Report of Inquiry into the Care and Treatment of Mr L and Mr M

mentalwelfare
commission for scotland

Contents

Section 1

Background to the inquiry

1.1 Terms of Reference

1.1.1

On 15 March 2005, the Commission was invited by the First Minister, the Rt Hon Jack McConnell, to conduct an Inquiry into the care and treatment of Mr L and Mr M. The Commission agreed to set up an Inquiry into the care and treatment of Mr L and Mr M under Section 3(2) (a) of the Mental Health (Scotland) Act 1984.

1.1.2

The Commission gave the Inquiry Team the remit to enquire into the care and treatment of Mr L from the implementation of his Restriction Order in 1997 until he was remanded in custody in October 2004 and to include the decision to grant him a conditional discharge in April 2003. The Inquiry Team were also urged to enquire into the care and treatment received by Mr M, the victim of Mr L's offence.

1.1.3

The Inquiry was directed to address itself, amongst other relevant issues, to the following questions:

(1) All aspects of the care and treatment of Mr L since the implementation of his Restriction Order in 1997 until he was remanded in custody in October 2004, including the decision to grant a conditional discharge in April 2003.

(2) To identify any lessons which might be learnt for the care and treatment of other patients.

(3) To enquire into the care and treatment received by Mr M, the victim of Mr L's offence, who was known to have a history of mental illness and was, briefly, a restricted patient himself.

1.2 Inquiry Team

Reverend Canon Joe Morrow
Commissioner (Part-time),
Mental Welfare Commission
Chair of the Inquiry

Dr Madeline Osborn
Medical Commissioner
Mental Welfare Commission

Mr Jamie Malcolm
Nurse Commissioner
Mental Welfare Commission

The Inquiry was assisted by Mr Charles Burns
Administration Manager
Mental Welfare Commission.

1.3 Method of undertaking the Inquiry

1.3.1

The Inquiry investigations began with the assembly and perusal of the medical, nursing and social work notes. Further written material was obtained from different agencies involved, and was also reviewed.

1.3.2

Mr L was interviewed by the Inquiry Team at the State Hospital and his brother was invited to give evidence to the Inquiry, but declined.

1.3.3

A list of the people interviewed who were involved in the care of Mr L and Mr M is given in Section 1.4 of this report. These interviews took place at various places in Scotland and shorthand notes were taken of the interviews. All those approached by the Inquiry Team co-operated fully and provided a substantial amount of information. The interview notes taken by the shorthand writer were sent to the person concerned for correction with regard to factual accuracy.

1.3.4

It was made clear to all those interviewed that the Inquiry would be reporting to the First Minister on conclusion in terms of the Mental Health (Scotland) Act 1984.

1.4 List of Persons Interviewed

Mr L
Patient
State Hospital

Medical Staff

Dr RMO1
Consultant Forensic Psychiatrist

Dr RMO2
Specialist Registrar in Psychiatry

Dr PA2
Psychiatric Adviser
Scottish Executive Health Department

Dr CD
Clinical Director for Forensic Services

Dr CP
Consultant Psychiatrist in General Adult Psychiatry

Dr GP
General Practitioner

Forensic Community Nursing Staff:

Ms FCPN1
Forensic Community Psychiatric Nurse

Mr FCPN2
Forensic Community Psychiatric Nurse

Mr FCPN3
Forensic Community Psychiatric Nurse

Prison staff:

Mr HCM
Prison Health Centre Manager

Social Work Staff:

Ms SW1
Social Worker
Forensic Service

Mr SW2
Practice Team Leader
Social Work Department

Scottish Executive Staff:

Ms SE1
Mental Health Division
Scottish Executive

Mr SE2
Directorate of Service Policy and Planning
Health Department
Scottish Executive

1.5 Acknowledgement

1.5.1

The Inquiry Team would like to thank all those who participated in the Inquiry for their co-operation, both in interviews with the Mental Welfare Commission and through the provision of reports in case file material as requested.

Section 2

Summary of key events

2.1

Mr L was born on 13 October 1958. He completed his education at 16 years old and began a four year apprenticeship as an insulation engineer which he completed. Thereafter he travelled throughout Britain, working in this capacity. He married in 1983 and has one son, with whom Mr L has had no contact since his son was 11 years old. The marriage broke down and he has had no long term relationship since then.

2.2

In 1991, he was charged with assaulting a man with a machete in England, and underwent a period of psychiatric treatment under section 28 of the Mental Health Act 1983. In 1994, he was charged with serious assault after attacking his eldest brother.

2.3

On 17 May 1997, Mr L seriously assaulted a man known to him. Psychiatric assessments indicated that the offence was associated with a mental illness.

2.4

On 10 December 1997, he was convicted of assault to the severe injury and danger to life and placed on a hospital order with a restriction order under sections 58 and 59 of the Criminal Procedure (Scotland) Act 1995.

2.5

He was initially treated in Murray Royal Hospital, Perth and then transferred to his home area under the care of the local forensic psychiatry service. His mental health appeared to fluctuate whilst he was an inpatient.

2.6

In January 2001, his Responsible Medical Officer (RMO), Dr RMO1, recommended that Mr L should be given a conditional discharge from hospital. A submission for his conditional discharge was first made to the First Minister in May 2002. On 22 April 2003, the First Minister granted Mr L's conditional discharge from hospital.

2.7

In the summer of 2004, Mr L showed signs of a relapse in his mental illness. He was not recalled to hospital. On 21 October 2004 he attacked Mr M, who was also a patient of the forensic psychiatry service. Mr L was charged with Mr M's murder on 25 October and remanded to prison.

2.8

He was transferred to the State Hospital, Carstairs on 2 November 2004 for further assessment and his case was finally disposed of in the High Court on 14 November 2005. Mr L was given a life sentence, with a punishment component of nine years. This was combined with a Hospital Direction, and he was returned to the State Hospital for treatment.

Section 3

Psychiatric aspects of Mr L's care

3.1 Evidence in respect of Mr L's psychiatric care

3.1.1

Mr L's past psychiatric history is vague until he entered the forensic psychiatric services. Mr L has confirmed previous contact with psychiatric services both in England and Scotland and in his early 20s had a history of drinking alcohol and smoking cannabis on a social basis. He also indicated that he had used "speed" and "magic mushrooms".

3.1.2

In 1991, he was remanded to a secure mental health unit in England under section 28 of the Mental Health Act 1983, after he was charged with assaulting a man with a machete. He remained an inpatient before being discharged on leave of absence in January 1992, when he returned to Scotland.

3.1.3

In 1994, he was charged with serious assault, after attacking his eldest brother.

3.1.4

On 17 May 1997, Mr L seriously assaulted a man known to him by stabbing him in the neck repeatedly with a screwdriver, repeatedly striking him with an axe, striking him on the head with an axe and kicking him repeatedly on the leg.

3.1.5

Mr L was remanded to a hospital, where he was diagnosed as suffering from a mental illness, probably an affective psychosis. Psychiatric reports prepared during the period of remand indicated that Mr L's offence was associated with psychotic beliefs and experiences. The reports described Mr L's account of the day of the assault. He had been invited to a cottage in the country for the day. On the way there, he had found a lamb which had escaped from a field. He replaced the lamb and later saw shafts of light coming down from the sky. He interpreted this as being a sign from God that he was 'a good shepherd' and that God was thanking him. Mr L believed that he could read the minds of the other people present and that the man he subsequently attacked had 'a negative and evil presence' and was trying to influence him in a negative way. He believed that the man was going to harm a lamb. He felt that he had to kill him and that his hand had been 'guided by God'. The reports indicate that Mr L was remorseful, however, afterwards and that he recognised that what he had done was wrong. The reports indicated that, at some point during this episode, he had taken an illicit drug, probably ecstasy.

3.1.6

He was ordered to be detained in a hospital away from his home, as no bed was available locally. The court did not consider at this time he required the special security of the State Hospital.

3.1.7

Mr L settled well in hospital: his symptoms stabilised on medication and he was co-operative and engaged in ward activities.

3.1.8

In April 1998, Mr L received a full neuropsychological assessment which revealed

that he had an impaired ability to process information. This might have been related to his medication or his psychotic illness. The results appeared to be in keeping with his estimated below average intellectual ability.

3.1.9

He made good progress and was transferred to a hospital in his home area in September 1998, under the care of Dr RMO1, Consultant Forensic Psychiatrist. He remained under Dr RMO1's care until he was charged with Mr M's murder in October 2004.

3.1.10

Following his transfer, his mental health appeared to deteriorate. He appeared socially disinhibited and over familiar with female staff and his behaviour appeared abusive and grandiose at times. He showed no insight into the apparent deterioration in his mental health state. Thereafter he improved and there followed a period of relative stability with regard to his mental health. He was allowed access to the hospital grounds.

3.1.11

In April 1999, staff were informed Mr L had brought amphetamines into the ward and had been injecting himself. There was no change to his mental state but he refused to give staff a urine sample. His leave was suspended.

3.1.12

In July 1999, Mr L became withdrawn and preoccupied. He became suspicious and then hostile. He was not happy about plans to move him to a newly opened secure forensic unit within his current hospital. He continued to deny his mental health problems. In September 1999, he smashed up the ward sitting room and required to be sedated. His leave was again suspended.

3.1.13

In February 2000, Mr L was placed on the Care Programme Approach. At a Care Programme Approach meeting held in May 2000, Dr RMO1 described Mr L's clinical progress and state of health as excellent and no concerns were expressed. At the meeting it was agreed Mr L could leave the hospital to live with his brother.

3.1.14

In preparation for this leave, Mr L was granted the First Minister's permission to have one overnight stay in his brother's house per week. Mr L handled this well and, by December 2000, was having a maximum of five days (four nights) leave per week with his brother. Mr L was also attending art and woodwork projects and an evening language course. He travelled to and from these places on his own. In January 2001, Dr RMO1 recommended to the Mental Health Division of the Scottish Executive Health Department that Mr L be conditionally discharged.

3.1.15

The recommendation for Mr L's conditional discharge was not pursued because his mental health deteriorated later in January 2001. Mr L had discontinued his Lithium and questioned the need for it. His Leave of absence was curtailed until his condition improved. In February 2001 urine testing was positive for Cannabis and in April 2001 it was positive for morphine. Mr L stated that he had been eating "hash cakes" but denied taking opiates.

He was offered, but declined, psychological intervention.

3.1.16

Dr RMO1 observed that his behaviour quickly stabilised and his leave of absence was reinstated. Mr L continued to be detained in hospital and in June 2001 the then Forensic Psychiatry Advisor to the Scottish Executive, Dr PA1, sought access to his notes and, in July 2001, in a "note for the record", stated that he showed subtle signs of relapse including irritability and sexually inappropriate behaviour.

3.1.17

On 30 July 2001, Dr PA1 indicated to the clinical team that it was too early to put the case for conditional discharge forward, as the First Minister would require a full risk assessment, and details of Mr L's past history and how he would be managed on discharge.

3.1.18

In September 2001, the Mental Health Division of the Scottish Executive Health Department (SEHD) wrote to Dr RMO1 to seek a risk assessment and asked him to address the issues of Mr L's mental health and drug abuse and how he would be monitored if discharged from hospital.

3.1.19

In October 2001, a substance thought to be cannabis was found in Mr L's medication box but a urine test was negative for cannabis. He claimed that someone else had put the substance in his medication box.

3.1.20

Later in the autumn of 2001, there were two incidents in which Mr L brought a drill, tools or drill bits on to the ward at his hospital. He stated that he was using the drill for work on one of his placement projects and it had been in his possession when he returned to the hospital. The clinical team checked this out and was satisfied there was nothing sinister in Mr L's actions. There was a further incident, reported by Mr L himself, which involved finding a young woman in distress and taking her home with him.

3.1.21

In December 2001, Dr PA2 who had taken up post as the Adviser in Forensic Psychiatry to the Scottish Executive Health Department, wrote to Dr RMO1 expressing concerns that relevant information had been withheld from the Executive. This included the possession of the drill on the ward and the use of cannabis. A further email from Dr PA2 in December 2001 expressed concerns about the recommendation Dr RMO1 was making for conditional discharge.

3.1.22

In December 2001, there were several communications between the SEHD's Mental Health Division and Dr RMO1, in which the Division expressed the need for a Critical Incident Review with regard to the "drill incident". The Division indicated that Mr L's overnight leave of absence should be withdrawn to allow an investigation of a further incident. This incident was reported by Mr L, who said that he had come to the aid of a woman who threatened to harm herself and had taken her back to his brother's flat. The Division also requested that a Critical Incident Review be held with regard to the cannabis in

Mr L's medication box in the previous October.

3.1.23

A Critical Incident Review was carried out in December 2001 and recommended a number of action points, including a risk assessment and development of a management plan.
On 11 January 2002, there was a full meeting, attended by officials from the Mental Health Division, to discuss Mr L's case. Dr RMO1 subsequently sent the Division a short summary of scores on a risk assessment measure.

3.1.24

In January 2002, Dr PA2 assessed Mr L and, at her interview, raised a number of concerns. These included his attitude towards drugs, the structure of his day and his presentation at interview, which was marked by irritability and argumentativeness.

3.1.25

On 22 March 2002, Dr RMO1 wrote to Dr PA2, indicating the risk factors in Mr L's case which would be monitored following his conditional discharge. In the letter, Dr RMO1 stated that "recall to hospital will be considered sooner, rather than later, if there are worrying changes in his mood, behaviour, drug or alcohol use or lifestyle".

3.1.26

On 11 April 2002, the Mental Health Division wrote to Dr RMO1 asking for a copy of the full risk assessment on Mr L. The letter also requested that Mr L undergo random drug testing in the community and asked what the proposed supervisory arrangements would be in the community, if he were to be conditionally discharged.

3.1.27

On 17 April 2002, Dr RMO1 sent a letter to Ms SE1, of the Mental Health Division, advising that the only documentation of a risk assessment was a single page prepared at a clinical meeting on 8 February 2002. Dr RMO1 confirmed that he would implement random drug testing for Mr L in the community. He proposed that he would see Mr L every two weeks initially and that the CPN and social worker would do so every week.

3.1.28

The Mental Health Division raised the issue of risk to young girls. In the letter of 17 April, Dr RMO1 responded that the clinical team had considered the matter and had discounted any risk to women or young girls, as Mr L's offences were never committed against women and he had no history of sexual offending.

3.1.29

On 29 April 2002, Dr PA2 indicated that, in the light of the unanimous agreement of the clinical team, she would not oppose a conditional discharge.

3.1.30

In May 2002, SEHD made a submission to the First Minister seeking approval for Mr L's conditional discharge from hospital, to his brother's house. In June 2002, the First Minister requested a delay of three months before reconsidering the request for a conditional discharge. On 15 April 2003, SEHD made a further submission to the First Minister seeking approval for conditional discharge, which he approved on 22 April 2003.

3.1.31

The delay of almost a year in Mr L's conditional discharge was due to concerns raised by the Mental Health Division of the Scottish Executive. It included an incident on 27 July 2002 when Mr L returned from four nights leave of absence to his brother's house and reacted badly to nursing staff who wished to carry out a routine search of his belongings. During this period Mr L was referred to a psychologist for assessment with regard to his anger management. In a letter of 4 October 2002 to Dr RMO1, the psychologist reported that an initial assessment raised a number of concerns. These included Mr L's continuing anti-authoritarian attitude and lack of insight into indicators that his mental health was deteriorating. She reported that his mental state did not appear to be stable and she raised possible issues about his future compliance with treatment. She also reported he was becoming increasingly irritable and unreasonable.

3.1.32

Prior to Mr L's release, a proposed care package was put in place. His care plan provided that Mr L should live with his brother; he should attend a work project at a riding stables; and he should receive injections of depot antipsychotic medication from his Forensic Community Psychiatric Nurse (FCPN). He was also to see his FCPN and supervising social worker weekly initially and Dr RMO1, his Responsible Medical Officer, twice in the first month and thereafter monthly. He was also to continue to be managed by the Care Programme Approach.

3.1.33

On 30 April 2003, Mr L was conditionally discharged from hospital and the police were informed.

3.1.34

Dr RMO1 continued to be responsible for the supervision of Mr L after his conditional discharge until he killed Mr M in October 2004, except for a two month period in July and August 2004. During this time, Dr RMO1 had a period of pre-arranged sick-leave and Mr L's care was transferred to Dr RMO2.

3.1.35

The Inquiry interviewed Dr GP, Mr L's GP. Dr GP indicated that Mr L registered with Dr GP's practice on 26 March 2003, prior to his conditional discharge. The practice had no previous contact with Mr L, though it had frequent contact with him following his conditional discharge; he attended the surgery on a number of occasions with a variety of minor physical ailments. The practice did not have any written information about Mr L, apart from a standard discharge letter dictated on 5 May. Dr GP indicated that the practice did not have a written risk assessment or management plan.

3.1.36

In May 2003, Dr RMO1 wrote to the Mental Health Division at the Scottish Executive with a positive report about Mr L.

3.1.37

On 5 June 2003, Dr RMO1 wrote to Dr PA2, the Adviser in Forensic Psychiatry, to state that he had seen Mr L on 5 June 2003 with the FCPN and the social worker. On this occasion Mr L seemed to be tired and low in spirit and had questioned

how long his supervision and medication would continue. It was confirmed that he was attending the stables once per week, but had no great interest in an occupational therapy placement he had been given. He had identified a potential flat for himself around the corner from his brother.

3.1.38

On 20 June 2003, Dr RMO1 confirmed to Dr PA2 that a Care Programme Approach meeting had taken place on 20 June 2003. No problems had been raised by the FCPN, who was seeing Mr L weekly, or the supervising social worker, who was seeing him every two weeks. There were also no medical problems. It was reported that Mr L had commenced antidepressant medication and was feeling more energetic and less irritable. Dr RMO1 was seeing Mr L every three weeks.

3.1.39

During the period from June 2003 to around March 2004, Dr RMO1 and the supervising social worker sent the Mental Health Division regular reports about Mr L, which did not highlight any problems in his mental state.

3.1.40

On 7 May 2004, Dr RMO1's Annual Report to the Mental Health Division stated that he had discontinued Mr L's depot antipsychotic medication in December 2003, at Mr L's request, and had prescribed an oral alternative. He also reported that Mr L's antidepressants had been discontinued. He reported that, from the start of 2004, Mr L had been taking only Lithium Carbonate, a mood stabilising drug, and that his compliance with this medication had been variable over the months. Dr RMO1 indicated he was keen to ensure that the dose of Mr L's Lithium was therapeutic but at that point his serum level was below the therapeutic range. At this time, Mr L had a diagnosis of manic depressive psychosis.

3.1.41

On 6 May 2004, Dr PA2 reported on an interview with Mr L on 29 April 2004 which was not attended by Dr RMO1. Dr PA2 had spoken to Dr RMO1 on the telephone and expressed concerns that Mr L had been taken off his depot medication and had not been started on an oral alternative as Dr RMO1 had stated in his previous letter. Dr RMO1 stated that Mr L was reluctant to take depot medication because he considered that it gave him side effects. He reported that Mr L's serum Lithium level had been checked and was found to be below a therapeutic level. Dr RMO1 reported that Mr L's mental health was good and was likely to remain so, as long as he took the Lithium medication. Mr L had reported that he was content with his life and felt better since the depot had stopped. He had moved into a new flat which he was sharing with his brother.

3.1.42

On 2 June 2004, a letter was sent from Dr PA2 to Dr RMO1 expressing concern that the depot medication that Mr L had been receiving had been stopped and, in particular, that it appeared that Mr L was not complying with his Lithium medication. She suggested that Mr L should be re-commenced on depot medication, if his tests indicated that he was

not taking his Lithium medication regularly.

3.1.43

On 4 June 2004, Dr RMO1 wrote to Dr PA2 stating that he and the FCPN had seen Mr L on 1 June 2004 as Mr L had forgotten his appointment on 28 May. The CPN had said that Mr L appeared to be more excitable and agitated than when she had seen him three days earlier. It was noted there was no obvious explanation and nothing to suggest substance misuse.

3.1.44

On 29 June 2004, a letter from Dr RMO1 to Dr PA2 stated that Ms SW1, Ms FCPN2 and Dr RMO1 had met with Mr L in his own home and that Mr L was in good spirits. On this occasion his serum Lithium level was again sub-therapeutic. He was either not taking his medication or the dose was too low. It was noted that Mr L agreed to Dr RMO1's proposal to increase the dose.

3.1.45

Dr RMO1 thereafter went on prearranged sick leave to undergo elective surgery and Dr RMO2, a Specialist Registrar within the forensic psychiatry service, took up the post as Locum Consultant and RMO for Mr L. Dr RMO2 was responsible for Mr L's care between 5 July and 31 August 2004.

3.1.46

The details of the handover between Dr RMO1 and Dr RMO2 are not clear, particularly on the question of whether this was done by verbal communication or through notes. At interview Dr RMO1 indicated that he did not recall speaking to Dr RMO2 about Mr L, nor did he recall whether he had written anything about Mr L. Dr RMO1 indicated that there was no risk management plan fully in place with regard to Mr L's case. Dr RMO1 also indicated that the arrangements for the handover between himself and Dr RMO2 were the same as they would be for any other patient.

3.1.47

Dr RMO1 also indicated at interview that he did not recall if he had any detailed discussion about the clinical supervision to be put in place for Dr RMO2 during his absence. Dr RMO1 indicated he could not recall if any formal procedure had been carried out with regard to Dr RMO2's support or supervision.

3.1.48

At interview, Dr RMO2 indicated that he had read Mr L's case notes thoroughly when he had responsibility for his care. He was aware that Mr L was subject to a restriction order. Dr RMO2 stated that he could not recall if there was a risk assessment plan in place or not, as there was a "big pile of casenotes". He did indicate that he did not recall seeing any sort of risk management plan or crisis plan with regard to Mr L. Dr RMO2 confirmed that he did not recall Dr RMO1 telling him about Mr L, with regard to his risk assessment or possible signs of relapse. Dr RMO2 also confirmed that he did not recall Dr RMO1 informing him about the undertaking to the Mental Health Division with regard to Mr L's conditional discharge.

3.1.49

Dr RMO2 confirmed that there were arrangements in place to help him with

difficult patients: he stated that he would talk over problems with the multidisciplinary team, of which he was part. He indicated that the team consisted of the ward team and the staff around the ward at that time. With regard to Mr L, it also included Ms FCPN2 and Mr FCPN1, his previous FCPN. Dr RMO2 confirmed that there were no arrangements made for him to consult a senior psychiatrist, if he had any doubts or difficulties.

3.1.50

Dr RMO2 told the Inquiry that he had taken annual leave during his locum period; this was for a period of a week, between 23 and 30 August 2004, just prior to Dr RMO1's return. Dr RMO2 took a further period of leave of absence for a period of three days, between 1 and 3 September immediately after his locum ended. Dr RMO1 returned from sick leave on 1 September 2004. There was no information on whether any Consultant Psychiatrist was responsible for Mr L during the period of Dr RMO2's leave and until Dr RMO1's return. Dr RMO2 and Dr RMO1 did not discuss Mr L's care prior to, or after, Dr RMO1's return.

3.1.51

During the period of Dr RMO1's leave, Dr RMO2 wrote to Dr PA2. On 28 July 2004, Dr RMO2 wrote that he had met Mr L, with Ms SW1 and Ms FCPN2, on 27 July 2004 and that his dose of Lithium had been increased.

3.1.52

In a further letter to Dr PA2, dated 20 August 2004, he reported that, together with Ms FCPN2, he had visited Mr L on 19 August 2004. Ms FCPN2 had reported to him that Mr L showed increased irritability, in relation to mental health professionals, and resentment of monitoring. Ms FCPN2 had also noted that his irritability might have been signs of a relapse of Mr L's mental illness. In his letter, Dr RMO2 reported that the stables in which Mr L worked had not expressed any concerns about his behaviour.

3.1.53

Dr RMO2 told the Inquiry that he had seen Mr L twice during his period as a locum. On the first occasion he had seen him at a CPA meeting and, on the second, at home on 19 August. On this visit, he was accompanied by Ms FCPN2. On both occasions, he found Mr L to be strikingly opposed to being followed up and monitored. At the home visit Mr L was irritable. In Dr RMO2's view, this was possibly as a result of his Lithium medication levels not being adequate. Dr RMO2 noted that Mr L's environment and personal care were of a high level.

3.1.54

Dr RMO2 stated that he was aware of the psychopathology associated with Mr L's index offence; from memory, he stated that it related to concerns about animals, especially the protection of animals from ill-treatment. Dr RMO2 stated that, when he visited Mr L, he asked him about his work at the stables to find out how he saw himself and how other people saw him.

3.1.55

In her written account, examined by the Inquiry team, Ms FCPN2 had noted that after she and Dr RMO2

had left Mr L's flat, he had shouted after them about his index offence. When asked about this, Dr RMO2 told the Inquiry that Mr L's behaviour was disinhibited. Dr RMO2 indicated that he was unclear how Mr L's language related to his psychopathology. He recalled that his discussions with Ms FCPN2 concerned the fact that Mr L's situation was not clear and that an early arrangement would be made for an appointment with Dr RMO1. Dr RMO2 stated that at this stage they had a discussion about Mr L's medication. At interview, Dr RMO2 indicated that he had considered prescribing antipsychotic medication but decided to await a check of Mr L's serum Lithium level and the outcome of follow up assessment of Mr L.

3.1.56

Dr RMO2 said he also spoke to Mr FCPN1, Mr L's previous FCPN, and obtained some further background information about Mr L. He indicated that he had made no enquiries into the likelihood of Mr L using illicit substances.

3.1.57

Dr RMO2 stated that, after the incident at Mr L's flat, he had not considered whether Mr L should be recalled to hospital. Dr RMO2 stated that when he took annual leave, prior to Dr RMO1's return from sick leave, he was not aware that Ms FCPN2 was also going to be away on annual leave. Dr RMO2 could not recall whether he had spoken to Ms FCPN2 or left a message for her before he went on leave. Dr RMO2 stated that he thought Ms FCPN2 would pass on the necessary information about Mr L's mental state to Dr RMO1 when he returned to work.

3.1.58

Dr RMO2 indicated that he was of the view that Mr L's serum Lithium level required to be checked at this time and indicated that he would have written to Dr GP concerning this matter. He indicated that he would have phoned to contact the doctor but might not have got through, and so would have sent a letter to the doctor. Dr RMO2 indicated that, on both occasions he had visited Mr L, a letter to the General Practitioner would have been sent.

3.1.59

Mr L's case notes show that his Lithium level was subsequently checked on 25 August and reported by the laboratory to be within the therapeutic range.

3.1.60

On 30 August, Mr L's General Practitioner, Dr GP wrote to Dr RMO2 to report a visit by Mr L to the surgery on 27 August. He reported that Mr L had expressed dissatisfaction with the psychiatry services and had threatened to report them to the media. Dr GP indicated to the Inquiry that, at that time, Mr L had come to the surgery inappropriately dressed and had behaved in a sexually disinhibited manner towards nursing staff.

3.1.61

During the period of Dr RMO2's care, Mr L had failed to attend interviews with his social worker on 27 and 30 August 2004.

3.1.62

After his return to work, Dr RMO1 saw Mr L on 2 September, together with Mr FCPN3, a FCPN who was deputising for Ms FCPN2 during her period of leave. (Nursing notes of that meeting described Mr L as irritable and confrontational and accusing staff of being liars. He stated that he deserved a medal for 'saving that wee lamb'. He again said he was going to go to the media about the hospital and that he intended to sue it). In a letter to Dr PA2, dated 8 September, Dr RMO1 described Mr L as showing increased irritability and lack of insight and also complaining about being unduly restricted by the requirements of his supervision. Dr RMO1 stated that he had considered recalling Mr L to hospital, but thought that "the problems were not of this magnitude". He had decided to refer Mr L to the local Community Mental Health Team.

3.1.63

Dr RMO1 asked Dr CP to work with Mr L. Dr CP is a Consultant Psychiatrist in General Adult Psychiatry. Dr RMO1 asked her to become involved with Mr L's care to assist with the management of Mr L's mental health and also because he had been becoming antagonistic towards the forensic psychiatric services. At this time, Mr L had become angry and suspicious with regard to his treatment; he believed that Dr RMO1 was acting on behalf of the Scottish Executive because of the Restriction Order.

3.1.64

Dr CP told the Inquiry that she saw Mr L on three occasions. The first was an introductory meeting on 9 September at a mental health resource centre. Dr RMO1, Ms FCPN2 and Mr L's social worker were also present. Dr CP also indicated that Mr L's brother and a friend were at the meeting. Dr CP indicated there was to be a follow-up meeting on 23 September, but Mr L missed this appointment. Another meeting was set up (on 30 September 2004), which coincided with a meeting with Dr PA2 who had been asked to attend by Dr RMO1, to explain Mr L's Restriction Order to Mr L and his companions.

3.1.65

Dr CP recalled that at the second meeting she had a discussion with Mr L and his friend about what should happen if he became unwell again. Dr CP indicated that she had discussed with them the possible need for more medication and indicated that she thought that "insight orientated treatment" could be helpful in the long term.

3.1.66

In a letter to Dr GP, dated 4 October, Dr CP described Mr L as 'rather irritable and tetchy' at the meeting on 30 September. She noted that 'he completely lacked insight into his bipolar illness or his index offence'. However, she commented that he was prepared to accept medication, if it meant that he could stay out of hospital.

3.1.67

Dr CP indicated that a third meeting took place at the hospital psychiatric outpatient department on 14 October. Dr RMO1 was also present at this meeting. Mr L had just come from the night-shift at the stables and Dr CP described him as looking dirty and dishevelled.

She described Mr L as being guarded, but happy to talk about his work.

3.1.68

Following the meeting, discussion took place between Dr CP and Dr RMO1 about Mr L's mental health. It was agreed that, because of Mr L's antagonism towards forensic psychiatry services, Dr RMO1 should not continue to sit in on the sessions with Dr CP. It was agreed that Dr CP would see Mr L monthly, with Dr RMO1 joining them at alternate monthly meetings. It was agreed that Dr RMO1 would continue as his RMO and that Ms FCPN2 would continue to see him fortnightly.

3.1.69

On 25 October 2004, Mr L was remanded by the police in connection with a serious incident relating to the death of Mr M, who was found badly beaten in a country park on 21 October 2004. (Mr M was a (non-restricted) patient of the forensic psychiatry service at the same hospital as Mr L). On 25 October 2004, Mr L was remanded to prison for committal for further enquiry after being charged with murder.

3.2 Observations on psychiatric aspects of care

3.2.1

Mr L had a history of major mental illness, which was associated with serious offences of violence. However, the Inquiry found no evidence that, either before or after his conditional discharge, the psychiatrists involved in his care took any systematic approach to the assessment and management of the risks posed by his illness.

3.2.2

It appeared to the Inquiry that, neither in his correspondence with the Mental Health Division, nor in his evidence to the Inquiry, did Dr RMO1 maintain an appropriate focus on the identification and management of risk in Mr L's case. Dr RMO1 did not appear to be aware of any written risk assessment, nor a risk management plan for Mr L. He had not drawn up a crisis management plan. He did not appear to have carried out any proactive planning in respect of the circumstances which would make Mr L's readmission to hospital necessary. Though Mr L was cared for under the Care Programme Approach, the section of the CPA documentation which addressed risk management had never been completed.

3.2.3

Mr L's case records showed that his illness was a relapsing and remitting one. They also indicated that his aggressive behaviour was associated with relapses in his illness. However, following his conditional discharge, the Inquiry did not find any evidence that Dr RMO1 or his team had systematically monitored likely signs of relapse, such as changes in his sleep, appetite or arousal.

3.2.4

Mr L's assault on a man in May 1997 appeared to arise from the abnormal ideas that Mr L had at that time. Psychiatric reports whilst he was on remand described the offence as being associated with his religiose delusional ideas; he believed that he had to kill the man, to save a lamb. However, it was not apparent to the Inquiry that, either before or after Mr L's conditional

discharge, Dr RMO1 had formally identified or documented those ideas of Mr L's that might herald an increased risk of violence. There appeared to the Inquiry to be no recognition that there was a need to systematically monitor his ideas, nor was there any attempt to do so. At the visit on 19th August Ms FCPN2 stated that Mr L voiced ideas consistent with those associated with his index offence. Ms FCPN's contemporaneous notes state that, as they left his flat, Mr L said that the victim of his index offence deserved it because "the b... killed a poor, wee lamb". While Dr RMO2 did attempt to establish if Mr L's mental state was significantly changed, he did not make adequate arrangements to monitor and follow up any possible deterioration.

3.2.5

Mr L was known to have a history of using illicit drugs. His index offence in 1997 was associated with the ingestion of ecstasy and, during his admission to hospital, there were repeated concerns that he might be taking either cannabis or opiates. Whilst he was in hospital, he had urine tests for the presence of illicit drugs. However, following Mr L's conditional discharge, Dr RMO1 did not appear to have requested any further drug testing, in spite of having given an undertaking to do so to the Mental Health Division. Following Mr L's conditional discharge, there was no recorded systematic monitoring of drug misuse.

3.2.6

Dr RMO1 appeared to be reactive, rather than proactive in his management of Mr L, who appeared to drive his treatment agenda to a large extent. For example, Mr L had a history of poor compliance with medication, but he was allowed to discontinue his treatment with antipsychotic medication, and further treatment was not enforced, even when he appeared to be becoming unwell. Attention only appeared to be paid to Mr L's serum Lithium level in May 2004, though there had been doubts about his compliance with this medication for some months previously. In addition, when Mr L appeared to be discontented with the psychiatric team, Dr RMO1 referred him to Dr CP to take over the management of his illness. To set up these new arrangements in September 2004, when Mr L was unwell, appeared inappropriate to the Inquiry.

3.2.7

The arrangement between Dr RMO1 and Dr CP appeared to be that both psychiatrists would supervise Mr L's care and make decisions about his management. The management of his mental illness appeared to be delegated to Dr CP. However, Dr RMO1 remained as his RMO, responsible for his supervision in respect of the Restriction Order, and, as such, managing the risk associated with his illness. Dr RMO1 and Dr CP did not work closely together, being in different services and having different bases. We think that this arrangement was likely to have led to significant communication problems and to have adversely affected the risk management in Mr L's case. There appears to have been no clarity about roles and responsibilities between the forensic clinical team,

Dr CP and Dr RMO1. In our view, without explicit lines of accountability and clear decision-making structures, this arrangement could have led to great confusion in managing Mr L's care.

3.2.8

In spite of Dr RMO1's sick leave being planned in advance, the locum arrangements for Mr L's care appeared to be extremely informal. Dr RMO2 was a trainee psychiatrist when he took over Mr L's care for a two month period at the beginning of July 2004. There were inadequate arrangements for his support or supervision by a consultant colleague.

3.2.9

Dr RMO2 had not previously been working with Mr L. However, neither Dr RMO1 nor Dr RMO2 could recall any written or verbal handover of relevant information to Dr RMO2 from Dr RMO1. From his evidence to the Inquiry, Dr RMO2 did not appear to have fully understood the history of Mr L's illness and its treatment at this time, and he did not appear to have understood all the risk issues in Mr L's case.

3.2.10

There appear to have been no handover arrangements at the end of the locum period. Indeed, Dr RMO2 was away on annual leave himself immediately prior to Dr RMO1's return and during the first few days after he resumed work. Although Mr L appeared to have relapsed, neither Dr RMO1 nor Dr RMO2 recalled speaking to each other about him. There was no evidence of any written information being given to Dr RMO1 by Dr RMO2, to update him about the situation in respect of Mr L.

3.2.11

During his period of annual leave, Dr RMO2 did not make any arrangements for another psychiatrist to assume RMO responsibility for Mr L.

3.2.12

Mr L showed evidence of relapse in August and September 2004. He was extremely irritable and antagonistic to mental health professionals. In addition, he showed disinhibited behaviour and evidence of possibly psychotic ideas when he was seen at home by Dr RMO2 on 19 August. The FCPN had alerted Dr RMO2 to the deterioration in Mr L's mental state. Dr RMO2 either failed to appreciate the extent of Mr L's relapse or failed to respond appropriately. He merely arranged for Mr L to have his serum Lithium checked; this was not done until six days later. He did not consider recall to hospital to allow the administration of antipsychotic medication. He did not arrange any follow up medical assessment, even though it was 12 days before Dr RMO1 was due to return to work. He did not consult a senior colleague or communicate directly with Dr RMO1 about Mr L's mental state.

3.2.13

Though there were copies of correspondence from both Dr RMO1 or Dr RMO2 to the Mental Health Division or Mr L's GP, the Inquiry was unable to locate any contemporaneous medical notes in Mr L's case-file, following his conditional discharge from hospital.

Neither Dr RMO1 nor Dr RMO2 were able to establish whether such notes did, in fact, exist. Lack of written notes may have contributed to the poor communication between Dr RMO1 and Dr RMO2 at either end of Dr RMO2's locum post.

Section 4

Nursing aspects of Mr L's care

4.1 Evidence in respect of nursing care

4.1.1

The forensic community psychiatric nursing for Mr L was carried out by three forensic psychiatric nurses, namely: Ms FCPN2, Mr FCPN1 and Mr FCPN3. These forensic community psychiatric nurses (FCPNs) worked for the Forensic Psychiatry Directorate and, at various times, were placed within Dr RMO1's team.

4.2 Evidence from Mr FCPN1

4.2.1

Mr FCPN1 was a forensic psychiatric nurse of twelve years standing in his present post in the Forensic Psychiatry Directorate. Mr FCPN1 indicated that he had worked with Dr RMO1, who was the Responsible Medical Officer for forensic patients in the hospital where Mr L was a patient. During the time that Mr L was an inpatient there, Mr FCPN1 attended regular clinical team meetings with Dr RMO1 and members of the inpatient nursing staff to monitor his progress and treatment.

4.2.2

Mr FCPN1 indicated that he had a particular role in Mr L's care in the "run up" period to Mr L's conditional discharge. He indicated that, during this time, Mr L's periods of leave of absence from the hospital were gradually increased. At various stages during this period, he was requested to make home visits to ascertain how well Mr L was coping. Mr FCPN1 indicated that he could not specify the frequency of his contact with Mr L while he was an inpatient but that, after his conditional discharge, he was making contact with him weekly. Later, the frequency of his visits was reduced to fortnightly. Mr FCPN1 indicated that, at the time of Mr L's conditional discharge, he had gained some knowledge of Mr L as an inpatient and was aware of his diagnosis and his general level of functioning in the community. He indicated that his role was to monitor his mood and his general functioning and to monitor him in his community placements, which were set up at a voluntary project and the stables. He indicated that part of his role was to monitor Mr L's adherence to the terms of his conditional discharge.

4.2.3

Mr FCPN1 stated that his role with Mr L in the community would be a "fairly intimate one", as part of a small forensic team. He stated that the roles of the people involved in Mr L's care would have been allocated and discussed during Care Programme Approach meetings. He indicated that the RMO and social worker were part of the overall structure for the supervision of his work.

4.2.4

In response to questioning, Mr FCPN1 told the Inquiry that he had to specifically monitor Mr L's mental state and any points that would lead to concern and his possible readmission to hospital. Mr FCPN1 indicated that Mr L was an irritable patient whose mood could vary both in hospital and in the community.

4.2.5

Mr FCPN1 indicated he could not recollect that there was any formal risk assessment carried out before or after Mr L was conditionally discharged. He specifically stated he did not recollect an Historical Clinical Risk (HCR20) assessment being carried out. He further indicated that he "would imagine" that there was a discussion about the sort of symptoms and signs that might indicate an increased risk in terms of Mr L's case. He stated he did not remember any specific meeting concerning this; but that he was confident it would have been discussed in relation to his index offence, mood deterioration and potential risks associated with that. Mr FCPN1 indicated that he was aware that Mr L's index offence had occurred in a context of "religiosity" and delusional thinking.

4.2.6

Mr FCPN1 also confirmed that, to his knowledge, there was no written risk management plan in place. He stated that he had written to Dr RMO1 about the need for a crisis plan to be put in place. Mr FCPN1 stated that, to his knowledge, no crisis plan was developed.

4.2.7

Mr FCPN1 told the Inquiry that it was clearly understood within the team that Mr FCPN1 would report back to Dr RMO1 and that he would carry out joint visits to Mr L with the supervising social worker, Ms SW1.

4.2.8

In January 2004, Ms FCPN2 took over from Mr FCPN1, as Mr L's forensic psychiatric nurse. With regard to the arrangements for the handover between Mr FCPN1 and Ms FCPN2, Mr FCPN1 indicated that Ms FCPN2 did not have an intimate knowledge of Mr L as an inpatient. When she joined the team, it was agreed that she and Mr FCPN1 would do several joint visits to Mr L, as part of the lead up to the handover of Mr L's care. Mr FCPN1 was asked how Ms FCPN2 was briefed about the risks in Mr L's case and how to assess and monitor the risks with regard to his care. He indicated that she would be part of the mental health team, along with himself and other nurses, and would be present at the various reviews of Mr L's case.

4.2.9

Mr FCPN1 did not remember himself or any other member of the team having any formal discussions with Ms FCPN2 about the indicators of increased risk in Mr L's case, or how to respond to them.

4.2.10

Mr FCPN1 indicated that he was Mr L's FCPN when his antipsychotic medication was reduced, and then discontinued, around the end of 2003. He indicated that it was discontinued because Mr L had complained about the long term effects of depot medication, in particular tiredness and restlessness in his legs which might have been described as akathisia. Mr FCPN1 indicated that, given Mr L's resistance to medication, he did not think it unreasonable to try to keep Mr L engaged in treatment by reducing his medication. He indicated that he was not "too convinced" that Mr L had akathisia or there was any objective evidence to sustain his complaint of being tired.

4.2.11

Mr FCPN1 also confirmed that with regard to risk management plans and relapse plans/crisis plans, it was not unusual for such plans not to be in place. He indicated that the team did not have easy access to psychology services to help develop such plans.

4.2.12

With regard to the composition of the clinical team, Mr FCPN1 stated that it consisted of ward nursing staff, the RMO (Dr RMO1), the Specialist Registrar, the social worker (Ms SW1), the FCPNs and an occupational therapist, when available. The style of the team was flexible and the members' views were heard by Dr RMO1. The management style was not autocratic and people felt relaxed about disagreeing with each other. It was a positive and constructive team.

4.3 Evidence from Ms FCPN2

4.3.1

Ms FCPN2 took up the responsibility of being Mr L's FCPN on or around January 2004 after a period of visiting him with Mr FCPN1. Before joining the forensic team in early 2003, Ms FCPN2 had completed the local mental health service's in-house CPN course and had been a community CPN for approximately seven and a half years within a generic mental health service. Ms FCPN2 indicated that she had no special training to become a FCPN.

4.3.2

Ms FCPN2 told the Inquiry that she first met Mr L almost immediately after taking up post with the forensic service towards the end of February/March 2003, but her involvement was minimal until January 2004. She indicated she visited Mr L approximately six times during 2003, which was her first year in the team. These visits were all with either Mr FCPN1 or the supervising social worker, Ms SW1. Ms FCPN2 indicated she was aware of Mr L's background, his history and psychiatric and forensic history and was clear about the risks associated with his case.

4.3.3

In the early part of 2004, after a restructuring of forensic service to create sector teams, Mr FCPN1 was moved to another area and Ms FCPN2 remained in Dr RMO1's team. Ms FCPN2 was then allocated Mr L's case. Ms FCPN2 indicated that from early 2004 until the homicide in October 2004, she was the FCPN involved in Mr L's care.

4.3.4

She indicated that, in conjunction with the team, her role was to manage all aspects of Mr L's care within the community, and to report any concerns that she had to Dr RMO1. Her role included monitoring his mental health, his compliance with medication, his compliance with appointments and any change in his mental health that would indicate a possible relapse in his illness. She also monitored any indications that Mr L was using illicit drugs or alcohol. She carried out this work by visiting Mr L regularly with Ms SW1. She visited Mr L once a fortnight either at his home or his place of employment, at the stables,

where he worked with the horses. She indicated that when she visited Mr L at home there would generally be someone else present, usually a member of his family such as his brother.

4.3.5

She indicated there were no formal handover arrangements when she took over responsibility for Mr L's care. There was no specific discussion about possible indicators of relapse, and she gained much of her knowledge about this from studying his casenotes. She also indicated that no one had talked to her about Mr L's thinking at the time of his index offence.

4.3.6

Ms FCPN2 said that she had considered indicators of relapse in Mr L's case to include an increase in his irritability, an increase in his volatile angry and aggressive behaviour, the presence of disinhibited behaviour or loss of his insight. However, she indicated that his was not an easy case to gauge, as he was by nature temperamental. He had a degree of irritability and was volatile and verbally aggressive on a number of occasions. She indicated that, in monitoring his mental state for evidence of relapse, she was aware that, in the past, he had appeared to be mentally well when he was not.

4.3.7

Ms FCPN2 also indicated that, with regard to the more general aspects of risk assessment and management, she was not aware there was any formal risk assessment in place, nor was she aware of any crisis relapse plan being in place. These documents were neither in place when Ms FCPN2 took over Mr L's case nor were they developed during her period of responsibility. She also indicated that there were no formal discussions with Dr RMO1 about a "shared view of risk" and any interventions that might be required if the risks were thought to be increased.

4.3.8

Ms FCPN2 indicated that she had began to see a change in Mr L's mental health and his general situation around the summer of 2004, in particular around late July of that year. She indicated that it was very difficult to gauge the significance of changes in Mr L, as his mood and behaviour often fluctuated from visit to visit. She indicated that, in August 2004, the indicators previously mentioned, such as irritability, mood change, aggression and being verbally demonstrative, became more evident. He became challenging and lost insight into his difficulties.

4.3.9

Ms FCPN2 indicated that, at this time, Dr RMO1 was on leave. She discussed Mr L's deterioration with Dr RMO2, who was the locum consultant at the time. She indicated that she had told Dr RMO2 that she felt Mr L's situation was deteriorating and had asked him to do a domiciliary visit, accompanied by herself.

4.3.10

Ms FCPN2 indicated that her concerns about Mr L began on or around 6 August 2004 and that she expressed her concerns to Dr RMO2 on 11 August. The domiciliary visit with Dr RMO2 did not take place until 19 August.

4.3.11

Dr RMO2 and Ms FCPN2 visited Mr L at his home on 19 August 2004. He had a friend present. In evidence to the Inquiry, Ms FCPN2 described Mr L's behaviour as so unnerving that his friend left. Ms FCPN2 indicated she was confident that some intervention was required at this stage, as Mr L was very angry, challenging and lacked insight. He was highly charged during the whole visit. He also used language such as "poor wee lamb". Ms FCPN2 had realised that this was similar to language he used at the time of his index offence. As he escorted Dr RMO2 and Ms FCPN2 from his flat he began to shout about his index offence in "a totally inappropriate and incongruous" manner. "The neighbours were listening to this and he was stating that, if he had to do it again, he would kill the b…… again, or words to that effect".

4.3.12

Ms FCPN2 then accompanied Dr RMO2 to the car and had a short discussion about Mr L's presentation. She stated that she told Dr RMO2 that she was extremely concerned and felt that Mr L required antipsychotic medication; if he did not comply with this, then his recall to hospital should be considered. At this stage Dr RMO2 wanted to return to the flat but Ms FCPN2 refused. She indicated she felt it was inappropriate to return as Mr L was in no position to communicate and was highly charged, volatile and aggressive. She stated that she felt the situation needed to be reviewed and decisions made on how to respond to it.

4.3.13

After the home visit, Ms FCPN2 recorded Mr L's aggressive behaviour and irrational thinking in her nursing notes (dated 19 August 2004). In evidence to the Inquiry, she confirmed the views she had recorded in her nursing notes after the home visit. She did not consider that Dr RMO2's response to her concerns were what she anticipated or thought appropriate. She stated that, on their return to the team base, she reiterated her concerns about Mr L. Dr RMO2 decided to enquire of other people involved in Mr L's care and also attempted to get a broader picture of Mr L. She believed that Dr RMO2 had attempted to speak to Mr L's employer at the stables and failed, but had spoken to Ms FCPN2's predecessor, Mr FCPN1. She believed that Dr RMO2 also spoke to Dr GP.

4.3.14

Ms FCPN2 indicated that she did not receive a copy of Dr RMO2's report of his findings until the Monday (23 August) following their visit and, by that stage, he had gone away on holiday. She did not get an opportunity to discuss matters further with him. She indicated that she had prepared her own report of the visit.

4.3.15

Dr RMO2 sent a letter, dated 20 August, to the Mental Health Division, reporting on Mr L's condition. Ms FCPN2 did not feel that his account of Mr L's state was representative, either of her report or of what actually happened on the day of the visit. She indicated that, in her report, she had described Mr L as someone who was deteriorating: although he was not overtly

floridly psychotic, everything he said or did had a marked paranoid flavour. His behaviour was irrational, challenging, unnerving and frightening. She stated that Dr RMO2 described Mr L's appearance and the state of his flat correctly: it was neat and tidy. However, his report did not take Mr L's circumstances into account: she had indicated to Dr RMO2 that Mr L did not live on his own, but with a brother and friend, who had contributed to the appearance of the flat. She thought that Dr RMO2's letter suggested that the appearance of the flat was a sign that Mr L was able to function at a good level. The Inquiry saw a nursing note (dated 23 August 2004) in which she recorded her concerns about the content of Dr RMO2's report.

4.3.16

Ms FCPN2 indicated that, as Dr RMO2 had gone on holiday and Dr RMO1 was still on leave, she reported to the supervising social worker, Ms SW1. She believed that Ms SW1 reported her concerns to the Scottish Executive.

4.3.17

Ms FCPN2 also contacted Dr RMO1's secretary to ask if there was a mechanism by which she could report directly to the Scottish Executive Mental Health Division. She was told that, in Mr L's case, it was not necessary as the FCPN was not required to report on him. Ms FCPN2 stated that she spoke to a senior nurse about Dr RMO2's letter and her own report. Ms FCPN2 stated that there was no senior nurse within the team and this is why she took the matter up with a senior nurse outside of the team. Ms FCPN2 was advised by the senior nurse to monitor the situation closely and to report to Dr RMO1 immediately on his return. The senior nurse also indicated she would speak to a senior colleague concerning the matter and would get back to Ms FCPN2. The senior nurse did not get back to Ms FCPN2.

4.3.18

Ms FCPN2 also indicated she went on holiday on 25 or 26 August and gave her colleague, Mr FCPN3, the reports from both herself and Dr RMO2, to pass on to Dr RMO1. She indicated that she had recommended to Dr RMO1 that Mr L should be recommenced on antipsychotic medication. She also ensured that an appointment was made for Mr L to see Dr RMO1 on Dr RMO1's return to work.

4.3.19

After returning from holiday at the beginning of September, Ms FCPN2, Dr RMO1, Dr PA2, and Dr CP, were involved in the management of Mr L. She indicated that they were firmer with him, to ensure he was complying with medication. Ms FCPN2 indicated that, after this, she was of the view that there was a gradual and steady improvement in Mr L's mental health. By the beginning of October 2004 she indicated that, though he was still irritable, his insight was returning and his reasoning had improved.

4.3.20

Ms FCPN2 indicated that she interviewed Mr L at the stables on 22 October 2004, the day following the homicide of Mr M. She indicated it was around 1 o'clock in the afternoon but she did not

know that the homicide had taken place. She stated that she was accompanied by a student nurse on this occasion. She said that she had found Mr L to be settled and pleasant. She indicated that she thought that he had gradually improved throughout the previous six weeks, that his Lithium medication levels had reached a therapeutic level and that the improvement was linked to this.

4.3.21

Ms FCPN2 indicated that the forensic team, in which she worked, consisted of Dr RMO1, his specialist psychiatric registrar, two FCPNs and a social worker (0.25 wte). She indicated that the team worked very closely together although the social worker did not get involved with every patient. Because of time commitments and case load.

4.4 Evidence from Mr FCPN3

4.4.1

Mr FCPN3 was a FCPN based in the forensic team, working with Dr RMO1, Ms FCPN2 and Ms SW1. He was seconded from general psychiatric nursing in April 2003, and given a substantive FCPN's post in April 2004. He stated that he had had some training in risk management in his former post in an Intensive Psychiatric Care Unit at another hospital, but had not had any formal training for his current post. He had attended a one-day course on the Memorandum of Procedure on restricted patients, but otherwise had no training in the management of restricted patients.

4.4.2

Mr FCPN3 indicated that his contact with Mr L was initially as a second-line person in the visiting team; he would visit Mr L with Mr FCPN1 to administer Mr L's depot medication, He also covered for holiday periods within the team, when the other FCPN was on leave. Mr FCPN3 confirmed that Ms FCPN2 took over the care of Mr L from Mr FCPN1 and that he covered for her during her holiday leave. He indicated that this was in the period August/September 2004.

4.4.3

Mr FCPN3 indicated that he only saw Mr L once during Ms FCPN2's leave, but was aware of the letter from Dr RMO2 to the Mental Health Division. He was also aware that Ms FCPN2's report differed in content and raised concerns about Mr L's management and his mental health state. He was also aware that Ms FCPN2 had arranged for Mr L to see Dr RMO1 immediately on his return. Mr FCPN3 indicated that Ms FCPN2 had talked to him personally about Mr L and the need to pass information to Dr RMO1 about her concerns.

4.4.4

Mr FCPN3 said that Mr L had been discussed regularly at the team meetings and also at the FCPNs' discussions about patients. He saw Mr L with Dr RMO1 on 2 September. He told the Inquiry that he had assessed Mr L as irritable and angry, but not overtly unwell. He said Mr L had denied Ms FCPN2's account of his behaviour on 19 August, calling her a liar. He could not recall Mr L being asked about his thoughts or ideas. Mr FCPN3 indicated that he could not remember the option of recalling Mr L being discussed between himself and Dr RMO1.

He and Dr RMO1 did not discuss the possibility of drug-testing nor whether Mr L should be prescribed anti-psychotic drugs.

4.4.5

On her return from holiday Ms FCPN2 and Mr FCPN3 had further contact concerning Mr L's care. He indicated that they had met at the hospital, following her return from leave, and that he had told her the details of the meeting with Mr L earlier in the week. He stated that he told Ms FCPN2 that he met Mr L with his family and friends and he seemed a bit more organised and that he had recorded his visit in the general nursing notes. He indicated that this was the last contact that he had with Mr L.

4.4.6

Mr FCPN3 was asked if there was a risk management plan for Mr L and indicated that he was aware of a "kind of risk profile for patients, at that time it was about a two page sheet about the kind of risks involved". He did not know when the risk profile had been carried out. He thought it would have been at the time Mr FCPN1 was responsible for Mr L's nursing care and would have been updated by Ms FCPN2.

4.4.7

Mr FCPN3 indicated that he was not aware of any crisis management plan or relapse plan being in place for Mr L. He indicated that this aspect of Mr L's care would be dealt with at the CPA meetings. However, he stated that he was aware of the hallmarks of relapse in Mr L's case, and that there would be formal discussions about that type of issue at the team meetings. He also stated that Ms FCPN2 had given him some information concerning relapse issues, during a discussion between them.

4.5 Observations on Forensic Psychiatric Nursing Care

4.5.1

Forensic community psychiatric nurses (FCPNs) had a very important role in monitoring Mr L's mental state, his compliance with treatment and his overall care plan. Mr FCPN1, Mr L's first FCPN, understood that mood fluctuation and irritability were clear indicators of Mr L's mental state. These features were identified during Mr L's period as an inpatient. Mr FCPN1 was also aware of his marked religiosity and delusional thinking at the time of his index offence. However, though these factors were recognised, no formal risk assessment was made prior to his conditional discharge, nor was there a crisis plan to guide staff if Mr L appeared to be relapsing.

4.5.2

The risk indicators mentioned above were not passed on to Ms FCPN2 when she took over the care of Mr L.

4.5.3

There was clear evidence in the nursing records that Mr L had a history of fluctuations in his mental state that might have been attributable to substance misuse. He had used illicit substances whilst in hospital, and he had undergone random drug testing whilst he was an inpatient. However, after his conditional discharge, there was no record of any random drug testing to monitor this aspect of his care.

4.5.4

Ms FCPN2 had been a generic CPN for seven years and had completed the "in house CPN course". She had received no specific training in forensic mental health and neither had Mr FCPN3. There was no specific training available for FCPNs, nor any formal system of clinical supervision for them.

4.5.5

There was a lack of formal handover of information, both between members of nursing staff and between nurses and doctors, when cases were handed over or staff were going on annual leave. It appeared to the Inquiry that staff assumed that information was being passed on when, in fact, it was not.

4.5.6

Dr RMO2 and Ms FCPN2 had conflicting views about Mr L, following their joint assessment in August 2004. Ms FCPN2 disagreed with Dr RMO2's assessment of Mr L's mental state and with his proposed course of action.

4.5.7

There was clear evidence from Ms FCPN2, which the Inquiry accepted, that she was frustrated that her concerns about Mr L's mental health were not given due regard by Dr RMO2 following their joint visit.

4.5.8

It was clear in evidence that Ms FCPN2 required support and advice on how to deal with the difference in view between herself and Dr RMO2. There was a weekly clinical meeting to discuss patient-related matters. However, it was not clear to the Inquiry whether there was any forum to discuss team management issues, such as dispute resolution. There appeared to be no clear line-management support or clinical nursing supervision for Ms FCPN2. She did raise her concerns with a senior nurse who recommended that she speak to the consultant. The evidence before the enquiry was that the senior nurse promised to take further advice and get back to Ms FCPN2, but that this did not happen.

4.5.9

Ms FCPN2 sought advice on how to report her concerns about Mr L to the Mental Health Division, but received no clarification. Ms FCPN2 was not aware that she could report matters directly to the Mental Health Division, if she had a concern about a restricted patient.

4.5.10

There was a lack of leadership with regard to the forensic community psychiatric nursing service and, in particular, with regard to supervision and the role of the FCPN within the care of restricted patients.

Section 5

Health service management aspects of Mr L's care

5.1 Evidence from Dr CD

5.1.1

Dr CD, a Consultant General Adult Psychiatrist and Clinical Director for Forensic Services, gave evidence concerning the structure, responsibilities and roles within the local forensic service. He indicated that he did not have a written job description with regard to his post as Clinical Director. There was a generic description for Clinical Directors throughout the city rather than one specific to the forensic services. Dr CD stated that his role was clear and was to take clinical leadership within the forensic service. It included leadership over the consultant psychiatrists, psychologists and nursing staff in the Forensic Psychiatry Directorate and leadership in the development of a new forensic unit. He also indicated that he had a role in the Forensic Mental Health Network, to link with other forensic services around Scotland. He reported directly to the Medical Director of the Primary Care Division and to the General Manager of the Forensic Psychiatry Service.

5.1.2

Dr CD indicated that he came from a general psychiatric background and did not have a background in forensic psychiatry.

5.1.3

Dr CD indicated that the Directorate of Forensic Services had difficulties when he took over and described the situation as sensitive. When he was asked to take on the Directorate he was a bit surprised because of his general psychiatric background. Dr CD stated that he took up his post around September 2003. At the time there was a general awareness that the Forensic Directorate was not a "happy place". He indicated that there had been a turnover of managers and changes in managerial arrangements, at both a clinical and an administrative level. He indicated there had been interpersonal difficulties within the Directorate, which was very hierarchical in nature. He indicated that there had been practical difficulties over a 20 to 30 year period, in that the forensic services functioned without access to a significant number of beds. He indicated that the bed situation in the local hospital could not be described as particularly secure. He indicated that he had found little planning either at a Health Board or national level in respect of the local forensic services. His understanding was that forensic services throughout the country were "bed based". He indicated that the local forensic services had become isolated from the wider psychiatric services, in both their clinical work and in aspects of service provision. He indicated that the service had not kept abreast of modern trends, particularly in its infrastructure.

5.1.4

Dr CD confirmed that when he took over the Clinical Directorate of the Forensic Services he was of the opinion that there was "an insufficient level of joined up working".

5.1.5

In relationship to his leadership role with consultant psychiatrists who were responsible for the care of restricted patients, Dr CD stated that the consultants were very experienced and that, in general, they would be left to carry out their own duties. With regard to Dr RMO1, he considered him to be an experienced and respected colleague, with all the specialist knowledge to discharge his duties as a forensic RMO. Dr CD stated that his own managerial role was a supportive one. Dr CD confirmed that, in his experience as Clinical Director of Forensic Psychiatry Services, he would not alter the role he carried out in respect of RMOs who supervised restricted patients.

5.1.6

Dr CD confirmed that he was aware that Dr RMO1 had a period of sick leave during the period in question in this Inquiry, and that Dr RMO2 had acted as locum in his absence. Dr CD told the Inquiry that his role with regard to the handover between Dr RMO1 and Dr RMO2 would be to see that the locum position was suitably filled and that the locum had the ability to do the job. He stated that he expected the handover to be carried out by Dr RMO1, who was an experienced consultant. He also stated that Dr RMO2 was known to the forensic psychiatric services, as he had previously worked with Dr RMO1 during his training, and had reached the Specialist Registrar grade. Dr CD stated that he would not ordinarily step in and check that the handover had been done to any standard. Dr CD stated that he met with all five of the consultants in his Department every Wednesday morning for one hour. He said that Dr RMO2 would have taken part in that meeting during his locum period. He indicated that there was nothing in the nature of this meeting that would highlight restricted patients. He stated a case would be raised if a patient was causing concern, rather than because of his or her status.

5.1.7

Dr CD confirmed that he had not done anything specific to satisfy himself that Dr RMO2 was fit for the locum post, but that he knew about it and felt it to be an appropriate appointment. He stated that the appointment of specialist registrars to locum posts did not take place until at least the third year into their specialist registrar training. He stated that there was a consultant psychiatrist who was the clinical tutor for the forensic psychiatry training scheme. The clinical tutor was a member of the committee that oversaw specialist registrar training. Dr CD indicated that he relied on the committee to ensure that specialist registrars were trained and on the clinical tutor to indicate their suitability for locum posts.

5.1.8

Dr CD confirmed that there was no formal guidance for someone working in the Forensic Psychiatry Service in Dr RMO2's position. There were no formal arrangements to support him in his duties as Locum Consultant. Dr CD stated that there was no general guidance to RMOs in the Primary Care Division about handovers between themselves and locums.

He stated that arrangements with regard to handovers and annual leave would be entirely between the individuals concerned.

5.1.9

In subsequent written evidence to the Inquiry, Dr CD indicated that the clinical tutor had made himself available to Dr RMO2 to discuss clinical problems, and that Dr RMO2 had availed himself of that opportunity on a number of occasions.

5.1.10

Dr CD confirmed that he did not know whether his Directorate had any specific forensic training requirement for general CPNs before or after appointment as FCPNs. Dr CD was unclear about how a FCPN would acquire the necessary skills to supervise a restricted patient in the community and how he or she would learn about the implications of a Restriction Order and what was expected in supervising restricted patients. However, Dr CD indicated that he would expect a junior forensic community psychiatric nurse to learn from senior nurses and also that aspects of Restriction Orders would be part of the Directorate's general training programme.

5.1.11

Dr CD stated that he was responsible for improving team working within his Directorate and that he had put a lot of effort into the development of teams since February 2004. He stated that he had a thorough understanding of the different disciplines within the team setting and had done shadowing work to obtain information. He also stated that there had been exercises over a three or four month period in team building and that new team structures had been put into place.

5.1.12

Dr CD indicated that, at the time Mr L killed Mr M, much of the work with regard to team building, guidance and policy was in its initial phase. Dr CD also stated that, at the time of Mr M's death, mechanisms for auditing performance in the Directorate were at an early stage.

5.1.13

Dr CD confirmed that the standards of note-keeping "were the worst I have ever seen in the Health Service". He indicated that he expected that handwritten medical notes would be kept, but it was no surprise to him that the Inquiry had discovered no handwritten medical notes. He indicated that the forensic psychiatric service had the worst medical record system he had seen in 25 years. Dr CD said that, in his period as Director, he had spent much time on improving medical records within the Directorate, and had given the issue a higher profile.

5.1.14

Dr CD indicated that he thought Dr RMO1's clinical team was working well. He had made direct observations of team meetings and been involved in discussions with individual members of the team.

5.1.15

Dr CD confirmed that he was now aware that Mr L did not have a relapse prevention plan or a clear risk assessment. He stated that there was now an ongoing audit process to make sure this information is in place. He also stated that

he met regularly with the Forensic Psychiatric Adviser, Dr PA2, to discuss issues arising from the care of restricted patients and any problems in the relationship between the Directorate and the Mental Health Division.

5.1.16

Dr CD stated that he had also spoken to both Dr PA2 and Ms SE1, the leader of the restricted patients team within the Division, about the quality and timeousness of Dr RMO1's reports. He had also discussed this issue with Dr RMO1.

5.1.17

Dr CD told the Inquiry that, in Mr L's case, management decisions were not related to any unavailability of psychiatric beds for conditionally discharged patients who required readmission. Within the Forensic Psychiatry Directorate, the policy was that if a restricted patient required to be readmitted, the RMO would negotiate with a consultant in the general psychiatry service to make a general psychiatry bed available. He indicated that this had become custom and practice within the forensic service. It did not require any kind of formal agreement with general psychiatrists. Dr CD indicated that no forensic patient in the area in need of admission would be turned away. He indicated that it was "basic stuff" within the forensic services that all consultants and locums would know of this policy.

5.1.18

Dr CD confirmed that he was supportive of the arrangement that had been made between Dr RMO1 and Dr CP and thought that it could assist in the overall care of someone in Mr L's position.

5.2 Observations on mental health management aspects of Mr L's care

5.2.1

Dr CD indicated that the role of the Clinical Director was to provide clinical leadership in the Forensic Directorate. However, it appeared to the Inquiry that Dr CD was somewhat detached in his view of the forensic service. He had not been trained as a forensic psychiatrist and his evidence to the Inquiry did not suggest that he felt accountable for the performance of the service. He described changes he had introduced to the service, such as improvements to team-working, but the Inquiry did not have a sense that he provided effective clinical leadership to the service.

5.2.2

It appeared to the Inquiry that there was a lack of clarity in the extent of Dr CD's responsibility for the quality of the forensic psychiatry service or its clinical governance.

5.2.3

From Dr CD's evidence, there appeared to be a very informal approach to locum arrangements within the Forensic Psychiatry Directorate. In the case of a locum who came from within the forensic psychiatry training scheme, there appeared to be no formal mechanism for assessing his or her suitability. There was no guidance to either the substantive consultant or the locum about handover arrangements. In addition, it appeared to the Inquiry that there was no guidance to locums about their leave arrangements.

Dr CD indicated that he had expected Dr RMO2 to know that he should arrange for another consultant to assume his RMO responsibilities during periods of leave.

5.2.4

From Dr CD's evidence to the Inquiry, it appeared that, even when locums were trainees in psychiatry, there were no arrangements within the Directorate for them to receive any clinical guidance from consultant colleagues. Dr CD indicated that he met with all five consultant psychiatrists once weekly for one hour and that Dr RMO2 would have attended that meeting whilst he was in his locum post. The Inquiry did not think that this was likely to be a forum in which it would have been appropriate for a locum to have been asked in detail about his work. In addition, it appeared that it was up to the locum to identify and flag up any cases which concerned him, though it was not clear how he might have been aware of this.

5.2.5

Dr CD's evidence indicated that the arrangements for the readmission of restricted patients were informal ones. He told the Inquiry that it was the custom for the patient's RMO to negotiate with a general psychiatrist colleague to get a bed within a general psychiatry unit. This was not a formal policy within the Directorate, nor did it appear to the Inquiry that it had been formally agreed with the General Psychiatry Directorate. There was no formal guidance to consultants in respect of this readmission procedure. It was not clear to the Inquiry how a locum consultant would have known about this procedure nor been in a position to carry it out.

5.2.6

Dr CD acknowledged that the record-keeping system within the Directorate was extremely poor. He confirmed that it was good practice for medical staff to keep written notes about patient care, but was not surprised that such notes were not available in Mr L's case.

Section 6

Social work aspects of Mr L's care

6.1

Mr L was supervised by Ms SW1 who was a social worker employed by the council, and based in the forensic psychiatry service at Mr L's hospital. Ms SW1 was responsible for Mr L's social work supervision from January 2003, another social worker had been responsible prior to this date. Ms SW1's practice was supervised by her line manager, Mr SW2 who was a Practice Team Leader (previously known as Senior Social Worker) with the council. Mr SW2 worked within the criminal justice services.

6.2 Evidence from Ms SW1

6.2.1

Ms SW1 was a social worker of some 13 years standing who had worked in addiction counselling, mental health and criminal justice projects, prior to moving to her present post in the forensic services at the hospital.

6.2.2

Ms SW1 indicated that her role was to assess, and to help manage, the care of patients who were resettled into the community from the forensic in-patient service. She was part of the forensic psychiatry team. Ms SW1's responsibility involved not only the community care assessment, but putting together care packages and providing support for the people discharged into the community. Ms SW1 did not work full-time with the forensic team.

6.2.3

Around May 2000, three years prior to Mr L's conditional discharge, a community care assessment and a home circumstances report had been carried out. It identified that he needed suitable accommodation, help with shopping, help with budgeting and monitoring of his mental health.

6.2.4

The home circumstances report was based on a visit to Mr L's brother and indicated that his brother was supportive of Mr L's treatment by the mental health services. The social work file also contains a letter about Mr L's home circumstances, in response to a request by Dr RMO1 asking for a report on Mr L's sister. The letter, dated 26 March 2001, was positive about the attitude of Mr L's sister and also her home circumstances.

6.2.5

While Ms SW1 officially took up responsibility for Mr L's care in January 2003, she had become involved with him in October 2002 to provide an overlap with his previous social worker who was due to retire.

6.2.6

At the time that Ms SW1 took over the responsibility for Mr L's care, a plan for discharge was already in place and a community care assessment completed. At this time Mr L was spending four nights on leave of absence from the hospital.

6.2.7

Ms SW1 indicated that her contact with Mr L was limited while he was on the ward, but she did attend meetings with the clinical team and FCPNs.

6.2.8

Ms SW1 also indicated that, after Mr L was conditionally discharged to his brother's

home, she was his supervising social worker until September 2004. During this period Ms SW1 indicated that she followed the Memorandum of Procedure guidelines for working with restricted patients in the community. The guidelines suggested that there should be weekly visits to the patient for the first month, moving to fortnightly visits after that. She visited weekly for approximately one month and thereafter fortnightly for a further two months. After this she visited Mr L monthly. Ms SW1 stated that she carried out the visits with a FCPN; initially Mr FCPN1 and then Ms FCPN2.

6.2.9

Ms SW1 indicated that, during these visits, she and the FCPN assessed Mr L's general situation, mental health and community needs, including his benefits, housing needs and other domestic matters. Ms SW1 indicated that conditionally discharged patients would normally be transferred to their local generic social work team three to six months after discharge. However, after discussion with her managers, she had continued to be responsible for Mr L, as Mr L was moving from his brother's flat to his own tenancy, which might potentially be unsettling. Mr L obtained a tenancy from a housing association. At this stage he required a furniture package and support and this was put in place by the Social Work Department, including contact from a support worker from a voluntary sector care provider. Ms SW1 indicated that this move took place but that the support from the voluntary sector provider was eventually terminated. She indicated that Mr L's brother accompanied him to his new accommodation and they continued to live together.

6.2.10

Between May 2003 and July 2004, Ms SW1 reported regularly to the Mental Health Division on the condition of Mr L The record contains reports made at approximately six weekly intervals. All these reports were positive about Mr L's progress until 29 July 2004 when, for the first time, she reported that he had shown resentment about continuing supervision and the Social Work Department's services.

6.2.11

At interview, Ms SW1 indicated that, in her joint visits to Mr L with Ms FCPN2, concerns were raised about Mr L's defensiveness and aggression and whether these were signs of him becoming unwell. She described him as generally difficult to deal with; he was quite compliant at times but was a changeable character.

6.2.12

In her penultimate report of 14 September 2004, she reported that Mr L had defaulted from appointments with herself and the CPN, on both 27 August 2004 and 31 August 2004. She also advised the Mental Health Division at this time that Mr L's case had been transferred to another area social work team. In a note dated 17 September 2004, Ms SW1 recorded the meeting on 9 September 2004 at the mental health resource centre, which was also attended by Mr L, his brother, his friend, together with Dr RMO1, Dr CP, and Ms FCPN2. This note described Mr L

as being irritable with a negative view of his care and treatment. It also described him as making exaggerated and unrealistic complaints about the Social Work Department and voluntary sector provider input. It stated that "both Mr L and his friend seem completely insightless".

6.2.13

The social work case file contains a brief summary of Mr L's history, with information in respect of his transfer to the other area social work team. The summary, dated 20 September 2004, noted, "there has been some recent deterioration in his mental health and he has become suspicious of others. A factor in this may be his renewed contact with his brother and girlfriend. The situation continues to be monitored". The case file contained no indications of any serious concerns about his mental state. It contained no assessment of risk or indication of risk management strategies.

6.2.14

On 28 October 2004, the last routine report was submitted to the Scottish Executive from Mr L's new social worker. She reported that she had met Mr L with Ms FCPN2 on 19 October 2004. Her report made no comment with regard to his mental health state or his social situation.

6.2.15

At interview, Ms SW1 confirmed that, to her knowledge, there was no formal risk assessment or crisis/intervention management plan put in place for Mr L and it would not be found in the social work or health notes. She did state there were copies of the CPA care plan with a section "Crisis Relapse Intervention Plan". (It should be noted that, when the Inquiry team examined the case-notes, this section had not been filled in.)

6.2.16

At interview, Ms SW1 indicated that she had no formal training in forensic mental health. She was not a Mental Health Officer, although she had supervision from Mr SW2 who was a Mental Health Officer. She stated that she had previously been a social worker in a community criminal justice mental health project. She indicated that she did not know of any specific forensic training for social workers in the council's area.

6.2.17

Ms SW1 stated that there had been a meeting about Mr L's handover to the social work team for his geographical area. The meeting was attended by Mr SW2, the new social worker, and herself; they had a full discussion about Mr L and the possible deterioration in his mental health. (The Inquiry team was unable to find a minute of this meeting in the social work case-file.) Ms SW1 said that she was not in a position to follow up Mr L's case further, as she was a social worker in a 50 bedded unit, which was a mammoth task.

6.2.18

Ms SW1 stated that she had a line manager and had meetings with her predecessor to discuss what basic information about risk was required. She stated that the report to the Scottish Executive was a proforma, containing specific questions about issues such as:

deterioration in mental health, compliance with medication and compliance with appointments. She attempted to answer these questions in her reports. She indicated that she had discussed filling in the reports with her line manager.

6.2.19

Ms SW1 also indicated that, when she took over Mr L's case, she was provided with his social work file. It did not have much information about his index offence but contained a community care assessment and basic information about home circumstances, based on visits to his brother's house. There was not a detailed forensic history in the file; it was a basic file.

6.2.20

Ms SW1 said that she had the opportunity to discuss Mr L's case within the forensic team, at the weekly ward meetings and at CPA meetings. She attended the ward meetings regularly, probably at least once a fortnight. She also met with Dr RMO1 and the FCPNs, when Mr L attended the outpatient department.

6.2.21

Ms SW1 told the Inquiry that she met with her line manager, Mr SW2, approximately every six weeks. She indicated that, at these meetings, she would discuss every active case in the community. She stated that they would particularly discuss cases of concern and cases of people being discharged into the community. Ms SW1 indicated that she did not know if Mr L's case was discussed at each of these supervision sessions, because she effectively had 50 patients on her case load and had to deal with their cases as appropriate.

6.2.22

Ms SW1 indicated that the forensic team was a fairly positive team that communicated well and had a fairly open style of communication.

6.3 Evidence from Mr SW2

6.3.1

Mr SW2, the Social Work Team Leader, stated that he was the supervisor of Ms SW1. He also had supervisory responsibilities for the social work service in the forensic unit at the local hospital. When Mr L's previous social worker retired Ms SW1 took over the care of Mr L. There was an an overlap for a few months prior to his retirement.

6.3.2

Mr SW2 indicated that, prior to taking up her post at the hospital, Ms SW1 had experience in criminal justice and mental health social work. She was given no formal training with respect to her post in the forensic psychiatry service at the hospital. He indicated that his ability to offer her training was limited, as there were currently few training opportunities available in the forensic field within the council area. He believed that there was some in-house training available through the Health Board. He stated that Ms SW1 had not been assessed to find out if she had any deficits in her training, before she took up the post in the forensic services.

6.3.3

Mr SW2 indicated that there would be a variation in the frequency of his meetings

with Ms SW1, to supervise her work. However, they would certainly occur monthly, and possibly two to three weekly. Mr SW2 said he had no record of the supervision sessions. He stated that, initially, Ms SW1 had indicated clear deficiencies in her skill base and she looked to Mr SW2, as an experienced Mental Health Officer, to plug the gaps in her knowledge. He stated that, for this reason, her supervision was every fortnight or three weeks for approximately her first year and a half in post. Thereafter, supervision meetings were every four to five weeks.

6.3.4

The supervision sessions would be split into case review, progress and any plans made with regard to patients concerning discharge planning, so issues to do with social needs and welfare benefits would be reviewed.

6.3.5

Mr SW2 stated that Ms SW1 would raise her training needs during supervision sessions with him. These training needs were discussed verbally. There was no written record of her identified needs and no documentary evidence that they were met.

6.3.6

Mr SW2 stated that, as Ms SW1 became more confident in her work, she would raise any concerns about Mr L's mental health with the psychiatrist, either directly or through the FCPN. He considered that her primary duty was to look at the social circumstances of the person.

6.3.7

With regard to Mr L's transfer to an area social work team, Mr SW2 said he was informed of this as part of the supervision process and discussed it with Ms SW1.

6.4 Observations on Social Work

6.4.1

The Memorandum of Procedure on restricted patients in place at the time suggested that supervising social workers of restricted patients should usually, although not always, be Mental Health Officers. Ms SW1 was not an MHO and had identified her training needs in respect of her role within the forensic services. These training needs were recognised by Mr SW2, Ms SW1's team leader. However, he indicated to the Inquiry that there were few training opportunities in forensic services in the council area. It appeared to the Inquiry that, if the supervising social worker of a restricted patient is not a Mental Health Officer, social work managers should identify a minimal level of relevant skills, knowledge and experience to discharge the supervisory role. This had not happened in respect of Ms SW1's role in Mr L's care.

6.4.2

The social work file on Mr L contained very limited information. The Memorandum of Procedure stated that the supervising social worker should be provided with full background information including psychiatric history, information about the index offence and any risk assessment issues. It would be essential information for any social worker supervising a restricted patient. This information was not available in Mr L's file.

6.4.3

The Inquiry heard that a community care assessment had been in place when Ms SW1 took over Mr L's case in January 2003. The Inquiry also heard that an assessment had been carried out in May 2000. There was no evidence before the Inquiry of an updated community care assessment, prior to Mr L's conditional discharge.

6.4.4

The social work input did not include an assessment of risk and, in particular, the social work service did not appear to share in a multidisciplinary risk assessment with regard to Mr L. There was no record of risk assessment being reviewed at key points after Mr L's conditional discharge: for example, when he moved into his own tenancy or when his mental health appeared to deteriorate.

6.4.5

The Memorandum of Procedure also emphasised the importance of a conditionally discharged patient having two supervisors, namely the RMO and the social worker, and the need for them to communicate with each other. The Inquiry recognised that team meetings did take place but had concerns about the level of communication about Mr L. There was also no information available to the Inquiry about the communication between the RMO and the area social work team, when Mr L was transferred to that team.

6.4.6

The frequency of Ms SW1's visits was in line with the minimum recommendations of the Memorandum of Procedure. The guidance in the Memorandum suggested to the Inquiry that the level at which Ms SW1 visited Mr L was a minimal one. There appeared to be no assertive attempt to increase the frequency of the visits when Mr L showed a lack of willingness to engage with services.

6.4.7

The social work notes should have been more detailed than they were in Mr L's case. There was a lack of recording of supervision sessions between Ms SW1 and her team leader. Ms SW1's training needs, as identified by herself and her team leader, were never addressed. The Inquiry noted that the team leader could not have adequately assured himself that there were no problems in Mr L's care, unless the supervision discussions had been recorded and actions agreed at the supervision sessions had been carried out.

6.4.8

The social work team leader should have had a more active role in ensuring the quality of the reports about Mr L that Ms SW1 was sending to the Mental Health Division.

6.4.9

The quality of the social work reports were generally poor. It was not clear to the Inquiry whether Mr SW2 saw Ms SW1's reports to the Mental Health Division on a regular basis, or carried out any control over the quality of these reports.

Section 7

Evidence from Mr L

7.1 Evidence from Mr L

7.1.1

Mr L was interviewed on 18 July 2005 at the State Hospital, Carstairs, by the full Inquiry Team. He was accompanied by his designated nurse, who was there to support him during the interview. Mr L indicated that he wanted to help the Inquiry with its investigations.

7.1.2

Mr L stated that there was "a lot of confusion going on" during the year in which the homicide took place. He confirmed that he had stopped his depot antipsychotic medication just before Christmas, 2003.

7.1.3

Mr L indicated that, at this time, he was irritable and confused and he could not remember more about that period. He stated that close friends were telling him that he was very irritable. He stated that this irritability was more than usual, for him; he became irritable over small things. He described his irritability as being more like "irritable anger".

7.1.4

Mr L was asked about his state of mind in the months July, August and September 2004, prior to the homicide of Mr M. He again indicated that he was quite irritable at that time and confused about the situation he was in. He described working at the stables and becoming very irritable and confused because people had been leaving the lights on too long and were not looking after the animals properly. Mr L indicated that he had been concerned about the condition and welfare of the horses; he was responsible for mucking them out, brushing them and making sure that they were well groomed. Mr L indicated that caring for the horses was quite stressful for him. He indicated that, on occasions, he had felt that they were being neglected; for example, their hay nets were not filled with hay and their buckets were not filled with water, so that they could not get a drink.

7.1.5

Mr L confirmed that he saw himself as "a protector" for the rights of people and creatures who couldn't protect themselves.

7.1.6

Mr L also indicated that, during this period, he wasn't eating much or sleeping. He was helping his brother with his charitable activities during the day, and was working on the nightshift with the horses. Sometimes he worked right through the whole day, with only one or two hours sleep in the afternoon.

7.1.7

Mr L indicated that he had tended to deny telling people about his symptoms or things that were worrying him, because he was concerned that he would be "punished" by having restrictions imposed on him or by being given extra medication. He told the Inquiry "I was actually saying "no, everything is fine", when it wasn't."

7.1.8

Mr L remembered Ms FCPN2 and Dr RMO2 visiting his home at the end of August 2004. Dr RMO2 had come because Dr RMO1 was off sick. Mr L indicated that this was the second time he had met Dr RMO2; the first meeting had been held in the hospital and went well,

but the second meeting was "a disaster".

7.1.9

Mr L indicated that the second meeting was a disaster because Dr RMO2 had suggested things to him which were like the questions someone is asked when first admitted to hospital. In describing an example of the sort of upsetting question that Dr RMO2 had asked, Mr L told the Inquiry: " there was a crowd of young boys standing at the corner and he [Dr RMO2] said "Do you think they talk about you? Are you getting messages from Jesus, God?" and all that you know, because I had told him I believed in God and Jesus and that, you know. He [Dr RMO2] said "Are you getting messages?" and I was very irritable and I got upset about it all, just the way he was doing it". Mr L explained that he had been upset by Dr RMO2's manner. He said "I had just met the doctor, you know, and it was the way he did it. I didn't like it and it was just horrible" He indicated that he felt Dr RMO2 was not sensitive enough to his feelings.

7.1.10

Mr L indicated he could not remember all the events of this meeting with Dr RMO2 and Ms FCPN2, but recalled that he went out of the house and was on the balcony and shouted after them. He stated he could not remember what he shouted other than "cheerio".

7.1.11

Mr L told the Inquiry that he felt he got on well with his clinical team including Dr RMO1, Ms SW1 and Ms FCPN2. He stated that the only time he had problems with the team was when there was a "stand-in doctor" and it became disastrous. The same thing had happened previously, when he was an inpatient and had been allocated another stand-in doctor, with whom it did not work out. He said that he had told Dr RMO1 about his problem with stand-in doctors.

7.1.12

Mr L indicated that he did not mind being supervised by staff and understood why it was necessary. He also indicated that he had no difficulty with taking his Lithium medication, but that the depot anti psychotic medication had made him sleepy.

7.1.13

At interview, Mr L indicated that he had smoked "a bit of grass now and again", but could not remember if he had ever taken any other drugs such as "speed". He also indicated he never touched alcohol but then said that, if he did, it might be one bottle or so. Mr L said he did not remember ever being tested for drugs following his conditional discharge and, in particular, ever having had a urine test.

7.1.14

Mr L stated that he understood Dr RMO1 had transferred half of his care to Dr CP, a new psychiatrist. He understood that the reason was to help with his irritability and his mental health. He understood that Dr CP was the new doctor and there would be a change in his treatment.

7.1.15

Mr L indicated that he did not know if he had taken any cannabis prior to the day he killed Mr M. He indicated that the event arose from

visiting a friend who was also mentally ill. There were six or seven men watching football in the house, including Mr M. They had been drinking and smoking pot. He indicated that he smoked pot himself that night and had drunk a bottle of low alcohol beverage.

7.1.16

Mr L indicated that, as it was winter and had got dark, his friend asked him to take Mr M home. Mr L indicated that Mr M was drunk and he could not get the address out of him, so he tried talking to him in the car and drove in the general direction of Mr M's home. The route took them close to an estate park near Mr L's workplace. Mr L drove into the park, because he wanted to go through the park and check on the horses at the stables. During the journey through the park, Mr M became sick and opened the door of the car while it was still moving. Mr L stopped to allow him to vomit. Mr M left the car to vomit. On his return, he asked Mr L if he was going to take him to another town, as he wanted to see his ex girlfriend. Mr M had said "I want to go and get her" and "if I can't have her, no one is having her". Mr L took this to mean he wanted to kill her. He indicated that Mr M had told him that he had injured her in the past; he had also told him that he had killed his cat and tried to plan murder in the past.

7.1.17

After further exchanges, Mr M went into the back of the car and took a knife out of a towel stating he was "taking the car". Mr L stated he had "panic signs" in his head, because he could see Mr M harming people with the car. Mr L had got a hammer, which he carried with him for protection. Mr L stated that both he and Mr M were out of the car and that he kicked the knife out of Mr M's hand and 'just flipped' and killed him with the hammer. Mr L stated it was to stop Mr M taking his car from him.

7.1.18

Mr L indicated that he now realised he should have driven away and left Mr M. He stated "I should have left him at the park, but because of his history and that, the whole thing was buzzing through my head, him causing mayhem".

7.1.19

After the killing of Mr M, Mr L stated that he drove away. He went to his mother's house and then went home. He did not go that evening to do his nightshift at the stables. He stated he had gone to the stables in the morning and confessed to the stable manager that he was responsible for Mr M's death.

7.2 Information from Mr L's family

7.2.1

Mr L's brother was invited to attend an interview but declined to give any evidence to the Inquiry.

7.3 Observations on Mr L's Interview

7.3.1

Mr L gave clear evidence to the Inquiry that during the summer of 2004 he was aware of a relapse in his mental health. He described feeling tired, irritable, missing sleep, overworking at the stable and possibly misusing drugs.

7.3.2

He also recollected that the meeting on 19 August 2004 with Dr RMO2 and Ms FCPN2 was very difficult.

He had become irritable with Dr RMO2 because of his line of questioning. He described the meeting as being “disastrous”.

7.3.3

Dr RMO1’s evidence was that Mr L was dissatisfied with the forensic team’s care and supervision. Mr L’s evidence was that he was satisfied with the team’s care and supervision. It appeared to the Inquiry that his dissatisfaction with the forensic team in the summer of 2004 was due to his relapse into illness.

7.3.4

Mr L gave evidence of taking Cannabis. However, he indicated that he did not have any drug testing after his conditional discharge.

7.3.5

Mr L’s attack on Mr M appeared to the Inquiry to be related to the relapse in his mental illness. Prior to the attack, he had been irritable, overactive and not sleeping. At the time of the attack he had the idea that Mr M was going to harm other people and acted to prevent it. He believed that Mr M might mow people down in his car and he also thought that he intended to take the car to go and kill his girlfriend. These ideas, and Mr L’s response to them, appeared to the Inquiry to be of the same nature as those which preceded his offence in 1997.

7.3.6

At interview, Mr L appeared to the Inquiry team to be cooperative, thoughtful and showing some insight. He was quietly spoken and appeared mildly depressed in his mood. There was no evidence of irritability or dissatisfaction with mental health services.

Section 8

The role of the Scottish Executive in Mr L's care

8.1

The Inquiry heard from the following witnesses from the Scottish Executive Health Department (SEHD): Ms SE1, Team Leader (B3 grade), Restricted Patients Casework Team, Mental Health Division; Dr PA2, Psychiatric Adviser with special reference to forensic issues; and Mr SE2, Head of Service, Policy and Planning Directorate.

8.2 Evidence from Ms SE1

8.2.1

Ms SE1 stated that she was a B3 grade officer in the Mental Health Division of the Scottish Executive Health Department and the Team Leader of the Branch of the Division dealing with restricted patients. She had oversight of all casework that was carried out in the Branch and ensured that the Psychiatric Adviser received support in the discharge of her duties. At the date of interview, there were approximately 295 restricted patients in Scotland. The administrative team dealing with this group of patients consisted of herself and five other members of staff. Her line manager was the Assistant Secretary (and Head of the Mental Health Division), who was responsible to Mr SE2, the Director of Service Policy and Planning.

8.2.2

Ms SE1 indicated that her team was responsible for preparing draft submissions for conditional discharge and other major decisions, which were passed to Mr SE2 for presentation to the First Minister. The process of putting a submission to Ministers was usually initiated by a recommendation from the RMO. The recommendation could be for conditional discharge or other decisions, such as absolute discharge or transfer from the State Hospital.

8.2.3

Ms SE1 indicated that, in preparing a submission, her staff would review the patient's case-file, to make sure that key issues of his or her care, such as risk assessments, supervision and management in the community, had been addressed. The team had checklists of information that Ministers required in order to make a decision. Mental health practitioners were given guidance about the information required in the Memorandum of Procedure on Restricted Patients.

8.2.4

Ms SE1 further indicated that the Psychiatric Adviser would be required to assess the patient and information from her report would be included in the draft submission. The more junior members of the team would normally prepare the submission, in discussion with Dr PA2, and Ms SE1 would check it. In some cases, Ms SE1 would be involved in preparing the submission at an earlier stage. The extent of her involvement would be proportional to the complexity of the case. The submission would go to the Assistant Secretary for comment, and to Mr SE2 to put forward to the First Minister.

8.2.5

As far as training was concerned, Ms SE1 indicated that she had been working in the Mental Health Division

since 1992. She and her staff were trained for their work through the Civil Service in-house training programme; none of them were medically trained, but they had observed Dr PA2's interviews with patients. Staff were also made fully aware of the Memorandum of Procedure on Restricted Patients and the key questions they should ask in relation to risk assessment and risk management. Ms SE1 and another member of her team had attended training in the use of two risk assessment measures, the HCR20 and the Hare Psychopathy Checklist – Revised (PCLR).

8.2.6

Ms SE1 indicated that she first became involved in Mr L's case when the previous Psychiatric Advisor, Dr PA1, was in post. At that time Dr RMO1 was his RMO. She indicated that Dr PA1 had left her post in August 2001, and Dr PA2 had joined SEHD as Psychiatric Advisor in November 2001. Ms SE1 indicated that, following Dr PA2's appointment, she had become more involved with Mr L's case because Dr PA2 was new to the post and did not know his case.

8.2.7

She recalled that Dr RMO1 had first recommended conditional discharge around October 2000, and also an increase in his leave of absence . She commented that this was unusual, because recommendations for conditional discharge are normally only made when patients have been fully tested out on leave. The Division received a further recommendation for conditional discharge in January 2001. She indicated that, at that time, Dr PA1 recorded her concerns about his previous offending and about Dr RMO1, perhaps, minimising some of the risks. She recalled that there was also concern that a critical incident, involving Mr L, had not been reported to the Division. She recollected writing to Dr RMO1 in or around November 2001, to express concerns that relevant information about Mr L was not being passed to the team. She advised Dr RMO1 that the submission could not proceed until he sent a report of the Critical Incident Review. This was done.

8.2.8

Ms SE1 told the Inquiry that she and Dr PA2 subsequently discussed their concerns with Dr RMO1 and his clinical team. It was agreed that they would prepare a full risk assessment and management plan. She stated that the Division did not receive a full HCR20 risk assessment from Dr RMO1, but did eventually receive a "sort of summary" of scores on risk items and an indication of how the risks would be managed. She also stated that a letter from Dr RMO1 indicated that he would recall Mr L sooner rather than later, if there was any deterioration in his mental health.

8.2.9

Ms SE1 indicated that her team had some difficulty in obtaining the necessary clinical information to make a comprehensive submission to the First Minister. Ms SE1 indicated that her team put together a "sort of risk assessment" from information gleaned from the notes from the case-file and from the clinical reports and letters that the Division had received. Ms SE1, when questioned on the components of the

risk assessment in Mr L's case, stated, "we would take bits from the correspondence and it would form part of it". She also indicated that she did not receive a formal risk management plan from Dr RMO1: her team had assembled such a plan from the various pieces of information about Mr L that Dr RMO1 had sent them.

8.2.10

Ms SE1 thought that, with hindsight, there probably should have been an insistence on a HCR20 and a PCLR being undertaken in Mr L's case.

8.2.11

Ms SE1 indicated that, when the initial submission was made to the First Minister (in May 2002), he asked for it to be reconsidered in three months time, after further aspects of risk had been addressed. This included assessment of whether Mr L's discharge should be disclosed to the police.

8.2.12

In the event, there was a delay of almost a year before a further submission was made to the First Minister. This was because the Division raised a number of concerns about Mr L's mental health.

8.2.13

Ms SE1 told the Inquiry that, after Mr L was eventually granted conditional discharge (in April 2003), she flagged his case up to her deputy in the team and indicated that any concerns about him were to be followed up assiduously. She was not involved again until a few days before he killed Mr M (21 October 2004). She stated that she saw a letter from Dr CP and queried how Dr CP fitted in to the care of Mr L.

8.2.14

Ms SE1 indicated, that, though she had "flagged up" concern about Mr L's case to her managers, she had never considered obtaining an independent psychiatric opinion at any stage during his care. She indicated that Mr L was recognised as a complex case who was difficult to manage. She indicated that she and her team met weekly to discuss such cases; they also scheduled time with the Psychiatric Adviser, to deal with particular questions.

8.2.15

Ms SE1 indicated that she and other members of SEHD had previously corresponded with the Health Board about Dr RMO1's work in relation to other restricted patients. She indicated that the correspondence arose from concerns about the quality of his reports and about his assessment of risk. Ms SE1 understood that the matter was dealt with by the Health Board. She understood that an audit of his reports on the restricted patients under his care had been suggested, but never carried out.

8.2.16

With regard to reporting arrangements with other members of the forensic psychiatry team, such as the FCPN and the social worker, Ms SE1 indicated that conditional discharge involved a formal requirement for the social worker to report to the Division. However, there was no formal mechanism to inform other team members that they could report their concerns about restricted patients directly to the Division.

8.2.17

Ms SE1 also indicated that, to her knowledge, the Mental Heath Division did not monitor or audit the training of social workers or CPNs working with restricted patients. The guidance in the Memorandum of Procedure on Restricted Patients, at that time, was that social workers should have Mental Health Officer training, if possible. However, assessment of the skills of such staff was left to the Social Work Department or the Health Board.

8.3 Evidence from Dr PA2

8.3.1

Dr PA2 stated that she was a Psychiatric Adviser to the Scottish Executive Health Department, with special reference to forensic issues; she was seconded to her present post from her substantive post as a Consultant Forensic Psychiatrist. She had been in her substantive post since 1988 and in her current seconded post since 22 November 2001.
She indicated that she had had no prior contact with Mr L, though had some prior knowledge of his case.

8.3.2

Dr PA2 indicated that the core of her role in the Scottish Executive was to give advice about patients who are detained under Restriction Orders to Scottish Ministers, in effect to the First Minister. She indicated that there were approximately 300 restricted patients in Scotland, each of whom she tried to interview at six month to two year intervals, according to the case.
The average interval between interviews was 15 months. She said that, if required, she would visit more frequently.
The knowledge about restricted patients within the Mental Health Division was based on her personal knowledge through interviews with them; additional information came from the statutory annual reports and other reports from RMOs, social workers and other members of the clinical team.

8.3.3

Dr PA2 indicated that the First Minister took personal responsibility for all decisions about restricted patients, in respect of granting transfers to lower levels of security, granting conditional or absolute discharges, lifting restriction orders and granting leave of absence for life sentence prisoners.
Dr PA2 indicated that, in conjunction with Ms SE1's team, she made decisions on all other matters.
She also had a role in policy issues and in relation to mental health legislation.

8.3.4

Dr PA2 indicated that, because of the number of restricted patients, she was often not in a position to read the routine monthly reports on conditionally discharged individuals that were sent by RMOs and supervising social workers. However, these reports were "scanned" by a junior member of Ms SE1's team. If the reports contained no significant information, they were filed. For example, if the report said "mental state stable, everything fine", she would not see the report. However, the team member would draw to her attention anything significant in a report (for example, a patient not taking his medication).
Dr PA2 stated that she saw all other reports herself; these included annual

reports, treatment plans from the State Hospital, and requests for leave of absence.

8.3.5

Dr PA2 indicated that she did not know the qualifications or training of the members of Ms SE1's team who saw the monthly reports in the first instance. She was of the view that they thoroughly analysed the monthly reports from RMOs and from supervising social workers and would pass them on for further scrutiny, if they identified significant information.

8.3.6

When Dr PA2 took up the post of Psychiatric Adviser in November 2001, her predecessor, Dr PA1, alerted her to two cases; one of these was Mr L. Dr PA1 had expressed particular concerns about Mr L's possible conditional discharge. Before Mr L was considered for conditional discharge, he had been seen as making progress. Dr PA2 indicated, however, that she had been alerted to some incidents. These included Mr L bringing a drill or drill bit on to the ward, and a suspicion that he was using illegal drugs. It was pointed out to the clinical team that a Critical Incident Review should be completed before conditional discharge would be considered. As a precaution, the submission for his conditional discharge was delayed. She indicated that, in January 2002, Mental Health Division officials met the clinical team to discuss the case. She stated that, at this stage, she was concerned about Mr L's mental state and his irritability; he was argumentative and appeared to have a "laissez faire" attitude towards drugs.

8.3.7

Dr PA2 indicated that, because of her concerns, she had written to Dr RMO1 in April 2002, asking for a full risk assessment on Mr L. She also asked that he undergo random drug testing, which had not previously occurred regularly. She asked for details of proposed supervisory arrangements when he was in the community. Dr RMO1 wrote with an undertaking to carry out drug-testing and gave details of the supervision he would arrange for Mr L. In April 2002, Dr PA2 reached the conclusion (which was a reluctant one) that she would support Dr RMO1's recommendation for Mr L's conditional discharge. She indicated that she supported the recommendation because it had "full support" from the full clinical team and his mental state was much more stable. She told the Inquiry that, at this stage, the submission was put to the First Minister. He indicated that he wished to delay making a decision.

8.3.8

Dr PA2 stated that, at this time, there was a further incident, in which Mr L had made a comment about the appearance of a female member of staff and joked about playing strip poker with other members of staff. However, his mental health had remained stable. On another occasion, three months later, there was a further incident, in which Mr L had reacted badly to his belongings being searched.

8.3.9

Dr PA2 stated that Mr L was seen by a psychologist for help with anger management

(in the autumn of 2002). The psychologist raised a number of concerns about his anti-authoritarian attitude, the apparent instability of his mental state, and his future compliance with medication. She had found him to be irritable and unreasonable. However, Mr L had agreed to comply with medication. In addition, the RMO had stressed that he had a good relationship with Mr L and there were no adverse reports from his leave in the community.

8.3.10

Dr PA2 indicated that, in October 2002, Mr L's leave of absence was suspended to allow him to be started on depot injections of antipsychotic medication. In the same month, Dr RMO1 wrote to Dr PA2 indicating that Mr L was upset at having to take a mood stabilising drug (namely Lithium Carbonate) along with his depot medication. By November 2002, Mr L was reported to be complying with medication and less tense. He was again having four nights leave of absence at his brother's home and was being seen by the FCPN, who reported no difficulties. Dr PA2 indicated that Dr RMO1 expected to again recommend conditional discharge within 2-3 months. Though other patients alleged that Mr L was dealing illegal drugs on the wards, the clinical team found insufficient evidence to support this. They decided to proceed to a recommendation for conditional discharge.

8.3.11

In January 2003, the Psychiatric Adviser received an updated home circumstances report from the social worker, who supported conditional discharge for Mr L to his brother's home.

8.3.12

Dr PA2 indicated that, around early 2003, Dr RMO1 asked that the case for conditional discharge should again be made to the First Minister. At this stage, Dr PA2 felt that they did not have enough information and that the care package and supervisory arrangements should be reviewed. She also asked for a psychological report. Dr PA2 saw Mr L at the end of February 2003. She stated that, at this stage, Mr L was less intense, less argumentative and appeared to be more aware of his situation. There had also been positive feedback from his work with voluntary organisations. She met with the multidisciplinary clinical team, including the social worker, Ms SW1; the team was supportive of his conditional discharge.

8.3.13

In March 2003, Dr RMO1 wrote to the Mental Health Division with a care plan which indicated that Mr L would be supervised weekly by the FCPN and a social worker and given depot antipsychotic medication by his FCPN in his brother's home. Dr RMO1's supervision was initially to be fortnightly and then monthly. At that stage Mr L was on the Care Programme Approach. Dr PA2 stated that, at that point, she could see no good reason to stand in the way of Mr L's conditional discharge. She advised the First Minister to accept the Dr RMO1's recommendation and the First Minister approved Mr L's conditional discharge on 22 April 2003.

8.3.14

Dr PA2 indicated that, after seeing Mr L on 26 August 2003, she next saw him on 29 April 2004. She had been concerned because Dr RMO1 had reported that he had stopped Mr L's depot medication and was starting him on an oral antipsychotic drug. She stated that this 'rang alarm bells' with her. She stated that she was even more alarmed when she found that Mr L had not been started on the oral medication, particularly as his serum Lithium levels were low. She had written to Dr RMO1 to express her concern. She had also telephoned him. When she saw Mr L, he seemed thinner, but there were no other significant problems.
She also spoke to his FCPN, MR FCPN1, who confirmed that Mr L was making good progress. Nevertheless, she said that she again wrote to Dr RMO1 to express her concerns.

8.3.15

Dr PA2 was clear that the treatment of Mr L was the responsibility of his RMO. She saw her role as advising the First Minister and not involving herself in the day-to-day management of patients. She indicated that she had reservations about intervening directly in the care of a patient, because she would not be as familiar with his case as the RMO.

8.3.16

Dr PA2 stated that there was further correspondence about Mr L between her Division and, first, Dr RMO1, and then the locum RMO. The letters reported changes in his mental state and concerns about him. Dr PA2 had the impression that Mr L was being closely monitored at this time. She stated that the Division had asked if he should be recalled to hospital and were told that he should not be.

8.3.17

When Dr RMO1 returned from sick leave, he contacted Dr PA2 and asked if she was willing to see Mr L's relatives. He also had by this stage involved Dr CP in the care of Mr L. Dr PA2 attended a meeting on 30 September 2004, with Mr L's brother and friends, to explain the Restriction Order and the need for it. She indicated that this was "a terrible meeting". She was concerned that at the meeting Mr L was "high or depressed". Mr L's brother, his friend, and another man attended the meeting. Dr PA2 indicated that she was harangued by Mr L's brother and friend for approximately half an hour. Dr PA2 stated that nothing satisfactory came out of the meeting. She indicated that Dr RMO2 and Ms FCPN2's joint visit to Mr L was not discussed. The Division had not been aware of Ms FCPN2's concerns, except insofar as they had been mentioned in Dr RMO2's letter of 20 August, in which he reported on the visit.

8.3.18

Dr PA2 indicated that, as Psychiatric Advisor, she had concerns about Dr RMO1's management of Mr L. She indicated that these were primarily about the reliability and promptness with which Dr RMO1 reported important information about Mr L. As an example of this, she described the incident on the ward with the drill bit. There was also a suspicion that Mr L was using illicit drugs, but no testing was done. She commented that

Mr L had been allowed to start a job at the stables, without it being previously discussed with the Division and without the suitability of the placement being assessed. She confirmed that she had not received or seen any formal risk assessment or relapse plan in the care plan that Dr RMO1 prepared for Mr L.

8.3.19

The Inquiry questioned Dr PA2 about the role that FCPNs had in reporting to the Division about conditionally discharged patients. She indicated that the Division sometimes requested reports from nursing staff, such as FCPNs, when a social worker was unavailable. This had not been so in Mr L's case. She indicated there was no formal process in place to allow people involved in the care of a conditionally discharged patient to contact the Division, other than the people specified in the conditional discharge order.

8.4 Information from Mr SE2

8.4.1

Mr SE2, who is head of the Service, Policy and Planning Directorate at the Health Department of the Scottish Executive, indicated that his group was concerned in the provision of advice to Ministers across the range of health and social care services. The Directorate had a separate Division for mental health services (the Mental Health Division). The subject of this Inquiry, namely the management of restricted patients, was included in Mr SE2's Directorate.

8.4.2

8.4.2 Mr SE2 indicated that he had a team that dealt with restricted patients within the Mental Health Division. Ms SE1 was the team leader and she and her team worked with the Psychiatric Adviser, Dr PA2.

8.4.3

Mr SE2 indicated that part of his task was specifically focused on handling submissions of cases for conditional discharge of restricted patients. Submissions were processed through Ms SE1's team and passed to Mr SE2, who put them forward to the First Minister. He indicated that, before a submission was put to the First Minister, Ms SE1's team were required to ensure that a proper risk assessment had been carried out and that a care plan had been clearly thought through. A submission required evidence that the patient's mental health justified discharge and that the psychiatric adviser had approved the submission. There was an opportunity to seek legal advice on the submission from the Office of Solicitors to the Scottish Executive, if necessary.

8.4.4

Mr SE2 indicated to the Inquiry that, when the submission had completed the above process, it would be circulated to a very restricted group of people and also to the First Minister. One of the First Minister's two Private Secretaries was allocated the task of going through the submission and summarising it for the First Minister. In essence, the Private Secretary extracted from the submission the information that the First Minister needed, in order to make a decision. At this stage the First Minister would essentially wish to

be reassured that there was a consensus in the clinical view of the restricted patient's treatment and the appropriateness of granting a conditional discharge. Risk to the public was a clear factor that the First Minister considered in making his decision.

8.4.5

Mr SE2 also indicated that, throughout this whole process, the civil servants involved had a focus on any warning signals; they fully understood the significance of the contents of reports they received, even though they might not have great understanding of clinical detail. Though they were not experts in mental health, they were able to examine written reports, and to extract from them points that needed further exploration or explanation.

8.4.6

Mr SE2 also indicated that he was aware that there had been concerns about Mr L's RMO, Dr RMO1, in relation to the standard of his reporting to the Mental Health Division, in both Mr L's case and those of other restricted patients. He was aware that his Directorate had previously referred the matter to the Health Board. The Board had inquired into his performance as an RMO and Dr RMO1 had undertaken to improve the quality of his reporting to the Division. Mr SE2 understood that there was to be an audit of standards of reporting among RMOs.

8.4.7

Mr SE2 indicated that he could not explicitly recall the recommendation made with regard to Mr L's conditional discharge. He had looked back at the submission to the First Minister and the section headed "Risk Assessment" did not deal with risk assessment. He indicated that he had subsequently discussed this with Ms SE1's team. He understood that a summary risk assessment had been submitted by Dr RMO1 some months previously, which had been the basis for a dialogue between the team and Dr RMO1. Mr SE2 understood that, in the absence of a formal risk assessment, Ms SE1's team would attempt to summarise a risk assessment from the material they had on file. Mr SE2 indicated that the assertion that there was no risk assessment was in danger of overstating the case.

8.4.8

Mr SE2 confirmed that the employer would be considered to be responsible for the supervision, accreditation and performance of clinical team members, such as RMOs, FCPNs and social workers.

8.5 Observations on Scottish Executive Role

8.5.1

There was no person within the Scottish Executive Mental Health Division with designated responsibility for strategic leadership with regard to restricted patients.

(a) Ms SE1's post was not of a sufficient seniority to provide the necessary strategic leadership.

(b) No one else within the Scottish Executive was providing strategic leadership.

(c) The job description of the Psychiatric Adviser did not place the responsibility of strategic leadership on that post.

8.5.2

It was not clear to the Inquiry what the respective responsibilities of the Psychiatric Advisor and the civil service team were in relation to the supervision of restricted patients' cases.

8.5.3

The Memorandum of Procedure on restricted patients, in place at the time, did not provide clear, focussed guidance on the nature of the information required by the Mental Health Division in reports from mental health practitioners.

8.5.4

The Mental Health Division did not require a formal risk assessment of restricted patients either at the time of conditional discharge or subsequently.

8.5.5

An ad hoc risk assessment for Mr L was "put together" by Ms SE1's team from letters and reports in Mr L's file.

8.5.6

The Mental Health Division had a high level of input into Mr L's case up until the final submission to the First Minister for conditional discharge. However, there was little focus and much less input after Mr L was conditionally discharged. The role of the psychiatric advisor was clear and proactive up to conditional discharge, but appeared to be reactive thereafter.

8.5.7

Mr L's case had been highlighted by a previous Psychiatric Advisor as a difficult and complex one. However, after his conditional discharge it appeared to the Inquiry that the Division adopted a generic approach to his supervision, rather than one which focussed on his particular circumstances and risks. Lack of a proper risk assessment may have contributed to this.

8.5.8

It appeared to the Inquiry that there was no explicit understanding between the Mental Health Division and the clinical team about the allocation of responsibility for managing the risks in Mr L's case.

8.5.9

The Mental Health Division was aware of omissions of significant events from the reports they received on Mr L, eg the drill and drill bits being brought on to the ward and allegations of drug misuse. There was little evidence that the Mental Health Division actively intervened in Mr L's case in respect of these omissions. The Division did not, for example, seek an independent second opinion in respect of his assessment and management.

8.5.10

There were indicators in the information to the Mental Health Division that Mr L was relapsing into illness during the summer of 2004. It appeared to the Inquiry that the Division either did not recognise the significance of these indicators, or did not act on them.

Section 9

Mr M's psychiatric care

9.1 Mr M's psychiatric history

9.1.1

Mr M's history was extracted from his Scottish Prison Service notes, interviews with Mr HCM, prison healthcare manager; Dr RMO2, Specialist Registrar in Forensic Psychiatry; and Mr FCPN3, Forensic Community Psychiatric Nurse. Dr RMO2 and Mr FCPN3 both dealt with the care and treatment of Mr M.

9.1.2

Mr M had a history of offending and schizophrenia. He had a history of violence which was associated with his psychotic symptoms. He also had a history of deliberate self harm and drug misuse. He was treated with antipsychotic medication. His cooperation with treatment was unreliable and his case-notes described his behaviour as "chaotic" at times.

9.1.3

The Scottish Prison Service health records for three prisons relating to Mr M dating from 1991 were examined. These included reports of medical examinations whilst he was in the custody of the police. They also included correspondence from Dr RMO1, dated from 1997, and a psychiatric report, dated 8 April 1997. This documentation indicated intermittent psychotic symptoms, vulnerability, disorganised functioning and suicidal thinking.

9.1.4

Mr M had several admissions to psychiatric hospitals and was well known to the forensic psychiatry service. He had been detained under both s18 of the Mental Health (Scotland) Act 1984 and s58 of the Criminal Procedure (Scotland) Act 1995, and had, briefly, been a restricted patient. His last admission to hospital, prior to his death, had been a lengthy one. During this admission he was an inpatient in hospital, under the care of the forensic psychiatry service. His RMO was Dr RMO1. He was discharged from hospital in March 2004. Arrangements had been made for him to move to England following his discharge. Although he had visited England briefly, he did not move there.

9.1.5

Mr FCPN3 became Mr M's FCPN while he was still an inpatient. Mr FCPN3's initial contacts were informal ones, taking Mr M to the swimming baths or cinema, for coffee or for a walk round the grounds of the hospital. In the period October 2003 to March 2004, when Mr FCPN3 engaged with him, Mr M was preparing for his discharge.

9.1.6

Mr FCPN3 saw Mr M initially in the hospital for a few weeks and then arranged hospital grounds visits, then community visits and eventually he was discharged into the community.

9.1.7

9.1.7 On 30 July 2004, Mr M was remanded to prison on a charge of driving while disqualified. During this period, the Scottish Prison Service's health care service was responsible for his mental health care. Mr HCM was the Healthcare Manager for the prison.

9.1.8

On 3 August 2004, a mental health assessment was carried out by the prison nursing staff and it was reported that Mr M had constant "whispering" auditory hallucinations and disturbed sleep. At this time, Mr M attributed his recent road traffic offence to the desire to get away from the auditory hallucinations. At this time also, his proposed move to England and its outcome were noted.

9.1.9

On 6 August 2004, Mr M appeared at the Sheriff Court and was further remanded. At this stage, he had been identified as being at possible risk of suicide.

9.1.10

On 20 August 2004, Mr M was seen by Dr RMO2, who was acting as locum consultant, during the sick leave of the usual prison psychiatrist, Dr RMO1. At this stage, Dr RMO2 noted that Mr M's account of his recent movements between England and Scotland conflicted with information that had been given by Dr RMO1. It was also noted that Mr M used cannabis only and had not misused alcohol, after his discharge from hospital. Dr RMO2 further noted the whispering auditory hallucinations. Mr M at this stage wanted to be transferred to hospital because he felt people were abusive to him in prison. However, he was "not keen" on follow-up by the forensic psychiatry services. Dr RMO2 seemed to accept Mr M's plan to go to stay with his sister if he was placed on bail. Dr RMO2 wrote to the prison's Mental Health Co-ordinator, saying that Mr M would require CPN follow-up if he was bailed.

9.1.11

On 3 September 2004, Mr M was seen by Dr RMO1, his usual consultant. Dr RMO1 sent a report in the form of a letter to the Mental Health Co-ordinator. It confirmed that Dr RMO1 had spoken to Mr M by phone in June 2004, and Mr M had said that he was living in England. It was also reported by Mr M that he had stopped his antipsychotic medication in England and had started oral antipsychotic medication. Dr RMO1 also noted that Mr M reported significant difficulties in Portsmouth, including florid psychotic symptoms. He had acted on voices by confronting his imagined persecutor. Dr RMO1 also noted that Mr M intended to plead guilty to the driving offences.

9.1.12

In his report to the Mental Health Co-ordinator, Dr RMO1 noted that, on examination, Mr M's mental health had deteriorated although he described him as "cheerful and engaging". Dr RMO1 noted he intended see him again and "certainly in anticipation of his release".

9.1.13

On 16 September 2004, the prison nursing notes reported that Mr M had "intense" auditory hallucinations and requested discontinuation of his oral antipsychotic medication and recommencement of his depot medication. On 17 September 2004, he was seen again by Dr RMO1 who reinstated his depot medication, although at a low dose. Dr RMO1 continued to prescribe an oral antipsychotic drug. Dr RMO1 also indicated

he would continue to review Mr M's case. Mr M commenced his depot medication shortly afterwards and received the prescribed dose fortnightly.

9.1.14

Mr HCM of the SPS health services indicated that during his last days in prison, Mr M was in the prison's High Dependency Unit, because of his vulnerability and risk of suicide.

9.1.15

Dr RMO2 indicated at interview that he only remembered that he had seen Mr M in prison, after seeing the report of a critical incident review which had been carried out by the NHS mental health service in relation to Mr M's death. He stated that he had not had much involvement with Mr M, but was aware that his FCPN was Mr FCPN3. He had had conversations with Mr FCPN3 about Mr M.

9.1.16

Dr RMO2 indicated that, as far as he could remember, he did not make any follow-up arrangements for Mr M on his discharge from prison.

9.1.17

In a Social Enquiry Report dated 13 October 2004, prepared in connection with the charges of driving a car without insurance, a social worker indicated that Mr M presented as courteous and co-operative and did not exhibit any symptoms associated with his mental illness. However, the social worker did express concern that the reasons stated for committing the offence could indicate that Mr M was ill at the time.

9.1.18

Mr M was placed on a 2 year probation order at the Sheriff Court on 19 October 2004.

9.2 Observations on Mr M's care

9.2.1

There was very limited thought given to aftercare for Mr M, despite clear indications that he had been mentally ill in prison.

9.2.2

The arrangements made for Mr M's care following his release from prison were vague. It was not clear to us what follow-up he would have received.

9.2.3

Mr L indicated to the Inquiry that, before he attacked Mr M, he had been worried about Mr M's ideas and behaviour. The Inquiry was unable to find any other evidence of a connection between Mr M's mental state and the circumstances of his death.

Section 10

Conclusions

10.1

The Inquiry concluded that Mr L had relapsed into mental illness at the time he murdered Mr M. The evidence before the Inquiry suggested that Mr L had a bipolar affective disorder, and had suffered a relapse of his illness. The management of Mr L's mental disorder was regarded as challenging and complex. He posed a high level of risk and was dangerous to others when he was unwell. The Inquiry is satisfied that Mr M's murder was linked to Mr L's mental illness.

10.2

The Inquiry concluded that there were clear indications, from several different sources, that Mr L had relapsed in the summer of 2004. He showed changes in his thinking and behaviour that were indicative of relapse. These included reduced sleep, irritability, disinhibition and marked dissatisfaction with the clinical team's care. The relapse was not adequately identified and not adequately acted upon.

10.3

There was no systematic approach to risk assessment in Mr L's care and supervision and there was an inadequate focus by the RMO and the clinical team on the risks Mr L could pose.

10.4

At no time before or after Mr L's conditional discharge was there a satisfactory risk assessment, risk management plan or strategy to deal with any relapse in his illness.

10.5

In particular, there was no crisis plan to enable those involved in Mr L's care or supervision to identify and deal with a relapse in his illness. In the absence of a shared plan, staff in the clinical team, the General Practice or the Mental Health Division were unable to recognise the significance of the changes in Mr L's behaviour and thinking.

10.6

In general, there was a "muddled" approach to risk assessment and management which was shared between the clinical team and the Mental Health Division.

10.7

There was inadequate communication between the clinical team and the Mental Health Division about Mr L's supervision. Dr RMO1 did not communicate adequately with the Mental Health Division. The Mental Health Division and its parent Directorate of Service Planning and Policy were not sufficiently proactive in addressing this problem.

10.8

The Inquiry concluded that there were clear deficiencies within the training and supervision of the FCPNs and Social Workers working with restricted patients. There was not an appropriate or proportionate level of training and supervision provided to the health and social work staff working with Mr L, bearing in mind the complexity of his case.

10.9

There was no strategic leadership within the SEHD's Directorate of Service Planning and Policy to identify and address the issues raised in Mr L's case.

10.10

There was limited clinical leadership within the Forensic Psychiatry Directorate at the Health Board and inadequate over-sight of the performance of Dr RMO1 and the clinical team.

10.11

There were inadequate arrangements in place to manage locum appointments and inadequate guidance and support was provided to Dr RMO2 in his role as locum RMO.

10.12

Dr RMO2 failed to take adequate steps to make sure Mr L was receiving appropriate supervision and treatment. This was despite Ms FCPN2 having raised clear concerns about Mr L's mental state.

10.13

While Dr RMO2 was on leave, Ms FCPN2 reported her concerns to a senior nurse. However, she was unaware of any procedure for reporting them to the Mental Health Division.

10.14

The "hand-over" of Mr L's care between Dr RMO1 and Dr RMO2 at the beginning and end of Dr RMO2's locum appointment fell well below acceptable standards of care. The General Medical Council's guidance to doctors states that "You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors" (GMC: Good Medical Practice)

10.15

The Forensic Psychiatry Directorate of the Health Board failed to establish a procedure to ensure there was a hand-over between consultants.

10.16

There was no evidence that the Forensic Psychiatry Directorate had a clear and explicit policy about the arrangements for readmitting conditionally discharged patients in general, or Mr L in particular.

10.17

The Inquiry concluded that the standard of the medical case notes following Mr L's conditional discharge was wholly unacceptable and fell well below professional standards and the guidance given by both the General Medical Council and the Royal College of Psychiatrists. In the Inquiry's view, the poor standard of note-keeping probably contributed to the poor hand-over of information between Dr RMO1 and Dr RMO2.

10.18

The Social Work notes contained limited information and, in particular, there was no description of Mr L's index offence. These notes were inadequate.

10.19

The extraction of information from letters and notes by the Mental Health Division to form a 'risk assessment' was pragmatic but ill-informed. This was a further failure in Mr L's care.

10.20

The Mental Health Division failed to insist on a formal risk assessment on Mr L and this contributed to the poor management of his case.

10.21

The arrangements between Dr RMO1 and Dr CP to "share" the care of Mr L were made without any explicit identification of roles and responsibilities. The Inquiry concluded that these arrangements were particularly inappropriate in managing Mr L's care, given the complexity of his case and the risks that any relapse could pose. The timing of these arrangements was dangerous because Mr L had shown recent evidence of a relapse in his illness.

10.22

The Psychiatric Advisor raised concerns about the clinical management of Mr L. She did not see her role as being involved in the day to day management of Mr L, but it was open to her to suggest that a clinical second opinion be sought in respect of the risk issues, prior to his conditional discharge. This was not carried out and further contributed to the failures in Mr L's supervision.

10.23

Though there were no firm aftercare arrangements for Mr M, the Inquiry considered it unlikely that this was a deficiency which contributed to his death.

11 Recommendations

11.1 Health Board

11.1.1

The Health Board must ensure that there is a systematic approach to risk assessment and management within the forensic psychiatry service. In the Inquiry's view, the systematic use of formal risk assessment measures may be helpful in this, but they should not be regarded as sufficient. In the present case, there was inadequate clinical risk assessment and monitoring. The Health Board should ensure, therefore, that clinical staff are aware of the need to analyse the relationship between an individual's mental disorder and the associated risks and that they take a systematic approach to monitoring this.

11.1.2

The Health Board must ensure that written risk assessments and management plans are shared between all members of the clinical team and are easily available in the patient's case notes. For restricted patients, it should consider sharing them with general practitioners and other primary care staff who may come into contact with the individual. The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 should be considered in deciding whether to share them with the patient and his or her carers.

11.1.3

The Health Board must review the functions of Community Psychiatric Nurses caring for high-risk patients, especially those subject to restriction orders. It should do this in consultation with the SEHD Mental Health Division.

11.1.4

The Health Board must improve the training of Community Psychiatric Nurses to ensure that they have the required competencies to carry out their functions in relation to conditionally discharged patients. It must also ensure that these nurses are supervised by senior practitioners who take a proactive approach to case scrutiny and discussion.

11.1.5

The Health Board must take immediate steps to improve the clinical governance of the service, in relation to the work of consultant psychiatrists caring for high risk patients in the community. It should review its arrangements for appointing locum consultants and take steps to give them appropriate guidance, support and supervision. It must ensure that there are standards for the handover of information between successive RMOs, and that these standards are audited.

11.1.6

The Health Board must ensure that a restricted patient has a Responsible Medical Officer at all times.

11.1.7

The Health Board must improve the clinical leadership within the forensic service, to ensure that the service has a culture which supports clinicians and promotes good standards of clinical care, communication and record keeping.

11.1.8

The Health Board must ensure that there are clear

readmission arrangements for conditionally discharged patients and that these arrangements have the support of the consultant psychiatrists involved. It must also ensure that these arrangements are clearly understood by any RMO taking over the care of a conditionally discharged patient.

11.1.9

In the light of the Inquiry's conclusions about the management of Mr L's case, The Health Board should audit the RMO's work in respect of other restricted patients, to ensure that their management is being carried out to a satisfactory standard. In addition, the Inquiry would encourage the Health Board to audit the work of all consultants responsible for the supervision of restricted patients.

11.1.10

The Health Board should consider making the conclusions of this report known to the locum RMO's present employer, so that it can consider whether to audit his work in respect of restricted patients.

11.2 Social Work Department

11.2.1

The Social Work Department must review its operational policies and procedures, in respect of its supervision of conditionally discharged patients; it should involve all relevant sections of the Department in the review. It should carry out the review in consultation with the Health Board and the SEHD Mental Health Division.

11.2.2

Social workers supervising conditionally discharged patients must be Mental Health Officers. The Social Work Department must ensure that these social workers have the necessary competencies and training to carry out their supervisory function. In the Inquiry's view, this includes mental state and risk assessment skills, as well as generic social work skills.

11.2.3

The Social Work Department should ensure that Mental Health Officers supervising conditionally discharged patients have regular supervision, in respect of this work, from a senior member of staff, who has experience of working with high-risk patients. The supervision sessions should be recorded.

11.2.4

The Social Work Department should review the written clinical information that it requires to carry out its supervisory functions and ensure that this is contained within the individual's case file. In the view of the Inquiry, this should include a formal risk assessment and risk management plan, including a crisis management plan. This documentation should be common to all the health and social care practitioners working with the individual.

11.3 The Mental Health Division of the Scottish Executive Health Department

11.3.1

The Mental Health Division should identify the competencies that it expects in RMOs caring for restricted patients. It should do this in consultation with Medical Directors of Health Boards and the relevant sections of the Royal College of Psychiatrists. The Division

should seek reassurance from Health Boards caring for restricted patients that the relevant RMOs either have these competencies or are being trained to acquire them.

11.3.2

The Division should insist that a formal written risk assessment and risk management plan, including a crisis management plan, is in place, before submitting a recommendation for conditional discharge to the First Minister. It should ensure that the symptoms and signs of the individual's mental disorder are addressed in such assessment and planning. The Division should insist on regular written reviews of the assessment and plan, following the granting of conditional discharge.

11.3.3

The Director of Service Planning and Policy should ensure that there is a post within his directorate which carries responsibility for strategic leadership of the SEHD's work with restricted patients. This post should be of sufficient seniority to review objectives, structures, procedures and roles, and to make changes where necessary.

11.3.4

The current Memorandum of Procedure on Restricted Patients should be reviewed in the light of the recommendations of this Inquiry.

Glossary

Care plan
A written document that outlines the types and frequency of care services that a person receives and who should deliver them.

Care Programme Approach
Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services. This includes the formulation of a care plan, which identifies the health and social care required from a variety of providers.

Conditional Discharge
Where a patient's discharge is subject to conditions determined by Scottish Ministers.

Hospital Order
The High Court or Sheriff Court may order a person who has been convicted of an offence to be detained in hospital if it is satisfied that he is suffering from a mental disorder which makes it appropriate for him to receive treatment in hospital as a detained patient.

Leave of Absence
Periods of leave from hospital granted to detained patients.

Responsible Medical Officer
In relation to a detained patient, any medical practitioner employed on the staff of that hospital who is authorised by the managers to act as responsible medical officer.

Restriction Order
An order granted by a criminal court, in conjunction with a hospital order, with the effect that the order is without limit of time and the patient may not be granted leave or transferred to another hospital without the consent of the Scottish Ministers.

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