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

May 2008

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A. Introduction

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

B. Definitions

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

"Mr Field" shall mean the above-mentioned Mr Derek Field.

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

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

"the 1983 Act" shall mean the Mental Health Act 1983 (including all amendments to it).

"CPA" shall mean the Care Programme Approach, being an administrative measure introduced in April 1991. It is applicable to all persons under the care of specialist mental health services. Its aims are to ensure good clinical practice and the provision to every individual client of all the facilities and services which he or she may respectively

require for the proper care and treatment of his or her mental health problems. It consists of four parts, namely the assessment of a client's health and social care needs, a written care plan, the appointment of a Care Co-ordinator with the prime responsibility for ensuring the delivery of that care plan, and regular reviews.

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

"CMHT" shall mean a Community Mental Health Team

C. Our Terms of Reference

3. Our terms of reference from the Authority are:

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

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

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

(a) his assessed health and social care needs,

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

(c) any previous psychiatric history, and

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

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

2. To examine the inter-agency relationships in the case, including the links between the General Practitioner and the secondary psychiatric services.

3. To consider any other facts that appear to be relevant.

4. To produce a report and to make recommendations to Essex Strategic Health Authority."

D. Executive summary

- Derek Field was convicted, on grounds of diminished responsibility, of the manslaughter of Mr Sean Hand on the 23 January 2003.

- Mr Field first required care and treatment for mental illness on the 12 December 2001 and between that date and the 23 January 2003 he received two periods of in-patient treatment and care in the community at other times. Varying diagnoses were made of Mr Field's illness at different times, including paranoid schizophrenia.

- The Review Panel was unable to commence its task until April 2005 and it completed its task with a report to the East of England Strategic Health Authority on the 14 July 2007. Between the sad events of the 23 January 2003 and the commencement of the Review Panel's work, the South Essex Partnership NHS Trust ("the Trust"), the National Health Service body responsible for the provision of the relevant care and treatment to Mr Field, had carried out its own internal review of that care and treatment and its review body (referred to in this summary as "the Internal Panel") had made numerous recommendations in relation to the services which it provided for patients such as Mr Field. Many of those recommendations either had been implemented or were in the course of implementation by the time the Review Panel was undertaking its work. In the course of its review the Review Panel obtained the clear impression that Mental Health Services in Basildon were under considerable pressure in late-2001 to early-2003. On the other hand, the Trust's ratings by the Health Care Commission in its Annual Performance Ratings for 2005/2006 were "Excellent" for its use of resources and "Good" for the quality of its services, and in January 2007 it achieved Level 2 in the NHS Litigation Authority's Clinical Negligence Scheme for NHS Trusts, which is an indicator of the Trust's competence broadly in the field of risk management achieved by only eight mental health trusts. These more recent developments provide grounds to believe that the Trust has resolved several of the service problems, which the Review Panel found to be existing in the early-2000s.

- The Review Panel identified twelve matters for more detailed consideration. The most serious of them was the standard of care and treatment provided for Mr Field between the 16 November 2002 and the 23 January 2003 (see paragraphs 76 to 87 of this report). In that

respect the Review Panel were first concerned as to how a member of the CMHT, who was engaged from an agency rather than being a substantive employee of the Trust and who had very limited experience and training in the care and treatment of patients who presented with problems similar to those of Mr Field, was appointed as Mr Field's Care Co-ordinator on or about the 21 November 2002. The Review Panel find that the appointment was wrong, certainly in the absence of intensive monitoring by an experienced supervisor, but in the circumstances they are not minded to suggest that the Care Co-ordinator was personally at fault in some way. They also find it regrettable that Mr Field did not see a Consultant Psychiatrist in the two-month period leading up to the 23 January 2003, particularly as he was seen by a Staff Grade Psychiatrist on the 24 December 2002 at the request of his General Practitioner and although that psychiatrist found no evident psychotic features in Mr Field, he had reason to expect that Mr Field would then be seen by the Consultant on the 27 December 2002, a consultation which apparently never took place on either the 27 December 2002 or any other date before 23 January 2003. The Review Panel also comment that there was little (if any) effective contact between psychiatrists and the CMHT at the relevant time.

- The Review Panel also met Mr Field's parents (see paragraphs 91 and 92 of this Report), who told them that they were not given enough information or feedback about their son's illness and were shocked and concerned when schizophrenia was mentioned. The Review Panel recognise the difficulties which can occur in communications between professionals using the terminology of their calling and lay persons, or even by the patient's right to confidentiality, but recommend that the Trust be asked to confirm that Consultant Psychiatrists and Care Co-ordinators are aware of their obligations to close relatives to ensure that the latter clearly understand the nature and effect of the patient's illness. The Review Panel are also concerned that there was no evidence that Mr and Mrs Field had been actively involved in the CPA process or that they had been offered a carer's assessment (see paragraph 99 of this report). Mr and Mrs Field, and their son's General Practitioner, were also concerned about the gaps in their son's treatment between the periods from December 2001 to April 2002 and May 2002 to October 2002. The Internal Panel had already recommended a review of the arrangement for non-emergency admissions and the development of monitoring arrangements for waiting times, and with particular regard to the General Practitioner's position the Review Panel expressed the view

that he was entitled to expect that delays such as occurred in this case should not be allowed to occur or that if, exceptionally, such delays are really unavoidable, then he should be kept fully and accurately informed of the reasons for them and the steps being taken to resolve or minimise them. These matters are considered in paragraphs 44 to 49, and 54 to 66 and 90 of this report.

- The Review Panel have also considered events which occurred very shortly before the 23 January 2003. In short, the Employment Co-ordinator of "Rethink", a voluntary body to whom Mr Field had been referred, says that on the 21 January 2003 she telephoned the offices of the CMHT to discuss certain concerns about Mr Field. Mr Field's Care Co-ordinator was unavailable and the Employment Co-ordinator told the Internal Panel that her call was not returned. The Trust could find no trace of the Employment Co-ordinator's call. The Independent Panel could not resolve that issue so long after the event. Unfortunately, the Employment Co-ordinator declined to meet the Review Panel, apparently after consulting with Rethink.

- The remaining concerns identified by the Review Panel are matters on which either:

  a. they are satisfied that the Trust has taken remedial action during the intervening time (e.g. the lack of an available bed in the Trust's own units when Mr Field needed admission in December 2001 and October 2002); or

  b. they are unable to reach definite conclusions due to the limited information available to them (e.g. the fact that records for Mr Field for the period 8 November 2002 to 15 November 2002 could not be found); or

  c. they find that no further action is necessary (e.g. a disciplinary investigation against one Consultant Psychiatrist in with he had already been exonerated by independent assessors, a decision with which the Independent Panel agreed); or

  d. a combination of the above factors apply.

- The Review Panel then set out certain conclusions and recommendations in paragraphs 100 and 105 on this report. The former include the considerable pressure apparently on Mental Health Services in Basildon in late 2001 to early-2003; the need to take every opportunity of providing someone in Mr Field's position with suitable care and treatment; ensuring that advice, assistance and training are available to all staff involved in that task; and the need for accurate and comprehensive communications between both different professional carers and between professional carers and relatives. The Review Panel also point out that it has been a noticeable factor in more than one case of this type that untoward incidents occur in the period following organisational change, whilst the bodies concerned are co-ordinating their policies and procedures and the constituent parts of the new body are "bedding down". As to recommendations, in paragraph 105 the Authority is recommended to seek confirmation from the Trust that a number of recommendations made by its Internal Panel and some other matters specified by the Review Panel (such as the need to ensure that relatives clearly understand the nature and effect of a patient's illness, the need for full and accurate communication between staff and the need for a pre-discharge CPA meeting to be held before a patient is discharged into the Community for care) have been implemented and/or already form part of the working arrangements of Mental Health Services in the Trust.

E. A summary of Mr Field's psychiatric history and treatment

4. Mr Field was born on the 8 October 1980.

5. His first contact with mental health services occurred when GP1, his General Practitioner, requested a domiciliary visit to him on the 12 December 2001. Mr Field had a history of drug abuse, heavy drinking, depression for three years and an attempt to hang himself three weeks previously. He had befriended two older women; he said he kept hearing their voices; and he felt that they had control over him. He complained that he could not get control of his actions and that his friends were playing mind games with him.

6. In accordance with GP1's request, Consultant Psychiatrist 1, made a domiciliary visit and assessed Mr Field on the 13 December 2001. Mr Field denied having used illicit drugs for the past fourteen months, but his father told Consultant Psychiatrist 1 that Mr Field was drinking to excess. Mr Field confirmed the earlier attempt to hang himself but said that the rope had been too long. He heard voices inside his head but was vague about the lady controlling him. Consultant Psychiatrist 1 found that Mr Field had good eye contact, a normal cognitive state and partial insight into his condition and his surroundings. Consultant Psychiatrist 1 concluded initially that Mr Field had personality problems and perhaps borderline intelligence, but he found it difficult to decide whether Mr Field had serious mental illness. In view of that doubt, Consultant Psychiatrist 1 advised Mr Field's father that the best thing to do was to try to admit Mr Field to hospital for close observation and a final diagnosis. There was no bed available at that time and so Consultant Psychiatrist 1 said that he would put him on the waiting list and would admit him as soon as a bed became available. Consultant Psychiatrist 1 sent a report to GP1 dated the 17 December 2001 and asked him to prescribe *Sertraline*, an anti-depressant, for Mr Field.

7. Mr Field's home address actually fell within the catchment area of Consultant Psychiatrist 2, another Consultant Psychiatrist, but Consultant Psychiatrist 2 was on holiday when GP1 requested the domiciliary visit and Consultant Psychiatrist 1 only saw Mr Field as he was covering for Consultant Psychiatrist 2. These facts will become significant in regard to the lapse of time which next occurred before Mr Field was actually treated following Consultant

Psychiatrist 1's domiciliary visit, a matter which we consider in detail in paragraphs 39 to 43 below.

8. On the 23 April 2002 Mr Field saw Consultant Psychiatrist 2 in an out-patient clinic at Basildon Hospital and on that same day he was admitted as a voluntary patient to Westley Ward, the psychiatric unit there. On admission Mr Field had good eye contact but found difficulty in expressing his problems. He felt low but did not mention any suicidal ideas. He was found to have a normal cognitive state and good insight into his problem. A risk profile was undertaken, which concluded that Mr Field did not pose any immediate risk at that time but that he had been admitted to assess his mental state.

9. On the 26 April 2002 Consultant Psychiatrist 2 diagnosed Mr Field as suffering from early schizophrenia and prescribed *Quetiapine*. On the 30 April 2002 Mr Field was tested positive for cannabis and was said to spend many hours off the ward.

10. In a ward round by Consultant Psychiatrist 2 on the 3 May 2002 the ward staff reported that Mr Field was not psychotic and that he had shown no mental problems. Generally, they found him to be quiet and settled on the ward. Mr Field was granted weekend leave and his discharge was contemplated, if the period of leave passed satisfactorily. In the event Mr Field was at home on leave for most of the time up to the 10 May 2002 without any problems occurring and he was discharged on that latter date. He was still on *Quetiapine* and was to be seen by Consultant Psychiatrist 2 at an out-patient's appointment in six to eight weeks.

11. The staff on Westley Ward made an initial request for community care for him on the 11 May 2002 and that request was followed up by Consultant Psychiatrist 2 in a letter to the Basildon West CMHT dated the 23 May 2002. As matters turned out, Mr Field was not seen by the Team until the 1 October 2002. We consider the reasons why this delay occurred in paragraphs 54 to 66 below.

12. In the meantime Mr Field was seen by Consultant Psychiatrist 2 on the 16 July 2002 at an out-patient clinic. GP1 had written to Consultant Psychiatrist 2 on the 3 July 2002 to advise him that Mr Field had been unable to tolerate *Quetiapine*, and also that according to his

father, Mr Field had relapsed to some degree, though he was not as bad as he had been in December 2001. On the 16 July 2002 Consultant Psychiatrist 2 found that generally Mr Field was more or less the same but changed his medication to *Risperidone 2mg* (an anti-psychotic) twice daily and *Efexor XL 75 mg* (an anti-depressant) at night and planned to see him again in four months' time. This was the only occasion when Mr Field was seen by the Trust's staff during the period between the 10 May 2002 and the 1 October 2002.

13. On the 1 October 2002 Mr Field saw Social Worker 1 of the Basildon West CMHT. She carried out an assessment for CPA purposes. Mr Field informed her that he drank in excess but only when others supplied him with alcohol and that he used cannabis regularly and crack cocaine every night. However, he did not feel that he had a drug problem or that he wanted to work with the drug and alcohol services. Mr Field also presented to Social Worker 1 as a high risk in relation to both suicide and violence and aggression to others. In that latter respect he stated specifically that he would harm the young girl whom he felt to be responsible for "*messing with his head*", stating expressly that *"I would tie her hands and feet behind her back and make sure that she is in agonising pain and then lift up a drain and drop her down it."* Social Worker 1 suspected that he was not taking his medication and his failure to do so had resulted in his experiencing thoughts of other people getting into his head, over which he had no control and which could be controlling him. Social Worker 1 concluded that Mr Field presented as unpredictable due to the ideas that others were controlling him and that he could pose a significant risk both to himself and to others. She discussed his case with her manager and it was decided to consider it further on the 7 October 2002 at the Team's regular Monday allocation meeting. Consultant Psychiatrist 2 was also to be asked to make a domiciliary visit and to assess Mr Field with a view to his possible, compulsory admission to hospital under the 1983 Act.

14. On Tuesday, the 8 October 2002, Mr Field was assessed for the purposes of the 1983 Act by Social Worker 2 approved to act for the purposes of the 1983 Act, including a person's compulsory admission to hospital under it. Consultant Psychiatrist 2 and GP1 provided the necessary medical recommendations on Mr Field for that purpose. They recommended compulsory admission to hospital under Section 3 of the Act on the grounds that Mr Field was suffering from mental illness, which required hospital treatment in the interests of his own health and the safety of himself and others. Mr Field's father reluctantly consented to

Mr Field's compulsory detention under the Act. Unfortunately, there was no bed available for him locally and arrangements had to be made for him to be treated in the Cygnet Clinic, a private mental health unit on the East London/Essex border at Beckton, which the Trust used when the beds in its own Mental Health units were fully occupied.

15. At the Cygnet Clinic Mr Field was under the care of Consultant Psychiatrist.3 We have been provided with copies of Mr Field's records from the Cygnet Clinic, which give us a full account of the care and treatment provided for him there. In view of that fact, we have not thought it necessary to meet Consultant Psychiatrist 3 or any one else from the Clinic involved in Mr Field's care and treatment there, as we have anticipated that more than three years after Mr Field's only stay there the great probability is that anyone whom we might now meet would only be able to confirm information which is contained in the records anyway.

16. The Cygnet Clinic records confirm that when Mr Field was admitted he was experiencing command hallucinations to harm others and that he stated that he would harm one person, a neighbour of his, when he was discharged. However, within two days he was settling; he denied having homicidal thoughts; and no longer heard voices. After three more days when it was difficult to engage him in conversation, on the 13 October 2002 an improvement in his mental state was noted and maintained. Also, he admitted that his medication was helpful to him and confirmed that he was not harbouring homicidal thoughts or plans. He did, however, continue to feel that neighbours were *"interfering"* with him, though denied that it bothered him any more. The improvement continued and he caused no management problems, though there is a nursing note dated the 29 October 2002 to the effect that he was *"still harbouring homicidal thoughts but* [was] *not bothered about it."* The one concern to the nursing staff seems to have been Mr Field's reluctance to engage with others on the ward, though he made some improvement in that regard from the 30 October 2002 onwards. At all times he seems to have taken his medication without demur. On the 8 November 2002 Consultant Psychiatrist 3 agreed to rescind the order for Mr Field's compulsory detention under Section 3 of the 1983 Act and so his status returned to that of an informal (i.e. voluntary) patient.

17. On the 5 November 2002 Consultant Psychiatrist 2 had received a letter from Mr Field's father in which Mr Field senior wrote of his son's worry that he was still so far from home nearly a month after the start of his compulsory hospitalisation, and of the stress caused to the parents in having to travel so far to visit their son. Efforts were then made to find Mr Field a bed in a unit more local to his home. Coincidentally a bed became available for him at Runwell Hospital, Wickford, Essex on the 8 November 2002 and he was transferred to Laburnum Ward there that same day.

18. Apparently, Mr Field was only a patient on Laburnum Ward for 7 days. He was then transferred on the 15 November 2002 to Westley Ward at Basildon Hospital because of its still greater proximity to his home, though in fact he actually spent much of this total period on leave at home. Mr Field subsequently confirmed that he was only a patient on Laburnum ward for 3 days and following his transfer to Westley Ward he spent all of this total period on leave at home.

19. On the 15 November 2002 Mr Field saw Consultant Psychiatrist 2 in the course of a ward round at which his mother was present. It was reported that he appeared settled in mood; that he was advised to stay away from drugs; and that the CMHT would allocate a key worker for him. The plan was that he should go on leave for one week and then return to Westley Ward for a CPA assessment or review the following week, with a view to possible discharge. The CPA meeting was scheduled for 11am "next week", but the next note, which ostensibly relates to this meeting, is actually dated the 16 November 2002. This note indicates that Mr Field was seen on the 16 November 2002 in the course of a ward round, which served also as a CPA meeting, and that his mother was again present. Everything was said to be going well and Mr Field was discharged from hospital with medication to take out with him, and the CMHT were said to be aware of his discharge. A preliminary report of his discharge dated the 16 November 2002 was sent to GP1, his General Practitioner, apparently erroneously giving the date of discharge as the 22 November 2002.

20. On the 21 November 2002 the Acting CMHT Manager, the Acting Manager of the Basildon West CMHT, wrote to GP1 to advise him that Social Worker 3, a Social Worker and member of the Team, had been appointed as Mr Field's Care Co-ordinator.

21. The CPA documentation for Mr Field was completed on the 22 November 2002. The assessment document, which formed part of this process, gave the diagnosis as paranoid schizophrenia and drug-induced psychosis and went on to say that Mr Field had difficulties coping with daily living activities without the use of alcohol and illicit drugs. It also recorded Mr Field's non-compliance with his medication regime while living in the community. The Care Plan drawn up on the 22 November 2002 by Social Worker 3 included the monitoring of Mr Field's mental health, his compliance with his medication regime and his attendance at out-patient appointments, a referral to the Community Drug and Alcohol Service and referrals to various voluntary bodies in connection with his social needs. A contingency plan was also drawn up, presumably on the same date, which identified Mr Field's non-compliance with his medication regime, the recurrence of his paranoia, his failure to attend appointments and his misuse of illicit drugs as early warning signs or indicators of a likely relapse. The contingency plan identified his family as the people to whom he was most responsive. The plan indicated that Mr Field was a risk to both himself and to others in the form of violence, self-harm and neglect. In the event of early warning signs of a relapse or further onset of his mental health problems, the plan stated that admission to hospital had worked in the past and information about contacting the Southend Hospital Accident & Emergency Department, the Emergency Duty Team and the Crisis Intervention Team was given.

22. Social Worker 3's contacts with Mr Field then seem to have been as follows:

- Social Worker 3 spoke to him by telephone on the 27 November 2002. He thought from the call that Mr Field was better than when he (Social Worker 3) had last seen him and sounded more positive. An appointment was made for them to meet on the 29 November 2002.

- Social Worker 3 then had to ring back on the 27 November to rearrange the appointment fixed for the 29 November 2002 to the 28 November. In this call Social Worker 3 spoke to Mr Field's mother who thought that he had not changed much, though she was concerned with the lack of any activities for him during the day.

- Social Worker 3 and Mr Field met on the 28 November 2002. Mr Field said that he was doing well at that moment, though he was doing nothing at home during the day; he was still taking his medication without any side-effects; he was attentive with improved eye contact and speech; and he displayed no visible signs of distress, as was the case when he was last seen a few weeks ago.

- On the 16 December 2002 Social Worker 3 telephoned Mr Field to tell him about an appointment with a voluntary body made for the 17 December 2002.

- Social Worker 3 then visited Mr Field on the 17 December 2002 to take him to the appointment and in the course of their meeting Mr Field told Social Worker 3 that he no longer had any thoughts of harming himself or others.

23. On the 24 December 2002 Mr Field attended his General Practitioner with his parents. The note of that attendance recorded (amongst other points) that Mr Field had not had any homicidal ideation, but that he had experienced recurrent suicidal ideation. GP1 spoke to Consultant Psychiatrist 2, who advised a referral to the duty psychiatrist at Basildon Hospital, and said that he (Consultant Psychiatrist 2) would see Mr Field during the ward round on Friday, the 27 December 2002. Indeed, the duty psychiatrist did then see Mr Field that same day at 12.30 p.m. The duty (staff grade) psychiatrist recorded his findings in the following terms *"..... Appropriate speech and behaviour. Mood low. Deny any suicidal intent. No psychotic features"* and prescribed two weeks medication of *Risperidone 2mg* twice daily and *Efexor XL 75mg* at night, intending also that Mr Field should see Consultant Psychiatrist 2 on the following Friday, the 27 December 2002.

24. The duty psychiatrist reported the outcome of Mr Field's appointment with him to GP1 by letter dated the 3 January 2003 and copied that letter to Consultant Psychiatrist 2. The copy of that letter in Mr Field's records bears a manuscript note, which reads *"Jan. Please ring him* [presumably Mr Field] *to come Friday 10.01.03 at 10 a.m. for the ward round. [Sgd] Consultant Psychiatrist 2".* The records also contain an undated and unsigned manuscript note which reads *"Consultant Psychiatrist 2. Derek Field turned up at 11.15 a.m. to ward round on Fri*[day*]. His next OPA* [Out Patient's Appointment] *is 27.1.03"* The date *"10.1.03"* has been added in below *"Fri"* and the time *"11.25 am"* has also been added

in below *"27.1.03"*. There is also a manuscript endorsement which reads *"He can come at 10 a.m. Friday (sharp)"*. The word *"sharp"* is underlined and the date *"17.1.03"* has been added below the word *"Friday"* in that endorsement. We have had a number of queries about the exact sequence of these events and we have been able to discuss them with Consultant Psychiatrist 2. We deal with his explanation of them in paragraph 81 below. The duty psychiatrist's letter bears no indication that it was copied to Social Worker 3 and from what Social Worker 3 told us it appears unlikely that it was.

25. On the 27 December 2002 Social Worker 3 telephoned Mr Field and spoke to his father. Mr Field senior told Social Worker 3 that his son had been *"manic"* at Christmas after a day out with his friends when he had been drinking alcohol. Mr Field senior added that his son was being taken to hospital for a visit with the Consultant and said that they would inform the CMHT, presumably of the outcome, after that visit.

26. On the 31 December 2002 Social Worker 3 telephoned Mr Field again. Mr Field was out but Social Worker 3 spoke to his sister. She told him that Mr Field was not doing too badly, but there had been a few problems over Christmas when he had taken some alcohol. Apart from that, he was fine and his moods had changed. How they had changed is not stated.

27. Several telephone calls followed between the 3 and 14 January 2003, mostly concerned with appointments for Derek to join voluntary bodies who might have helped him with employment or other assistance. These conversations apparently made no reference to Mr Field's condition.

28. There is a typed note of a home visit to Mr Field on the 15 January 2003, which does not state who made the visit, nor is it signed. We assume that it was made by Social Worker 3, though it is a typed note and all Social Worker 3's other notes are in manuscript. However, the note states that Mr Field appeared somewhat drowsy and denied that he had been drinking alcohol or taking illicit substances on the previous day. Mr Field subsequently confirmed that it was Social Worker 3 who made the visit on 15 January 2003.

29. On the 21 January 2003 Social Worker 3 telephoned Mr Field but he was out and Social Worker 3 spoke to his mother instead. In the course of the conversation Mrs Field said that

her son was doing well and had no concerns apart from having to spend most of the days at home.

30. Indeed, on the 21 January 2003 Mr Field had kept an appointment with the employment co-ordinator from Rethink Employment and Training, arranged for him by Social Worker 3. The employment co-ordinator subsequently wrote two letters to the Trust. The first of them, dated the 28 January 2003, was addressed to Social Worker 3 and it is important to set out its terms in full:

> "*In the light of recent events I felt it might be relevant to forward to you written details of my first and only meeting with Derek. He came to see me on the 21st January and arrived twenty minutes early for his appointment. He waited calmly and patiently until I was able to begin my meeting with him.*
> *We spent an hour together during which time I talked through his referral form with him and his reasons for wanting our service. He said he wanted to get out of the house but seemed to be experiencing severe ideations concerning two female neighbours whom he referred to as 'schizophrenics'. He believed that these women had messed with his mind, stolen his soul and his conscience, ruined his life and sapped his strength and energy. He seemed determined to kill them or have them killed.*
>
> *He had found someone who would kill them for a cost of £3000; this seemed to be his long-term goal and motivation for wanting to return to paid work. He seemed to believe the only way he would feel 'normal' again would be if the younger woman were dead, because only then would the soul leave her body and return to him.*
>
> *I made another appointment to see Derek on the 28 January but felt very concerned about his state of mind, as he seemed to lack any insight into his own mental health problems or possible repercussions if he were to carry out his threats. I passed on my concerns to my team leader about the appropriateness of this referral and left a message with your office for you to contact me to discuss the case, and other matters that arose in the interview in more detail.*

> *I called you today at 11.55 because Derek was due in at 12 noon and was shocked and saddened to hear of the tragedy that had occurred only the day after he had been in to see me. You are probably aware of these disclosures however they may shed some light on the police investigation."*

Then in answer to a request from the Acting Manager of the Basildon West CMHT for details of the telephone call in which the employment co-ordinator 1 had requested Social Worker 3 to ring her, the employment co-ordinator 1 wrote again on the 4 February 2003 in the following terms:

> *"In response to your letter dated 30th January I am writing to confirm that I called Sankey House on Tuesday 21st January between 1.15pm and 1.40pm and spoke to a female telephone receptionist."*

31. On the 23 January 2003 Social Worker 3 received a call from the Essex Police notifying him that Mr Field had been arrested early that morning on suspicion of murder.

F. Our approach to our task

32. We have identified in paragraph 36 of a report in another, similar case, which we are submitting to the Authority, the difficulties which arise when we are only able to commence our work some considerable time after the material events, and when members of staff involved in the care and treatment in question are no longer available, or when they are unwilling, to meet us. In that last respect, we have no power to enforce their attendance at a meeting. There is the further point that the NHS trust responsible for the provision of the care and treatment will, entirely understandably, probably have carried out their own review of the case, considered changes and improvements to the service and implemented some or all of those changes. We, however, have no way of independently assessing the effect of any such changes. In any future review commissioned by it, the Authority may wish to consider the scope of its review panel's terms of reference in order to clarify the extent of the panel's role insofar as any other NHS body involved in the care and treatment in question is concerned.

33. Fortunately, in this case the factors mentioned above have had less of an impact than in our other case, because Mr Field's care and treatment started more recently than that of the other client, and, with two exceptions, we have been able to meet all the people we wished to meet. The exceptions were a member of the immediate management of the Basildon CMHT at the times of Mr Field's care and treatment and the employment co-ordinator, whose limited part in the case is considered in paragraph 30 above and paragraphs 94 to 98 below. On the other hand, we have been unable to draw on the transcripts of the Trust's internal review as much as we did in the other case because of their limitations.

34. Our procedure in this case has broadly followed that which we used in the other one, involving considering Mr Field's records, with the exception of Runwell Hospital notes for the period from the 8 to 15 November 2002 which are missing, and the papers relating to the Trust's internal review; meeting the members of the Trust's staff involved in his care and treatment who were still available and willing to meet us; meeting Mr Field's parents; and receiving written comments on the case from GP1, his General Practitioner, who also kindly provided us with a transcript of the General Practice notes.

35. When meeting "witnesses", we followed the practice of making the interviews as informal as the proper discharge of our duties allowed and we excluded cross-examination in a legal sense. Witnesses were, however, informed that they were entirely at liberty to seek advice and to attend meetings with us accompanied by a representative (professional or trade union) or a friend. Two of our members (Dr Bradley and Mr Brown) have adopted that approach in previous cases and are satisfied that it is more conducive to an open dialogue with a witness rather than having any formal, legal structure to such meetings. We believe that in this way we obtain a more complete and open account of the relevant events and a better understanding of the part played by each witness in the relevant care and treatment. However, this approach need not, and does not, prevent adverse findings being made by us where they are justified. Witnesses were also advised that if the Panel finds it necessary to criticise any of them, then an extract from our draft report setting out the criticisms would be sent to the witness concerned, who would then be given a further opportunity to comment on our draft findings affecting them either in writing or at another meeting, before the report is finalised. This approach to witnesses is generally helpful in overcoming reservations about meeting us, particularly in a case like this one where the material events occurred some years ago.

36. We met Consultant Psychiatrist 1, Social Worker 1, and the Director of Inpatient and Rehabilitation Mental Health Services, on the 10 October 2005; Consultant Psychiatrist 2 and Mr Field's parents on the 11 October 2005; and Social Worker 3, Mr Field's Care Co-ordinator from the 21 November 2002 to the 23 January 2003, on the 3 August 2006, after he had been traced and certain doubts on his part about meeting us had been resolved.

37. Finally within this section, we confirm that this report is our final report.

G. The legal position

38. We feel that it is important that this matter is seen in the context of the present legislation (the 1983 Act), which does not necessarily provide the public with a complete means of protection against the risk of injury from another person, even though that other person may have a history of mental disorder and at times be a recognised danger to others. The limitations of the 1983 Act have been recognised for some considerable time but new draft legislation has only recently been published in November 2006.

H. Issues arising in the case and our consideration of them

Consultant Psychiatrist 1's position following his domiciliary visit to Mr Field on the 13 December 2001

39. Consultant Psychiatrist 1 did, of course, see Mr Field in a domiciliary visit on the 13 December 2001. Consultant Psychiatrist 1's conclusion was that Mr Field should be admitted to hospital so that a firm diagnosis of his condition could be made. In the event, the next step in Mr Field's treatment was an out-patient appointment with Consultant Psychiatrist 2 four months later, with his admission following that appointment.

40. The Trust's internal review panel recommended that:

> *"....the trust review the clinical and managerial arrangements for non-emergency admissions and develop regular and robust monitoring arrangements for waiting times both for admissions to individual wards and for the service as a whole, and that this information is made available regularly to managers and clinicians. Should a decision be made not to admit to a bed, in these circumstances it is the consultant's responsibility to ensure that appropriate care is provided in the community."*

This recommendation followed findings by the panel that the expectation was that, where a client was not admitted immediately, the Consultant would refer the client to the CMHT so that they could monitor his well-being while admission was being awaited, and that in this case there had been a period of over three months where no clinician had been responsible for monitoring Mr Field's care, even though the initial assessment at the domiciliary visit had been that he needed a high level of care.

41. Responsibility for the situation was laid at Consultant Psychiatrist 1's door, because the Trust's internal review was followed by an investigation of his actions under the Trust's Human Resources Policy 32, "Disciplinary Procedure for Hospital and Community Medical & Dental Staff". It is right that we should state immediately that the allegations made against Consultant Psychiatrist 1 in those proceedings were found not to have been

substantiated by the two assessors carrying out the investigation. In other words, Consultant Psychiatrist 1 was fully exonerated.

42. In fact, the first allegation made against Consultant Psychiatrist 1 was that he failed to copy the letter which he wrote to GP1, the General Practitioner, reporting on the outcome of the domiciliary visit, to the CMHT or to the responsible medical officer, thereby failing to ensure that an interim management plan in the community was arranged for Mr Field for the period until a bed became available. This allegation surprises us somewhat in that it seems to us that it gave insufficient weight to the facts first that Consultant Psychiatrist 1 only saw Mr Field because Consultant Psychiatrist 2, the appropriate catchment area consultant, was away on leave on the 13 December 2001, and second that responsibility for Mr Field's care reverted to Consultant Psychiatrist 2 when he returned from leave four days later on the 17 December 2001. It is also right for us to say that additional evidence from Consultant Psychiatrist 1, Consultant Psychiatrist 2 and Consultant Psychiatrist 2's secretary was available by the time of our investigation, confirming that Consultant Psychiatrist 2 had seen a copy of Consultant Psychiatrist 1's letter to the General Practitioner explaining in some detail what action had been taken to put Mr Field's name on the waiting list and to liaise with Mr Field's father.

43. On the full evidence on these points, therefore, we respectfully agree with the assessors' conclusions and do not feel there are any grounds justifying any criticisms of Consultant Psychiatrist 1 by us.

The gap in Mr Field's care and treatment between the 13 December 2001 and the 23 April 2002

44. When we met Consultant Psychiatrist 2, he was unable to recall with any certainty how Mr Field came to be given the Outpatient's appointment with him on the 23 April 2002, when Consultant Psychiatrist 1's conclusion had been that Mr Field needed in-patient admission. That point remained in doubt until GP1, the General Practitioner, provided us with a transcript of the general practice notes.

45. GP1's note of the 5 February 2002 shows that *"Mother been in regular contact with Consultant Psychiatrist 2's secretary. Mum asking re Outpatient appointment from*

Consultant Psychiatrist 2's secretary who is to sort." The note of the 19 February 2002 then states that *"Outpatient* [appointment] *arranged for April 2002."* It appears, therefore, that the appointment for the 23 April 2002 for Mr Field to see Consultant Psychiatrist 2 was arranged sometime between the 5 and 19 February 2002 at the request of Mr Field's mother.

46. That prompts the question why no earlier steps had been taken for Mr Field to be seen or admitted. Our discussion with Consultant Psychiatrist 2 suggested that the only answer to that question was pressure of work following his return from holiday. Consultant Psychiatrist 2 told us that in February 2002 he covered a very large catchment area and had a very long waiting list. Also, he was expecting the ward to contact Mr Field once a bed was available.

47. However, it appears that both admission and an out-patient's appointment were being considered. Whether this dual approach caused any confusion or delay we cannot now say, but it certainly seems to have been a potential source of confusion and delay. Perhaps it was Mrs Field's action in actually asking for an appointment, which was instrumental in one being sent out rather than her son being admitted.

48. Recommendation No. 1 of the Trust's internal review panel's recommendation appears to be directed at this aspect of the case. It recommends that

> *".... the Trust reviews the clinical and managerial arrangements for non-emergency admissions and develop regular and robust monitoring arrangements for waiting times..."*

The action taken by November 2003 in consequence of this recommendation reads

> *" Waiting times are monitored weekly for OP appointment waiting list information is available on the intranet".*

49. In view of the work pressures faced by Consultant Psychiatrist 2 in the first half of 2002 and the improvements in medical staffing and bed management about which we have heard

from Consultant Psychiatrist 2 and the Director of Inpatient and Rehabilitation Mental Health Services (see paragraphs 51 to 53 below) we do not think that it is necessary or fair for us, five years after the material events, to offer any criticisms in relation to the delay which occurred in Mr Field's treatment between December 2001 and April 2002.

The Trust's inability to provide Mr Field with a bed on the 13 December 2001 and on the 8 October 2002

50. A bed was required for Mr Field on the 13 December 2001 and again on the 8 October 2002. On both of these occasions the Trust could not provide a bed for him in its own units. On the first occasion Consultant Psychiatrist 1 was willing to put Mr Field on the waiting list. On the second of them, when Mr Field was to be compulsorily admitted under the 1983 Act, he was placed in the Cygnet Clinic, a privately-run clinic in Beckton, East London. In the light of these facts, we enquired about the bed situation in the Trust's area.

51. The Director of Inpatient and Rehabilitation Mental Health Services gave us the following information:

> *"Derek Field would have been in the old Thameside area and up until 1st April 2000 there was no problem with bed availability.....However, in 2000, as we have already discussed, we* [i.e. Thameside] *merged with the then Southend Community Care Trust and, unfortunately, in the Southend part of the organisation there was a large out-of-area treatment issue. Southend sent a very high proportion of patients to out-of-area treatment beds.....and it took us probably four years to resolve the issues. First of all, what we tried to do is we tried to use some of the capacity we had in the old Thameside to help the Southend agenda to try and make sure that there were more beds easily available to patients in Southend/Castle Point/Rochford. But, of course, we did not have enough beds so we always had to rely on out-of-area treatment beds and it peaked actually in January 2004."*

52. We did, of course, also ask the Director about the present position regarding beds. In reply he told us that a Bed Management Group had been set up from the 1 September 2004 and that with the exception of two patients who were also employees of the Trust, no-one

had been admitted outside of the Trust's area since the 1 September 2004. He explained to us how the new system operated and said that the Trust now has *"a minimum on a daily basis of 15 beds free for admissions."* We were also told that the new bed management arrangements were working well.

53. Accordingly, we see no need to make any further comments or recommendations on bed-availability.

The delay between the 10 May 2002 and the 1 October 2002 in the CMHT actively taking up Mr Field's case

54. Mr Field was discharged from his first period of in-patient care on the 10 May 2002. The note of the Ward Round on that day reads as follows:

> *"Consultant Psychiatrist 2, House Officer 1, a Social Worker and S/N. Derek appears well and has told Consultant Psychiatrist 2 the medication has worked with no side-effect. PLAN - Discharged with TTAs* [Medication to take out with him]. *6/52 OPA* [Out-patient appointment in six weeks]."

55. A preliminary report was sent to GP1 by House Officer 1, Consultant Psychiatrist 2's House Officer, which for some unknown reason bears the date of the 24 April 2002, although it refers to Mr Field's discharge on the 10 May 2002. It records the diagnosis of Mr Field's condition as being a "Brief psychotic illness".

56. An Initial Request for Community Care form was sent out by the Ward, presumably to the Basildon West CMHT, on the 11 May 2002 containing a request that although the Team was busy, Mr Field should be seen at its earliest convenience.

57. It appears that Mr Field's allocation was discussed on the 20 May 2002 and on the 21 May the Team's Duty Officer wrote to Mr Field offering him an appointment for an assessment at 10.30 a.m. on the 3 July 2002.

58. On the 23 May 2002 Consultant Psychiatrist 2 wrote to the Team, requesting an

assessment of Mr Field.

59. The appointment of the 3 July 2002 had to be cancelled by the Team due to staff shortages and the Team wrote to Mr Field on the 4 July apologising for that situation and offering him an alternative appointment at 10.30 a.m. on the 31 July. Unfortunately, it appears that this letter was wrongly addressed to Mr Field and did not reach him.

60. At the same time GP1 wrote to Consultant Psychiatrist 2 on the 3 July 2002 to advise him that Mr Field had stopped his medication completely, as it was making him feel dreadful and that he (GP1) had seen him recently and that there had been some improvement on the *Quetiapine* but then a relapse to some degree, though he was not as bad as at the original presentation. Consultant Psychiatrist 2 saw Mr Field at an Out-patients' clinic on the 16 July 2002. Mr Field confirmed to him that he had stopped taking the *Quetiapine* because of its side-effects and that he had no confidence and felt depressed. Mr Field's sleep and appetite were poor and generally he was more or less the same. Consultant Psychiatrist 2 prescribed *Risperidone 2mg* twice daily and *Efexor XL 75mg* at night for him and said that he would see Mr Field again in four months' time. We have some concerns about the four months period before the next out-patient appointment. Consultant Psychiatrist 2's explanation was that he believed that Mr Field was being seen by the CMHT at that time, who would let him know if there were any adverse consequences of the change. We now know, of course, that Mr Field was not being seen at that time, though Consultant Psychiatrist 2 did not know that then. However, we think it desirable generally that when new drugs are prescribed, the prescriber checks on their suitability at about one month after the change of medication.

61. This appointment on the 16 July 2002 was the only occasion on which Mr Field was seen by any member of the Trust's staff between early May 2002 and the 1 October 2002.

62. On the 7 August 2002 the CMHT wrote to Mr Field offering him a further alternative appointment on the 5 September 2002, which Mr Field was unable to keep.

63. Finally, this unfortunate sequence of events was brought to an end on the 6 September 2002 when the Team offered Mr Field yet another appointment, this time on the 1 October 2002, which he did keep.

64. It does not seem from the events described above that Mr Field was "lost" somewhere in the CMHT's system. Indeed, with the exception of the wrong address on the letter of the 4 July 2002, there were no specific faults of commission or omission, which caused the delay of approximately five months in Mr Field being seen by the CMHT. So why did that happen?

65. The CMHT seems to have been under very considerable pressures of work at that time, pressures which, for whatever reason, do not seem in this instance at least to have been relieved by management action. In making that comment, we have to acknowledge two points: first that we have not had an opportunity of discussing the case with any member of the immediate management of the CMHT at the material time, but instead have had to rely on transcripts of the meetings between the Trust's internal review panel and some of the Team's managers, which transcripts are less than complete; and second that we have looked at problems occurring in only two cases. Nevertheless, we draw support for our concerns from the fact that the internal review panel felt it necessary to make several recommendations on matters which seem previously to have been the responsibility of Team management. Moreover, the very number of the problems which arose in this case alone over a comparatively short period of time is a prima facie indication to us a lack of pro-active management in the Team. Put in every-day terms, what should have happened in this case once it became apparent that things were going wrong - say at the start of July when the letter was sent out wrongly addressed - was that someone in the CMHT should have telephoned Mr Field or his parents and fixed a mutually convenient time and date for an assessment there and then. The fact that that sort of simple, but direct, approach was not adopted causes us concern about the management of the Team at that time. In addition, if an effective CPA meeting had been held in Hospital before Mr Field's discharge, attended by Consultant Psychiatrist 2, a member of the ward nursing staff and a representative of the CHMT (preferably the person appointed or to be appointed as Mr Field's Care Co-ordinator), then it seems to us more likely that the CMHT would have (a)

understood the urgency of Mr Field's case better; (b) given Mr Field an earlier appointment; and (c) been more diligent to ensure that he actually was seen.

66. However, four years on and in the absence of interviews with members of the CMHT's management in 2001/02 and particularly as all or nearly all of them now seem to have left the Trust's service for whatever reasons, we simply do not have the evidence to justify any further comments on the position of individual managers.

The steps leading to Mr Field's compulsory admission to the Cygnet Clinic on the 8 October 2002

67. We know, of course, that Social Worker 1 saw Mr Field on the 1 October 2002 at a routine appointment offered to him by the Basildon West CMHT with the object of a CPA assessment being carried out. She undertook that task as the Team's Duty Officer on that day, the Duty Officer being responsible for carrying out CPA assessments. The purpose of a CPA assessment is different from that of an assessment for the purposes of the 1983 Act. The purpose of the former is to assess the client's needs, whilst the purpose of the latter may include assessing whether the compulsory admission of the client to hospital is appropriate.

68. Social Worker 1's assessment was that Mr Field could pose a significant risk to himself and others. She discussed her opinion in that respect with her manager on the following day and it was decided to discuss the case further at the Team's allocation meeting on the following Monday, the 7 October 2002. At that meeting, it was decided to arrange a further assessment of Mr Field, this time for the purposes of the 1983 Act and with a view to his compulsory admission to hospital. Such an assessment has to be carried out by a Social Worker approved for the purpose, which Social Worker 1 was not at that time. That assessment was then carried out on 8th October 2002 by SW2, an Approved Social Worker.

69. The first question is: why in the light of Social Worker 1's concerns was the assessment for the purposes of the 1983 Act not carried out until a week after she saw Mr Field on 1st October? Social Worker 1 told us that at that time only the client's General Practitioner or

the client's family could ask for an assessment for the purposes of the 1983 Act. She added that the situation in that regard had changed since that time and any professional could now request such an assessment. Obviously, it was thought necessary for an assessment for the purposes of the 1983 Act to be discussed at an allocation meeting before steps were taken to arrange it, though we are not aware of the reasons for that decision.

70. The General Practice notes then provide the most detailed picture of what happened next. Social Worker 1 telephoned GP1 on the 7 October 2002 to alert him about the decision to carry out an assessment for the purposes of the 1983 Act, as the usual practice would have been that he would be one of the two doctors required to provide medical recommendations, supporting the need for compulsory admission.

71. On the 8 October 2002 the General Practice notes record that Social Worker 1 telephoned GP1 again and asked him to request Consultant Psychiatrist 2 to make a domiciliary visit to Mr Field, a different course of action from that proposed on the previous evening. GP1 did not support that proposal and discussions followed between him, Consultant Psychiatrist 2 and the Acting CMHT Manager, Social Worker 1's manager. The outcome was an agreement to proceed with the assessment for the purposes of the 1983 Act, which was carried out at the CMHT's offices between 4.30 p.m. and 6.00 p.m.

72. There was, therefore, some limited delay on 7/8 October 2002 before the assessment was carried out, but that delay does not seem to us to have been unreasonable, as the doctors asked to provide the medical recommendations have an obligation to consider other means of providing the necessary treatment apart from compulsory admission, which may possibly involve a domiciliary visit.

The absence of records relating to Mr Field during his period as a patient on Laburnum Ward, Runwell Hospital from the 8 November 2002 to the 15 November 2002

73. It will be recalled that Mr Field was transferred from the Cygnet Clinic, Beckton to Laburnum Ward at Runwell Hospital on the 8 November 2002. It appears that he was only a patient on Laburnum Ward for 7 days before a further, nominal transfer to Westley Ward

at Basildon Hospital on the 15 November 2002. We say "nominal", as Mr Field was on leave for the whole, or almost the whole, of his ostensible period on Westley Ward.

74. We have seen no records of the care and treatment provided for him during his week on Laburnum Ward, though Consultant Psychiatrist 2 told us that he took detailed notes about Mr Field. Consultant Psychiatrist 2's statement in that respect is supported by references to the contents of those notes contained in one of the psychiatric reports prepared for the purposes of the subsequent criminal proceedings. It may be that the records in question were misplaced when being copied for the psychiatrist preparing that report or were even sent to him in their original form.

75. Whatever the reason for these records having been lost, we note that the problem was tackled, as best it may be, by Recommendation 11 of the internal review panel and that as at November 2003 a tracking system was in operation, though it did not extend to all of the Trust's departments. There is nothing more we can add, save to question whether the system has since been extended to all departments.

The standard of the care and treatment provided for Mr Field between his discharge from hospital on the 16 November 2002 and the 23 January 2003, including compliance with the CPA and assessing risk

76. Mr Field was, of course, first seen in a scheduled appointment on the 23 April 2002 and on that occasion a Joint CPA Agreement form was completed, an initial care plan was prepared and a Risk Profile form was also completed. No evidence of any history of significant risk behaviour was established: no risks were thought to exist at that time; and no further action in relation to risk was proposed. Mr Field was discharged from Basildon Hospital on the 10 May 2002 and, as already stated, he was only seen again in one Out-patients' clinic before the CMHT were eventually able to assess him on the 1 October 2002. On that latter date Social Worker 1 assessed Mr Field for the purposes of the CPA and also carried out a risk assessment. She noted that *"At sixteen he was arrested for possession of cannabis, he has been charged with numerous other offences including assault with an offensive weapon."* On the specific matter of risk, Social Worker 1 said that *"Derek presented as a very high risk when we started to complete the risk*

assessment. I asked him if there were any individuals that he wanted to harm. Derek described how he would harm the young girl who he felt was responsible for messing with his head. Throughout the assessment Derek had difficulties in expressing himself and his eye contact was minimal however, when talking about how he would harm this person eye contact was good and he was very specific. 'I would tie her hands and feet behind her back and make sure she is in agonising pain and then lift up a drain and drop her down it'." In her evaluation, Social Worker 1 described Mr Field as *"unpredictable due to the ideas that others are controlling him and could pose a significant risk to himself and to others."* In was in the light of that conclusion that arrangements were made for Mr Field to be assessed with a view to possible compulsory hospitalisation under the 1983 Act, followed by compulsory hospitalisation in the Cygnet Clinic on the 8 October 2002.

77. We should add at this stage that it is not entirely clear from the papers provided to us that Mr Field was actually charged with assault with an offensive weapon at any time. An alternative scenario emerging from the papers is that he was convicted and fined for shoplifting and possessing an offensive weapon as opposed to actual assault with one, and that he admitted in an interview after the unfortunate events of the 23 January 2003 to carrying such a weapon (a snooker ball in a sock) and, indeed, to using it on another man on one occasion. What is not clear, however, is whether he was convicted for any such attack. Mr Field subsequently confirmed that he was not charged with assault, just possession of an offensive weapon and shop theft. He was given a twelve month conditional discharge in relation to the offence. We are not aware of any other history of actual violence.

78. Social Worker 3 was appointed as Mr Field's Care Co-ordinator, the notice of his appointment to the Consultant and General Practitioner being dated the 21 November 2002. Social Worker 3 had, however, met Mr Field on the 6 November 2002, when accompanying Social Worker 1 on a visit to the Cygnet Clinic to gather information for the purposes of a Mental Health Review Tribunal report. A CPA assessment form, a CPA Care Plan form and a CPA Contingency Plan form were then all completed by Social Worker 3 on the 22 November 2002. The records contain no indication of further face-to-face contact with Mr Field before those forms were completed. We return to Social Worker 3's involvement in Mr Field's care and treatment in paragraphs 83 to 86 below.

79. We know from the records that Mr Field was seen by the duty Psychiatrist responsible for liaison with the Accident and Emergency Department at Basildon Hospital on the 24 December 2002 at the request of GP1, the General Practitioner. Full notes exist for this consultation and the duty Psychiatrist wrote to GP1 on the 3 January 2003 reporting on his findings at the consultation, copying his letter to Consultant Psychiatrist 2. duty Psychiatrist did not find any evident, psychotic features and according to the letter it was intended that Mr Field would be reviewed by Consultant Psychiatrist 2 on the 27 December 2002 after the Westley Ward ward-round.

80. We also know, because there are two Prescription Card entries, that Mr Field was given a prescription for his medication (*Risperidol* and *Efexor XL*) on the 10 January 2002, though there is no record that Mr Field was seen at that time or of his mental health condition then.

81. What we were not able to establish with any certainty until almost the end of our meeting with Consultant Psychiatrist 2 was whether he saw Mr Field at any time after the latter's discharge from Basildon Hospital on the 16 November 2002. We do not criticise Consultant Psychiatrist 2 for his initial inability to deal with this point because the material events occurred nearly four years previously, when we met him. The records contain certain notes which indicated that attempts were made to arrange for Consultant Psychiatrist 2 to see Mr Field after a ward-round in early-January 2003, but after we had explored the factual position with him inconclusively, Consultant Psychiatrist 2 told us that he did not think that he had seen Mr Field at all after his discharge from hospital. Consultant Psychiatrist 2 added that if he had seen him, it should definitely have been recorded in the notes, which it is not. Mr Field subsequently confirmed he was not seen by Consultant Psychiatrist 2 at anytime after he was discharged from Basildon Hospital on 16 November 2002.

82. So, during that period of just over two months, Mr Field's psychiatric care was limited to the consultation with the duty Psychiatrist. Particularly in the context of the sad events of the 23 January 2003 it is regrettable that Mr Field did not see a Consultant during that two-month period, especially as the duty Psychiatrist’s expectation was that he would do so. It

is also regrettable that the records relating to that period do not clearly explain why Mr Field was not seen by a Consultant.

83. We turn now to Social Worker 3's involvement during this period. We discussed the case with him on the 3 August 2006, when he was accompanied to the meeting by a friend. Prior to that date he had been reluctant to meet us, because his perception of the proceedings of the internal review panel was that he would be cast as the scapegoat in this matter and because he had not been supplied with a copy of that panel's report. It is, of course, neither necessary nor appropriate for us to comment further on that aspect, save to say first that the Trust tell us that they made numerous attempts to engage Social Worker 3 in our review and second that Social Worker 3 was still somewhat reluctant to participate fully in the discussions, when we met him.

84. He did, however, tell us that that he held a Diploma in Social Work and that he started in Social Work in 2002. He joined the Trust as an agency social worker; he had never worked previously with a similar team to the Basildon West CMHT; and he had never worked previously with patients suffering from schizophrenia or patients with drug abuse problems. Social Worker 3 also told us that he had received no training in risk assessment at the time when he was Mr Field's Care Co-ordinator; such training as he did receive in that field was not provided until April 2003.

85. As we have not been able to meet anybody who was a manager in the Basildon West CMHT in November 2002/January 2003, we do not know how it came about that an agency team member of very limited experience and training was appointed as Mr Field's Care Co-ordinator. However, we are of the view that it was wrong to appoint Social Worker 3 to that role, certainly in the absence of intensive monitoring by an experienced supervisor.

86. Social Worker 3 visited Mr Field on three occasions and spoke to him or one or other of his family on eight occasions, though a considerable proportion of these contacts related more to the arrangements which Social Worker 3 was trying to make for Mr Field in connection with his housing and future employment needs. As we have concluded that Social Worker 3 should not have been appointed as Care Co-ordinator for Mr Field

without intensive monitoring, in the absence of such monitoring we are not minded to suggest that he was personally at fault in some way.

87. Another factor in this case was that there was little (if any) effective contact between the psychiatrists and the CMHT.

The standard of record-keeping in Mr Field's case

88. There are examples of inadequate record-keeping in this case. A letter to the Cygnet Unit on the 9 October 2002 stated that Mr Field used to attend an outpatients clinic "regularly", whereas between 10 May and 8 October 2002 (the period in question between two episodes of in-patient care) his one outpatient clinic attendance had been on the 16 July 2002. This statement found its way subsequently into one of the reports prepared for the purposes of the criminal proceedings. There is confusion about dates in some of the records (see paragraphs 19 and 55 above) and at least one example of a letter not being copied to the Care Co-ordinator (see paragraph 24 above).

89. There are no actual records of the domiciliary visit made by Consultant Psychiatrist 1 on the 13 December 2001, merely a file copy of Consultant Psychiatrist 1's letter to GP1 of the 17 December 2001, reporting his findings and the action to be taken to the General Practitioner. However, we do not criticise Consultant Psychiatrist 1 for the absence of records in this respect. He told us that on such a visit he tries to make notes, but he also told us of the need to observe the patient, which may make full note-taking difficult. He also told us that he dictates the letter to the General Practitioner on the same day as the visit. We accept that generally there may be limitations to the ability to take notes in the course of a domiciliary visit and that in any event the letter back to the General Practitioner was a full one. In these circumstances, as we say, we do not criticise Consultant Psychiatrist 1 at all.

GP1's comments to us

90. As mentioned above, GP1, Mr Field's General Practitioner made some observations on the matter to us in correspondence. He was understandably concerned with the delay in Mr

Field's care between the 13 December 2001 and the 23 April 2002, an aspect of the case with which we have dealt in paragraphs 44 to 49 above. He was also concerned that the December 2001/April 2002 delay had eroded the confidence of Mr Field and his parents in the Mental Health Services, leading to difficulties in subsequently engaging with Mr Field. Whilst we have not found any contemporaneous evidence of such an erosion, a General Practitioner is entitled in our view to expect that delays such as those occurring in this case first between December 2001 and April 2002 and then between May and October 2002 will not be allowed to occur by the Mental Health Services, or that if such delays, exceptionally, are really unavoidable, then the General Practitioner will be kept fully and accurately informed of both the reasons for them and the steps being taken to resolve or minimise them, so that he can keep relatives informed, if they approach him.

The concerns of Mr and Mrs Field, Derek Field's parents

91. We met Mr and Mrs Field on the 11 October 2005. Their main concern was that they were never given enough information or feedback about their son's illness, and they were shocked and concerned when schizophrenia was mentioned. Whilst this complaint on their part may seem simple to remedy at first sight, that may not necessarily be so in practice. Practitioners in any profession naturally become accustomed to using the terminology of their own profession and they need to be aware that matters may have to be explained in everyday terms, when they are discussing them with people who are not familiar with the professional terminology. The result can be that the parties to a conversation can come away from it with different perceptions of what has been said. Moreover, it is no more than natural for a person, who has been given information about a relative's condition, to need to think about that information for two or three days and then have an opportunity of talking to someone about the implications of what he or she has been told. We regard these matters as the responsibility of the Consultant Psychiatrist, the Care Co-ordinator or (if necessary) the other members of the multi-disciplinary team.

92. Patient confidentiality may then become a consideration. It seems to us first that a suitable opportunity should be sought to obtain the patient's consent to his or her closest relatives being given the diagnosis and an explanation of it in everyday terms. If consent cannot be obtained, then legal advice on this aspect may have to be obtained and ultimately this

matter may have to be resolved by legislation. It seems to us to be inconsistent that relatives should be encouraged or expected to assume the role of lay carers in many cases, if they cannot be told of the patient's illness and its meaning and implications in everyday terms.

93. Mr and Mrs Field's other concerns were the gaps in treatment for their son between December 2001 and April 2002 and then between May and October 2002, which are matters already considered above.

The Employment Co-Ordinator

94. The Employment Co-Ordinator was the Employment Co-ordinator for "Rethink", formerly the National Schizophrenia Fellowship, whom Social Worker 3 approached on Mr Field's behalf, to see if they could provide him with work, training or other opportunities or support which would involve him more in the community.

95. It appears that Mr Field went to see the Employment Co-Ordinator on the 21 January 2003 to go through his referral form and his reasons for wanting "Rethink's" services. The employment Co-Ordinator says that because of certain concerns about Mr Field she telephoned Sankey House, the offices of the Basildon West CMHT, between 1.15 p.m. and 1.40 p.m. on the 21 January 2003 and spoke to a female telephone receptionist. The Employment Co-Ordinator then set out her concerns in a letter dated the 28 January 2003 addressed to Social Worker 3 in the following terms:

> *"He* [Mr Field]*.....seemed to be experiencing severe ideations concerning two female neighbours whom he referred to as 'schizophrenics'. He believed that these women had messed with his mind, stolen his soul and his conscience, ruined his life and sapped his strength and energy. He seemed determined to kill them or have them killed.*
>
> *He had found someone who would kill them for a cost of £3000; this seemed to be his long-term goal and motivation for wanting to return to paid work. He seemed to believe the only way he would feel 'normal' again would be if the younger woman were dead, because only then would the soul leave her body and return to him."*

96. The Employment Co-Ordinator went on to say in her letter:

> *"I made another appointment to see Derek on the 28 January but felt very concerned about his state of mind, as he seemed to lack any insight into his own mental health problems or possible repercussions if he were to carry out his threats. I passed on my concerns to my team leader about the appropriateness of this referral and left a message with your office for you to contact me to discuss the case, and other matters that arose in the interview in more detail.*
>
> *I called you today at 11.55 because Derek was due in at 12 noon and was shocked and saddened to hear of the tragedy that had occurred only the day after he had been in to see me. You are probably aware of these disclosures however they may shed some light on the police investigation."*

97. The Trust could not trace receipt of this call, but the Employment Co-Ordinator's Team Leader, confirmed to their internal review panel that the call was made because she was in the room when the Employment Co-Ordinator made it. Social Worker 3 suggested to us that it was not made. We invited the Employment Co-Ordinator to meet us, but she did not respond to our invitation. Mr Brown both wrote to her and contacted her by telephone and understood from her, when he spoke to her briefly over the telephone, that she had been advised by Rethink not to become involved in our review.

98. The Employment Co-Ordinator and her Team Leader both met the Trust's internal review panel and the transcript of that meeting records the Employment Co-Ordinator as saying that:

> *" At the end of the meeting I wasn't concerned that in the next couple of days he was going to kill someone - that was the furthest thing. He was quite calm and relaxed. It was more the appropriateness of the referral that why was he referred to us.....I phoned [Social Worker 3], or attempted to phone [Social Worker 3], not to say that I'm really concerned about him* [Mr Field] *being an immediate danger to people but more that I didn't really think it was appropriate* [we assume "it" means

the referral of Mr Field to Rethink]. That prompts the question whether, even if there had been a telephone conversation between the Employment Co-Ordinator and Social Worker 3, any steps would have been taken to forestall the events of the 23 January 2002, given the chances that the conversation would have concentrated on the question of why Mr Field was being referred to Rethink. We assume that the Employment Co-Ordinator was not trained in risk assessment or mental state examination.

Support for Mr Field's parents as carers

99. Our concerns under this heading are that there is no evidence that Mr Field's parents were actively involved in the CPA process or that they were offered a Carer's Assessment. Also, even though it may lie outside our remit, we would hope that they were given the opportunity, after the unfortunate events of the 23 January 2003, to talk through those events with representatives of the Trust. Mr Field’s father has subsequently confirmed that he did meet with the Chief Executive and another representative following the incident of 23 January 2003.

I. Conclusions

100. We are left with a clear impression of a service under considerable pressure in late-2001 to early-2003. The adverse effect of that pressure seems to us to have been exacerbated in this individual case by the absence of effective systems or management in a number of the areas mentioned above. Had the pressure been less or management been more effective, then surely the delays in care and treatment, which Mr Field experienced between December 2001 and April 2002 and then between April 2002 and October 2002, would have been avoided. Then, as stated in paragraph 85 above, we are firmly of the view that the decision to appoint Social Worker 3 as Mr Field's Care Co-ordinator was flawed, certainly in the absence of intensive monitoring. We stress that this is not a criticism of Social Worker 3 personally; his very recent qualification and inexperience in 2002/early 2003 entitled him to support. There is also the confusion about the events occurring around Christmas 2002, when Mr Field was not seen by a Consultant.

101. In offering the views set out in the previous paragraph, we are conscious that we have not been able to discuss the case with any member of management of the Basildon West CMHT in post at the material times; nevertheless the delays in question, the service problems which we have identified and our concerns about the decision to appoint Social Worker 3 seem to us to provide a cogent base for those views.

102. The question arises in an exercise such as that which we have just carried out: did any act or omission in this case cause, or contribute to, the loss of life in question? That is a question which seldom has a clear-cut answer, because of the unpredictable nature of the effects of schizophrenia. All that can be said is that no opportunity of providing suitable care and treatment to someone such as Mr Field should be missed and to ensure that no such opportunity is missed, then several conditions need to be satisfied. The professional carers concerned must have time regularly to assess their clients and keep them under active review. Clients must be assigned to professional carers, whose abilities and experience enable them to meet the needs of the clients assigned to them. As professional carers' skills and experience develop, with the result that clients with more complex problems and needs are referred to them, then all necessary advice and assistance must be available to them and their working environment must encourage them to seek such

advice and assistance and avoid giving them any reason to feel that they are not "pulling their weight" when they seek advice. Furthermore, all necessary training must be provided for them and systems must be available to demonstrate that such training has been received.

103. Also, it cannot be stressed too highly that accurate and comprehensive communications between different professional carers and between professional carers and the client's relatives in a case such as this one are vital to the provision of both effective care and treatment for the client and for the protection of others. Care and treatment inevitably involves a number of different people and they all should be entitled to expect two things: first that they will be told what others in the multi-disciplinary team are doing for the client and second, that they can rely on the information they are given as being accurate and complete. If it is suggested to us that in making these remarks, we are stating the obvious, then we would reply that in both this case and the other one which we have recently considered the points which we have just made have not been observed.

104. We would add the following general comments. The National Health Service has undergone many reorganisations and structural changes. It has been a noticeable factor in more than one such case that untoward incidents seem to occur in the period shortly following a reorganisation or change, while the Trusts or Authorities concerned are co-ordinating their policies and procedures and the constituent parts of the new body are "bedding down". Particular attention needs to be given, therefore, to the working environment and working practices in the period immediately following such a reorganisation or change. In the same way, the period following contemporaneous changes of two or more leading members of a multi-disciplinary team, for example the Consultant Psychiatrist and the Care Co-ordinator, can be a time of heightened risk that a client's condition may deteriorate without that deterioration being recognised or of the client's disengagement from Mental Health services, and either of those scenarios may give rise to an untoward incident.

J. Recommendations

105. We are conscious that for reasons beyond our control this report is being made approximately four years after the sad events of January 2003 and also that the Trust has made and implemented a considerable number of recommendations made by its own internal review panel in the meantime. Where we have discussed the problems arising from this case with members of the Trust's staff whom we have met, we have been told that improvements in the service have been made. Nevertheless, we feel it appropriate to make the following recommendations to the Authority:

105.1 That the Trust be asked to confirm that its internal review panel's recommendations covering the matters listed below have been implemented, with the reasonable expectation that problems connected with those matters should not occur in any future case. The matters in question are:

- **a.** Procedures for keeping track of clients in need of admission or other care and treatment following a domiciliary visit and ensuring the active follow-up of any such client within a reasonable time;
- **b.** Procedures for ensuring that a new client is assessed by the CMHT in question within a reasonable time after referral for community care;
- **c.** That patient records are held in safe custody, and are traceable, at all times throughout the whole of the Trust's organisation;
- **d**. That Cluster Leaders, who we understand now appoint Care Co-ordinators, ensure that Care Co-ordinators so appointed have the requisite training, skills and experience to perform their duties properly in accordance with the principles of the CPA;
- **e.** That regular and effective support, in the form of management and clinical supervision and training, is provided for all Care Co-ordinators and that records are kept of when each Care Co-ordinator is supervised and undergoes training; and
- **f.** The recommendations relating to lay carers.

105.2 That the Trust be asked to confirm generally that channels of communication between Psychiatrists and Care Co-ordinators are now sufficiently effective to ensure the provision of a proper standard of care and treatment.

105.3 That the Trust be asked to confirm that the new bed management system referred to above continues to operate effectively.

105.4 That the Trust also be asked to confirm that all professional staff are aware of the need to keep General Practitioners fully informed of all matters affecting, or likely to affect, the care and treatment of their respective patients, particularly where any such matter has repercussions for the care and treatment which the General Practitioner himself may be called upon to provide.

105.5 That the Trust be requested to confirm that Consultant Psychiatrists and Care Co-ordinators are aware of their obligations to close relatives of clients to ensure that such relatives clearly understand the nature and effect of the client's mental illness.

105.6 That full and accurate communication between members of staff about the clients in their care is a principle constantly promoted by the Trust among its staff, in the interests of the care and treatment of those clients and the protection of others.

105.7 That where a client's care and treatment is transferred from an in-patient ward to a CMHT, a pre-discharge CPA meeting should be held on the ward and attended by the Consultant Psychiatrist or his representative, a member of the ward nursing staff and a representative of the CMHT (preferably the Care Co-ordinator, if then appointed).The client, near relatives who will be caring for him and his General Practitioner should also be invited to attend.

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

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Mrs Dee Fagin, RMN
Member of the Independent Review Panel

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