



*North East*

**REPORT TO THE NORTH EAST  
STRATEGIC HEALTH AUTHORITY  
OF THE INDEPENDENT INQUIRY  
INTO THE HEALTH CARE AND  
TREATMENT OF GARRY TAYLOR**

October 2007



## The Panel

### **The members of the panel were:-**

- Mr Euan Duff – Barrister (Chairman)
- Dr Christopher Fisher – Consultant Psychiatrist and Director of Clinical Governance and Assurance, Tees Esk and Wear Valley NHS Trust
- Mr Thomas Welsh – former Director of Nursing / General Manager of Mental Health Services, Craven Harrogate and Rural District Primary Care Trust

## Acknowledgement

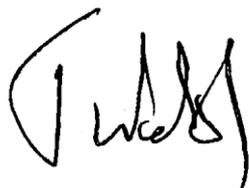
The inquiry panel wishes to express its gratitude to the panel co-ordinator, Mr Richard Smith, for all of his hard work and assistance in the administration of the inquiry.



Mr Euan Duff



Dr Chris Fisher



Mr Tom Welsh



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# 1 Introduction

On 17 January 2004 Garry Taylor went to Colin Johnson's home in Sunderland and attacked him with an axe. Colin Johnson died as a result of the attack. Colin Johnson was a 40 year old local man who had lived in the Sunderland area for his entire life; he was well known and liked in the area. He left two daughters and a fiancée with whom he had had a long-term relationship.

Garry Taylor had known Colin Johnson since school days. There is no evidence to suggest that there had been any violence or untoward incidents between the two prior to the attack that killed Colin Johnson. After his death some evidence emerged that Colin Johnson had become a little tired of Garry Taylor visiting him at his home. There was no obvious motive for the attack but, in the light of what was to emerge, it seems highly likely that Garry Taylor had become suspicious that his girlfriend was having an affair with Colin Johnson. Such a suspicion was wholly unfounded; there is no suggestion that there was any such relationship between the deceased and Garry Taylor's girlfriend.

Following the death of Colin Johnson police investigations centred on his known associates, of whom Garry Taylor was one. Police officers attempted to speak to him on 19 January at his home, but he ran off. Later that day he was seen and spoken to and, because of his evasive attitude, arrested on suspicion of the murder. He was detained and interviewed over a number of days but declined to answer questions and was released on 23 January. On 25 January a bag was found which contained blood stained clothing and an axe. Scientific tests linked these to Garry Taylor and he was re-arrested on 9 February and charged with the murder of Colin Johnson on 10 February.

After his remand in custody Garry Taylor was admitted to Rampton Hospital on 30 June 2004. In reports for the court his consultant psychiatrist expressed the opinion that it was very clear that Garry Taylor was suffering from a psychotic mental illness, which was most likely to be paranoid schizophrenia. He had rarely encountered an individual who was psychotically disturbed to the extent of Garry Taylor and it was clear that he was at risk of causing serious harm to the public.

In September 2005 Garry Taylor pleaded guilty to the manslaughter of Colin Johnson on the ground of diminished responsibility. That plea was accepted and it was ordered that he be detained under the provisions of Section 37 of the Mental Health Act 1983 (MHA) with a restriction order pursuant to Section 41, without limit of time.

At the time of the killing of Colin Johnson, Garry Taylor was a patient under the care of South of Tyne and Wearside Mental Health NHS Trust and had been under the care of the mental health services for many years. Under the terms of Health Service Guidance (94)27 (as amended 2005), Northumberland, Tyne and Wear Strategic Health Authority commissioned this independent inquiry into Garry Taylor's health care and treatment with the terms of reference set out hereinafter. Since the commissioning of the inquiry, the authority has been succeeded by the North East Strategic Health Authority.

## INTRODUCTION

During the course of the inquiry the panel met with the sister and fiancée of Colin Johnson to whom the panel wish to express their gratitude and condolences. Notwithstanding their loss, both were anxious to assist in any way they could. Their overriding desire was to learn the true history of what led to the killing of Colin Johnson and that any lessons which can be learned from the tragic events should be absorbed in the hope of preventing any repetition of such an occurrence.

The panel also met the family of Garry Taylor and were considerably assisted by their accounts and evidence. The family had strong feelings about his treatment with which the panel felt sympathy. The panel also met Garry Taylor in Rampton Hospital.

The panel met on 49 occasions between 19 January 2006 and 11 October 2007. The panel had access to comprehensive records and documentation, which is set out in the bibliography attached.

In addition to the families and Garry Taylor, the panel interviewed 27 witnesses. All formal interviews were recorded and witnesses were provided with transcripts for correction.

The panel considered the complete history of Garry Taylor's involvement with mental health services and was conscious that it was in the uniquely advantageous position of being able to consider all material without the pressures of day-to-day management of numerous service users for whom clinicians and other professionals have responsibility. The panel has attempted to guard against the wisdom of hindsight.

In order to have an understanding of the various problems that Garry Taylor presented and of his treatment, it is necessary to consider in some detail the entire history of his life and involvement with mental health services. Although the panel has considered the whole history, ultimately it concentrated on the two to three years leading up to the killing of Colin Johnson, which it considered the crucial period.

The panel only considered the mental health services with which Garry Taylor and his family had any involvement i.e. those that served working age adults.

## 2 Terms of Reference

To examine the circumstances of the surrounding health care and treatment of Garry Taylor, in particular:

- The quality and scope of his health care and treatment, in particular the assessment and management of risk;
- The appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary care programme approach and the assessment of risk in terms of harm to himself or others;
- The standard of record keeping and communication between all interested parties;
- The quality of the interface between the mental health services, other agencies and family members, including the provision of needs assessment and support for carers;
- The extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health.

To prepare a report for, and make recommendations to, Northumberland, Tyne and Wear Strategic Health Authority.



### 3 Chronology of Key Dates and Events

#### **EARLY HISTORY**

Garry Taylor was born on 12 July 1965 and was therefore 38 years of age at the time of the killing of Colin Johnson, on 17 January 2004. Prior to 1993 he had no involvement with any psychiatric services and, so far as can be judged from the material before the inquiry panel, there was nothing that had occurred in his life that is of particular significance in relation to later events. Garry Taylor was the youngest of four children and seems to have had a relatively trouble free childhood. The family lived in the Millfield area of Sunderland and Garry attended a local school, leaving after achieving five "O" levels. He gained employment on leaving school and, as his last employment, worked for a computer firm until 1989.

#### **INVOLVEMENT WITH COURTS AND POLICE**

By June 1992, Garry Taylor had appeared before the criminal courts eight times. These were in January 1979 (aged 13) for burglary when he was conditionally discharged; March 1981 (aged 15) for handling stolen goods when he was made the subject of a probation order; July 1982 (aged 17) when he was fined and bound over for threatening words and behaviour; October 1982 (aged 17) when he was fined for assault occasioning actual bodily harm; May 1983 (aged 17) when he was fined for criminal damage; October 1984 (aged 19) when he was made the subject of a community service order for assault occasioning actual bodily harm; September 1988 (aged 23) when he was made the subject of a six months sentence of imprisonment suspended for two years for an offence of causing grievous bodily harm and in June 1992 (aged 26) when he was fined for stealing a vehicle. He was dismissed from his employment in 1989 following a violent incident.

Following his involvement with psychiatric services he was convicted on four further occasions. In August 1993 he was convicted of possession of a bladed instrument and fined. In July 1998 he was fined for an offence contrary to Section 4 of the Public Order Act 1983. On 7 May 2003 he was fined and disqualified from driving for an offence of excess alcohol and again on 20 October 2003 was dealt with for a similar offence for which he was also fined and disqualified from driving.

As well as those convictions Garry Taylor is noted on police records as having been involved in other violent incidents, some involving weapons, which did not result in convictions. In May 1991 Garry Taylor locked his longstanding girlfriend (Girlfriend 1), naked in a bathroom from Saturday to Monday morning having been violent to her beforehand; later that year he threatened her with a knife when she was babysitting, and used a hammer to break the windows of the car of the person for whom she was babysitting. In July 1992 he threatened the partner of Girlfriend 1's sister with a knife, accusing him of having an affair with Girlfriend 1. In August 1992 he left a soft toy on the doorstep of Girlfriend 1's sister with its throat cut. The conviction in August 1993 resulted from his having chased Girlfriend 1 with a knife,

## CHRONOLOGY OF KEY DATES AND EVENTS

threatening her and scratching her neck. The relationship with Girlfriend 1 came to an end in 1993.

### **Commentary**

*The history of offending and violence throughout Garry Taylor's life, even before he had any involvement with psychiatric services, was clearly of very great significance in relation to his subsequent management and the risks that he presented. This entire picture was not known to the psychiatric services and there was a failure for the whole of this history to be drawn together and held in an accessible form within his psychiatric records.*

### **EARLY PSYCHIATRIC CONTACT 1993 - 1995**

In January 1993 Garry Taylor was referred, at the behest of his mother, to the Community Addiction Team. The outcome of this is unclear, but by 4 June 1993 he was noted in his general practitioner (GP) records to be possibly depressed and paranoid, aggressive, moody, suicidal and possibly schizophrenic. He was prescribed chlorpromazine, an anti-psychotic drug. By 14 June 1993 he had assaulted both of his parents, fracturing his mother's arm and knocking his father unconscious. As a result, he was the subject of an emergency outpatient referral by his GP (GP1) to Cherry Knowle Hospital. He was admitted on 23 June when his history was said to be of his life falling apart over the last few months, losing his job, his girlfriend leaving him and his house being re-possessed. He had been abusing drugs (ecstasy, amphetamine and cannabis). Garry Taylor himself was of the view that his problems related to depression and a bad temper. His brother (Brother 1) was of the opinion that the problems were extreme rage and paranoia. Garry Taylor said that he wanted to kill his brother-in-law for breaking up the relationship with his girlfriend and he believed that people were talking about him in sign language. He was discharged from Cherry Knowle on 29 June, on chlorpromazine. In a letter of 27 July to GP1 he was described as having had an 18 month history of alteration of mood, which had become much worse in the last three months. The diagnosis was of a paranoid psychotic illness, which was possibly secondary to abuse of ecstasy and amphetamine. It was also possibly secondary to a depressive illness with features of morbid jealousy. He was reported to have settled well on the ward and he was encouraged to continue on the medication, to avoid illicit drugs, to be reviewed in a couple of weeks and, if improving, for the medication to be reduced.

It was at this time that he was convicted, in August 1993, following the incident in which he had threatened Girlfriend 1 with a knife.

In September 1993 he refused to continue on his medication and his GP switched him to haloperidol (an anti-psychotic). On 4 October Consultant 1 was reporting that he had seen Garry Taylor on 15 September and that he had stopped taking his

medication a few weeks ago, was feeling much better, was pleasant and cooperative without any evidence of psychotic symptoms and that he would be seen again in outpatients in about two months.

During the later part of 1993 and in 1994 he was seen intermittently as an outpatient at Cherry Knowle Hospital (the Wellfield Clinic) by Consultant 1. By December 1993 he was being prescribed chlorpromazine again. In April 1994 he was reported to be feeling better but still suspicious from time to time and of the view that others were using sign language. By June he was complaining of a lack of concentration and a lack of interest and was prescribed flupenthixol (an anti-psychotic with anti-depressant properties). In August 1994 he was feeling very low with little appetite and feelings of worthlessness, he was extremely paranoid around people. Consultant 1 changed his medication to clomipramine (an antidepressant). When seen at the Wellfield Clinic on 28 October 1994 Garry Taylor said that he was extremely withdrawn, could not face meeting people, was not feeling himself and was feeling confused. He had stopped taking the clomipramine and was prescribed trifluoperazine (another anti-psychotic drug). He was to be seen again in two weeks. He attended for that appointment on 11 November 1994 when he was much the same but failed to attend his next appointment on 25 November. Four days later he did attend with his mother and was reported to be improving. Having failed to attend an appointment on 10 January 1995 he was seen on 17 January when he was said to be continuing to improve, having more good days than bad. On 26 March 1995 he again attended the Wellfield Clinic when he reported that he was getting better but that his mood was up and down and he was worse when by himself. He felt that the trifluoperazine was not doing him any good and he was commenced on sulpiride (another anti-psychotic drug). During the middle part of 1995 he was seen at the Wellfield Clinic only on 25 April and 15 August when he reported similar problems to those which had existed for the last year or so and on the second occasion said that he was not getting on well with his girlfriend (Girlfriend 2) but could not explain why.

### **Commentary**

*This first period of two years nine months, was – in retrospect – a precursor to his subsequent behaviour. Garry Taylor's illness developed gradually with the first significant violence resulting in his admission to hospital. Thereafter he was managed in an outpatient setting, with reluctance on his part to comply with prescribed medication and appointments. There was a gradual deterioration, although with occasional brief improvements, and then a further escalation into the serious violence referred to hereinafter. This pattern ought to have served as a warning and lesson for future events.*

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### ADMISSION TO REGIONAL SECURE UNIT 1995

On 9 September 1995 Garry Taylor stabbed Girlfriend 2 in excess of 25 times with a pair of scissors. He had had a relationship with her since 1993. He was arrested and found not fit to be interviewed and was first admitted under Section 2 MHA to Cherry Knowle and then transferred to a locked ward at St Mary's Hospital, Stannington. At this time, as a result of this episode, Garry Taylor's dangerousness was well recognised. It was rapidly strongly suspected that he was suffering from a paranoid illness that had been developing over the last three to four years and it was arranged that he be transferred to the Regional Secure Unit for assessment under Section 35 MHA by order of Sunderland Magistrates Court. He was admitted to the Regional Secure Unit on 29 September 1995. Reporting for a Care Programme Approach (CPA) meeting on 23 October, Consultant 2 took the view that the most likely diagnoses were a brief psychotic episode related to drug taking or a schizophreniform-type illness, but that he should be further assessed. It was clear that, when psychotic, Garry Taylor was dangerous. On 1 December in a further report for a CPA review meeting Senior Registrar 1 was of the view that Garry Taylor was potentially very dangerous and likely to harm others again. Girlfriend 1 was particularly at risk. At this stage the indications were of a process illness rather than a drug induced psychosis. Minutes of the meeting of 1 December stress Garry Taylor's dangerousness and the family felt that if he were to be released "someone would undoubtedly be killed". Although it was thought that the charges against him were likely to be dropped there was no doubt that he was detainable under the MHA.

No criminal charges were preferred against Garry Taylor on that occasion because of the unwillingness of Girlfriend 2 to give evidence or press charges; he was detained under the provisions of Section 3 MHA on 7 December. He remained an inpatient at the Regional Secure Unit for over a year until November 1996. During that period he received treatment, was monitored and assessed. By July 1996 the diagnosis of his condition was of paranoid schizophrenia in relation to which illicit substances were an aggravating factor. Concerns were expressed about his willingness to comply with oral medication in the community and he expressed reluctance to have depot injections. Consultant 2 was firmly of the opinion that depot injections were necessary and that the possible consequences of a relapse were "worrying indeed". It was stated that, clearly, following any discharge it would be necessary for Garry Taylor to be closely followed up in the community.

During the period of inpatient treatment at the Regional Secure Unit the various reports demonstrate a cautious and concerned approach towards his condition and treatment and his possible transfer, first to Cherry Knowle and then into the community. In August 1996 it was recognised that so far as dangerousness was concerned there were three main areas of concern: defaulting from compliance with medication; abuse of illicit substances and possibly alcohol; and his relationships, especially with women. At this time his mother was telling social workers that she was concerned that Garry Taylor could hoodwink staff, that he was intelligent and that he would possibly consent to depot injections if it would facilitate his transfer to Cherry Knowle.

### **Commentary**

*This period of inpatient treatment at the Regional Secure Unit appeared satisfactory but there were concerns about the content of medical records that were found to be incomplete and disorganised. There was a clear and, the panel believe, accurate diagnosis. Garry Taylor's dangerousness was well recognised and the basis of a clear community care plan was laid out with warnings raised as to relapse signs. Save in relation to the one matter referred to in the next commentary section, the panel was impressed with this period of care.*

### **TRANSFER TO CHERRY KNOWLE HOSPITAL**

A case conference on 16 August 1996 envisaged a programme to transfer Garry Taylor to Cherry Knowle but there was unanimity that he required anti-psychotic medication to be given in depot form and, at that stage, he had refused a test dose of such medication. All of the concerns referred to above were present and a cautious approach continued. By late August Garry Taylor indicated that he would reluctantly accept depot injections and these were commenced on 3 September.

By early November 1996 it was agreed that Garry Taylor could be transferred to Cherry Knowle and that transfer took place on 8 November 1996. At this time his social worker (SW1) noted that she had grave concerns over the discharge of Garry Taylor, which concerns she had voiced to other professionals but was not sure if these had been recorded in the nursing or hospital notes. She later communicated this to Consultant 1 in writing. On 14 November a leave programme was decided upon, granting Garry Taylor overnight leave the next weekend, which was repeated in the following weeks. On 4 December, following discussions between Consultant 1 and Consultant 3 consideration was given to allowing Garry Taylor's Section 3 MHA status to lapse, but within the next week consideration was also given to his going into the Wellfield Rehabilitation Project. At that stage it was wrongly believed that his Section ended on 12 December, whereas in fact it was due to expire on 6 December. A Section 117 after care meeting took place on 11 December at which, since the Section 3 Order had expired on 6 December, it was agreed that he be placed on the Supervision Register under the category "Active/Vulnerable". He was to reside at his mother's address, to attend the Day Hospital on a daily basis and his position was to be reviewed after two months. He was to remain on the depot injection, which was to be administered at the Wellfield Clinic. A statement of risk at this time, contained within the minutes of case conferences held on 16 August and 6 November, recognised the significant past history of violence and the serious danger that he might present to others, particularly those close to him. He was formally discharged from Cherry Knowle on 19 December.

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### **Commentary**

*Whilst there is no doubt that Garry Taylor's dangerousness, confirmed diagnosis and details were discussed fully between Regional Secure Unit staff and those in attendance from Cherry Knowle at the case conference, it is unfortunate that there was not a single comprehensive discharge document prepared by Regional Secure Unit staff for reference purposes. Whilst all of the information relating to Garry Taylor was to be found in his medical notes, there was no one place to which quick reference could be made to give an accurate and full overview of the opinions formed at the Regional Secure Unit. The panel questions whether Garry Taylor's discharge from Cherry Knowle may have been somewhat premature, given that he had spent over a year in the Regional Secure Unit. Furthermore, although Garry Taylor's Section 3 status was allowed to lapse, the panel questions whether this was a conscious decision or came about simply through the misunderstanding as to the date of its cessation. Had the correct date been known there would have been more options as to his regime at the end of his period in Cherry Knowle. Further, although the dangers of relapse and consequent danger to others were well recognised in the case conference and the Regional Secure Unit notes, these were not thoroughly reflected in the discharge letter sent to Garry Taylor's GP by Consultant 1. The panel regarded it as surprising that the diagnosis contained within the discharge letter relating to the period spent in Cherry Knowle was one of Drug Induced Psychosis, in view of the fact that he had spent over a year in the Regional Secure Unit prior to transfer, during which period it is unlikely he could have had access to illicit drugs. This diagnosis contrasted with the clear Regional Secure Unit diagnosis of paranoid schizophrenia. The panel questioned whether this recorded diagnosis might have adversely influenced future treatment and management of Garry Taylor.*

### **LATE 1996 - 1997**

At this time there were initially some difficulties in relation to the organisation of Garry Taylor's care in the community with a request from Consultant 1 to Consultant 4 to take over his care. This was declined and Consultant 1 continued as his consultant and also as his key worker. He was transferred from the North to the South Sector Team, because of his residence with his mother.

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Within a very short time of Garry Taylor's discharge into the community problems with his compliance with medication and management became evident. Although on supervised discharge, which required his daily attendance at the Wellfield Day Hospital, he failed to attend his first appointment and thereafter there were a very limited number of attendances. It was clear that he was only willing to have his depot injections in order to please his mother and keep on the right side of the authorities. He displayed no insight whatsoever into his condition and maintained that there was no evidence at all that he was responsible for the attack on his girlfriend. Concerns were raised that, if he failed to comply with his medication or began to take illicit drugs, he would probably be able to cover up his symptoms.

During 1997 the management of Garry Taylor's case was achieved by home visits, the administration of depot injections at those home visits and periodic CPA reviews. Over that year he presented no extreme problems but a picture of reluctant compliance with medication, continued lack of insight and an unwillingness to engage in any activities designed to assist his position emerged. There were intermittent concerns in relation to the taking of cannabis and other illicit drugs.

### **Commentary**

*This period demonstrates the beginning of what was to be a repeated pattern with Garry Taylor. There was poor compliance with the regime and those who had responsibility for his management, in the face of difficulties presented by him, did not rigorously enforce the discharge plan. This is particularly of concern given that Garry Taylor was on the Supervision Register.*

### **1998 – 2000**

This pattern essentially continued during 1998. In February 1998 Garry Taylor was removed from the Supervision Register, he was re-graded to level three CPA and it was agreed that the depot injections would be changed to every four weeks rather than every three. Social work contact was to be every six weeks and Mrs Taylor was told to contact social services if she had any concerns. On the whole, reports after home visits were reasonably positive, although his mother remained concerned about illicit drugs and wondered what his thought processes were. It was clear that he still had no insight into his illness. By November 1998 Consultant 1 had ceased to be his key worker with a community psychiatric nurse (CPN1) being assigned this role and at that time his depot injections were reduced from 75 to 50 mg of zuclopenthixol on a four weekly basis.

The majority of 1999 was again a similar sort of pattern with Garry Taylor's management raising no serious concerns. He complied with his depot injections and whilst there were intermittent fears raised about his using illicit drugs and the occasional concern by Mrs Taylor about his behaviour; on the whole the CPA seemed

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to be working satisfactorily. A positive urine drug screen for amphetamines and cannabinoids in June was explained (probably falsely) by him on the basis of his drink being "spiked". He went on a holiday to Florida without incident. Towards the end of 1999 the concerns over illicit drug use increased with Garry Taylor admitting to his mother that he had been taking illicit substances.

In the early part of 2000 concerns continued over his drug use and there was a dip in his well-being with his thoughts racing and his being anxious and depressed. This resulted in his being prescribed paroxetine (an antidepressant) and in February his depot injection was increased. Thereafter the pattern was much as in the previous years with fluctuations of his well-being, continued concerns over drugs but no major problems arising. Toward the end of 2000 it was decided to involve the Assertive Outreach Team (AOT), which had recently been created, in his management and a social worker (SW2) from that team met him in December 2000.

### **Commentary**

*This period in Garry Taylor's care is fairly unexceptional with the sort of problems that one would expect with a patient of his type. At this stage the relationship with CPN1 was positive, there is evidence that the basics of a CPA were being followed, Garry Taylor was, albeit reluctantly, accepting depot injections and was being managed within the community.*

### **2001 – SEPTEMBER 2002**

2001 had begun in similar vein to the preceding period. There was a temporary split from Girlfriend 2 in February and March and he continued his reluctance to engage with any activities. He was living with his mother after the split from his girlfriend and she reported increased concerns about his mental well-being and behaviour. Thereafter there was some moderate improvement, with Garry Taylor participating in a football group, but on a home visit on 9 August 2001 he refused to have his depot injection. His last injection had been on 4 July 2001. In August he apparently won some money and went on holiday with Girlfriend 2 and her son to Majorca. On his return from holiday it was reported that he had exhibited bizarre behaviour whilst abroad. He was said to have believed that the mafia and underworld figures were trying to kill him and as he was about to return to the UK he had apparently assaulted a fellow passenger, which had resulted in his being refused permission to board the plane and having to return via a circuitous route. His family were very concerned on his return and said that he was extremely paranoid and unwell. Mrs Taylor rang and requested that he be given a depot injection and this was achieved on 10 September, but thereafter she complained that he was experiencing severe side effects. There was limited contact in September with some failed visits and a CPA review was held on 21 September. Garry Taylor attended initially but left at an early stage whilst recent developments were being discussed. At the review

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meeting the numerous problems were discussed and provisional plans were made for a multi-disciplinary team meeting to consider further actions in the light of his disengagement from the services and the potential risks. At this time he was prescribed amitriptyline (another antidepressant) by his GP. His condition, as reported by his family, varied but evidence of his being unwell was clearly demonstrated when he began to suspect CPN1 of having a relationship with his girlfriend; this being triggered by the fact that CPN1 called spontaneously to see him when she was there. In October and November the problems continued and at the end of November he was prescribed risperidone (an atypical anti-psychotic). He attended a hastily arranged CPA on 30 November and it was agreed that he would continue on that anti-psychotic drug and night sedation of temazepam.

A care plan drawn up on 11 December set out his medication, the programme of monitoring and plans, and had a number of telephone numbers, including mobile telephone numbers of three members of the AOT for Garry Taylor, his mother, family or carers to ring to notify of any signs of deterioration, relapse or crisis.

2001 ended with fairly regular visits and Garry Taylor continuing to deny that he was ill and attributing any problems to lack of sleep. He was continuing on the medication, with which he appeared to be complying.

The first months of 2002 continued in the same pattern with regular home visits and an apparent fair degree of co-operation from Garry Taylor. His urine drug screen reports were negative and he was apparently fairly, although not 100%, compliant with his medication. Mrs Taylor continued to express concerns about the use of illegal drugs and his mental well-being. He attended for CPA reviews and his care plan was updated regularly. Home visits continued into the middle of the year. During such a visit on 10 July, Mrs Taylor expressed concerns that his mental health was deteriorating; he was pacing the room and was unwilling or unable to converse. Concerns were such that, in discussions between Consultant 1, CPN1 and SW2, the possibility of voluntary hospital admission was considered. It was decided, at that stage, that MHA intervention was not warranted.

On 22 July a letter was written by Garry Taylor to the Chief Executive of the Trust requesting a change of doctor from Consultant 1 as, according to the letter, he felt that he was not making any progress and was of the opinion that a change of doctor would help him move forward. This letter was in fact written at the behest of Garry Taylor's family.

On 24 July during another home visit, at which Garry Taylor was distracted and restless and left after 10 – 15 minutes, Mrs Taylor expressed her unhappiness with Consultant 1 and said that she wished for Garry Taylor to be admitted to hospital. For the next month home visits and telephone contact continued with mixed success. During this period Consultant 1 wrote to Consultant 4, on 2 August, asking him to take over Garry Taylor's care, outlining the history and offering to discuss "this difficult case" with him. In fact Consultant 1 continued in charge of the case for some time thereafter before care was effectively transferred. This was due to the normal six weeks changeover timescale and the fact that Consultant 4 was on annual leave from 12 – 26 September. Garry Taylor only became Consultant 4's patient on his subsequent admission to Cherry Knowle.

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In August and September there was a clear deterioration in Garry Taylor's condition. On 6 September CPN1 telephoned Consultant 4's secretary and she noted that Mrs Taylor was very worried; that Garry Taylor was floridly psychotic, very paranoid and that CPN1 was wanting to talk to someone about options as Garry Taylor was quite dangerous, was deteriorating, not taking his medicine and could mask things quite well. Between that date and 24 September there was a good deal of activity with a number of calls from Mrs Taylor reporting bizarre behaviour and requesting an assessment by an approved social worker (ASW), but then changing her mind and wishing to see how Garry Taylor was. Appointments with Consultant 1 were offered and declined and there was an unsuccessful attempt by Consultant 5 (covering in Consultant 4's absence) to see Garry Taylor in the company of social workers and CPN1 at a home visit to Girlfriend 2's house.

The culmination of this activity was a home visit by SW2 on 24 September in which Garry Taylor was displaying overtly psychotic behaviour. He accused his girlfriend of being a government spy and said that she was signalling to people on Chester Road who were "wearing dodgy shoes". Garry Taylor informed SW2 that he had not been taking his risperidone since June and stated that he did not need any medication and would get better on his own without any help from doctors or other agencies and that there was nothing wrong with him.

Following that visit and a request by Mrs Taylor for a MHA assessment, the next day on 25 September, Garry Taylor was seen by Consultant 6, a forensic medical examiner (FME1) and ASW1 and was admitted to Cherry Knowle Hospital under Section 3 MHA. A report by Consultant 6 noted that Brother 1 thought that "he was ready to kill someone", and that Brother 1 and Mrs Taylor said that he was only well when he was on injections. He was started on 10 mg of oral olanzapine (an atypical anti-psychotic) daily. A Worthing Risk Indicator on that date scored him at 62, to put him in the middle of the "Severe" category.

### **Commentary**

*A hugely significant event in this period was the cessation of depot medication, which Garry Taylor was refusing after July 2001, although with one further injection taking place in September 2001. It is clearly evident that within a relatively short period of time there was a significant deterioration in his condition and behaviour and whilst there were intermittent brief periods of improvement thereafter the trend was for his condition to become worse until it necessitated his admission to Cherry Knowle. Most of the concerns which had been raised at the end of his period in the Regional Secure Unit were realised and, whilst happily there was no violence used towards anyone prior to his admission, this period can be seen as a repeat of the previous pattern which had led to his initial admission to Cherry*

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*Knowle in 1993 and his admission to the Regional Secure Unit in 1995. Although his condition deteriorated and he presented increasing problems to his management team, these were dealt with appropriately by regular home visits, CPA reviews and interventions by CPN, social workers and medical staff; finally resulting in an emergency admission pursuant to Section 3 of the MHA following a family request and a well coordinated and successful assessment.*

### **ADMISSION TO CHERRY KNOWLE HOSPITAL SEPTEMBER 2002**

On examination on 27 September SHO1 (a senior house officer on her first psychiatric placement), at the end of a full assessment of Garry Taylor, formed the impression that he was suffering from "drug induced psychosis or bipolar disorder with manic episode", was "a dangerous man" and "may well pose a threat soon (violence) on the ward". It was planned that he be observed and have no leave from the ward. A further review on 30 September concluded that he had lots of paranoid ideas and had uttered threats against both his girlfriend and his mother. He was to continue to be observed and prescribed olanzapine; it was considered that it may be necessary to increase the dosage. On 2 October SHO1 noted that whilst Girlfriend 2 denied that he had been unwell before coming into hospital and wondered why he was in there, she "looked very apprehensive to speak".

On 3 October (a Thursday) Consultant 4 met Garry Taylor for the first time and at the end of a review with a staff nurse (SN1) formed the impression that he currently seemed well and not psychotic or paranoid. The plan was to transfer him from Dene Ward to East Willows Ward, observe over the weekend and possibly to begin leave after a review on 7 October, if all was well. He was warned that if he absconded he would be picked up by the police and would be "back to square one". A Worthing Risk Indicator completed on that date showed Garry Taylor as having apparently reduced to a score of 33 placing him in the lower part of the "Moderate" bracket. On 4 October Mrs Taylor phoned Consultant 4's secretary raising her concerns about Garry Taylor's past behaviour, stating that she understood he may be given day leave and that he was not disclosing how things really were.

On 7 October Garry Taylor was seen by Consultant 4 and SHO1 with SN2 and CPN2. He was sitting forward in his chair and is recorded as being "intimidating" and fidgety. He was still of the view that his girlfriend was having an affair with his mate as he had found his new phone number on his bill. He was given day leave and told that he must not drink on leave. It was planned to hold a Section 117 meeting the next week. When given leave he left quickly and by the time that SN2 phoned his mother at 12 40 pm he had already been home and was reported, by his mother, to have "blown his top" as she had cancelled his car tax and insurance, thinking that he would be in hospital for six months. Mrs Taylor was not happy that he had been given leave and said that he had grabbed some clothes and gone to his flat in his car.

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She reported that she believed him to be far from well; that he could “pull the wool over your eyes” and that she was sure that he was “up to something criminal”. She would not say what this was but assured SN2 that it did not involve anything violent towards anyone. This was noted and was to be passed to Consultant 4 and also to CPN1. Garry Taylor returned to the ward at 1 10 pm bringing in a pool cue as the one on the ward was broken, had a game of pool and then left in his car. Consultant 4 was informed of the developments and said that there should be no change of plan at that time. CPN1 was contacted and informed of Mrs Taylor’s misgivings. He was not surprised at her reaction and, whilst he felt that she over-reacted in most circumstances, he felt that there was cause for concern in view of the very serious nature of events in Garry Taylor’s past and that he was perfectly capable of masking his symptoms and getting exactly what he wanted from psychiatric services. CPN1 was told to pass on his concerns to Consultant 4 that day and said that he would. On return to the ward at 6 30 pm Garry Taylor left almost immediately with another patient, returning at 7 50 pm at which time he admitted to having consumed “two cans”.

On 8 October Garry Taylor was seen by SHO1 and he asked to stay out late that night as he had met someone and wished to take her out. It was explained that this was not possible. The fact that he was driving his car without tax and insurance was noted. When told that he could not stay out beyond what had been agreed he became angry and left the ward, driving off in his car, the details of which were noted. Consultant 4 was informed of this and felt that, as leave had been agreed, whilst the situation was not ideal, all that could be done was to await his return and inform the police. Garry Taylor returned to the ward at 7 pm when he went to his room where he remained all night without any problems.

On 9 October he went on day leave and it is noted that he had been granted overnight leave, by Consultant 4, for Thursday 10 October which was to be reviewed on the following day if it had gone well. He returned to the ward at 8 15 pm when he admitted to drinking half a can of lager. He refused to hand over his car keys when told that he should not be driving as an inpatient.

On 11 October following a discussion with Consultant 4 he was granted overnight leave for that night and Sunday 13 October. He returned to the ward at 8 pm on 11 October and, after a full discussion with SN2, in which he said that he had had a pint in the afternoon, he seemed much better than he had been and presented quite well. Routine ward tests for drugs and alcohol were negative. He left the ward promising to return by 6 pm next day. He duly returned at 5 50 pm and displayed no problems.

On 14 October he returned from his overnight leave and, although a little agitated and wound up, which necessitated the administration of an as required tranquiliser, had a rational discussion with a nursing assistant about a television programme that he had seen as to possible adverse effects of a certain drug. He slept undisturbed.

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On 15 October Consultant 4 with SN3 saw him on East Willows when he seemed well and was reporting that he had sorted things out with his mother and Girlfriend 2. Nursing staff reported that there had been no problems, although he was edgy and pacing about if not getting what he wanted. It was planned that he remain on the ward overnight and that a Section 117 review would take place the next day.

On 16 October the review took place with Consultant 4, SN4, AOT1 (who was a CPN and the manager of the AOT), Garry Taylor, Brother 1 and SW3. His brother reported that he was "a different person" since he had started taking his medication and that his temper was improved. It was resolved that he would be removed from his Section and, as he was not willing to stay as an inpatient voluntarily, he would be discharged. A plan was drawn up which is variously recorded as of twelve or thirteen points in the medical and multi disciplinary notes and was subsequently put into a care plan on 17 October by SN5. Garry Taylor was recorded as being of low risk of neglect and suicide; the risk of violence was assessed as "low while receiving treatment, significant if stops medication". He was to be seen by the AOT on a monthly basis and an outpatient appointment was to be arranged with SHO1 within two weeks. He was to continue on olanzapine.

### **Commentary**

*The panel had grave concerns about this period of admission and Garry Taylor's discharge from Cherry Knowle. On admission his dangerousness and paranoia were readily recognised; thereafter, however, his dangerousness seems to have been overlooked or miscalculated. The second Worthing Risk Indicator score of 33 was seriously miscalculated, as some risk factors, which were constant, were not taken into account.*

*The assessment of Garry Taylor was inadequate with no one who had prior knowledge of him being involved and there was a wholly inadequate handover of care from Consultant 1 to Consultant 4. Insufficient heed was paid to comments from Mrs Taylor and CPN1 and there was poor communication of symptoms displayed by Garry Taylor whilst on the ward.*

*In the light of Garry Taylor's history, the granting of leave, removal of his Section 3 status and discharge were too rapid. There was insufficient consideration given to a longer period as an inpatient and the possibility of re-establishing him on depot injections.*

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*The plan to see him only monthly was not adequate for his needs, particularly since a completely new team was involved who had no prior knowledge of him and also given his history of poor compliance.*

*Of the 'twelve point plan' in fact only three points – his medication regime, his being seen monthly by AOT, and the proposed outpatient appointments – were relevant to his treatment.*

*At this time there were, nominally, two care plans in existence. One was contained in the medical records (with roughly similar entries in the medical and nursing notes); the second was that drawn up on the official documentation and filed with the CPA records. Some entries in the official CPA bore no relation to the reality of what was proposed for Garry Taylor.*

### **16 OCTOBER 2002 - 14 APRIL 2003**

AOT1 and AOT2 became Garry Taylor's contacts on the AOT, with AOT1 designated as care co-ordinator. They visited him on 21 October when he seemed well, was reluctant to engage with mental health services, but was willing to meet on a monthly basis. He spent 20 minutes in the company of the two, agreeing to spend longer with them on the next arranged meeting of 21 November.

On 29 October he failed to attend his outpatient appointment with SHO1 at the Wellfield Day Unit. A further appointment was arranged for 21 November, the same day as, and to follow on from, the meeting with the AOT.

On 21 November he met with AOT1 and AOT2 for 1¾ hrs during which time he explained that he should not be in the system as he had had a breakdown eight years previously due to a number of factors and exacerbated by use of illicit drugs. He said that he was taking his medication as they gave him a good nights sleep, which was important in relation to his ability to function. He said that he would not be attending the appointment with SHO1, but was willing to meet the AOT workers in one month's time. He was given a months supply of olanzapine. AOT1 and AOT2 met SHO1 and reported what had occurred at the meeting. SHO1 was to discuss this with Consultant 4 on his return from holiday (in fact that was the following day) as to future management.

On 5 December an outpatient appointment was arranged which Garry Taylor failed to attend. He had not been seen by anyone from the mental health services since 21 November and his next appointment was on 20 December.

On the day of that arranged appointment he failed to attend to meet AOT1 and AOT2. They contacted his parents and gave them the number of the Crisis Resolution

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Team (CRT) and informed same of the need for Garry Taylor to be supplied with medication as he was due to run out the next day. This was subsequently achieved.

He was next due to be seen on 9 January by SHO1 for an outpatient appointment but failed to attend. AOT1 notified Consultant 4's secretary that no one from AOT would be able to attend that appointment and was informed that Garry Taylor was not expected to attend. An appointment with the AOT was arranged for 21 January 2003. He again failed to attend this appointment but telephoned to say that he had just missed them.

On 22 January 2003, by which time since his discharge on 16 October he had been seen on two occasions only by members of the AOT and had failed to attend three outpatient appointments and two meetings with AOT members, Mrs Taylor rang AOT1. She reported that she was concerned as Garry Taylor had smashed a kettle and a door at his flat, he was losing his temper two or three times a week, was drinking a bottle of spirits a day and she believed that he was not taking his medication. This was reported to Consultant 4's secretary. A home visit was made to Mrs Taylor who repeated her concerns and a visit was arranged for the next day the time of which was to be passed on to Garry Taylor by his mother. This was also reported to Consultant 4's secretary.

On 23 January AOT1 and AOT2 visited the home of Mrs Taylor and Garry Taylor arrived a little later. He claimed that he was taking his medicine, save for the odd tablet, and that he was not drinking too much. He apologised for missing the appointment on 21 January and arranged another appointment to meet the AOT on 21 February. He was offered an appointment with Consultant 4, which he refused, but promised AOT1 that he would contact her, if he were going to stop taking his medication. These matters were reported to Consultant 4's secretary and Consultant 4 noted the events of the last two days, on that day.

There was no contact with Garry Taylor until the appointment arranged for 21 February but on 20 February Mrs Taylor rang and expressed concern that he was not taking his medication and that she remained concerned about him, but did not want him to know that she had telephoned.

On 21 February Garry Taylor failed to keep the arranged appointment to meet AOT1 and AOT2, his father was contacted and told that the Crisis Resolution Team would arrange delivery of his medication. A message was left that Garry Taylor should contact AOT1 on 24 February and this was done. He said that he had forgotten the appointment on 21 February. A further arrangement was made to meet on 26 February.

On 26 February he attended the appointment with AOT1 and AOT2 but was very reluctant to stay. He said that he had no problems but that he did not need more tablets, as he had not been taking them every night. He asked for a lower dose of tablets as he had previously taken half a tablet and that this had not resulted in his feeling so sedated the next morning. He refused to attend any appointments with Consultant 4 to discuss this. He agreed that the AOT could contact him two days before his next appointment to remind him of it. There is within the records a

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Worthing Risk Indicator completed by AOT1 and dated 26 February, which purports to give a total violence/aggression indicator of 48 placing Garry Taylor at the top end of the "Moderate" bracket. In fact, had the individual scores been added up correctly, the total would have been 62. That would have placed him in the middle of the "Severe" band and been the same score as the day that he was admitted to hospital under Section 3 MHA on 25 September 2002. The next day AOT1 contacted Consultant 4 who agreed to reduce his dosage of olanzapine to 7.5 mg per day.

On 11 March there was a series of telephone calls. First Mrs Taylor tried to ring AOT1 and left a message for her that she was very worried about Garry Taylor who was refusing to take his medication and that she was concerned as he was very aggressive and frightening. AOT1 rang her back and was told that Garry Taylor had been taking the 7.5 mg tablets since Friday but was extremely sedated, that they had had an argument during which she had hit him and threatened to have him locked up. Garry Taylor was reported to be saying that he "might as well hang himself". AOT1 arranged to ring back and speak to him, which she did at 3 30 pm. He had just got up and was unsure if he was willing to continue to take his medication, but would consider an alternative. He was still unwilling to see Consultant 4. This information was communicated to Consultant 4's secretary, noted and seen by Consultant 4 that day.

The next day AOT1 rang Consultant 4's secretary and was told that Consultant 4 would be agreeable to change his medication, but would need to see him in order to do so. AOT1 said that she would attempt to persuade him to keep an outpatient appointment on 25 March. There was further contact informing Mrs Taylor of the above.

On 17 March Mrs Taylor contacted AOT1 voicing her concerns. It was reported to Consultant 4's secretary by AOT1 that Mrs Taylor was worried that Garry Taylor was becoming more suspicious of Girlfriend 2; that he was just taking half a tablet "now and again"; that there had been a blazing row between them after she had gone to the girlfriend's and indicated to her that he was not right in the head and that Mrs Taylor had said that "she would end up killing him, putting all his tablets in his tea". AOT1 had discussed with Mrs Taylor the necessity for Garry Taylor to come into hospital, but Mrs Taylor said that he would not come in. The note ended up asking that if Consultant 4 had any specific advice would he please let AOT1 know. Consultant 4 saw this note that day. Garry Taylor agreed to see AOT1 and AOT2 on Friday 21 March.

On 21 March Mrs Taylor rang AOT1 saying that Garry Taylor had arrived at her house that morning having been up during the night and that she had administered 10 mg of olanzapine in his tea. A message was left for Consultant 4 and his outpatient appointment was changed to Monday 24 March. Garry Taylor failed to attend the meeting with AOT1 and AOT2 that afternoon.

On 24 March there was a telephone call in the morning between Mrs Taylor and AOT1 in which it was said that Garry Taylor knew that he had an appointment that afternoon. AOT1 attended the outpatient appointment which Garry Taylor failed to attend. It was reported to Consultant 4 by AOT1 that Mrs Taylor had said that he

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had been better over the weekend, having been very concerned about him for some time; that he had possibly not taken any medication since Christmas or was taking it only sporadically. A plan was noted in the medical records that day that AOT1 was to encourage Garry Taylor to accept an appointment with Consultant 4 for 15 minutes every three months.

On 27 March AOT1 rang Mrs Taylor and was informed that she was still worried as Garry Taylor was irritable and, she suspected, non-compliant with his medication. She was given out of hours numbers and told that she could contact AOT1 at any time.

On 3 April Mrs Taylor again contacted AOT1 telling her that she suspected that Garry Taylor was trying to get cocaine and that his brother had been trying to lay the law down with him. He had been "dreadful" over the weekend. AOT1 left a message for Garry Taylor to ring her and that she would ring the next day. She did so, speaking to Garry Taylor's father, and again left a message for Garry Taylor to ring her.

On 7 April (Monday) AOT1 left a message for Consultant 4 relaying the above, having been trying to get through the previous week. She reported that she would be around for two days but was then at university and then away for two weeks. Consultant 4 saw this message that day.

On 10 April AOT1 again left another message for Consultant 4. She reported that Mrs Taylor was putting olanzapine in his tea, so that he was "champion". Consultant 4 saw the message that day.

On 14 April AOT2 rang Garry Taylor, who was out, and spoke to Mrs Taylor telling her that the team needed to see Garry Taylor as he was due some more medication. Mrs Taylor said that he still had some left as he was not taking it regularly. She was concerned as he was quite agitated, gritting his teeth and staring into space, although he had been "OK" over the weekend.

### **Commentary**

*The panel thought it noteworthy that the care of a patient of this seriousness was given in the first place to an SHO on her first psychiatric placement. The panel noted also that AOT1 had limited experience in the community and was assisted by AOT2, who was very new to mental health. During this period Garry Taylor's unwillingness to engage with services became very evident. In the three month period from leaving Cherry Knowle he had been seen only twice by the two members of the AOT, had missed all of his outpatient appointments and was reported to have been involved in violence in January 2003. At this stage, two of the three points relating to his treatment had clearly failed and there was a report by his mother that a third (compliance with*

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*medication) had also failed. That failure was confirmed by 26 February at the latest. There were also concerns over possible illicit drug use, which, although not mentioned in the discharge plan, was something that had previously been a significant problem and risk factor. In this period the panel felt that there was enough concern over his behaviour and the failure of his treatment regime to warrant serious consideration of his re-admission. The period also demonstrates what were to become increasingly troublesome features in the case; namely the failure of communication between members of the care team and the absence of effective joint working. The risk assessment was clearly inadequate in that it was incorrectly calculated. At the very least this period called for a formal review of Garry Taylor's care plan.*

### **16 – 20 APRIL 2003**

On 16 April Garry Taylor was alleged to have assaulted Girlfriend 2. Mrs Taylor contacted social services and asked for a MHA assessment on the basis that he was non compliant with his medication, had hit Girlfriend 2 after a domestic argument and that he needed to go into hospital. ASW2 informed the police of the allegation of assault at 4 53 pm and gave the police the details of Garry Taylor's vehicle. This was recorded by AOT2 and it was believed that a MHA assessment process had begun. The police called at Garry Taylor's home at 7 06 pm looking for Girlfriend 2; she was not there but Garry Taylor was. As they believed that they could not act without a complaint from the girlfriend, he was not detained. It was only at 4 10 am on 17 April that Girlfriend 2 was traced to her own home; at which time she declined to make a complaint and accordingly the police took no further action.

On 17 April Mrs Taylor telephoned AOT2 upset and mystified as to the events of the previous night but feeling guilty at having asked for an assessment. At 11 am AOT2 and AOT3 called to see Mrs Taylor and at noon Brother 1 rang AOT2 and said that Garry Taylor's mental health was deteriorating but that he felt that his mother would go back on her request for an assessment, as she felt guilty. At 2 pm AOT 2 and AOT3 again visited the home of Mrs Taylor and were informed again of Garry Taylor's increased violence, drug taking, paranoia and deteriorating mental health. AOT2 returned and spoke to ASW3 at 2 45 pm and put a MHA assessment in train. This was the afternoon of Maundy Thursday, with the Easter weekend beginning. ASW3 liaised with ASW4, the out of hours ASW, and between them they made application for a warrant under Section 135 (1) MHA. Pursuant to that application, there was liaison with a Section 12 approved doctor and, in the early hours of 18 April, the police and ASW4 broke into Garry Taylor's flat, but he was not there. The flat was secured with new locks and, the warrant having been executed, Mrs Taylor was informed of what had occurred, given the keys for the new locks and asked to contact the police if Garry Taylor should appear.

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On 20 April (Easter Sunday) Mrs Taylor again rang social services asking if the warrant was still outstanding but nothing further occurred, despite discussion with the duty ASW.

### **Commentary**

*This was a major missed opportunity and demonstrated a number of failures by the services. There were clear failures of communication within social services and between social services and the police. Had there been proper communication, then a MHA assessment should have been arranged and could have taken place in liaison with the police officers who attended at Garry Taylor's flat rather than his being seen and simply allowed to go.*

*There is no evidence of any documentation in relation to the first request for a MHA assessment and no documentary evidence of any handing on of information from ASW2 to the next ASW on duty. A second assessment was begun with documentation correctly completed. When Garry Taylor was not located on the execution of the Section 135 warrant no further steps were taken. There was no proper follow up with the nearest relative to pass on the proposals to attempt to complete the assessment, future plans for Garry Taylor's care or to give an explanation in writing of the reasons for his not being detained, as required by the MHA.*

### **21 APRIL 2003 – 2 MAY 2003**

On 22 April AOT2 and AOT3 called at Mrs Taylor's house and found Garry Taylor there. Mrs Taylor was very angry towards him in relation to his behaviour but left after a short while. There was a 45 minute discussion with him during which he admitted that he was not taking his medication and expressed his suspicions of Girlfriend 2 having an affair.

On 24 April Mrs Taylor contacted social services and was rung back by AOT3. She expressed grave concerns about Garry Taylor (who had expressed the wish to "wrap the house in sellotape"), said that he needed sectioning and that she intended to take him up to Cherry Knowle the next Monday when she hoped that he would be admitted. AOT3 explained the formalities of a MHA assessment and was told by Mrs Taylor that that was no good as Garry Taylor was very clever at covering up his illness and that people would need to take account of the family's story. AOT3 said that he would attempt to get an urgent appointment with Consultant 4 and Mrs Taylor said that she would try to get Garry Taylor to attend. Immediately following this AOT3

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contacted Consultant 4's secretary and, after some further phone calls, an outpatient appointment was arranged for the next day.

On 25 April Garry Taylor attended an outpatient appointment with Consultant 4 at which AOT3, Mrs Taylor and Brother 1 were present. Garry Taylor said that he was very suspicious of people, especially Girlfriend 2, that he was living on a knife-edge, had had arguments with Girlfriend 2 and had hit her. Mrs Taylor reported that he was taking illicit drugs which he did not believe affected him and Brother 1 reported that he had not taken any medication for a few months. It is recorded in Consultant 4's notes that Brother 1 was recording the interview. It was clear that Garry Taylor was reluctant to take any medication. At the end of the appointment Consultant 4 prescribed quetiapine (an alternative anti-psychotic) and arranged for review of Garry Taylor on 3 June.

On 28 April Mrs Taylor rang AOT1 telling her that she thought that Garry Taylor could be persuaded to be admitted to hospital. AOT1 contacted Consultant 4's secretary informing her of this. The secretary spoke to CN1 (a charge nurse at Cherry Knowle) and was informed of the position in relation to beds and that, if Garry Taylor needed to be admitted, something would be sorted out. AOT1 left her mobile telephone number, which was noted by Consultant 4's secretary. The secretary then had a discussion with Consultant 4 who said that he was not desperate to have Garry Taylor admitted, and that he would rather give the medication a go. The secretary passed on this information to AOT1. The day's events had been relayed to Mrs Taylor at various stages and she was given the number of the Crisis Resolution Team. That night Mrs Taylor took Garry Taylor to Cherry Knowle and sought to have him admitted. He was not keen to be admitted and after discussion with CN1, who read the notes on his medical file, he was sent away.

On 29 April AOT1 was contacted by the CN1 and told of the night's events and also that the ward was apparently bed blocked. There was telephone contact between AOT1 and Mrs Taylor and late in the day Mrs Taylor told AOT1 that Garry Taylor had had no sleep for three days and had been unhappy with his new medication, which made him feel "heavy". She wanted a note absolving her of all responsibility. AOT1 arranged to meet Garry Taylor the next day. All of this was passed on to Consultant 4's secretary and noted.

On 30 April AOT1 and AOT2 visited Garry Taylor at his home. He was very animated and visibly on edge, but bright in mood. He was guarded throughout the visit but claimed to have plans for the future, although would not say what they were, or allow questions about them. He claimed not to be abusing illicit drugs, but the team were not convinced given his presentation, and AOT1 thought that he might be taking amphetamine. Mrs Taylor phoned AOT1 and said that Garry Taylor was collecting things, such as tea bags and drawing pins and that she was going to try to get some help elsewhere. She is recorded as being "very cryptic" and AOT1 could not phone her back as Garry Taylor was going to her house after the visit.

The 1 May was a day of considerable activity. Mrs Taylor rang AOT1 voicing concerns that Garry Taylor was "wanting to get a gun" and that she had "found something in his car" that it was "horrible" but she would not say what it was (it has since been

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disclosed by Mrs Taylor that this was an axe). AOT1 communicated this to AOT2 and to Consultant 4's secretary. Following a discussion between Consultant 4 and his secretary as to the week's events Consultant 4 decided that Garry Taylor would be admitted. He decided that the nurses would have to look closely at him to make sure that he had no gun and that, if he was not willing to be admitted, then Mrs Taylor should be told to tell the police about her suspicions. After a series of phone calls AOT2 rang Mrs Taylor at 1 pm and was told that Mrs Taylor did not think that Garry Taylor would go into hospital voluntarily but that she did not want to contact the police yet. At 3 30 pm SN5, from East Willows, rang AOT2 expressing concerns in relation to Garry Taylor turning up with a gun and with no police involvement. Following discussions with Manager 1, AOT2 rang Mrs Taylor to discuss the public safety issues. Mrs Taylor became upset, as she did not want the police involved as she felt that Garry Taylor needed hospital, not prison. Following further telephone calls in which the police were informed of the situation, and following discussions between SN5 and Consultant 4, the latter decided that Garry Taylor would not now be admitted. Later in the day Garry Taylor spoke to AOT2 and asked, as he was willing to go into hospital but there were "no beds", what was to be done about it? He further stated that Consultant 4 "obviously does not think that I am unwell" and he therefore no longer wished to have any contact with the AOT. AOT2 asked again if Garry Taylor could be admitted but was informed by Consultant 4's secretary that he was not to be admitted. Mrs Taylor was very upset by the day's events and said that she would be contacting her MP.

On 2 May Consultant 4 returned a telephone call from Mrs Taylor at 11 25 am and was told that Garry Taylor was not taking any medication, that the police had spoken to him on the telephone yesterday, that she thought that he was taking drugs but had not found a weapon the previous day and that it had been a hat and gloves in the car. She was continuing to express her concerns about him.

### **Commentary**

*This period, following immediately after the failures of the preceding episodes, contained further significant missed opportunities and laid the seeds of other problems in the future. The explanation of the formalities of a MHA assessment were of little comfort to Mrs Taylor when two such requests in the preceding week had resulted in no assessment being carried out and social services having failed properly to liaise with her.*

*The review at the outpatient appointment on 25 April resulted only in a change of medication without dealing fully with all that had gone on in the preceding weeks. Had there been reference back to the risk assessment by Consultant 2 at the end of Garry Taylor's time in the Regional Secure Unit, or even to the care plan of October 2002, it would have been realised that all of*

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*the factors rendering him a high risk namely: non-compliance with medication; paranoia in relation to his girlfriend; abnormal thinking and possible drug abuse, were all present. This ought to have resulted, at the least, in a formal review of his CPA care plan.*

*Although it is by no means certain that Garry Taylor would willingly have gone into hospital on 28 April the panel were somewhat concerned that the approach of Consultant 4 was to discourage admission, in the light of all that had occurred in the recent past.*

*The 1 May represented another significant missed opportunity, showed failures of communication and liaison and a change of attitude to admission, which the panel found surprising and unjustified. In the light of all that had gone on in the recent past, the decision in the early part of the day that Garry Taylor should be admitted was appropriate. Thereafter the management of the proposed admission left much to be desired. There was no satisfactory liaison with the police to facilitate the admission and check that Garry Taylor did not in fact have a weapon. The understandable concerns of the nursing staff on the ward were dealt with not by taking steps to ensure the safety of all concerned and the admission of Garry Taylor to hospital but simply by a reversal of the earlier decision to admit.*

*There was a failure properly to manage this incident and develop a comprehensive plan to deal with the situation. The panel were surprised that this was dealt with by telephone communication with Consultant 4, who was in London, rather than by delegation to the consultant assigned to cover for Consultant 4 in his absence.*

*This episode further undermined the faith of Garry Taylor's family in the services and reinforced Garry Taylor's belief that he was well and had no need of involvement with the mental health services.*

*The family maintain that at around this time they found and disposed of a number of weapons hidden in Garry Taylor's house, including a wrench, knife and gun. They are adamant that they communicated this to members of the AOT although there is no reference to this in the records.*

### 2 MAY – 21 AUGUST 2003

On 8 May AOT1 rang Consultant 4's secretary asking if Consultant 4 wished to meet up prior to an arranged outpatient appointment for Garry Taylor on 6 June. She explained that the family were livid about what had occurred at the beginning of May and that AOT1 felt that it was best to give them some space. AOT1 said that she felt that Garry Taylor was "a ticking time bomb" and wondered how he had got into their service and that she felt that he would be better handled by forensic psychiatry. Consultant 4 did not sign this note until 20 May.

On 19 May AOT1 rang Consultant 4's secretary leaving a message that Mrs Taylor had been on the phone to her and was now minimizing everything that she had previously said about the gun, that Garry Taylor had thought that she was trying to poison him but did not think so now. His sleep was reported to be not good and he was said to be taking olanzapine sporadically, but was due to run out. Mrs Taylor wanted him to have depot injections and to be told that he must have the injections or else go into hospital. She had been to see her MP and if she did not get any satisfaction would be taking it further. AOT1 wanted to know what Consultant 4 wished to do about medication as Garry Taylor was not willing to take the quetiapine, which had been prescribed on the last occasion, and would Consultant 4 be willing to prescribe olanzapine at a reduced dose. This note was also seen by Consultant 4 on 20 May and on that day a reduced dose of 5 mg Olanzapine per night was prescribed.

On 21 May AOT1 and AOT2 visited Garry Taylor at his mother's home. He was asleep on the sofa and appeared to have had a lot to drink, although insisted that it was "just a couple of pints". He said that everything was "brilliant" and that there was nothing wrong with him and that the medication did nothing for him. He had had a pain in his chest and had been for an ECG, which demonstrated no problems, but he said that the doctor had said that his medication might be causing the pain, which also confirmed that the medication was doing nothing for him. He was not mixing well with other people. On the same day, prior to the home visit, AOT1 was contacted back by the local MP's office and informed that Mrs Taylor had been there asking how to get Garry Taylor sectioned and AOT1 left a message for Consultant 4 informing him about the exchanges. Manager 1 was to liaise with the MP's office and inform them of the protocol in relation to procedures for sectioning. This note was initialled on 22 May.

On 22 May AOT1 left a message with Consultant 4's secretary about the previous day's home visit and informing him that Garry Taylor had indicated that he would not be attending the appointment with Consultant 4 on 3 June, although AOT1 was to speak to him before that date.

On 23 May AOT1 left a message for Consultant 4 that Mrs Taylor had called and told her that she had thrown Garry Taylor out of the house but that he had not taken his medication with him. This was because of his irritability and bad moods. He had been annoyed that AOT1 had called to see him on 21 May. Consultant 4 saw this note on the same day.

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On 28 May Mrs Taylor rang Manager 1 complaining about Garry Taylor not taking his medication and informing her that she was putting it in his cups of tea and was still concerned about his mental health. This was passed to AOT2 who rang Mrs Taylor and arranged a visit for the next day. Mrs Taylor said that Garry Taylor was still having stupid thoughts about Girlfriend 2 having affairs. She repeated that she was putting his medication in his tea and that he would not be happy about a visit the next day and she would not tell him about it. She reported that he had recently been charged with drink driving and was due to appear in court.

On 29 May Mrs Taylor rang AOT2 to stop her coming for the home visit as Garry Taylor had gone out for a drink. She said that she would like more medication as she thought that he would realise that she had been putting the medication in his tea. A visit was arranged for the next day.

On 30 May AOT1 and AOT2 visited as arranged but at first Garry Taylor was not there. Mrs Taylor was complaining that the tablets were not working and that she was not being listened to. Garry Taylor arrived home, having been out drinking, he said that AOT1 and AOT2 were "pests", that there was nothing wrong with him, he did not need any medication and that "he was being used as a guinea pig" in relation to medication. AOT1 and AOT2 left when he became quite agitated. It was agreed to make contact about the forthcoming outpatient appointment with Consultant 4. This visit was reported to Consultant 4's secretary who noted that Mrs Taylor was quite angry about Garry Taylor not being admitted to hospital previously. The secretary noted the covert medication of Garry Taylor and Consultant 4 saw this entry on the same day.

On 3 June Garry Taylor attended an outpatient appointment with Consultant 4. Mrs Taylor, Brother 1, AOT1 and AOT2 were also in attendance. Garry Taylor claimed that he was "OK" and said that quetiapine had made "his head feel heavy" and that he had stopped taking it. He said that his mood was low and that he felt that he needed a lift. Mrs Taylor and Brother 1 disagreed saying that he had been better on other medication and both said that they felt that he would be much better on depot injections. At the end of the appointment he was prescribed 75 mg of venlafaxine (an anti-depressant) daily.

On 9 June Mrs Taylor rang Consultant 4's secretary and, when told that Consultant 4 was on leave that week, said "Oh God, no. What am I going to do?" She said that Garry Taylor was taking the tablets that Consultant 4 had prescribed but that they were keeping him up all night. There was then a series of phone calls between AOT1, Mrs Taylor and Consultant 4's secretary at the end of which the secretary noted "NB very difficult to make sense of what mother says".

On 11 June AOT1 phoned Consultant 4's secretary reporting that Mrs Taylor had been in touch and was quite upset and distressed. She reported that Garry Taylor was not sleeping and having "dreadful thoughts, too dreadful to tell AOT1". He was reciting the alphabet and had had no sleep for the last two nights. Mrs Taylor wanted him locking up "or she would do something to him". AOT1 was told that she could

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offer an appointment with Consultant 4 for the next Monday (16 June). There was further contact between AOT1 and Mrs Taylor that was reported back to Consultant 4's secretary. Mrs Taylor was again reporting that he was not sleeping, reciting the first nine letters of the alphabet and talking and singing through the night. AOT1 had not offered an appointment for the next Monday as she said that things could be entirely different by the end of the week and that nothing that was offered was good enough for Mrs Taylor. AOT1 said that she would ring Mrs Taylor back the next day.

On 13 June there was a further telephone call from AOT1 to Consultant 4's secretary. AOT1 reported that, having spoken to Mrs Taylor the previous day, she had met her and Garry Taylor that afternoon. Garry Taylor said that there was nothing wrong with him and he refused an earlier appointment with Consultant 4 on that basis. He did not want any medication. AOT1 also reported that Mrs Taylor was so over involved with him that it was unbelievable and that she did not listen to a word that AOT1 said.

On 16 June AOT1 again phoned the secretary reporting that following a phone call from Mrs Taylor asking for more olanzapine she and AOT2 had visited and seen Garry Taylor for about an hour. He had made them a cup of coffee and reported that he was "jerking up" with pains in his chest, which he attributed to the olanzapine. He was taking this medication but the dosage and regularity were unclear.

A later entry by Consultant 4's secretary dated 13 June would seem to have in fact been made on either 16 or 17 June. She reported two telephone calls from Mrs Taylor in the first of which Mrs Taylor said "she was not putting up with this". Later AOT1 reported that Mrs Taylor was complaining that Garry Taylor had been listening to music and when the word "manchild" came up he did not know the meaning of it and so had looked it up in the dictionary and then phoned the university. AOT1 said that she did not know what Mrs Taylor wanted and that she negated everything that AOT1 said. She had put Garry Taylor on alert with the crisis team.

All of the entries relating to the period from 9 June to the last entry were seen and initialled by Consultant 4 on 17 June.

On 20 June Mrs Taylor phoned AOT1 concerned that Garry Taylor was pacing around, washing his hands, flushing the toilet, tidying the mantelpiece and then repeating what he had done. There was also concern that he had continuing chest pains and a further ECG was arranged for him the next week.

At about this time Consultant 4 received a request from a firm of solicitors, acting for Garry Taylor, for a psychiatric report on him, relating to a drink driving charge. He replied on 25 June saying that commitments would prevent his preparing such a report before 25 July.

On 2 July Mrs Taylor rang AOT1 and told her that Garry Taylor was not too bad although he had been having terrible thoughts previously. She believed that he was due at court and that could result in his going to prison, but she wanted him in hospital. She believed that he was suspicious of her putting medication in his tea. She had thrown him out of the house. This was reported by AOT1 to Consultant 4's secretary.

## INTRODUCTION

On 4 July there was a further phone call from AOT1 to Consultant 4's secretary reporting that Mrs Taylor had phoned and wanted more medication. AOT1 had talked to Garry Taylor on the phone but he had refused to allow her and AOT2 to visit at that time. He agreed to a visit on 9 July. AOT1 was to deliver medication to Mrs Taylor on 7 July. AOT1 said that she was not prepared to walk into a situation set up by Mrs Taylor, involving her meeting Garry Taylor, which had previously resulted in her receiving a barrage of abuse from him.

On 9 July AOT1 and AOT2 saw Garry Taylor in the Chesters (a local public house) at which time he had clearly had quite a deal to drink. They were with him for about 1½ hrs during which time he attempted to persuade them to go out for a drink socially with him. He was only willing to see them as he was obliged to and was not taking any medication as he was of the view that there was nothing wrong with him. He was not intending to see Consultant 4. This was reported to Consultant 4's secretary.

On 14 July Garry Taylor failed to attend an outpatient appointment with Consultant 4. Mrs Taylor did attend as did AOT1. Mrs Taylor said that Garry Taylor had been better on venlafaxine and asked Consultant 4 to prescribe those at a lower dosage. She informed Consultant 4 that she had been giving Garry Taylor olanzapine in his tea on a daily basis. She was advised against this and told that Consultant 4 could not prescribe for Garry Taylor without seeing him. Nonetheless, a further increased prescription of 10 mgs per night of olanzapine was provided.

On 16 July the solicitors, wrote to Consultant 4 asking for a report about the possibility of Garry Taylor having a psychiatric defence to a charge of drink driving. Ultimately this request was passed on to Consultant 7 at the Regional Secure Unit.

On 17 July AOT1 rang Mrs Taylor asking her to attend the office to collect medication for Garry Taylor the next day. She did so and was unhappy that she was still being left to care for him; she became tearful and left the office. At this time Garry Taylor was referred for an ECG because of his complaints of chest pains and it proved to be normal, although he claimed that he had been told by a doctor in A & E that the pains could result from his medication.

On 5 August he rang AOT1 complaining of headaches and was advised to visit his GP. On 7 August AOT1 was informed by Consultant 4's secretary that the ECG was normal and reported that to Mrs Taylor. AOT1 arranged to see Garry Taylor on 8 August prior to her going on leave and did so. There is no note of what occurred on that occasion.

On Friday 22 August Mrs Taylor rang and spoke to SW2 informing him that Garry Taylor had been speaking to Brother 1 and had informed him that he intended to murder a man who had "cut him with a knife" several years earlier. Garry Taylor had been leaving the house in the middle of the night and wandering the streets. She had been slipping venlafaxine into his tea, which had caused this behaviour to subside. She was told that as Garry Taylor was refusing to see Consultant 4 she should see her GP. Consultant 4 was informed of this and said that that was appropriate. Later there was another call from Mrs Taylor in which she said that if nothing was done she would go to the newspapers and television. She repeated

that he was leaving the house in the middle of the night and intended to murder his previous assailant. Mrs Taylor was told to inform the police of these concerns.

### **Commentary**

*There were no incidents of great moment during this period but the picture continued as before and none of the problems had disappeared. The period is characterised by a number of requests from Mrs Taylor, either explicitly or implicitly, for a MHA assessment. The panel was concerned that the involvement of the MP's office merely resulted in advice being given to Mrs Taylor as to what the formalities for a nearest relative's request for an assessment were rather than in one being carried out.*

*Covert medication of Garry Taylor continued throughout this period and this had now become long-term and was known about by all of those involved in his care. Whilst token advice was given to Mrs Taylor that she should not be doing this, it was wholly unrealistic to expect her not to do so when she was so concerned about her son and witnessing his behaviour day to day. The panel felt that the reality was that the professionals colluded with this by continuing to prescribe and supply medication. This alone was a serious failure in that Garry Taylor was denied the protection of the MHA and was arguably the subject of criminal conduct. The knowledge of this behaviour ought to have triggered a Multi Agency Public Protection for Vulnerable Adults (MAPPVA) strategy discussion. The panel regarded this covert medication as clearly falling within the definition of physical abuse within the MAPPVA policy. This collusion with covert administration by those responsible for Garry Taylor's care could well be construed as professional misconduct. This practice was potentially dangerous as there was little or no control over the dose and it is surprising that it continued following the reported opinion from the A & E doctor that his chest pain could have been linked to his medication. Even ignoring the question of covert medication, the panel struggled to understand the logic of the medication regime during this period.*

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*The risk factors of alcohol, non-compliance, abnormal thinking, overt threats of violence to others and paranoia continued. Yet again there was no review of the care plan and there is no evidence of proactive treatment by the care team.*

### **22 AUGUST 2003 – 1 SEPTEMBER 2003**

On 25 August (Bank Holiday Monday) Brother 1 telephoned CRT1 informing her that Garry Taylor had attempted to stab him and requesting a MHA assessment. CRT1 informed the police of this call and they responded by creating an incident log and contacting the family. Brother 1 was spoken to and said that he did not wish to make a complaint and that Garry Taylor had long term mental health problems which were not being addressed by the mental health team and that the family wanted him sectioned and asked the police to make them aware of this.

On 26 August Brother 1 contacted AOT2 reporting the incident the day before informing her of what had happened and asking for a MHA assessment. AOT2 had contact with CRT1, Mrs Taylor and the police and completed the paperwork for a MHA assessment. A little later Brother 1 himself contacted the police again and asked that an officer attend in relation to the incident the day before. The upshot of this was that Garry Taylor was arrested at 2 25 pm, but not before he had been CS gassed and had fallen through a shop window, during the struggle. Several police officers were involved in the arrest. Once he was arrested, he was first of all seen at 3 40 pm by FME2 who noted that he had a history of paranoid schizophrenia but refused to take his medication. He was to be psychiatrically assessed. At 7 pm he was seen by FME2, Consultant 6 (the duty consultant, this being an NHS holiday) and ASW4. It proved impossible properly to assess him, as he had to be interviewed through the cell hatch owing to issues of personal safety and the residual CS gas. He refused to engage and the view was formed that it was not possible to say, on what was seen, that he warranted an application for his detention under the MHA. It is specifically recorded in the Social Circumstances Report that a further assessment was envisaged the next day by staff from the Regional Secure Unit. Consultant 6 contacted the Regional Secure Unit in order to attempt to have them become involved in such an assessment. He spoke to a forensic nurse (FN1), the nurse in charge, but could not speak to a consultant forensic psychiatrist. Consultant 6 believed, at the end of that conversation, that a consultant forensic psychiatrist from the Regional Secure Unit could become involved in an assessment the next day. He agreed with both the police and the Regional Secure Unit staff that Garry Taylor should be detained overnight and he hoped that the police might be able to expedite a forensic assessment.

The next morning there was a good deal of communication between various different parties. The custody officer spoke to staff at the Regional Secure Unit and was informed that the Regional Secure Unit would not become directly involved in the assessment of Garry Taylor. Consultant 6 first of all left a message for Consultant 4 informing him of the events of the night and his expectation that the Regional Secure

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Unit would assess him that day. Later he spoke to Consultant 4 who noted on his secretary's note pad "police will chase forensics". ASW3 who came on duty that morning also spoke to Consultant 4 and was informed by him that he believed that the Regional Secure Unit were to arrange a forensic assessment. ASW3 thought that there might have been a breakdown in communications and rang the police back, to be informed that the Regional Secure Unit would not get involved. He therefore rang Consultant 4 back informing him of this but was told by Consultant 4 that he believed that procedures were in place for the Regional Secure Unit to respond. ASW3 therefore rang the Regional Secure Unit directly to be told that Consultant 2 (who had been Garry Taylor's consultant in 1995 – 1996) was not available until later that day. ASW3 asked to be contacted by FN2, a senior nurse from the Regional Secure Unit, and in due course was telephoned by him. It was made clear that the Regional Secure Unit would not become involved in the assessment process earlier than five days after an urgent referral. The advice from the Regional Secure Unit was that Consultant 4 needed to see Garry Taylor to decide whether or not he should be detained. FN2 had also telephoned the police informing them of the position; that a FME should attend and that Consultant 4 should respond. ASW3 spoke to the police and was told that they had spoken to FME3, who had agreed to speak to Consultant 4. ASW3 informed them that he was standing by. At that time he was in the Hetton office. FME3 attended the police station and saw Garry Taylor who refused to speak to him, but appeared to understand what he was saying. FME3 was aware of that fact that he had a history of mental illness and that he did not cooperate with treatment. He spoke to Consultant 6 and concluded, on the basis of his conversations with Consultant 6 and Garry Taylor's appearance, that he did not appear unwell at that time and that it was reasonable for the police to interview him. By this time Brother 1 had made it clear to the police that he did not wish to make a complaint and that he would not press any charge so that, after Garry Taylor had been interviewed, he was released by the police with no further action to be taken. All of this information was passed to AOT1 and there was liaison between her and ASW3.

On 28 August AOT1 left a message for Consultant 4 on the basis that the day before it seemed to have gone from having a forensic assessment to Garry Taylor simply being released. It was noted by Consultant 4's secretary that: "the family are tolerating a huge amount of violence from him and it's escalating" AOT1 was not sure whether this was to do with his mental illness or with drug taking. It was also noted by AOT1 that he had an appointment for the psychiatric report, which had been requested by his solicitors, at the Regional Secure Unit on 1 September. The next day the secretary contacted AOT1 saying that Garry Taylor's notes had been sent to the Regional Secure Unit.

On 1 September Garry Taylor attended at the Regional Secure Unit with his mother. They were interviewed by Consultant 7 who had access to the psychiatrist's records from Cherry Knowle, but not the multi-disciplinary records, as well as the papers relating to the charge to which Garry Taylor was subject; which was an allegation of drink driving on 14 December 2002. The report had been requested to make an enquiry as to whether he might have a defence to the charge based on duress of

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circumstances and his psychiatric condition. Following the interview Consultant 7 spoke to Consultant 4 who agreed that Garry Taylor would be provided with a bed at Cherry Knowle, should the court make an order under Section 35 MHA, as was recommended in Consultant 7's report. The report expressed the opinion that Garry Taylor's mental health had deteriorated over the preceding year, although not to the extent that he had required detention under the MHA, and that his behaviour was suggestive of a re-emergence of the psychotic features similar to those prior to his admission to the Regional Secure Unit in 1995. So far as the purpose for which the report had been commissioned was concerned, however, it concluded that his mental condition had no relevance to his behaviour leading to the charge.

### **Commentary**

*This period, and in particular the events of 26 – 28 August, represented yet another missed opportunity of great significance. The desperation of the family and their repeated efforts to have Garry Taylor either admitted to hospital or, at the very least, made subject to a treatment regime which was effective, culminated in the pretence (as it was later accepted to be) that Garry Taylor had stabbed his brother.*

*Although a MHA assessment process ought to have begun on 25 August it did not do so until 26 August following a second request for an assessment from Brother 1. The process started satisfactorily but began to go wrong with the attempt to liaise with forensic services. Whilst it was reasonable to adjourn the assessment of Garry Taylor, when it was not possible properly to assess him, the system fell down with a failure to have an assessment the next day by someone who had full knowledge of Garry Taylor and his recent past.*

*On the morning of 27 August the panel feels that Consultant 4, as Garry Taylor's responsible consultant and the only person involved who had full knowledge of the history, ought to have taken control of the situation and ensured that he was directly involved in an assessment. Furthermore given that it was known by mental health services in Sunderland that forensic services would not become involved in an assessment other than on a five working day time scale; it ought to have been known by his consultant that the best means of facilitating such an assessment would have been by Garry Taylor being an inpatient in Cherry Knowle, if necessary pursuant to Section 2 rather than Section 3 of the MHA. The panel was*

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*surprised that Consultant 4 did not make it his business to go to the police station and regard it as a matter of regret that neither ASW3 nor FME3 insisted that he did so. The hoped for full assessment by forensic services did not take place and the situation ended up with an assessment by a FME who had no prior knowledge of Garry Taylor assessing him alone and his working on the basis that this was an assessment to see if he was fit to be interviewed.*

*Had there been earlier full and effective liaison with the police (for example in the context of a Multi Agency Public Protection Arrangements (MAPPA) or MAPPVA meeting) the panel feel confident that Garry Taylor could have been detained, even in the absence of a complaint from Brother 1, for a longer period in order to allow more time for a full assessment by those who knew of his recent history.*

*The coincidence of the request for a psychiatric report from the forensic services for the purposes of the drink driving charge was utilised by Consultant 4 as a means of obtaining a forensic assessment. However, there was a total failure to communicate the problems that Consultant 4 wished a forensic opinion to address and any of the details of Garry Taylor's recent behaviour to Consultant 7 or to liaise fully with him. It is also unfortunate that Consultant 7 did not obtain the permission of Garry Taylor to forward a copy of his report directly to Consultant 4 or, failing that, write to him outlining his findings in order that those risks and findings were communicated to Consultant 4.*

*The panel were hindered in their consideration of this period for some time by the absence of the social circumstances report from the case notes but eventually were assisted by a copy being provided by ASW4 who had retained a copy.*

### **2 SEPTEMBER 2003 – 17 JANUARY 2004**

On 2 September AOT1 attempted to ring Garry Taylor, his father answered the phone and informed her that he was still in bed and that Mrs Taylor was out. She rang back the next day and spoke to Garry Taylor who gave monosyllabic answers and refused to see her; he agreed that she could telephone the next week. She left messages for Manager 1 and Consultant 4. At this stage the medical notes relating to Garry Taylor were at the Regional Secure Unit and a post-it note to that effect was appended to the typewritten notes made by Consultant 4's secretary, dated 5 September.

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On 11 September AOT1 met Mrs Taylor at the Sunderland Royal Hospital, following a telephone call, in order to deliver medication for Garry Taylor. Mrs Taylor was complaining that she believed that Consultant 4 had not treated Garry Taylor appropriately. She believed that he should have gone to the police station when Garry Taylor was detained and she was still concerned about Garry Taylor's mental health. She was considering contacting the media in the form of the television and local press. AOT1 reassured her about Consultant 4, but she took little notice. AOT1 left messages for Manager 1 and Consultant 4 in relation to the conversation.

On 16 September and 25 September there was contact between AOT1, Garry Taylor and Mrs Taylor in relation to his computer. Mrs Taylor rang AOT1 on 26 September asking for Garry Taylor's medication.

On 29 September Mrs Taylor rang the Patient Advice and Liaison Service (PALS) and spoke to PALS1, having been referred to her by the PALS office at Sunderland District General Hospital, and informed her that she was unhappy at Garry Taylor's treatment by Consultant 4, that she was putting his medication in his tea and was worried that he would get out of control. PALS1 arranged to meet Mrs Taylor on Wednesday 1 October and then rang AOT1 to let her know of the contact. The next day there was further contact between AOT1 and Mrs Taylor.

On 1 October Mrs Taylor met with PALS1 for approximately three hours and informed her of her concerns about Garry Taylor's treatment and mental health and her worries about his behaviour. Following this PALS1 wrote to Consultant 4 informing him of the contact, telling him that the family felt that they could not cope any longer with the current situation and suggesting that Mrs Taylor's concerns should be discussed with him. She said in that letter that AOT1 was aware of its contents. Later that day Mrs Taylor rang PALS1 again, telling her that Garry Taylor had bought a large knife and she was concerned as to his intentions. PALS1 passed this information on to AOT1 who asked that PALS contact the police. PALS1 felt that that was inappropriate and contacted Manager 2, the general manager with responsibility for inpatient services, who said that he would deal with the situation. Both AOT1 and Mrs Taylor were informed of his involvement. It is not clear to the panel whether this was acted upon. There is no documentary evidence to that effect.

There is a little confusion as to what occurred on 2 October. Early in the morning AOT1 rang Mrs Taylor and arranged for her to attend the office at John Street in the afternoon to collect Garry Taylor's medication. She failed to attend that appointment and was phoned at her home by CRT2. He called at the house and delivered medication to Mr Taylor who said that the family was doing the best that it could with Garry Taylor but that it was difficult. Mrs Taylor was out at that time. At some stage on 2 October there was a telephone conversation between Mrs Taylor and PALS1 in which Mrs Taylor reported that Garry Taylor had been put out of the house, as the family could no longer cope.

On 3 October Mrs Taylor rang PALS1 saying that Garry Taylor had been without medication for days and enquiring what was happening. Later she rang back asking what had happened to the forensic report of four weeks ago. Later again Manager 1 rang PALS1, following the events of 1 October, and informed her that the family had

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been advised to contact the police when they were frightened, that there had been no change in Garry Taylor's dangerousness and that CRT2 had called at the house the day before and delivered medication and been told by Mr Taylor that he did not have any concerns.

There is no corresponding entry relating to this in the multi disciplinary records so that it seems that that information may not have got to them until 6 October when PALS1 rang AOT1 asking if anyone had been in touch with Mrs Taylor and informing her of Garry Taylor being put out of the house.

The telephone call from PALS1 prompted AOT1 to ring Mrs Taylor who informed her that she wanted someone to collect the medication, as she was no longer giving it to Garry Taylor. Later in the afternoon AOT1 and AOT2 called at Mrs Taylor's home and were informed by her that Garry Taylor had not eaten anything but a packet of crisps for some time; she wanted him locked up as she believed that he was wanting to kill someone who had "cut him" 10 years previously. This prompted AOT1 and AOT2 to call at Garry Taylor's home and, as he was not in, they left a note arranging to meet him at the Chester's the next day.

On 7 October AOT1 left a message for Consultant 4 informing him of the events of the past few days and, after Garry Taylor had failed to attend the arranged appointment, a further message was left for Consultant 4 enquiring if he had any thoughts as to future plans for Garry Taylor. AOT1 had a discussion with Manager 1 about the situation following which Manager 1 contacted PALS1 and suggested that the involvement of PALS was causing some confusion as messages which should be going to the AOT were going to PALS and suggesting that PALS1 should tell Mrs Taylor to direct queries to the AOT.

On 15 October AOT1 and AOT2 met Garry Taylor for an hour and he accepted some medication to help him sleep. His conversation was superficial and he maintained eye contact to a degree that was uncomfortable for AOT1 and AOT2. This meeting is not recorded in any notes but was referred to in a subsequent letter to Consultant 4. On 17 October a representative of PALS made a telephone call to Mrs Taylor.

On 20 October Garry Taylor appeared at Sunderland Magistrates Court and was fined £100 for the offence of excess alcohol and disqualified from driving for three years. The report that had been obtained from Consultant 7 was not relied upon at court and the court made no order in relation to any treatment or mental health assessment.

On 23 October AOT1 wrote a letter to Consultant 4 in which she set out some of the history of Garry Taylor's case since the August Bank Holiday weekend and her and Mrs Taylor's concerns and suggesting a professional meeting to discuss future management of Garry Taylor's case. This letter was copied to Manager 1 and had, in fact, been written in conjunction with her.

On 30 October Consultant 4 noted in the medical notes that these had been retrieved from medical records the day before, after he had realised that they were "missing". The note referred to the forensic report and the fact that he had agreed to provide a

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bed for a Section 35 MHA assessment. It concluded with a reference to the need for an urgent appointment although this was not arranged until the 25 November.

On 12 November Mrs Taylor telephoned AOT2, Garry Taylor was with her and apparently believed that he was due to have a meeting with AOT1 at 1 pm that day. She was informed that that was not the case. Mrs Taylor said that she felt that "something needed to be done" and reported that Garry Taylor was "up all night", "laughing at nothing", "pacing around" and "doing other stuff". She was told that an appointment was to be arranged with Consultant 4 and said that that should occur "sooner rather than later". AOT2 spoke to AOT1 who explained that she had arranged to meet Garry Taylor on 18 November and AOT1 suggested that AOT2 speak to Consultant 4's secretary to arrange the outpatient appointment. She did this and was told that his file was on Consultant 4's desk with a note attached saying that an urgent appointment was needed. Consultant 4 was away but was back at work on Monday 17 November and would deal with it then. Mrs Taylor was informed of all of this and expressed her fears that Garry Taylor would not attend the meeting or appointment, but that she would do her best to get him to attend.

On 17 November Consultant 4 phoned Mrs Taylor pursuant to the request that had been passed on from PALS. She was unable to talk to Consultant 4 as Garry Taylor was in the room with her. Mrs Taylor phoned Consultant 4 back and he noted that the court case had been and gone, that Garry Taylor's temper was not so bad now, he regarded olanzapine as a sleeping tablet, that he was "laughing for no reason", not sleeping "but is not as bad now".

On 18 November a meeting took place between AOT1, AOT2 and Garry Taylor at the Chester's. He stayed for less than five minutes, asking for his tablets and then leaving. During this period he would not engage in any conversation and answered questions by nodding, shaking his head or shrugging his shoulders. There is within the records a Worthing Risk Indicator of that date which is precisely the same as that completed on 26 February and contains exactly the same mathematical error.

On 25 November AOT2 was telephoned by Consultant 4's secretary informing her of an outpatient appointment that had been arranged for 28 November, of which Mrs Taylor had been made aware, as had AOT1.

On 28 November that arranged outpatient appointment took place with Garry Taylor, Mrs Taylor, Brother 1, AOT1 and AOT2 in attendance. Garry Taylor was not happy at being there and left after only five minutes. Mrs Taylor was upset, tearful and worried about his well-being. She reported to Consultant 4 that "she got olanzapine into him usually". AOT1 reported that she was seeing him monthly but that he was not happy about it. Brother 1 reported that he was "doing OK". At the end of the appointment Consultant 4 prescribed venlafaxine 75mg daily and Mrs Taylor was asked to monitor his sleep. A further outpatient appointment was arranged for 23 December.

On 1 December Consultant 4 wrote to Consultant 7 asking for a copy of his report and at the same time wrote to Garry Taylor's GP informing him of the change in his medication. That letter demonstrated a misunderstanding about the events of

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August and September in that it stated "I understood that because of an alleged assault on his brother he was going to be admitted to Cherry Knowle Hospital from court. This did not happen, though I do not understand why".

Consultant 7 replied to Consultant 4 on 10 December informing him that he had written to Garry Taylor's solicitors who had commissioned the report asking for their permission to forward a copy to him.

On 16 December AOT1 rang Garry Taylor who refused to see her and informed her that he would not see Consultant 4 either. A message to this effect was left by AOT1 for Consultant 4.

On 23 December Garry Taylor duly failed to keep the outpatient appointment. AOT2 noted that Consultant 4 had explained that he had spoken to Mrs Taylor the previous day who stated that Garry Taylor was better on venlafaxine and olanzapine but that he did not get his medication each day. He was refusing to see the members of the AOT, a fact of which Consultant 4 was aware.

On 24 December Mrs Taylor rang AOT1 saying that Garry Taylor needed medication over the Christmas period and asking that someone contact her. There was an exchange of telephone calls but the medication was not picked up and was left with the CRT for over the Christmas period.

On 30 December AOT1 noted that there had been no contact with the CRT over the Christmas period and left a message for Mrs Taylor to contact her. On 31 December, after a series of telephone calls, AOT1 met Mrs Taylor at the Sunderland Royal Hospital and gave her Garry Taylor's medication. Mrs Taylor was upset and "weepy" and said that he was "OK", "but she was worried that it was the quiet before the storm."

On 13 January 2004 Mrs Taylor attempted to contact AOT1, eventually leaving a message for her on 14 January that she would like Garry Taylor's medication in syrup form as he was getting suspicious.

On 17 January Garry Taylor killed Colin Johnson.

### **Commentary**

*This period was one of continued failures of the care plan and regime as had occurred previously. Whilst there was no single event of major significance until the killing of Colin Johnson the warning signs continued in the same pattern as before.*

*The administration of medication continued covertly and as late as 13 January Mrs Taylor was requesting medication in syrup form, as this would be easier for her to administer. This was by then a period of over nine months during which the care team had been aware of the administration of medicine in this manner and had*

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*taken no steps properly to deal with the situation.*

*There was no formal review of the care plan in any proper setting. The only thing that came close was the outpatient appointment of 28 November. Whilst this was regarded as a CPA review by Consultant 4, the panel regard the holding of CPA reviews in a case of this gravity and complexity in the context of a 20-minute outpatient appointment as inappropriate given the constraints of time, with prior and succeeding appointments. Even if that could be regarded as a formal CPA review, the only result that emerged was a plan for AOT to deliver his medication, to continue to attempt to engage with him and for him to attend a further outpatient appointment on 23 December. By that date that plan had failed totally and yet no action was taken.*

*During this period there was at least one and arguably two further requests for MHA assessments, which were neither recognised as such nor responded to. Under the Sunderland Social Services policy, Mrs Taylor's remarks to the effect that she "wanted him locking up" and that "something needed to be done" ought to have prompted a response from AOT2 as to whether or not an assessment was being requested.*

*A noteworthy event was the turning to PALS by Mrs Taylor to seek assistance. That involvement was positive and the needs of Mrs Taylor were recognised by PALS1 and acted upon appropriately. Far from acting as a catalyst and producing some change of approach and positive action from the care team, the only result was that the involvement of PALS was discouraged on the basis that it was causing confusion. The panel felt that this involvement could have been turned to positive effect whereas it was in fact another missed opportunity.*

*The letters of PALS1 of 1 October and of AOT1 of 23 October ought to have prompted Consultant 4 to respond by calling a full review meeting. Neither letter received a reply nor did the letter of 1 October prompt a search for the medical notes, which had been returned by Consultant 7 and held in medical records since 9 September. The only response was that an "urgent" appointment was noted as being needed on 30 October and such appointment was not arranged until 25 November for three days later on 28 November. There was a further note of urgency on 12 November*

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*when AOT2 spoke to Consultant 4's secretary. The panel question why nothing was done during Consultant 4's absence and why the cover arrangements were not utilised with the matter being referred for consideration to another consultant who was detailed to cover Consultant 4's patients during his regular absences in London.*

*Risk assessment continued to be poor during this period with the error of calculation on the Worthing Risk Assessment and a failure to document, within the multi-disciplinary records, the potential of Garry Taylor having acquired a serrated knife and a failure to communicate this to practitioners due to attend the next day.*

*There was a complete failure of the team to monitor the progress of Garry Taylor within the criminal justice system and it would appear that Consultant 4 believed the recent court appearance and related matters had been in connection with the alleged stabbing of his brother and not the drink driving offence. When Consultant 4 was informed that the case had been disposed of this did not prompt any change of plan which the panel would have expected, given that the intention had been to use that appearance as a vehicle for admitting Garry Taylor to Cherry Knowle for assessment under the Mental Health Act.*

### EVENTS POST KILLING OF COLIN JOHNSON

On Monday 19 January the police attended his flat in order to question Garry Taylor, who was a known associate of Colin Johnson; he made off from the premises before he could be spoken to. Later in the day officers returned to the premises and spoke to him in relation to the killing of Colin Johnson. His attitude was evasive to such an extent that he was arrested on suspicion of the murder of Colin Johnson. He was detained until 23 January and questioned on a number of occasions, during which interviews he refused to answer questions and was released from police custody on that date.

Owing to his arrest and the requirement for an appropriate adult to be present during questioning, the police contacted Manager 1, as a result of which an ASW attended the interviews as the appropriate adult.

On 20 January AOT1 was notified by Manager 1 of the arrest of Garry Taylor. There were a series of telephone calls between Mrs Taylor, AOT2 and AOT1 during which Mrs Taylor said that if Garry Taylor had not done it she wanted him in hospital. This was passed on to Consultant 4 and Manager 1. Garry Taylor was released on bail on 23 January. On 26 January, after speaking to Manager 1, AOT1 contacted Consultant

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4's secretary asking for an urgent outpatient appointment and CPA meeting. Consultant 4 was unavailable until 29 January.

On 27 January there was a discussion between AOT1 and Manager 1 as to Garry Taylor's future management in which the possibility of involving ASW3 in the case was discussed (because of his background in forensic psychiatry). On 29 January AOT1 spoke to Consultant 4 expressing her concerns over Garry Taylor's disengagement from professional services and a professional meeting was arranged for 6 February to which Consultant 4, Manager 1, AOT1, AOT3 and SW4 were to be invited.

On 4 February AOT1 discussed in supervision the issues that needed to be addressed at the professional meeting. The main concerns and areas to be addressed were noted as: "Medication – collusion with mother; pattern of disengagement; history of violence and escalating violence; level of risk and the contributory factors thereto; to check with the police why Garry Taylor had been arrested initially; what his bail conditions were; the responsibilities of the care co-ordinator; the failed MHA assessments and the link to his disengagement; feedback from forensic services; public protection; the team's opinion about the expectation of violence including previous strategies and history in particular the Supervision Register and depot IMI."

On 5 February AOT1 noted that she had attempted to complete a Worthing Risk Indicator and Health of the Nation Outcome Scale (HONOS) but was unable to do so accurately and completely as she had not seen Garry Taylor since the outpatient appointment on 28 November the previous year. In fact, within the records, the Risk Indicator is completed and is precisely the same as those on 26 February and 18 November 2003, with the same mathematical error. The HONOS is not fully completed.

The professional meeting took place on 6 February with Consultant 4, Manager 1, AOT1 and AOT3 present. At that meeting Garry Taylor's history of violence was discussed and it was noted that perhaps the team did not know the extent of his violent history. A plan for his future management was formulated in which the options of continuing with the then current regime or discharging him from care were considered not to be possibilities. A Public Protection meeting was considered, as was the use of the MHA to assess him for detention and also referral for a specialist forensic opinion. At this meeting Manager 1 identified missed opportunities of failed MHA assessments. After discussions it was agreed that a referral to the new community forensic team for assessment was the most appropriate course and Consultant 4 started the process by contacting the Regional Secure Unit.

On Sunday 8 February Mrs Taylor contacted social services requesting a MHA assessment. The appropriate documentation was completed and an application made for a Section 135 (1) MHA warrant. This was obtained and executed and Garry Taylor was taken from his home to Gillbridge Police Station in the early hours of 9 February. At 2 15 pm he was seen at the police station by Consultant 4, FME2 and ASW1. It was noted by Consultant 4 that the circumstances of the alleged complaint, with which the request for the assessment had originated, had possibly been engineered by the family in order to get Garry Taylor assessed. Garry

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Taylor replied “No Comment” to all questions and refused to engage at all with the examination. It was difficult to assess him properly owing to his lack of any response. Consultant 4 concluded that it was difficult to justify his detention under the MHA as there were no “evident” symptoms of mental illness. The formal conclusion of the assessment was that the grounds for detention under the MHA were not met. At the end of the assessment the police informed the assessing team that they had just acquired evidence to connect Garry Taylor to the murder of Colin Johnson and that he was to be re-arrested.

On 9 February a CPA Care Plan was updated by AOT1.

Garry Taylor was, indeed, arrested on 9 February after his MHA assessment and charged with the murder of Colin Johnson. The matter proceeded and, in due course, he pleaded guilty to the manslaughter of Colin Johnson on the ground of diminished responsibility. He is currently detained in Rampton Special Hospital pursuant to an order under Section 37 of the MHA with a Section 41 restriction, without limit of time where he is diagnosed as suffering from paranoid schizophrenia.

### **Commentary**

*The panel considered that this period was of considerable significance and shed a good deal of light on what had gone before. It was noteworthy that within three days of Garry Taylor’s release on bail a meeting was called, which was precisely the type of meeting that ought to have taken place on a number of occasions after his discharge in October 2002. At that meeting despite a number of the failures being identified there was still no satisfactory action taken. Although referral to the forensic services was discussed and the Regional Secure Unit contacted, the panel has seen no evidence that any referral actually took place. The panel question the wisdom of considering a referral to a community forensic team as opposed to the inpatient based forensic service given the circumstances at that time.*

*The panel found the decision, taken on 9 February, that Garry Taylor was not detainable under the Mental Health Act, difficult to comprehend. The panel struggled to see which part of Section 2 of the Mental Health Act was not fulfilled since it was clear that he was suffering from a mental disorder (otherwise there was no basis for his medication) it was clear that an assessment was indicated (hence the intended referral to the forensic services) and in the light of the history of violence and non-compliance in the community the panel were of the view that his detention in*

## CHRONOLOGY OF KEY DATES AND EVENTS

*hospital for such assessment was warranted. Had he been made the subject of either a Section 2 or Section 3 order this may well have led to his being detained within the hospital system rather than simply remanded into the prison system and may well have impacted upon his subsequent care and treatment.*

*The completion of a care plan on 9 February 2004 merely underlines the failure to complete or update one after October 2002. The risk assessment score of 48 which was completed on the same document as the assessments of 26 February and 18 November 2003 demonstrated the continued inaccuracy of assessment and the panel questions why, at this time, AOT1 did not herself wonder why there was no apparent change in his risk status and why, on her inaccurate addition, it placed him in the "Moderate" bracket. The question "Is the client presently misusing alcohol?" which is posed in both the Suicide Indicator section and the Violence / Aggression Indicator section is answered in the affirmative on all three occasions in the former and in the negative on all three occasions in the latter.*

## 4 Psychiatric Commentary

### THE PERIOD PRIOR TO JUNE 1993

Garry Taylor was first seen by the psychiatric services in June 1993 when he was aged 28 years. It is of note that he had been referred earlier that same year to the Community Addictions Team but the outcome of this is unknown.

Prior to 1993 there is nothing contained in his records that would suggest he had suffered from, or received treatment for, any form of psychiatric problem. His early childhood appears to have been unremarkable. He lived with his parents and three siblings, his birth was normal, he attained normal developmental milestones and was an average scholar at a local school. After leaving school he held down a number of different jobs, mainly of a manual nature.

The most significant factor in this period is violence. There were three offences of a violent nature, two assaults occasioning actual bodily harm and one offence of causing grievous bodily harm; the last of these convictions having taken place in June 1992. In 1991 and 1992 the police had details of three more episodes of violence. He had threatened his then girlfriend with a knife, he had kept her prisoner in a house for a whole weekend and he had threatened a relative of his girlfriend with a knife. In 1989 he had been dismissed from work as the result of a violent incident. Thus when Garry Taylor was first seen by the psychiatric services in June 1993 he had a significant history of violence against persons, including the use the weapons, that had escalated in recent years.

### JUNE 1993 TO SEPTEMBER 1995

By June of 1993 the general practitioner had raised the possibility of a diagnosis of schizophrenia and started treatment with oral anti-psychotic medication. He was referred urgently to the psychiatric services and seen on an outpatient basis on 16 June. A three month history of psychotic symptoms was elicited including delusional ideas, some of a paranoid nature. A history of recent drug and alcohol intake was sketchy as was the forensic history, however, it did record some of his past violent behaviour. The diagnosis was one of a paranoid psychotic illness with a question of this being secondary to illicit drug use or a depressive illness. Treatment with anti-psychotic drugs was continued on an outpatient basis.

Ten days later he was admitted to an acute psychiatric ward as an emergency on an informal basis following assaults on both his parents, in which his mother received a broken arm and his father was rendered unconscious. He was again noted to have delusional ideas of a paranoid nature and treatment with anti-psychotic medication was continued. He only spent two days on the ward before being granted leave with his family. He failed to return from this leave and was discharged in his absence a few days later. The care plan at the time of discharge was minimal and seemed to consist of a medical outpatient appointment. In the discharge letter to the GP the diagnosis had changed to drug induced psychosis.

## PSYCHIATRIC COMMENTARY

By September of 1993 it was noted that he was beginning to fail to comply with oral anti-psychotic medication.

From September 1993 through to April 1995 he was seen in the psychiatric outpatient clinic. It was noted that he continued to use cannabis and possibly other illicit drugs on a recreational basis despite being advised to the contrary. His paranoid delusional symptoms continued in that he made reference to believing others talked about him in "sign language". At times there were some vague depressive symptoms and he was tried on anti-depressant drugs for short periods of time without any documented beneficial effect. However, the mainstay of his treatment during this period of time was oral anti-psychotic medication, although his compliance with such medication was less than perfect. By August of 1995 it was noted that he had stopped all his psychiatric medication but at the conclusion of this outpatient appointment it is not clear what, if any, future action was planned.

### SEPTEMBER 1995 TO DECEMBER 1996

In September 1995 Garry Taylor seriously assaulted Girlfriend 2 and as a result of this was detained under the MHA in a regional forensic unit for 14 months. This was an important period of assessment and treatment in that he was detained for a prolonged period of time in an environment where there was little or no access to illicit drugs. Psychological testing revealed a normal IQ. For the first two months of this admission he did not receive treatment with anti-psychotic medication, the forensic psychiatrists identified probable delusions of reference, thought broadcasting and paranoid delusions during this time. They came to the conclusion that a diagnosis of drug induced psychosis was unlikely and it was changed to one of a process illness ie paranoid disorder. A risk assessment noted 'a history of considerable violence against others' and that he was 'potentially dangerous and likely to harm others again'. Eight months into the admission the forensic consultant psychiatrist arrived at a definitive diagnosis of paranoid schizophrenia. Three months later the forensic team had identified that he had problems with compliance on oral anti-psychotic medication and it was decided that he would require treatment with depot injections prior to any transfer to a less secure inpatient setting. At the same time a risk assessment was conducted which identified three main areas of risk:-

- 1 Defaulting from compliance with medication;
- 2 The abuse of illicit drugs and possibly alcohol;
- 3 His relationships with women.

In addition it was noted at a CPA review on 2 April 1996, when senior Sunderland staff were present, that he had the potential for a rapid relapse and that complaints of pain (headache and toothache) might herald such a relapse.

On the 8 November 1996 Garry Taylor was transferred from the Regional Forensic Unit to Cherry Knowle Hospital. No comprehensive discharge or transfer summary setting out diagnosis, risk assessment or advice on future management accompanied him. Some of this information was contained in copies of forensic unit documents

in the Sunderland notes but it was difficult to piece together a comprehensive summary of the findings of the forensic team. No information appears to have been communicated to the GP. Within one week of the transfer a programme of home leave started. Within one month his Section had been allowed to lapse, possibly as a result of a mix-up with the expiry date. In little over a month he was residing permanently at his parents' house and discharged from Cherry Knowle Hospital. The consultant's discharge summary letter to the GP at the end of the admission glossed over his stay in the Regional Forensic Unit. It suggested that throughout the 14 month inpatient admission to the Regional Forensic Unit and Cherry Knowle Hospital he had displayed few if any psychotic symptoms. The diagnosis was changed back to one of drug induced psychosis and there was no reference to the forensic psychiatrist's risk assessment.

The discharge in December 1996 was premature; planning in the run up to this discharge from hospital was chaotic and a number of consultants were involved, with none maintaining an oversight of the process. The information gathered during his time in the Regional Forensic Unit should have been used to produce an accurate summary of the history, diagnosis, risk assessment and future management plan. The fact that it was not done was a major failing. Concerns about the premature nature of the discharge and the level of risk posed by Garry Taylor were brought to the attention of the consultant in a letter dated 15 January 1997 from the Social Services Department.

### **DECEMBER 1996 TO SEPTEMBER 2002**

From 1997 through to the middle of 2001 Garry Taylor was managed as an outpatient in conjunction with the community mental health team (CMHT) and later the AOT; the mainstay of treatment was depot anti-psychotic medication. This period of time was relatively uneventful, communication between professionals involved in the care appears to have been good and the CPA process, although basic, appeared to work well. Written communication from the consultant to the GP was however scarce, consisting of only one letter in November 1997. Towards the end of this period he was removed from the Supervision Register and insisted on a gradual reduction in the dose of depot injection. The consultant faced a difficult but not uncommon situation where an informal outpatient insists on the withdrawal of medication contrary to advice. A difficult balance often has to be struck between the risks associated with relapse and the patient's right to self determination. The panel is of the opinion that this balance may have been different had the forensic psychiatrist's risk assessment and diagnosis together with a full history of Garry Taylor's previous violent behaviour been fully documented in a comprehensive risk management plan. In addition, the return to the diagnosis of drug induced psychosis in December 1996 led to greater focus on the monitoring of urine tests to pick up illicit drug use, which in some respects was thorough and laudable, but may have diverted attention from the reduction or cessation of anti-psychotic medication - a major cause of relapse in schizophrenia.

## PSYCHIATRIC COMMENTARY

In August 2001 there was a brief relapse. Garry Taylor had insisted that his depot injection be stopped the previous month. There was clear evidence of a recurrence of his psychotic symptoms associated with an assault on a stranger whilst he was off anti-psychotic medication. As a result of this a further dose of depot injection was given in September. There then followed a period of around nine months when he received outpatient treatment on a mixed regime of oral anti-psychotic and anti-depressant drugs. In August and September of 2002 the family lost confidence in the consultant and requested a change. At around the same time evidence was emerging of poor compliance with medication and a deterioration in his mental state. Eventually this led to detention under Section 3 of the Mental Health Act and admission to Cherry Knowle Hospital on 25 September 2002.

### THE ADMISSION SEPTEMBER – OCTOBER 2002

On admission Garry Taylor was noted to have stopped his oral anti-psychotic medication four months earlier. The patient and his family described delusions of reference including systematised paranoid delusions and abnormal mood. The patient denied regular use of illicit drugs. SHO1 came to a differential diagnosis of drug induced psychosis or bipolar disorder. During the early part of this admission Garry Taylor was treated with oral anti-psychotic drugs and was identified as potentially dangerous. In a little under two weeks, on two different wards, despite anxieties from Mrs Taylor and CPN1, a decision had been made to begin a programme of leave leading towards discharge. The whole admission lasted approximately three weeks. It is of note that during this brief admission all three significant professionals involved in his care (consultant psychiatrist, CPN and social worker) were changed. The diagnosis at the time of his discharge was one of 'paranoid psychosis ? drug induced or delusional disorder'. There was partial documentation of his history of violence and psychotic symptoms when unwell and a minimalist risk assessment contained in the discharge summary sent to the GP. The three main components of his treatment plan were; outpatient appointments with SHO1, monthly AOT appointments and oral anti-psychotic drugs. The risk assessment of violence was 'low on treatment significant if stops Rx'. A difficult case of this nature and a case where the family had recently requested a change of consultant should not have been allocated to outpatient follow up with an inexperienced SHO following the discharge from hospital in October 2002.

The admission in September/October of 2002 should have been seen as an opportunity to re-instate treatment with depot anti-psychotic medication and no consideration appears to have been given to the use of a new atypical depot injection that became available at around that time. At the very least consideration should have been given to a longer period of detention with periods of extended leave. In short, the discharge from inpatient status was again premature

### **OCTOBER 2002 - MARCH 2003**

It is of note that Garry Taylor failed to attend the first five consecutive outpatient appointments following discharge.

By January 2003 there was evidence that all three components of the treatment plan had failed, in addition he was drinking heavily and had had a violent outburst. Despite this there was no re-evaluation of the care plan or updated risk assessment.

### **MARCH 2003 – FEBRUARY 2004**

By April there had been a second serious assault by Garry Taylor on Girlfriend 2. This, taken together with his continuing failure to engage with professionals; failure to comply with medication; use of alcohol and, later in the period; a history that he was acquiring weapons, should have led to a re-assessment of the risk to Girlfriend 2, her son and others. This may have led to greater consideration being given to a more proactive use of the MHA. Consultant 4 failed to track Garry Taylor's progress through the criminal justice system during this time in relation to his drink driving cases and periods of detention by the police.

When interviewed by doctors during this period, Garry Taylor would say very little or respond with the phrase 'no comment' and he usually terminated interviews after only a few minutes. The consultants and forensic medical examiners who saw him seemed to place an over-reliance on the absence of florid psychotic symptoms at interview. The presentation at interview seems to have been equated with there being no signs or symptoms of mental illness. An alternative hypothesis that this was abnormal behaviour and part of a paranoid illness does not seem to have been given due consideration. Independent accounts from the family or AOT members were seldom sought and even when such independent accounts were available, little attention appears to have been paid to them.

In May 2003 Garry Taylor developed chest pain and this was investigated with ECGs over a period of a few months. In August he developed headaches. There was a failure to identify these as potential signs of relapse as set out in the Regional Secure Unit CPA review documentation of 2 April 1996.

### **FEBRUARY 2004 ONWARDS**

Garry Taylor was remanded in custody on 11 February 2004 and refused all medication. By March his mental state had deteriorated significantly with a worsening of psychotic symptoms, including thought disorder and paranoid delusions. He made attacks on staff and was considered to be extremely dangerous. Following his transfer to Rampton Hospital the diagnosis was confirmed as schizophrenia; it was also confirmed that he experienced auditory hallucinations. His response to atypical and typical anti-psychotic medication has been partial and latterly he has required treatment with a combination of clozapine and anti-depressant medication.

### DIAGNOSIS

Some professionals, directly involved in the treatment of Garry Taylor, were reluctant to consider a diagnosis of schizophrenia, stating that he was not typical of a patient with chronic psychosis. The panel understood that what they meant by this was that there was a relative preservation of inter-personal skills. Whilst this may well have been the case, there was evidence of deterioration in the fields of occupation, independent living skills, interpersonal relationships, and forward planning. It is of note that the forensic psychiatrist had referred to a deterioration in his personality as early as 1995.

It was difficult to understand the frequent return to a diagnosis of drug induced psychosis throughout this case and much more weight should have been given to the diagnosis arrived at by Consultant 2 (a forensic psychiatrist) who had the benefit of a prolonged assessment of Garry Taylor in a relatively drug-free environment. The very nature of a drug-induced psychosis is that it is short lived (days) and responds rapidly to the withdrawal of the causative agent. The panel concurs with the opinion of Consultant 2 that Garry Taylor met the criteria for a diagnosis of schizophrenia. At that time he was documented as having symptoms of thought broadcasting and delusions of a paranoid nature over a prolonged period of time. Consultants 1 and 4, who had been most involved with Garry Taylor's care in Sunderland, seemed to place little importance on differentiating between a diagnosis of drug induced psychosis and schizophrenia. They implied that the treatment, ie anti-psychotic medication, was the same in both cases and so the accuracy of diagnosis was not of paramount importance. The panel did not agree with this view and believes that there are significant differences in the management of these two conditions. The former would require short to medium term treatment with anti-psychotic drugs together with a programme aimed at reducing or stopping illicit drug use; involving where necessary specialist input from a substance misuse team such as education, drug withdrawal, relapse prevention, etc. The latter would require long-term maintenance treatment with anti-psychotic medication in conjunction with a programme of psychosocial interventions. The risk of relapse with the use of illicit stimulant drugs is common to both conditions but, in the absence of such use, poor compliance with anti-psychotic medication is unlikely to lead to relapse in a drug induced disorder, whereas there is a high risk of relapse when maintenance anti-psychotic medication is stopped in schizophrenia.

A general overview of the case would have revealed that there was only one lengthy period of time, December 1996 to July 2001, when Garry Taylor was relatively well, free of acute psychotic symptoms and there were no documented episodes of violence. This is the same period that he was maintained on depot anti-psychotic medication. This factor does not seem to have been taken into account when considering diagnosis and future treatment plans.

In summary, the adoption of a primary diagnosis of schizophrenia from 1996 onwards together with a comprehensive, well-documented risk assessment might have led to significant and beneficial changes to the way in which Garry Taylor's condition was managed from that time on.

## DRUG TREATMENT

The mainstay of Garry Taylor's drug treatment from October 2002 onwards was the oral atypical anti-psychotic, olanzapine. For a brief period of time this was unsuccessfully changed to an alternative anti-psychotic quetiapine and on two separate occasions he received periods of treatment with the anti-depressant, venlafaxine. There was no attempt to conduct routine monitoring of side effects, weight, blood pressure or blood tests in relation to the use of these drugs. Little consideration was given as to whether physical symptoms (headaches and chest pain) were possible side effects from the medication. When it was known that the patient had problems with compliance venlafaxine should not have been used as a first line anti-depressant, given its propensity to cause a withdrawal syndrome.

There appears to have been over-reliance by Consultant 4 on the practice of changing medication when there was evidence of deterioration instead of a more global approach to care planning. It was difficult to understand why some changes consisted of a return to a medication regime that had previously failed and why some appear to have been instituted at the insistence of Mrs Taylor rather than as part of a planned programme of care agreed with the patient and wider team. The panel felt that greater consideration should have been given to the re-instatement of treatment with depot anti-psychotics.

From March 2003 onwards anti-psychotic medication was covertly administered to Garry Taylor by his mother. Whilst on a few occasions the care team may have advised against this practice, the underlying pattern was one of collusion by Consultant 4 and the AOT with Mrs Taylor in this covert administration. The panel were concerned on a number of points in relation to this practice; technically it may have amounted to an assault on Garry Taylor and should have led to the MAPPVA policy being invoked (the covert use of medication is given as a specific example in the Sunderland MAPPVA policy). He was denied the safeguards usually afforded by the MHA, it was dangerous given there was little or no control over the dose and it gave him a false impression of his ability to manage without medication.



## 5 Provision and Delivery of Mental Health Services in South of Tyne & Wearside

### **PROVISION**

#### **1 Primary Care**

Primary health care on South of Tyne & Wearside (STW) was throughout the history under consideration provided through GPs and other health care professionals attached to practices.

Attachment of mental health staff to practices was a relatively recent development which commenced in pilot form in the mid to late 1990's and has since been introduced across each of the localities. Teams consisted predominantly of mental health nurses who were available on a sessional basis and were provided and managed by South of Tyne and Wearside Mental Health NHS Trust.

GPs can also refer directly to the secondary mental health services including specialist community services but at the time Garry Taylor was receiving mental health care in Sunderland access was restricted to referrals via consultant psychiatrists.

#### **2 Secondary Mental Health services**

Most secondary mental health services in the area were provided by South of Tyne & Wearside Mental Health NHS Trust, which was founded in April 2002. Prior to this, the services had undergone significant organisational change and had been managed by Barton Memorial Unit until 1994 when Priority Healthcare Wearside was formed.

Services are provided on a locality basis across three sectors in the Sunderland district, namely North, South and West.

Planning mechanisms were in place to deliver the National Service Framework and this was undertaken with the service commissioners (Sunderland Teaching Primary Care Trust) and Northumberland, Tyne & Wear Strategic Health Authority.

Within South of Tyne and Wearside, secondary mental health services which were available in the key period leading up to the offence included:

- Multi-agency community mental health teams
- Crisis intervention service (on an out of hours basis only)
- Assertive outreach service
- Primary care mental health teams
- Deliberate self harm team
- Drug and alcohol service
- Approved social worker services
- Acute inpatient psychiatric service, including an intensive care ward

# **PROVISION AND DELIVERY OF MENTAL HEALTH SERVICES IN SOUTH OF TYNE & WEARSIDE**

## **DELIVERY OF SERVICES**

It is of importance to note that the services described in this section are restricted to those that may have been relevant to Garry Taylor's care and do not attempt to describe the overall services provided by either health or social care agencies within the local area.

### **1 Primary Care**

It is generally a feature of modern mental health care that primary care plays a prominent part in co-ordinating the general overall healthcare needs of patients attached to their practice, and as such GPs usually have well developed communication systems with secondary specialist mental health services. This includes consultant psychiatrists and community mental health teams.

Garry Taylor was registered with a local multi-partner GP practice that also cared for other family members.

There is evidence from the records that Garry Taylor attended the practice infrequently for a variety of minor ailments but, apart from some early interventions between 1993-1995, his mental illness was not a significant feature of his engagement. Although the GPs were copied in to correspondence from Cherry Knowle Hospital and were aware of Garry Taylor's journey through the mental health system, his care was very much left to the intervention of the specialist mental health staff.

Garry Taylor's main care provider in the period leading up to the offence, the Assertive Outreach Team, did not seek to engage the GP practice in any aspect of his overall care. To a large extent, therefore, their input was marginalised.

### **2 Secondary Mental Health Care**

There are four acute wards within Cherry Knowle Hospital, East Willows, West Willows, the Beeches and Dene ward.

East and West Willows and the Beeches provide access via the three localities within Sunderland district. Dene provides an intensive care function for those who require increased levels of observation and support.

Garry Taylor received treatment on West Willows ward in 1993 and 1996 and on Dene ward and East Willows in 2002.

### **3 The Assertive Outreach Services**

The Assertive Outreach Team consisting of nurses and social workers was formed in October 2000 with a view to providing care for people with severe and persistent mental disorder of an intensity that disables the individual from functioning adequately in terms of meeting their basic needs.

In meeting the criteria for access to the AOT individuals must have:

- a history of high inpatient or intensive home based care;
- difficulty in maintaining lasting and consenting contact with services;
- registered under Enhanced CPA.
- multiple complex needs to include three of the following:
  - i history of persistent offending
  - ii history of violence
  - iii risk of persistent self harm
  - iv risk of neglect
  - v failure to respond to treatment
  - vi combined substance misuse and serious mental illness (Dual diagnosis)
  - vii have been detained under the Mental Health Act
  - viii unstable accommodation or homelessness

Clearly Garry Taylor met the criteria for intervention by the Assertive Outreach Team. From the guidance contained within the Trust's operational policy for assertive outreach it was expected that the following interventions would be available:

- Develop meaningful engagement with service users, provide evidence-based interventions – as per psycho-social interventions (PSI) strategy to include cognitive behavioural therapy, family psycho-educational social functioning, medication concordance and promote recovery.
- Increase stability within service users lives, facilitate personal growth and provide opportunities for personal fulfilment.
- Provide a service that is sensitive and responsive to service users cultural, religious and gender needs.
- Support the service user and their family/carers for sustained periods.
- Promote effective inter-agency working
- Ensure effective risk assessment and management

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The general principles of establishing assertive outreach services were embodied in the Mental Health National Service Framework (MHNSF) in 1999 with more detailed analysis issued in the subsequent Mental Health Policy Implementation Guide, both issued by the Department of Health. In simple terms, however, the expectation was that those individuals suffering from severe mental illness who had a history of none engagement would have their needs met by a specialist team who carried a small caseload and were trained in the techniques of engagement, relapse prevention and therapeutic interventions. Wherever possible this intervention would be carried out in a community setting as close to the patients' homes as possible. Care co-ordination would be provided by the team and the emphasis would be on maintaining contact with the patient and building relationships.

It is commendable that such a team was established in Sunderland and there is no doubt that Garry Taylor met the criteria for involvement. It is however an issue for consideration elsewhere in this report as to how effective this involvement was to be.

### **4 Crisis Resolution Team**

This service commenced in pilot form in November 2001 comprising nurses and social workers and was restricted to patients active within the service and subject to the CPA. This was an out of hours service only and due to the limited brief of the team, the service was not promoted or accessible to GPs until late 2004.

The remit of the team was to respond to psychiatric crises, provide an assessment and signposting service and, if required, either arrange for urgent admission to hospital via the on duty consultant psychiatrist, engage the patient in a home environment for time limited periods or refer on to relevant services/agencies.

Whilst Garry Taylor was primarily seen by the Assertive Outreach Team, the Crisis Team were occasionally involved either through the supply of medication out of hours to him or, more usually, his mother on his behalf, or through the provision of an approved social worker for the purpose of arranging a Mental Health Act assessment.

As the Assertive Outreach Service only operated during office hours, there may have been an expectation that at times when family crises occurred, the Crisis Team may have become more involved in providing support to the family, but as is illustrated elsewhere in the report they appeared to accept that the AOT were the main care providers and therefore did not actively participate in Garry Taylor's care.

### **5 Community Drug and Alcohol Team**

This is a long established team within the Trust and comprises medical, nursing and social care staff.

Principally, its remit is to engage with people who are referred for the management of drug and alcohol problems and the referral route into it is open to all.

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A key element of its role is to assess the degree of drug/alcohol abuse and to engage with the patient in devising coping strategies or signposting to more relevant agencies.

Garry Taylor was referred to this service in 1993, but there are no available records to indicate the outcome.

It must be noted, however, that he had a long history of occasional drug and alcohol abuse and, whilst engagement would no doubt have been problematic, it is surprising that their expertise was not called upon to assist with the formulation of a more comprehensive treatment regime.

### **6 Acute Psychiatric Inpatient Services**

In keeping with the modernisation of mental health services, the Trust are continuing with the decommissioning of Cherry Knowle Hospital to a stage where only essential services remain on site and others are devolved to more appropriate environments.

The reduction of beds and the introduction of new teams and facilities in the community provides a more modern and less stigmatised service than that provided through old Victorian asylums and although the pace of change in this Trust is perhaps slightly behind that of others, there is a willingness to achieve a modern service supported through investment by the commissioners. It must be noted, however, that this willingness is not shared by all. The panel have heard in evidence that some medical and nursing staff have been less motivated to embrace change and have been obstructive and resistant to the modernisation programme. This issue is addressed in more detail elsewhere in this report.

### **7 Mentally Disordered Offenders Service (MDO)**

The panel feel that it is relevant to mention the absence of a specialist service to deal with mentally disordered offenders. We are aware that such a service did exist but was disbanded in 2001 due to staffing issues. The objective of an MDO service is to identify offenders who potentially have a mental illness and to divert them away from the criminal justice system into health and/or social care.

Considering Garry Taylor's history of offending and his contact with the criminal justice system, it would appear that had such a team been available he may have been afforded the opportunity of specialist intervention which may have complemented and assisted other services offered by the Trust.

### **8 Care Programme Approach**

In recognition of the complexities of managing the needs of those with mental illness in the community, and to ensure that needs were appropriately assessed and provided for, in 1990 the Department of Health issued Health Circular HC(90) 23: "The care programme approach for people with a mental illness referred to the specialist psychiatric services".

## PROVISION AND DELIVERY OF MENTAL HEALTH SERVICES IN SOUTH OF TYNE & WEARSIDE

The CPA applied to all who came into contact with secondary mental health services.

The CPA was introduced to provide a framework for effective mental health care. Its four main elements were:

- systematic arrangements for assessing the health and social care needs of people accepted into the specialist mental health services;
- arrangements for the formulation of care plans which identify the health and social care required for the patient from a variety of providers. Depending on level of need, patients are assigned a minimum, medium or complex care approach level;
- appointment of a key worker to coordinate care;
- regular review and, where required, revision of care plans.

There was general recognition throughout England, particularly from senior medical staff, that whilst the principles of the approach were reasonable enough, the application was perceived to be overly bureaucratic and there was a reluctance to engage with the process.

In an attempt to simplify matters, and to bring together the key elements of the health led "Care Programme Approach" and the social care led "Care Management", the NHS Executive and the Social Services Inspectorate issued new guidance in 1999 entitled "Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach"

The key statement taken from the National Service Framework states:

"Services will be much more accessible; intervene more quickly to offer help and support; seek out those who are difficult to engage; involve service users in planning developments; use effective care processes; and be delivered in partnership across health and social care as well as other key agencies".

The new approach saw the introduction of two levels of CPA, standard and enhanced and abolished the need for Supervision Registers. A care co-ordinator was to be identified who would pull together all aspects of care and there was to be an emphasis on recognising the needs of carers subsequent to the Carers (Recognition & Services) Act 1995. The guidance clearly illustrates that it is critical that the care co-ordinator has the authority to coordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency or origin.

An emphasis was also placed on risk assessment and management. Risk assessment is an essential and ongoing part of the CPA process. Care plans for severely mentally ill service users should include urgent follow up within one week of hospital discharge. Care plans for all those requiring enhanced CPA should

## PROVISION AND DELIVERY OF MENTAL HEALTH SERVICES IN SOUTH OF TYNE & WEARSIDE

include a “what to do in a crisis” and a contingency plan. It goes on to say that where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements, including ongoing risk assessment are essential.

In respect of care plans and reviews the new guidance states:

- Good practice dictates a move towards more integrated operational practice. Integrated records are an example of such practice. The maintenance of shared records will further reduce unnecessary form filling and bureaucracy, will improve communication and, most importantly, will contribute to a streamlined care process to the advantage of the service user and provider.
- There is no longer a requirement for a nationally determined review period of six months for care plans. Review and evaluation of the service user’s care plan should be ongoing. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer must also be able to ask for reviews at any time. All requests for a review of the care plan must be considered by the care team. If the team decide that a review is not necessary the reasons for this must be recorded. The annual audit of CPA should check that reviews of the care plan have been carried out.
- To reduce risk, the plan as a minimum, should include the following information:
  - Who the service user is most responsive to;
  - How to contact that person, and
  - Previous strategies which have been successful in engaging the service user.

This information must be stated clearly in a separate section of the care plan that should be easily accessible out of hours.

Quite correctly, Garry Taylor was placed on enhanced CPA when he was discharged from Cherry Knowle Hospital in 2002 and was assigned to a care co-ordinator in the Assertive Outreach Service. This should have ensured that his care would be coordinated, his risk level assessed on a regular basis and his care plans reviewed as outlined above.



## 6 Conclusions

### INTRODUCTION

There is no doubt that Garry Taylor was an extremely difficult patient to manage. At all times with which the panel was concerned he attempted to disengage from the services and at no time did he recognise or accept that he had any mental illness. He presented very significant problems for those engaged in his care. Such problems are, however, to be expected in patients with complex mental health problems and are precisely what the secondary mental health services are designed to deal with.

The panel identified failings at numerous points in the history of Garry Taylor's case. The chain of events leading up to the killing of Colin Johnson was, inevitably, complex. No single event or individual element of Garry Taylor's care could be said to be directly causative of the failures that led to the eventual outcome. The panel found that there were significant failures by professionals responsible for his care. Any individual failure on its own, however, could and should have been overcome by the actions of others and by safeguards within the relevant agencies; had those agencies operated in accordance with accepted national standards and guidance.

The individual failures occurred at several levels and were substantially contributed to by the culture existing within the Sunderland locality of the Trust. This had been allowed to continue by management at all levels, despite long term concerns about that culture and the problems that flowed therefrom. Although the panel were informed by a number of witnesses that significant changes and improvements had occurred in recent times there were also several members of staff who felt that little had changed and who expressed the view that a similar chain of events could occur again. It was recognised by some at senior levels that there is still a great deal of work to be done to bring services in Sunderland up to modern standards.

### THE SUNDERLAND CULTURE

The panel heard consistent evidence from a number of witnesses that there existed, and continues to exist, a medical culture in Sunderland. This culture results in decisions having to be made by, and channelled through, consultants at almost all stages. There is reluctance by other professionals to challenge such decisions or to initiate steps that will potentially bring them into conflict with the consultants. The panel believes that the various changes that have taken place in the structure of the health service and the management of those services, whilst intended to improve the workings of the mental health services, have resulted in the consultants feeling increasingly marginalised and separate from the modernisation process. A senior psychiatrist, who was a former director, most graphically illustrated this to the panel by describing the culture in Sunderland as "toxic". That culture has prevented the effective modernisation of the services and was largely responsible for the situation in which individual failures were not identified and managed.

## CONCLUSIONS

### SERVICE MANAGEMENT

The panel heard evidence that the problem of the culture referred to above was well known at all levels of management up to and including the Board. The panel felt there was a failure to deal robustly with this problem.

A new medical director was appointed at the time of the Trust merger in April 2002. He introduced a new medical management structure and attempted to change the medical culture through various initiatives. He was, however, unable to overcome the high level of resistance from the consultant body. The panel recognises that the implementation of the new consultants' contract around this time would have occupied a significant proportion of his time, but this could have provided an opportunity to look creatively at the effective deployment of existing consultant resources at a time when new services were being introduced. This opportunity was missed.

There was a change of clinical director in January 2003. The traditional role of the clinical director in the service had been to represent the views of consultants to management rather than to performance manage medical staff. The new clinical director continued in that role rather than attempting to engage his colleagues in new ways of working. In addition there were a number of unresolved disputes over the need for investment in new consultant posts and those disputes stifled service development.

Arrangements for learning lessons from multi-disciplinary critical incident reviews were lacking and the panel could see little in the way of positive response to the February 2002 'Report of the Independent Review Panel into Serious Untoward Incidents and Complaints at Cherry Knowle Hospital', which had been commissioned because of the higher than usual level of adverse incidents and complaints.

The manager of community services was, from a relatively early stage in 2003, aware of the difficulties that AOT1, as care co-ordinator, was experiencing in the management of the case and in obtaining adequate responses from Consultant 4. She assisted in drafting the letter of 23 October 2003 to Consultant 4, had prior knowledge of Garry Taylor from when he was detained in the Regional Secure Unit and had a background in forensic services. When she became aware of the failure of Consultant 4 to respond to the repeated concerns of AOT1 she ought to have involved herself directly in the problem and either spoken to Consultant 4 about the problems or referred the matter to more senior management.

Consideration ought to have been given to changes in the personnel involved with Garry Taylor at an earlier stage, particularly the allocation of an experienced social worker. There was a lack of performance management in respect of care co-ordination and the ASW role. There was a failure properly to supervise this case and to coordinate joint working across the AOT, CRT and the ASWs.

### USER/CARER INTERFACE

The panel were surprised that, given the complexities of this case and the close involvement of the family as carers, no carers' assessment was undertaken as required in the MHNSF. Had such an assessment been undertaken it would have enabled the professionals to provide a greater level of support to the family and would have impacted on the treatment that Garry Taylor received.

At no time was the family fully informed in relation to Garry Taylor's condition, diagnosis and prognosis, and the implications for his future management and treatment. Had the family had a clearer understanding of the picture it would have assisted their reporting back to the professionals. Likewise there was little or no information provided on other key areas eg CPA, user/carer support groups, PALS and complaints procedure.

Little use was made of the knowledge that the family possessed in respect of changes in Garry Taylor's mental state. It was the panel's view that, had there been greater and more coordinated recognition of the family's concerns, then a more effective approach to his management may have resulted. There were numerous instances of reports of concerns by the family and changes in his behaviour. These appear to have been viewed in isolation and, on occasions, not taken as seriously as they ought to have been. There was never any proper appreciation of the overall picture which the family's reports represented and the professional judgements applied to those reports were, on occasions, seriously flawed. Greater use ought to have been made of the family as a resource when devising engagement strategies. In addition there were repeated failures to deal effectively with the nearest relative's requests for MHA assessments.

### CARE AND TREATMENT

#### **The care programme approach and care coordination**

In 1999 the Department of Health guidance, Effective Care Coordination, integrated CPA with Local Authority Care Management and re-named it Care Co-ordination. The new system was designed to simplify the process and to provide safeguards for patients in secondary mental health services. In this case there was a failure to implement this guidance effectively at all levels in the organisation and as a consequence necessary safeguards for Garry Taylor's overall care and treatment were not in place.

Due to poor document control there was confusion as to which version of the Trust's CPA policy was in place at any given time. Whilst the general direction of CPA policy within the Trust appeared to be in accordance with national guidance, medical staff failed to embrace this Trust policy and went as far as to develop their own parallel arrangements. However, these were not referred to in the general Trust policy.

Despite the failings outlined above, the panel noted that CPA arrangements appeared to work reasonably well until Garry Taylor's discharge in October 2002. After October

## CONCLUSIONS

2002 however, following his transfer to the south sector services, there is little evidence that the clinical team followed CPA procedures. In the view of the panel, there was a failure by the clinical team to apply CPA from 2002 onwards and this failure was not identified or acted upon by management. As a minimum, regular CPA review meetings should have been held on a six monthly basis. In addition, there were many occasions between October 2002 and January 2004 where a failure of the care plan or evidence of increased risk should have triggered an urgent review. All CPA meetings should have included a review of the care plan and the production of appropriate documentation.

The failure by Consultant 4 to provide any reply or effective response to the letter of 23 October 2003 from the care co-ordinator should have led to a full CPA and Section 117 MHA review. If the care co-ordinator or family were of the view that Garry Taylor's needs were not being fully met by the mental health services a formal statement of unmet need should have been recorded and reported to senior management as set out in the Priority Healthcare Wearside CPA policy, the MHA Code of Practice and national guidance.

### **The contributions of key professionals**

The panel found clear evidence of a failure to meet expected standards from a number of key individuals concerned in the care of Garry Taylor.

Consultant 4 failed fully to discharge those responsibilities normally expected of a consultant psychiatrist. He dealt with situations on an ad hoc basis; without regard to the entire history of the case; without ever taking an overview of the case; past patterns of behaviour and responses to treatment. There was a failure properly to engage with the AOT, take note of the observation of others or respond to the concerns of other professionals. The practice of regarding 20 minute outpatient review appointments as the venue for a CPA review was inappropriate. He failed to give due consideration to the use of the Mental Health Act. The panel acknowledge that messages coming from the family were not entirely consistent but the overall pattern was of clear concern and a desire to have Garry Taylor either admitted to hospital or put on a depot injection throughout the period from October 2002 up to the time of the death of Colin Johnson. Consultant 4's responses to the family and key professionals seemed to be to rely upon messages that suggested that there was some improvement in Garry Taylor's condition but to have a somewhat sceptical attitude to messages that suggested deterioration or crises. There was a tendency to deal with the case at a distance, and through the medium of messages via his secretary, a reluctance to delegate to others and yet, paradoxically, an expectation that others would deal with critical situations. Consultant 4 was regularly away from Sunderland engaged in other work. Cover arrangements were in place yet the panel saw no evidence of emergency situations being dealt with by other consultants who were detailed to cover his cases in his absence, or reference to them of immediate problems. Consultant 4 regarded the AOT as a highly resourced service with a very limited caseload, which he expected to have considerable input into the care of Garry Taylor, and yet failed to respond to the concerns of the members of the AOT or work with them in a coordinated way.

AOT1 had a dual role first as care co-ordinator for Garry Taylor, and secondly as his AOT key worker. In those roles she had the responsibilities set out in the policy booklet *Effective Care Co-ordination in Mental Health Services* and in the *Department of Health Policy Implementation Guide (Assertive Outreach)*. In the panel's view she failed adequately to fulfil those roles. She informed the panel that she appreciated the difficulties of working with Garry Taylor and his dangerousness. The panel accepts that she felt she was doing her best to deal with what was an extremely difficult case.

Nonetheless we conclude that, in a difficult position, she ought to have managed the case more forcefully and insisted that she obtained more intensive input from Consultant 4. When, in early 2003, it had become clear that the care plan that had been drawn up on Garry Taylor's discharge was failing on virtually all points, AOT1 ought to have insisted on a proper CPA review and completed a new care plan. That was an ongoing failure throughout 2003 and into early 2004. The completion of a care plan on 9 February 2004 served to highlight those earlier failures.

Whilst Garry Taylor's reluctance and at times complete refusal to engage with the mental health services meant that his management was extremely difficult a more pro-active approach ought to have been taken. This should have included a carer's assessment for Mrs Taylor and an ongoing risk assessment, which ought to have involved the calling of a MAPPA or MAPPVA meeting. In the light of the repeated inaction of Consultant 4 and his failure to respond to messages and requests, there ought to have been reference to professional line management, as well as to her immediate line manager. The panel understood the care co-ordinator's reluctance to take more extreme steps, such as whistle blowing or complaint given that the entire treatment of Garry Taylor was taking place within the culture referred to above and that she felt that to do so would have compromised her role within the organisation.

In addition to the above, the panel felt that there were a number of occasions on which the standards of professionals with less central roles fell below expected levels.

### **Communication and record keeping**

A key feature of Garry Taylor's management was the remarkable lack of communication between the professionals and teams responsible for his care. There was little evidence of effective information sharing between the professionals and an unwillingness to communicate either orally or in writing. The panel struggled to understand the apparent reluctance of the care co-ordinator and the consultant to speak directly to one another; instead messages were often relayed through third parties, principally Consultant 4's secretary. The absence of proper CPA reviews removed the option of sharing information and informing future care planning.

The panel recognise that a thorough assessment of Garry Taylor was undertaken when he was in the Regional Secure Unit, which included multi-disciplinary CPA reviews attended by Cherry Knowle Hospital staff. However, when he was transferred back to the Cherry Knowle Hospital, the panel was unable to find any record of discharge/transfer information setting out diagnosis, risk assessment and advice on future management.

## CONCLUSIONS

The panel saw no evidence of any attempt in Sunderland to integrate mental health records as recommended in the policy booklet "Effective Care Co-ordination in Mental Health Services". The standard of record keeping was, in some cases, of low quality. After October 2002 the multi-disciplinary records described events that had occurred but there is little evidence of thorough assessments or robust intervention programmes.

Medical and multi disciplinary records were held separately and there was a failure to communicate the information contained in each to other professionals involved. A particularly striking example of this was that Consultant 4 was unaware that, in April 2003, Garry Taylor had expressed a wish to "wrap the house in sellotape". He stated in evidence "That is not in the medical records so I have never seen that and that is the first time that I have heard of it". The panel regarded the lack of effective communication and poor record keeping as highly disturbing in the light of numerous previous reports of inquiry panels into Serious Untoward Incidents that have highlighted this as a major issue. It is of concern to the panel that many of the lessons of those reports appear not to have been learned in Sunderland.

### Engagement

A recurring feature of Garry Taylor's care was his inability to engage with his care providers. It is evident that many attempts were made to see him either in a community setting or at outpatient clinics and he frequently did not attend. It is of concern to the panel that no attempt appears to have been made to audit his non-attendance, particularly for outpatient appointments, and if this had occurred it may have prompted a review of his future management.

## RISK ASSESSMENT AND MANAGEMENT

Risk assessment arrangements left much to be desired. The Trust has been unable to supply the panel with a clinical risk assessment / management policy in force at the time of these events. AOT1 supplied to the panel a copy of a document entitled "Mental Health Practitioner's Guidance for the Assessment and Management of Risk". The status of this was not clear and it appears largely to have been taken from a Department of Health guidance document issued in 1995, HSG(95)56. The practice of the AOT in Garry Taylor's case fell short of the advice in that guidance. The panel was informed by medical staff that they followed The Royal College of Psychiatrists guidance (Council Report CR 53). The management of the risks presented by Garry Taylor fell far short of that guidance. When risk assessment tools were utilised (Worthing Risk Assessment) the panel saw evidence of these being inaccurately completed and of errors being perpetuated. Significant changes did not result in re-assessments of the risks presented by Garry Taylor. As early as 1993 it was evident that he had a significant history of violence to others, a mental illness in which paranoid delusions were a feature and that these were probably linked. It was also clear that he lacked insight into the need for treatment and that compliance with treatment was poor. Given these features it is surprising that management was not more intensive and cautious.

The panel were informed that MAPPA was in place in the critical period leading up to the incident, although at an early stage of development. It was not, however, an option that was considered until February 2004. The panel felt that consideration should have been given to this at a much earlier stage. Similarly MAPPVA was in place and indeed staff referred to it in their evidence. Considering that Garry Taylor was placed in a vulnerable position through the covert administration of medication, it is surprising that MAPPVA procedures were not invoked during 2003. The panel noted the absence of a policy to deal with the covert administration of medication.

### **ADMISSIONS POLICY**

There was no clear bed management policy or any common understanding of the criteria for admission at Cherry Knowle. There were two occasions when Garry Taylor could have been admitted to the hospital in 2003. This did not happen because he was suspected, in the first instance of possessing an offensive weapon and in the second of displaying violent behaviour that was viewed as unmanageable within the hospital. There is little evidence to support that, on either occasion, he would not have been appropriate for admission but the perceptions of the staff involved militated against this happening. The panel felt that in both instances he could have been managed within the Psychiatric Intensive Care Unit.

### **USE OF THE MENTAL HEALTH ACT**

There were several shortcomings in relation to the application of the MHA. There was a failure to recognise repeated comments from Mrs Taylor and other members of the family as implicit nearest relative requests. When assessments were undertaken there was poor communication from social workers to the police, poor hand over of the case from one ASW to the next, poor record keeping and a failure to inform nearest relatives of the outcome of assessments. The panel had difficulty in obtaining documentation in relation to each recognised request for an assessment. There were several missed opportunities to utilise the MHA, when Garry Taylor's care plan had failed, in order for him to be re-assessed and an effective treatment programme to be established.

The panel were left with the impression that arrangements for MHA assessments in Sunderland at that time were poorly managed and uncoordinated. This was demonstrated by the absence of integrated working, the inability of professionals within the service effectively to communicate with one another in a timely manner and professionals' poor interpretation and application of the Act.

The panel recognises that Section 117 MHA requirements were integrated into the care coordination arrangements within Sunderland, but poor compliance with the application of CPA constituted a failure to discharge the duties under the Act, as set out in the MHA Code of Practice.

## **CONCLUSIONS**

### **PRIMARY CARE**

There is little evidence that the GP played a significant part in Garry Taylor's treatment. This, in part, was due to the reluctance of the family to share concerns with the GP. It is however a concern that the community mental health teams in Sunderland did not regard the GP as a central figure and attempt to engage him in managing Garry Taylor's problems. The panel have also heard from GPs that the relationship with the mental health services in Sunderland was poor. The mental health services were viewed as remote and at times inaccessible and there were clearly communication problems that still remain to be resolved. It is acknowledged that the GP received some communication from the mental health services but it was far from comprehensive. It is of note that the diagnosis of schizophrenia by the Regional Secure Unit appears never to have been communicated to the GP. Had there been an effective relationship between the AOT and primary care, the GP would have been empowered to act as an advocate for more effective treatment in Garry Taylor's case.

### **FORENSIC SERVICES**

There was no cohesive approach to the commissioning and provision of forensic services for Sunderland. The perception in Sunderland was that Newcastle forensic services concentrated on Tyneside and Middlesbrough on Teesside, leaving clinicians in Sunderland feeling marginalised. As a result, working relationships were poor but no effective action was taken to address this. After September 2002 referral to the forensic services was considered by a number of professionals, yet no formal referral was ever made. This appears to have been partly due to poor organisation and partly due to Consultant 4's lack of confidence in the referral and assessment process.

There was an absence of any effective liaison with the criminal justice system for people with mental health problems in Sunderland. Had such a service been in place it may have afforded an opportunity for a coordinated approach to Garry Taylor's management when he came into contact with the criminal justice system.

The panel are aware of the presence of staff within Sunderland who had knowledge and experience of forensic services however it is surprising that little attempt appears to have been made to utilise this resource.

### **POLICY DEVELOPMENT**

During the course of this inquiry the panel had cause to request and examine a number of key policies. We were surprised to find that a number of policies were not in place and many others appeared to be in various stages of drafting or implementation. The process for the development and introduction of policies appeared to lack a cohesive framework and was hindered by poor document control.

### EDUCATION AND TRAINING

A key feature of modernising mental health services is the need to educate and train the workforce. The introduction of new services and new policies and procedures requires robust training programmes to ensure that staff are informed and clinical practice is evidence based. Apart from some CPA basic training, the panel were unable to obtain any confirmation that service changes were supported by systematic education and training processes designed to meet the evolving modernisation agenda.

### SUMMARY OF CONCLUSIONS

The panel examined the circumstances of the health care and treatment of Garry Taylor in accordance with the terms of reference and found that the quality and scope of his treatment was poor. Risk assessment and management was inadequate and there was poor communication and record keeping. The quality of the interface between the mental health services, other agencies and the family left much to be desired. The panel were conscious of the central role played by the family of Garry Taylor in his care and the need fully to involve and support them; there was a failure to achieve this. The CPA ought to have provided a framework within which his care could have been managed effectively. There was a failure to follow CPA in this case and only partial compliance with statutory obligations and other national guidance.

After looking at the whole of the evidence before it, the belief of the panel is that the death of Colin Johnson was an event which, in all probability, would not have occurred had the management of Garry Taylor's treatment been carried out in the manner and to the standards which the patient, his family and the members of the wider community were entitled to expect.



## 7 Recommendations

The Mental Health National Service Framework published in 1999 set out a vision of a better mental health service.

It expressed the case for reform in 11 principles, stating that people with mental health problems should expect that services will:

- involve service users and their carers in planning and delivery of care
- deliver high quality treatment and care which is known to be effective and acceptable
- be well suited to those who use them and non-discriminatory
- be accessible so that help can be obtained when and where it is needed
- promote their safety and that of their carers, staff and the wider public
- offer choices which promote independence
- be well coordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support their staff
- be properly accountable to the public, service users and carers
- reduce suicides.

These principles govern the process of reform. The subsequent Mental Health Policy Implementation Guide set out a framework for achieving those objectives.

The panel was of the view that those objectives have not been achieved in the Sunderland area and that the failure to achieve those objectives lies at the heart of the deficiencies referred to in the conclusions set out above. The panel's opinion is that a long list of detailed recommendations addressing each of those deficiencies would detract from the need for a comprehensive programme of service modernisation in Sunderland. The panel has therefore taken the unusual step of making a single recommendation in relation to the mental health services for working age adults in the Sunderland area.

**The panel recommends that the SHA should require the Trust to establish a service improvement team, with appropriate external representation, to bring about a fundamental change of attitude in the Sunderland area, to modernise mental health services in line with the eleven principles for reform contained in the MHNSF and to ensure that there is commitment to such reform at all levels. The actions of this team and the responses of professionals to it will need to be monitored in such a way as to assure the Trust Board and SHA that effective action has been taken.**

## RECOMMENDATIONS

The panel recognises that this may take some time to implement and, whilst in no way wishing to detract from the above, has set out in Appendix A certain steps that the SHA ought to require the Trust to take as a matter of urgency.

In addition to the above recommendation, which is restricted to the Sunderland area, the panel felt that the circumstances of this case warranted a further recommendation for all forensic mental health services.

**The panel recommends that when the care of patients is transferred from forensic services to local secondary care mental health services, a transfer summary should accompany them and be copied to the GP. The summary should detail the outcome of the assessment by the forensic services and include, as a minimum, sections on diagnosis, risk assessment and advice on future management.**

## 8 Glossary and Abbreviations

AOT	Assertive Outreach Team
ASW	Approved Social Worker
CMHT	Community Mental Health Team
CN	Charge Nurse
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRT	Crisis Resolution Team
Diminished Responsibility	A finding that a person is not wholly responsible for his actions by reason of mental illness which reduces a charge of murder to manslaughter
ECG	Electrocardiograph
FME	Forensic Medical Examiner (formerly Police Surgeon)
FN	Forensic Nurse
HONOS	Health of the Nation Outcome Scale
MAPPA	Multi Agency Public Protection Arrangements
MAPPVA	Multi Agency Public Protection for Vulnerable Adults
<b>Mental Health Act</b>	
Section 2	Provides authority for someone to be detained in hospital for assessment
Section 3	Provides authority for someone to be detained in hospital for treatment
Section 12	Provides for doctors to be approved to make recommendations under the Act
Section 35	Allows a court to send a person to hospital for assessment and a report to the court rather than remanding in custody
Section 37	Empowers a court to send a person to hospital for treatment
Section 41	A restriction section that means that the patient sent to hospital by a court cannot be given leave, transferred or discharged without the agreement of the Secretary of State
Section 114	Provides for social workers to be approved to make arrangements for assessments and admissions under the Act
Section 117	Imposes a duty on statutory authorities to make arrangements to provide continuing care and support to persons who have been treated under the provisions of the Act
Section 135	Allows an ASW to obtain a warrant which permits a police officer to enter premises and remove a person to a place of safety for an assessment
MDO	Mentally Disordered Offenders Services
PALS	Patient Advice and Liaison Service
PSI	Psycho Social Interventions
SHO	Senior House Officer (Doctor in Post Graduate Training)
SN	Staff Nurse
SR	Senior Registrar (Doctor in Post Graduate Training)
SW	Social Worker



## 9 Bibliography

- 1 The report of the internal review undertaken by trust management and the trust's action plan response

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- 2 Written statements and other documentation supplied by Garry Taylor's family

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- 3 Clinical and multi-disciplinary records relating to the health and social care provided to Garry Taylor over his adult lifetime

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- 4 Primary health care records

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- 5 Social services department records

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- 6 Relevant police records

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- 7 CHAI/Healthcare Commission report of their clinical governance review in the Trust and the Trust's action plan response February 2005

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- 8 CHAI/Healthcare Commission annual performance ratings for the trust, 2003/04 – 2005/06

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- 9 CHI National Staff Survey 2003 – results for trust

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- 10 Report of the Independent Review Panel into Serious Untoward Incidents and Complaints at Cherry Knowle Hospital – February 2002

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- 11 Report of the Mental Health Act Commission Annual Report of the trust December 2005 and the trust's action plan response

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- 12 Trust's business plans and annual reports for the previous five years

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- 13 Information relating to the merging of the trust and local authority mental health services 2002 -2003

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- 14 The trust's delivery plan 2005/06

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- 15 Relevant national (Department of Health) guidance including:
  - NHS Executive reports on combining NHS:LA care management;
  - National Service Framework (NSF) for Mental Health Services – Modern Standards and Service Models, 1999;
  - Effective Care Co-ordination in Mental Health Services – modernising the Care Programme Approach. 1999;
  - NSF Mental Health Policy Implementation Guide;
  - Keys to Engagement in the Health of the Nation series;
  - MH Act Code of Practice – assessments at family request

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- 16 The Trust's responses to the above in the form of operational policies and staff guidance documents and particularly in relation to:
  - CPA – several versions
  - Risk management
  - Serious Untoward Incidents management
  - DNA/failure to engage
  - Crisis Resolution Teams
  - Primary Mental Health Teams
  - Secondary Mental Health Teams
  - MAPPVA procedures 2002 onwards
  - Relatives requesting mental health assessments

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- 17 Royal College of Psychiatrists – ‘Good Psychiatric Practice’, 2000

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  - 18 General Medical Council – ‘Good Medical Practice’, 2001

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  - 19 Post-mortem report of the death of Colin Johnson

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  - 20 Royal College of Psychiatrists - ‘Assessment and clinical management of risk of harm to other people’ pamphlet

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  - 21 Professor Maden report – Review of Homicides by Patients with Severe Mental Illness, 2006

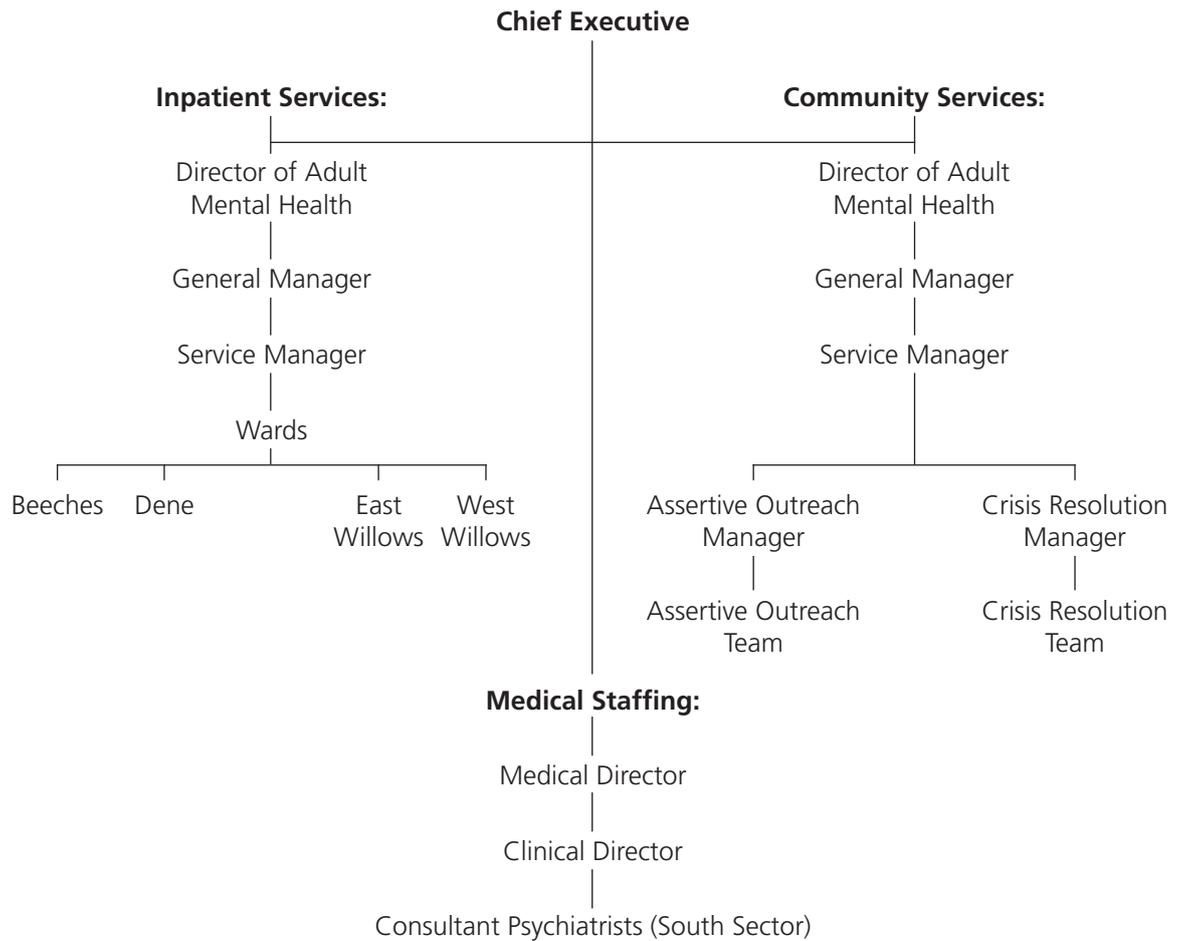
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  - 22 University of Manchester - five year report of the national confidential inquiry into suicide and homicide by people with mental illness: Avoidable Deaths, 2006

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# 10 South of Tyne & Wear Mental Health Trust – Organisational Chart – Sunderland Locality circa 2002 - 04

The services presented below are restricted to those that may have been relevant to Garry Taylor and are not inclusive of the extended range of services provided by the Trust.





## 11 Appendix A

- Ensure that there are effective performance management arrangements in place for service managers and clinical teams;
- Undertake an audit of clinical supervision in order to ensure that robust systems are in place;
- Review and ensure that the arrangements for carer assessments are effective;
- Ensure that the contributions of carers are fully integrated into CPA;
- Review the effectiveness of PALS, complaints processes and access to advocacy services;
- Undertake a comprehensive audit and review of the operation of CPA to include the role and effectiveness of care coordinators;
- Approach the Local Authority with a view to conducting a detailed review of the ASW service to ensure effective operation, compliance with the MHA Code of Practice, and that there are opportunities to learn lessons from case reviews;
- Implement a unified system of clinical records and undertake an audit of the quality of clinicians record keeping;
- Review the operation of the AOT to ensure compliance with national policy guidance, with a particular emphasis on engagement;
- Develop and implement effective arrangements for clinical risk management that are subject to regular audit and review;
- Develop and implement a policy on covert administration of medication;
- Review the role and function of Dene Ward with a view to developing an effective operational policy in line with current national policy guidance;
- Engage with primary care in Sunderland in order better to understand the concerns of GPs regarding the provision of specialist mental health services.





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