CPA reviews". We have found the system for simple CPA to be informal and unstructured, responding more to problems with individual patients than a systematic review of all patients and their progress (Chapter 3 paragraph 32).**

RECOMMENDATION 1

The Trust (CPT) should within six months

a) review the drafting and implementation of its CPA policy and

b) ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.

Additionally all policies must be dated and the date of implementation be clear.

See also chapter 4

RECOMMENDATION 2

The Trust (CPT) should ensure that all clinical and operational policies are consistent with National Guidance and are implemented promptly. All policies should be introduced with a detailed implementation plan that identifies resource implications, training requirements and changes from previous practice.

<u>Care Planning</u>

52. H had two periods of care in the community: from 17 June 1999 to 30 December 1999 and from 18 January 2000 until 14 November 2000. His care during the first episode was formulated by Ms Mansell and described in a multi-disciplinary treatment plan dated 30 June 1999. Care transferred from Ms Mansell to Mr Condon on 22 October 1999, but no new care plan was produced. The details of H's presentation during this time are set out in chapters 3 and 4.

53. His care during the second episode in the community was described in a multi-disciplinary treatment plan formulated by Mr Condon and dated 24 January 2000. A further care plan was produced by Mr Condon on 6 July 2000, but this related to care and interventions for M and was signed by her; as such it should not be considered a care plan for H.

54. Finally, a care plan was produced dated 14 November 2000 by Mr Condon, which describes a mixture of interventions for the patient and his partner. However, there is uncertainty as to when precisely this plan was written.

55. As stated in the previous section, H was initially considered by Ms Mansell to satisfy the requirements for simple CPA which, according to the practice at the time, meant that there was no separate CPA documentation. This decision does not appear to have ever been formally reviewed; H seems to have remained on this level by default.

56. Therefore the only summary of his proposed care is the multi-disciplinary treatment plan as described above. Ms Mansell stated that H had been allocated to her care probably on Tuesday 19 July. She had not been present at that meeting and believes she would have been informed by her colleague who had attended.

57. She subsequently telephoned H and made an appointment to see him at home, probably on 28 July. She describes having a detailed discussion with H and his partner following which she wrote the treatment plan. Two of the nine care interventions/actions described administrative actions: "liaise regularly with M.D.T" "Visit once a week approximately 1 hour". The other seven actions describe specific interventions designed to either understand or monitor H's illness or to increase his knowledge on management of his illness.

58. Ms Mansell visited H twenty three times during her engagement with him. Within the clinical record of these visits she made nineteen appointments to see him again. Of these seventeen took place as planned, one was cancelled by Ms Mansell due to a crisis elsewhere on her caseload, and the other was cancelled by H. These clinical entries describe H's symptoms at the time generally. They are presented in relation to his social context e.g. what was happening with regard to employment or his relationship with M.

59. During her interview Ms Mansell was asked to explain how the visits were conducted. She stated M tended to be present and was involved in the discussions. She described M as being a good source of information regarding H, particularly his compliance with medication. She never discussed the consequences of H's illness with M without him being present or made aware of the content of that discussion.

60. H's care transferred from Ms Mansell to Mr Condon on 22 October 1999. Mr Condon did not write a new care plan and does not appear to have negotiated

a change of frequency of visit. However, his first visit following handover was two weeks later and the next visit was a further four weeks later. During each of these visits Mr Condon records an improvement in H's mental state associated with improving employment prospects.

61. On 21 December he contacted H by telephone rather than a home visit. He recorded further apparent improvement in H's mental state and employment prospects. However, the following day he was visited at the CMHT base by M. She was distressed and described a significant recurrence of H's psychotic symptoms, associated with tension in the relationship. Mr Condon visited H at home on 23 December where he admitted to stopping his medication "sometime ago". Mr Condon records his view that compliance would remain problematic.

62. Despite this deterioration Mr Condon made no arrangements to support H or M during the Christmas period other than providing them with duty desk numbers. It is also noteworthy that Mr Condon records passing information to M without H's knowledge: "M also informed covertly that duty desk support is available and should be used". This is in stark contrast to Ms Mansell's approach of open, shared communication between H and M.

63. On 30 December M called the duty desk as H's condition had continued to deteriorate because he had not restarted his medication. H was subsequently admitted under section 2 of the Mental Health Act 1983 (MHA) to Trengweath Hospital where he remained until his discharge on 17 January, 2000.

64. On 14 January 2000, Dr Hand interviewed H and M together and agreed that he should have a period of weekend leave following which, if it went well, she would discharge him from his section 2 and from Hospital. H was visited on the 15 and 16 January by a CPN who reported the weekend had gone well. H was visited on 17 January by Dr Hand and Mr Condon who agreed he should be discharged from hospital and Section 2. No record was made of that visit by either Dr Hand or Mr Condon.

65. The next clinical entry was on 24 January, when Mr Condon visited H at home. Mr Condon also formulated a multi-disciplinary treatment plan dated 24 January. On this he described H's problem as "H has recently been discharged from T/G following a recurrence of his psychotic illness including

66. auditory hallucinations of a derogatory nature and paranoid thoughts against wife". The goals of care identified by Mr Condon were "for H's current stable mental health to be maintained and for planned separation from wife to be facilitated with minimum of trauma".

67. To achieve this Mr Condon identified seven care intervention/actions. Four of these were administrative: "offer CMHT contact numbers" "liaise with GP as appropriate" "liaise with Dr Hand re: ongoing OPA", "visit weekly". One related to the proposed separation: "explore at the appropriate time the question of amicable separation of H and his wife". One related to H's mental health: "ongoing assessment of H's mental health and efficacy of medication" and the final action describes liaison with M: "liaise with M to assess ongoing domestic situation and its effects on family". The above plan was to be reviewed in 3 months, but this never happened.

68. This was the only care plan produced by Mr Condon describing his proposed interventions to support H in the community. Throughout his time as H's key worker Mr Condon made twenty clinical entries. In sixteen of these he made appointments saying when he would see H next; five of these took place as planned and eleven did not. There is no explanation for why any appointment was delayed. The frequency of visits – weekly - described in the only treatment plan Mr Condon wrote for H lasted for three visits following his discharge in January 2000. , A review date for that treatment plan was not followed.

69. By 15 June 2000 M had secured alternative accommodation and was making plans to move in approximately three weeks time. On 4 July 2000 Mr Condon recorded a major argument between H and M regarding M's imminent departure. This involved threatening behaviour and made M fearful for her safety. Mr. Condon's clinical entry includes statements such as "[H] freely expressing thoughts of intense anger at M". "Surreptitiously agreed to meet M tomorrow to discuss evasive plans if she becomes fearful for her safety".

70. This meeting in fact took place two days later on 6 July and the full clinical entry states "Met with M this morning and appraised her of safety plan that I have compiled and informed her that I have spoken to Sergeant Nick Clarke (Domestic Violence Unit) all parties involved in Care/Safety plan informed. I will visit next week with Sean who will provide clinical cover in my absence".

The entry on 6 July describes Mr Condon making cover arrangements for a period of annual leave he was about to take.

71. The clinical notes contained the plan described in this entry. It is recorded on a multi-disciplinary treatment plan form and purports to be a plan for H. The problem is described thus "[H] has recently recovered from a severe psychotic illness and currently symptom free – wife now wishes to separate and her departure is imminent, causing [H] increased feelings of anger resulting in threatening behaviour towards [M], although no physical violence has occurred. The risk of this happening should not be minimised as date for M's departure draws closer". The care intervention/actions described all relate to M and not to H. There is no corresponding care plan describing interventions to maintain H during this traumatic period nor are there any clinical entries in the notes describing such discussions having taken place.

72. On 2 August Mr Condon had returned from leave and notes that the move had not yet taken place while the situation at home appeared to have deteriorated "[H] has been making threats of retribution if she leaves, although today he emphasises this is borne out of anger and not actual intent – although the potential remains very high. Has also stopped taking medication, although currently no evidence to suggest his psychosis has returned. For urgent liaison with Dr Hand."

73. There is no evidence of any liaison, urgent or otherwise with Dr Hand at this, or any other, time. Dr Hand stated that she only became aware of this safety plan when she scrutinised the clinical records following the homicide.

74. Despite the urgency and concern expressed in this entry of 2 August there is no clinical entry or apparent support provided to H or M during the next sixteen days. The following entry is the record of a phone call of 18 August with M when she tells Mr Condon she moved home "a week last Saturday". The move presumably took place on Saturday 5 August 2000. While Mr Condon continued to maintain that the reason he had not provided any support during the time when M moved to her new home was because he was on annual leave, scrutiny of his diary and correspondence with Sergeant Clarke indicated that the leave had taken place between 16 July and 2 August. Mr. Condon's diaries contained appointments between 2 and 18 August. He should therefore have been available to provide the support he himself had identified as being crucial to both H and M during this time.

75. The entry of 18 August relates only to a telephone conversation with M; there is no evidence of direct conversation with H. Mr Condon concludes the entry by saying "M sounded very relaxed and pleased at current status. M also feels that H's mental health status is stable. Agreed to see H when convenient to his work situation". The next entry relates to a telephone conversation on 24 August with H. The entire entry is as follows:

> eventual contact with [H] who was at [M's] new address family enjoying a barbeque this evening. [H] sounding well on phone – spoke at length about [M] moving out and anger being replaced by a wish on his part for the split to be amicable and stressed the importance of remaining friends for the sake of the children. Spoke about new job and appears to be enjoying this superficially (by phone conversation) no evidence of deterioration in his mental health and [H] spoke about CPN withdrawal as Crisis had now passed. Agreed I will review this over next few weeks.

76. Mr Condon makes no reference in either this entry or the one of the 18 August to H having reported stopping his medication during the home visit on 2 August. There is no mention of any liaison with Dr Hand. The review over the next few weeks does not take place and the next clinical entry is on 13 November when M contacted him to report H's arrest for breach of the peace that morning, the day before the homicide.

77. Mr Condon's final care plan in this case is dated 14 November. It was formulated on the basis of a telephone call from M on the morning of 13 November informing him that H had been arrested following a disturbance at her home. Mr Condon later visited M around midday on 13 November. He gained further information during that visit, and although the visit has no clinical record, some of the information gained then is included as if it was part of the telephone call earlier in the morning. Mr Condon also reports having discussed these issues with Dr Hand, and it emerged during his interview that this conversation probably took place mid afternoon on 13 November.

78. Mr Condon made a further entry regarding a home visit with H at 16.30 on 13 November. Mr Condon describes H as "looking subdued, despondent and unwell, very angry towards M whom he accuses of spreading malicious rumours about him concerning molestation of children. This has been done to destroy him". "Obviously unwell and delusional components similar to

when he broke down in Aberdeen. Admits to cessation of medication several months ago, I will maintain contact with M, but visits to H should BE MADE WITH CAUTION – MENTALLY VERY FRAGILE NEW CARE PLAN IN SITU".

Comment

78. Mr Condon's management of this case is very different from that of Ms Mansell. Ms Mansell's care plan predominantly related to the management of H's illness, her visits followed the arranged frequency on all but two occasions and her clinical entries described H's mental health status at that time and contextualised this in his domestic and employment circumstances. While Ms. Mansell did not review this plan according to her original time scale, that is one month, the nine actions/interventions which she formulated remained relevant and accurate throughout her engagement with H.

79. Mr Condon's care plan contains mainly administrative details and makes only cursory reference to the fact that H is mentally ill. The only appointments Mr Condon kept as arranged were two or three following H's discharge from inpatient care in January 2000; all of the others were either days or weeks later than arranged.

80. While Ms Mansell made sure H was aware of all the conversations she had with M about his mental health or other circumstances, Mr Condon quite deliberately made arrangements to discuss matters with M so that H would not know what was being planned. Whatever the risk may have been to M this was inappropriate in the context of H's mental state where he believed M was plotting against him. This approach is exemplified in the safety plan produced by Mr Condon on the 6 July 2000. This is explicitly a plan for M and not for H. There was no equivalent care planning or discussion with the patient nor was the plan discussed with the patient's RMO, Dr. Hand. This is remarkable since the plan incorporates the active involvement of another statutory agency, the Police.

81. We consider Mr Condon's practice over his discussions with M, the lack of a care plan for H and the lack of formal reviews with Dr Hand were unacceptable, particularly as H's delusions when ill were focused on M "ruining" his life.

82. Dr Hand's evidence that she only became aware of the safety plan when she reviewed the clinical records following the homicide is an indication of the lack of supervision of care planning at the material time in the Cornwall Health Care Trust. Throughout their interviews both Mr Condon and Dr Hand stated the view that they must have discussed H from time to time. Dr Hand described being aware of the tensions around the time of the planned split of the relationship and M moving to alternative accommodation. However, such discussions were never formally recorded anywhere. Mr Donnelly, Mr Steer, Ms Hostick and Mr Bridges all stated during their interviews that at the material time there was no formal robust process in the Trust for auditing the content of care plans or clinical records. We have been told that such measures are now in place.

83. Mr Condon's clinical entries for 13 and 14 November purport to be contemporaneous records, but in fact neither can be. The first entry contains information which was not available at the time. Indeed there is information from three separate episodes: Mr Condon's conversation with M on the telephone, his visit to M's home later that day and his conversation sometime mid afternoon with Dr Hand. The second entry suggests it was made at 4.30 p.m. on 13 November, while the care plan stated to be in situ is dated the following day, that is 14 November. These issues were explored with Mr Condon during his interview, and at that time Mr Condon stated that he believed the entries were made on the morning of 14 November.

84. The care plan produced by Mr. Condon has questionable provenance regarding the time it was written. It does, however, demonstrate a passivity on Mr Condon's part in response to the unique and dramatic events of 13 November. Mr. Condon had not seen his patient for around 15 weeks, at which time he had been made aware that H had stopped taking his medication. He was now aware that circumstances had deteriorated to the extent that H had created a disturbance at M's home at 7 a.m. sufficient to warrant his arrest.

85. When Mr Condon saw H later that day he had been unable to persuade H to attend the emergency outpatient clinic appointment Dr Hand had arranged for him. During his conversation with H, H demonstrated florid

psychotic symptoms e.g. delusions re: spreading of rumours about child molestation. Mr Condon's plan in response to this is at best defensive. The care interventions actions formulated are as follows:-

1.	Attempt to maintain regular contact with [H] accepting he will attempt to sabotage contact.
2.	Retain regular contact with ex-partner as an intermediary contact point if 1. fails
3.	If requested to attend either [M's] home or [H's] home due to disturbance/disturbed behaviours ascertain circumstances and exercise caution.
4.	Determine probable need to attendance by two male staff
5.	Liaise with local police as appropriate
6.	Liaise with GP, Consultant and Social Services if necessary to facilitate Mental Health Act assessment if deemed necessary.

86. This plan does not address any issues of vulnerability of H as a consequence of stopping his medication, his deteriorating mental health or the threat that might pose to his judgement. Neither does it address the vulnerability of M. The only reason for contacting her is as an intermediary should H avoid contact with Mr Condon in the future. This begs the question as to whether Mr Condon believed the circumstances on 13 November to be less dangerous than those on 6 July when he felt the need to put in place a safety plan for M. The plan appears to address Mr Condon's safety in points 3 and 4, whilst point 6 suggests an awareness of the seriousness of H's mental illness at that time.

87. This was a situation maintained by the poor CPA procedures in place, as described above, and the lack of any auditing process to reveal the problems in practice which this caused. We believe the deficiencies in Mr Condon's practice should have been picked up through a process of formal review that should have been part of the CPA, clinical supervision and audit. They should have been addressed through adequate training.

88. When asked about systematic audit of clinical records Mr Donnelly stated:

> There was no systematic audit when I arrived and now every month 10 records in each CMHT are pulled as random as anything can be so that you have 60 every month and these are part of the care co-ordination audit so that we can ……. but they do it against the check list proforma of this present, or that present, have they considered education, has it been signed……. but there was no system in place when I started.

89. Ms Hostick, during her interview on 23 January, described a system at the time where teams self-audited care plans as part of supervision. This was a tick box exercise and provided feedback to individual clinicians. The system was not as comprehensive or regular as she would have chosen; she stated "I know from Vic and the practice care managers latterly, that [care plan audit] is in place all of the time, but back then it was not such a regular formatted experience it was done when we could. Certainly you would think, 'We have not done that for ages, we must do that'".

90. Mr Bridges supported the position as described by Ms Hostick, he also stated that this system was something which he had developed himself, as it was not a requirement of the Trust. "It was something I did off my own back to be honest, because there was not a requirement".

91. Mr Steer when describing the process at the time (and subsequently) for auditing clinical records stated:

> Then it would have been very much down to the ability of the line manager to ensure that they provided supervision to the staff member…..There would have been some random audits, but there was not the definition that there is today with regard to someone having accountability in each team as a Practice Care Manager to view and demonstrate and audit records that that was not in place……We have identified earlier in the conversation, the audit processes would not have been in place to ensure that was happening and, as we have moved on in the evolution and development of the provision of mental health care, care co-ordination now and the documentation is very, very clear and in this present day – if I can comment on it – there is someone in place to ensure that.

RECOMMENDATION 3

The Trust (CPT) must audit the quality of clinical record keeping within six months. This must include the relevance of clinical entries to the patient's care and the comprehensiveness of that record and compliance with Trust policy and procedure.

RECOMMENDATION 4

The Trust (CPT) should commission an independent review of the changes to clinical policies and practice described by senior managers to the panel in the course of this inquiry. In particular the review should measure the effectiveness of these changes at the patient interface.

Clinical Supervision and training

92. The problems described above relating to clinical record keeping and practice should have been identified and addressed partly through the process of clinical supervision. The panel was supplied with a number of documents describing supervision arrangements before and after the homicide. The panel was also supplied with copy of Mr Condon's diary entries for the period he was H's keyworker. The diaries show four appointments for clinical supervision in this timescale.

93. In his interview, however, Mr Condon stated that he had monthly supervision with his G grade colleague. During this meeting the supervisor would ask Mr Condon if there were any particular problems with his caseload. Mr Condon also stated that both he and his supervisor kept a record of the content of the supervisions sessions. It proved impossible to obtain a copy of these records either from the Trust or Mr Condon. The Trust could not say whether such records had been retained or destroyed, Mr Condon said he had kept his copy but could not find it.

94. During her interview on 23 January, Ms Hostick described the supervision arrangements at the time of the homicide as being a fairly standard hierarchical arrangement where she would supervise the team leaders who would in turn supervise the G grade CPNs or the equivalent senior staff of other professions in the CMHT and they would then supervise the F grade CPNs.

95. Ms Hostick showed the panel a standard form for recording clinical supervision that had three sections: educative, restorative and enumerative. Ms Hostick went on to say that these forms were available to staff, but not all staff used them. She did state that whether or not the form was used, supervision followed that format.

96. Mr Steer during his interview on 23 January described the model of clinical supervision as follows "the model has been very much a confidential, self-initiated, restorative, reflective process".

97. Additionally, the Trust wide arrangements for access to both clinical and managerial training were imprecise and seemed also to act as a disincentive to accessing training. Mr Donnelly described arrangements for management training when he arrived as being a box of videos: "there was no formal support at the time in the Trust for management development or coached management development. I set about doing some myself. My approach to the training department led me to a box of video tapes as a basis for management development".

98. When discussing the availability of clinical training Mr Donnelly said "first of all when I first arrived there was no system for identifying training needs. Not only were there no systems for identifying training needs there was no system for identifying whether training had been undertaken and I am still struggling to get them to tell me who had undertaken what bit of training, because Mark [Steer], Maggie [Hand] and I were very clear that what we wanted to do was to close the net on those people who did not put themselves forward for training and to set standards for CMHT's for so many days training each year on some of the key topics".

99. The clinical supervision arrangements in place at the time of the homicide were consistently described as 'supervisee led' and following a 'cascade' or 'hierarchical' model. While such models tend to be fairly formal and regularly monitored it would appear that at that time, in the Cornwall Health Care Trust, much of the responsibility for supervision and its recording rested with individual clinicians. This position was repeatedly stated by Mr Steer during his interview with the Panel.

100. Ms Hostick pointed out that within this hierarchical system the supervisor would almost always be the supervisee's Line Manager. As such it was possible to conduct managerial and clinical supervision simultaneously. Within this arrangement the supervisee's training requirements should have been routinely identified.

101. Mr Condon's diaries from the time he was H's key worker show four entries for clinical supervision, 6 August 1999, 27 August 1999, 2 February 2000 and 5 September 2000. When asked what training he had attended since returning to clinical practice, either as a consequence of clinical supervision or through other routes, Mr Condon stated that he had updated himself mainly through a process of self-learning by reading, learning and keeping up to date as much as he possibly could. When specifically asked what training courses he had attended, Mr Condon stated "I have never actually gone on many courses, I must admit".

102. Scrutiny of Mr Condon's diaries suggested he may have attended some half-day courses regarding computerised records. However, many of these were crossed through in the diary. Mr Condon did not identify any of these as training events during his interview. The only course Mr Condon identified was a one-day course on risk assessment which happened after the homicide.

103. Mr Donnelly described the problem of identifying which members of staff had undertaken what training during his interview.

104. Mr Steer was very clear when he described supervision arrangements at the material time to this inquiry: "at the time of the incident it was very much left to the local teams to have in place the line management process and mentorship to individuals to ensure that they were competent". Mr Steer emphasised that for all aspects of supervision and identification of development plans and training needs it was left to either individuals or local managers to make suitable arrangements, rather than following formal Trust wide procedures. However, such procedures were now in place across the new Trust.

Comment

105. It would appear that the absence of formal arrangements for supervision and review contributed to Mr Condon's ability to remain without any training from when he returned to clinical practice in 1995 up to and beyond the time of the homicide. Whilst it is true to say that individual clinicians bear responsibility for identifying their training needs, their employers must share the responsibility for monitoring their fitness to practise.

106. The Trust produced a strategy for education, training and development dated January, 1996. In this document post registration, education and practice (PREP) requirements as defined by the United Kingdom Central Council (UKCC) for Nursing and Midwifery (later replaced by the Nursing and Midwifery Council – NMC) are described:

> The UKCC requires all nurses to demonstrate their attendance at the equivalent of five study days in 3 years in order to maintain registration. Each registered nurse is accountable and responsible for maintaining evidence based professional portfolio of learning outcomes gained through work experience and professional development equating to attendance at five study days in three years. It is clear that the trust must take responsibility for ensuring that a range of in-house study days and/or secondment experiences are available for nurses to select from, that are of relevance to their current practice. Subsequent negotiation of attendance at courses and portfolio maintenance is the responsibility of the individual and will not be a function of the Training Department nor should it be the role of managers to police the fulfilment of the PREP requirement. It is anticipated that nurses will voice, negotiate and agree their development needs at IPR/Appraisal with subsequent liaison with the Training Department.
>
> Key Points
>
> 1. All nurses have a statutory requirement to attend the equivalent of 5 study days in 3 years and maintain a professional portfolio of learning outcomes.
>
> 2. The Trust has a responsibility to ensure all nurses have access to study days of relevance to their specialist area of practice.
>
> 3. It is the responsibility of the individual to access study days/courses in negotiation with line managers.

107. In the case of Mr. Condon, he quite clearly failed to meet the professional nursing requirements defined by the Nursing and Midwifery Council for Post Registration, Education and Practice (PREP). This was not identified at the time, or apparently subsequently, by the Trust.

RECOMMENDATION 5

The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.

RECOMMENDATION 6

The clinical supervision arrangements described above (paragraphs 92 to 104) must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 7

The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

RECOMMENDATION 8

All agencies must ensure that all documentation likely to be of relevance to an internal or external inquiry is secured as a matter of priority following a serious adverse event.

<u>Social Worker Co-location</u>

108. In January 1999 social worker co-location with CMHT's was implemented throughout Cornwall. This has failed in the Kerrier district largely because of a disagreement between the CHT and Social Services over the appropriate supervision for ASWs.

109. In practice this meant two ASWs were allocated from the previous Social Services mental health teams to be based with each of the six CMHTs across the county. During her interview on the 15 May, Sandra Whitehead, Assistant Director of Community Care, Cornwall Social Services, described both the rationale and the preparation for Social Worker co-location. Ms Whitehead stated that from the point in 1998 when co-location was agreed it was always

intended that the ASWs would be line managed by the CMHT team leader and clinical manager.

110. During his interview Mr Donnelly described being pleasantly surprised, when he took up post in September 2000, to find that co-location had been in place for some 9 months. However, he soon realised that there were persistent problems associated with co-location. Mr Donnelly described his impression that co-location had been imposed on ASWs rather than emerging as a positive new direction from a stakeholder process.

111. Mr du Feu was one of the ASWs co-located to the West of Cornwall CMHT. In his written submissions to the panel Mr du Feu had identified co-location as a major problem and this was explored during his interview with the panel on 8 January. Mr du Feu described the process of co-location and the changes this meant for ASWs. He identified three aspects of co-location which he found problematic. Firstly ASWs were to be managed by the CMHT Managers, but they remained Social Service employees and their former Social Services Managers retained responsibility for ensuring that the cases they were allocated were appropriate. Social Services Managers also retained responsibility for administrative issues such as booking holidays, sickness absence monitoring and health and safety issues. Mr du Feu, and other ASWs within West Cornwall CMHT, found this dual accountability difficult.

112. The second problem identified by Mr du Feu was a reduction in the range of tasks he undertook following co-location; essentially he believed that his work become dominated by statutory Mental Health Act work. He attributed this in part to the reduction in the number of ASWs routinely undertaking these activities. Prior to co-location work had been shared by five ASWs in the Social Services Mental Health Team. Following co-location this work fell almost exclusively to the two co-located ASWs.

113. The final problem for the West Cornwall ASWs identified by Mr du Feu was the most significant in his opinion and this was the professional supervision arrangements for ASWs following co-location. This issue was acknowledged by Ms Whitehead, Mr Donnelly, Ms Hostick, Mr Bridges, Kay Green (Social Services general manager), and Mike Faulds (Social Services senior operations manager).

114. Essentially the question was whether it was possible or appropriate for ASWs to receive professional supervision of their Mental Health Act work from anyone who was not themselves an ASW, and perhaps more particularly from a different profession, that is nurses.

115. It was the view of CMHT management in West Cornwall that it was not possible for cross discipline supervision of ASWs and the social services took the opposite view. Social services evidence was adamant that it had been agreed prior to formal implementation of co-location that supervision of ASWs would be conducted by the CMHT leadership and this was what was expected of them.

116. Social Services provided the Panel with correspondence between Mr Bridges and Neil Doverty, who was the Social Services Policy lead at the material time. This correspondence described the problems as perceived by the West of Cornwall CMHT managers and their co-located ASWs, particularly Mr du Feu. In addition to the correspondence provided, all of the Health and Social Services Managers interviewed by the panel described regular meetings between the agencies where the issue of co-location was debated, particularly but not exclusively, supervision arrangements for ASW.

117. Co-location and particularly supervision and workload issues became the focus of extensive interagency discussion from its introduction in January 1999 up to and well beyond the time of the homicide. Mr Donnelly and Ms Whitehead separately described their perceptions of the reasons for this intractable problem. Ms Whitehead suggested that this was really only an issue in the West of Cornwall CMHT. The other five areas may have had some teething troubles, but these had been quickly resolved with co-location becoming an effective example of joint working. She also described the process by which Social Services audited the level of ASW work in the West of Cornwall and their allocation of additional resources. In Ms Whitehead's opinion there should have been no problem for CMHT managers in providing supervision for ASWs. She described a body of common practice and knowledge between the professional and standard managerial supervisory practices that could and should have been used.

118. Mike Faulds and Ms Green explained a different mechanism of supervision available to ASWs. In essence there was a cohort of senior social work managers who were ASWs, any ASW could access any of these managers

and use their professional expertise to explore issues of concern they might have. Ms Whitehead and Mr Faulds also described an extensive programme of training and support for its ASWs instituted in 1998 and designed specifically to support ASWs and maintain and develop their professional competence. These sessions were known as training all day sessions (TADs) and practice and mentoring sessions (PAMS). Mr du Feu acknowledged that this training and support programme was in place, but did not accept that this constituted professional supervision as he had received it prior to co-location.

119. During their interviews Mr Bridges and Ms Hostick stated very clearly that they did not believe they were competent to supervise the statutory work of ASWs. They referred to the code of professional conduct for nurses, specifically the requirement that they would not undertake any work which is outwith their personal competencies. Mr Donnelly agreed with these views.

120. The view of the independent ASW expert instructed by the Panel on this issue was unequivocal and stated that professional guidance on ASW practice cannot be provided by CMHT managers "unless they have the appropriate professional background and knowledge, that is, they have been ASWs or ASW advisors." This position was also taken by the Social Services Inspectorate during their visit to Cornwall Social Services Department in 2001. In response, specific professional supervision arrangements for statutory work were put in place for ASWs within CMHTs by Social Services between August 2001 and March 2002.

121. It would appear that the consequence of these differing views was to produce an impasse. Social Services believed they were providing robust supervision and support arrangements for co-located ASWs, while health service managers, and particularly nurses in management, believed they were being asked to perform duties outside their sphere of competence. Extensive meetings over many months, perhaps years, at various tiers of management and exchange of correspondence failed to resolve this issue in the West of Cornwall.

122. It emerged during the evidence that, following the homicide, Social Workers were withdrawn from the Kerrier area of the West of Cornwall CMHT. This was confirmed by both Mr Donnelly and Ms Whitehead. ASWs for the Kerrier area are currently being directly managed by Social Services.

123. Mr du Feu's performance of his duties in respect of this homicide is explored elsewhere, but within this section the issue under consideration is whether the difficulties described above were sufficient to have contributed to the identified deficiencies of performance. Ms Whitehead in her evidence to the panel, both written and oral, was unequivocal. Cornwall Social Services Department had reviewed Mr du Feu's performance following the homicide and had concluded that he had discharged his duties effectively on 13 November.

124. Ms Whitehead's evidence demonstrated that Social Services had provided extensive training and support for all ASWs including Mr du Feu. They had also audited workload and provided evidence that the demand on ASWs to conduct Mental Health Act assessments was not excessive.

125. Mr du Feu, however, clearly believed his work experience deteriorated as a consequence of co-location. He did not feel supported professionally, and he believed that the range of duties he performed had narrowed. During her interview Ms Whitehead painted a picture of Mr du Feu as an experienced and long-serving ASW who was no longer enjoying his work.

Comment

126. All of the evidence described above clearly shows that in the West of Cornwall co-location did not work, particularly for Mr du Feu. Managers at all levels in health and social services were unable to resolve these problems in this CMHT. Mr du Feu decided at some point after the homicide that he needed a change of work environment and he secured an alternative post within Cornwall Social Services. The Social Workers who replaced him in the West of Cornwall CMHT were no more successful at making the system work. Social Services took the decision to withdraw the Social Workers from the CMHT and they are still being directly managed by Social Services. The Panel believe this to be an unacceptable position.

127. We endorse the view that the ASW carries specific statutory responsibilities in the discharge of his/her duties which places a burden on them over and above that of other practitioners. We do consider that this requires direct supervision from a practitioner of the same discipline.

128. **Health and Social Services have a duty to maximise the effectiveness of their interagency working for the benefit of people who are mentally ill. They do not appear to have discharged this responsibility. We recommend that this anomaly receives urgent attention from both organisations.**

129. **We accept that the problems associated with co-location were such as to make working within the CMHT difficult and unsatisfactory for Mr du Feu and his ASW colleagues. We do not think that they are sufficient to mitigate the deficiencies of Mr du Feu's professional practice as an ASW of long standing on 13 November 2000. Our view is that he was left exceptionally jaded by these arrangements and allowed this to affect his work. We are critical of Cornwall Social Services for failing to act on the matter given Ms Whitehead's evidence that Mr du Feu was no longer enjoying his work before the homicide. They did not act even after the homicide, until Mr du Feu himself asked for a change of job.**

RECOMMENDATION 9

The Trust (CPT) and Social Services must act to resolve the co-location difficulties in the West of Cornwall CMHT. Appropriate professional/clinical supervision that is acceptable to the body of practitioners must be provided for all staff. We recommend that external expert advice be sought on this issue and that the recommendations of the Social Service Inspectorate be taken into account.

RECOMMENDATION 10

The Trust (CPT) and Social Services must as a matter of urgency review the effectiveness of their joint working at all levels of both organisations.

Internal Review

130. This Inquiry has investigated two separate homicides in Cornwall. In the course of our investigations we have reviewed the internal investigations conducted after each homicide. The different processes conducted in each case are striking, as are the reports submitted to the Cornwall Healthcare Trust (CHT) Board for consideration. In summary we believe the other internal review[5] closely followed its terms of reference and produced a comprehensive and coherent report for the Trust Board's consideration.

131. The CHT took the lead in what became a joint process with Cornwall Social Services. The internal inquiry into this incident has two clearly defined phases. The first was in an immediate review conducted by Ms Hostick, the second was commissioned by the then chief executive, Frank Harsent, and involved Dr Mary Lindsey, the then medical director, and Mr Steer, the then assistant director of nursing. We find Dr Lindsey and Mr Steer's review to be flawed and to have either consciously decided not to follow the terms of reference set by the chief executive, or construed them unjustifiably narrowly, so as to exclude consideration of the actions of individual practioners and the care of H leading up to 13 November. While the quality of this report is criticised the panel is concerned that neither a) the actions of the ASW co-located within the West Cornwall CMHT nor b) the actions of the key nurse (CPN) responsible for monitoring H in the community, were reviewed. Mr Steer, as lead nurse for mental health should have reviewed the actions of the CPN.

Immediate Investigation

132. Within three days of the homicide Ms Hostick produced a good report, the contents of which are as follows:-

a. Approved Social Worker Assessment – 13 November 2000

b. Summary of Events (Report 1)

c. Immediate notification of serious untoward incident

[5] See *Report of Inquiry into the care and treatment of S* published by South West Peninsula Health Authority on 19 September 2003

d. Accident/Incident Form

e. Statement by Mike du Feu, ASW

f. Statement by Derrick Condon, CPN

g. Incident Report

h. Appendices 1-4

i. Subsidiary statements:-

    i. Community Psychiatric Nurse

    ii. Occupational Therapist

    iii. Temporary clerk

    iv. Team secretary

    v. Medical Secretary

    vi. Medical Secretary

133. The incident report provides a synopsis of H's care since his first episode of mental illness up to and including the day of the homicide. The summary demonstrates the gap in contact with the CPN, Mr Condon, from the end of August 2000 until the 13 November. It goes on to describe the actions taken immediately following the homicide. This includes all the relevant notification of interested parties and the collection of statements from all key staff members. It goes on to describe actions taken on 16 November and concludes by identifying four issues for further consideration, these are:

a. Communication between assessors at the custody centre and regular care team.
b. Use of CPA
c. Inconsistencies in various areas
d. Aspects for greater in-depth investigation which may be required to take place.

134. This report is signed by Juliette Prowse (now Hostick) and dated 17 November. She told us that c. and d. above went together and referred to inconsistencies between the statements of the ASW, Mr du Feu, and the CMHT team at Bolitho House, relating to whether or not they received a call for Dr Hand from Mr du Feu at the Camborne custody centre on 13 November 2000. Ms Hostick was interviewed by Dr Lindsey and Mr Steer as part of the internal review and her report was available to them.

Board Level Internal Review

135. The Board Level Internal Review was conducted by Dr Lindsey, the then Trust medical director and Mr Steer, then assistant director of nursing. The review was commissioned by the then chief executive, Mr Harsent in a letter of the 16 November 2000. In this letter Dr Lindsey and Mr Steer are asked to do four things; "I ask that the two of you act as an internal review team and:

- Establish the involvement of mental health services with H prior to 13 November and form an opinion of their appropriateness.
- Review the actions of Trust staff after H's release from the custody centre on 13 November 2000 and form a view of their appropriateness.
- Review the use of risk assessment and a care programme approach for H.
- Recommend any changes to the mental health services as a result of any lessons learned."

136. The Panel were provided with all of the documentation assembled by Mr Steer and Dr Lindsey, this included Social Services documentation in the form of a report written by Mr Doverty and dated 18 December 2000 which included a chronology of Social Services contact with H. Dr Lindsey and Mr Steer also had access to Ms Hostick's initial incident review.

137. The notes documenting the progress of Mr Steer and Dr Lindsey's review contain a number of drafts of the action plan presented to the Trust Board, some handwritten notes of Mr Steer and the notes of two joint Health and Social Services meetings, the first on 20 November, the second on 18 December. There were no notes of interviews with staff. The people present at the meeting on 20 November were Mr Steer, Dr Lindsey, Mr Donnelly and Ms Whitehead. It was agreed to create a chronology of events relating to H's

care, health staff to be interviewed by Dr Lindsey and Mr Steer, and Social Services staff to be interviewed by Ms. Whitehead. The notes conclude as follows:-

> During the whole of this process the aim is to identify any *obvious or glaring issues that need correcting immediately*. (emphasis added) It is not the role of the internal review process to either apportion blame or to conduct an inquiry. The external inquiry will be commissioned by the Health Authority when or if [H] is convicted of homicide.

138. There is uncertainty as to whether this minute represented an agreed dilution of the terms of reference set by the Chief Executive or not. It is not documented as such. Mr Steer's view is that it reflects a decision to alter the original terms of reference agreed by managers at the highest level within the CHT. The result was that there is no evidence that the appropriateness of the actions of individual practitioners formed a part of the internal review. It was not contained in the paper presented to the CHT Board. Nor is there evidence that the appropriateness of the involvement of mental health services with H prior to 13 November was considered, and again it did not feature in the paper to the CHT Board.

139. The confidential paper presented to the Cornwall Health Care Trust Board Meeting on the 27 February 2001 was very brief. It stated:

> Alleged homicide of 14 November, 2000.
> Alleged homicide took place in [town], client [H] was arrested and held in custody.
> [H] was cared for by the Cornwall Health Care Trust Mental Health Services as an in patient and out patient.
> On the day before the incident [H] was taken into the custody centre following a disturbance at the home of his ex-partner, the deceased. [H] was assessed at Cambourne Custody Centre by an Approved Social Worker and a Police Surgeon who decided that a Section 12 Doctor Assessment was not necessary.
> Following [H's] release from the Custody Centre, attempts were made by his community psychiatric nurse to facilitate [H's] attendance at an emergency out patient consultant appointment, but he refused. The community psychiatric nurse visited [H] at home and instigated a new care plan on the afternoon on 13 November.

The attached papers reflect the outcomes of a review of the alleged incident and supporting clinical activity commissioned by the Chief Executive.
The review was completed by the Medical Director and the Deputy Director of Nursing.

140. This paper was supported by a combined chronology and action plan. The recommended actions are detailed below:

Ensure there is a clear criteria for the tiers of Care Management/Care Programme Approach.
Ensure the revised comprehensive risk assessment policy takes into consideration non-compliance with a care plan and medication.
Teams need to set standards in respect of care co-ordination, risk assessment/management and communication. Performance against these standards needs to be reflected in the clinical records.
Ensure that information sharing with other agencies is carefully planned and managed through the multi-disciplinary team. This is essential until the health community agrees on a sharing of information policy.
Clarify who, from the Cornwall Health Care Trust is responsible for liaison with the Police and in what forum, to enable better information sharing with regards to 136 issues and liaison with the Health Authority re section 12.2 arrangements.
Ensure that all agencies and administrative staff have a comprehensive orientation to their role.
Review the provision of community mental health team reception facilities to ensure reception staff have the ability to identify degrees of urgency and the actions to be taken.
Recommend liaison with the Police with regard to the role of the Police Surgeon.
Review communications systems at community mental health team bases, to ensure that communication is managed in a quality and effective way.
Review the line management of Approved Social Workers. All staff involved in 136 assessments to access and assess the client information that is practically available.
Emergency care plans need to clearly reflect the risks with time framed planned interventions.

141. The panel were told that this plan was agreed between the Trust and Cornwall Social Services Department. While the document was presented as a confidential Trust Board paper Ms. Whitehead informed the panel that within Social Services this report had been dealt with at officer level.

Comment

142. The Panel found the investigation by Ms Hostick to be timely and to raise proper areas for consideration by the internal review. The recommendations for further action were appropriate and should have guided the subsequent inquiry by Mr Steer and Dr Lindsey.

143. The minutes of the meeting on 20 November (above) demonstrate, in the view of the Panel, a dilution of the original terms of reference set by the Chief Executive and we have been told that this was the intended consequence by all those at the meeting and known to Mr Harsent. It was certainly Mr Steer's understanding that it was so intended. The second action detailed by Mr Harsent was to "review the actions of Trust staff after H's release from the Custody Centre on 13 November, 2000 and form a view of their appropriateness". Action one was to "establish the involvement of Mental Health Services with H prior to the 13 November and form an opinion of their appropriateness".

144. Taken together these actions required the scrutiny of the quality of individual practice of members of the CHT and Social Services staff since the Approved Social Worker was on secondment to the Trust and being line managed within the CMHT. They also required a scrutiny of the quality of contact with mental health services prior to 13 November.

145. By excluding these areas of investigation, there was a failure to scrutinise the clinical and managerial practice of staff involved in the incident and the operational processes of the CMHT. Mr Steer confirmed to the Panel that the internal review focused on procedural issues arising on 13 November.

146. The recommendations for further action made by Ms Hostick were apparently not followed through by Mr Steer and Dr Lindsey. In particular no effort appears to have been made to explore the ''inconsistencies'' noted by her which she told us referred to those

occurring between Mr du Feu's account of his attempts to communicate with Mr Condon and Dr Hand on 13 November and the written statements provided by the secretarial staff involved when interviewed by Ms Hostick. The chronology produced jointly by Health and Social Services reflects events as described by Mr du Feu as being factually correct, while the contemporaneous evidence gathered by Ms Hostick casts doubt on this account. We were not provided with a satisfactory explanation for why this had not been pursued.

147. Another serious omission as a consequence of this decision to alter the original terms of reference was the lack of any detailed scrutiny of the practice of Mr Condon, CPN, in the period leading up to 13 November. Mr Condon had no formal training to undertake the role of a CPN and, since returning to clinical practice in 1995, he had not had even a day's clinical training, but had learnt the job as he went along. Since the homicide he has attended one training course on risk assessment. Mr Steer's interview suggested that the Trust may have become aware of this problem as they now provide return to nursing courses which had not been provided previously.

148. The requirement to assess the care provided to H by mental health services prior to 13 November should have involved consideration of the content of his clinical records. Had this taken place the panel believes it would have been impossible to overlook Mr Condon's inadequate care planning, inconsistent care and effective withdrawal of monitoring of H without review in August 2000. Although the paper to the Trust Board indicated that a new care plan was instituted on 13 November, the plan was in fact dated 14 November in the records. Mr Condon stated that it was written up on a later date, but could not be precise as to when it was written.

149. We consider that the questions over the actions of Mr du Feu raised by Ms Hostick in her report and the poor practice of the key nurse, Mr Condon, constituted 'obvious and glaring issues' of the kind that required immediate attention as discussed at the meeting of 20 November.

150. **The panel does not accept the reasoning that such scrutiny would be more appropriately left to the independent inquiry. It is routine management practice to review the quality of care provided and, where deficiencies are identified, to institute remedial action, for example, training, as soon as possible, to avoid potential recurrence. It is always the case that completing the criminal process can take up to nine months or longer and a more immediate response is required prior to any external inquiry. Where an acquittal is the result, there will be no independent inquiry at all.**

151. **Even as the least senior manager present at the meeting of 20 November, the Panel believe Mr Steer must bear some specific responsibility for the dilution of the original terms of reference. This refers particularly to his more significant responsibility for the failure to review Mr Condon's practice. As the assistant director of nursing in the Cornwall Health Care Trust, Mr Steer was the lead nurse for mental health. As such he is accountable to the Trust Board, via Executive Nurse and the Nursing and Midwifery Council, for the standards of practice of mental health nurses employed by the Trust. This is clearly expressed in his job description of the time which states under 'Job Purpose': 'To provide high profile, visible and effective professional leadership to all Mental Health nursing staff and to be responsible for the quality of nursing practice with respect to the assessment, treatment and care of patients with Mental Health problems.' Under 'Key Results Areas' it states, amongst other things:**

- **To ensure high quality of patient care through the provision of expert and timely advice and guidance on all Mental Health nursing practice matters to (amongst others) Deputy Chief Executive/Chief Nurse**
- **To provide visible and effective professional leadership and direction to all Mental Health nursing staff and to act in a consultative role to advise on clinical, professional and ethical issues relating to their work to benefit input into patient care.**
- **To be responsible for the setting and monitoring of professional Mental Health nursing standards of clinical practice in conjunction**

with Clinical Managers to ensure that standards of care are maintained or improved as necessary.

- **To participate, as directed, in enquiries and investigations examining standards of nursing and clinical practice and to make recommendations to the Chief Executive and Chief Nurse for improvement as required.**

152. **It was the role of the internal review to alert the Trust Board and Social Services to deficiencies in practice, including of individuals. The proper process of accountability of services to the public demands this level of scrutiny so that immediate remedial action may be considered. In the context of the events discussed in this report, these deficiencies did not require any in depth investigation to uncover. We do not consider that it would be adequate to deal with serious deficiencies in individual practice at local management level alone.**

RECOMMENDATION 11

The Trust (CPT) policy on Investigating Serious Untoward Incidents should be reviewed to ensure its consistency with the guidance issued by the National Patient Safety Agency. Particular attention should be paid to a) root cause analysis, b) in all cases terms of reference should be followed and c) any change of these terms should be formally recorded.

List of Recommendations in Chapter 2

1. **The Trust (CPT) should within six months**
   a) **review the drafting and implementation of its CPA policy and**
   b) **ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of care co-ordinator and the regular, comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.**

   Additionally all policies must be dated and the date of implementation be clear.

2. **The Trust (CPT) should ensure that all clinical and operational policies are consistent with National Guidance and are implemented promptly. All policies should be introduced with a detailed implementation plan that identifies resource implications, training requirements and changes from previous practice.**

3. **The Trust (CPT) must audit the quality of clinical record keeping within six months. This must include the relevance of clinical entries to the patient's care and the comprehensiveness of that record and compliance with Trust policy and procedure.**

4. **The Trust (CPT) should commission an independent review of the changes to clinical policies and practice described by senior managers to the panel in the course of this inquiry. In particular the review should measure the effectiveness of these changes at the patient interface.**

5. **The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.**

6. **The clinical supervision arrangements described above must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.**

7. **The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.**

8. **All agencies must ensure that all documentation likely to be of relevance to an internal or external inquiry is secured as a matter of priority following a serious adverse event.**

9. **The Trust (CPT) and Social Services must act to resolve the co-location difficulties in the West of Cornwall CMHT. Appropriate professional/clinical supervision that is acceptable to the body of practitioners must be provided for all staff. We recommend that external expert advice be sought on this issue and that the recommendations of the Social Service Inspectorate be taken into account.**

10. **The Trust (CPT) and Social Services must as a matter of urgency review the effectiveness of their joint working at all levels of both organisations.**

11. **The Trust's (CPT's) policy on Investigating Serious Untoward Incidents should be reviewed to ensure its consistency with the guidance issued by the National Patient Safety Agency. Particular attention should be paid to a) root cause analysis, b) in all cases terms of reference should be followed and c) any change of these terms should be formally recorded.**

CHAPTER 3

FIRST ADMISSION TO HOSPITAL AND FOLLOW UP IN THE COMMUNITY

MAY TO DECEMBER 1999

- **Introduction**
- **H's psychiatric history**
- **Admission to Royal Cornhill Hospital, Aberdeen**
- **Admission to Trengweath Mental Health Unit, Redruth, Cornwall**
- **Clinical and nursing record entries**
- **Discharge from Trengweath Mental Health Unit**
- **Supervision in the community (Hilary Mansell, CPN)**
- **Supervision in the community (Derrick Condon, CPN)**

Introduction

1. This chapter documents H's psychiatric history from his first episode of mental ill health. His first admission to hospital took place in May 1999, while H was working in Scotland. Initially H was a voluntary patient but was later detained in hospital having been assessed as representing a risk to himself. After ten days H was transferred back to his home area in Cornwall into the care of Dr Margaret Hand, consultant psychiatrist at Trengweath Hospital, Redruth. He was detained under section 2 of the Mental Health Act 1983 (MHA) and was discharged home after seven days, on 17 June 1999.

2. His diagnosis was recorded as "acute psychotic episode" on this and his subsequent admission in December 1999 (Chapter 4). Following the homicide his diagnosis is of chronic paranoid schizophrenia. We do not consider there to be any issue arising as to diagnosis.

3. H was allocated a community psychiatric nurse (CPN), Hilary Oates (now Mansell) from the Penwith community mental health team (CHMT) to maintain contact with H after his discharge and to monitor his progress as well as to supervise and coordinate his care in the community. The Panel found Ms

Mansell to be a competent nurse and commend the quality of her work with H (see also Chapter 2, Care Planning, pages 35-45). His care transferred in October 1999 to CPN Derrick Condon, in whose practice we have found there to be deficiencies.

4. There were a number of features of H's mental illness that became increasingly apparent over the course of his contact with the psychiatric service. H's illness proved to be susceptible to oral antipsychotic medication and the florid symptoms during times of relapse resolved relatively quickly. However, H disliked taking medication and there were difficulties over his continued compliance with the medication. This led to deterioration in his mental state. His partner, M, figured prominently in his delusional beliefs. H saw her as being instrumental in getting him admitted to hospital and expressed much verbal anger against her.

5. The Inquiry found clear evidence of the effects on practice of the lack of proper implementation of the CPA policy, supervision and training as discussed in Chapter 2. Consequently, there was no proper discharge meeting, poor documentation around discharge and no formal multi-disciplinary reviews of H's progress in the community by the CMHT. Additionally, there were no contingency plans to address his non-compliance with medication.

6. During this period in 1999 H attended three outpatient appointments with Dr Hand's senior house officer (SHO), and the CPN home visits became increasingly sporadic over time and more superficial in their surveillance of H's mental state. We comment on this further in Chapter 4.

7. We set out below the clinical history of the May to June 1999 hospital admission of H based mainly on information from his records.

H's psychiatric history

8. When first admitted to hospital, in Aberdeen, H told staff he had no previous psychiatric history. While this was true in the sense that he had not been admitted to hospital nor received psychiatric treatment from his general practitioner, he had had previous episodes of being mentally unwell. Some of these episodes he did later acknowledge to hospital staff. The medical

member on the Panel, Dr Tim Exworthy, interviewed H as part of this Inquiry and an abridged version of the account he gave is included here for the sake of completeness and to give a sense of the manner in which his illness progressed over time. Some of this information was provided by M to the clinical team in Aberdeen which began the process of piecing together evidence of previous symptomatic episodes. H's sister has also confirmed possible prior episodes of mental illness that went untreated.

9. H recalled that his first episode of illness occurred in approximately 1980 (date per H), when he was working on the cross Channel ferries out of Dover (although there is evidence that it may have been a few years earlier than this when he was a merchant seaman in Japan). He developed the belief he was a messenger from God, and consequently took an interest in religious matters, which was a change in his character. He said he also became more introverted during this time. He described how one night, in a storm, he stripped off his clothes and stood at the bow of the ferry. Crew from the bridge spotted him and dragged him back to his cabin. H was sent home from work for a 'rest' but did not see his own doctor or the company's medical officer. After being off work for about a week he was informed he had been dismissed from his job. By this stage H said he was beginning to feel better and this was without being prescribed any medication.

10. H said his next brief episode occurred five or six years later, and by this time he was working on the ferries out of Southampton. H said that approximately six days into his job he started feeling persecuted by the crew and felt he had to leave the ship. The captain allowed him to go home, but shortly afterwards H was given the sack. H returned home to Cornwall and within a few days was back to his normal self.

11. Later, in about 1998, when H found employment working on supply ships servicing the oil rigs in the North Sea he became ill again. Gradually H began to believe other people were against him. He gave as an example an occasion when he was waiting at the airport to fly to Aberdeen. H believed the other passengers in the terminal were talking, laughing and joking about him. These feelings did not last long and he was able to disregard them, but H did telephone M from his ship to say something was going on but that he was not sure what it was. By the time of his fourth tour of duty H began to

believe the crew on his ship were 'persecuting' him. It was this trip which ended with H being admitted to the Royal Cornhill Hospital in Aberdeen.

Admission to Royal Cornhill Hospital, Aberdeen

12. H was admitted to the Royal Cornhill Hospital on 31 May 1999, having been escorted from the oil supply vessel on which he had been a crew member for the previous 3 ½ weeks. He was admitted under the care of Dr Douglas Fowlie, consultant psychiatrist.

13. On admission H was interviewed by a senior house officer (SHO) in psychiatry. H was very preoccupied and distressed and gave a history of feeling confused and of being hassled by other crew members whom he believed were accusing him of paedophilic activities. H said the accusations had started within a few days of him joining the ship. He felt picked on by the crew and thought they knew of his past although he did not know any of his crew mates. H was uncertain whether they could read his thoughts, described hearing voices inside his head and admitted to having visual hallucinations although was unable to elaborate on these. He said he did not feel safe in hospital and was regarded as being potentially suicidal.

14. At that stage H did not acknowledge any previous psychiatric history. He was described as having his first presentation to psychiatric services with a paranoid psychosis and auditory hallucinations, of unknown cause.

15. The following day the SHO had a telephone conversation with H's partner, M. She gave an account of H reporting similar events, namely of the crew accusing him of being a 'child pervert' and talking about him after his previous trip to sea. He had left Cornwall on 4 May 1999 to join his ship. M described him as an athletic person, who preferred his own company and had no close friends. He was 'fixed in conversations' and 'unable to change topics quickly'. She also described difficulties in their relationship with a number of arguments, and him easily losing his temper, but no physical violence was reported. M had wanted them to see a relationship counsellor but as H was against this the idea was dropped.

16. On the ward H remained paranoid and spoke of hearing the taped voice of M being played through the walls and ceiling. The content of the taped voice

was their arguments over the previous four months. In telephone conversations from the ward H accused M of being part of conspiracy against him and of disclosing details of his past to other people. He also claimed to hear verbal abuse from people walking past his room in the hospital.

17. On 2 June 1999 H believed hospital staff were telling him to 'get lost' as he was no longer 'wanted'. Assessment showed this to be a hallucinatory experience but he lacked insight into this. He wanted to leave the hospital but also feared he would be attacked or mugged once outside. He was regarded as ill enough to be detained under mental health legislation but was persuaded not to leave the hospital. Later that day he again wanted to leave. H was assessed by a specialist registrar in psychiatry, and detained under an emergency recommendation (section 25, Mental Health (Scotland) Act 1984) on the grounds of his health or safety.

18. On 3 June 1999 a small degree of improvement in his mental health was noted since starting medication (Risperidone 1 mg twice daily) but H remained 'suspicious and a little bemused'. The next day he was described as 'delusional and insightless' but had altered his view about his partner being involved in the conspiracy. Instead he suggested his neighbours were taping their conversations. H continued to experience auditory hallucinations and the dose of Risperidone was increased.

19. Also on 4 June Trengweath Mental Health Unit in Cornwall, the catchment area unit for H, was contacted to arrange for his transfer. Dr Hand, the catchment area consultant psychiatrist was on annual leave until the following Monday (7 June). At Trengweath her medical secretary took down details of the referral and also noted that one of the other doctors had advised the Royal Cornhill Hospital there were no beds available in the Trengweath Unit at that time.

20. H was interviewed by Dr Fowlie on 5 June. He remained deluded and believed, on the basis of auditory hallucinations, he was being 'accused of sexual exploitation of children'. Dr Fowlie observed H had 'fleeting insight' and although he could briefly accept the voices were not genuine he quickly returned to the delusions. On the basis of the 'continuing risk that he will end his life – as just punishment for his past' Dr Fowlie completed the medical

recommendation for continued detention in hospital (section 26, Mental Health (Scotland) Act 1984 equivalent to section 2 MHA 1983 for England and Wales).

21. Again H's detention was regarded as appropriate in the interests of his 'health or safety' but not including the protection of others. Dr Fowlie wrote '[H] is convinced that he is being persecuted because of molesting children. He is experiencing voices accusing him of being a pervert. He is haunted by these experiences and is convinced that he will be killed and consequently he might as well kill himself'.

22. The written entry for 7 June described H as 'delusional but less distressed since (increase) in Risperidone'. The next day he was described as 'interacting more with other patients …. Superficially more forthcoming and denying suicidal thoughts and feeling persecuted'. However, on closer questioning H acknowledged he had to accept the fact that people were 'getting at him'.

23. The plan to transfer H back to Cornwall as an inpatient remained. On 8 June Dr Hand wrote to Dr Fowlie's specialist registrar, at the Royal Cornhill Hospital, confirming the availability of a bed for H at the Trengweath Unit on 10 June.

24. The specialist registrar's discharge letter to the general practitioner, Dr Nicholas Gibson, dated 9 June 1999, recorded H had 'developed paranoid ideas while working on supply vessel. Became disturbed and ship returned to port in Aberdeen'. He was said to have 'initially (been an) informal patient but required to be detained on 2/6/99 under section 25 as he became more paranoid and wished to leave. Now on section 26. At no point has he been so disturbed as to require to be restrained. No management problem'. His diagnosis was given as 'possible schizophrenia' and his mental state on transfer as follows: 'remains paranoid. Believes he has been accused of child abuse. Also experiencing auditory hallucinations'. At the time of transfer H was being prescribed Risperidone 2mg twice daily along with Lorazepam (4mg four to six hourly) and Droperidol (10 mg four to six hourly) on an as required basis.

Comment

25. **The Inquiry Panel regarded H's assessment and treatment at the Royal Cornhill Hospital as entirely appropriate. The main symptoms were described and recorded clearly. They included persecutory delusions and auditory hallucinations, which initially incorporated H's former crewmates. However, within a short space of time they clearly related to H's partner, M. Features also present at that stage included other psychotic symptoms such as the possibility of having his thoughts read by other people, probable visual hallucinations and being potentially suicidal. In addition H's understanding that he was mentally unwell was absent to begin with and never more than 'fleeting'.**

26. **H was seen as a temporary admission until his transfer back to Cornwall could be organised. Nonetheless, H's partner, M, was contacted and she provided further background information not only about his previous episodes of psychiatric symptoms but also about the relationship difficulties they were experiencing. At that stage any risk considered towards M from H was in the context of their domestic situation, although M was specifically mentioned by H with regard to his symptoms and he identified her as being part of a conspiracy against him. The temporary admission of H and the physical distance between H and M at that stage produced obvious limitations on the completeness of the assessment of H prior to his transfer back to Cornwall.**

27. **The clinical team were also beginning to piece together details of previous symptomatic episodes H had experienced. These had not reached official psychiatric attention before but suggested an underlying relapsing condition. H was not cooperative with this process. At the time of his transfer to Cornwall, H was already showing a response to his prescribed, oral medication.**

28. **H had initially been admitted as an informal patient but when he made repeated requests to leave hospital he was detained under Scotland's mental health legislation. He was regarded as being a risk to his own safety and had insufficient insight into his condition to be allowed to leave hospital**

Admission to Trengweath Mental Health Unit, Redruth, Cornwall

29. H was transferred from Scotland while detained under section 26, Mental Health (Scotland) Act 1984 on 10 June 1999. In Cornwall this translated automatically into a detention under section 2 Mental Health Act 1983 (MHA).

30. H was admitted to Trengweath Mental Health Unit under the clinical care of Dr Hand, consultant psychiatrist.

31. Dr Hand told the Inquiry Panel that in the period when the homicide occurred she had a dual role, working as clinical director and also as a consultant psychiatrist. She said her catchment area responsibilities covered the practices of three general practice surgeries with a total population of approximately 30,000. She held an outpatient clinic once a week and on average would see six patients.

32. In addition, there was what she described as a "CPA review" meeting each Friday when CPNs would attend to discuss their patients. It was left for the CPNs to determine who was to be seen in the meetings and could include patients and their relatives. Patients were reviewed approximately every three months, or sooner if required, and the next appointment was fixed at each meeting. On occasions a CPA review would be conducted by a CPN alone, but Dr Hand told us she was always available for an emergency review. She also conducted a 'substantial' number of her CPA reviews during her outpatient clinics. A CPA review meeting would be followed each Friday by a CPN review when they could run through their caseloads, briefly mentioning those who were causing concern.

33. These Friday meetings were informal, with no systematic review of all patients, unstructured and not recorded in the patients' clinical records. Dr Hand also held a weekly ward round, which was attended by a CPN who could provide a link with the CMHT. She was assisted with her clinical workload by a senior house officer (SHO), whose work and supervision she was responsible for, occasionally a specialist registrar and, in the community team, a part-time clinical assistant.

34. Dr Hand saw H on admission and recorded:

> obviously improved recently. Still feels he was being persecuted though belief not unshakeable. Denies suicidal thoughts, not currently experiencing aud[itory] hallucinations. Keen to get home. Plan - observe mood/sleep/appetite, continue his med[ication], I/V [interview] with girlfriend, CPA before discharge ?Mon [i.e. 4 days time], escorted leave.

35. She authorised escorted leave for H, initially of half an hour and for increase if successful, on the appropriate form for section 17 leave.

36. On admission H was also assessed by Dr Hand's psychiatric SHO. H was described as having an 'acute psychosis'. It was recorded he had been 'paranoid that co-workers were talking about him and hearing voices. Became convinced was going to be killed'. His symptoms had settled with Risperidone and he was said to be 'now back to "normal"'. H was seen along with his partner and a 'long history of episodes of feeling others talking about/against him' as well as 'tensions at home' was elicited.

37 On behalf of the nursing team a staff nurse made a brief entry on 10 June to document H's transfer from Aberdeen. The entry made no comment on H's mental state or the management plan. In another section the presenting problem for the admission was documented as 'increasingly paranoid and suspicious over the past six weeks. Has admitted to hearing voices'. The staff nurse also completed a mental state assessment pro forma. This recorded H as presenting as 'casually dressed, clean shaven and showered'. He was described as 'slightly suspicious' in behaviour, his mood/emotions as 'calm/a little bewildered' but having no obvious thought disorder. It was said he had recently (that is a month ago) heard voices, was orientated, had good concentration and memory and 'recognise(d) things have not been right'. The provisional diagnosis was of a 'psychotic presentation'.

38 On the Risk Identification Section form the staff nurse assessed H's level of risk as 'unknown' in the four domains of Relapse, Neglect, Harm to self and Harm to others. Under the heading 'What events or situations would increase the likelihood of the person being at risk' the nurse wrote 'Recently lost his job but does not know this'. 'Increasingly paranoid behaviour' had been given as the observable feature if risk in any of the categories were increasing. An

immediate safety plan was ticked as being in existence. This seemed to refer to the multidisciplinary treatment plan, dated 10 June 1999.

39 The goal of that treatment plan was stated as 'full and thorough review of [H's] mental state in a safe and supportive environment'. The specific actions were as follows:

1)	provide [H] with information re his current detained status,
2)	monitor and record [H's] current mental state presentation. Noting in particular any psychotic phenomena,
3)	give [H] time to ventilate any fears or worries,
4)	for [H] to be checked every 15 [crossed through and rewritten as 60] minutes to assess his current mental state,
5)	liaise with his partner re any additional information we require.

Comment

40 The treatment plan addresses assessment of H's mental state more than risk of self harm and ignores the potential risk to others. Approaches to M were to be made on the basis of what information the hospital needed to know rather than to hear what information she might hold about H.

41 The absence of entries on the Risk Identification form should have acted as a prompt to the clinical team to complete their own risk assessment of H. There is no indication this was carried out in a systematic way nor recorded as such. It should not need stating that the assessment of risk and the level of risk is essential for all patients detained under the MHA. The detention criteria explicitly refer to risk of harm to self or others.

<u>Clinical and nursing record entries</u>

42 On 11 June Dr Hand made an entry referring to a conversation with M the previous day. M was said to be 'understandably upset at recent events and frightened anxious about [H]. Very supportive but needs reassurance and education re [H's] condition'. There was no documented exploration of M's ossible concerns about having H back at home again.

43 The nursing entries on that day reported H as being 'very settled and [having] no signs of any paranoia'. Later he was said to be 'anxious' about being in hospital and wanted to go home. He was informed he needed to see his consultant first as he was detained under the Mental Health Act.

44 In the evening of 12 June H was 'very appropriate' and talked about his job although he was uncertain whether he had lost it because of his behaviour. The next entry recorded a telephone conversation with his partner who had rung to inform staff she was going to tell H he had been dismissed from his job.

45 On the following morning (13 June), although H had been compliant with taking his medication, he did speak about his wish to stop taking the Risperidone 'as he now feels he doesn't need it'. He accepted advice to continue with the medication until he was seen by a doctor on Monday. In addition, H spoke about 'an ongoing conspiracy' against him in which his family was involved. He did not appear alarmed or agitated by this thought ….. the thoughts of a conspiracy did appear entrenched' and he appeared to lack insight.

46 That afternoon, when H was visited by his partner and children, he expressed his discontent with medication and said he thought 'it would [be] better to be off his medication before he [went] home'.

47 H had an individual session with a member of the nursing staff on 14 June. He talked about how his 'crew mates on ship had been abusive towards him and when he confronted them about this they didn't know what he was talking about'. H also expressed his thoughts about his relationship and almost seemed in favour of ending the relationship.

48 However in the ward round with Dr Hand on the same day H was reported as being 'quite settled' on the ward. He was seen in the ward round and said he was 'very keen' to go home. He believed he had been 'set up' but now thought he could trust the staff in the hospital. By contrast, on admission to the Royal Cornhill Hospital H had believed staff were involved in the conspiracy against him. Relationship difficulties were noted between H and his partner, whom it was said had started to see a counsellor. Dr Hand

advised H that he was suffering from an acute psychotic episode and he should remain on medication 'for at least a year'. It was decided he could go home on leave 'after talking with girlfriend'. It is not clear who was expected to talk to M. Dr Hand told us that she spoke to M although this is not documented.

49 Dr Hand wrote up leave under section 17, MHA as follows: 'time out unescorted today in town. Tomorrow, time out at home, if successful on 16/6/99 O/N (overnight) leave then review'.

50 An entry following ward round noted H had telephoned M to tell her he could go home if she was agreeable. A member of the nursing team later telephoned M to check this was acceptable to her. M herself later telephoned the ward to say she would collect him the following morning but wanted to speak with Dr Hand first. No indication was found in the multidisciplinary records that M did speak with Dr Hand and so it is not known why she wished to do so.

51 The only entry on 15 June was to record that H had gone home on leave that morning and was due back in the evening. There is no written record to document how the leave had gone. On 16 June a nurse made an entry recording a discussion with Dr Hand and confirming H could go on overnight leave that evening and was to return early the following afternoon.

52 Ms Mansell, as the CPN on the duty desk, telephoned H at home on 15 and 16 June to check on him but received no reply on either occasion. His case had not been allocated to her at this stage.

Discharge from Trengweath Mental Health Unit

53 H was seen by Dr Hand on 17 June. Her entry in the notes recorded:

> Leave successful. No psychotic symptoms, Agrees to continue medication and to receive support from CPN. Worries about looking after kids when partner goes back to work and about benefits, refer to S[ocial] W[orker] [and] Hilary Oates [now Mansell – CPN]. Very keen to go home. Can go home when medication organised and above referrals made.

54 On the hospital discharge prescription, signed by the SHO, and faxed to the GP, Dr Gibson, on 17 June it was noted H was being prescribed Risperidone 4 mg once daily. H had been given 7 days' supply of the medication and Dr Gibson was asked to continue the prescription. The diagnosis was recorded as an 'acute psychotic illness' and ongoing care was listed as including CPN follow up, to be seen in the outpatient clinic in '1-2 weeks' and H had been referred to Social Services.

55 H returned to Trengweath the following day, 18 June, to collect his medication. Dr Hand told a member of the nursing staff she did not need to see H as he had been discharged the previous day and would be reviewed by her junior doctors in the outpatient clinic. Ms Mansell made another unsuccessful telephone call to H.

56 Three other items were noted on the Discharge Checklist:
Is patient/carer willing to be involved in Satisfaction Survey/Forum? – 'No';
and two questions relating to emergency alterations to the discharge arrangements had been marked as 'not applicable'.

57 The discharge summary was prepared by the then SHO on 25 June and typed three days later. H's diagnosis was given as an 'acute psychotic illness' and the various changes in his legal status were accurately documented. The description of events leading to admission in Scotland and his progress there were briefly referred to in five lines each. H's past psychiatric history was said to be 'nil'. In describing H's progress at Trengweath the SHO relied heavily on Dr Hand's written comments in the clinical records. It was mentioned that H had returned to live with M and 'things have been quite difficult for them lately'. However, there was no risk analysis with the discharge summary and H's views of M, particularly when he had been very psychotic were not recorded.

58 The discharge summary concluded with 'Recommendations and Follow-up'. This included the following information: that he should continue with medication for at least a year, he had returned to live with M, had lost his job and had been referred to Social Services regarding his benefits, would be allocated a CPN (Ms Mansell), had an appointment to see the SHO in the outpatient clinic on 8 July and would have a CPA review 'in the near future'.

Comment

59. Three key points emerge from a consideration of the documents relating to the June 1999 inpatient period, which reinforce the findings in relation to the admission to hospital of H in December 1999 and his discharge in January 2000 discussed in chapter 4. These are:

a. There was no proper discharge meeting;

b. CPA level was not properly applied;

c. There was no formal system for reviewing patients in the community.

60. The Inquiry views the lack of a discharge planning meeting as a serious failing in the discharge process. The lack of such a meeting denied the multi-disciplinary team a forum in which they could, in addition to the issues raised above, consider: the risk H posed to himself or to others, the needs of M both as carer and also as the object of H's delusional beliefs and the appropriate CPA level on which H was to be supervised in the community. Without the discharge meeting H was assigned to the simple CPA level by default.

61. In our view H should have been allocated to the complex CPA level to reflect his needs at the time. Reflection on issues such as H's impaired understanding of his illness, his avowed reluctance to comply with a regime of oral medication and the social circumstances to which he was returning is likely to have led to the decision to place H on the complex CPA level.

62. A robust and properly implemented CPA should ensure that a proper discharge planning process takes place. The use of CPA and policy is discussed in more detail in Chapter 2.

<u>Supervision in the community (by Hilary Mansell, CPN)</u>

63. H returned home to resume living with M and their two young children. By this time he was again out of work. M was due to return to work the following week and there were concerns as to how H would manage in looking after the children. He was referred for a social services assessment of benefits and child care issues.

64. David Willmot, social worker, visited H at home on 21 June. His summary of the assessment includes consideration of risk: 'To self – stopped medication for 2 days, started getting paranoid again. Has restarted medication again – settled again. To others – wife confirms no risk to her or children. No risk identified by medical team'. H was given advice regarding his benefits, and no help was seen as necessary for child care, but counselling via Relate was advised for H and M.

65. Ms Mansell was allocated as the CPN to make contact with H and supervise his care following discharge.

66. Ms Mansell told us she trained at Plymouth University and holds a Diploma of Higher Education in Nursing and Mental Health from there. After qualification she took up a nursing post at Trengweath Hospital in October 1997 and remained there in a succession of posts. She joined the Penwith CMHT in December 1998, initially in a developmental post, but became a substantive F grade CPN in June 1999. Ms Mansell subsequently left the CMHT to complete a BSc (Hons) course on community health care nursing, mental health and specialist practitioner, at Plymouth University.

67. Ms Mansell described having a caseload of 30 to 35 people at any particular time. All had severe and enduring mental health conditions. We were told new patients would be allocated to members of the CMHT at a weekly meeting held at Bolitho House. While account was taken of the workload a particular member of the team might have at a given time, discussion regarding allocation of patients did not involve consideration of the CPA classification of that patient.

68. In her evidence to the Inquiry Ms Mansell also explained the process whereby patients would be discharged from the CPNs' caseloads. Straightforward cases would be discharged by the CPN at their own discretion. More complicated cases would be discussed 'regularly' and, if they were subject to a complex CPA plan, would be reviewed at three monthly intervals. However, in between times, the decision as to whether or not to take a case back to the CMHT for further discussion lay with the team member concerned. Ms Mansell described how her personal practice would be to 'discuss discharge

with the person, explain to them why they were being discharged, explain to them the procedure, if they were any problems, go through their early warning signs (of relapse) so that they could recognise them in the future and, after I had been there a while, the people I would discharge I would actually give a copy, like a contract, so that they knew that'.

69. Ms Mansell confirmed to us she only received the referral after H had been discharged from hospital. She made contact with H via a telephone call on 22 June and arranged to visit him at home on 25 June. The home visit actually took place on 28 June and in her evidence to us Ms Mansell could not remember why the change in dates occurred. She explained that prior to seeing H for the first time she would have read his clinical notes looking 'for any risk scenarios, anything which would tell me about early warning symptoms, precipitating factors for the person being unwell, what happened while they were in hospital, things like that'.

70. At the home visit on 28 June, having discussed H's needs as well as those of his family, it was agreed to adopt an 'educational approach, supportive role for him and family, monitoring role re symptoms and medication'. The meeting also provided both H and M with an opportunity to express their feelings. Ms Mansell noted H may have had psychotic symptoms in the past which he may have coped with by resorting to alcohol. She also recorded H's views about his illness – how real the illness had seemed and how it was difficult to realise the same features were not real to other people. It was also documented H had become psychotic again after stopping his medication for two days but resumed it again having realised it was beneficial to him. M raised the question of whether H would be able to attend Relate (to sort out their relationship difficulties).

71. The next visit planned for 7 July did not take place. However, the following day H attended the outpatient clinic with M and was seen by the SHO working with Dr Hand. This accorded with the date given in the discharge summary. In her letter of 8 July to the GP, the SHO mentioned H had stopped his Risperidone as he had found it difficult to believe he had been unwell. However, he then began hearing his partner's or father in law's voice shouting abuse, as an auditory hallucination. Upon restarting his medication the voices stopped. He was again advised of the need to maintain his treatment

for at least a year. It was commented that he seemed happy to do this. H also reported he had found the CPN contact, including the educational material, useful. Outpatient follow up was now to be handed on to the next SHO, who was due to start with Dr Hand shortly.

72. On 12 July Mr Condon, as covering CPN, made a home visit following a 'distressed phone call' from M. She had told H the previous evening of her wish to end their relationship and as a result he felt 'depressed and negative'. He was also ruminating on other losses, such as his job, financial pressures and the resultant loss in self-esteem. Beyond the plan to see Ms Mansell on the Wednesday there was no particular outcome to the visit.

73. Instead H was seen by another CPN on 14 July. H reported himself to be feeling better but was still experiencing mood swings and anxiety symptoms. They reviewed symptoms he had had prior to admission and H referred to 2 or 3 previous episodes when he had not sought out official help. The reasons he gave for this included their short duration, and he believed he was having 'flashbacks' to when he had used LSD. At this visit H seemed to be resigned to the end of the relationship, and M seemed more ambivalent about their future together but was willing to remain with H while his mental state improved.

74. The following day Ms Mansell telephoned the house and made contact with M. She reported the situation to be more settled and declined the offer of a home visit. M also asked if she could contact the team over the weekend rather than the other way round.

75. The next home visit took place on 20 July and was conducted by Ms Mansell. H appeared 'somewhat subdued' but without biological features of a depressive illness. There was some discussion of negative automatic thoughts and he was given the opportunity to express his feelings and concerns as well as being offered support and reassurance. Specific enquiry of thoughts of self-harm yielded a negative reply.

76. On 22 July Ms Mansell visited again as planned. Earlier H had been out surfing as he believed exercise helped him to relax. His relationship with M was 'not hopeful' although she had no immediate plans to leave him and was

wishing to attend a carers' group. Ms Mansell explored for possible features of depression. None were present but her entry in the notes also recorded 'Time offered for ventilation. Support offered. Education given'.

77. The next home visit had to be delayed by two days because of a 'crisis' – where or its nature was not recorded. Ms Mansell telephoned H and the entry of that conversation noted the absence of depressive signs along with 'some positive outings and good times with his children'. The re-arranged visit took place on 29 July. H reported feeling low and subdued. Time was spent discussing his 'beliefs and assumptions', as well as challenging his negative automatic thoughts and problem solving approaches. By the end of the visit H seemed 'brighter [and] was able to relate to theory and plans to attempt it in real life'.

78. Again an arrangement for a home visit the following week was made. In the event that visit was made by Mr Condon on Ms Mansell's behalf. H was low in mood but was also looking after both children as M was out at work. H said he had been short-listed for a job but was anxious at having to disclose his psychiatric condition. He was advised to 'inform the panel … but minimise its impact and emphasise recovery'.

79. Ms Mansell telephoned H on 3 August and left a message on his answer-phone for a visit on 16 August. This did not take place and it is assumed the date given was not convenient for H. The next entry is dated 24 August and this referred to another telephone conversation. Again H was in a low mood and it was agreed to refer him to the occupational therapist (OT) in an attempt to raise his self-esteem and confidence.

80. On 26 August Ms Mansell visited H at home. Time was spent examining his preoccupation with the loss of his job and his relationship. An absence of any deterioration in his mental state was noted but he expressed concern about a possible relapse and how to avoid it. Future work identifying signs of relapse and psychosocial interventions was noted. There were no reported problems with his medication.

81. In September Ms Mansell was on annual leave and, by prior arrangement, Mr Condon took on the home visits of H. He saw H twice. On 3 September, H

was feeling depressed and 'trapped' because of difficulties, primarily related to finding alternative accommodation in order to make his relationship with M more tolerable. He also found it difficult looking after the children all day while M was at work. Mr Condon agreed to get some literature on housing benefits that might be available to H.

82. Mr Condon returned to see H on 11 September. Again he found H was 'depressed and demotivated, continually ruminating on former employment' which had helped finance his (leisure) interests. H had been unable to find any new employment. The possibility of starting antidepressant medication was raised. Two days later Ms Mansell also saw H on a home visit. He remained 'low in mood. Reports lack of motivation, hopelessness and rumination of present situation'. She assisted him to concentrate on situations in the past when he had helped himself and not to dwell exclusively on his current difficulties. For her part, Ms Mansell agreed to discuss antidepressant medication with H's medical team and to chase up the OT referral as well as refer him for social work input regarding assistance with housing.

83. Although the next visit was scheduled for 20 September, four days prior to that date M telephoned Ms Mansell as she was concerned about H's low mood and his comment that he could not 'go on like this'. He had not disclosed any plans to harm himself. In response Ms Mansell made attempts to discuss the situation with H's general practitioner to request the prescription of an antidepressant for him. She also made contact with H. He felt 'hopeless' about his situation and talked of death being the easy way out. However, beyond acknowledging fleeting thoughts of self harm he did not disclose any plans to end his life. He also admitted to having some hope for the future. Ms Mansell spent some time explaining the plan of antidepressant treatment and how it would help him. She also checked that he knew he could contact the team base at Bolitho House if he needed to talk to someone.

84. The following day, 17 September, Ms Mansell and Dr Steven Naylor (specialist registrar from the CMHT) visited H at home. Dr Naylor's written entry reads:

> Seen with Hilary [Mansell], CPN, who has noted increasing [depressed] mood over last few weeks/months.
> He reports tired, lacks motivation, can't be bothered to do things. Can't face his problems. Sleeps during day if he can and at night (has) gloomy thoughts. Not suicidal. Doesn't enjoy things anymore. Concentration ok, eating normally. Feels flat. Feels like withdrawing from things.
> Problems - unemployed – doesn't think he'll get another good job.
> - relationship problem with partner [M] – thinks they will separate soon, he would prefer not to.
> Not psychotic. No paranoid thoughts. No auditory hallucinations.
> Impression
> Depressive episode following psychosis in June.
> Plan - fluoxetine 20mg/day
> - continue to monitor with CPNs
> - when established on Fluoxetine consider possible cautious reduction of Risperidone if no improvement (say to 3mg/day) ? could tiredness be Risperidone but was ok (in) July on it.

85. Dr Naylor also wrote to Dr Gibson to keep the GP appraised of the situation with H.

86. Ms Mansell also added an entry, timed at 16.50 pm that day:

> Plan – duty desk number to be used if problems occur over (weekend). Visit Monday 10 am Collect and commence antidepressant tomorrow. Letter delivered to Dr Gibson (the GP) at (his) health centre by hand.

87. Coincidentally, on the same day as Dr Naylor and Ms Mansell's visit, H was also seen by an occupational therapist. H's 'inability to find appropriate employment' was said to be his main concern. The plan to address this included 'career guidance initiation, enabling sporting activity and co-work with Hilary [Mansell] on his negative beliefs'.

88. As planned Ms Mansell visited H on the Monday following her visit with Dr Naylor. H remained negative about his future. In part this was related to his decision, with M, for one of them to move out. Ms Mansell enquired as to thoughts of self harm but none were apparent and, indeed, H was said to

making plans for his future and considering his children. He was again encouraged to think of past situations he had successfully dealt with rather than dwelling solely on his present problems.

89. Two days later, on 23 September, H was seen by the then SHO in the outpatient clinic at Bolitho House. She noted he had been compliant with his Risperidone (at the dose of 4mg a day) and he had no features that might have heralded a relapse in his mental health. He also claimed:

> that his mood has been low ever since the situation has hit him with losing his job, feeling a failure, his mind has let him down, about to start a new job Monday 9 –5 , labouring job …. Motivation v. poor, having some suicidal thoughts, appetite is ok, sleep well in fact rather a lot – more than usual, sometimes doesn't feel it's worth getting up.
>
> Plan – Continue Prozac
>
> Review in one week,
>
> (CPN) to maintain close contact.
>
> Try CBT *[Cognitive Behavioural Therapy]* approach.

90. The SHO also wrote to the GP, copied to Ms Mansell, setting out the above information and planning to review H in a week's time.

91. The following day, 24 September, Ms Mansell visited H at home. Her long entry, timed at 19.45 pm that evening, recorded that he had felt 'less negative and anxious' that day and was not as hopeless about his future. Other indications of an improvement in his mood were noted although he continued to experience fleeting thoughts of self harm. Ms Mansell took time to explain the likely course and time span of future improvements in his mood. The next home visit was negotiated around his daughter's birthday and the start of his new job.

92. On 25 September Ms Mansell wrote to Dr Gibson (although unfortunately the letter was not typed until 22 October) to bring him up to date with H's progress since the fluoxetine had been started. She ended the letter by outlining her plan for H, which was to:

> continue monitoring [H] quite closely, using a cognitive approach to challenge [H's] negative thought processes and at times a client centred approach when [H] has felt the need to simply ventilate some of the frustrations and concerns

he has. It is my intention to continue with this approach and also to monitor his mood and mental state whilst observing for any side effects of his newly prescribed medication. This of course includes risk assessment and should there be any further cause for concern I would obviously contact yourself and our medical team.

93. On 28 September another CPN telephoned H to check on his progress. He reported 'everything OK' although he was disheartened his new job had not worked out and he gave it up after one day. He said he was continuing to take his medication and was finding his mood was lifting. There seemed to be careful exploration of his mental state. It was noted ' No suggestion of psychotic ideation, reasons for not attending work again were centered (sic) on conditions and difficulty of work, not other people employed there'. This entry showed the CPN was aware of H's previous presentation when unwell.

94. Ms Mansell made contact with H again on 29 September 1999. By that stage he had found another job, his mood was improving and there was no evidence of psychotic symptoms. He had had no suicidal thoughts for the previous 3 days. The following day H rang to cancel his outpatient appointment with the SHO. He said his mood was improving, the medication was helping and he felt more positive about dealing with his problems. The duty CPN telephoned H over that weekend. On the Saturday there was no reply. The next day he reported feeling 'brighter in mood and more optimistic about his life. Feels (Fluoxetine) is helping and denies any current suicidal ideation'.

95. On 4 October Ms Mansell visited H at home again. Further improvement in his mood was evident and she noted he was able to 'undertake challenging NATs [negative automatic thoughts] and to be slightly [more] objective re his current situations. Discussed prodromal symptoms and trigger factors for [H] and put them into perspective re use in future'. He was due to start a new job later that day.

96. The next visit took place a week later. His mood seemed to have returned to its former state and no deterioration in his mental state was apparent. He had left his second job but remained positive about his future. On 18 October 1999 Ms Mansell visited H with Mr Condon to whom she was handing over

H's care because she was being relocated to a different area to work. 'No evidence of mental state or mood deterioration' was recorded. Ms Mansell also wrote to Dr Gibson to inform him of the transfer of community supervision to Mr Condon.

Supervision by Derrick Condon, CPN

97. Mr Condon had qualified as a registered mental health nurse in 1970 and as a registered general nurse in 1973. He told us he held a succession of clinical posts culminating as a charge nurse on an acute admissions ward for seven years until 1984. From then until 1989 he was Assistant Director of Nursing based at St Lawrence's Hospital, Bodmin, before becoming the Director of Nursing at the Cornwallis Health Group. Mr Condon returned to clinical practice as an F grade community psychiatric nurse in 1995. He told the Inquiry he held a number of temporary posts within the Trust for the next three years. Mr Condon said he had no prior experience of community psychiatric nursing before becoming a CPN and he has received no specific training or qualifications in that area since appointment.

98. On 21 October H attended his outpatient appointment with the SHO. She noted he was sad not only at the loss of his 'original job' but also at the loss of his relationship. She advised he should continue with his present medication (Risperidone 2mg twice daily and Fluoxetine 20mg daily) and should remain on it for 'at least six months'. Another outpatient appointment was made for H to return on 22 November.

99. Mr Condon made his first home visit as H's allocated CPN on 8 November. Beyond the comment that he was 'much brighter and positive today' there was no indication of an exploration of his mental state. The rest of the entry dealt with H joining a work training programme. The next home visit was scheduled for two weeks' time. In the meantime H did not attend his next outpatient appointment on 22 November and the SHO wrote to H asking him to contact the medical secretary for a new appointment or to discuss it with Mr Condon.

100. In giving evidence to the Inquiry Mr Condon said the key symptoms which would have indicated a relapse in H 'would be a recurrence of his paranoid thinking, usually of voices of a derogatory nature. He quite often used to infer

that he felt that people were talking about him, calling him a paedophile and child offender and that sort of thing'. He acknowledged M seemed to be the focus for many of H's allegations. When asked about his understanding of H's level of insight into his illness, Mr Condon said 'at face value his insight would be good …. He tended to say to a degree what he thought you wanted to hear … (and) he tended to dilute quite often the impact that his illness had upon him'.

101. On 22 November H was visited by Mr Condon, who recorded 'improvement maintained – no frank symptoms of mental ill health currently. Commencing full time training for PCV (sic) licence next week and will be working 9 –5 Monday to Friday – looking forward to being re-employed and feeling very positive about this. Arranged that next visit will coincide with late shift of myself and I will contact [H] accordingly'.

102. In the event the next contact did not occur until 21 December 1999 when Mr Condon telephoned H. He was told H had not been able to pursue the driving course because of the medication he was taking but had quickly started on a joinery course. Over the telephone H sounded 'relaxed, euthymic and very positive regarding future'. Mr Condon wrote that he offered to visit H at home but H declined this, and the situation was left in H's hands to 'contact … if necessary'.

103. The very next afternoon it was H's partner, M, who made the contact. Most unusually, she visited Bolitho House, the CMHT base, and Mr Condon's written entry for that day reads as follows:

> Distressed and tearful. [H] has been unwell and argumentative and appearing to be hearing voices – accusing her of talking and whispering behind his back. Admits to curtailing his medication some time ago. Denies being fearful for her safety but admits to being concerned regarding his unpredictability and obvious deterioration in his mental health. Advised to stay with friends tonight and I will see [H]) tomorrow morning.

104. M took this advice and went to stay that night with a friend.

105. On 23 December Mr Condon visited H at home. H appeared 'mildly agitated and distressed' and 'insist(ed) (M) has been talking behind his back to incite a

response'. H also admitted he had not taken his medication for 'some time' but apparently promised to restart it. Mr Condon suspected H's compliance would remain 'problematic'. He also informed H of the availability of the 'duty desk' if further problems should occur over the holiday period. M was also told 'covertly' of this source of support.

106. In his oral evidence Mr Condon acknowledged his concerns about H were 'allayed to some degree' at the home visit because H 'accepted that he need(ed) to restart his medication'. He also rejected the suggestion he might have been slow to respond to M's request to have H admitted to hospital. He clarified his suggestion to M to spend the night at friends was based not on a perceived risk to her if she remained in the house with H but to give them 'some breathing space'. While agreeing that H's mental health had deteriorated, Mr Condon said he would have sought a Mental Health Act assessment only if H's 'non compliance (with medication) was going to continue and with that non compliance there could be an anticipated further deterioration'. He believed H would restart his medication and comply with it, although after he had recovered again further episodes of non, or partial, compliance were likely.

107. Mr Condon was, unsurprisingly given the passage of time, unclear exactly what arrangements he made with regard to H to cover his absence over the Christmas period. He said he left a verbal message to alert the duty desk to the possibility of calls from M and thought he might have asked for his senior colleague, Shaun Wright, to visit on his behalf.

Comment

108. The events of 22 and 23 December form a significant episode as they provide a vivid example of many features in H's presentation forming a distinctive pattern and which should have been observable in November 2000 on a review of H's records (see Chapter 5). M reported he had stopped (or at least 'curtailed') his medication. His mental state had deteriorated and he had become symptomatic. M was clearly and specifically identified in his psychotic symptoms. She felt concerned enough to spend that night away from H.

109. **In the opinion of the Panel Mr Condon was over-reliant on H's verbal undertaking to resume medication. Now, if not before, non-compliance with medication should have been given prominence in future treatment plans. Ways in which H's compliance could be monitored and a plan to deal with any future non-compliance should have been stated.**

110. **The link between H's mental health and M's wellbeing should have been established. In the light of the above events the Inquiry Panel were very concerned at Mr Condon's lack of contingency planning for the holiday period while he was absent from work. We have considered the care planning process in more depth in Chapter 2.**

111. **The Inquiry was concerned at Mr Condon's lack of training to fulfil the role of CPN. We consider that this is a matter falling within the responsibility of the Trust and individual professional responsibility. These issues are discussed in greater detail in Chapter 2 (see sections Care Planning and Clinical Supervision and Training and relevant Recommendations).**

CHAPTER 4

SECOND ADMISSION TO HOSPITAL AND FOLLOW UP IN THE COMMUNITY

DECEMBER 1999 TO AUGUST 2000

- **Introduction**
- **Second admission to hospital – December 1999**
- **Assessment by Dr Hand**
- **Supervision in the community by Derrick Condon CPN (January to August 2000)**

Introduction

1. H's second admission began on 30 December 1999 when he was admitted to hospital under the Mental Health Act 1983 (MHA) following assessment at his home. H was discharged home, to return to live with M and their two children on 17 January 2000. His supervision in the community was taken up again by Mr Derrick Condon, who had taken over as H's CPN from Ms Hilary Mansell the previous October.

2. M had made it known to H that their relationship was at an end and during this period she found a new home for herself and the children to which they moved in August 2000. Mr Condon remained allocated to H throughout and up to the time of the killing of M on 14 November 2000, although he failed to visit H again after M and the children moved out in August.

3. Once again there were a number of features of H's mental illness that demonstrated an increasingly apparent pattern in his presentation. H's illness proved to be susceptible to oral antipsychotic medication and the florid symptoms during times of relapse resolved relatively quickly. However, H disliked taking medication and there were difficulties over his continued compliance with the medication. This led to deterioration in his mental state. His partner, M, figured prominently in his delusional beliefs and his aggression towards her was intensified.

4. The Inquiry found clear evidence of the effects on practice of the lack of proper implementation of the CPA policy, supervision and training. There was inadequate assessment and management of risk (principally of H towards M), precipitate discharge, no proper discharge meeting and poor documentation around discharge. Once in the community H was not subject to regular reviews by the CMHT and there were no contingency plans to address his non-compliance with outpatient appointments or medication.

5. The Inquiry found evidence of poor follow up of H in the community by Mr Condon. More crucially, H was allowed to withdraw from further psychiatric supervision immediately following the departure of M and the children from the family home in August 2000. Supervision lapsed without any formal review or discussion with Dr Margaret Hand.

6. The Inquiry also found Mr Condon was allowed to practise in an unsupported, autonomous fashion without effective monitoring of his performance by way of adequate clinical supervision, auditing of his practice or the provision of any training. In Chapter 2 we set out our findings that the responsibility for these failings is to be jointly apportioned between Mr Condon and the Trust.

Second Admission to Hospital – December 1999

7. On 30 December 1999 M again contacted the CMHT to report that H was not taking his medication. The entry in the clinical record says M reported H to be 'increasingly paranoid over past three days. Accusing wife of trying to get him readmitted to Trengweath. ….. some concern he may become violent towards her'. In response Dr Steven Naylor (specialist registrar in psychiatry working with the CMHT) and Cathy Clegg (CPN) visited H at home the same day.

8. Dr Naylor's written entry records H had stopped medication some 2 months previously before starting his college course. For about two weeks he had been 'more paranoid/touchy' and for the previous two days he had been 'hearing voices saying derogatory things about him; believes his wife (sic) is saying under her breath comments about him – committing incest with their children. Also calling him a pervert. Voices coming from his wife and TV; believes wife is setting them up to persecute him'.

9. Examination of his mental state revealed him to be 'irritable, perplexed and annoyed' and to be 'reporting and responding to auditory hallucinations

throughout interview'. At one point H believed Ms Clegg was making comments accusing him of incest. H also described paranoid thinking, specifically that M was forming a plot to 'put him down'. He denied he was unwell and insisted the voices were real.

10. In her written statement to the Inquiry, Ms Clegg said on that day she was working on the duty desk at the CMHT and so responded to the telephone call from M, accompanied by Dr Naylor. Ms Clegg said they had H's clinical notes available to them as well as Dr Naylor's prior knowledge of H. She also said that M appeared frightened of H who was expressing his persecutory ideas about her accusing him of incest. Ms Clegg added that H believed she was also talking about H in the same manner, and as her presence seemed to be inflaming the situation she left the house at that point.

11. Dr Naylor believed H was suffering from a paranoid psychosis and identified the primary risk as being towards M. It was said he had already verbally threatened her with physical violence. H refused either to restart medication or voluntary admission to hospital. Dr Naylor completed a medical recommendation form for H's involuntary admission to hospital under section 2 MHA, as both a section 12 MHA approved doctor and one who had 'previous acquaintance with the patient'. H's admission was recommended in the interests of his own health and 'with a view to the protection of other persons'. Dr Naylor gave the following reasons why informal admission was not appropriate:

> The patient is paranoid and psychotic. He does not see the need for medication. He has not been compliant with medication prescribed for him. He has refused admission to hospital informally. His paranoid beliefs are directed against his wife who he has threatened.

12. H was also assessed by a general practitioner from H's local surgery but not one who had prior knowledge of him. Her medical recommendation stated H ought to be detained in the interests of his own health and safety and for the protection of others. Her written reasons stated:

> Patient refuses admission. Paranoid delusions re wife and CPN. Aural hallucinations of people accusing him of incest. Making threats to make wife 'black and blue'.

13. The approved social worker (ASW) to make the application that evening for the compulsory admission was Michael du Feu. On his Social Services Specialist assessment form he noted that M 'can no longer cope with the strain and hostility. Tearful and tired. Still concerned and wants (H) to recover'. Mr du Feu's summary of the assessment recorded

> [H] had his 1st breakdown in '99. He has been reluctant to take medication recently and had began (sic) to formulate conspiratorial views about others. He has become hostile to partner. He believes CPN is also involved in conspiracy. He was repeatedly offered informal admission but refused to accept any need for this. Section 2 applied and taken to Trengweath.

14. Dr Naylor also wrote an entry in the inpatient records and summarised the conclusions from his discussion with the general practitioner thus:

> On balance due to risk to wife, lack of insight, needs to be admitted. Declines admission. I do not think he will comply with medication. He and wife in same house is risky while he has paranoid delusions directed toward (sic) her.

15. Mr du Feu's risk assessment noted:

> (A) conspiracy fears worsening – [H] could potentially act on his suspicions and cause harm to partner; (B) further deterioration of mental state if not treated.

Comment

16. **This episode brings into question Mr Condon's response to events only a week earlier (Chapter 3) and represented a point of learning for the future. H had not resumed his medication as Mr Condon had assumed. His mental health deteriorated further and it was left to M, in the absence of any plans for active monitoring by the CMHT, to contact the service for assistance.**

17. **Evidence from the family and friends of M was that she did not regard Mr Condon to be sufficiently responsive to her concerns at this time. Mr Condon's view is that he had a good relationship with M. He did not recall her expressing to him with any force that she wished H to be admitted to hospital. He disagreed with the suggestion that he may have been reluctant to admit H to hospital. He said that "If I felt at any stage that he required – in my professional opinion, if I felt that he required a Mental Health Act assessment, then I certainly would not have relinquished that responsibility".**

18. **The episode itself was handled competently by the CMHT. M telephoned the duty desk with her concerns about the deterioration in H's mental state. Those concerns were acted on promptly by two members of the CMHT, including a Section 12 MHA doctor, culminating in a mental health act assessment, which was also attended by a local GP and an ASW. Those assessing H had access to his clinical records and would also have been assisted, to some extent, by Dr Naylor's previous, although limited, acquaintance with H.**

19. **The mental health act assessment identified certain key features in H's presentation. A deterioration in his mental state had come about after he stopped his medication some two months previously and the rate of decline was gaining momentum. Active features of H's mental illness which were identified particularly involving his partner, included auditory hallucinations and persecutory delusions. He lacked an awareness of being mentally unwell. Involuntary admission was required because H represented a risk to his partner and refused to consider informal admission.**

20. **Mr du Feu was to be involved in conducting another MHA assessment on H the following year. On this occasion he recognised that although there was no direct threat to M there was a <u>potential</u> risk of H acting on the basis of his abnormal beliefs. Furthermore, that without medication H's mental state was not going to improve, and was likely to deteriorate further. Thus the risk of harm to M was likely to increase with time.**

21. **Admission for treatment, under section 3 MHA, would have been possible and also appropriate. M, as H's nearest relative, was unlikely to object to the admission and the required doctors and ASW were present. The Code of Practice to the Mental Health Act 1983 states (at paragraph 5.3(a)) that a pointer to the use of section 3 is when 'the patient is considered to need compulsory admission for the treatment of a mental disorder which is already known to his clinical team, and has been assessed in the recent past by that team'.**

22. **Although we do not consider it productive to focus on this as a criticism of the admission process, admission under section 3 would have brought with it certain advantages, including the possibility of an assessment over a longer period of time, the potential for a more extended leave of absence from the hospital prior to discharge from liability to detention, the right to formal aftercare planning and provision of services (section 117 MHA), and also the possibility of invoking aftercare under supervision (section 25A, MHA) after discharge from hospital.**

23. The admission notes at Trengweath are timed at 20.30 hours on 30 December 1999. The reason for the admission under section 2 is summarised as having 'paranoid delusions about wife and CPN. Auditory hallucinations – wife and neighbours. Voices saying derogatory things eg accusing him of incest. Has made threat towards wife'. During the initial interview H, although said to be reluctant to talk, did give a reasonable summary of the events leading to his first admission and his account is consistent with the circumstances as known to the panel.

24. H said after discharge from his first admission he had been feeling 'very low' as he had lost his job, there were difficulties in his relationship with M and he had 'increasing anxieties about (her) having had affairs'. He said the current problems had 'really started' three days previously when M had begun making allegations of incest against him. In addition, H told the interviewing doctor he had stopped his medication, as he did not believe it was necessary.

25. Mental state examination at that stage showed H to be 'suspicious/anxious…a bit low (in mood) … preoccupied with (his) situation and allegations of incest'. He believed M had 'said things to do (his) head in

and get him put in hospital'. H also reported the auditory hallucinations and although being unhappy with the admission to hospital did agree to restart medication.

26. The entry for 31 December 1999 recorded H's belief that his wife had instigated the hospital admission because he was on a 'good college course'. H also said he could hear staff and patients from the unit shout out 'pervert' as they passed his room. Later that day another entry quoted him as being 'astonished' that he was in hospital and he said he was bored with 'nothing to do'. He also voiced resentment towards his partner and blamed her for his admission. However he did speak to M on the telephone. On the ward he was calm but did not socialise with the other patients. He was said to be pleasant when spoken to. On New Year's Day 2000, when M entered the unit, H 'immediately accused her of saying things although she had not spoken'. There was said to be 'obvious tension' between H and M during that meeting.

27. On 3 January 2000 H was thought to be experiencing ongoing psychotic symptoms, possibly including auditory hallucinations and was said to have no insight into these features. In addition he had appealed to the Mental Health Review Tribunal against his detention in hospital under the Mental Health Act. That afternoon M and their children visited him and the meeting seemed to be more cordial than the previous one. The following day H said he wished to leave and 'sort out his family life'. However, he stressed he wanted to do this in an amicable way and not create further difficulties in his relationship. It was also recorded that he had no intention of harming his partner and he believed that was something M was concerned about.

28. That afternoon H was seen by Dr Naylor as he wished to go home. H said he was not unwell but he wished to leave so he could restart his course. He was worried that the organisers of the course would find out he had been in a psychiatric hospital and was taking medication. He said he would lose his place on the course if this happened. He was also quoted as saying 'it's not fair that I'm in here because my wife has been calling me names…I think she has also been slandering my sex life'. H told Dr Naylor that other people had been saying things against him including calling him names. Dr Naylor's conclusion was that H was still psychiatrically unwell and showing no

indication of insight. He was also said to cooperate reluctantly with medication, which at that time was Risperidone 2mg twice daily.

29. On 5 January a staff nurse met with H and M. M said their relationship was effectively over but they were staying together because of the lack of alternative accommodation. M also spoke of her concern that H was not getting well as quickly as she had hoped and mentioned his problematic compliance with medication at home. For his part H remained adamant that his problems were caused by his partner.

30. On 6 January H again asked to leave in order to go home, saying there was nothing wrong with him. He accused M of lying about him in order to precipitate an argument, and did not believe he could have been hallucinating. He also said he did not believe he needed medication and, when informed that the police would come for him if he left the ward, he reluctantly agreed to remain in the unit.

Assessment by Dr Hand

31. On 7 January H was seen by Dr Hand for the first time in the admission. Her entry in full reads as follows:

> Continues with paranoid delusions re his wife. Although last episode of illness recovered from now believes that it was wife's fault. Has auditory hallucinations of wife's voice but also staff and patients voices although these have decreased since on medication. He does not link these. Not happy about remaining in hospital but needs to do so for health sake. Major difficulties with wife who is very frightened of him although no actual violence documented, but threatening at times (therefore) safety of others is an issue. Does not see need for medication but taking as he knows implications of being on section 2. On Monday review and consider transfer to section 3 [Mental Health Act]. [SHO] to arrange interview with partner.

32. Had Dr Hand made the initial admission assessment she would have admitted H under section 3 MHA due to her previous knowledge of him. She told us it is for that reason she considered converting the section 2 MHA to section 3 MHA and not for reasons of extending admission under compulsion.

Comment

33. **Dr Hand's first assessment of H during that admission clearly recorded the continuing presence of psychotic symptoms including persecutory delusions and auditory hallucinations. In addition, H's level of insight into his illness was very limited. Not only did he attribute current auditory hallucinations to his partner, he also blamed her for his previous episode of illness. Although H's symptoms were showing a response to antipsychotic medication, H did not acknowledge the reason for the change and so saw no need to continue with the medication.**

34. **Dr Hand also identified M as being at risk from H. She was seen as the instigator of H's problems around the time of the admission in May 1999, he had given her a role in the current episode and she had been threatened, although not physically assaulted, by H. It would have been important to have more detail from her perspective, and the senior house officer was tasked with arranging an interview with M.**

35. The entry on 8 January indicated some improvement in as much as he was attempting to rationalise the voices he heard. He also reported he had heard people shouting derogatory comments about him on New Year's Eve. The staff nurse gave him some information about mental ill health generally and auditory hallucinations in particular. H was said to believe he was better on medication but also felt he did not need it. A similar comment was made to the night staff who recorded he did not believe his medication was doing him any good. In a one to one session with another nurse the following day H admitted that when he was at home with his partner he would set 'little traps' for her which 'proves that she is lying about his mental illness'.

36. On 10 January Dr Hand held her ward round. The note of that meeting read as follows:

Wants to go home. Accepts that his relationship with [M] is over, feels that she was 'taking the piss' feels that she has told him 'she is going to destroy me', denies having had any hallucinations, 'it's just my word against hers'. He says wife has now stopped saying abusive/nasty things to him. Last conversation he had with her was alright and mostly concerned with the children's welfare. Accepting medication at present. Agreed for meeting with [M], CPN and Dr Naylor on Wednesday. Community support needs setting up. He still wants to go on his course/carpentry. Dr Hand: leave is probably appropriate. He is close to accepting that he is suffering from mental illness.

37. In the oral hearings Dr Hand told the Inquiry she had thought it appropriate to allow H to return home with M. She pointed out H had 'responded very quickly on his previous admission to medication and had a relatively short period in hospital. One of the things that had particularly distressed (H) following his first admission was his loss of job and, in fact, that seemed to head a depressive reaction. That seemed to be partly due to his loss of work previously. He had had an offer of a full time course and was very keen to get going and weighing up the advantages of getting him involved in his course and that he was very much improved … even in that short time'. Dr Hand also said H was gaining insight into his illness.

Comment

38. **An improvement is evident in H's mental state in the three days since Dr Hand first assessed H. The intensity of his symptoms had diminished and, in particular, H no longer attributed auditory hallucinations to M. Although H was said to be 'accepting' his medication, it is not clear from the entry whether this indicated a return of some insight into his condition and that he recognised the benefit of medication. An alternative view is that H was still complying because he knew the implications of being detained under section 2, as Dr Hand had identified during her meeting with him on 7 January.**

39. **In contrast with the earlier entry, there is no comment on M's perception of the situation. M had not yet been interviewed by the hospital staff. A meeting had been arranged for the next few days. The inclusion of the CPN for that meeting suggested a move towards discharge planning.**

This notion is reinforced by the references to community support and the probable start of leave.

40. On 12 January Dr Naylor and Mr Condon met with H. The entry reads:

> Some insight but limited. No hallucinations at present, he was still deluded re: source of hallucinations recently. Believes it was partner [M] who was saying the things at Christmas/New Year. Says he will continue medication because we have advised him to. Does not think he was having hallucinations 'because they are too real' but accepts that it could be possible if hallucinations really do sound real. Seems perplexed by this and anxious about possibly being ill but additionally anxious about losing his place on his college course stated his desire to go home asap.

41. Dr Naylor and Mr Condon then met with M, with H's agreement. That entry reads:

> She states anxious about how he will behave at home – has been verbally very aggressive – anxious about having him home but if this (is) in his best interest she is prepared to give it a trial at home. States she thinks he's much better but still annoyed with her and blames her for calling him names (hallucinations) and setting him up to be in hospital and (losing) his course. Argued with him when she came to visit yesterday about his belief that she was the source of the hallucinations and engineered his admission.
>
> Conclusion - Anxious about him going home but willing to consider it but would like to have chance to make appropriate arrangements at home i.e. sleeping arrangements/bedrooms. Would fit in with this and her work if could go on leave Friday ([M] seeming rather anxious and worried by the whole episode but just coping probably).

42. H then joined M for a discussion with Dr Naylor and Mr Condon. Leave arrangements were discussed with the proposal of him going on home leave from Friday to Monday with a review on Monday to assess progress and possible discharge. It was said H became angry at this proposal, raised his voice and stormed out of the room. He 'later returned and was calmer but making some seemingly hostile comments to M about her being behind him being admitted for her behaviour towards him'. The entry then continues as follows:

Assessment

Risks

1. Aggression/verbal mainly towards [M] after discharge – she may not cope well with this as she is seemingly quite fragile from the stress of all this. – He is still paranoid about her, her intentions and even in the meeting today was unable to contain his frustration, airing his annoyance at her.
2. Relapse of hallucinations – more likely if does not comply with medication or in situations of stress/conflict.
3. Suicide risk low – not depressed

…on balance plan to arrange for leave to be set up as for practicalities so that when [H] is ready to go he can do so straight away. At the moment I have suggested this be discussed again on Friday as I am not happy to arrange leave today following his still having difficulty with anger and paranoid feelings towards [M] and becoming easily irritated today when seen with [M] and Derrick (Condon). Therefore to review by team Friday (Dr Hand usually in on Friday).

43. In the oral hearings before the Panel Mr Condon said H later told him he had become angry in that meeting 'because he felt he had to falsely continue to present this persona of being totally compliant and subscribing to everything we wanted to actually get out of hospital'.

44. On 13 January H had escorted leave with members of the nursing staff and this was uneventful. It was also recorded that M would attend the ward at 3.30pm the following afternoon to meet with Dr Hand. The night report for that evening said H was settled in mood and 'looking forward to going home on leave'.

45. On 14 January Dr Hand interviewed M and H together. Her report reads as follows:

No return of auditory hallucination and very much calmer. Accepting that he was ill and voices were hallucinations although states that at time were very real. Real relationship difficulties present despite his illness but made worse by this, but he and [M] have come to agreement to separate and both want to remain friends. Agreed over weekend not discussed their separation. Paranoia

re [M] appears to have lessened to greater degree with no suspiciousness. However, given reaction on Wednesday need to assess further his ability to be at home and to comply with meds. Therefore continue on section 2 meanwhile – give weekend leave with assessment daily by CPN and I will review Monday if no problems then will discharge from section and hospital.

46. Dr Hand also wrote up authority for leave of absence from the hospital under section 17 MHA. This read 'weekend leave at home dependent on daily assessment by CPN and no deterioration in mental health. To be reviewed on Monday at home if leave successful, in hospital if not'. This was dated 14 January 2000.

47. The duty CPN for the weekend was informed of this arrangement by a phone call from Dr Hand on the Friday afternoon. The CPN's entry in the clinical notes also added that Mr Condon was to liaise with Dr Hand on Monday regarding a joint visit to assess progress and suitability for extended leave (under section 17 MHA).

48. The first home visit took place on Saturday 15 January and H was said to be quite relaxed and spontaneous. His relationship with M seemed to be amicable, although both admitted they had had a long discussion the previous evening about their difficulties. H was said to be 'quite insightful' regarding the need for continued medication and was also able to provide an account of the factors leading up to hospitalisation. He was said to be keen to return to his carpentry course and no evidence of psychotic or untoward behaviour was elicited during the visit.

49. The following afternoon the second home visit took place and there was little change from his presentation the previous day. On that day H had taken his children to the swimming pool and the atmosphere between H and M seemed 'supportive and understanding'. The CPN confirmed Dr Hand and Mr Condon were proposing to visit the following day to evaluate the leave.

50. There is no written record of such a visit by Dr Hand and Mr Condon taking place. Dr Hand did discharge H from section 2, effective from 17 January.

51. Dr Hand told us she and Mr Condon spent 'a long time' with H on that visit. He accepted the need to be on medication and could recall symptoms had

returned on a previous occasion when he stopped his medication. Dr Hand felt confident H's 'symptoms were coming under control' and 'things were going well at home'. Dr Hand agreed that by this time it was established that non-compliance with medication by H led to relapse of his mental illness.

52. Dr Hand told us she considered that the home visit on 17 January represented H's discharge meeting.

53. Dr Hand was asked about her change of mind over her earlier thought of converting H's section 2 to a section 3. In her response she said that, had she not been on annual leave at the time and been involved in the admission decisions, she would have detained under section 3 from the beginning. Her reasons for this included her previous knowledge of H and that section 3 is the main treatment order in the Mental Health Act. She was not swayed by the thought that section 3 could last for up to six months in the first instance. Dr Hand explained her practice was to make patients informal as soon as possible because she believed this made for a better working relationship.

54. Dr Hand acknowledged considering conversion to section 3 but changed her mind primarily because H's auditory hallucinations had lessened in the meantime, and also because at the later interview he displayed a greater willingness to continue with his medication. Other relevant factors included having a job waiting for him, being prepared to look at his relationship with M, and she being prepared to 'try it out at home'. Because H had responded well and quickly to oral medication (Risperidone) Dr Hand believed it was not necessary to consider the use of depot medication, although H was known to be unreliable at times with taking his medication. Dr Hand wished to maintain H on medication that had minimal side effects. She told us that even if he had been detained under section 3 MHA from the outset, she would have considered that he was ready for discharge at this time.

55. Mr Condon told the Inquiry it was his fault there was no CPA documentation following H's discharge from hospital. He told us that the paperwork was usually not raised unless a specific decision was taken to put a particular patient on the enhanced level of CPA monitoring. This was not applied to H. Dr Hand made a similar point in her oral evidence. In retrospect Mr Condon agreed H should have qualified for an enhanced CPA level, but at the time he

and Dr Hand did not discuss whether H should be on a simple or an enhanced CPA.

56. Mr Condon also told us his approach to the risk issues in this case was 'more intuitive as opposed to being based on fact. …… there was very little evidence that he had ever actually physically assaulted his partner. If I am honest about it, I always felt that he had the potential because of his unpredictability, there was always a potential for risk but, as I say, that was based more on intuition as opposed to historical evidence'.

Comment

57. **The Panel has a number of concerns regarding the process and planning of H's discharge. M's anxieties about having H at home were expressed by her on 12 January. Those concerns would have been reinforced by H's accusations towards her the day before and exacerbated by his behaviour during the joint meeting H and M had with Dr Naylor and Mr Condon. However, two days later Dr Hand felt it was appropriate to send him home on leave over the weekend. An assessment of risk at this stage should, at the very least, have led Dr Hand to exercise caution in granting H leave to return to live with the person he believed had conspired to have him admitted to hospital.**

58. **There was a lack of clarity as to what would happen if the weekend leave was unsuccessful or, indeed, what criteria were to be used to judge success. It was not stated who was to make the decision that if leave at home was so unsuccessful that it should be revoked and H return to the hospital. The original plan, if leave was successful, was to assess H's progress and consider the possibility of extending the period of leave. In the event, H was discharged from his detaining section and from hospital.**

59. **It is of particular concern to the Panel that no written record of the final assessment, by Dr Hand and Mr Condon prior to discharge, exists. Our concern is heightened because Dr Hand regarded the visit as the discharge meeting. There is no record of H's mental state at that time, his attitude to M, his compliance with medication, what M's needs and views were or, indeed, what the follow up arrangements were. We**

consider proper record keeping as the key to the accountability of services.

60. **The Panel was assured during their interview with Dr Hand, and accepts, that there was no pressure to discharge H quickly in order to free up a bed in hospital.**

61. **We remain of the view that the use of further leave or conversion to section 3 MHA could have ushered in a more reflective period of treatment. While Dr Hand's general approach of avoiding admission and use of the Mental Health Act whenever possible in order to promote a better therapeutic relationship is laudable, we believe H's case was increasingly demonstrating the need for a more assertive style of management. H could be seen as an articulate caring family man, but he was also developing a number of features of the 'revolving door' patient.**

62. **The Panel believes the choice of which section to detain H under was determined more by the expected time to achieve symptomatic recovery alone rather than the overall complexity of his needs. There is evidence in this case that his brief admissions reflected rote thinking and allowed insufficient time for analysis of his situation. There is little evidence that anything more was achieved than stabilising H's symptoms on medication and then discharging him on the same medication that he had previously defaulted on. Such a process throws more responsibility on to the CPN to provide adequate monitoring and in this case the community supervision fell short of reasonable practice.**

63. **Our findings with regard to this discharge process reinforce the comments made in relation to the discharge process in June 1999 in Chapter 3. It is also our view that, due to the complexity of his needs, H should have been subject to a complex/enhanced level of CPA.**

64. **Dr Hand's aspiration to develop a good therapeutic relationship with H, as with her other patients, by permitting him to become an informal patient could not be translated into practice. She never saw H in the outpatient clinic between the admissions and not at all after discharge**

on 17 January. The responsibility for supervision passed to Mr Condon as the allocated CPN. He was believed to understand the issues requiring monitoring and treatment but they had not been made explicit. This was then compounded by the lack of an effective and formal system of communication between the inpatient and the outpatient sides of the service, for example in a formal review meeting. The Panel is of the clear opinion that the poor implementation of the CPA policy and the informal review arrangements that were allowed to exist for patients subject to CPA militated against efficient channels of communication and reasonable care.

65. **The Inquiry Panel views H's discharge and subsequent supervision in the community as an example of how care can be allowed to drift in the absence of firm procedures (see Chapter 2 sections on CPA and Care Planning for more detail).**

66. **It is unacceptable practice to have discharged H without CPA procedures being implemented and no properly documented discharge meeting. There must be a common, agreed agenda for professionals to work to, regular reviews to evaluate progress and plan further interventions, and contingency plans for anticipated events such as non-compliance with medication or outpatients appointments. With H discharged on the simple CPA level by default, there was no timetable for review of his care and most obviously no assessment of risk whether to H or M. Mr Condon, as the sole provider of psychiatric care, was allowed to practise in an unsupported and autonomous manner, which we heard was the style in which this CMHT operated.**

67. **Contingency plans in the event of non-compliance should be a standard part of any CPA. Dr Hand suggested that there was no such contingency plan in the event that H defaulted on outpatient appointments on discharge in January 2000 because he had not previously done so. We do not accept this as sufficient justification for this omission.**

See RECOMMENDATION 1 (Chapter 2)

The Trust (CPT) should within six months

a) **review the drafting and implementation of its CPA policy and**
b) **ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.**

Additionally all policies must be dated and the date of implementation be clear.

68. An admission summary, dated 12 January 2000, was prepared by the then SHO to Dr Hand, and sent to the GP, Dr Gibson. The summary briefly outlined the prelude to the admission and recorded the principal features in H's mental state at the time of admission, including H's preoccupation with the role he believed M had played over this period. The summary also included a brief review of his past psychiatric history, including mention of earlier episodes which had not lead to psychiatric attention or admission.

69. The discharge summary, also prepared by the SHO, was dictated on 21 January and typed up five days later. The diagnosis was recorded as an 'acute psychotic episode' and the medication on discharge was listed as Risperidone 4mg once daily. Treatment and progress was summarised in less than ten lines although the other section on 'Recommendations' also contained relevant information for the previous section. The discharge summary erroneously gave the discharge date as 18 January but it did record the name and dose of medication and give the date of the first outpatient appointment as well as the fact H would be followed up in the community by Mr Condon. On 26 January a letter was also sent to H informing him of the outpatient appointment five days later on 31 January.

Comment

70. **The admission summary was an adequate document but the discharge summary was deficient in some aspects. The 'relationship difficulties' between H and M are mentioned but the phrase does not adequately reflect the potential risks flowing from H's incorporation of M into his abnormal mental state. The impression is also given that H is accepting of the planned separation, which is only delayed while H finds a job and**

suitable accommodation. The summary also lacks a clear statement as to H's mental state at the time of discharge. The risk issues must be formulated in clear, unambiguous terms.

71. **The discharge summary, like the admission summary, is sent to the GP but a copy also resides in the clinical records. The value of the summaries is in clearly documenting how a patient presents and comes to be admitted to hospital, how they are treated, what progress they make and how they are when they leave hospital. Accurate recording of this information allows future readers to form judgments about the patient's progress or presentation on other occasions, such as when readmission or a change of medication may be contemplated. It also permits trends in a patient's history to become apparent. These can also influence the treatment and management of the patient. They are also useful summaries for those with no knowledge of a patient and requiring information for an urgent assessment.**

72. **Moreover, the discharge summary should include the discharge plans in some detail, including the dates of appointments and reviews. A formulation of risk issues developed over the admission should be included. Mention should be made of the circumstances when the risk is heightened, who might be at particular risk and how the risk should be managed, including consideration of possible scenarios such as failure to attend clinic appointments or to take medication as prescribed.**

73. **This comment is also relevant to proper record keeping and accountability. Recommendations relating to discharge summaries and record keeping have been made in previous Inquiry reports.**

RECOMMENDATION 12

The Trust (CPT) should review the way in which discharge summaries are written to ensure compliance with the findings of this Inquiry as set out above and mental health policy and best practice. In particular discharge summaries should record the detailed decision as to why discharge is considered appropriate at that time, the specific arrangements for follow up of the patient including the names,

designations and contact details of those responsible for ensuring follow up plans are maintained.

Supervision in the community by Derrick Condon CPN (January to August 2000)

74. Mr Condon made his first home visit, after H's discharge, on 24 January 2000, in the evening. That is one week after H's discharge. He reported the situation to be 'settled' with H attending his day course and M no longer 'emotionally distressed'. H was said to be taking his medication regularly and the 'family dynamics appear more relaxed'. H seemed to have more 'clarity' about recent events but still spoke 'tongue in cheek' regarding his illness. The next home visit was arranged for the following week.

75. Mr Condon drew up a treatment plan, dated 24 January, although it did not carry H's name on it and he did not sign it. The plan reads as follows:

> Problem No. [H] has recently been discharged from T/G following a recurrence of his psychotic illness including auditory hallucinations of a derogatory nature and paranoid thoughts about his wife.
> Goals of care with review dates: For [H's] current stable mental state to be maintained and for planned separation from wife to be facilitated with minimum of trauma.
> Care intervention/Action:
>
> 1. offer CMHT contact numbers
> 2. visit weekly Monday evenings on [H's] return from training course
> 3. ongoing assessment of [H's] mental health and efficacy of medication
> 4. liaise with [M] to assess ongoing domestic situation and its effect on family
> 5. explore at the appropriate time the question of amicable separation of [H] and his wife
> 6. liaise with GP as appropriate
> 7. liaise with Dr Hand re ongoing (outpatient appointment)
>
> Review (3 months)

76. This treatment plan was, Dr Hand said, 'broadly' agreed between her and Mr Condon on 17 January.

Comment

77. **This treatment plan is acceptable. In it Mr Condon recognised H had incorporated M into his psychotic beliefs. It showed a need for the continued use, and monitoring, of the prescribed medication. The plan also acknowledged the ongoing difficulties in the home situation as the separation came closer.**

78. **However, the treatment plan lacked a formal, systematic review. Its review date was put at three months but no such review took place. As discussed in Chapter 2 above (see Care Planning), the treatment plan contains a preponderance of administrative actions rather than detailing the monitoring and delivery of care.**

79. **The treatment plan was drawn up after the home visit of 24 January and not after Mr Condon and Dr Hand visited H at on 17 January. There is no written evidence of any involvement from Dr Hand in its preparation, implementation or review. She says she was aware of it in 'broad' terms. The Inquiry panel would have expected some consultant input and its absence further illustrates the unsupported way in which Mr Condon was allowed to practise. (see Chapter 2, CMHT Structure)**

80. On 31 January H failed to attend his outpatient appointment at Bolitho House (CMHT base) with the then SHO to Dr Hand. The SHO wrote in the unified record 'CPN to investigate asap. ? compliance issues, needs assessment.' She also wrote to Dr Gibson, H's GP, informing him of the missed appointment but mentioning she had contacted Mr Condon who was due to visit H that evening and would 'ensure that he is complying with his treatment'. The letter also stated Dr Hand would be asked to review H 'in the near future' as the SHO was leaving her post. The SHO also wrote to H, in a letter dated 3 February 2000, supplying the date of the next appointment, which was to be on 21 February and with Dr Hand. However, in a letter dated three days before the appointment Dr Hand's secretary wrote to H cancelling the appointment and rearranging it for 3 March.

81. Mr Condon visited H at home on 31 January, as previously planned, although his entry gave no indication he had been told of H's non appearance at the

clinic earlier in the day. The home situation remained 'settled' and 'relaxed'. M was said to not look as 'strained' as on the previous visit. H reported he continued to take his medication but also talked 'expansively about his illness and the need to continue his medication regime although suspicions still remains that he says 'what you want to hear' but overall remains fully cooperative'.

82. A week later the third home visit after discharge took place, on 7 February, and again was in the evening because H attended his building and joinery course at the nearby college during the day. Mr Condon believed the domestic situation remained settled 'probably' because H and M avoided difficult issues; presumably referring to the planned separation. H 'assured' Mr Condon he was 'religiously taking his medication'. A further home visit the following week was arranged and this took place on 16 February. Again the home situation was 'calm' and the relationship between H and M was 'settled but probably based on continued avoidance of discussing future and probable separation – both parties admit to ongoing problems if the subject is brought up'. From the point of view of his mental health H remained well and continued with his medication.

83. It was noted that H was going to Scotland for four days the following week as part of his college course. Mr Condon wrote that he would try to arrange an outpatient appointment with Dr Hand for what seemed to be the Friday of that week. There was no indication that this was to be anything other than a routine outpatient appointment although it is not clear why Mr Condon was arranging the appointment rather than it being done through the clinic. He also wrote he intended to take the opportunity of H's absence in Scotland to speak with M on her own.

84. On 28 February Mr Condon made a home visit to see H who had returned from Scotland. The entry is briefer than normal and made no reference to any outpatient appointment or to any conversation with M in the period since the previous home visit (and there was no other entry suggesting this had in fact taken place). The entry made no mention of H's mental health or his compliance with medication. The home situation was recorded as remaining 'settled'. The entry concluded with the apparent agreement that Mr Condon would make his next home visit after his return from annual leave.

85. On 3 March H failed to attend the outpatient clinic at Bolitho House to see Dr Hand. She wrote to the GP, Dr Gibson, that day informing him of H's non appearance and adding she would liaise with Mr Condon before sending another appointment.

86. The next home visit was four weeks after the previous one, on 27 March. Mr Condon was able to confirm with H that he continued to attend his training course although he was now attempting to find employment on ships again. He was said to be taking his medication as prescribed and there was no change reported in the domestic situation. The reason for this seemed to be their continued avoidance of the subject as M reported that if it was discussed H became angry. There was no mention of H's failure to keep his outpatient appointments in Mr Condon's written entry of the home visit.

87. The frequency of the home visits reverted to fortnightly for the next one, which took place on 13 April. It was recorded that H continued to comply with medication, the home situation was stable and the reason for this remained their 'ongoing avoidance of sensitive issues'. The next home visit did not take place as planned in a fortnight's time (on or around 27 April) but on 23 May 2000. This seemed to be the result of Mr Condon being on compassionate leave and H being away at a training course. M was said to have 'probably' found a place to move to and her separation from H might be within the next few weeks. However, when the subject had been raised by M, H had either refused to accept it or became verbally angry. In contrast, Mr Condon found H to be 'composed and symptom free' during the home visit although the topic of the potential separation from M was not raised. Mr Condon wrote that he would arrange an appointment with Dr Hand 'asap' and he would return in two weeks time.

88. In a letter dated 30 May 2000, Dr Hand's secretary wrote to H with an appointment to see Dr Hand on 19 June at Edward Hain Hospital in St Ives. The letter mentioned at the outset that the appointment had been made at the request of Mr Condon. There are no further letters in the clinical records relating to outpatient appointments. H did not attend the appointment on 19 June and, indeed, we found H did not attend the outpatient clinic once between his discharge from hospital in January and the homicide in November 2000.

89. Mr Condon's next home visit was over three weeks later, on 15 June. It seemed he only met with M on that occasion. She confirmed she had found somewhere else to live and would probably be moving there within the next three weeks. She reported this news did not seem to have had a major impact on H's mental health but Mr Condon noted that 'careful monitoring would be required over the next few weeks' in case this situation altered. He agreed he would return the following Monday evening to see H. He also advised M that she could phone him at any time if H became 'distressed or disturbed'.

90. On 19 June Mr Condon returned for another home visit and this time met with both H and M. H seemed to be 'superficially' accepting of the imminent change in their living circumstances but was also described as being unhappy and resigned to the fact. He seemed to understand that the separation had come about through long-standing relationship difficulties between them and was not just because of his mental illness. He was said to have restarted Prozac to 'counteract anticipated depressive symptoms that will coincide with family's departure'. The entry for that visit did not record what H's mental state was like. Mr Condon agreed to make the next home visit in two weeks time.

91. On 4 July he returned to see H and the entry read as follows:

> bad weekend. Major argument regarding [M's] impending departure resulting in threatening behaviour by [H] which left [M] frightened and fearful for her future safety. When I met [H] shortly after my arrival he spoke of the incident although minimising its ferocity and effect on [M] but really expressing thoughts of intense anger directed at [M] who he feels is responsible in the main for the break-up of the relationship and as the departure date becomes more imminent the fear of retribution cannot be ignored. From a mental health point of view [H] is currently very stable showing no evidence of psychosis but there remains a strong undercurrent of anger and loss. Surreptitiously agreed to meet [M] tomorrow to discuss evasive (sic) plans if she becomes fearful for her safety.

Otherwise no date for the next home visit was apparently agreed.

Safety plan for M

92. Mr Condon met with M on 6 July and informed her of the 'safety plan' he had compiled. It is reproduced in full below:

Multidisciplinary Treatment Plan

Patient/Client Name: [H]

Problem No: [H] has recently recovered from a severe psychotic illness and currently symptom free – wife now wishes to separate and her departure is imminent causing [H] increased feelings of anger resulting in threatening behaviour towards [M] although no physical violence has occurred the risk of this happening should not be minimised as date for [M's] departure with children draws closer.

Goals of care with review dates:

Care intervention/Action

1. reiterate to [M] contact numbers for duty desk and out of hours number for St Lawrence's Hospital,
2. inform [St Lawrence's Hospital] and duty desk of safety plan,
3. inform [M] that any threat to herself should result in immediate notification to police,
4. liaison and appraisal of prevailing circumstances should take place with Sgt Nick Clarke (Domestic Violence Unit),
5. if disturbance occurs and duty desk is alerted two male staff members only to attend,
6. notification of above discussed and agreed with [M]

The treatment plan is signed by Mr Condon and M and is dated 6 July 2000.

93. Mr Condon also put a typed version of the above, entitled 'Formalizing of Safety Plan', in the unified record. Copies were sent to the duty desk, St Lawrence's Hospital, Sergeant Nick Clarke, of the Domestic Violent Unit based at Penzance Police Station, and Dr Gibson, the GP. This version was almost identical to the actual safety plan but it did omit interventions 5 and 6. In other words the duty desk at Bolitho House was not informed of the need for two male staff to attend if the CMHT were called after a disturbance.

94. Mr Condon also told M he had spoken to Sgt Clarke. On 7 July Mr Condon wrote to Sgt Clarke, in the following terms:

> Following our recent telephone conversation, I thought that I would appraise you currently of the situation regarding [H]. [H] has suffered a severe psychotic illness 18 months ago which necessitated admission into hospital. Currently he remains mentally very well on medication and [is] virtually symptom free. [There is mention of the separation and the reasons for this]. The impending separation is now imminent and will take place, certainly within the next two weeks. I have seen [H] on a number of occasions since he became aware of this and although it has not affected his mental health he does have a great degree of anger directed at both himself, for past indiscretions and also anger at [M], for making the ultimate decision to leave, which he thought she would never do. Whilst he has never threatened myself or indeed there is no history of assaults on his partner he has, when the discussion has centred on the impending separation, become threatening in his stance and general demeanour, without actually perpetrating any physical assault. The last instance of this threatening stance being adopted was last weekend, which frightened [M] and therefore, I felt it prudent to compile the enclosed safety plan to which [M] has seen and signed agreement. She is aware that in the event of any behaviour, which threatens her safety that the Police should be informed immediately. ……. I will be annual leave as from the 16 July 2000 but next week I intend to visit [H] with my colleague Shaun Wright who will assume clinical responsibility in my absence.

95. The Inquiry Panel wrote to Sgt Clarke who responded that he had 'never served in or performed any duties in relation to the domestic violence unit'. Sgt Clarke did acknowledge he had had professional contact with Mr Condon, among others, with regards to setting up 'partnership links and a joint information exchange protocol'. The clinical file does, however, contain copies of letters to a Sgt Clarke at the domestic violence unit and there was a follow up record of contact from the police on 24 July asking whether M had moved out. They were advised by the duty CPN to keep their log open.

96. Mr Condon also told M that he would visit the following week with Shaun Wright who was to provide clinical cover in Mr Condon's absence. There is no entry in the clinical record that Mr Condon did visit the next week either on

his own or with Mr Wright. The Inquiry Panel found it impossible to establish clearly the timing and exact duration of Mr Condon's leave.

97. Mr Condon told the Inquiry he compiled the safety plan because he 'thought something might happen when M made the physical move to actually leave' and this might involve her own safety. Mr Condon accepted formulating such a plan was an exceptional occurrence which he had performed on only one previous occasion. He said he did discuss with H that he made M frightened on occasions (although possibly not on this occasion) and he would 'grudgingly' accept the comments but would 'constantly minimise' their impact.

98. We were told by Dr Hand in the oral hearings that she was not involved in discussing or formulating the safety plan. She saw the plan for the first time after the homicide had taken place. She agreed with us it was a matter that should have been brought to her attention. After reading the safety plan in the hearing Dr Hand commented that, although it was appropriate to involve a patient's carer in such a matter, there should also have been a discussion with the patient about the risks other people were worried about. Dr Hand considered there was a need for an additional plan for the patient himself.

Comment

99. The Inquiry Panel has a number of serious concerns about Mr Condon's level of supervision of H following his discharge from hospital at the beginning of that year. Mr Condon's entries in the clinical records showed little investigation, if any, of H's mental state beyond observation. Some entries contained no reference to H's mental state. Mr Condon took H's word for his continued compliance with medication. Moreover, there was very little evidence of liaison or communication with Dr Hand. On two occasions Mr Condon made home visits on the same day as an outpatient appointment had been planned. There was no evidence Dr Hand was kept informed of developments over time and particularly as Mr Condon's written concerns heightened as summer approached.

100. As tensions between H and M grew ever more apparent, so contact between Mr Condon and H became more erratic and infrequent and his monitoring became superficial. It is acknowledged that H was not keen on the community supervision and saw no need for it or, more latterly, for medication. However, he did accommodate Mr Condon at the times of the home visits. There were no indications in the records of H not being at home at the agreed time of a home visit.

101. It seemed to the Inquiry Panel that Mr Condon was disengaging from his supervisory role when all the indications pointed to the need for closer supervision.

102. The safety plan devised by Mr Condon was explicitly for M. There was no corresponding treatment plan for H, designed to address the perceived increased level of risk he now posed.

103. We consider it unacceptable that Dr Hand was not involved or informed of the safety plan. Anxiety to such a degree about M's safety demanded the involvement of the patient's consultant.

104. M's departure along with the children from the home they shared with H might have been expected to have some impact on H's mental well-being. Ongoing assessment of H's mental state had been identified as a care intervention/action in Mr Condon's first treatment plan after H's discharge from hospital in January 2000. By July that treatment plan, which should have been reviewed in April, was being ignored.

105. The Inquiry Panel also has major reservations about the adequacy of the safety plan. It was a passive, rather than active, plan. The plan, in the main, needed H to cause further disturbance before it had relevance. It relied on M to notify the appropriate people rather than increasing the level of monitoring or calling for a case review to evaluate the situation and decide on the most appropriate course of action. In effect, Mr Condon was abrogating his responsibility towards both H, his client, and M.

106. **Implicit in the plan was the acknowledgement that H now posed an increased risk to M. Mr Condon's letter to Sgt Clarke gave detail to that acknowledgement. It mentioned H's anger not only towards himself but specifically towards M when the topic of her departure was discussed. At such times he could become 'threatening' towards her. Mr Condon's entry after the home visit of 4 July, which was the last time he had seen H before compiling the safety plan, referred to his 'intense anger' and it having a 'ferocity' that left M threatened, frightened and fearful. Mr Condon also expressed a 'fear of retribution' by H as the separation drew closer. However, no active steps were taken to attempt to contain or diffuse H's anger. The Panel noted that while M's safety plan did not actually contain any measures designed to decrease the likelihood of her becoming a victim of H's anger and frustration, it did call for the presence of two male staff when visiting H if a disturbance had taken place.**

107. **Although Mr Condon stated in the safety plan and his letter to Sgt Clarke that H was symptom free, the Panel were unable to accept this at face value. Details were not always recorded about H's mental state during earlier home visits. Both Mr Condon (on 15 June, although this relied on M as informant) and H (noted at the visit on 19 June) referred to the possibility of the future onset of symptoms specifically in relation to M's departure.**

108. **Finally, anger towards M had been a principal feature of H's presentation in hospital earlier that year and had also led to a delay in him being given home leave. However, Mr Condon took no action to inform Dr Hand of the deteriorating home situation or to secure a mental health assessment as a check as to whether H's mental state had changed.**

109. **It was inexplicable to the Panel that Mr Condon should have been sufficiently concerned to draw up a safety plan for M and to send a copy to the police but not to share it with Dr Hand, who was H's consultant psychiatrist. We regarded this as the result of Mr Condon being allowed to practise in an autonomous manner with insufficient oversight of his work, through clinical review and supervision.**

110. **The Panel is critical of Dr Hand for presiding over a system that allowed cases to remain without review. Hers was a system that relied on the CPN to bring cases subject to simple CPA for review. It was only patients on enhanced CPA who were subject to more formal three monthly reviews with her. The Panel also criticises the Trust's management for its failure to promulgate and implement proper CPA procedures, supervision and training, which in our view is likely to have identified and addressed the professional shortcomings of any practitioner. However, the Panel is also critical of Mr Condon for the manner in which he discharged his professional responsibilities to access adequate supervision and training. (See Chapter 2, Clinical Supervision and Training, for more discussion of this point.)**

111. **Mr Condon wrote to Sgt Clarke that H was still on his medication. The previous mention of medication in Mr Condon's written entries had been in April, although H had said, in June, he had restarted an antidepressant in anticipation of symptoms when M moved out. H was known to be reluctant to take his medication at times but his compliance was not specifically questioned. In the course of the Inquiry the Panel learnt that H did not complete the prescription for Risperidone filled on 28 June. In retrospect, it would seem H was on the point of defaulting from his antipsychotic medication at around this time. It has to be left to speculation whether an open discussion with H on the need and benefits of such medication and the possible consequences of not taking medication would have made any difference to his decision to eventually stop all his medication then or shortly thereafter.**

112. **We know from Dr Gibson, H's GP, that no further prescriptions were issued to H after 28 June and accept his view that it is not for the GP to monitor actively a CMHT patient's compliance with prescribed medication. Furthermore, we were told the system for issuing repeat prescriptions would not alert the GP to a patient's failure to request further prescriptions. The Panel regards periodic checks with the GP, by the CPN or other key worker, that the patient has collected his prescriptions at the appropriate time as one way in which attempts can be made to monitor a patient's compliance with his medication.**

Withdrawal of CPN monitoring

113. Mr Condon's next home visit was dated 2 August. His entry read as follows:

> home situation very poor. [H] very angry and threatening with [M] as impending move is imminent (within next week). [H[] feels betrayed and angry that he is about to lose his children and directing his anger solely at [M] who is distressed and fearful for her safety – [H] has been making threats of retribution if she leaves although today he emphasises this is borne out of anger than actual intent – although the potential remains very high. Has also stopped taking his medication although currently no evidence to suggest his psychosis has returned. For urgent liaison with Dr Hand.

114. There was no written entry to confirm that Mr Condon did liaise with Dr Hand. Mr Condon accepted no written record existed and told us he could not recall whether or not he spoke with Dr Hand on this occasion.

115. Dr Hand told us she had no record of Mr Condon liaising with her. Had she been informed she would have responded appropriately. Possible responses would have included seeing H in the outpatient clinic and monitoring his compliance with medication there, arranging to conduct an assessment herself that might have resulted in admission to hospital.

116. Mr Condon's next entry is not dated until 18 August, over two weeks since the previous entry, and only records telephone contact with M. Mr Condon could not explain to the Panel why he did not visit or make contact sooner with either H or M, given that the level of anxiety he had when making the safety plan had not diminished in the meantime. M reported to Mr Condon she had separated from H 'a week last Saturday'. She also said H had been 'pleasant and accepting of her departure and had even helped her to move'. He had visited the children most evenings without any obvious signs of anger or hostility. In addition H was said to have found a new job and M was described as sounding 'very relaxed' and pleased at current status. She also indicated H's mental health was stable and Mr Condon wrote in the clinical record that he would see H 'when convenient to his work situation'.

117. Mr Condon's next entry is dated 24 August and again referred to a telephone conversation. He spoke with H who was attending a family barbecue at M's new address. Mr Condon reported that H sounded well on the phone and he spoke at length about M moving out and of how he wished for their separation to be amicable. He wanted to remain friends with M for the sake of the children. He also discussed his new job and how he was enjoying it. Mr Condon wrote that over the telephone conversation there was no evidence of a deterioration in H's mental state and that H asked about 'CPN withdrawal as crisis has now passed. Agreed I would review this over next few weeks'.

118. In evidence to the Inquiry Mr Condon accepted he had not followed up with H the fact that he had stopped his medication before the home visit on 2 August. Mr Condon pointed to the fact that his 'conversation with [H over the telephone] indicated to [Mr Condon] that his mental health status was very stable at that time'. Mr Condon did agree with the proposal that even though H had apparently accepted the separation in the initial stages his attitude could change and so should have been monitored.

119. Regarding H's suggestion of withdrawal, Mr Condon told us he was very much aware that with H living alone and starting a new job, any appointments would be successful only with H's agreement. However, he admitted he did not test this hypothesis out at any time. Mr Condon recalled being reassured that M had moved out and left it with her that she should make contact if any problems with H occurred. He acknowledged he did not consider the stresses and tensions around H's access to his children. He also remained reliant still on M to inform him of the effect of the separation on H but did not see this as an abrogation of his responsibility towards his client.

120. In her evidence to the Inquiry Dr Hand had no recollection whether Mr Condon had discussed with her his withdrawal from supervising H in the community. She regarded the main period of potential crisis as being around the time M moved out from living with H but added 'ideally the support (from Mr Condon) should have continued.' Later in evidence she was stronger in her comments and said H 'should have been actively followed up'. Dr Hand agreed that in the absence of this information, her level of concern about H and M at that time was lower than Mr Condon's concern seemed to be from his written entries.

121. Mr Condon's next entry is not dated until 13 November 2000. This entry was written after M contacted him to inform him H had been taken to Camborne custody centre.

Comment

122. Mr Condon's approach to the risks he identified when he put in place the "safety plan" on 6 July for M, and thereafter, was inconsistent. That plan indicates a high degree of risk to M, sufficient to involve the police. Although records of Mr Condon's leave arrangements are missing, it is highly likely that he was back from his period of annual leave before M actually moved out. By 2 August, Mr Condon's last face to face contact with H before 13 November, he was back from leave and M had still not moved. In spite of his earlier concern the evidence is that he did not monitor H over the move itself.

123. After Mr Condon's meeting with H on 2 August, he recorded H as being angry and threatening to M. A concern from the records was H's clear acknowledgement that he had stopped his medication. We consider the failure to liaise with Dr Hand over this and the safety plan to be unacceptable. In spite of the increasing worry evident in that entry of 2 August and his previous concerns over M's safety, Mr Condon did not see H again for a further three months and until a time of crisis.

124. Subsequent entries recorded either M's impression of H's mental state or relied on the impression from a telephone conversation with H himself. The Inquiry Panel is firmly of the view that, at the very least, Mr Condon should have increased the frequency of his visits to H at this point. Instead Mr Condon adopted a casual approach to ongoing contact. He would see H 'when convenient' (from 18 August) or would review H's request to withdraw from contact 'over next few weeks' (from 24 August). The Panel was given the impression that Mr Condon regarded M's separation from H as the sole point of crisis. When that passed without incident it was as if there was no further need for supervision or monitoring. This ignores H's needs completely; either from the point of view of recovering from a psychotic episode that necessitated a formal hospital admission the previous December or,

more immediately, from that of readjusting to life without his partner and children. Mr Condon's approach was blind to the fact that H would still have regular contact with M whenever he visited to see his two children. Such meetings clearly carried the potential for further conflict between H and M.

125. The Panel is, therefore, highly critical of Mr Condon's effective withdrawal from this case between August and November 2000. A separation H never wanted had just taken place, this was against a background of increasing anger and threats towards M, Mr Condon had lost a reliable informant on H's mental state as M no longer lived with him and H acknowledged he had stopped his medication.

126. Mr Condon told us he had not withdrawn from the case. However, the reality was that H was not seen by him again until 13 November, after H had been released from police custody. H had no outpatient appointments made for him to be seen in the clinic in this period. There is no evidence of a CPA review of H's case by Dr Hand or the CMHT which is noted in the records or recalled by them.

127. We consider these to be issues of competency and the lack of suitable supervision and training. Proper supervision should have identified these inconsistencies in practice.

128. We also consider that the lack of adequate CPA policy and procedures governing formal reviews was a significant contributory factor to this poor practice. The existence of such procedures should have detected that a case was being allowed to lie dormant.

See Chapter 2, Recommendations 5, 6 and 7:

RECOMMENDATION 5

The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.

RECOMMENDATION 6

The clinical supervision arrangements described above must include checks on the degree of autonomy being exercised by individual

practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 7

The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

LIST OF RECOMMENDATIONS IN CHAPTER 4

RECOMMENDATION 12

The Trust (CPT) should review the way in which discharge summaries are written to ensure compliance with the findings of this Inquiry as set out above and mental health policy and best practice. In particular discharge summaries should record the detailed decision as to why discharge is considered appropriate at that time, the specific arrangements for follow up of the patient including the names, designations and contact details of those responsible for ensuring follow up plans are maintained.

From Chapter 2:

See RECOMMENDATION 1

The Trust (CPT) should within six months

c) review the drafting and implementation of its CPA policy and

d) ensure regular and effective audit of its use to reinforce the need for discharge planning, conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.

Additionally all policies must be dated and the date of implementation be clear.

RECOMMENDATION 5

The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.

RECOMMENDATION 6

The clinical supervision arrangements described [in Chapter 2] must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 7

The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

CHAPTER 5

FIRST ASSESSMENT ON 13 NOVEMBER 2000:

- **Introduction**
- **Visit to police station**
- **Outcome of assessment**
- **Response of Dr Hand**
- **Missing Information**

Introduction

1. M was killed on 14 November 2000 at about 5.30 p.m. By mid-November it had been three months since H had been spoken to by anyone from the mental health services. He had last seen his community psychiatric nurse (CPN), Derrick Condon on 2 August 2000 and last spoken to him by telephone on 24 August shortly after M had moved out of the joint family home. H had not been formally discharged by the West Cornwall community mental health team (CMHT).

2. We have been unable to uncover much detail of the period leading up to November. M's family recounted that she brought the children home to Dover in October for a week. She did not talk about her problems with H but he did ring every day, ostensibly to speak to the children, but usually ended up speaking to M, making her cry on one occasion. Her sister in law told us that M had become frightened for her own safety.

3. Her friends have described how happy she was in her own home and how she enjoyed decorating it. It was in an idyllic, though lonely, spot along a poorly lit, unmetalled road and no more than a ten minute drive from the home she had shared with H.

4. We heard that H did not accept the fact of their separation and would increasingly come to M's new home without prior arrangement and spend his evenings there long after the children had gone to bed. She had told family and friends that she would call them, and not to telephone her because H was there so often she could not talk openly or in a relaxed way. She also became aware that H was probably watching her home as he once was able to tell her who had visited her after he had left.

5. One friend recalled that during this time H became more physically aggressive during their rows which usually concerned arrangements over visiting the children. One occasion M told her he grabbed her round the throat and threatened to kill her but M did not want to restrict H's access to the children. None of this was known to the services and we have been unable to determine what efforts M made to contact services before 12 November.

6. There is no evidence of contact between H and the mental health services from 24 August to 13 November. He was last seen by Mr Condon on 2 August (see Chapter 4 for details).

7. On 12 November M went in to Camborne police station in a distressed state about H and was given advice on what to do. On 13 November she called the police to her home early in the morning because H was there creating a disturbance and banging on the window. The police operator recorded that she was "very frightened of [H]". This led to his being arrested for breach of the peace and taken to Camborne custody centre where he was assessed under section 136 of the Mental Health Act 1983 (MHA). The police officers involved were concerned about his mental health.

8. There followed two key assessments of H. The first at Camborne custody centre by an approved social worker (ASW) and police surgeon and the second, later the same day, by the CPN Mr Condon. We have examined whether these assessments demonstrated reasonable and defensible practice. The Inquiry's approach is set out in the Preface. We have found serious and numerous deficiencies in these assessments and have concluded that had proper assessments been carried out at either time, it is highly likely H would have been compulsorily detained in hospital on 13 November and, in any event, prior to the time that M died on 14 November.

9. H was not detained, prompting the police to act on their concerns and install a "panic" button in M's home on 14 November. Also on that day M spoke to the headmaster of her daughter's primary school alerting him to problems at home and requesting that H not be allowed to take their daughter from the school. She had alluded to his mental health problems but stressed that she did not think that he was a danger to the child. She had spoken calmly and sensibly.

10. The facts and events of the 13 November are complicated to relate. We have, therefore, focused on the two key assessments and the way in which events and information fitted into and around them. This should enable a clear understanding of the deficiencies we describe. The second assessment by the CPN is described in the next chapter.

11. Where conflicts in the evidence emerged we have relied more on the contemporaneous records made by the police, for example the custody record and the Trust and social services internal review procedures, than on memories reconstructed some two and a half years later for the Inquiry.

12. The Inquiry was concerned to establish how the requirements of section 136 MHA, the relevant MHA Code of Practice and the local joint section 136 policy were implemented on that day. We heard evidence relating to the difficulty of obtaining a section 12 MHA approved doctor to attend at a police station to perform mental health assessments during office hours, and a resistance to the requirement of the local policy that a section 12 MHA doctor should always be called to attend. We heard that two such doctors would have been available by the afternoon of 13 November.

13. What follows is a summary of the relevant parts of the detailed evidence we have received of the events of that crucial day.

12 November: visit to Camborne police station

14. On Sunday 12 November 2000 during the early afternoon M went into the enquiry office at Camborne police station and spoke to the station enquiry officer. She did not give her name but the description of the woman given by the enquiry officer after the homicide fits M closely, as do the facts of the situation she described herself to be in. She was distressed and appeared at the end of her tether. She explained that she and her partner had separated; that he had mental health problems and had stopped taking his medication which made him volatile and very angry although he had not been physically violent. She stated that he blamed her for all his troubles and was not taking their separation well. She sought advice and information.

15. She was advised that she did not have to allow H into her own property and that she should dial "999" if any problems arose. The enquiry officer suggested that M contact her general practitioner about family counselling and the possibility of help for her ex partner or even a consideration of

whether he might be "sectioned". They also discussed seeing a solicitor about an injunction against H. When asked about his medical team at Trengweath Hospital, M is recorded as saying that she had never found them very helpful and that "they don't seem particularly interested".

16. After she had calmed down, some ten to fifteen minutes later, M left the police station. No log was made of her visit by the enquiry officer because she said no offences or concerns were disclosed and only advice was offered. Notes of the conversation were made on 15 November after the death of M.

Comment

17. This provides a good independent account of M's state of mind and the extent of her concerns regarding H at this crucial time. It is clear evidence corroborating the information M is said to have provided to the police and CPN on 13 November. It is evidence of what she is more than likely to have told those responsible for assessing H's mental state the next day at the custody centre had they contacted her.

18. It is also enlightening with regard to her opinion of the mental health services. We also heard from family and friends that M did not regard Mr Condon to be sufficiently responsive to her concerns. This related in particular to the episode in December 1999 when recollections are that she felt he was slow to respond to the deterioration of H's mental health that ultimately led to his detention under section 2 MHA at Trengweath Hospital (see Chapter 3). In Mr Condon's view he had a good working relationship with M.

19. We have no further evidence of precisely why M may have felt that the service was not helpful.

20. M was offered good advice by the enquiry officer. Nothing was logged on the police computer system. The practice is that at least an address would have been logged if M was complaining about a specific incident.

21. We recognise that not every suspicious or worrying incident can be entered on to the police system and that there has to be a threshold for doing so. The advice given included dialling '999', contacting a solicitor about an injunction and the possibility of a detention under the MHA. We recognise also that at this time this was unverified information from

one source and the propriety of recording it against H, without further investigation or some known and relevant information, would need to be carefully considered.

22. As far as the outcome in this case is concerned, there was in fact much contemporaneous information from M available on 13 November when H was being assessed at the Camborne Custody Centre. This is set out below. The information from 12 November was, therefore, not crucial to the decision on that day.

13 November: section 136 MHA. First assessment.

23. H was arrested by two police officers, sergeant Simon Selley and constable Anthony Bilsland, outside M's home in Hayle at about 9.15 a.m. on Monday 13 November 2000. The police had been summoned via a '999' call made by M at 7.46 a.m. H was booked in at Camborne custody centre by the custody sergeant at between 9.40 and 9.50 a.m.

24. The arresting officers had clear concerns regarding H's mental health, but initially arrested him in order to prevent a breach of peace. H had freely expressed delusions focused on M and was agitated. They were concerned that he would return to M's house if not detained. At the police station they were advised that they must choose between a straightforward arrest procedure and a section 136 MHA if they wanted a mental health assessment to be performed. The latter was chosen.

25. Sgt Selley (now acting chief inspector) made a detailed entry in the custody record of the circumstances of the arrest, which is set out below at paragraph 164.

Comment

26. Having arrested H and brought him into the custody centre to prevent a breach of the peace it was unnecessary to use a section 136 MHA to achieve an assessment of his mental state. The custody sergeant could have requested the attendance of an ASW and an assessment of H's mental state could have been arranged other than under section 136 MHA[6] and should have resulted in the attendance of an ASW and a section 12 MHA approved doctor. Once H had already been conveyed to

[6] Home Office Circular No. 66/90, paras 4(iii) and 7

the custody centre, section 136 MHA was otiose and probably inappropriate because H had already been removed from M's home under other powers.

27. It is impossible to say whether, had this alternative course been followed, a section 12 MHA approved doctor was more likely to have seen H that day at the custody centre or that greater efforts would have been made to obtain information about H's past psychiatric history. In our view, the more likely scenario is that there would have been no difference in the assessment process that day. The relevance of the need for a section 12 MHA doctor and more information is discussed further below.

28. The reality is that H was assessed by an ASW and a police surgeon at the custody centre and it is their approach and practice on that day that falls to be analysed. The police should, however, consider the criteria for the use of section 136 MHA and issue appropriate guidance and training.

29. We commend the actions of the arresting officers, and ACI Selley in particular, who appeared to us to be an insightful officer. He did everything within his power to ensure that the relevant information was available to those assessing H and, due to the level of his concerns, arranged for a panic button to be fitted in M's home when he was informed that H had been released from custody.

RECOMMENDATION 13

The Devon and Cornwall Constabulary review the guidance and training to custody sergeants on methods of obtaining mental health assessments for persons already in custody.

The ASW: Michael du Feu
Approach to assessment and information gathering

30. There is inconsistent evidence relating to the timing of the arrival at Camborne custody centre of Michael du Feu. In his statement to the police on 29 November 2000, Mr du Feu stated that at about 9.20 a.m. the Kerrier CMHT base at Trengweath Hospital was contacted by Camborne custody centre and an ASW was requested to attend and perform an assessment of H, who had been conveyed to the centre under section 136 MHA. Mr du Feu was at Trengweath Hospital at the time of the referral and he says he arrived at the custody centre at approximately 9.50 a.m.

31. The police custody record notes that the ASW was called at 10.07 a.m. with an "ETA 30 mins". The social services referral form is timed at 9.30 a.m. The time of his arrival is relevant to the extent of the opportunity he had to research H's psychiatric history and speak to the arresting officers. In evidence he recalled the impression that this was a hurried assessment and it is likely that he did in fact arrive at the station sometime after 9.50 and probably also after the arresting officers had left at 10.17 a.m. We have little doubt that given the concerns of the arresting officers (below), they would have seized an opportunity to speak to the assessing ASW had he arrived at the police station before they left.

32. The case was assigned to Mr du Feu by the CMHT team leader. He told us it fell to him by chance, because he was present when the call came and the so-called "floating" ASW who had dedicated duties to the police station, was off sick that day. As far as he was concerned it had not been allocated to him because of his involvement in assessing H for admission to Trengweath Hospital on 30 December 1999.

33. He told the Inquiry that he gave the case priority and put off his other plans for that day. He said he was aware that he was under some time pressure that afternoon as he was due to see a consultant psychiatrist regarding a section 4 MHA admission (emergency admission for assessment) at about 2 p.m. at Trengweath Hospital. He said he arrived at that appointment at about 2.30 p.m. although he could not be precise about the time. His ASW log sheet confirms that he did meet with a doctor, client and family after dealing with H regarding a section 2 MHA assessment but this is not timed.

34. Mr du Feu told us that his job with the CMHT at that time put him under considerable work pressure and he found it difficult to meet his commitments to attend at ward rounds, team meetings and work other than statutory assessments. He identified the cause of his dissatisfaction as being the co-location arrangements introduced in early 1999 which resulted in an effective halving of the ASWs available to the CMHT. He now works as a generic social worker in Penzance and is no longer under the same kind of pressure.

35. Mr du Feu has been a qualified ASW since 1991 and a Kerrier district ASW attached to what would become the West of Cornwall CMHT since early 1999 and the introduction of co-location. The Penwith and Kerrier CMHTs merged into one West of Cornwall CMHT in or around late 1999. Juliette Hostick was clinical manager and although for a time there were two team leaders, by November 1999 there was one team leader for both teams. (Co-location and changes in the structure of the service are discussed in more detail in Chapter 2).

36. Mr du Feu's evidence was that his usual practice when conducting an assessment under the MHA included reading all available notes, always contacting the person's nearest relative and visiting the family if there was sufficient time. He would normally respond to a request for an MHA assessment promptly.

37. He described some differences and difficulties encountered when conducting an assessment in a police station. Firstly, he said there were significant delays with access to a section 12 MHA approved doctor, scant information about the patient, a time pressure to complete the assessment within six hours and no staff or relatives on hand to describe any significant recent behaviour or mood changes. An added disadvantage, he said, was that there was no opportunity to observe the patient's response to social situations whether communicating with others in a ward setting or at home.

38. In oral evidence to the Inquiry Mr du Feu said that he would have been concerned to gather as much information as possible on his arrival at the police station. He knew that H lived in Hayle which is in the Penwith district and that the psychiatrist for that area was contactable via the CMHT base at Bolitho House, Penzance. This was Dr Margaret Hand and he said he tried to contact her in order that she could act as the section 12 approved doctor or to

obtain further information from her about H in the event that she had been unable to attend.

39. On his arrival at the police station he also picked up a message left by Mr Condon stating that he could be contacted at Bolitho House and knew H quite well. Mr du Feu knew that the police surgeon had been contacted by the police and was on her way.

40. The following is an account of Mr du Feu's activity at the custody centre that morning:

    a. He did not make contact with M until after the assessment had been completed and H was to be released from custody. We know that she was at her home during that morning and at least until after H was released from custody at around 12.30 p.m. The reason he gave for not doing so was confused, on the one hand that he did not have H's consent to contact her, but also that H did not seem overtly and severely mentally ill. He was, however, able to speak to her by telephone at her home as soon as the assessment was completed at about 11.30 a.m. to inform her that H had not been detained.

    b. He was unclear as to whether or not he read the custody record which contained an extensive entry by ACI Selley, one of the arresting officers, who was worried about H's mental state on arrest and that those assessing him should have as much information about his behaviour earlier that morning as possible. ACI Selley told us his entry in the custody record was longer than usual as a result and that he would have been available to be contacted by telephone if necessary. He had been unable to remain at the custody centre due to his continuing duties. Mr du Feu's recollection is that he was told ACI Selley had gone off duty. The custody record shows that both arresting officers were at the centre until 10.17 a.m. and ACI Selley's entry in the custody record is timed at 10.08 a.m. Thereafter they returned to their usual base and to M's house. Mr du Feu said he glanced at the detention log but did not recall such a detailed entry. Later he said that the knowledge he took into the interview of H "may have included" the information from the custody record.

c. He did not attempt to contact the arresting officers once they had left the custody centre. On his own account, Mr du Feu is likely to have arrived at the centre well before the officers left.

d. He did not access his previous assessment of H conducted on 30 December 1999 and which led to H's admission to Trengweath Hospital under section 2 MHA. This would have been available by telephone from the Penwith social services offices in Penzance, or with the assistance of the Kerrier social services office, which the social services general manager, Kay Green, informed us was "a hundred yards" away from the Camborne custody centre. In oral evidence Mr du Feu said that he did not in any event consider accessing social services records that day, but confined himself to making contact with the CMHT, because they would have had a copy of his assessment on 30 December 1999 and more, for example, the outcome of the admission to hospital. He accepted, in response to questioning, that it was important to look at or evaluate the reasons for H's admission on 30 December 1999 and the presentation leading to his admission at that time.

e. Mr du Feu could also have accessed his previous assessment of H and details of H's integrated health record by telephone from the duty desk officer at the Bolitho base of the CMHT. This information was not accessed by Mr du Feu.

f. He did not make contact with Mr Condon prior to the assessment. His assessment note (below paragraph 122) does note a telephone call to contact Mr Condon. Mr Condon told us that he received no bleep or message between 9.50 and 11a.m. A pager bleep reached Mr Condon at around mid-day when he was seeing M at her home and after H had been released from custody. Mr Condon assumed it was a message to contact Mr du Feu. They spoke later that afternoon.

g. Mr du Feu did not make contact with Dr Hand at all. She was the patch consultant for the Penwith area in which H lived. As it happened she was also his responsible medical officer during his two in-patient periods at Trengweath Hospital, although it would appear that Mr du Feu did not assume that Dr Hand knew H. Mr du Feu was adamant and insistent in his evidence to the Inquiry that he had rung

the St Lawrence's Hospital switchboard to contact Dr Hand and been put through to the CMHT at Bolitho House, and his assessment note (below) does record his attempt to contact Dr Hand. He said he was told that Dr Hand may be in 'clinics' and there was some difficulty contacting her. He said he alerted those to whom he spoke to the urgency of the matter. At this time he was also told that Mr Condon was out on business. Statements to the Trust internal review, dated 15 November 2000, by the receptionist staff and medical secretaries to Dr Hand, indicate clearly that no urgent calls were received for Dr Hand on 13 November from the Camborne custody centre. Mr du Feu probably did make telephone calls as he recounts and notes in his assessment record, but there is no evidence that he left any messages for either Mr Condon or Dr Hand or conveyed that there was any urgency to his call.

h. Dr Hand told us that she was in fact at home that morning because her son was ill. Staff at Bolitho House were aware of that fact. She came back to work after 1.30 p.m. when her husband returned home from his work to relieve her. She had a clinic starting at 2 p.m. She was available to see H later that afternoon during her clinic. In her absence the arrangement was that Dr Prem Menon, consultant psychiatrist for Camborne, would cover MHA assessments and he has confirmed that he would have been able to see H at about 4 p.m. This was an arrangement which Mr du Feu should have known about or is likely to have discovered, had he tried to contact Dr Hand for an urgent assessment. In evidence he said that there was no duty psychiatrist at that time and he would have been concerned about the possibility of getting a psychiatrist to attend in office hours. Having failed to make contact with Dr Hand, Mr du Feu said he assumed that he could not get another section 12 doctor before 5 p.m. unless H "had been sufficiently disturbed to be presented as being extremely disturbed", which, in his opinion, he was not. He said there was a duty section 12 rota that operated from 5 p.m. Mr du Feu said that even before arriving at the police station he would have felt frustrated at what he knew would be a difficulty in obtaining the attendance of a section 12 MHA approved doctor. The Inquiry's finding (below) is that following an initial assessment of H, the need for an admission to

hospital was considered inappropriate, and so the attendance of a section 12 doctor was not pursued.

i. He did not attempt contact with H's general practitioner.

41. Mr du Feu referred to what he believed to be "the six hour PACE regulations" operated by the custody sergeants which required an assessment to be completed within six hours of a person being brought into police custody. He later referred to this as a policy requirement although he did know that section 136 MHA allowed a person to be detained for an assessment for a maximum of 72 hours. He accepted that he was not put under pressure by the custody sergeant on this occasion.

42. The Devon and Cornwall Multi-Agency Policy, Practice and Procedural Guidelines on Sections 135 and 136 of the Mental Health Act 1983 (re-issued May 2000) states in bold:

> 1.10 It is expected that mental health assessments will be COMMENCED WITHIN TWO HOURS of the persons arrival at the place of safety i.e. relevant persons should be present. (Reasonable allowance should be made for geographical constraints.)
>
> 1.11 Every effort will be made to ensure that the assessment (and if applicable the transfer to hospital) is COMPLETED WITHIN SIX HOURS of the individual arriving at the "place of safety.

43. Although, as stated above, Mr du Feu said that he would have been concerned to obtain as much information as possible on arrival at the police station, it is clear that he did not access any information, save possibly for the entry on the custody record. Importantly, he also said that the level of information gathered would depend on the result of the initial assessment of the detained person. He would make an initial assessment before deciding on the telephone calls he would have to make. This statement accords with his practice on that day: he and police surgeon, Dr Christine Relf conducted an initial screening assessment and decided that H did not fulfil the criteria for compulsory detention. No information gathering was attempted thereafter.

44. This practice applied also to the need to contact a section 12 MHA doctor. His understanding was that under section 136, "a medical practitioner and an ASW need to see the patient, examine the patient and if there is agreement

that an individual would need a compulsory admission it would need to then move to the next stage, where we would need to contact a section 12 doctor.."

45. His actions and information gathering on 13 November were influenced by H's calm presentation and co-operative attitude. He emphasised the fact that H did not present in a particularly disturbed way and so he [Mr du Feu] did not consider there to be any grounds to break, what he perceived to be, the six hour requirement which would have been the result had he waited for a section 12 doctor. He did not think it would be fair or in accordance with his human rights, to hold H for longer. He said that if H had presented in a more disturbed way, he would have asserted his statutory authority and insisted that H be detained beyond six hours.

46. H was "extremely co-operative" and did not show signs of any "toxic confusion" and no signs of "current impairment". Mr du Feu said that "had he been stripping off his clothes and bashing his head against a wall and doing things that other people I have seen do, I would have had absolutely no hesitation about making him wait even to the next day if possible. That does happen from time to time where the patient is so disturbed and so unwell that they are unable to have a conversation with you, they are unable to present themselves or explain their situation to you and certainly not willing to accept any alternatives such as taking medication."

47. In terms of consequences he also said that breaching the six hour policy would not promote a good working relationship with the police. Although six hours was the "norm", he acknowledged, however, that on 13 November no explicit pressure was applied by the custody sergeant to complete the assessment within that time and that was because, he said, the assessment was conducted well within that time.

Comment

48. Although Mr du Feu understood the need to gather background information once at the police station, his stated practice under section 136 MHA was to conduct an initial examination and then to decide what

information was required or whether a section 12 doctor should be called to attend. He conducted the assessment on 13 November accordingly. His practice runs contrary to the advice contained in the MHA Code of Practice and also section 136 MHA local policy (and expressed in the introduction section to reflect the policy of the Cornwall Social Services). Although we have heard of the difficulties in obtaining a section 12 MHA doctor to attend at a police station during office hours, it is the lack of information which was most crucial to the outcome of this assessment.

49. Mr du Feu was, in our view, wrongly influenced by H's calm and apparently stable presentation during the initial assessment. As a result he failed to gather even the most easily available information, namely that contained in the custody record, which is likely to have alerted him to the need for a more careful and considered assessment. Or if he did read it, chose instead to assess H only on the basis of his immediately observable presentation.

50. He told us of his dissatisfaction at the co-location arrangements and his opinion that he was working under undue pressure. This led him to complete the assessment as quickly as possible and without gathering or properly considering the relevant and available information, firstly from M, secondly the custody record and police, and thirdly of H's past psychiatric history from the CMHT or the social services office. Had he gathered this information he was likely to have come to the conclusion that a full MHA assessment was necessary and a section 12 doctor would have to be summoned and waited for.

51. In our view the problems with co-location were not sufficient to mitigate poor professional practice by an experienced practitioner. We have considered co-location and its impact on Mr du Feu in more detail in Chapter 2.

52. We acknowledge that his assessment form (below) recorded attempts to contact Mr Condon and Dr Hand. We are struck by the fact that the investigations immediately after the homicide did not reveal any record of messages being left or of urgent calls being made. Mr du Feu probably made the calls as he recounts and notes in his assessment record, but it is highly questionable whether he left any messages for

either Mr Condon or Dr Hand or conveyed the urgency of his call. We are more confident that no urgent messages were left by Mr du Feu for either of them and this is the heart of our criticism in this regard.

53. Dr Hand's whereabouts that morning were known to her secretarial staff. She had checked the message book on her return to work at around lunch time and again later when writing her statement for the Inquiry and was certain that there were no calls made to her regarding an urgent assessment at the Camborne custody centre. She expressed confidence that her secretarial staff would have brought an urgent call from the custody centre to her attention even while she was at home.

54. We also now know that had such an urgent call been made either Dr Hand or Dr Menon would have been available to attend the custody centre later that afternoon, and probably no more than seven hours after H was arrested i.e. at 4 p.m.

55. Section 136 MHA provides:

"(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care and control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved social worker and of making any necessary arrangements for his treatment and care."

56. Section 136 is not, therefore, only about assessing a person for compulsory admission to hospital, it only talks of "necessary arrangements for [his] treatment and care". Compulsory admission is only one option and if a mentally disordered person is assessed not to fulfil the admission criteria under the MHA, then they may still be

detained pending other arrangements for their care and treatment being made.[7]

57. **The key to the proper discharge of the statutory functions under section 136 involves gathering information. It is simply not possible to make decisions regarding the need for compulsory admission or the necessary arrangements for treatment and care in the absence of information about psychiatric history and treatment.**

58. **An ASW is a statutory creation. S/he is "an officer of a local social services authority appointed to act as an approved social worker for the purposes of this Act" (section 145(1) MHA).**

59. **The statutory duties of an ASW are placed on the individual officer and not on the employing authority**[8]**. An ASW is a "public authority" within the Human Rights Act 1998 and so must not act arbitrarily to interfere with a person's rights under the European Convention on Human Rights (see also the Guiding Principles in the MHA Code of Practice (1999) at 1.1). However, this is not intended to be at the expense of the protection of the public, whose rights are to be balanced against those of the individual.**

60. **The approach to the performance of the duties of an ASW under the MHA must be uniform with respect to any assessment which may lead to an application for admission under the MHA. Chapter 2 of the MHA Code of Practice sets out the roles and responsibilities of ASWs and doctors in this respect and the acceptable standards of practice to be expected from practitioners. These requirements are mirrored in the role of an ASW assessing a person detained under section 136 MHA (Chapter 10.15). It is necessary not only to consider the statutory criteria for admission but also,**

a) The guiding principles in Chapter 1;
b) The patient's wishes and view of his or her own needs;
c) The patient's social and family circumstances;
d) The nature of the illness and its course;

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[7] See Jones, Mental Health Act Manual 8th ed, para. 1-1201
[8] *St George's Healthcare NHS Trust v S* [1998] 3 AER 673 at 693.

e) What may be known about the patient by his or her nearest relative [M], any other friends [M] or relatives and professionals involved, assessing in particular how reliable this information is;
f) Other forms of care or treatment including whether the patient would be willing to accept treatment in hospital informally or as an outpatient;
g) The needs of the patient's family or others with whom s/he lives;
h) The need for others to be protected from the patient
i) The burden on those close to the patient of a decision not to admit under the Act [M]. (para. 2.6)

61. The Code states also that ordinarily, "only then should the applicant (in consultation with other professionals) judge whether the criteria stipulated in any of the admission sections are satisfied....In certain circumstances the urgency of the situation may curtail detailed consideration of all these factors". (2.6)

62. The Panel considers that the need to consult directly with M fell within c) and e) above as indicated. Also given the circumstances of H's arrest when he was threatening M, consultation with her was vital in the process of assessing the risk H posed to her. It is irrelevant to say that M was not consulted because she was no longer H's "nearest relative" as they were separated, and furthermore this is unsupported by the MHA (section 26(6)). Additionally, a suggestion made that the fact that any future Mental Health Review Tribunal would criticise admission based on her evidence because it was likely to be biased due to the fact she was separated from H, is also irrelevant in the circumstance of this case. H was reported to have been threatening to M, the details of which were highly relevant to any assessment, and could have been corroborated by other evidence, namely that of the arresting officers.

63. The Code emphasises that the overall responsibility for co-ordinating the process of assessment is that of the ASW (para. 2.11).

64. In relation to a section 136 MHA assessment, the Code advises that the medical practitioner examining the patient should be section 12 approved wherever possible and if s/he is not, the reason for this should be recorded (10.12).

65. A compulsory admission to hospital requires two medical recommendations one of which must be from a section 12 MHA approved doctor. This refers to approval by the Secretary of State that a doctor has "special experience in the diagnosis or treatment of mental disorder" (section 12(2)). As will be seen below, Dr Relf was not section 12 approved, and had not undertaken any training in psychiatry. In these circumstances, a heavy onus is placed on the ASW to ensure that an assessment is properly carried out. Mr du Feu told us that his role focused largely on mental health assessments at this time.

66. This is not to deny that experienced police surgeons and general practitioners are fully capable of performing adequate mental health assessments, and in many circumstances are required to do so without the presence of an ASW or section 12 MHA approved doctor. This might happen where a detained person (other than under section 136 MHA) begins to manifest signs of mental illness while in custody and the police surgeon is summoned in the first instance, or where, on conducting a routine physical examination, mental health problems become apparent. What is important is that those conducting such assessments comply with the need to gather available information and are aware of any limitations in their own training, such that considerable caution is exercised prior to either releasing the person without a full assessment, or allowing them to remain further in a police cell which may be unsuitable if the person is mentally disordered.

67. The Devon and Cornwall Multi-Agency Police, Practice and Procedural Guidelines on Sections 135 and 136 of the MHA (Re-issued May 2000) reflect and underline the above. Mr du Feu said he was "fairly familiar" with the guidelines.

68. The policy makes it clear that calling a section 12 approved doctor is mandatory. It divides the role of the police surgeon distinctly in two: first to conduct a physical assessment of fitness to detain and second, to act as the second doctor for any MHA assessment (para. 2.3). Mental health assessments are expected to be completed within 2 hours of a person's arrival in custody and every effort must be made to complete an assessment within 6 hours. (1.10)

69. Mr du Feu stated clearly that he did not see the policy being implemented in that way. When asked whether he "understood that the policy made it clear that there was a need for a section 12 doctor to be involved in a MHA assessment", he replied "not as clearly as you are defining it now".

70. The expert ASW opinion provided to the Inquiry confirmed our opinion that Mr du Feu's procedure on 13 November did not accord with the requirements of the MHA Code of Practice, local policy or the standards required of a reasonable assessment in a number of respects as outlined above. Most importantly, he failed to obtain available and crucial background information from M, the police, mental health services.

71. This information was readily available because we know that M was at home, the custody record was available at the custody centre and, in the absence of Mr Condon, the duty officer at the CMHT base at Bolitho House could be contacted by telephone and fax. He only obtained information from H.

72. In his statement to the Inquiry Mr du Feu recalled that he had little experience of H save for the emergency admission in December 1999 and he acknowledged that he had "scant information about the history of the patient''.

73. The Inquiry received evidence that the joint local policy was not agreed by the consultant medical staff who constitute the majority of section 12 MHA doctors in the region. There was in fact only one police surgeon who was also section 12 MHA approved and a shortage of section 12 doctors is acknowledged. Dr Hand confirmed that there could be delays during office hours in section 12 doctors attending at a police station at that time. She also confirmed that the policy had been issued without the agreement of consultant medical staff, who were concerned at the requirement that they should attend even, for example, where a person had accepted voluntary admission to hospital. This seems to be a reasonable concern.

74. **In her statement to the Inquiry the custody sergeant said that she queried the fact that no section 12 MHA doctor had been called but was told by the ASW that it was not necessary on this occasion.**

75. **In spite of these difficulties, our view is that the real problem on this occasion was the lack of information obtained by Mr du Feu, from readily accessible sources, which meant that the need for a full mental health assessment with a section 12 MHA doctor was not appreciated. The gathering of information is a matter of fundamental practice.**

76. **We do also consider that the issue of section 12 MHA doctor availability is one that needs to be addressed.**

77. **The information that was available to Mr du Feu and its likely impact on the assessment and its outcome is discussed below at paragraphs 165 – 186.**

RECOMMENDATION 14

The Strategic Health Authority (SHA), Cornwall Social Services and the Devon and Cornwall Constabulary should jointly agree and provide for section 12 MHA training for police surgeons and general practitioners with a view to increasing the availability of section 12 MHA approved doctors in the locality. In the interim, there should be clear joint agency guidelines on the requirements for gathering available and relevant information about an individual, prior to mental health assessments, consistent with the MHA Code of Practice.

RECOMMENDATION 15

Cornwall Social Services must reinforce to all ASWs that, in accordance with paragraph 2.11 of the MHA Code of Practice, the overall responsibility for co-ordinating the process of a mental health assessment for a potential admission to hospital under the MHA rests with them.

RECOMMENDATION 16

The Trust (CPT), Cornwall Social Services, Devon and Cornwall Constabulary provide multi agency, cross-discipline training and guidance on the processes involved in conducting a mental health assessment to include general practitioners and police surgeons.

RECOMMENDATION 17

The Trust (CPT) should review its method of disseminating the findings and recommendations made in past and future Independent Inquiry (or other similar) reports into homicides outside Cornwall with a view to reviewing practice and ensuring, where appropriate, that lessons are learned.

The police surgeon: Dr Christine Relf

78. On 13 November 2000 Dr Relf was in general practice at the Trevithick Surgery in Camborne having qualified as a general practitioner in 1969. She had been on the list of police surgeons for six years and had completed all the police surgeon training modules. She has never undertaken any postgraduate psychiatric training and is not a section 12 MHA approved doctor. The psychiatric element of the general police surgeon training was limited. At a guess she said that she might have been at the police station assessing a patient brought in under section 136 MHA once a fortnight, although sometimes it was more often.

79. We found that her recollection of the events of 13 November in oral evidence to the Inquiry was, unsurprisingly, clouded by information learned after the homicide and that the more contemporaneous documents were, therefore, the more reliable. For example, Dr Relf's recollection that the police had discussed the installation of a panic alarm button in M's home while she was at the Camborne police station, whereas the evidence we have received from the police is that a personal alarm decision was taken at Hayle police station after the decision to release H was made known to the arresting officers.

80. She was quite confident, however, that Mr du Feu had information about H's past psychiatric history which she relied upon and led him to take the lead in questioning H. This did not accord with Mr du Feu's recollection. It was Dr Relf's impression that Mr du Feu had made contact with the CMHT and

obtained information about his past history directly from that source. Her recall of the detail of that information was poor.

81. In relation to the custody record she said that usually these did not contain much information. She said she obtained a "potted history" from the custody sergeant. She thought that this would have been to the effect that H was arrested at M's home for fear that he would do something to her. She had a recollection of speaking to a policeman from Hayle, but could not recall a name or further details of this conversation.

82. Dr Relf did not obtain any background information herself. If Mr du Feu had not already collected the information she thought he had, then she said she would have followed her usual practice which was to contact H's general practitioner. In her experience it would have been difficult for her to contact the psychiatric services and she would not have tried to do so. She also said that she would have gathered her own information if, after the initial assessment, H appeared mentally ill.

83. In this respect her evidence supported our conclusion from Mr du Feu's evidence (above) that the question of information gathering would have been addressed only after an initial examination and if there was clear and observable evidence of severe mental illness.

84. Dr Relf's initial statement to the police following the homicide demonstrated her understanding of the dual role of a police surgeon, namely that it firstly involved assessing a person's physical fitness to be detained and thereafter could include performing a MHA assessment as a second doctor. To the Inquiry she also stated that it was not unusual for her to be called in to do a MHA assessment without assessing fitness to detain.

85. She told the Inquiry that it was quite usual for her to arrive at the police station and there to be no section 12 approved doctor. She would then proceed to complete her part of the assessment and if she believed the person to be in need of detention under the MHA she would fill in her part of the appropriate form and leave it at the station. She would quite often complete her part of the assessment prior to the section 12 doctor. It was her clear understanding that a full MHA assessment could not be conducted without a section 12 doctor.

86. In her written statement she said that "more frequently I am making an assessment as to whether a detainee is fit to be detained or fit to interview and any mental health problems become evident within this context and may lead to referral to the ASW and consultant psychiatrist for further assessment re possible detention under section 2."

Comment

87. We obtained expert evidence on the role of a police surgeon performing a section 136 MHA assessment (see Appendix D). It has been confirmed to us that the role of a non-section 12 MHA approved police surgeon is to ensure the safety and well-being of the detained person by conducting a 'physical' screening to determine that the individual is fit to be detained (referred to as "fitness to detain") in police custody pending the mental health act assessment. Thereafter, their role is confined to providing any second recommendation for a compulsory admission to hospital.

88. The police surgeon conducting this physical assessment should consider obtaining the following information from custody staff:

a) Details of arrest;
b) Any medication or prescriptions in the person's possession at the time of arrest;
c) Information from other sources eg family, GP, police, hospital.

89. Dr Relf endorsed the custody record that H was fit to detain. She said that she had obtained some information from the custody sergeant and although there is no record of any specific assessment of H's risk of self harm which we consider to be important in this context, we consider that her assessment of H's fitness to be detained was acceptable.

90. Her further role in conducting what was to all intents and purposes a primary mental health assessment was contrary to accepted practice and local policy. Her understanding of the outcome of the assessment and the arrangements to be made for H were at variance with those actually arranged by Mr Du Feu (see below). We find that she relied on Mr du Feu's apparent knowledge without having taken sufficient steps to satisfy herself as to his actual knowledge or the sources of the same,

e.g. what medication and at what dose, or other such information of more relevance to a medical as opposed to a social work assessment. In any event she was not absolved of the need to exercise her own clinical judgment based on H's presentation at interview (see below).

91. If Mr du Feu had in fact collected information as Dr Relf believed him to have, and if no section 12 doctor was in fact available within a reasonable time, Dr Relf's participation in the assessment may have been sufficient.

Interview and assessment of H on 13/11 by ASW and police surgeon

92. There is no evidence that the conduct of the interview with H was designed by prior discussion between Mr du Feu and Dr Relf. According to the custody record the interview lasted 34 minutes. Dr Relf arrived at about 11 a.m.

93. By their own accounts, both Dr Relf and Mr du Feu were looking for clear and obvious signs of mental illness before they would have considered that H required compulsory detention under the MHA. Neither of them formed the opinion that H displayed such signs. Mr du Feu was looking for the kind of behaviour and symptomatology he described as set out above at paragraph 46.

94. Mr du Feu's approach to the statutory criteria for compulsory admission under the MHA focused on the risk of potential harm to self or others or serious neglect. He said the patient's ability to comprehend the concerns raised and willingness and insight will indicate how the assessment will conclude. If a patient is co-operative and acknowledges the concerns then, in his experience, he said that they are usually co-operative in planning for alternatives to hospital care.

95. In a situation where the patient is unable to negotiate or compromise, or they are sufficiently disturbed to need hospitalisation, he favours compulsory detention. Key issues include social functioning, loss of sleep, poor appetite, chaotic financial situation, inappropriate dress for the setting, or season and relationship problems.

96. Mr du Feu assumed that H was stable and not deteriorating. In terms of an admission under section 2 MHA he focused on the apparent degree of H's

mental illness. He was not conspicuously ill and he would have wanted something more conspicuous to admit him compulsorily.

97. Dr Relf described her approach to a compulsory admission under the MHA. She said she keeps in mind the health and safety of the patient and the protection of others. Key factors she would look for include lack of insight into serious psychiatric pathology or suicidal ideation or a history of violent behaviour or delusional ideation likely to put other people at risk if acted upon.

98. She tried to assess the level of H's psychiatric symptoms and the risk he posed to M. She said that in thirty minutes it was impossible to do a full assessment. She referred to the added pressure of patients back at her surgery. She was looking for "signs of psychiatric illness associated with a degree of risk to make it necessary to remove [his] liberty".

99. They both said that H spoke calmly and answered questions co-operatively without being overly forthcoming. At other points in their evidence they said that H was angry. Dr Relf said that H was "sweaty and tense" which worried her. The following are the contemporaneous notes of Mr du Feu and Dr Relf which, in our view, are the most reliable evidence of their assessments.

> MICHAEL DU FEU:
>
> History of psychiatric support via Bolitho unit - usually prescribed anti-psychotic medication. But [H] does not adhere to prescription.
>
> Summary of assessment:
>
> [H] is 37 yr old male, born in Liverpool. He had a nervous breakdown when working in Aberdeen some years ago.
>
> He was admitted to Trenweath voluntarily last year due to intense anger towards his ex partner "ONLY"
>
> He had been to visit today and was again very angry, the police were called and he was admitted under MH Act as they suspected he was unwell.
>
> He denies he is unwell and clearly believes his ex-partner is spreading damaging rumours about him which is destroying his reputation.
>
> Risk assessment:

A. Self - low, no threats, no indicators.

B. To others. Possible risk to ex partner due to [H's] belief and hightened (sic) concerns about his reputation.

C. Neglect - low

DR RELF:

Section 136
SW, Mike du Feu
Joint interview. H/O [history of] delusions in the past but he says "head was done in then". Has been signed off by CPN some months ago. ?Feb. Says not on medication since then. Brought in for threatening ex wife - says he thought it a good idea so that he could calm down. Says he wants to sort things out with her and persuade her not to spread rumours about him. Denies any voices. Refuses voluntary admission and does not appear sectionable. ? can charge be put. ASW will arrange for consultant to assess further.

100. Even though neither of them had probably read ACI Selley's entry in the custody record (set out below), when shown it by the Inquiry, they both indicated that most of the information he recorded was provided to them by H. The rumours referred to by Mr du Feu in his note referred to M supposedly telephoning all potential customers at the take away restaurant he worked at and warning them away. They said they discussed these with him.

101. Dr Relf said she suspected that the rumours were probably not true, but that when a couple have separated one cannot always believe either party. She accepted in response to questioning that this rumour was unlikely to be true, but could not recall precisely what she knew of it at the time of the interview. She said she did consider whether it could be delusional and that both she and Mr du Feu had their suspicions about it.

102. Mr du Feu said he thought H was unwell and seemed to be "extremely angry and very, very tense". Hence he thought H needed medication and anger management which H thought was a good idea. He said that there was a

strength to H's convictions regarding the rumours but that it did not preoccupy the interview. This was in contrast to his initial evidence that H was calm and co-operative, which he now says was intended to include that H was "tense in mood".

103. Later in evidence he qualified his view about the rumours. He now reflects that it might have been delusional and "at the time I just felt that I did not know enough about the situation". However, he was not convinced as to the degree to which H held this belief and the extent to which it represented formal thought disorder on H's part. His preoccupation, Mr du Feu said, was "not of a nature or degree as I would see it for formal detention, but he certainly did seem to be preoccupied with the idea that M had been saying things about him". Mr du Feu did feel that there could be basis in fact that M had been contacting customers and was not clear on that part of H's presentation. When ACI Selley's entry was put to him, he agreed that it was less likely that it could be factually possible that M had been telephoning potential customers.

104. Mr du Feu's note indicates that he had probably read the information from Mr Condon on the custody record that H fails to take his anti-psychotic medication. It also shows that he may have had some recollection of his previous assessment but mistakenly believed H's admission to hospital was informal. Alternatively this was information provided by H. He notes the anger to M at that time.

105. Mr du Feu was clear that they knew that H had not been taking medication for some six months. He understood that H had been failing to take his medication. Dr Relf on the other hand understood that he had been allowed to stop his medication and had been given a "clean bill of health". She accepted H's account that he had been "signed off" by his CPN some time ago.

106. The Inquiry was concerned about Dr Relf's note that H wanted to "sort things out" with M and to persuade her not to spread rumours about him. Dr Relf said that they did not discuss with him how he was going to do this. He was simply told not to pursue her.

107. Dr Relf appreciated that he had been threatening to M and that the potential risk to her was a particular concern. In Mr du Feu's opinion any risk to M was

no more than a "nuisance risk", that he might go back to her house and make a nuisance of himself. He was not aware that "he could explode, erupt in such a way. I had assumed there was a risk he would go and bash on the door". At one point he told the Inquiry that H was "extremely angry", but later he said that the anger had subsided and he was less angry than when he had seen him in December 1999. He was still tense. He assumed that H was stable rather than deteriorating.

108. In his police statement Mr du Feu said that H did not "disclose any plans to be violent to the victim in this case". When it was suggested to him that this was a simplistic approach he said that in his experience "it is not terribly simplistic at all. When I am talking to people in the police station or in other situations who are conspicuously disturbed, a lot of that information does come out - that there is a plan to attack someone or to embezzle them or whatever.."

109. Mr du Feu denied that his approach to compulsory admission was black and white with the person needing to be on the extreme end of mental disturbance and said that he was capable of proceeding to assess a person for admission who was in an earlier stage of deterioration.

110. Earlier in his evidence he had been asked how he would justify the admission under section 2 MHA of a person not conspicuously mentally ill. He said "it would depend on what else you can see around the risk element and, in particular,.....I would need to be satisfied that the criteria for the compulsory detention were met, so there would be a nature or degree element to that. But it would be somebody more openly saying, "This person is dead against me. Everything I try to do they interfere with and they have got contact with this person and that person. People are after me. The police are after me." More usually here people with quite complex systems - it is not always on one person, particularly an ex-partner. It is often a more complex series of ideas which intertwine with each other".

111. Dr Relf formed the view that at that moment in time H's mental illness was not of a degree that warranted an admission to hospital against his will. She did think that "he might have well been brewing up to have a mental illness that did not appear to be of the degree of risk to either himself or anybody else that one felt able to admit him against his will".

112. She accepted that H had a mental illness of some import in the past and he could be mentally ill again. She did not feel there were gaps in her information at that time. She was interested to find out what treatment and medication he had before and was satisfied, on H's indication, that he was not under follow up presently, he was not on medication and that he was not under treatment.

113. She was asked to explain her note that H did "not appear sectionable". She said that she and Mr du Feu would have "discussed the interview and whether he showed sufficient signs of illness or of a wish to go back and confront his wife to warrant us sectioning him, or whether he appeared willing to agree to another course of action and care as we obviously were both a bit suspicious that possibly he was covering some illness, which is no doubt why the next arrangement was for him to have assessment by a consultant psychiatrist". She said that this was the conclusion of them both. She raised the question whether a charge could be put to H because she did not want him to be released and to disappear. Her expectation was that H would remain in custody until assessed by a psychiatrist. Such an arrangement was, in her view, needed because H needed care and not necessarily because he needed to be detained in hospital.

114. In her view, in retrospect, the decision not to compulsorily admit H to hospital was on the borderline, but it did not seem so at the time.

115. Later she said she was telephoned by Mr du Feu, who informed her that he had arranged such an assessment. There is no record of such a telephone call and Mr du Feu does not refer to one. He has not documented any referral to a psychiatrist.

116. Mr du Feu was asked how he assessed H's likely compliance with a treatment plan and medication in the future. He said "I knew a lot of people who come into the revolving door category. I know from frequent experience of speaking to people in that category that they will say, "Yes, I will do A, B and C" and then renege on that very shortly. I also know that those same people come into hospital, go onto medication, leave hospital and stop the medication and then end up being called back in again. But I did not see [H] in that category at the time.... I think most of the people that I have met have fallen right out of the social framework: they were not working, they did not have relationships. They were often single people living in bedsits".

117. In terms of insight, H had denied that he was unwell, but he also agreed that he was getting out of control and ought to do something about it. He did not see it in illness terms.

118. Prior to that Mr du Feu said "I felt that [H] did not warrant a detention under the Mental Health Act on that day, quite clearly, and that he was presenting in such a co-operative manner that a compulsory admission would not have been the least restrictive alternative for him and it would have been against his human rights to detain him". Given a list of information that he did not have in making that assessment and asked whether he was looking for a severe mental illness and evidence of an immediate risk of harm to M or other people, he said firstly "yes", but that he was also aware of "deteriorating patient advice in the code of practice".

"Q. You have also said to us today in evidence that you were looking for conspicuous evidence of a mental illness.

A. For me, the main bit is the degree of co-operation and risk that is identified on the day and whether that risk can be prevented with or without using the MHA.

Q. How did you apply the deteriorating patient guidance in the MHA?

A. I assumed that he was stable rather than deteriorating. I had not understood that he had got a lot worse".

119. It was put to Mr du Feu that he was not in a position to make a decision about the nature of H's illness on that day because he did not have the necessary information from M or his past psychiatric history including his own previous assessment. He did not agree.

120. Mr du Feu was somewhat vague as to why he did not contact M prior to the assessment, this included that he did not have H's consent to do so. See paragraphs 62 and 147 for comment on this issue.

121. Mr du Feu said that he would have been receptive to any information provided by Mr Condon or others. It would have been helpful but even with it, he does not think he would have made an application for compulsory admission.

122. Dr Relf said that she "may have decided that a section was appropriate for H" with the benefit of all the additional information.

Outcome of assessment. Panic alarm fitted by the police.

123. There is a conflict in the evidence between Dr Relf and Mr du Feu as to the outcome or the intended outcome of their assessment.

> MICHAEL DU FEU:
>
> Recommendations:
> Care plan
> 1) T/call to CPN D.C not available.
> " " sec 12 - not available (Dr Hand)
> Discussed with collegue (sic) CMHT CPN PZ [Penzance].
> I have advised [H] to re-engage with CPN service asap and accept medication to help calm him.
> 2) Police surgeon Dr Relf not prepared to sign a medical recommendation leading to compulsory admission.
> 3) [H] not prepared to accept voluntary admission
> sec 12 doctor not called as:
> A) no duty doc system in office hours
> B) P. surgeon would not recommend hospital care.
> 4) Client advised of his rights and care needs then discharged.

124. Dr Relf's note (above at paragraph 99) clearly states that a consultant assessment was to be arranged by Mr du Feu. It was her understanding that such an assessment would be arranged while H remained at the police station and she recalled a telephone call later that afternoon from Mr du Feu that one had been arranged. Mr du Feu said he did not make such a call to Dr Relf. Her statement to the police was more equivocal and to the effect that a further assessment would be arranged if in Mr du Feu's opinion one was required. Again Mr du Feu said his opinion was already formed and he thought he had made this clear to Dr Relf.

125. Dr Relf expressed surprise when shown the above care plan which she had not seen prior to being interviewed by the Inquiry. In her view it did not accurately reflect her attitude to hospital admission at 3B, nor did it set out her

understanding that a further assessment was to be obtained from a consultant psychiatrist.

126. She told the Inquiry that she was concerned that the authority to detain H would lapse following the assessment and so she queried whether a charge could be put to him to prevent his immediate release.

127. Dr Relf's note (above) was kept in her personal record of assessments. There was no relevant summary of the assessment in the custody record by her, Mr du Feu or a joint entry. Her only entry into the custody record was a signature verifying on the computerised record that H was fit to be detained "ASW to decide appropriate treatment if any." Her understanding of the outcome of this assessment is at odds with what actually happened.

128. The outcome of the assessment was notified verbally to the custody sergeant. This was conveyed to ACI Selley by PC Bilsland while at Hayle police station. ACI Selley arranged for a personal alarm to be fitted to M's home. He told us that he was very disappointed at the decision not to detain H under the MHA but did not feel qualified to question it. He was not aware that in fact no full MHA assessment had been carried out. An alarm was fitted the following morning to M's home. This was an alarm of a type normally used in serious domestic violence situations. It happened that one was available and fitted on the basis of ACI Selley's "gut instinct". He took the decision in discussion with PC Bilsland.

129. ACI Selley's admitted limited knowledge of psychiatric medication told him that any medication now taken by H was likely to take a number of days to take effect. He considered it prudent and reasonable to offer that extra protection. The use of an alarm was far beyond what is normally done on first call to a domestic incident.

130. PC Bilsland's evidence indicates that they were likely to have learned that H had been released at around 12.30 p.m. while at Hayle police station and the decision taken to fit the alarm then taken. It was fitted by lunch time on 14 November.

131. Mr du Feu also spoke to M by telephone at her home at around midday and shortly before Mr Condon arrived to see her. She was, therefore, able to tell Mr Condon that H had been released. Mr du Feu had spoken to the duty

CPN at the CMHT, once it was decided to release H, to ask if it was reasonable to suggest to H that he should re-establish contact with the CMHT. The duty officer also stated that Mr Condon would make contact. It is not clear whether this was to be with Mr du Feu or H. The duty officer is now resident overseas and the Inquiry were unable to contact him for clarification. Mr du Feu says that later he spoke to Mr Condon (see below).

Response of Dr Hand had she been called to the custody centre

132. In her capacity as a local consultant psychiatrist and H's treating doctor, the Panel sought to establish what Dr Hand is likely to have done had she been called to assess H on 13 November. On the basis of the assessment documents of Mr du Feu and Dr Relf, Dr Hand's evidence was clear. The entries indicate that H was displaying the same symptoms as before his admission to hospital in December 1999.

> Q: So your assessment is that these entries demonstrate that he [H] was psychotic at this point?
>
> A: I think it is the same symptoms, believing his ex partner is spreading damaging rumours destroying his reputation, the same psychotic symptoms.

133. Asked what she would have done if called out to the custody centre to assess H, she said that she would have initially wanted to know what kind of treatment he was willing to accept and that she would probably have offered an informal admission to hospital and asked him to re-commence medication. If he refused treatment she 'would probably have detained him or recommended a section 3 detention'. She was reminded that H had in fact refused a voluntary admission and then said

> I imagine that he would have refused the intervention and he would have been detained the way he was before. I imagine that is what – but I suppose, given I did not see him, and I know that the consultant who saw him a couple of days later [when [H] was in custody after the homicide] did not feel he was acutely psychotic.

134. Asked what her view was as H's consultant she said

> I cannot imagine that he would have agreed to a treatment plan that would have been acceptable and if he had not agreed, I would have recommended detention.

She also suggested that even without any knowledge of H's past and if it had been his first presentation, and 'he was psychotic and had threatened his wife" she is likely to have admitted him to hospital, but 'knowing him from before I would have known that he was psychotic'

She said

> I cannot imagine not admitting him, but I suppose it would depend on what the safety – if [M] was going to move away, if [M] was somewhere else safe and he was agreeing to a care package and to take medication, there is a possibility that we would have tried a care plan in the community.

But in the absence of that

> It is a possibility. I imagine it would be more likely that we would have admitted him.

135. M did not move away, she remained where she was and accessible to H who wanted access to the children. It is now a matter of record that he expressed his intention to go back and sort things out with her.

Comment

136. We have identified the significant procedural failures in carrying out this assessment. While the lack of a section 12 MHA doctor was in breach of policy and the MHA Code of Practice, we know that an experienced GP and police surgeon is or ought to be capable of a competent mental health assessment and the real problem here was the lack of information.

137. **There is no disagreement over the fact that information was not obtained. M was not spoken to, the arresting officers' views and H's presentation at that time were not obtained, easily available health and social services records were not accessed.**

138. **For the breach of the MHA Code of Practice alone, it is patent that this assessment was not conducted to an acceptable standard, and on balance, the evidence of Dr Hand indicates that the information omitted is likely to have made a material difference to the outcome of the assessment.**

139. **We have evaluated the evidence carefully. The time that has elapsed since the death of M has meant that all the witnesses have gained information not available to them at the time through the process of the police investigation, the internal review or press coverage. For example, Dr Relf's belief that police officers discussed the installation of a panic alarm at Camborne police station in her presence cannot be correct as the decision was taken at Hayle police station well after the assessment had concluded at Camborne.**

140. **Further, in guarding against a reconstruction of past decisions with the benefit of hindsight, the Inquiry has tried to put itself in the shoes of those assessing H as he presented on 13 November. And so we have considered carefully the evidence that H presented calmly and in a co-operative manner; that he agreed to resume medication and apparently to resume contact with the CMHT. We received varying evidence on the issue of H's presentation at the police station and we have had to assess how hindsight may have affected the evidence of witnesses in that regard.**

141. **We accept that H may have at times presented the façade of someone appearing to be in control and admitting his mistakes. This is a known phenomenon to be taken account of when assessing a person's mental state. Both Mr du Feu and Dr Relf appreciated that a person can present calmly when removed from the context which provoked a reaction. Further, if he was calm, this should have alerted them to the need to find out more detail of how he was behaving at the time he was arrested in the morning.**

Assessment

142. Simply on the basis of H's presentation, as noted by Dr Relf and Mr du Feu, and without any additional past information, this was clearly a case for a full assessment by a section 12 MHA doctor with liaison with Mr Condon and the information available from the CMHT and M.

143. In terms of mental disorder, H had acknowledged and Mr du Feu knew that he had been on medication and had probably defaulted in taking it. He had not been on medication for some six months. That Dr Relf had understood H to have been signed off medication, demonstrated a lack of communication between Mr du Feu and her in relation to what little was known. Whatever her view of the information available to Mr du Feu, in this regard, she relied solely on information provided by H.

144. It was known that H had had a recent admission to hospital, whether voluntarily or not, and Dr Relf was clear that he had had a major disorder at that time. What was known about that admission, so far as noted by Mr du Feu on this occasion, is that H had presented a threat to M at that time.

145. They both knew that H had been arrested while creating a disturbance at M's home and that he was saying that he would go back and "sort things out" with her. He was angry and tense at times and denying that he was ill, but was managing to remain in control of himself.

146. H was expressing potentially delusional ideas about M spreading rumours about him and thereby preventing customers from coming to the takeaway restaurant he worked at. These were inherently improbable and at the least should have been probed further with H and of course with M herself.

147. If, at this point, any final decision regarding compulsory admission may have been finely balanced, what was clear was the need for further investigation and information from readily available sources. Mr du Feu's suggestion that he could not speak to M because of confidentiality and without H's consent is completely at odds with the MHA Code of Practice guidance (see paragraphs 62 and 120 above).

148. The evidence elicited by Mr du Feu and Dr Relf, in our view, demonstrates that the situation which confronted them did not lead to a straightforward conclusion that H was not detainable. H said he would restart medication, but that likelihood was not tested and H appeared reliable because he was not outside the social framework. Mr du Feu's ideas of a non-compliant, "revolving door" patient were a caricature (see paragraph 116 above). H's denial of mental illness and insight was also not explored.

149. Mr du Feu and Dr Relf were looking for conspicuous signs of mental illness in H. Any assessment of risk based on the lack of violence to M in the past was simplistic; it ignored the fact that H's delusions were focused on M and that he had been arrested outside her house behaving threateningly towards her. There was an over reliance on information provided by H. In doing so they decried their joint and considerable experience which should have fairly quickly highlighted the need for more information.

150. Additionally, if the evidence is equivocal, reasonable practice requires that a section 12 doctor is called and that, as long as the assessment is then done as speedily as appropriate and within the seventy-two hours, it must not be compromised by a policy intention to complete an assessment within six hours. Administrative targets cannot and must not be allowed to interfere with the proper assessment process.

<u>Missing information</u>

151. This is set out separately below. Tragically, both Mr du Feu and Dr Relf failed to obtain the necessary and available information which is highly likely to have made a material difference to their assessment on this day and its outcome, including the arrangements made in the absence of admission to hospital. By failing to do so their individual and joint practice fell below an acceptable standard. It is our firm view that had the information in the custody record been considered and/or details of H's past psychiatric history obtained, then it is likely that a section 12 doctor would have been called to perform a full MHA assessment. In our view the likely outcome is that H would have been compulsorily detained in hospital.

152. We have already tried to answer, from Mr du Feu's perspective, why a section 12 MHA doctor was not called (above and Chapter 2). In addition we think that Dr Relf was misled (unintentionally) into believing that he had more information about H's past history than he did. It is understandable that in those circumstances she would not have wanted to duplicate the information he already had.

153. The responsibility for gathering information rests with both the ASW and the doctor. The responsibility for calling a section 12 doctor rested with the ASW who also carried the statutory responsibility for making the necessary arrangements for care and treatment (see Recommendation 16 above).

154. We have found that the practice adopted on this occasion was to conduct an initial assessment of the patient prior to deciding what information was necessary. An approach which we consider to be back to front.

<u>Arrangements for care and treatment plan</u>

155. Dr Relf and Mr du Feu were completely at odds as to their respective understanding of the outcome of this joint assessment and whether or not a psychiatric opinion was to be obtained. Further, the actual arrangements made, in the form of advice to H to re-engage with the CMHT and accept medication seem far from robust or sufficient.

156. Mr du Feu may have relied overly on Dr Relf's apparent assessment that H was not "sectionable", which she qualified in evidence to say that she felt he still needed assessment by a psychiatrist at least for his future care. We think that her clarity in evidence that she expected such a further assessment is not supported by the contemporaneous records, which are more equivocal in relation to her understanding of what was to happen. The only note that mentions a further psychiatric assessment is the one kept in her private book. Neither her statement to the police, nor her entry on the police computer are that clear.

157. There should be a summary of the joint decision in writing, possibly on the custody record, which should record the outcome and in the

absence of detention under the MHA, indicate what care plans were being implemented. See Recommendation 19 below.

Criteria for admission under the MHA and the "deteriorating patient" guidance

158. Admission to hospital under sections 2 and 3 MHA requires a mental disorder or illness of a nature or degree warranting detention in hospital for assessment or treatment (sections 2(2)(a) and 3(2)(a) MHA).

159. Although the statutory language is disjunctive in this regard using the word "or", in many cases the nature and degree of a patient's disorder will inevitably be bound up together. "Nature" refers to the particular mental disorder, its chronicity, its prognosis and the patient's previous response to receiving treatment for it. "Degree" refers to the current manifestation of the disorder.[9]

160. Thus admission may be supported where a known asymptomatic patient has ceased to take medication for his mental disorder and who has a history of significant deterioration in his mental health after ceasing to take medication.

161. This approach is also supported by the "deteriorating patient" guidance mentioned by Mr du Feu, which originates from the "Committee of Inquiry into events leading up to and surrounding the fatal incident at the Edith Morgan Centre, Torbay, on September 1 1993".[10] It has been endorsed by the Mental Health Act Commission[11]. "The nature of a person's disorder is revealed by its history and, if the historical evidence is particularly compelling, the law would permit early intervention''.

162. In our view, H's presentation on 13 November fulfilled the criteria of both nature and degree for admission to hospital. The nature of his disorder was demonstrated by his failure to comply with medication, which had in the past led to a deterioration in his condition necessitating admission to hospital. There was a strong likelihood that

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[9] *R v Mental Health Review Tribunal for the South Thames Region, ex p. Smith (1999) 47 BMLR 104. Popplewell J.*

[10] *The Falling Shadow: One Patient's Mental Health Care 1978-1993, Duckworth 1995.*

[11] See '*The Threshold for Admission and the Relapsing Patient*' in response to the '*Falling Shadow*' at paragraph 4

this pattern was repeating itself. The degree of his disorder was evidenced by his delusional thinking focused on M resulting in threatening behaviour towards her.

163. We endorse the following approach which has been suggested elsewhere[12] to be taken by those involved in assessing a [revolving door] patient who has ceased to take his medication:

(1) a withdrawal from medication is a significant, but not a determining factor in the assessment;

(2) the role of the professionals involved in the assessment is to assess the patient's response to the withdrawal and to identify the reasons for his decision to cease taking medication; and

(3) although it would not be possible to determine that the provisions of either section 2(2)(a) or 3(2)(a) are satisfied solely on the ground that the patient has cased to take medication, an evaluation of the patient's history, and, in particular, of his reaction to withdrawal from medication in the past, could lead to a decision that the "nature" of his mental disorder justifies an application being made in respect of him.

Clearly, the greater the knowledge that the doctors and the approved social worker have of the patient's psychiatric history, the easier it will be to determine when to intervene by sectioning him…"

164. We think this guidance was relevant to the assessment of H. His ceasing medication needed more investigation from sources other than H himself. Mr du Feu mentioned the "deteriorating patient" guidance and stated that in his opinion, H was stable and not deteriorating. In our view, there was no basis for his opinion in this regard. We do not consider that he applied this guidance to H at the time of the assessment.

RECOMMENDATION 18

The Trust (CPT), Cornwall Social Services and Devon and Cornwall Constabulary must ensure that a joint agreed S136 assessment is recorded in writing and that it includes brief details of information

[12] *Jones, Mental Health Act Manual, 8th ed, para. 1-051.* Also in earlier editions, see 6th edition (1999) para. 1-043.

available and unavailable and details of arrangements made for the person. A copy of the assessment should be provided for the records of a person where they are known to mental health services, or otherwise be available to those making subsequent assessments of the person.

Information available to Mr du Feu and Dr Relf on 13/11 but not obtained

165. **Police information.** The custody record entry timed at 10.08 by ACI Selley was in the following terms:

> Notes from Sgt present at scene. [H] was clearly indicating at the scene that all his problems stemmed from his partner. He stated that the fact last night that there were no customers at the Chinese restaurant was because she had telephoned them all and told them about him and so they didn't attend the restaurant. He tried to remain calm but once he realised he had to leave he became agitated and angry and indicated if he did leave he will only return later. He made some threats towards his partner indicating she had been saying things about him and was ruining his life for a second time. I would be concerned if he did return to the address in an angry/agitated state. His partner indicates when on medication he is "fine" but he states he finished his medication approx. 6 months ago. She indicates his mental state has declined and that he was treated earlier this year.

166. ACI Selley spoke to H outside M's house on the morning of 13/11. He formed a lay opinion based on the content of H's conversation that he was "clearly paranoid". He said H blamed all his misfortunes on M including his experiences on the ship in Scotland in 1999. He turned every suggestion, made in an effort to assist the situation between H and M, against M. For example a suggestion that he should ring M before simply turning up at her house he interpreted as being necessary because she may have another man in the house and needed warning. ACI Selley says he formed the opinion that H considered that he had been signed off by his CPN and that he no longer needed to take medication.

167. ACI Selley and PC Bilsland were concerned about H's mental state and that he should be assessed to ensure that he did not present a threat to M.

168. ACI Selley's level of concern was such that he wanted to pass on as much information as possible via the custody record. He took what he said was the unusual step of leaving a very full and detailed entry in the hope that further contact may be made with him if necessary. He was also concerned that away from M's house and in the environment of a police cell H could present differently and in a less agitated manner. He felt it was important therefore for whoever was going to assess H to have information of his behaviour up to the point of arrest.

169. He had been unable to remain at the centre because he was the Patrol Sergeant on duty for all of Penwith and had several incidents running. Therefore said could not have remained at the custody centre in order to await the arrival of the doctor and the ASW. He did not go off duty as Mr du Feu said he had been informed. He could have been contacted via any convenient police station if necessary. In fact the first thing he and PC Bilsland did was to return to M's home. PC Bilsland returned H's car to his home. They did not want there to be any excuse for H to return to M's home. ACI Selley and PC Bilsland then talked further to M.

170. They were at Hayle police station when PC Bilsland learned of H's release at around 12.30 p.m. and steps were then taken to arrange for an alarm to be fitted in M's home.

171. The statements of ACI Selley and PC Bilsland on 15 November for the police investigation into M's death provided additional details that would have been provided had contact been made with them by those assessing H. This included that H was in clear mental turmoil and agitation and was becoming more agitated. In the early part of the morning H had been banging on the windows of the chalet. He had been taken to the custody centre in handcuffs.

172. PC Bilsland had spoken to M that morning. She expressed her fears regarding H's mental state, mentioned that he had been prescribed medication and suffered from "persecution paranoia". She was concerned that he was not taking his medication.

173. PC Bilsland also submitted intelligence to the crime information system: "[H] arrested under MHA 136 at 0900 131100 in Hayle this man suffers from persecution paranoia and if he fails to take his medication things get progressively worse he did not show any form of violence toward officers at

the time of arrest but was very agitated he is short but very strong and if things went pear shaped he would certainly be a handful". This entry is timed 12.29 p.m.

174. The police log of that morning's call out noted that "[H] outside the house at the window. Caller very frightened of him".

175. There was also an entry in the custody record that H had a police computer entry for "violence and drugs". Having investigated this further, the Inquiry have been told that the entry was an error and did not relate to H.

176. **Information from M.** The information that M is likely to have provided to Mr du Feu or Dr Relf is noted above.

177. **Mr du Feu's assessment on 30/12/99.** This was as follows:

> Crisis/ASW assessment
>
> About [M]: can no longer cope with the strain and hostility. Tearful and tired. Still concerned and wants [H] to recover.
>
> About [H]: Very suspicious believes there is a conspiracy against him from partner and others CPN etc.
>
> Sleep: not assessable on this visit.
>
> Summary of assessment: [H] is a 36 yr old man from Liverpool originally. He worked in Merch. Navy for many years and had his 1st breakdown in '99. He has been reluctant to take medication recently and had began (sic) to formulate conspiratorial views about others. He has become hostile to partner. He believes CPN is also involved in conspiracy.
>
> He was repeatedly offered informal admission but refused to accept any need to this. Sec 2 applied and taken to Trengweath.
>
> Risk assessment: A. conspiracy fears worsening - [H] could potentially act on his suspicions and cause harm to his partner. B. further deterioration of mental state if not treated.

178. **Health record information**. In our view, at least the discharge summary for the admission which ended in January 2000 would have been made

available. A copy is also to be found on the GP record. This was one page long and states:

> [H] was treated with risperidone 2 mg bd, which he took reluctantly. For some time he said he was only taking it because he was told to, he did not believe he was ill, that he had really heard [M] and other people say things, and they could not be hallucinations because they were too real. However, with explanation about the nature of hallucinations, and as his mental state improved, he no longer heard these voices. From the beginning of January he began to accept that our explanation of events was perhaps more likely than his own interpretation. On review on 14 January 2000 he began to accept that perhaps he was unwell and the risperidone was helping to keep him well. There are relationship difficulties with [M]. These are manageable, but when he becomes unwell, [M] finds she can no longer cope. They have agreed to separate and aim to remain friends for the sake of the children. [H] is reluctant to move out until he can gain employment, and thus pay for reasonable accommodation for himself……He will be following in outpatients on 31 January 2000 and monitored in the community by his CPN, Derek Condon.

179. The admission summary may also have been made available. This was much longer and the relevant parts in our view are as follows:

> [H's] wife rang the Duty Desk following concerns about [H's] mental health, especially since he had stopped taking his medication. After assessment…he was detained on a Section 2 and admitted to hospital.
>
> [H] had a first episode of psychotic illness at the end of May 1999, and made quite a good recovery and was being well maintained on risperidone 2mg bd. However, he stopped taking this prescribed medication some 2 months ago, and over the last 2 weeks has become increasingly unwell. He has no insight into his illness. ….he now describes auditory hallucinations of his wife and neighbour's voices saying derogatory things, for example, accusing him of incest. He also expressed some paranoid ideas about his wife persecuting him because she does not want things to go well for him.…He described increasing anxieties about his partner having had affairs, and he is worried that someone else may end up bringing up his children……

> He appeared quite suspicious and anxious but maintained good eye contact and was calm and co-operative. His speech was normal....There was no formal thought disorder, but he was preoccupied with his situation and allegations of incest. He spoke about a feeling that his partner was involved in a conspiracy against him and delusional ideas around this subject.....There were no abnormal perceptions during the interview, but there were reports of auditory hallucinations witnessed by Dr Naylor. His insight is not good. ...He is unhappy to be in hospital and has only agreed to take his medication reluctantly.

180. **General Practitioner.** There is an entry on the GP notes for 13 November that H had "Tel disturbed. Paranoia recurring. Threatening. DNA." There is no time given.

Comment

181. It is quite clear that H's presentation as described in the records above for December 1999 and early 2000, was highly relevant and similar to that on 13 November. There is little doubt that, had that information been accessed, the need for a full MHA assessment would have been recognised and a section 12 MHA doctor summoned and waited for.

182. It is also our view that had such an assessment taken place, H is likely to have been detained under the MHA and admitted to hospital compulsorily. In our view, that would have been the reasonable outcome of such an assessment. The only justification for not compulsorily detaining him would have been his voluntary admission to hospital, which he had refused.

183. Our comments above concerning the nature of H's illness are underlined. These notes demonstrate clearly that his illness was of a nature that it deteriorated without medication to a position where his delusions regarding M were attenuated. His insight into his illness was limited and his compliance with medication a real difficulty. Mr du Feu had himself noted the potential risk to M on his previous assessment and he associated this risk with a further deterioration in H's mental state if he remained untreated. In the circumstances, simply requesting

H to remake contact with the CMHT and to accept medication was a wholly inadequate response.

184. We have already stated that making proper arrangements for care and treatment falling short of admission to hospital also requires the gathering of historical information. The arrangements made for H were based on inadequate information and were inappropriate. The past information clearly calls into question his reliability where compliance with medication was concerned, such that a simple statement from him that he would comply should have been treated with some caution.

185. We are not satisfied that, given the deterioration in H's mental state and the risk he posed to M, he could have been safely managed in the community. We accept that the level of risk posed did not necessarily include that he would kill her. We do think that he posed a risk of some serious harm to her and this was sufficient to trigger a compulsory admission to hospital.

186. The evidence of Dr Hand set out above supports our conclusions in this regard.

LIST OF RECOMMENDATIONS IN CHAPTER 5

RECOMMENDATION 13

The Devon and Cornwall Constabulary review the guidance and training to custody sergeants on methods of obtaining mental health assessments for persons already in custody.

RECOMMENDATION 14

The Strategic Health Authority, Cornwall Social Services and the Devon and Cornwall Constabulary should jointly agree and provide for section 12 MHA training for police surgeons and general practitioners with a view to increasing the availability of section 12 MHA approved doctors in the locality. In the interim, there should be clear joint agency guidelines on the requirements for gathering available and relevant information about an individual, prior to mental health assessments, consistent with the MHA Code of Practice.

RECOMMENDATION 15

Cornwall Social Services must reinforce to all ASWs that, in accordance with paragraph 2.11 of the MHA Code of Practice, the overall responsibility for co-ordinating the process of a mental health assessment for a potential admission to hospital under the MHA rests with them.

RECOMMENDATION 16

The Trust (CPT), Cornwall Social Services, Devon and Cornwall Constabulary provide multi agency, cross-discipline training and guidance on the processes involved in conducting a mental health assessment to include general practitioners and police surgeons.

RECOMMENDATION 17

The Trust (CPT) should review its method of disseminating the findings and recommendations made in past and future Independent Inquiry (or other similar) reports into homicides outside Cornwall with a view to reviewing practice and ensuring, where appropriate, that lessons are learned.

RECOMMENDATION 18

The Trust (CPT), Cornwall Social Services and Devon and Cornwall Constabulary must ensure that a joint agreed S136 assessment is recorded in writing and that it includes brief details of information available and unavailable and details of arrangements made for the person. A copy of the assessment should be provided for the records of a person where they are known to mental health services, or otherwise be available to those making subsequent assessments of the person.

CHAPTER 6

SECOND ASSESSMENT ON 13 NOVEMBER 2000

- **Introduction**
- **CPN assessment**
- **Response of Dr Hand**
- **14 November 2000**

Introduction

17. This chapter deals with the second of two key assessments of H on 13 November 2000. The first is dealt with in detail in Chapter 5 and was conducted earlier in the day at Camborne custody centre by ASW Michael du Feu and police surgeon, Dr Christine Relf. The second was conducted by Derrick Condon, CPN with West Cornwall CMHT. We have examined whether these assessments demonstrated reasonable and defensible practice. We have found serious and numerous deficiencies in these assessments and have concluded that had proper assessments been carried out at either time, it is highly likely H would have been compulsorily detained in hospital on 13 November and, in any event, at some time prior to the time M died on 14 November.

18. H was not detained, prompting the police to act on their concerns and install a "panic" button in M's home on 14 November. On that day also M spoke to the headmaster of her daughter's primary school alerting him to problems at home and requesting that H not be allowed to take their daughter from the school. She had alluded to his mental health problems but stressed that she did not think that he was a danger to the child. She had spoken calmly and sensibly.

19. The facts and events of the 13 November are complicated to relate. Where conflicts in the evidence emerged we have relied more on the contemporaneous records made by the police, for example, the custody record, and the Trust and social services internal review procedures, than on memories reconstructed some two and a half years later for the Inquiry.

CPN: Derrick Condon. Second assessment.

20. Mr Condon was called by M at about 9.15 a.m. on the morning of 13 November while ACI Simon Selley and PC Anthony Bilsland were outside talking to H. He was at the Bolitho office. She was able to tell him that H was being taken to Camborne custody centre by the police which prompted his call there offering his telephone number and brief information regarding medication. This was the message picked up by Mr du Feu.

21. Mr Condon said she described H as being unwell for a few weeks presumably having ceased medication "resulting in a resurgence of his delusional thinking, feeling general public ignore him and whisper that he is a child molester…" He was blaming her again and she told Mr Condon that H was increasingly angry with her because he "sees her as the architect of all his problems admitting hatred towards her and has made veiled threats about harming her".

22. Mr Condon understood from what M was saying that H's mental health was deteriorating. He thought 7 a.m. was an odd time for an incident to occur and he knew that she did not embellish facts.

23. Mr Condon assumed that a MHA assessment would take place within six hours. He expected whoever was conducting the assessment to contact him and did not see it as his responsibility to go to the custody centre. He said he was aware that section 136 allowed 72 hours but that policy stipulated that assessments be done in six hours. Mr Condon was emphatic that he was not contacted by anyone between 9.50 and 11.00 a.m. He said he rearranged his diary to see M at around 12 p.m.

24. If Mr Condon had been contacted that morning by Mr du Feu and asked to provide information about H's psychiatric history, he said that he is likely to have stated that "he has a fluctuating severe mental health problem and it would appear, if there has been an altercation this morning, that he is currently unstable and requires a Mental Health Act assessment".

25. If told that H did not appear obviously mentally ill Mr Condon would have sought more information. because he knew that H could present superficially as being well. When shown the detail of Mr du Feu's assessment on that day, Mr Condon said his response would still have been to advise a MHA

assessment. He would have supported compulsory admission to hospital, if asked, because of the potential threat H posed to M since he was repeating thoughts and ideas expressed previously when he was "demonstrably unwell". This evidence is at odds with what he actually did, or did not do, on seeing H that day.

26. Mr Condon visited M at her home at around mid-day on 13 November when she was able to tell him that H had been released from custody. She was quite distraught at that news. This contrasts with Mr du Feu's description of her response: "she was supremely confident that Mr Condon would be helpful and understood the situation well. When I spoke to her that morning she gave the impression of having a good working alliance with Mr Condon and perhaps a frequent one. She seemed to understand that Mr Condon would make himself available and he would be committed to making sure she was okay and that [H] had the help he needed".

27. Mr Condon's records of his conversation with M in the morning and following his visit at mid day are conflated into one so that it is difficult to disentangle one from the other. It is reproduced below and also seems to indicate that the likelihood of H returning to M's house was appreciated.

> MR CONDON:
>
> 13.11.00 P/C contact with [M] – [H] has been unwell for a few weeks – presumably ceased medication resulting in resurgence of his delusional thinking. Feeling general public ignore him and whisper that he is a child molester, also becoming increasingly angry with [M] whom he sees as the architect of all his problems admitting hatred towards her and he's made veiled threats about harming her. [H] arrived at the house this morning at 07.00 but denied access but refused to leave resulting in [M] contacting Police. Removed to Camborne Custody centre where it was determined he was not detainable and subsequently released. Local Police are installing "panic button" and [M] has been forcibly advised by Police and myself to deny [H] access and to phone emergency numbers if she feels threatened in any way. Above discussed with Dr Hand.
>
> [H] seen at home. Looking subdued despondent and unwell. Very angry towards [M] whom he accuses of spreading malicious stories about him concerning molestation of children - this has been done to "destroy him".

> Helping on weekends in "Take-away" restaurant but because over weekend there were few customers he felt that locals had become aware of these accusations. Obviously unwell and delusional component similar to when he broke down in Aberdeen. Admits to cessation of medication several months ago. I will maintain contact with [M] but visits to [H] should be made with caution. Mentally very fragile. New care plan in situ.

28. While at M's house, he received a pager message, which he stated in his unsigned statement to the internal review was a request to contact Mr du Feu. He did not do this immediately because he did not want to discuss H's case in front of M, and also he did not regard it as urgent because he knew that H had been released. In view of the information given to him by M, Mr Condon was "extremely surprised" that H had been released.

29. In his statement to the Trust internal review Mr Condon stated that M said H had arrived at her house in a "distressed" and "agitated" state. This statement also records that Mr Condon spoke to Dr Margaret Hand at about 3 p.m. and informed her of the day's events. There is no formal record of this conversation or of Dr Hand's advice. In the signed internal review statement he stated that she asked him to get H to Bolitho where she would see him between 3.30 and 4 p.m. Dr Hand confirmed this to the Inquiry. There was no contingency plan in the event that H refused to come to see her or that Mr Condon was unable to contact him.

30. The record of Mr Condon having spoken to Mr du Feu is only contained in subsequent internal review statements. To this Inquiry Mr Condon said that it may have been Mr du Feu who contacted him but he was vague on the detail of that conversation. He could not recall what advice Mr du Feu had given H about remaking contact with the CMHT. He was simply told that H was not detainable. He did not mention any information relating to anger management or counselling which is what Mr du Feu told us H had agreed to, even though this is not in his note of assessment.

31. It has been very difficult to ascertain what information Mr Condon passed on to Dr Hand. She said she was reassured by the fact that H had been seen by a doctor and ASW and assumed that they had background information available to them. She mentioned that Mr du Feu knew H from his one previous assessment. She was unable to say, however, whether she remembered that at the time or not. It is difficult to be certain of more than

that she was told that H was not considered to be "detainable" and that M had fears for his mental health.

32. Dr Hand could only assume that she must have been told about his non-compliance with medication and about the panic button. Mr Condon said that he would have told her what was in his note regarding the morning conversation and visit, although perhaps not word for word.

33. At about 3.20 p.m. Mr Condon says he met with H who refused the offer to be taken to see Dr Hand. He made this known to Dr Hand. H played down the day's events but agreed to Mr Condon visiting him at home. This occurred at approximately 4 p.m. and there is a note in the health record timed at "16.30" and written as before, as if contemporaneous, but we know now that it was also written the next day. The new care plan referred to is one dated 14 November.

34. Mr Condon did not consider arranging a further formal assessment of H as a result of his visit. He knew that Dr Hand had not seen him and probably that he had not been seen by a section 12 doctor; in other words, that no full MHA assessment had in fact been done. He did not contact Dr Hand to inform her of the result of his meeting with H, nor did she contact him. It was his view that the risks he identified were containable by H remaining at home. He did not think that H would return to M's home. We now know that H did return to her home at 7 p.m. that night. She did not let him in and there was no incident.

35. Mr Condon's care plan devised on 14 November without H's input was as follows:

> CARE PLAN:
>
> Since reducing/stopping anti psychotic medication [H's] mental state has deteriorated resulting resurgence of paranoid thoughts directed at ex partner who he accuses of spreading unfounded rumours of child molesting.
>
> Goals of care: for [H] to recommence regular medication to stabilise current unstable mental health.

Care intervention/Action:

1. Attempt to maintain regular contact with [H] accepting he will attempt to sabotage contact.
2. Retain regular contact with ex partner [M] as an intermediary contact point if 1) fails.
3. If requested to attend either at [M's] home or [H's] home due to disturbance/disturbed behaviour, ascertain circumstances and exercise caution.
4. Determine probably need to attendance by two male staff.
5. Liaise with local police as appropriate.
6. Liaise with GP, consultant and social services if necessary to facilitate MHA assessment if deemed necessary.

36. In his Trust internal interview Mr Condon stated that he was alerted, as a result of his meeting with H, to the re-occurrence of H's delusional thinking. This was supported when H told him that he had ceased his medication. Mr Condon's own previous notes would have revealed to him that H told him on 2 August that he had stopped taking his medication, and that he did nothing to ensure that H re-commenced it.

37. The Panel were given access to one of the sealed exhibits taken from H's home by the police following the death of M. It consisted of tablets found in a drawer in H's house after his arrest. Present was a prescription made out on 28 June 2000 of Risperidone tablets of 2 mg each. The number of remaining tablets indicated that out of a twenty eight day supply, H had taken only fourteen days worth of his medication. H may not have taken his tablets in fourteen consecutive days. He indicated to Mr Condon on 2 August 2000 that he had ceased his medication. It is likely, therefore, that he had in fact stopped taking his tablets by that time.

38. Mr Condon did not relay to Dr Hand that H refused to come to see her in her clinic. Nor did he tell her the outcome of the meeting with H and his own assessment of him. Dr Hand did not follow up with Mr Condon why H had not come to her clinic on 13 November or the next day.

Comment

39. **We have already commented on Mr Condon's lack of formal training as a CPN and that he did not go through any form of re training on returning to clinical practice after a significant period of time. He told us that he was self taught and that he did not find the transition back to clinical practice difficult at all. We have considered the issue of training and the systemic framework within which Mr Condon practised in detail in Chapter 2. We found there to be a dual responsibility between the Trust and Mr Condon in relation to what we see as deficiencies in his competency which need to be addressed as a matter of priority through training.**

40. **It is our view that failing to act to obtain an MHA assessment of H after his visit to him at 16.30 given the contents of his note, probably fell below a reasonable standard. For someone in Mr Condon's position, with intimate knowledge of H's past of non-compliance with medication, deterioration and resistance to follow up, not to mention the risks to M which had been previously identified, to seek to maintain H in the community without a further assessment was unreasonable.**

41. **His treatment plan gives no indication of agreement by H that he will re-start medication. In fact it notes the likelihood that H would sabotage contact. The plan is not time limited and so cannot be said to be, for example, an overnight holding plan. If, as may have been the case, Mr Condon took some reassurance from the panic button, we think that this would have been unreasonable for anything but the shortest period of time. He could not abrogate his own professional duties due to the fact that the police had stepped in. He could not have known how long M would have been allowed to keep the panic button. He failed to recognise the urgency of the situation revealed by H's presentation when he saw him and to act accordingly. Dr Hand confirmed that they should have acted to have H admitted to hospital on the basis of this presentation.**

42. **The visit to H revealed quite clearly that he was deteriorating in a manner that was strikingly similar to December 1999 and before, although at the precise time of H's admission to hospital, Mr Condon was on annual leave.**

43. As with the period in the community in 2000 when there was minimal input from Dr Hand, we think there was probably a failure to give her key information such as that H said he had stopped his medication for several months. We think that Mr Condon sought to manage this situation on his own as far as possible which, in our view, is a direct consequence of his lack of training and over confidence which went unchecked by higher management.

44. It is also striking that Mr Condon rearranged his diary to see M that morning, but did not go to the custody centre to see H since he did not think was his role; he did not think that the assessment would take place so quickly. It is our view that, at this stage too, he should have sought to inform Dr Hand that her patient was in custody, and Dr Hand told us that it would be normal practice for her to be informed if one of her patients was taken to Camborne.

45. We are critical of the way in which Mr Condon wrote up his notes of 13 November. They were written to give the impression that they were contemporaneous, which may not have been deliberate, but writing them the next day without stating as such is misleading. Conflating information received at different times into one entry is inaccurate recording. Mr Condon eventually said these notes were written the following morning but we cannot be confident as to when precisely they were written. We accept information from Mr Victor Bridges, CMHT team leader, that the entries were there on 15 November when he reviewed the notes following M's death.

46. We are also dissatisfied at the state of the evidence regarding communication between Mr du Feu and Mr Condon. Mr Condon is quite sure that he was not paged in the morning, and the telephone message books do not carry any messages for him at that time. Later on the evidence is quite confused as to who called whom and when, and what was discussed. There are no notes of the afternoon conversation made by Mr du Feu or Mr Condon.

47. It seems odd that in light of the fact that the events of that day must have been gone over in detail and repeatedly shortly afterwards, we do not have a clearer account. Both Mr Condon and Dr Hand raised the possibility, albeit fleetingly, that they spoke before any discussion with

Mr du Feu. Dr Hand said that it may have been before her clinic started at 2 p.m. On balance we accept that there was a brief conversation between Mr du Feu and Mr Condon that afternoon probably before Mr Condon spoke to Dr Hand. She was clear that at the very least she knew, and was reassured by, the fact that H had been seen by a doctor and ASW.

48. We are critical at the lack of any record of these discussions. It would have been important for Mr Condon to know what H had agreed to with Mr du Feu prior to his seeing him. We think also that a copy of Mr du Feu's assessment should have been requested as a matter of urgency and by fax to assist Mr Condon in his review of the situation. In the end this was not necessary because he was able to see for himself that H's mental state had deteriorated significantly. His note demonstrates H's abnormal mental state which is unlikely to have changed significantly from the morning, and which persisted thereafter.

49. Good record keeping is the key to accountable practice. When things go wrong, practitioners are asked to account for their decisions and actions often several years later. Without decent contemporaneous records, i.e. not those written later but as if written at the time, memories and recollections are unreliable. This is a fundamental requirement of good practice.

50.

RECOMMENDATION 19

The Trust (CPT) and Cornwall Social Services to ensure, through suitable training, audit, monitoring and management, that practitioners are consistently making useful and proper records designed to demonstrate good practice.

What would Dr Hand have done?

51. Her actions at the Camborne custody centre had she been called in during the first assessment are set out above chapter 5 at paragraphs132 -135.

52. Dr Hand's evidence was that, had the contents of the assessments by Mr du Feu and Dr Relf been brought to her attention later that afternoon by Mr Condon, it would have been reasonable to consider a MHA assessment. If she had seen Mr Condon's note of 13 November timed at 16.30 (but not

written till the next day) recording his visit to H, she would have done an assessment of H. "I would have wanted him in hospital and on medicine". An assessment with a view to admitting H to hospital would have been reasonable. She considered that the note indicated a level of psychosis that could not be contained in the community.

53. She was shown the care plan in which no agreement had been reached with H regarding re-starting medication and stated that they should have acted to conduct a MHA assessment with a view to admission to hospital. She accepted that the treatment plan did not convey a sufficient degree of urgency given the presentation of H.

54. Dr Hand received no feedback from Mr Condon after their conversation on the afternoon of 13 November. The last she had heard was that H would be brought in to see her. She did not make contact with Mr Condon that evening or the next day to find out what had happened and why H had not come to the clinic.

Comment

d) **We think that there should have been further contact between Mr Condon and Dr Hand. It was the responsibility of them both to ensure that this happened. We feel that this demonstrates yet again, the way in which this CMHT worked; Dr Hand relied on Mr Condon and in effect endorsed the approach that allowed him to practise semi-autonomously.**

e) **Had she known more detail of the earlier assessment she may well have been more proactive, but she told us that she was reassured by that assessment and so was not more active in her response. In the face of what was likely to have been imperfect information it would be harsh to criticise her unduly for not having responded more proactively on this occasion. We accept that had she been better informed she is likely to have become more involved if not that afternoon (due to her own domestic difficulties), the following morning. Alternatively she may have alerted the duty doctor of the possibility of an assessment that evening.**

14 November 2000

40. We know that H did return to M's house on the evening of 13 November but do not have details of that visit.

41. On the morning of 14 November M took her daughter to school and talked to a teacher and the head teacher about her recent problems with H. She was concerned about any effects on her daughter.

42. A police victim support co-ordinator called M at home. She noted that M was "really scared" of H when he does not take his medication. M had said that the police had given her a personal alarm.

43. The alarm had been fitted at around 11 a.m. by PC Rowell. M spoke to Mr Condon saying that if H wanted to see the children he had to resume his medication. She had arranged for H to see the children in the local park that afternoon and had intended to tell him that he could not come to the house any longer. She met a friend while at the school gate picking her daughter up and was later seen by another friend together with H at the park.

44. At around 5.30 p.m. the alarm was activated and the police alerted to an emergency at M's home. They arrived approximately ten minutes later to find that M had been strangled by H who had broken the door down and entered her home. M was already dead when the police arrived. H was seated with the children in the sitting room awaiting the arrival of the police.

45. At the police station H was found to be unfit to be interviewed. He was seen by an approved social worker and recorded as being in extreme distress over what he had done to M and to the children.

Comment

46. **The trigger to M's death may have been her refusing H access to the children on 14 November. In our view, given H's recorded presentation on 13 November, it was probable, and indeed foreseeable, that she would seek to restrict or prevent his access to the children and that H is unlikely to have accepted this calmly. Our view is that, on balance, in these circumstances, a serious incident between H and M was predictable at this time.**

LIST OF RECOMMENDATIONS IN CHAPTER 6

RECOMMENDATION 19

The Trust (CPT) and Cornwall Social Services to ensure, through suitable training, audit, monitoring and management, that practitioners are consistently making useful and proper records designed to demonstrate good practice.

APPENDIX A

Terms of reference

The remit of the inquiry is as follows having been discussed and agreed with the Chief Executive of the South West Peninsula Health Authority

1. With reference to the homicide that occurred on 14 November 2000, to examine the circumstances of the treatment and care of H by the mental health services, in particular:

   (i) the quality and scope of his health, social care and risk assessments;

   (ii) the appropriateness of his treatment, care and supervision in respect of any of the following that are relevant:

      (a) his assessed health and social care needs;

      (b) his assessed risk of potential harm to himself or others;

      (c) any previous psychiatric history, including drug and alcohol abuse;

      (d) the number and nature of any previous court convictions;

      (e) (estatutory obligations, national guidance (including the Care Programme Approach) HC(90)23/LASSL(90)11, Supervision Registers JSG(94)5, and the discharge guidance HSG(94)27 and local operational policies for the provision of Mental Health Services.

   (iii) the extent to which H's prescribed treatment and care plans were

      (a) documented,
      (b) agreed with him,
      (c) communicated with and between relevant agencies and his family,
      (d) carried out,
      (e) complied with by H.

2. To examine the appropriateness of the training and development of those involved in the care of H.
3. To review the structure of the internal inquiries into the care of H.
4. To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require.
5. To prepare a report on and make recommendations as appropriate to the South West Peninsula Health Authority

The following schedule of documents will be used by the panel in undertaking its inquiry:

1. All medical records relating to H, including all hospital records whether as an inpatient or outpatient, GP records, all records prepared by any other doctor or nurse.

2. All medical records of H relating to his treatment whilst a patient at Hospital.

3. All documents relating to H in the possession of the Social Services Department.

4. All documents relating to H in the possession of Education Departments.

5. All records relating to H in the possession of the Probation Service.

6. All documents in the possession of the Police relating to the investigation into the death of M and the subsequent prosecution of H.

7. All documents in possession of the Home Office relating to H including the C3 Departmental records.

APPENDIX B

Inquiry procedure

INTRODUCTION

1. The Inquiry is independent of its sponsors.
2. The Inquiry will be known as "the independent inquiry into the care and treatment of H".
3. All hearings of the Inquiry will be held in private: this means that the press and other media will not be allowed to attend hearings. There will be no cross examination of witnesses except by members of the Inquiry panel and counsel for the Inquiry panel.[13]
4. Witnesses will be given an opportunity to comment on the evidence of others where relevant and necessary and as provided for below by way of written representations (see paragraphs 10, 17 and 18).
5. The Inquiry hearings will be conducted as informally as possible. The role of counsel will be predominantly to lead the evidence and to ensure that the views of all those participating in the inquiry process, and in particular the victim's family, are properly and fully canvassed in evidence (see paragraph 16 below).
6. Factual evidence will be sought from a) those working for the agencies/services involved with H at the relevant time, b) "lay" witnesses, being family, friends or others with direct knowledge of H and not within the identified agencies/services.
7. Advice may be sought from relevant experts on practice issues.

<u>Written evidence</u>

8. Each factual witness will receive letters informing them:
   a) of the terms of reference and the procedure adopted by the Inquiry
   b) of the proposed timetable for the Inquiry
   c) of specific areas and matters on which the Inquiry wishes them to provide evidence in addition to anything the witness him or herself wishes to raise
   d) of the method of accessing records relevant to their own role in the care of H for the limited purpose of responding to the Inquiry.

[13] Counsel was not appointed

9. Witness evidence is to be provided in writing in the first instance; written statements will provide the basis for any oral evidence which the Inquiry may deem necessary.
10. Not every witness written to will automatically be invited to give oral evidence unless this is specifically requested by the witness, with reasons.
11. All witnesses asked to provide written evidence will be provided with a list of factual witnesses written to so that they may i) indicate whether in their opinion any material witness has been omitted and ii) suggest areas of inquiry with any of the proposed witnesses.

Hearings and oral evidence

12. Details of venue and recoverable expenses incurred in attending to give oral evidence will be provided at the time a factual witness is notified by the Inquiry panel of the need for such evidence. Witnesses will be offered an opportunity to familiarise themselves with the venue in advance of giving evidence.
13. Witnesses attending in person to provide evidence may raise any matter they feel might be relevant to the Inquiry.
14. Witnesses may bring with them, at their own personal cost, a lawyer or a member of a defence organisation, friend, relative, colleague or member of a trade union, provided that no such person is also a witness to the Inquiry: it is the invited witness who will be expected to answer questions. It is expected that if required agencies/services will provide legal assistance to staff/officers from whom evidence is requested by the Inquiry.
15. Factual witnesses will be asked to affirm that their evidence is true.
16. Questions asked will take into account representations made by the family and other factual witnesses or agencies or professional bodies and any advice received from experts.
17. Oral evidence will be recorded and a transcript sent to the relevant witness to check for accuracy.
18. Any points of potential criticism concerning a witness of fact which may be material to the Inquiry's findings will be raised with that witness either directly at the time they first attend to give evidence to the Inquiry in person, or in writing at a later time. They will be given a full opportunity to respond (usually in writing). A summary of any relevant evidence or, if

appropriate an extract of the same, will be provided by the Inquiry for that purpose.

19. 17 above will also apply to any matter which falls short of a criticism but where the evidence of one witness may be material to that of another.

Other evidence

20. A press statement inviting anyone with relevant information to contact the Inquiry has been issued and the Inquiry may invite such persons to make written or oral representations.

21. Representations may be invited from relevant professional bodies, agencies and individuals as to their views and any recommendations on the issues arising, including on the present arrangements for persons in similar circumstances to H.

Victim's family

22. The family of M will be given a full opportunity to contribute to the Inquiry process and to consult with the Inquiry. In particular, family members will:
    a) Be provided with copies of the terms of reference and procedure
    b) Meet informally with the panel members, counsel and/or the inquiry manager
    c) Be asked to provide a list of potential witnesses together with issues/questions they consider to be relevant
    d) Be provided with a list of proposed witnesses prior to hearings for their comments and questions
    e) Give formal evidence to the inquiry
    f) Be provided with a copy of the final Inquiry report.

Publication of report

23. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the report, and any recommendations, will be based on those findings.

24. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as disclosed within the body of the Inquiry's final report.

25. The findings and any recommendations of the Inquiry will be presented in a report and made public by the Health Authority.

16 October 2002

APPENDIX C

Chronology

Key dates and events in H's life

History prior to engagement with mental health services

12 May 1963	H born in Liverpool.
2 April 1979	Suffers injury to finger, which results in long term damage, later preventing his subsequent plans to join the RAF as a career.
1980s	H joins merchant navy.
	Family notices alterations in behaviour on visits home from sea.
	Merchant Navy dismisses H.
	H goes to work for P&O Ferries in Dover.
	H takes sick leave but is dismissed from his employment.

Early years with M

1989	Meets M, when he joins Sealink ferries Limited, where M is also employed.
Late 1991	H and M move to Cornwall.
1990s	H and M purchase a house in Cornwall, which they occupy jointly until August 2000.
1992	H registers with local GP.
1993	Daughter born to H and M.
1998	Son born to H and M.
1990s	H gets job working on the ferry service between Penzance and the Isles of Scilly.
Late 1990's	H resigns from post as the working hours impact on his leisure and family time.
1998	H obtains employment on the North Sea oilrigs, off the coast of Aberdeen.

First contact with mental health services

31 May 1999	H is admitted from oilrig to Grampian Healthcare NHS Trust in Aberdeen, following increasing paranoia and pre-occupation whilst at sea.
1 June 1999	Hospital record to effect that focus of his delusions is on M.
2 June 1999	H is detained under Mental Health Act in the interests of his own safety. Is recorded as being delusional and a "suicide risk". Experiences voices accusing him of being a pervert. Is convinced that he will be killed and may as well kill himself.
8 June 1999	RMO in Cornwall confirms that H will be accepted as a patient locally.
10 June 1999	H is admitted to Trengweath Unit in Camborne, Cornwall, as a transfer and remains under section 2 MHA detention.
15/16 June 1999	RMO approves overnight leave for H.
17 June 1999	H is discharged from Trengweath and returns home to M and the children, with support from community psychiatric nurse, Hilary Oates, West Cornwall CMHT.

Support in the community from the mental health services

23 June 1999	GP records that H still has conspiratorial thoughts.
25 June 1999	Clinical note records that H had stopped medication for 2 days and become psychotic again. H realised that he did need to take his medication.
30 June 1999	Hilary Oates, CPN assigned to support EL, evaluates treatment plan and builds in one-month review period.
12 July 1999	M makes distressed telephone call to CPN. She reports H as being depressed and negative, and unwilling or unable to accept that relationship is coming to an end.
14 July 1999	CPN visits H who reports feeling better. Has mood swings and anxiety but denies hallucinations.
3 September 1999	H talks to CPN about alternative accommodation to make the situation between him and M better.
21 September 1999	Social Work intervention to gain support towards social housing and access to appropriate facilities. M confirms to Social Worker that H is not a risk to her or the children.
30 September 1999	H cancels outpatient appointment at Bolitho House.

21 October 1999	H attends outpatient appointment at Bolitho House. Reports feeling low because of loss of job and loss of relationship with M.
22 October 1999	CPN care for H transfers from H Oates to D Condon, West Cornwall CMHT.
3 November 1999	H fails to attend GP appointment.
22 November 1999	H attends outpatient appointment at Bolitho House.
22 December 1999	M attends at Bolitho House, distressed and tearful. Expresses concerns that H unwell and argumentative and appears to hear voices. H accuses her of talking and whispering behind his back. H has admitted to curtailing his medication some time previously. M expresses concerns about H's unpredictability and obvious deterioration in mental health. CPN advises M to stay with friends for the night and agrees to visit H the next day.
23 December1999	Notes of CPN meeting with H record: "H… mildly agitated and distressed regarding the breakdown of his and M's relationship. Admits to being argumentative … insisting M has been talking behind his back. Admits to me that he stopped medication some time ago but accepts he needs to restart this and maintain compliance although I suspect his compliance will remain problematic …. M also informed covertly that Duty Desk support is available and should be used."

Second admission to in patient unit

30 December 1999	CPN records telephone conversation with M, indicating that H increasingly paranoid over previous 3 days. Had stopped medication and was accusing M of trying to get him re-admitted. Records: "some concern he may become violent towards her."
30 December 1999	Seen by doctor and Mike du Feu, ASW. H declines voluntary admission to hospital and is admitted under section 2 MHA to Trengweath.
3 January 2000	H has escorted leave with nursing staff.
4 January 2000	Nurses have discussions with H about leaving M.
13 January 2000	H has escorted leave with nursing staff.
17 January 2000	H discharged from Trengweath and returns home to M and the children, with support from Derrick Condon, CPN, of West Cornwall CMHT.

Support in the community from the mental health services

January 2000 et seq	CPN continues to support both H and M.
24 January 2000	CPN records refer to H's paranoid thoughts against M.
31 January 2000	H fails to attend outpatient appointment at Bolitho House. CPN asked to investigate as soon as possible.
7 February 2000	H now attending course at college.
16 February 2000	H goes to Scotland for a week as part of college course.
3 March 2000	H fails to attend outpatient appointment at Bolitho House.
27 March 2000	CPN records that H angry whenever the subject of separation (him and M) is broached.
April 2000	M finds new home for herself and the children.
4 July 2000	CPN records that there has been a bad weekend with arguments about M moving out. Threatening behaviour by H left M feeling frightened and fearful for her future safety…..strong undercurrent of anger and loss. CPN surreptitiously agrees to meet M the next day to discuss evasive plans if she becomes fearful.
6 July 2000	CPN shares safety plan with M and notifies DVU. He records: "Violence has occurred and risk of this happening should not be minimised as date for M's departure with children draws closer".
24 July 2000	Hayle Police Station contacts CPN to clarify whether M has now left the joint home.
2 August 2000	CPN records H as being very angry and threatening retribution, and that he has stopped taking his medication. Notes for urgent liaison with RMO.
August 2000	M and children move into new home.
16 August 2000	Occupational Therapist discharges H from his caseload, as he has not seen him for some time.
25 August 2000	GP writes to H re missed appointments with the CMHT.
August 2000	H obtains employment in plumbing trade in Penzance.
5 September 2000	Social Services close file on H.
11 November 2000	M tells friend that H is hearing voices in his head again and has stopped medication.
13 November 2000	M telephones H's employers to advise that H is unwell and will not be going to work. H does not return to work.

Arrest and assessment under Section 136 of MHA

13 November 2000

H goes to M's new home early in the morning. M frightened by his presence and feels unable to leave the house to take the children to school.

M calls the police. PC Bilsland arrests H. Sgt Selley present.

H taken to Camborne Custody Centre. Custody sergeant contacts ASW and police surgeon to attend custody centre to undertake a Section 136 assessment of H.

Mr du Feu, ASW and Dr C Relf, police surgeon, attend Camborne custody centre and assess H under Section 136 of the Mental Health Act. Their decision is that detention under the Act is not warranted. H is released and returns home. He is asked to re-establish contact with the CMHT.

ASW advises CPN of H's release. Latter already aware of the arrest following contact by M.

Sgt Selley takes unusual step of arranging for a panic alarm to be fitted in M's home.

RMO suggests that H should see her that afternoon and an emergency outpatient appointment is arranged. H declines to attend but agrees to see CPN and this takes place at 16.30. CPN's subsequent notes record that H was "Subdued and despondent and unwell. Very angry towards M. Obviously unwell and delusional… similar to when he broke down in Aberdeen. Admits to cessation of medication several months ago. I will maintain contact with M but visits to H should be made with caution. Mentally very fragile. New care plan in situ". Does not share this information with RMO.

The homicide

14 November 2000

M meets with H, by arrangement, in local park at 4.00 p.m. to discuss his access to the children. H upset by M's placing restrictions on access for the first time. M returns home with the children.

H then goes to M's house as he was upset and wanted to see the children again. M does not let him into the house. An argument ensues and M threatens to call the police.

H starts to walk away but then turns back and, being unable to enter the house by the front door, goes to the back of the house and kicks the back door down.

H strangles M in the hall of the property.

Daughter strikes the panic button.

Police arrive at M's home approximately 10 minutes later.

6 July 2001	H pleads guilty to manslaughter on grounds of diminished responsibility at Exeter Crown Court and made subject to order under sections 37 and 41 MHA. H remains detained in medium secure unit pursuant to order.

APPENDIX D

List of witnesses

Notes: Job titles relate to the time of contact with H or M and may have changed subsequently. # denotes where hearing with witness was not in Redruth

1. Witnesses who provided written evidence

Dr R Arnold	**Specialist Registrar, Grampian Primary Care NHS Trust**
Mr B Arnot	**Registered Mental Nurse, Cornwall Healthcare Trust**
PC A Bilsland	**Devon and Cornwall Constabulary**
Mrs T Camps	**M's work supervisor**
Det Sgt N Clarke	**Devon and Cornwall Constabulary**
Ms C Clegg	**Community Psychiatric Nurse, Cornwall Healthcare Trust**
Sgt. N Cudlip	**Devon and Cornwall Constabulary**
Sgt. J Curtis	**Devon and Cornwall Constabulary**
Dr D Fowlie	**Consultant Psychiatrist, Grampian Primary Care NHS Trust**
Dr N Gibson	**General Practitioner**
Mrs I Jenkin	**M's neighbour and friend**
Mrs C Lee	**M's friend**
Dr P Menon	**Consultant Psychiatrist, Cornwall Healthcare Trust**
Dr S Naylor	**Consultant Psychiatrist, Cornwall Healthcare Trust**
Mrs A Norman	**M's neighbour and friend**
Mr S Pascoe	**M's neighbour and friend**
Mrs P Peek	**M's friend**
Mrs W Pisawacki	**M's friend**
DC M Rowe	**Devon and Cornwall Constabulary**
PC S Rowell	**Devon and Cornwall Constabulary**
Dr J Slater	**General Practitioner**

Mr D Willmot	**Approved Social Worker, Cornwall County Council**

2. Witnesses interviewed by the Panel (* one member of the Panel)

H*#	**Subject of Inquiry**
DH*#	**H's sister**
Mr M du Feu	**Approved Social Worker, Cornwall County Council**
Mrs H Mansell	**Community Psychiatric Nurse, Cornwall Healthcare Trust**
Mr D Condon	**Community Psychiatric Nurse, Cornwall Healthcare Trust**
Dr M Hand	**Consultant Psychiatrist, Cornwall Healthcare Trust**
Dr C Relf	**Locum General Practitioner**
Mr RM	**M's father**
Mrs VM	**M's mother**
Miss SM	**M's sister**
Mrs RM	**M's sister in law**
Mr S Corbin	**Registered Mental Nurse, Cornwall Healthcare Trust**
Acting Chief Inspector S Selley	**Devon and Cornwall Constabulary**
Ms J Fisher	**M's friend**
Mr M Steer	**Assistant Director of Nursing, Cornwall Healthcare Trust**
Mrs J Hostick	**Locality Manager, Cornwall Healthcare Trust**
Mrs K Green	**General Manager, Cornwall County Council**
Mr M Faulds	**Senior Operations Manager, Social Services, Cornwall County Council**
Mrs S Whitehead	**Assistant Director of Social Services, Cornwall County Council**
Mr M Cochrane	**Strategic Coordinator, South West Peninsula Health Authority**
Mr M Donnelly *#	**General Manager, Mental Health services, Cornwall Healthcare Trust**

3. Expert witnesses who provided written advice to the Panel

Mr A Newland	**Mental Health Services Consultant**
Dr G A Norfolk	**GP and Expert in Legal and Forensic Medicine**
Dr S P Robinson	**Senior Police Surgeon. Honorary Lecturer in Clinical Forensic Medicine**

4. Witnesses who were contacted informally for evidence

Ms J Baker	**Haven Underwater Centre**
Mr F Harsent	**Chief Executive, Cornwall Healthcare Trust**
Mr Sellars	**Westcountry Watersports (where H a customer)**
Mr D Smale	**The Plumb Centre (Employer of H)**
Ms D Wilshire	**Vice Principal, Cornwall College**

APPENDIX E

Map of Cornwall

(awaiting file)

APPENDIX F

List of recommendations

Chapter 2

RECOMMENDATION 1:

The Trust (CPT) should within six months

e) review the drafting and implementation of its CPA policy and

f) ensure regular and effective audit of its use to reinforce the need for discharge planning conforming to national standards, the role of the care co-ordinator and the regular, comprehensive and systematic review of all patients under the care of the CMHT.

Additionally all policies must be dated and the date of implementation be clear.

Recommendation 1 also appears in Chapter 4

RECOMMENDATION 2:

The Trust (CPT) should ensure that all clinical and operational policies are consistent with National Guidance and are implemented promptly. All policies should be introduced with a detailed implementation plan that identifies resource implications, training requirements and changes from previous practice.

RECOMMENDATION 3:

The Trust (CPT) must audit the quality of clinical record keeping within six months. This must include the relevance of clinical entries to the patient's care and the comprehensiveness of that record and compliance with Trust policy and procedure.

RECOMMENDATION 4:

The Trust (CPT) should commission an independent review of the changes to clinical policies and practice described by senior managers to the panel in the course of this inquiry. In particular the review should measure the effectiveness of these changes at the patient interface. (See also (1) above)

RECOMMENDATION 5:

The Trust (CPT) must provide relevant professional/clinical supervision to all staff employed by Cornwall Partnership Trust.

Recommendation 5 also appears in Chapter 4

RECOMMENDATION 6:

The clinical supervision arrangements described above must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

Recommendation 6 also appears in Chapter 4

RECOMMENDATION 7:

The Trust (CPT) should put in place new arrangements within six months to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

Recommendation 7* also *appears in Chapter 4

RECOMMENDATION 8:

All agencies must ensure that all documentation likely to be of relevance to an internal or external inquiry is secured as a matter of priority following a serious adverse event.

RECOMMENDATION 9:

The Trust (CPT) and Social Services must act to resolve the co-location difficulties in the West of Cornwall CMHT. Appropriate professional/clinical supervision that is acceptable to the body of practitioners must be provided for all staff. We recommend that external expert advice be sought on this issue and that the recommendations of the Social Service Inspectorate be taken into account.

RECOMMENDATION 10:

The Trust (CPT) and Social Services must as a matter of urgency review the effectiveness of their joint working at all levels of both organisations.

RECOMMENDATION 11:

The Trust (CPT) policy on Investigating Serious Untoward Incidents should be reviewed to ensure its consistency with the guidance issued by the National Patient Safety Agency. Particular attention should be paid to a) root cause analysis, b) in all cases terms of reference should be followed and c) any change of these terms should be formally recorded.

Chapter 4

RECOMMENDATION 12:

The Trust (CPT) should review the way in which discharge summaries are written to ensure compliance with the findings of this Inquiry as set out above and mental health policy and best practice. In particular discharge summaries should record the detailed decision as to why discharge is considered appropriate at that time, the specific arrangements for follow up of the patient including the names, designations and contact details of those responsible for ensuring follow up plans are maintained.

Chapter 5

RECOMMENDATION 13:

The Devon and Cornwall Constabulary review the guidance and training to custody sergeants on methods of obtaining mental health assessments for persons already in custody.

RECOMMENDATION 14:

The Strategic Health Authority, Cornwall Social Services and the Devon and Cornwall Constabulary should jointly agree and provide for section 12 MHA training for police surgeons and general practitioners with a view to increasing the availability of section 12 MHA approved doctors in the locality. In the interim, there should be clear joint agency guidelines on the requirements for gathering available and relevant information about an individual, prior to mental health assessments consistent with the MHA Code of Practice.

RECOMMENDATION 15:

Cornwall Social Services must reinforce to all ASWs that, in accordance with paragraph 2.11 of the MHA Code of Practice, the overall responsibility for co-ordinating the process of a mental health assessment for a potential admission to hospital under the MHA rests with them.

RECOMMENDATION 16:

The Trust (CPT), Cornwall Social Services, Devon and Cornwall Constabulary provide multi agency, cross-discipline training and guidance on the processes involved in conducting a mental health assessment to include general practitioners and police surgeons.

RECOMMENDATION 17:

The Trust (CPT) should review its method of disseminating the findings and recommendations made in past and future Independent Inquiry (or other similar) reports into homicides outside Cornwall with a view to reviewing practice and ensuring, where appropriate, that lessons are learned.

RECOMMENDATION 18:

The Trust (CPT), Cornwall Social Services and Devon and Cornwall Constabulary must ensure that a joint agreed S136 assessment is recorded in writing and that it includes brief details of information available and unavailable and details of arrangements made for the person. A copy of the assessment should be provided for the records of a person where they are known to mental health services, or otherwise be available to those making subsequent assessments of the person.

Chapter 6

RECOMMENDATION 19:

The Trust (CPT) and Cornwall Social Services to ensure, through suitable training, audit, monitoring and management, that practitioners are consistently making accurate and relevant records designed to demonstrate good practice.

APPENDIX G

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF (***H***)

SAMPLE STANDARD WITNESS LETTER

(Lay witness)

November 6th 2002

Dear (Name),

Request for written statement of evidence

This Inquiry has been set up by the South West Peninsula Health Authority by virtue of its obligation to do so under NHS (National Health Service) Executive Guidance (HSG (94) 27) following the murder of (***M***) by (***Name***) on 14 November 2000. It has been agreed with his solicitors that (***Name***) will be referred to as ("***H***") by the Inquiry in its work.

I have been appointed as manager to the Inquiry and am writing to you on behalf of the Inquiry panel. The members of the Inquiry are Ms Aswini Weereratne (chair), a barrister, Dr Tim Exworthy, Consultant Forensic Psychiatrist, and Mr Charles Flynn, R.M.N., R.G.N., BSc, Director of Secure Services/Deputy Chief Executive of Mersey Care Trust.

Copies of the Terms of Reference set for the Inquiry, and of the procedure to be adopted are attached for your information. Please read these documents, which have been drafted with the aim of enabling the Inquiry panel to fulfil its duty to investigate the relevant matters fully and fairly. A copy of the Inquiry's anticipated schedule for completing its work is also enclosed although it must be emphasised that this is of necessity flexible and liable to change.

An Inquiry panel was originally established under a previous chair who unfortunately became unable to progress the matter due to ill health. This did not come to light immediately and the appointed medical member then found that he could not continue with his role due to commitments overseas. As a result there has regrettably been some unavoidable delay in proceeding with this Inquiry. It is now hoped that matters will press ahead as expeditiously as possible.

I know from (***Names of M's family***) that you were a very good friend to (***M***) and the children and that you had contact with (***H***) and/or (***M***) prior to her death and you may have relevant evidence to contribute to the inquiry.

At this stage you are not being asked to attend a hearing, but to provide a written commentary of your involvement with (***H***) and/or (***M***). The Inquiry panel will then decide whether or not you will be invited to give oral evidence at a hearing and you will be given as much advance notification of this as possible. As well as writing to people, who knew (***H***) and/or (***M***) on a personal basis, we are also currently writing to all those people from statutory services who can be identified from the records we have received as potentially having relevant evidence for the Inquiry. We are sending you a list of those being written to in accordance with paragraph 11 of the enclosed procedure.

You will note from the procedure and schedule that the Inquiry hearings will be held in private and are presently proposed for January, on the dates shown below at a venue in Cornwall, which has yet to be identified. It would be of great assistance if you could let us know now what your availability is on those dates in January, in the event that you are required to attend a hearing.

Please ensure that your statement reaches us at the address at the top of this letter by December 4th 2002

If you encounter any difficulty in preparing your written evidence, please do not hesitate in contacting me and I will arrange the necessary assistance. I am also happy to answer any questions you may have about the Inquiry procedure in the event that you are asked to give oral evidence to the Inquiry. The Inquiry hearings will be conducted as informally as possible but, if you are asked to attend, you may find it easier if you have some idea in advance of the procedure and who is involved

<u>Matters to be covered in the statement</u>

It is for you to decide what information you think would be of help to the Inquiry but we should be grateful if your statement could outline your relationship with (***H***) and/or (***M***) - how and when you got to know him/her/them and how long the relationship lasted; relevant information shared with you etc. Could you also please review the enclosed list of factual witnesses and include in your statement the following:-

1) The name and, if possible, the contact details of any material witness you consider to have been omitted from the list

2) Suggested areas of questioning for any of the witnesses on the list or for any new witnesses you identify

The panel is particularly interested in events in the period from August to November 13th 2000 and knowing the answers to the following questions, where relevant:-

- Did you have any contact with (***H***) or (***M***) in that period?
- If so, where and when did it take place
- If appropriate, can you say how (***H***) was at that time? Was he different at other times? If so, can you describe the difference
- If you had contact with (***M***), could you describe as carefully as possible how she was and what she said directly to you. If you are relating a conversation told to you by someone else, please let us know who that person is and how we can contact them directly

I know that the preparation of a statement may raise painful memories for you but I am sure you will agree with the need for a full Inquiry to allow recommendations to be made for any improvements to services to prevent future homicides and I thank you for your willingness to assist the Inquiry

We look forward to hearing from you and enclose a SAE for your reply.

Yours sincerely

Rae Wallin

Inquiry Manager

APPENDIX H

INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF (***H***)

SAMPLE STANDARD WITNESS LETTER

(professional)
CONFIDENTIAL

November 6th 2002

Dear (Name),

Request for written statement of evidence

This Inquiry has been set up by the South West Peninsula Health Authority by virtue of its obligation to do so under NHS Executive Guidance (HSG (94) 27) following the murder of (***M***) by (***Name***) on 14 November 2000. It has been agreed with his solicitors that (***Name***) will be referred to as ("***H***") by the Inquiry in its work.

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An Inquiry panel was originally established under a previous chair who unfortunately became unable to progress the matter due to ill health. This did not come to light immediately and the appointed medical member then found that he could not continue with his role due to commitments overseas. As a result there has regrettably been some unavoidable delay in proceeding with this Inquiry. It is now hoped that matters will press ahead as expeditiously as possible.

(***H***) has given his consent to the disclosure of all the records relating to the medical treatment he received and the care provided by all the agencies with which he has been in contact up to and including the time of the murder of (***M***). An initial examination of these records indicates to us that you may have relevant evidence to contribute to the Inquiry.

Procedures and timetable

At this stage you are not being asked to attend a hearing, but to provide a written commentary of your involvement with (***H***). The Inquiry panel will then decide whether or not you will be required to give oral evidence at a hearing and you will be given as much advance notification of this as possible. We are currently writing to all those who can be identified from the records we have received as potentially having relevant evidence for the Inquiry. We are sending you a list of those being written to in accordance with paragraph 11 of the enclosed procedure.

You will note from the procedure and schedule that the Inquiry hearings will be held in private and are presently proposed for January, on the dates shown below at a venue in Cornwall, which has yet to be identified. It would be of great assistance if you could let us know now what your availability is on those dates in January, in the event that you are required to attend a hearing.

Please ensure that your statement reaches us at the address at the top of this letter by December 4th 2002

The original records are being held by (***Name***) at (***Location***), after being copied by the Inquiry. It would probably help you in completing your statement to refer to those records to which you were a direct contributor.

Matters to be covered in the statement

The information we presently have indicates that you were (***details of professional contact/relationship with*** (***H***)) for the period from (***Date***) to (***Date***) 2000

Please feel free to raise any issue that you may feel is relevant to the Inquiry whether personal or professional. We will deal with all information received as sensitively as possible. More specifically, we should be grateful if your statement could outline your background, training and experience. It should define the entire period of your contact with (***H***), state the reasons for that contact and describe your role and involvement, with particular reference to:

(***Questions specific to the individual professional and his/her contact with (H) follow here***)

We look forward to hearing from you and enclose a SAE for your reply.

Yours sincerely

Rae Wallin
Inquiry Manager