NHS
North East

REPORT TO THE NORTH EAST STRATEGIC HEALTH AUTHORITY OF THE INDEPENDENT INVESTIGATION INTO THE HEALTH CARE AND TREATMENT OF LOUISA OVINGTON

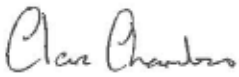
February 2011

The panel

The members of the panel were:

- Margaret Crisell – Solicitor-Advocate and Tribunal Judge (Chair)
- Dr Clare Chambers – Consultant Psychiatrist, Bradford District Care Trust
- Tom Welsh – former Head of Nursing and General Manager for Mental Health Services, Craven Harrogate and Rural District Primary Care Trust

Margaret Crisell 

Dr Clare Chambers 

Tom Welsh 

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Preamble

When Louisa Ovington was five years old she witnessed her father stabbing her mother to death.

22 years later on 8 January 2006 Louisa Ovington killed her former partner Mr Maurice Hilton by a single stab wound to the heart. She pleaded not guilty to murder and on 16 August 2006 was convicted of manslaughter on the grounds of provocation. She received an indeterminate sentence for public protection. In the previous 11 years she had been a patient with several different mental health services. She had been given various diagnoses including drug induced psychosis, personality disorder and alcohol abuse. She had convictions for 30 offences, some of which were violent and involved the use of knives. She had been the subject of three Community Orders (CO)/Community Rehabilitation (probation) Orders (CRO).

The panel was very grateful to the close relatives of Mr Hilton who agreed to meet the panel and talked openly with them. The panel wishes to express its condolences to the family who have suffered a dreadful loss.

Introduction and terms of reference

The panel was appointed in September 2008 by the North East Strategic Health Authority (SHA) to enquire into the health care and treatment of Louisa Ovington and to deliver to the SHA a report, including findings and recommendations. The investigation was established under the terms of the Health Service Guidance (HSG) (94) 27 as amended in June 2005.

The terms of reference were:

"To examine the circumstances surrounding the health care and treatment of Louisa Ovington, in particular:

- The quality and scope of her health care and treatment, in particular the assessment and management of risk;
- The appropriateness of the treatment, care and supervision in relation to the implementation of the multidisciplinary CPA and the assessment of risk in terms of harm to herself or others;
- The standard of record keeping and communication between all interested parties;
- The quality of the interface between general mental health services and other agencies;
- The extent to which her care corresponded with statutory obligations and relevant national guidance;
- To prepare a report of that examination for and make recommendations to the North East Strategic Health Authority.

The investigation panel consisted of:

- Margaret Crisell, Solicitor-Advocate and Tribunal Judge (Chair).
- Dr Clare Chambers, Consultant in General Adult Psychiatry, Bradford District Care Trust.
- Tom Welsh, former Head of Nursing and General Manager, Craven Harrogate and Rural District Primary Care Trust.

The panel expresses its gratitude to the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) for their cooperation in the investigation and to the North East Strategic Health Authority for affording the panel the necessary facilities to conduct the investigation.

The panel's independent coordinator was Ms Barbara Milligan, without whose support the panel would have been unable to function and to whom the panel is extremely grateful.

Provision of evidence

Between 1993 and January 2006 Louisa Ovington was involved with psychiatric services as an inpatient and an outpatient at seven different hospitals. She was also involved with community mental health services throughout the region.

The panel had access, with Louisa Ovington's consent, to all known documentation detailing her involvement with health, police, social services and probation other than her education records and children's social services records (which may have been destroyed). All the agencies were helpful and cooperative in producing records and also in assisting the panel with details of policy and procedure documents and copies of protocols.

The documentation was vast and amounted to in excess of 6,500 pages.

Louisa Ovington was, over the years, involved with ten different trust areas, primarily those which now comprise the Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), as well as Newcastle, Durham and Edinburgh and an independent sector hospital, Kneesworth House, in Hertfordshire. Because Louisa Ovington was involved with so many different trusts, because she moved around a great deal and because of many organisational changes, it proved complicated to establish who had clinical/CPA oversight of her at any one time.

The police authority with whom she was involved was at all times Durham Constabulary.

The probation services were provided mainly by Durham Probation Service with a short involvement by Teesside Probation Service.

The panel had access to the Tees Esk and Wear Valleys NHS Foundation Trust's internal investigation report dated February 2008 as well as the police Domestic Homicide Review[1] . This included part of the trust's internal investigation report and the internal review reports of Durham Probation Service and County Durham Social Services.

Sadly, Louisa Ovington consistently declined to meet the panel or have any contact, direct or indirect, with them. Although the panel has striven to ensure that what is reported here is factually correct, it has not been possible to check those facts with her. The panel was, however, assisted by an opportunity to visit the prison where Louisa Ovington is currently detained and where she was a participant in the Primrose Project, a government pilot programme dealing with dangerous and severe personality disordered offenders and by a discussion (which took place with her consent) with the team of clinicians involved in her care there.

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[1] *See Chapter 5*

The panel met on 14 occasions, totalling 34 days.

The panel interviewed 21 witnesses whose names have been withheld in this report. They and the others who were involved in Louisa Ovington's care are referred to by their professional titles and numbered, e.g. Psychiatrist 1. The names have been made available to the SHA. The witnesses' evidence was transcribed and then checked by each witness for factual accuracy.

Despite the coordinator's strenuous efforts it was impossible to contact some of the witnesses whom the panel wished to interview and therefore conclusions about their work with Louisa Ovington had to be drawn from other evidence.

The panel fully recognised the difficulty faced by witnesses who, in some cases, were being asked to recall events in which they were involved up to 11 years ago. The panel is very grateful to all the witnesses for their admirable efforts to 'flesh out' the paper records.

The panel was grateful to:

- Dr E Gilvarry, Consultant Psychiatrist, Northern Regional Drug and Alcohol Services, Newcastle upon Tyne
- Ms M Trendell, Professional Head of Social Work, Sussex Partnership NHS Foundation Trust, trainer in MAPPA issues for the Mental Health Tribunal
- Mr Jeff McCartney, former Assistant Chief Officer, Northumbria Probation Service with lead responsibility for public protection and offender management in Tyne and Wear

for their expert and illuminating explanation and commentary on, respectively:

- the provision of addiction services generally; insight into the type of problems with which clients may present and services offered;
- The provisions of MAPPA (Multi Agency Public Protection Arrangements)[2];
- The workings of the probation service, its functions and responsibilities.

Some of the information about Louisa Ovington's early life comes from accounts given to health and other professionals by her great aunt and uncle, who brought her up after the death of her mother.

The panel of course fully recognises that it alone had the benefit of a perspective which was not limited to a snapshot of events but has been informed by a vast amount of information from different agencies - something which no other single agency had at the time.

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[2] *See Chapter 5*

This introduction has noted the difficulties faced by professionals who were being asked to remember past events and judgements made, in some cases, long ago. By the same token the panel regrets that this report is published more than four years since the death of Mr Hilton. However, the trust's internal review was not completed until February 2008 and the work of collating the information from so many sources meant that the panel's work could not commence until the autumn of 2008. Although there has been no attempt at all by the SHA, the family of Mr Hilton or any of the agencies to place pressure on the panel to complete its work, the members of the panel have been acutely conscious of the need to produce a useful and comprehensive document within a reasonable timescale and have striven to do so.

Chapter 1 - Narrative of key dates and events

Birth to 23 December 1995 (her first admission to hospital)

1. Louisa Ovington was born on 31 August 1978. She was brought up in Scotland. Louisa Ovington's mother left her husband (Louisa Ovington's father) following episodes of domestic violence and moved to Edinburgh with her daughter. She withheld her address from him. In August 1984, when Louisa Ovington was five years old, her father tracked them down. (It has been suggested that Louisa Ovington might have inadvertently given away their whereabouts). He then stabbed Louisa Ovington's mother to death in front of Louisa Ovington. There are reports that following this Louisa Ovington stayed by her mother trying to give her food. Following her mother's death Louisa Ovington was then briefly taken in by her mother's sister before being moved to her maternal great aunt and uncle in the Durham area. She took their name and they brought her up and acted as her guardians until she was 18.

2. There are comments within her psychiatric notes which indicate that she began to present with behavioural problems from early on in her time with her great aunt and uncle. She had nightmares and drew violent pictures. In 1988, at age 11, she started at St Bede's Comprehensive School in Peterlee and from then on she was often in conflict with her teachers due to her behaviour. According to later reports from her great uncle (now deceased) she never cried; never said sorry; showed no signs of remorse for her actions and was a compulsive liar. The great aunt and uncle also reported that she slept with knives under her bed.

3. Social services became involved with her for nine months from October 1993, but there are no records of this. However, her first contact with psychiatric services appears to have been in November 1993 when she was assessed by Consultant 1, a Child and Adolescent Psychiatrist at the Royal Free Hospital in London, who was an acknowledged expert in the trauma suffered by children who witnessed one parent killing the other.

4. Consultant 1's opinion was that Louisa Ovington was not showing any signs of post-traumatic stress disorder, but that she was showing signs of mild behavioural problems, which Consultant 1 considered to be normal teenage behaviour, rather than deep-seated effects of her genetic endowment or of the trauma that she witnessed.

5. Louisa Ovington's behaviour continued to cause concern both at home and at school, from which she was temporarily excluded, apparently for pretending that a white powder was cocaine. She started using street drugs while a student at Peterlee College. In respect of academic achievements her own accounts vary so much from

each other, as well as from other accounts, that it is not possible to say what results she actually achieved at school or at college. She saw a private counsellor at Peterlee College and she had at least one session with staff from the Peterlee Drug and Alcohol Service.

6. When Louisa Ovington was aged 16 she was seen by Consultant 2 and Consultant 3 at Hartlepool General Hospital as an out-patient regarding substance misuse.

7. At some point around this period she moved out from home, initially to live with a girlfriend in Peterlee and then with a 34 year old boyfriend.

8. On 18 February 1995 at age 16 she committed her first criminal offence of common assault for which she was convicted. On 26 July 1995 she was given a 12 month conditional discharge and fined £70. She had assaulted a female after a dispute in a public house, punching and kicking her in the face and body. She later wrote in her diary "wish I'd killed the f-n bitch".[3]

9. On 19 December 1995 she was taken to the casualty department of Hartlepool General Hospital by a teacher who was concerned both about her drug use and a recent argument involving knives. Louisa Ovington was referred to Peterlee Drug and Alcohol Service following this assessment in casualty and information about the assessment was passed on to North Tees child psychiatry department.

10. Over the next few days she wandered away from home, was aggressive and irrational and at times was disorientated in time and place. On account of her bizarre behaviour she was brought to casualty at Hartlepool General Hospital and admitted to a psychiatric inpatient unit for the first time on 23 December 1995, when she was 17.

COMMENT

To witness, as a small child, the murder of her mother by her father was bound to have a seriously traumatic effect on Louisa Ovington, resulting as it did in the immediate loss of her parents in a particularly violent way. It is said that she inadvertently gave her mother's address away to her father, which may have compounded the inevitable emotional damage. Her mother's sister who took her in immediately afterwards felt she could not cope with her and she was moved away from her home town to Durham to live with a great aunt and uncle. In a short time she had lost her home, her parents and direct contact with her immediate family. The panel was surprised that there is no record of her receiving any professional help regarding this.

Her behaviour began to deteriorate in her early teenage years. In view of her history she was referred to an expert (Consultant 1) who concluded that her behaviour was not out of the ordinary for a teenager.

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[3] *1st offence and 1st conviction*

This opinion was referred to by many professionals dealing with Louisa Ovington over the next few years. It may have influenced their own judgements about what was at the root of her problems or what her needs were. Consultant 1 told the panel that she did not think that Louisa Ovington was suffering from a conduct disorder and she noted that 'it is not permitted to make a diagnosis of personality disorder before the age of 18' and that 'it was my responsibility to make a full and accurate assessment of Louisa Ovington and it would be the responsibility of any subsequent doctor to do the same'.

Subsequently, Louisa Ovington's behaviour became more disturbed, including drug misuse, criminally assaultative behaviour and the possession of knives.

23 December 1995 to 20 May 1998

11. On 23 December 1995 Louisa Ovington was admitted to a psychiatric ward at Hartlepool General Hospital under the care of Consultant 4 for a total of 81 days[4]. She was admitted informally but subsequently detained under Section 3 of the Mental Health Act.[5] She was suffering from psychotic symptoms and her behaviour was unpredictable, disruptive and abusive. Prior to her admission her use of street drugs had been extensive. A transfer to a child and adolescent unit at St Luke's Hospital in Middlesbrough was considered. The psychiatrist who assessed her concluded that she was suffering from a drug induced psychotic episode. He did not think that it would be appropriate for Louisa Ovington to be transferred to St Luke's Hospital because her main problem by the time that he assessed her was behavioural disturbance rather than mental illness. He noted her marked lack of remorse and expressed concern for Louisa Ovington, stating that she might well have problems into the foreseeable future. He recommended that EEG and CT head scan examinations be carried out but the panel was unable to locate any results.

12. During this admission Louisa Ovington was physically aggressive to staff and other patients and consequently had to be transferred to the Duggan Keen Secure Unit at Winterton Hospital for nine days. Whilst there she was under the care of Consultant 5 (later to treat her in the Tony White Unit at the County Hospital Durham in 1998 and to be her named supervisor in a probation order dated June 2001). Louisa Ovington was verbally abusive and threatening, required control and restraint and treatment with substantial doses of medication, including intramuscular sedative medication.[6] Her behaviour improved after a couple of days, after which she returned to Hartlepool General Hospital. She recovered and was discharged to live with her great aunt and uncle after having had a trial period of leave.

13. A care planning meeting was held prior to her discharge, at which CPN 1 (Community Psychiatric Nurse) was allocated to work with her. She was diagnosed as having been suffering from a drug induced psychosis and from a conduct disorder. She was discharged on antipsychotic and other psychotropic medication.[7] An out-patient appointment was arranged to review her two weeks post discharge.

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[4] First admission to hospital

[5] For an explanation of the purpose and effect of the various sections of the Mental Health Act see Chapter 8

[6] Lorazepam

[7] Medications to treat mental disorders

14. Louisa Ovington was reviewed in the outpatient's department at Hartlepool General Hospital and Peterlee Health Centre on five occasions during 1996. She was also seen regularly by CPN 1. Her medication was adjusted from time to time. She continued to accept intramuscular antipsychotic medication but the frequency of administration of doses was reduced over the course of the year and she used the oral medication intermittently. Up until December 1996 she appeared to be doing well: she was doing an 'A' level course and living with her great aunt and uncle.

15. On 5 December 1996 she spent a night in police cells for breach of the peace. A Mental Health Act assessment was done but she was found not to be detainable. It appears Louisa Ovington's behaviour at home had deteriorated; there had been an altercation in which knives had been involved and her great aunt and uncle temporarily refused to allow her to remain in their home. On 10 December she was seen at an urgent outpatient appointment at Hartlepool General Hospital. Consultant 6 concluded that her behaviour was anti social rather than psychotic in nature, despite concerns expressed by her college tutors and the CPN. Nonetheless two days later on 12 December 1996 she was admitted on a voluntary basis as an inpatient at Hartlepool General Hospital under the care of Consultant 2 for four weeks[8].

16. A care planning meeting was held on 20 December 1996. Concern was raised that Louisa Ovington was due, in relation to the murder of her mother, to receive a substantial amount of criminal injuries compensation as she had reached 18. Social Worker 1 expressed concern that Louisa Ovington would not be able to manage this money and she wondered whether the Court of Protection should be involved, but this was not pursued.

17. On 9 January 1997 Louisa Ovington insisted that she wished to discharge herself. She agreed however to take leave instead. She returned the following day seemingly intoxicated by drugs. Urine testing was positive for opiates and amphetamines and she admitted to the use of amphetamines and cannabis whilst on leave. She was discharged because of this. Because the discharge was sudden there was no discharge care planning meeting, but she was discharged on antipsychotic depot medication[9].

18. As her great aunt and uncle would not allow her to return to their home Louisa Ovington went to Edinburgh to stay with her mother's sister for a few days but then returned. She attended three outpatient appointments and also saw CPN 1. Social Worker 1 had done an assessment of need and was visiting her at home. The social worker was concerned to hear from her that she was having unprotected sex, was abusing drugs and that she enjoyed deceiving her guardians. She also told the social worker that she was having a relationship with a male nurse from Hartlepool General Hospital. Social Worker 1 immediately reported this and subsequently the nurse was dismissed.

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[8] *2nd admission to hospital*

[9] *Slow- release antipsychotic medication given by injection.*

19. On 6 March 1997, there was a one-day admission to Hartlepool General Hospital[10] on the recommendation of CPN 1 after Louisa Ovington had started using street drugs again and was hallucinating. She was discharged because she smoked cannabis on the ward.

20. Following this brief admission Consultant 7, who commented in a letter he wrote to her GP that Louisa Ovington was taking a "phenomenal" amount of cannabis, reviewed her in the outpatients' department. Consultant 7 took her off the depot medication and commenced her on oral antipsychotics. His opinion was that all her problems were drug related and he was worried that her drug taking might produce a 'schizophreniform'[11] illness. There was some attempt to engage her by social services and CPN 1 (who was about to leave her post). A care planning meeting was held (in her absence) on 22 April 1997. Her guardians did not know where she was but it later transpired that in March 1997 she had moved to Edinburgh.

21. While in Edinburgh it seems that Louisa Ovington was in touch with her father, who was still in custody for the murder of her mother. At this time she met a man and entered into a form of marriage with him under Muslim law. She subsequently reported that she had married him to make her boyfriend jealous. The 'marriage' lasted three months.

22. She became psychotic in Edinburgh, possibly precipitated by her discontinuing her anti psychotic medicine; by the stresses of life, which included recent contact with her father, who had just been released from prison and by her unstable social situation. She was admitted to the Royal Edinburgh Hospital on 20 May 1997[12] and remained there for ten days during which time she settled on another anti-psychotic drug. She had a negative drug screen which supported the diagnosis made of schizophrenia, rather than drug induced psychosis. Her medication on discharge was chlorpromazine.

23. Knowing by then that she had moved to Edinburgh and because she was subject to CPA[13], she was discharged from the Hartlepool and East Durham CPN service and the CPA manager in Hartlepool notified services in Edinburgh. The Edinburgh hospital staff arranged for her to be reviewed in outpatients. She missed two appointments and was therefore discharged.

24. Louisa Ovington returned to live with her great aunt and uncle some time after her discharge from Edinburgh. In early July 1997 she saw Consultant 6 (who thought the diagnosis at this point was 'veering towards schizophrenia') at outpatients at Hartlepool General Hospital and at Peterlee Health Centre and claimed to have seen the CPN 1 (although at the care planning meeting on 22 April 1997 the CPN had said she was leaving). Although there is mention of visual hallucinations and apathy in the records Louisa Ovington denied taking street drugs. The GP records indicate she was taking an antipsychotic daily from July 1997 to February 1998. There are no social services records of contact with her during the next few months and the police recorded no contact either.

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[10] 3rd admission to hospital
[11] A schizophrenia- type illness
[12] 4th admission to hospital
[13] See Chapter 4

25. On 14 February 1998 after an incident in a club, Louisa Ovington was charged with two counts of assault and indecent assault (on two separate victims). Two days later she was charged with a further assault and with an attempt to pervert the course of justice after attempting to intimidate one of the witnesses. Sedgefield Magistrates' Court remanded her on bail.[14]

26. Certainly by April 1998 (and possibly before that) Louisa Ovington was taking street drugs again. There were reports that she was spending between £400 and £500 per day on drugs, injecting heroin and snorting cocaine. She funded her habit through her Criminal Injuries Compensation Authority award of £46,000 and apparently used about £30,000 of this money in a year mainly on drugs, clothes and a car.

27. On 27 April 1998 Louisa Ovington was admitted to Ward 8 at Hartlepool General Hospital[15] from casualty after having had two blackouts following use of cocaine and cannabis. She was offered referral to Drug and Alcohol Services, but she declined.

28. On 18 May 1998 Louisa Ovington stole two gold necklaces from a jewellers' shop for which she was prosecuted.[16]

29. On 19 May 1998 she was again seen by the Hartlepool General Hospital casualty staff after she had possibly taken an overdose of cocaine and later in the day there was an incident involving the police at a post office where she was demanding cash from her giro before it was due.

COMMENT

During this period Louisa Ovington first became significantly involved with mental health services and appropriate attempts, including a lengthy inpatient admission, were made to diagnose and treat her mental disorder. Formal mental illnesses such as schizophrenia, drug induced psychoses and personality disorders, were all rightly considered, but it appears that most attention was paid to the issue of whether she suffered from schizophrenia. She was treated appropriately for this illness but was not referred to addiction services and the issues relating to her early trauma were not addressed.

She was awarded a considerable sum of compensation for her mother's murder. It was unfortunate that this fuelled an escalating drug habit. Concerns were expressed by Social Worker 1 about her ability to manage the money; the Court of Protection was mentioned but was not proceeded with, possibly because Louisa Ovington being over 18 and having capacity would not have met the criteria. Her behaviour became increasingly chaotic and dangerous and brought her into contact with the criminal justice system.

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[14] *Her 2nd and 3rd groups of offences*

[15] *5th admission to hospital*

[16] *4th offence*

20 May 1998 to 12 January 1999

30. On 20 May 1998 a serious incident occurred which resulted in Louisa Ovington's arrest. She had been found wandering in the street, bleeding, having apparently been threatening children at a school. She pulled a knife on a policeman and CS gas was used to restrain her. She was arrested and taken to a police station (where she damaged her cell). She was charged with threats to kill, possession of a bladed article and two counts of criminal damage.[17] She was remanded in custody to Low Newton Prison.

31. While there, she was noted to be suffering from "severe psychological and behavioural disturbance" and referred to Consultant 8 who, after assessing her, concluded that she was suffering from a drug induced psychosis. She had been taking large quantities of cocaine and PCP (angel dust) prior to being arrested. Consultant 8 prescribed antipsychotic medicine but when after a week or so her symptoms did not subside, he approached consultants at St Luke's Hospital, Middlesbrough and the Tony White Unit at Durham County Hospital.

32. On 5 June 1998 the court remanded Louisa Ovington under Section 35[18] of the Mental Health Act for the second to fifth groups of offences. She was admitted to the Tony White Unit at Durham County Hospital in the care of Consultant 5[19] to enable a report on her mental condition and recommendation as to sentence, to be prepared for the court. The Tony White Unit was a small five bedded unit that functioned as a local Psychiatric Intensive Care Unit (PICU). Thus, it was geared towards working intensively with patients with mental illnesses over short periods of time. (It had replaced the Duggan Keen Unit at Winterton Hospital where she had been admitted for a short period in 1996 under the care of Consultant 5.)

33. At the time of her admission Louisa Ovington complained of hearing voices that told her to kill herself. She had some biological symptoms of depression. She denied having any paranoid thoughts.

34. The probation service was asked to prepare a pre-sentence report[20]. The probation officer was clear that they could not support a community (i.e. non-custodial) penalty.

35. Twelve days after admission Consultant 5 recorded the dilemma he faced in relation to his recommendation to the court. If he recommended that she be detained under the Mental Health Act he felt that this could be "an opportunity to rescue her from a tragic future by means of treatment", but he was worried that she would not engage and thus it would be very difficult to treat her effectively. If he did not recommend that she be detained the court would have to consider a non- hospital disposal.

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[17] 5th group of offences
[18] See Chapter 8
[19] 6th admission to hospital
[20] A report prepared for the court to enable them to consider the options considered appropriate by the Probation Service

36. Consultant 5's opinion as expressed in his report for the Court dated 16 July 1998 was that Louisa Ovington was suffering intermittently from psychotic symptoms and that she was experiencing episodes of over-activity, aggression and distress punctuated by brief periods during which she was more controlled and communicative. He concluded that she suffered from both a mental illness and "to an extent" from a psychopathic personality disorder. He thought that the mental illness element was "quite strongly prevalent" at the time of her offending.

37. Consultant 5 recommended that the court dispose of the case by making an order under section 37[21] of the Mental Health Act to allow Louisa Ovington to be treated in a systematic way. He said that in the first instance a bed was available for Louisa Ovington at the Tony White Unit but that she might later require transfer into a different level of security because of the seriousness of the problems that she posed for nursing care (which later proved to be the case).

38. Consultant 7, a Locum Consultant Psychiatrist was asked to give the necessary second opinion as to whether a Section 37 Hospital Order would be appropriate and he therefore assessed Louisa Ovington at the Tony White Unit on 13 July 1998. He commented at some length on her extensive use of street drugs and said that he thought that when she committed the "index offence"[22] (the stabbing of the police officer, presumably regarded as the most serious of the cluster of offences with which she was charged) she was in an altered state of consciousness through the use of LSD, crack cocaine and magic mushrooms. He concluded that Louisa Ovington was suffering from a mental illness, describing the symptoms (for example, thought disorder, hallucinations, mood swings) and noting that at one point he thought she was going to attack him. He said she was "desperately in need of further treatment" and that due to her aggression this needed to be in conditions of medium security. He supported the recommendation that the court impose a Section 37 order.

39. On 17 July 1998 Peterlee Magistrates Court placed Louisa Ovington under Section 37 of the Mental Health Act in relation to the offences committed between 21 May 1998 and 20 July 1998.[23]

40. On 3 August 1998 Sedgefield Magistrates Court did likewise in respect of the offences committed in February 1998.[24]

41. She later appealed her detention to the Hospital Managers. The detention was upheld. There is no record of a Mental Health Review Tribunal.[25]

42. While at the Tony White Unit Louisa Ovington had a full assessment of her physical as well as her mental health and was afforded ongoing physical health checks.

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[21] *See Chapter 8*
[22] *The main offence which led to the detention in hospital*
[23] *2nd group of convictions*
[24] *3rd group of convictions*
[25] *See Chapter 8*

43. The Tony White Unit notes are detailed and record the treatment given to Louisa Ovington for her mental illness - a combination of medication and nursing care.

44. Although Louisa Ovington's sleep improved and there was some improvement in her presentation she was extremely distressed from time to time and her behaviour was extremely disturbed. She targeted particular members of staff and made serious threats of harm to them; she made formal complaints alleging staff brutality and sexual and physical assaults. She made malicious phone calls to the police; was sexually provocative, preoccupied and disinhibited; caused damage to the premises and assaulted and threatened staff and on one occasion another patient, as well as behaving aggressively to the more vulnerable patients. She attacked and bit one nurse on the inner arm, apparently because she did not like her mannerisms. By the beginning of November there had been 248 recorded incidents of aggression, confrontation, or hostility, including 36 physical attacks and 15 threats to kill. The level of her violence and aggression was so high that the police were involved and charges were pressed but this appeared to have little impact on her. Not all charges were proceeded with but in September 1998 she was charged with assault occasioning actual bodily harm - in respect of three assaults on nurses, including the bite injury.[26] She later said that during one of her assaults she had wanted to kill the victim.

45. At one point Consultant 5 commented that he believed that Louisa Ovington's behaviour was a manifestation of psychopathic disorder. She herself commented to a nurse that she would "get away" with what she had done because she was "mad". She expressed no remorse for some of the assaults. However in December 1998 she asked for anger management training as "her father had found it helpful".

46. Louisa Ovington also self-harmed while she was at the Tony White Unit. She claimed to have taken an overdose of her contraceptive pill, poured hot coffee over her head (without sustaining injury), stabbed herself in the hand and made superficial cuts to her arm.

47. The nursing staff noted that she was very variable in her presentation and Sister 1 told the panel that they did not think that Louisa Ovington experienced true delusions or hallucinations, although she was "an unsettled character who thought the world was against her". They thought that her behaviours stemmed from her personality problems. They did not think that she had access to, or was abusing, drugs on the ward.

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[26] *6th group of offences*

48. The panel noted that the medical and nursing staff differed in their opinions as to diagnosis. Sister 1 told the panel that she would be surprised to hear that Louisa Ovington had a psychotic illness. Her view was that Louisa Ovington had personality problems with psychotic symptoms. When seen by the panel Consultant 5 however was equally firm in his conviction that Louisa Ovington was suffering from a psychotic illness.

49. It was clear from a fairly early stage in her stay at the Tony White Unit that it was not geared to the particular demands that Louisa Ovington was making upon the staff. It was a very small, locked Psychiatric Intensive Care Unit (PICU) that focussed on the intensive, speedy resolution of acute distress as part of a serious mental illness. (One of the nurses eloquently described the physical surroundings to the panel, saying "the atmosphere was sometimes like a tinder box".) Consultant 5 and his staff felt that it could not provide the structured, consistent and predictable management plan that Louisa Ovington required. He told the panel (and indeed many people at the time), that he was concerned for the safety and well being of his staff. He therefore began to look for alternative forensic placements for her.

50. Between September and November 1998, Consultant 5 approached several medium secure forensic units in his search for another placement. The Hutton Unit in Middlesbrough (part of St Luke's Hospital) declined to take her as she had assaulted relatives of members of staff who then worked there. The consultant at Wakefield felt that it would be too far from her home, with consequent difficulties in resettling her. The Roycroft Unit at St Nicholas Hospital, a medium secure adolescent unit in Newcastle, had no beds but did send a forensic nurse and a forensic psychologist to assess her and provide advice on her management.

51. The detailed psychometric/psychological assessments carried out by the clinical psychologist from the Roycroft Unit concluded, amongst other things that Louisa Ovington was "a violent young woman" who was "highly manipulative, impulsive and difficult to manage"; that she was likely to have a selfish, callous and remorseless interpersonal style; that she had little motivation to change and that she was not suitable for an adolescent unit, but that there should be a further full assessment for psychopathy.

52. Consultant 9 from St Nicholas Hospital Medium Secure Unit in Newcastle, also assessed Louisa Ovington. He said the most likely diagnosis was schizophrenia. He said that Louisa Ovington fully accepted that there were times when she had acted very dangerously and that she had admitted that she "could have killed someone" at the time when she was running about with a knife. He thought that the Crown Prosecution Service should continue with charges against Louisa Ovington (for the assaults on the nursing staff) despite her being on a Hospital Order, because her past

behaviour combined with severe mental illness meant that it would be appropriate for a Crown Court to decide whether or not a further Hospital Order should have restrictions imposed on it under Section 41 of the Mental Health Act[27] as this would assist her future management. At this stage however (November 1998) he did not think that Louisa Ovington needed to be transferred to the medium secure unit in Newcastle: she was being adequately managed in a low secure facility and the fact that she was being given escorted leave in the community did not support the suggestion that she needed to be placed in a more secure environment.

53. Consultant 9 told the panel that at this time the NHS forensic services tended to run at 100% full and to a large extent the forensic consultants had to act as "quite severe gatekeepers" only offering places in medium security if the patients really could not be managed in low security.

54. Consultant 5 had also approached Hartlepool General Hospital and Louisa Ovington was assessed by Consultant 7 who had prepared a second opinion for the court hearing in August 1998 (see paragraph 38) to see if she might be suitable for their open adult psychiatric ward. Consultant 7 recognised that Louisa Ovington was more stable than she had been when he had previously interviewed her but nonetheless felt she was not suitable as she still needed clearly cut, defined and closed boundaries. He thought she was suffering from bipolar affective disorder and personality disorder.

55. In November 1998 Louisa Ovington was arrested for three further assaults on nursing staff, but was not prosecuted (they were apparently dealt with as "TICs"[28]).

56. On 14 December 1998 Louisa Ovington was due to appear in court again in relation to the assaults on nursing staff. Consultant 5 told the court that he could not accept liability for inpatient care for more than a further week because he was so concerned for the safety of his staff. Furthermore, he said in his report for the court that Louisa Ovington had developed a vengeful dislike against particular nurses, which he considered had a very dangerous potential. He described the arrangements at the Tony White Unit as 'unsafe in the extreme'. At this stage he indicated that he believed that Louisa Ovington had largely recovered from her mental illness (through treatment) but that she still had a considerable residual psychopathic disorder. He thought that in view of the severity of the threat which she posed to a number of people it was appropriate for the matter to be referred to the Crown Court for a Section 41 Restriction Order[29] to be imposed and said that he thought Louisa Ovington should be in a regional secure unit. The case was adjourned to January 1999.

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[27] See Chapter 8

[28] TIC's- offences 'taken into consideration' when sentencing for other offences

[29] See Chapter 8

57. On 22 December 1998 a review meeting was held at the Tony White Unit to consider whether she could be discharged (concluding that she could not) and aftercare arrangements if she were to be. A social worker, Social Worker 1, who had known Louisa Ovington and the family for some time and had had discussions with them, said that Louisa Ovington was extremely damaged and expressed the fear that Louisa Ovington would at some point go on to commit a serious crime as her father had. Her great uncle had expressed similar fears, as well as fears for his own safety.

58. Further discussions had taken place as a result of which Consultant 9 agreed to take Louisa Ovington on the medium secure forensic ward at St Nicholas' Hospital. There was discussion as to which section of the Mental Health Act would be most appropriate. Consultant 9 told the panel that he favoured the use of Section 38[30] - an order lasting 12 months permitting assessment during ongoing court proceedings. This would, he told the panel, have kept her in hospital and obliged the court to remain involved. If she had been detained under Section 37/41 and the proceedings against her had been discontinued, there was a chance she could have successfully appealed against the Section 37 and been discharged by a Mental Health Review Tribunal. There was no such appeal possible against Section 38. His clear view was that the matter should ultimately be disposed of with a Section 37/41.[31] Consultant 5's view was that by December 1998 it was no longer helpful for her to be treated at the Tony White Unit; the important thing was for her to be transferred somewhere where she could have exposure to a wider range of treatments. He therefore supported Consultant 9's recommendation of a Section 38, so that Consultant 9 would accept her at St Nicholas' Hospital. Nonetheless Consultant 5 told the panel that he would have preferred to recommend that Louisa Ovington be either continued on Section 37 or made subject to a Section 37/41.

59. Despite the immense difficulties that the staff faced whilst looking after Louisa Ovington on the Tony White Unit, there is evidence within the notes of the staff doing their best to support her. During this admission Louisa Ovington had numerous visits from family members and was visited by her father who contacted the ward through his supervisor at Edinburgh prison, asking if he could visit her. (Louisa Ovington's feelings towards her father appeared to fluctuate: on 22 August 1998 she said she intended to kill him when she was 20 years old.) Louisa Ovington's religious needs were met by her having visits from Catholic priests on several occasions, as and when she requested this. Louisa Ovington was given occasional escorted leave in the grounds of the hospital and to town. Staff reported however that at these times she was quite excitable and often exhibited inappropriate behaviour. On 24 December 1998 Louisa Ovington was supported by staff when she wanted help to write to the Mental Health Act Commission[32] to inform them of her discontent about being at the Tony White Unit.

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[30] See Chapter 8

[31] See Chapter 8

[32] The Mental Health Act Commission was the body charged with monitoring the use of detention under the Mental Health Act. It has now been replaced with the Care Quality Commission.

60. As was common in 1998, there were few formalised risk assessments. Staff Nurse 1 told the panel: "We very much worked on a sort of activities of daily life model ... we didn't have a specific risk assessment at that time on the unit, it was very much down to the experience of staff. And as part of the care plans, you know from the initial assessment … through observing the actions and the outcomes of those actions then the level of risk would be assessed and the care plan would be updated or discontinued or a new plan written."

COMMENT

Louisa Ovington was admitted to the Tony White Unit from Low Newton after the symptoms of psychosis failed to abate with medication. It was clear from fairly early on that the clinical view was that the unit was not an ideal setting in which to treat Louisa Ovington. On admission Louisa Ovington exhibited florid symptoms of mental illness; as time went on the symptoms abated but her persistent, extremely disturbed and aggressive behaviour continued and she clearly presented a major challenge in a unit which, although it was a PICU, was not designed for long term treatment of persons with personality disorders. The nursing and medical records are full and detailed but effective intervention was limited by a lack of appropriate resources and by the fact that as a result of the risks she posed to the staff, containment and transfer to more appropriate surroundings, rather than any more elaborate therapeutic plans, were uppermost in the minds of those treating her. The panel noted the reluctance of the clinical team to involve the police and to charge Louisa Ovington for her behaviour, despite the extreme level of her aggressive assaults. They were told by Consultant 5 that although there is the potential in principle to charge people for criminal damage to fittings or aggression towards people within hospital, in his experience the police are terribly reluctant to pursue these and if charges are brought the Crown Prosecution Service (CPS) drops the cases. Sister 1 told the panel that nonetheless the hospital had "good relations with the police" because they would come in with the sniffer dogs on a fairly regular basis to keep the drug problem on the open wards down to a minimum.

Cuthbert Ward, St Nicholas' Hospital, Newcastle: 13 January 1999 to 16 August 1999

61. On 13 January 1999 Louisa Ovington appeared in court in relation to her assault on one of the nurses at the Tony White Unit. The Section 37 under which she had been detained was discharged and the court ordered that she be subject to an assessment under Section 38 of the Mental Health Act at St Nicholas' Hospital in order to determine whether her personality disorder was treatable and whether it would be appropriate to recommend that she be detained under Section 37 or Section 37/41. Section 38 has a maximum duration of one year and needs to be renewed every 28 days by the court.[33] (Louisa Ovington was apparently hopeful that the order would be rescinded; in May 1999 however she appears to have accepted that it would not and the records show that she was becoming more realistic and prepared to accept some responsibility for her actions.) After the hearing she was admitted to Cuthbert Ward (medium secure forensic ward) at St Nicholas' Hospital under the care of Consultant 9.[34]

62. In view of her history of aggression and of making false allegations whilst at the Tony White Unit, Louisa Ovington was very carefully supervised. Initially she had two members of staff with her at all times, one of whom was always female. She was segregated for the first two months. During the following two months the observation levels were gradually reduced. She was first allowed ground leave, escorted by three members of staff, on 23 April 1999. She was regarded as being at risk of suicide and of serious violence and self neglect both on admission and at meetings held in March and May 1999.

63. In March 1999 the minutes of a meeting record that Louisa Ovington had been vocal, aggressive and threatening on admission, but that since then although her mood had been changeable and she was verbally hostile and abusive at times, there had been no physical attacks. She became hostile when challenged about her present and past behaviours and particularly guarded when discussing assaults upon others, feeling that staff were "trying to goad her" and "judge" her. The staff also noted that Louisa Ovington tried to "split" staff in attempts to manipulate situations by claiming that other staff had verbally backed up her cause. There was a consensus that assessment of whether Louisa Ovington had a mental disorder that was treatable should take place in conditions of at least medium security and work was started to find an appropriate placement.

64. On admission to St Nicholas' Hospital Louisa Ovington was being treated with an anti-depressant, a mood stabiliser and antipsychotic depot medication. In April 1999 however, the depot medication was stopped because her psychotic symptoms appeared to be in remission. In addition Louisa Ovington had stated that she had been feigning these symptoms. However Consultant 9 told the panel that he thought that she had a genuine psychotic illness and that he did not think she was astute enough or a good enough actor to have feigned all symptoms.

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[33] *See Chapter 8*

[34] *7th admission to hospital*

65. Louisa Ovington had multidisciplinary assessments and treatment whilst at St Nicholas' Hospital. This included working with occupational therapists, nursing staff and psychologists. She attended numerous groups: social skills, social activities, expressive art, baking, cookery, thinking skills and healthy living groups. Initially she had individual sessions with the occupational therapist and later group sessions to assess her interactions with others. She was noted to be able to concentrate for long periods on activities in which she was interested. Her behaviour in group sessions varied from appropriate to subtly disruptive. She was described as exercising self control when she chose to but also seen to wind herself up to anger.

66. Anger management sessions were carried out. The staff and Louisa Ovington looked at her past assaultive behaviour in order to help her to identify and divulge feelings that may precede behaviour, control feelings, not harm herself or others and accept her own responsibility. In March 1999 Louisa Ovington stated that they were a waste of time and that she didn't have a problem with managing anger, though she said she would continue with the sessions 'because of the courts'. She took part in eight planned sessions but found them very difficult and so eventually the sessions were suspended whilst she continued her work with the forensic psychologist.

67. A thorough psychological assessment was carried out by Psychologist 1, a consultant forensic clinical psychologist and Assistant Psychologist 1. This process consisted of clinical interview, completion of established psychometric inventories relating to personality and interpersonal behaviour and an interview with Louisa Ovington's great aunt and uncle to get a corroborative history. Louisa Ovington's great uncle also provided a brief written summary of Louisa Ovington's life in which he commented "Even now I think she could kill – we love her but are apprehensive as regards the future – she is capable of anything".

68. Psychologist 1 noted that Louisa Ovington minimised her problems with anger and aggression, stating they were in the past. She related all her past difficulties to abuse of illegal drugs. She reported a promiscuous period in her life when she was ill. She described an erratic mood, changeable emotional state and general impulsivity. Psychologist 1 felt that Louisa Ovington had been "much more disturbed and affected by the trauma of seeing her mother being murdered than was first understood".

69. In her evidence to the panel Psychologist 1 said: "There were certainly always issues that remained essentially off her agenda and they included the murder of her mother" and also commented that she was very "closed off" (a comment repeated in the notes from Kneesworth).

70. The psychologists' report concluded that she suffered from a probable borderline personality disorder with psychopathic features; that she had some anxiety, difficulty with anger and behavioural control but no mental illness. Allowance was made for some unreliability of self reporting. They noted that Louisa Ovington denied or ignored emotional difficulties. They recommended further work on dealing with stress and problematic emotions and targeted relapse prevention work. In her evidence to the panel the psychologist said: "We felt that in terms of offering treatment she would need to be in a contained and consistent environment where they would have the opportunity to build up over time the kind of relationship that would maybe make therapeutic change possible" and that Louisa Ovington would need a significant period of time - 18 months to two years.

COMMENT

Whilst the assessment appears to have been thorough the recommendations were not very clear or specific.

71. Consultant 9 arranged for Louisa Ovington to be seen by Consultant 10 from Rampton Hospital to give an opinion about her management. Consultant 10 met Louisa Ovington on 29 April 1999. His view was that Louisa Ovington was suffering from a treatable form of psychopathic disorder, although he had no doubt that she could become mentally ill when under the influence of cocaine - and needed treatment with "exploratory psychotherapy, careful matching of management control to risk assessment, specific substance abuse counselling and the provision of a long-term mentor to provide a stable link while she is struggling to re-position and resocialise herself". He found her complex, quite profoundly disturbed and said that she required treatment in a controlled setting until there was a satisfactory understanding of her instability and insecurity and adequate support to ensure that she did not take drugs, otherwise the consequences could be "serious or indeed grave". He thought her mother's death played a part in the situation she was in.

72. Consultant 9 concluded that the primary diagnosis was one of personality disorder. He told the panel "I think the picture was mainly of borderline personality disorder, (there were) strong anti-social personality disorder components".

73. Louisa Ovington made very good progress from about April 1999 onwards - her behaviour improved, she was less aggressive and there was no evidence of mental illness. Consultant 9 felt she should not be treated long term at St Nicholas' Hospital as it was not set up for severely personality disordered young women. It was a mainly male ward for people with severe mental illness. Kneesworth House in Hertfordshire (part of the independent provider Partnerships in Care) was identified as the most appropriate hospital. It was a private facility but the panel was told by Consultant 9 that at the time there was very little provision for severely personality disordered

women. Registrar 1 prepared a very thorough summary, taking considerable trouble to collate as much information as possible, verbal and written, of Louisa Ovington's past history. Consultant 11 from Kneesworth agreed that Louisa Ovington was suitable for treatment at Kneesworth and wished her to be transferred under the same Section 38 Order which had been regularly renewed, but by the time of transfer had only five months to run. The former Tees Health Authority approved and funded the placement.

74. During her stay at St Nicholas' Hospital Louisa Ovington continued to have intermittent contact with her father.

75. There was some social work input while Louisa Ovington was in Cuthbert Ward, primarily to provide a social circumstances report to Hospital Managers[35]. In March 1999 Social Worker 1 (who had been her social worker for some months and had known the family for some time) handed the care to Social Worker 2 and a meeting is recorded on 1 March 1999 where it is commented that Louisa Ovington showed no remorse for her offences.

COMMENT

Cuthbert Ward was a forensic unit and proved to be a far more suitable and therapeutic environment for Louisa Ovington than the Tony White Unit. As a forensic unit they had the benefit of greater resources including a high staff to patient ratio, access to psychology, occupational and recreational therapy and a more spacious environment. She had the benefit of seeing her key worker regularly. She also benefited from being very closely supervised. Whilst it was acknowledged that Louisa Ovington was highly manipulative the panel was told that it was unlikely that she could have kept her true impulses and behaviour under control in this way for such a lengthy period of time. Consultant 9 told the panel that he had little doubt it was the very strict boundaries that made the difference and the fact that there was a zero tolerance of aggression.

The care planning process identified key issues and how they should be addressed and this was supported by regular review meetings. The clinical care was entirely appropriate. Detailed medical and nursing records were kept. The handover to Kneesworth was well planned and executed.

Given the above it was unfortunate that she had to be transferred away from St Nicholas' Hospital. Consultant 9 told the panel that by a fairly early stage he had decided there was insufficient evidence of mental illness, (rather than personality disorder) being the primary diagnosis, but that he considered Louisa Ovington still to be sufficiently dangerous as to need conditions of medium security. He did not think that the facilities he had on Cuthbert Ward would meet her needs, particularly as it

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[35] *See Chapter 8*

was a predominantly male ward. Consultant 9 had no personal experience of Kneesworth and after a time lapse of ten years could not remember exactly what enquiries he had made, but he knew it to have a medium secure specialist personality disorder unit with males and females and told the panel that he had reason to believe it to be reputable and it was one of very few places that offered personality disorder services. The panel agrees that once the decision to transfer Louisa Ovington was made, it was reasonable on the information available to choose Kneesworth.

It was also unfortunate that Louisa Ovington had to be moved several times. Her placements at the Tony White Unit and St Nicholas' Hospital appear to have arisen through urgent necessity rather than choice. However, the move to Kneesworth House occurred when Louisa Ovington was over half way through a one year maximum detention under Section 38. The staff at Kneesworth House were therefore left with having to make their final decisions about her within less than five months of her admission there. Given Louisa Ovington's complex presentation, this was bound to be difficult. Consultant 11 commented to the panel that the team at Kneesworth House could have done with longer to work on engagement with Louisa Ovington.

As was the case at the Tony White Unit, few formalised risk assessments were carried out at St Nicholas' Hospital - but the forensic psychologist told us that "individual disciplines would be collecting information, discussing, sharing it and then a general discussion at case conference would produce a view." Registrar 1 told us: "I have to say that in the last ten years the process of risk assessments has changed beyond belief. It was simply a clinical judgment type of risk assessment in the past. The risk assessment process that is carried out these days bears no relation to good clinical practice in those days".

Consultant 9 told the panel that although he did not recommend that Louisa Ovington be detained under Section 37 (for the reasons given and further commented on in Chapter 8) prior to the transfer to Kneesworth House Hospital, he thought she met the criteria for a hospital order.

Kneesworth House, Hertfordshire: 16 August 1999 to 12 January 2000

76. Louisa Ovington was admitted to Clopton Ward at Kneesworth House, Hertfordshire on 16 August 1999[36] under the care of Consultant 11, in order to assess the treatability of her mental disorder. It was anticipated by staff at St Nicholas' Hospital (and by Consultant 10 at Rampton) that she would then need a further protracted period of time at Kneesworth for treatment. At the time of admission she was classified under the Mental Health Act[37] as suffering from mental illness. Kneesworth House is a hospital in the independent sector. Clopton Ward was a mixed gender ward dealing with personality disordered patients. The staffing was multi disciplinary in nature, including ward-based psychologists.

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[36] *8th admission to hospital*

[37] *See Chapter 8*

77. One of the major components of Louisa Ovington's treatment at Kneesworth was input from the psychology service, including assessment and treatment. Psychologist 2 and Assistant Psychologist 2 were the authors of the report. Psychologist 2 was a counselling, not a clinical psychologist; Assistant Psychologist 2 had a degree in psychology, but no previous practical experience. Her assessment was supervised by a clinical psychologist, Psychologist 3, who did not work on Clopton Ward. Assistant Psychologist 2 told the panel that from her recollection (nearly ten years ago) Psychologist 2 did not participate in psychology meetings and was somewhat isolated. Consultant 11 told the panel that Psychologist 2 was very forceful in making her views known.

COMMENT

The panel was unable to contact Psychologist 2. It is apparent that she left Kneesworth House about a year after Louisa Ovington did. Strenuous efforts were made to track her down without success; therefore comment that is made about the psychology assessments is made without the benefit of hearing her account. The panel was able to talk to Assistant Psychologist 2 but she was junior at the time, had little recollection of Louisa Ovington after such a long time and was unable to clarify many of the issues.

78. Psychological assessment sessions were carried out by Psychologist 2, in which Louisa Ovington's history was explored. She was, by the fourth session, described as participating well, although there were also remarks about her being guarded and "closed off". Although the assessment sessions noted that Louisa Ovington had nightmares relating to guilt, death and punishment (presumably arising from her mother's death) and was ambivalent about her father, these were not identified as issues to work on.

COMMENT

Consultant 11 told the panel that Psychologist 2 had concluded that it would be very difficult to engage Louisa Ovington in any work in relation to her mother's death and her unresolved feelings about her father.

79. The assessment did identify drug use as an issue to work on and noted that Louisa Ovington attributed all her problems to this and "is blithely convinced she will have no difficulty avoiding drugs in the future" – but alcohol use was not apparently considered. At the end of the assessments Louisa Ovington agreed to start some individual work with Assistant Psychologist 2 relating to substance abuse/relapse prevention.

80. The formal psychological assessments that were carried out included an incomplete substance abuse profile based on records without any interview with Louisa Ovington; a personality assessment inventory which relied very heavily on self reporting and was an automated assessment, i.e. results were fed into a programme which then gave an automated result and an IQ assessment showing an overall IQ of 88 and a verbal IQ of 92.

81. Louisa Ovington had ten individual treatment sessions with Assistant Psychologist 2. There was a CPA review on the ward on 4 November 1999, (attended by social workers from the 'home' authority), when it was decided that Louisa Ovington would be given a drug free trial period. Some of the sessions with Assistant Psychologist 2 were used to support and monitor her in this process. Others attempted to explore other issues including drug use but a recurrent theme seems to have been her tendency to avoid dealing with issues and again she was described as guarded.

82. The last session was on 22 December 1999. Louisa Ovington was again guarded about the extent of her urges to use drugs and there was some acknowledgement in the session about Louisa Ovington's tendency to avoid issues. They were planning to work on drug issues in future sessions after the Christmas break (which never happened as she was discharged).

83. An external CPA meeting was planned for 21 October 1999, but was cancelled as the external parties were unable to attend that day. It finally took place on 4 November 1999. There was a good review of progress with reports from occupational therapists and nursing staff and a good review of plans. At this meeting it was noted that the psychology assessment of personality had been completed and Louisa Ovington was "not considered to be suffering from a severe personality disorder."

84. Other treatment/assessment strategies were made available to Louisa Ovington, some of which she engaged in and some she did not. There did not appear to be any particular pattern to this although the OT department noted that she preferred social groups to 'treatment' groups.

85. During her stay at St Nicholas' Hospital Louisa Ovington's great uncle had developed cancer. She became very distressed as his health deteriorated and the staff at St Nicholas' were very supportive of her, facilitating visits. Kneesworth House staff were equally concerned that she should be able to maintain contact but shortly after Louisa Ovington was admitted to Kneesworth, he died, three days before a planned

visit to see him. A little later, one of her cousins also died. It was noted that she was appropriately affected by the bereavements, particularly in relation to her great uncle.

86. During the five months Louisa Ovington remained at Kneesworth House there was no evidence of psychosis and up to December 1999 her mental state and presentation remained stable, in marked contrast to how she had been in the Tony White Unit only one year previously, despite the fact that she had to cope with two significant bereavements whilst she was there. She was compliant with medication. Ward rounds took place on a regular basis and were appropriately recorded with few problems noted.

87. She was given escorted leave, both to home and locally. All passed without incident. She was well supported by the nursing staff. One noted that Louisa Ovington told her that "she did not like people knowing too much about her business" this being why she did not say much in 'sessions'. In the few weeks leading up to her discharge one or two incidents were noted on the ward, when she exhibited sexually challenging behaviour and was emotionally unstable. At this time she had been taken off Carbamazepine. The relationship between the deterioration in behaviour and the cessation of Carbemazepine was not explored. At the point of discharge she was considered not to be suffering from a mental illness.

COMMENT

The panel noted the apparent disparity between the nursing records and the conclusion drawn at the ward round about the stability of Louisa Ovington's mental state when off medication. There were several potential reasons for the change in Louisa Ovington's behaviour: she was approaching another court appearance with the possibility of being released; she will have been increasingly frustrated at being detained in hospital; being provocative to staff, by being mildly badly behaved, may have been a way of distracting them from talking with her about real issues of concern such as how she was going to manage in the community if she was released.

88. Louisa Ovington was due to appear in court again on 12 January 2000. By then she would have been on Section 38 for a year and consequently the Section could not be further renewed. By that date therefore Consultant 11 had to make a recommendation to the court regarding the final disposal of the case. But it is clear that even just one week prior to the court hearing there was uncertainty amongst the clinical team as to what that recommendation should be. After the New Year, on 7 January 2000, there was an MDT[38] meeting in which Louisa Ovington was told that Consultant 11 would be recommending a Section 37 order.

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[38] *Multi Disciplinary Team*

89. A nursing progress report, prepared for that meeting, recommended further monitoring and observations without medication, work on Louisa Ovington's antisocial behaviours and continuation of scheduled psychology, drama therapy, education and substance abuse sessions. Assistant Psychologist 2 (a graduate with no previous clinical experience) had a session with Louisa Ovington on 22 December 1999 and noted then that she was planning to work on drug issues in future sessions after the Christmas break. Thus it seems that the nursing and psychology staff did not feel that they had concluded their work at this point.

90. However three days later on 10 January Consultant 11 told Louisa Ovington that she would be recommending instead a probation order with a condition of psychiatric treatment. There was no explanation in the notes for this change but Consultant 11 when interviewed told the panel that "she thought it was likely to have been partially influenced by Louisa Ovington's desperation to get out and partly by the psychology staff feeling that there was little point in keeping Louisa Ovington in hospital as they were unlikely to be able to make progress with her."

91. Because of the imminence of the expiry of the Section 38 order two days later there was no time for any properly planned discharge process. Louisa Ovington's cousin had offered Louisa Ovington a place in the home she shared with Mr Hilton and the children from each of their relationships.

92. Consultant 11 produced a report for the court hearing on 12 January 2000 that set out the results of the psychological assessments. It said that Louisa Ovington had 'characteristics' of antisocial and borderline personality disorders but did not meet the criteria for a major personality disorder; that there were no signs of mental illness and that thus she did not fit the criteria for a Section 37 order. Consultant 11 told the panel that at the time she accepted the psychologists' view as she regarded them as expert in the field of psychological assessment and deferred to that expertise.

COMMENT

The panel noted that Louisa Ovington was only withdrawn from medication for a few weeks prior to being discharged from Kneesworth and wondered whether this was a sufficient length of time in which to assess whether she required medication. Consultant 11 told the panel that she would have liked to have had the opportunity to observe Louisa Ovington drug free for longer.

93. The final report from the psychology department post dated Louisa Ovington's discharge in January 2000. It noted that:

- External factors that appeared to have played a part in her psychotic breakdowns included her drug use, relationship instability, a drug using peer culture and a lack of purpose and direction in her life.

- Louisa Ovington had an 'underlying antisocial strand' but that it had not been possible to understand this due to her reluctance to explore this in any depth.

- She was 'not ready' to engage in a community based drugs rehabilitation programme or psychodynamic psychotherapy, commenting: "She will only explore these things when she is ready (if ever) and when the pain of not finding out about herself is greater than the pain of doing so."

94. Consultant 11's report recommended a probation order with conditions of both treatment (follow up by local services) and residence. Whilst Consultant 11 was under the misapprehension that Louisa Ovington was not entitled to Section 117 aftercare[39], nonetheless she suggested that as a matter of good practice there should be a care planning meeting.

95. On 12 January however Louisa Ovington was discharged from Kneesworth House. She attended Peterlee Court and was bailed (to allow for the preparation of a pre-sentence Probation report) to her cousin's address. Prior to her departure there had been no discharge planning meeting, no CPA/ Section 117 meeting[40] and no coordinated consideration of the future, apart from an acceptance that Louisa Ovington would be able to reside with her cousin and Mr Hilton.

COMMENT

This period in a specialist unit (in the private sector) for personality disorder may have identified some of the issues that needed to be addressed and the notes appeared to suggest a number of coping strategies but there was little evidence of a robust treatment package. There was no evidence of ongoing or formalised assessment of the risks Louisa Ovington posed.

[39] *See Chapter 8*
[40] *See Chapter 8*

The results of the psychology assessments (and in particular the Personality Assessment Inventory- PAI) were crucial to the recommendations made by Consultant 11. The assessments themselves however may have been unreliable in that the PAI was based on self reporting. Consultant 11 volunteered to the panel that in retrospect she now would not have written that Louisa Ovington did not meet the criteria for a personality disorder. She commented that the PAI is not ideal because it is self reporting and Louisa Ovington had completed it in an 'almost provocative way', so that the picture that emerged was of someone who did not have the problems Louisa Ovington really had.

The PAI in addition was an automated assessment whereby the results were determined by a computer programme. This of itself would not invalidate the results provided that they were read in the context of other clinical findings, but the psychologist who was interpreting the results was unqualified and very inexperienced. She told the panel that she found it very difficult and could not recall whether she had been supervised in that task.

As a result of the fact that the Section 38 expired and that Louisa Ovington was not considered to meet the criteria for further detention under the Mental Health Act she was discharged back into the community and did not receive treatment for her psychological difficulties in a contained and supported environment over a period of time, as had been anticipated by professionals at St Nicholas' Hospital.

The panel discussed the rationale behind Consultant 11's decision not to recommend a Hospital Order with some of the other medical staff whom they interviewed. These witnesses explained that given Louisa Ovington's good behaviour at Kneesworth House, the conclusion that she was not suffering from a personality disorder and her lack of engagement it could have been difficult to argue that she fitted the criteria for detention. However, they also noted that there is no evidence that Louisa Ovington was "tested out" during her stay at Kneesworth House, through being given increasing freedom.

Post Kneesworth - the discharge process

96. The records are very confusing at this point. There were few social work records contained in the Kneesworth notes, although it is clear from the local social services notes that there was communication with the Kneesworth Social Worker. It appears that the local services were involved to the following extent:

- Social Worker 2 was Louisa Ovington's community social worker and was liaising with Social Worker 3, the Kneesworth social worker. Social Worker 2 is recorded as speaking to Kneesworth on 6 January to try to organise a CPA/Section 117[41] meeting. Because of the imminence of the expiry of the Section 38 it was not possible to organise this before the 12 January and it was finally scheduled for 24 January, ten days after her discharge.

- Team Manager 1 from Easington Community Mental Health Team (CMHT) recorded his concern that good practice had not been adhered to: Section 117 Mental Health Act requires a discharge meeting between the host authority and the local services to "hand over care" and the Code of Practice states that a joint meeting needs to be held (before discharge) so as to arrive at a suitable discharge package. Before the decision is taken to discharge a patient or grant leave it is the responsibility of the Responsible Medical Officer (RMO) to ensure a consultation with all other professionals, to discuss the patient's needs and that the care plan addresses them.[42]

- To complicate matters Probation Officer 1 commented to Team Manager 1 that he did not think a probation order was appropriate simply to ensure treatment and although the later discharge report prepared on 31 January 2000 (19 days after discharge) by Associate Specialist 1 emphasised the necessity of a probation order having a condition of psychiatric treatment, it appeared that since there was no apparent diagnosis of mental illness, the probation service did not regard it as appropriate.

97. Consultant 11 when she spoke to the panel agreed that the discharge had been hasty and there did not appear to have been much in the way of planning.

98. On 24 January 2000 the delayed Section 117/CPA meeting took place in Durham. It was attended by representatives from Kneesworth House and local services. There was no consultant psychiatrist present although Associate Specialist 1 was in attendance. At this meeting it was stated that Louisa Ovington did not suffer from a mental illness and although she may have some personality difficulties did not meet the criteria for a personality disorder. It was agreed that:

- Louisa Ovington would live with her cousin and the cousin's partner Mr Hilton;

- Consultant 12 would become Louisa Ovington's consultant psychiatrist;

- Her social worker and key worker would be Social Worker 2;

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[41] *See Chapter 8*

[42] *and see, further, Chapter 8*

- Louisa Ovington would be referred to the community drug and alcohol team "if she required further support" – Louisa Ovington did not wish to be referred to the drug and alcohol service at that time;

- Louisa Ovington would be assessed by the CPN service to decide whether or not a CPN would be allocated;

- Louisa Ovington would be assessed by Stonham Housing, so that in the event of a breakdown in the care package, she could occupy one of their crisis beds.

99. According to the later discharge letter from Associate Specialist 1 the possibility of a probation order was discussed and Associate Specialist 1 expressed Kneesworth's concerns but Team Manager 1 and Probation Officer 2 felt that that appropriate care and support and contingency plans from the CMHT[43] and Social Services could be offered without any condition of psychiatric treatment.

100. On the 25 January 2000 the following day a letter was written by Social Worker 3 from Kneesworth to Social Worker 2 in which Social Worker 3 expressed concern about the care plan and whether it provided enough support; she was particularly concerned about drug use and about monitoring the relationship with her cousin. Social Worker 2's view in response was that she did not want to add to Louisa Ovington's stress by over visiting and over monitoring.

COMMENT

In the event there is no record of Social Worker 2 ever visiting or monitoring Louisa Ovington; the next entry from her is some three months later, two days before she was due to leave her post - by then Louisa Ovington had entered into a sexual relationship with Mr Hilton and they had been asked to leave her cousin's house.

101. Consultant 9 was surprised to hear that Louisa Ovington had been discharged. When Louisa Ovington was transferred to Kneesworth House Consultant 9 had given a written undertaking to the funding health authority that his team would be the point of contact regarding her. He was initially given no details of proposed aftercare. He wrote to Louisa Ovington on 27 January 2000 inviting her to contact him for support and follow up. Subsequently when he received the full discharge summary and was told she had a named social worker and psychiatrist he wrote to Louisa Ovington again to say that she need not contact him. He was not asked to be involved in her care. There was no referral to forensic services. Given that he had been expecting that Louisa Ovington would ultimately be on a Section 37/41, he was

[43] *Community Mental Health Team*

surprised and told the panel that he would have asked one of his team to make contact with her if he had known that she was not being followed up.

102. Probation Officer 2 prepared a pre-sentence report for the hearing on 9 February. She said that there was a low risk of reconviction, (which should be assisted by continuing contact with the mental health services) but a high risk to the public if Louisa Ovington did reoffend. As, in addition, Consultant 11 'did not attach any mental health diagnosis' to Louisa Ovington, her recommendation to the court was for a conditional discharge.[44]

103. On 9 February 2000 Louisa Ovington pleaded guilty to the assault on the nurse at the Tony White Unit and was duly given a conditional discharge[45].

104. On 17 April 2000 Louisa Ovington was asked to leave her cousin's home as she had started a relationship with the cousin's partner Mr Hilton.

105. On 26 April 2000, Social Worker 2 contacted various professionals to inform them that Louisa Ovington was at an unknown address. At the same time she sent out the minutes of the meeting that had taken place three months earlier on the 24 January. She pointed out that she had agreed to refer Louisa Ovington to the CPN service but that she was leaving her post in two days time and that there was no social worker allocated. Thus, she said, any future concerns should be raised with the social services team manager.

106. Louisa Ovington was sent three appointments to see Consultant 12 but she failed to keep any of them. She was then discharged. The letter said: "when people do not attend and do not let us know that they are not attending, then we can assume that things are going well for them at present and that they no longer need our services".

COMMENT

The discharge planning process was highly unsatisfactory:

- *The actual decision to discharge from Kneesworth was made only two days before the Section 38 was due to expire, allowing no time for a pre- discharge meeting to arrange after care under Section 117 as required by the Code of Practice of the MHA.*

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[44] If the offender reoffends within a certain period, s/he can be brought back to court to be re-sentenced for the original offence.
[45] 4th conviction for the assault on the staff member at the Tony White Unit.

- *There was no record of the home authority being involved in discharge arrangements or Consultant 9 having been consulted or even informed prior to discharge. The effect of this was that there was no opportunity for a well planned handover to the home services.*

- *Forensic services should have been involved (they were the agency that referred Louisa Ovington to Kneesworth House) and it was made clear to the panel that in view of Louisa Ovington's history they were expecting and willing to be involved with her post discharge.*

- *It is regrettable that Consultant 9 (the referring consultant) was not contacted when Louisa Ovington's discharge from Kneesworth House was first considered. He told the panel that his team would have been able and willing to provide follow up in the community. Louisa Ovington was known to have difficulties with engagement. She was much more likely to engage with a team she already knew than with people with whom she had no prior relationship.*

- *The rationale for Louisa Ovington not meeting the criteria for further detention was not clearly explained. There was a contradiction in the fact that the clinical team at Kneesworth House expressed the view that Louisa Ovington was not suffering either from mental illness or from a personality disorder yet were taken aback and concerned when the home community team accepted the probation view that since there was no mental illness there was no need for probation with a condition of psychiatric treatment.*

- *In March 1999, government policy was published which defined the new arrangements for Effective Care Co-ordination[46]. This drew together the previous arrangements for the CPA and the previous arrangements for care management which had been the responsibility of social services departments and required staff to work together to ensure that effective discharge arrangements were in place particularly for those under enhanced CPA (which Louisa Ovington was). Under these terms the care planning prior to discharge fell well short of what might have been expected. The home social services team was clearly concerned about this and a full meeting was held on 24 January. However it appears that of the important elements of the care plan none was effectively implemented: Louisa Ovington did not see her Key Worker (Social Worker 2); she did not wish to be referred to drug and alcohol services; she was not assessed by the CPN service; no referral was made to Stonham Housing and she did not attend any outpatient appointments with Consultant 12.*

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[46] *See Chapter 4*

- *Consultant 9,in his evidence to the panel, emphasised the importance of good quality handovers i.e. the importance when a patient moves from one service to another, of assembling as much information as possible about the person for the benefit of the service taking over care. That clearly seems to have been the case in the handover from St Nicholas' to Kneesworth, when Registrar 1 collated a very significant amount of information. It was not matched by the handover from Kneesworth.*

May 2000 to January 2003

107. In May 2000 the case was allocated to Social Worker 4, a mental health social worker from South Durham (Spennymoor) who made immediate attempts to locate Louisa Ovington. He first met her on 30 May 2000. Louisa Ovington's cousin had told Social Worker 4 how concerned she was about Louisa Ovington's presentation - that she had been shouting and screaming down the phone causing her cousin to believe that her mental health had declined and that she might pose a threat to her and her family. When Social Worker 4 met Louisa Ovington he wondered whether she was under the influence of illegal substances.

108. Social Worker 4 was Louisa Ovington's social worker from May 2000 until February 2003. During this time there is clear evidence that he went to a great deal of trouble for Louisa Ovington, whose life was chaotic. He had frequent and regular contact with Louisa Ovington and with professionals on her behalf; he accompanied her to meetings and helped her deal with innumerable issues including benefits, housing and employment as well as issues relating to her lifestyle, offending and mental health. He assisted her in dealing with communications from her father, who had been released from prison. He referred her to the addictions team. He discussed (to an extent) her childhood experiences with her. He went to considerable lengths to arrange meetings to discuss her psychiatric care; tried to find out who was the responsible psychiatrist; attempted to arrange for her to see a psychologist and a CPN. He seems to have built a relationship with her; certainly she kept in touch with him as well as vice versa. He told the panel: "The … focus in my work at that time was centred on my concerns for Louisa Ovington's psychological state. She was very good at putting across that she was okay and I think despite the several assessments she did have, psychological, psychiatric or whatever… at the time people did not pick up what this girl was going through."

109. In June 2000 Louisa Ovington was discharged from the care of Consultant 12 (who had never seen her) as she had failed to attend three outpatient appointments. An assumption was clearly made that she no longer needed help and she was told that she would only be seen again if her GP referred her. She had not seen a psychiatrist since she had left Kneesworth six months earlier.

110. During this period Louisa Ovington's living arrangements were in a state of flux – she moved around to various places and was occasionally homeless. Her relationship with Mr Hilton was 'on and off'.

111. As she acknowledged that she was using drugs, including heroin and cocaine, Social Worker 4 referred her to the Community Addictions Service (CAS). Despite some ambivalence, she did eventually engage with them.

112. In December 2000, CAS 1 suggested that Louisa Ovington should see her GP and wondered whether CPN support would be helpful, as she was concerned about her mental health - a concern echoed by Social Worker 4.

113. On 1 January 2001 Louisa Ovington was arrested and charged with possession of an offensive weapon[47] having been found walking down the road with a knife with which she said at the time that she was going to kill her cousin (Mr Hilton's ex partner.) Subsequently she told the police in a telephone call that she had mixed drink with anti psychotic medication and had "gone off it".

114. Social Worker 4 convened a CPA meeting which was cancelled as various professionals could not attend. *(Social Worker 4 told the panel that it was always difficult to set up these meetings with all relevant professionals, due to the demands on their time. GPs in particular were rarely able to attend)*. However, the care plan dated 25 January 2001 suggests that he referred Louisa Ovington to Consultant 5 with a view to his referring her for psychotherapy.

115. Louisa Ovington saw her GP who referred her to a psychiatrist as she was self harming, weepy and depressed. On 1 February 2001 she was admitted to Darlington Memorial Hospital[48] but left the following day and did not return.

116. On the day she discharged herself she was arrested for breach of the peace - there are no further details of this incident, other than the fact that no further action was taken.

117. In February 2001 Louisa Ovington's GP changed.

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[47] *7th offence/group of offences*

[48] *9th admission to hospital*

118. Between early 2001 and May 2001, because of mounting concerns felt by Social Worker 4, there were a number of attempts by Social Worker 4 and her GP to refer Louisa Ovington to a psychiatrist, to psychology and to CPN services. The records show a great deal of confusion, with Social Worker 4 making considerable effort to little effect. There does not appear to have been psychiatric follow up after her admission to Darlington Memorial Hospital, there was no apparent referral to CPN services despite Social Worker 4 obtaining confirmation from the hospital that they would do this and the referral to psychology had to be done by the GP and psychiatrist and could not apparently be done by the mental health social worker, Social Worker 4, who knew her best and had most contact with her. At this point Louisa Ovington, despite her admission to Darlington Memorial Hospital, had not apparently seen a psychiatrist in the community since her discharge from Kneesworth in January 2000.

119. On 12 February a pre-sentence report by Probation Officer 3, in relation to the offensive weapon charge had concluded that Louisa Ovington posed a high risk of reoffending, risk of dangerousness and harm to the public; that she had used a knife in the past and was irrational and unsafe. The probation officer noted that "past psychiatric assessment does not regard Louisa Ovington's behaviour as warranting the attachment to it of any mental health diagnosis". However she suggested that a psychiatric report was needed. She concluded that a period in custody would add to Louisa Ovington's instability, particularly as she had told the probation officer that she would attempt to harm herself if detained in prison.

120. On 16 May 2001 Louisa Ovington saw Consultant 5 for the preparation of a court report. The report dated 5 June 2001 concluded that there was substantial evidence of personality disorder and an ongoing liability to suffer with mental illness. He noted that she was still abusing drugs and alcohol and recommended a probation order with a condition of psychiatric treatment which he said he was prepared to supervise.

121. Although it is quite unclear how it came about, a domiciliary visit was made by Consultant 13 (a locum consultant) to Louisa Ovington on 25 May 2001. He recommended she continue with Trazadone (as already prescribed by the GP) and attend outpatients with Consultant 14.

122. On 7 June 2001 Louisa Ovington was convicted[49] of possession of an offensive weapon and of breaching her previous conditional discharge of 9 February 2000. She was given an 18 month Community Rehabilitation Order (CRO) with a condition of psychiatric treatment. It was not made clear how the condition of psychiatric treatment was supposed to operate.

123. On 22 June Social Worker 4 was informed that Consultant 5 would be the responsible doctor for the CRO.

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[49] *5th conviction*

124. On or about 23 June 2001 Louisa Ovington assaulted Mr Hilton with a knife and self harmed by cutting her own neck (and reported that she had attacked her cousin). She was charged with a public order offence[50] and she appeared at court on two occasions and was bailed. The outcome of this case is not recorded. It would seem that probation, the domestic violence unit at Durham police, social services and the CPN service were informed. It is not clear who took what action as a consequence or how much communication there was between the agencies

125. Social Worker 4 convened a CPA on 10 July 2001 (which neither probation nor the GP was able to attend). The minutes were not available to the panel but it seems that Consultant 5 was present and agreed to take Louisa Ovington on and see her on a monthly basis. Social Worker 4 felt she was in a very volatile state. There were concerns about her father's attempts to contact her.

126. On 13 July 2001 Consultant 5 referred Louisa Ovington for psychotherapy with Psychotherapist 1. (Unfortunately due to a combination of factors - the appointment letter going to the wrong address, Louisa Ovington not completing the paper assessments and only attending one appointment and delay, the conclusions were incomplete and were not available until the following June (11 months later). Psychotherapist 1 commented that on the information available she seemed to have made reasonable progress over the past two or three years. He did not think she was suitable for psychotherapy.

127. In August 2001 Louisa Ovington attended outpatients with a consultant whose name she could not remember. It was not Consultant 5. She only attended one appointment with him. After some confusion it seemed that she had attended with Consultant 14 at Peterlee Health Centre, but Social Worker 4 having tried to keep track of whom she was seeing was told in November 2001 that Consultant 14 had left and that Consultant 13 was her consultant. In early 2002 however, Social Worker 4 (who had been trying to access her notes, with great difficulty and had been told by Consultant 13's secretary that if he wished to access her outpatient notes, he must do so through her GP) was finally told that Consultant 2 was now the consultant in charge of her care. (The panel could find no reference to Louisa Ovington having any contact with Consultant 2).

128. The CRO lapsed as at 3 December 2002. The identity of the psychiatric supervisor remained unclear (there is little reference to it in the probation notes).[51] She occasionally attended at outpatients where she saw several different psychiatrists. She only saw Consultant 5 once in outpatients in July 2001.

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[50] *8th offence*

[51] *See Chapter 6*

129. Although Louisa Ovington continued to suffer from the same sorts of underlying problems (mental health, substance – mainly alcohol - abuse, pressure from her father), her overall situation remained reasonably stable throughout 2002 and she appeared to be attending some sort of college course. Social Worker 4 felt it was the right time to hand her over to her local CMHT in Easington (East Durham). Additionally he told the panel that because of a border reorganisation Louisa Ovington's home address was no longer in his catchment area. Until that point Social Worker 4 told the panel, his team (Spennymoor, South Durham) had been purely a mental health social work team. Now the new CMHTs were multi disciplinary. Care was handed to Social Worker 5, who was a mental health social worker. Social Worker 4 tried to set up a CPA meeting so that the handover could be done in a planned and informed way, but the meeting was cancelled. Social Worker 4 visited Louisa Ovington on 28 January 2003 and explained what was happening.

COMMENT

Psychiatric organisation:

It was evident to the panel from the records and confirmed by several witnesses that in this locality there were significant medical staffing issues in from 2000 to 2002. Louisa Ovington was notionally involved with eight different psychiatrists between January 2000 and December 2002. There was a series of locums, each staying in post only a matter of weeks or months. Consequently Social Worker 4 did not know who had consultant responsibility for Louisa Ovington. This, added to her own generally chaotic behaviour, made it understandable that Louisa Ovington did not engage with the psychiatric services. Medical continuity was further impaired by the fact that Louisa Ovington changed GP during this period.

CRO:

The Community Rehabilitation Order carried with it a condition of psychiatric supervision. There was never any clarity about who would take responsibility for this, despite the fact that Consultant 5 had stated in his report for the court that he would be content to be the supervisor. He only saw Louisa Ovington once. Social Worker 4 repeatedly tried to find out who she was supposed to be seeing.

Consultant 5 told the panel that whenever he made a recommendation for a condition of psychiatric treatment he would offer to be the supervisor but that it was "very seldom" that he was given written confirmation of this or any other details of the order. He was not given any certification of this sort following Louisa Ovington's appearance in Court on this occasion and thus she fell through the net.

Probation Manager 1 told the panel that there is nothing in legislation or regulations that defines who is responsible for managing the condition of psychiatric supervision - her view was that it should be the probation officer in charge of the case. It seemed that in this case probation tended to channel their enquiries through Social Worker 4. There was evidence that they were concerned about the matter but did not quite know who they should be contacting.

Care coordination:

There is clear evidence that Social Worker 4 worked very hard to support Louisa Ovington and to coordinate her care but was frustrated in this by the organisational chaos within mental health services. When he took the case over there was no formal handover; he was given no verbal information about her. Social Worker 4 was part of a uni-disciplinary social services team; although he did not perceive this as having inhibited his work with Louisa Ovington, information sharing, care planning and liaison with other professionals can certainly be more easily facilitated in a multi disciplinary team.

Social Worker 4 had tried to organise several CPA meetings regarding Louisa Ovington. The first was planned for January 2001, but it was cancelled at the last minute because Louisa Ovington's GP and her worker from the CAS were unable to attend. He arranged another for July 2001, which did take place. The third (when he was transferring Louisa Ovington's care to another worker) was cancelled. Social Worker 4 told the panel that it was a "nightmare" trying to get people to attend meetings, especially GPs. He told the panel he was given very little information about her past on the handover to him. When he transferred care to the next care coordinator he set up a CPA meeting, but it had to be cancelled. He then made a joint visit to introduce her new care coordinator.

February 2003 to February 2004

130. Louisa Ovington's behaviour deteriorated following the transfer of care. Social Worker 5 first visited her on 10 February 2003. When she next visited her on 13 March 2003 Louisa Ovington told her she had snapped a woman's gold chain when she was assaulted by that woman.

131. At the next visit on 7 April 2003 she said she had been drinking excessively and that she had been quarrelling a lot with Mr Hilton. Nonetheless Louisa Ovington agreed with Social Worker 5 that six-weekly appointments would be frequent enough, with the proviso that she could contact Social Worker 5 in between if necessary.

132. Social Worker 5 visited Louisa Ovington at home on 19 May 2003, 1 July 2003 and 11 August 2003. Apart from a minor complaint on 1 July 2003 about suffering from PMT for two weeks per month, which was "causing difficulty in her relationship with her partner", no problems were noted. However, on 31 July 2003 her GP had written to her consultant at Louisa Ovington's request (she was complaining of lack of appetite) asking for an appointment as her last appointment had been cancelled due to earlier non attendance. In fact she had failed to attend three outpatient appointments.

133. It appears that by now Louisa Ovington was under the care of Staff Grade Psychiatrist 1, who had been a locum psychiatrist but later became a permanent staff grade psychiatrist, under the supervision of Consultant 13 and then Consultant 2. He had care of Louisa Ovington until she was remanded after the death of Mr Hilton. She saw Staff Grade Psychiatrist 1 from time to time. Staff Grade Psychiatrist 1 described to the panel the complicated arrangements for psychiatric oversight in the area; he confirmed that until his appointment in 2003 there had been a rapid turnover of locums. He told the panel that he was supervised by Consultant 13, then Consultant 2; that he would have seen Louisa Ovington every two or three months; that he remembered her; that she had a serious alcohol problem but that she was a pleasant and intelligent girl. He did not feel she was mentally ill.

134. In October 2003 she told Social Worker 5 that she had been having relationship problems due to excessive alcohol and later in the month she saw Staff Grade Psychiatrist 1 and told him that she was depressed, anxious and drinking to excess. When she asked him about coming off her antipsychotic medication he suggested that she talk to the GP about it.

135. Staff Grade Psychiatrist 1 referred Louisa Ovington to the drug and alcohol service. She attended one appointment in December 2003 and another in January 2004 but others were cancelled by her or she did not attend and she was discharged. *(CAS 2 from the service told the panel that the service would not have been given much information about her; that their input would have been limited to drug and alcohol issues rather than exploring deeper issues; that they would not have had contact with other agencies and that they would normally have a policy of taking what clients told them about drug or alcohol use at face value.)* It seems that the GP was concerned about the discharge and asked them to reconsider this in May 2004.

136. On 3 November 2003 Louisa Ovington phoned Social Worker 5 and confessed that she had in fact been drinking to excess and that there were huge problems in her relationship with Mr Hilton.

137. Social Worker 5 visited her on 13 November and was told that things were more under control but she was splitting up with Mr Hilton.

138. On 15 November 2003 (two days later) the police were telephoned by Louisa Ovington several times, reportedly very drunk, including a call informing them that she had stabbed Mr Hilton and he was lying dead. When the police arrived he was not there. The truth of what happened is not known. It is not known whether the police made contact with the CMHT about this.

139. On 7 December 2003 Social Worker 5 visited Louisa Ovington and noted that she was low in mood. Louisa Ovington told her that she had seen CAS 2, (although the panel found no evidence of this) and that there had been domestic violence. She was given the name of agencies to contact, but she did not do so.

140. Social Worker 5 may have been on sick leave in January; at any rate she did not see Louisa Ovington until February 2004.

141. On 12 February 2004 Social Worker 5 visited Louisa Ovington. Louisa Ovington said that she had been drinking excessively; that things were "terrible" in her relationship; and that she may have had "some psychosis" recently. She had missed her appointments with CAS 2. Her father wanted her to move to Edinburgh. Social Worker 5 advised her to make another appointment with CAS 2 and to reduce her alcohol intake. Social Worker 5 told Louisa Ovington that she was leaving her post and the next visit would be her last.

142. On 24 February 2004 Social Worker 5 visited for the last time. She recorded that Louisa Ovington agreed that she did not need any further input from the team but that she would continue to attend outpatients with Consultant 2 (although there is no evidence that she had ever attended any appointments with Consultant 2). Louisa Ovington was told that the case was closed to social services but that it was 'still open' to the CMHT whom she could contact at any time and that she was still entitled to Section 117 aftercare. The new care coordinator was to be Consultant 2. Social Worker 5 wrote to him on 30 March (over a month later) to inform him of this. There is no evidence of any coordinated planning or discussions, nor that Consultant 2 agreed to take over.

COMMENT

- *It is recognised that it can be very difficult for patients when they are passed from one worker to another. It appeared to the panel that Social Worker 4 did his best to ensure a smooth handover to Social Worker 5. Nonetheless it also appeared to the panel that Louisa Ovington's behaviour deteriorated following*

the transfer of care: soon afterwards she was involved in a physical altercation with a woman, she drank excessively and she quarrelled a lot with Mr Hilton.

- *Although Social Worker 5 was a member of the CMHT which should have enabled access to a broad range of support for Louisa Ovington, in comparison with the level of support she had received from the previous care coordinator, there was a noticeable reduction in the service offered. This culminated in Louisa Ovington apparently agreeing that she did not need social worker support and the case being closed to social services, despite the fact that Louisa Ovington's presentation remained unchanged and her problems had not diminished. There is no evidence that Social Worker 5 employed effective techniques to ensure Louisa Ovington's engagement with the services.*

- *In the panel's opinion it was inappropriate when Social Worker 5 left, for Louisa Ovington not to be allocated a care coordinator from the CMHT. Her mental state remained fragile and she had only recently admitted to drinking excessively most days. Louisa Ovington was told that she could contact the CMHT manager if she felt the need, but it was well known that her engagement with services was limited and (in the panel's view) it was obvious that she was most unlikely to do this.*

- *Although the case was closed to social services Louisa Ovington remained subject to CPA, yet there is no evidence to suggest any arrangement to hand over to another care coordinator apart from a letter to Consultant 2, nominating him as care coordinator. There is nothing in the records to indicate that Louisa Ovington ever met Consultant 2. It is evident that he was not asked if he could take on this role: he was simply written to and informed that he was to do so. Furthermore, Staff Grade Psychiatrist 1 told the panel that Louisa Ovington was not under the care of Consultant 2 at this time; she was under the care of Consultant 13, who was Staff Grade Psychiatrist 1's supervising consultant. It appeared from what Staff Grade Psychiatrist 1 said to the panel that at that time there was little correlation between the named care coordinator on CPA documents and who actually took on the role.*

- *Staff Grade Psychiatrist 1 was a locum staff grade doctor at this time. It proved impossible for the panel to clarify which of the consultants was his supervisor, there being so many changes in consultants. In any case, Staff Grade Psychiatrist 1 told the panel that he had "very, very minimal supervision". From the records it appears that Staff Grade Psychiatrist 1 effectively took over the role of care coordinator, but it is unclear whether or not he ever did so officially.*

February 2004 to August 2004

143. Following the case being closed by Social Worker 5 Louisa Ovington's situation deteriorated even further, her behaviour becoming ever more chaotic and volatile, with many reported incidents involving the police as well as mental health services. There was, during this time and until August 2004, no allocated mental health social worker; the case was closed to social services. There was also no active involvement by the CMHT and no contact with general mental health services, other than with the Crisis Resolution Team (CRT).

144. On 5 March 2004 Louisa Ovington was arrested for being drunk and disorderly and for criminal damage. She was said to be labile and volatile. The criminal justice liaison nurse spoke to Staff Grade Psychiatrist 1 querying whether Louisa Ovington might be suffering from a bipolar illness. He however said she suffered from a personality disorder but that she might have a drug induced psychosis. He advised that the nurse should contact the CRT service. (The panel found no further information about what happened.)

145. On 10, 19, 20, 30 April and 3, 8,and 9 May 2004 police records note allegations of mutual assaults and reports of serious drinking, involving Louisa Ovington and Mr Hilton; abusive and drunken telephone calls to the police; and an allegation by Louisa Ovington (very drunk) that she had been raped, but could not identify the men involved or the vehicle.

146. On 10 May 2004 Louisa Ovington presented to the University Hospital of Hartlepool A&E department, apparently initially complaining of a respiratory condition. She was diagnosed as having a psychiatric condition and admitted to Ward 16[52] under the care of Consultant 13. On discharge she was said to have presented with aggressive behaviour associated with use of alcohol. She said she was unable to cope. She alleged she had been raped two weeks previously.

147. During the admission she underwent a detoxification from alcohol process and tests were done in the light of the alleged rape. The police liaison officer and the liaison nurse were brought in.

148. Louisa Ovington did not suffer from marked withdrawal symptoms. Her mood was stable and there was no evidence of "mental illness as such". She did have a few bruises on her body.

149. On 11 May 2004 a neighbour of Louisa Ovington's visited the ward and warned the staff that she was a high risk to herself and others and had had to be stopped recently from going out with a knife to get revenge on someone.

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[52] *10th admission to hospital.*

150. On 14 May 2004, during a session with nursing staff, Louisa Ovington talked about the alleged rape and said that if she were to see the two men involved she would stab them and was willing to go to jail as a result. Later that day she became "very aggressive" towards Mr Hilton in an argument over money – after resolving this they had a cup of tea together.

151. On 15 May 2004 Louisa Ovington requested her own discharge and was permitted to leave "against medical advice". She was discharged on no medication. She was referred to the CRT who agreed to be involved until the CPA meeting on 18 May 2004 when their continued involvement would be discussed.

152. On 16 May 2004 Mr Hilton contacted the ward to say that Louisa Ovington needed some follow up as she was not back to her usual self. CRT were contacted and agreed to visit to assess her mental state.

153. A CPA meeting took place on 18 May 2004 on the ward. Louisa Ovington attended. At the meeting she admitted she was unable to control her temper; that alcohol was her main problem and that she was aggressive to her partner. It was agreed that Louisa Ovington would be referred for anger management and to ESMI (the local drug and alcohol service) and that a social worker was to be engaged. She was to be seen in outpatients'. She was diagnosed as having a borderline personality disorder and alcohol dependence syndrome. She was discharged on no medication.

154. No social worker was appointed. There is no evidence that she took up the services although her GP wrote to the drug and alcohol service asking them to try to engage her by seeing her at home. There was a CPA document, unsigned by Louisa Ovington, dated 10 May 2004 which identified her needs as monitoring of mental health through attendance at the CMHT offices (Merrick House, Easington) with Staff Grade Psychiatrist 1 and education in relation to substance abuse through ESMI. Increased alcohol use would be a risk factor and should be monitored.

155. A patient discharge form detailing the current management plan, diagnosis and medication (none) was sent out by 26 May 2004. The discharge letter relating to this admission was dated 9 July 2004.

156. On 17 May 2004 CRT 1 (from the CRT) visited Louisa Ovington at home and told the ward that she noticed hostility and abuse towards her partner. The CRT had only a fleeting involvement with her at that point since she was not regarded as high risk nor was there thought to be a mental health issue, rather the main diagnosis was alcohol related. They agreed to refer her to drug and alcohol services and for anger management.

157. On 27 May 2004 Louisa Ovington created a disturbance in a post office and on the same day she rang the police saying she would kill Mr Hilton. She was arrested for breach of the peace. The police noted 'markers' for weapons, violence, mental illness and previous convictions, (listing them) but took no further action.

158. There were police reports of further incidents and disturbances on 1 June 2004, 3 June 2004 (when she had to be removed from A&E by the police), 6 June 2004 (arrested at the house after doors and windows were smashed; neighbours reporting abusive language) and 9 June 2004 (drunk and disorderly). She was charged with a public order offence[53] in relation to the incident on 6 June 2004, but not charged in relation to the other incidents.

159. On 10 June 2004 her landlady reported to social services that her behaviour over the last three weeks had been extremely disturbed, involving running naked in the streets, foul language, offering sex to a neighbour and drinking excessively. At this point the emergency duty social worker rang the GP. He told her to contact the CRT. The CRT refused to take a referral from the social worker, as it 'needed to come from a professional who had seen her within the past 24 hours'. The social worker rang the Staff Grade Psychiatrist 1 (the care coordinator at this time) who told her to ring the GP again and ask him to make the referral to either the CRT or the CMHT.

160. When the referral was made, the CRT visited twice, but Louisa Ovington was out. Subsequently they note that Mr Hilton contacted them to tell them that she was out of control and consuming excessive alcohol again. The CRT then spoke with Staff Grade Psychiatrist 1 and reported that Louisa Ovington had been assessed as "not having mental health problems, as she had a primary diagnosis of alcohol dependency". The CRT wrote to Louisa Ovington's GP, to say that as she had not taken up offers of hospital admission, support from drug and alcohol services or anger management from OT services and in view of their not being able to contact her, they were not offering her further involvement at that time. However, they planned to discuss her with Staff Grade Psychiatrist 1 to agree a plan for future involvement of services.

COMMENT

The events of 10 June 2004 clearly illustrate the difficulties that can arise when a patient such as Louisa Ovington is left without a clearly defined care coordinator and support system. It appears that most of the professionals were following their standard procedures for referrals, but this did not assist the situation. Team Manager 2, the manager of the service, told the panel that the CRT took referrals from anyone, although they "would often try and direct people via their GP in the first instance". Whilst they preferred referrers to have seen the patient within the previous 24 hours,

[53] *9th offence*

there was "some latitude" in this, although some staff would operate this policy more rigidly than others. In the panel's view, the fact that someone has a primary diagnosis of alcohol dependency does not mean that they do not have mental health problems. This question of when psychological/emotional difficulties etc constitute a mental disorder that warrants treatment by secondary mental health services and when they do not, is an issue that is common to many mental health services. In this case there was clear evidence that Louisa Ovington had significant mental health difficulties. It appears to the panel that the issue at this point was more about the difficulty in engaging her. It may well have been appropriate that the CRT did not work with her, as their role would have been short term and Louisa Ovington needed long term consistent input. She should, however, have been allocated a care coordinator from the CMHT.

161. On 11 June 2004 Louisa Ovington was convicted at South Durham Magistrates of a public order offence[54].

162. On 16 June 2004 the police received a report that Louisa Ovington had stabbed Mr Hilton. There was no evidence of this but she and Mr Hilton were visited and warned by the police. The police records noted that they were two people in very volatile relationship and the police feared that "one day one will seriously assault the other".

163. On 18 June 2004 Louisa Ovington told Hartlepool social services that she was fleeing violence; she had bruises and was not drunk. She was offered temporary accommodation. On the same date it is reported that she presented at the police station "frightened of Mr Hilton".

164. On 25 June 2004 Louisa Ovington was arrested for being drunk and disorderly[55]. She was due to appear in court on 2 July 2004 for a previous drunk and disorderly offence; the pre-sentence report noted escalating domestic problems and domestic violence but the risk assessment that was carried out at the same time did not note any previous history of offences with weapons (this was clearly incorrect).

165. In July 2004 Louisa Ovington's disturbed behaviour escalated further. Police reports note that:

i. On 1 July 2004 she reported that she was frightened of Mr Hilton and was taken to a refuge;

ii. On 6 July 2004 she reported to the police (untruthfully) that Mr Hilton was at her house and that she wanted him removed. When warned about the misuse of 999 calls she said she would 'kill (Mr Hilton) to sort her problems out';

iii. On 12 July 2004 she was fined £30 for the public order offence of 5 June 2004;[56]

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[54] *6th conviction*
[55] *10th offence*
[56] *7th conviction*

iv. On 13 July 2004 she was fined £50 for being drunk and disorderly on 26 June 2004;[57]

v. On 17 July 2004 she threw an object at a till in a public house and was charged with criminal damage;[58]

vi. On 18 July 2004 she called 999 and reported that someone had tried to assault her (untrue);

vii. On 19 July 2004 she climbed up a tree, claimed she was tied there, used foul language and had to be brought down by the fire brigade;

viii. On 22 July 2004 she made several 999 calls to the police threatening to kill Mr Hilton. She was visited by the domestic violence officer and a constable and contact was apparently made with the mental health team (there are no details of which team), who apparently contacted Louisa Ovington;

ix. On 24 July 2004 a 999 call was made reporting a disturbance at Louisa Ovington's home;

x. On 25 July 2004 she made a further 999 call reporting an assault for which there was no evidence;

xi. On 25 July 2004 she was arrested, carrying a knife in a public place;[59]

xii. On 26 July 2004 she was charged with criminal damage to her cell[60].

166. On 30 July 2004 she made a "hysterical and foul mouthed" call stating she was going to "murder" Mr Hilton as he had been harassing her (the harassment consisted of him "passing a pleasantry" to her).

167. The police domestic violence worker reported to Durham social services that Louisa Ovington had said that she would kill her ex partner - that she had a knife, a gun and a sword and would not think twice about killing someone - and that she was frightened at how out of control she felt.

168. On 30 July 2004 a police inspector, accompanied by Social Worker 6 visited Louisa Ovington at home. They found her calm and rational, there was no evidence of weapons and they felt there was no cause for concern, although she did say she would kill Mr Hilton if he came to the house. She was advised to make use of the current support she had.

COMMENT

The panel was unclear as to what support this would have been, given that there was no active community mental health worker.

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[57] *8th conviction*
[58] *11th offence*
[59] *12th offence*
[60] *13th offence*

169. The following day CRT 1 visited Louisa Ovington at home at the request of her GP. Louisa Ovington talked about the problems with drinking and with her temper and explained that she did not mean the threats to Mr Hilton. CRT 1 concluded there was no role for the CRT - there were no signs of mental health problems - but she recommended anger management and said she would discuss the provision of mood stabilisers with Staff Grade Psychiatrist 1.

170. At this point there was still no allocated social worker. On 20 July 2004 the GP had rung social services to find out whether there was and been told there was not, because Louisa Ovington's whereabouts were unknown.

COMMENT

This is surprising as the police, GP and staff at the CRT appear to have been in touch with her.

171. The disturbed behaviour continued. Police reports note:

i. On 3 August 2004 Louisa Ovington was reported to have threatened a neighbour with a 7-8 inch kitchen knife. She is alleged to have been chatting to the neighbour when her mood suddenly changed; she picked up the knife and said "If I don't murder you I will murder somebody just to get out of this shithole";

ii. On 4 August 2004 she reported being harassed by neighbours;

iii. On 5 August 2004 she made five 999 calls while very drunk;

iv. On the same day she was charged with criminal damage, assaulting a police officer and being drunk and disorderly;[61]

v. On 11 August 2004 she committed an assault in a public house;

vi. On 12 August 2004 Louisa Ovington was arrested for a public order offence. No further action was taken. She was taken to North Durham hospital A&E under the influence of alcohol but discharged herself;

vii. On 13 August 2004 she was arrested for shoplifting;[62]

viii. On the same day she smashed three windows in a house;[63]

ix. On 20 August 2004 while in custody awaiting sentencing for various offences she was aggressive and threw urine over staff.

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[61] *14th offence*
[62] *15th offence*
[63] *16th offence*

172. As a result of the incident on 3 August 2004 Durham Constabulary sent an adult concern form to Durham social services. There was still no allocated social worker. The head of the CRT, Team Manager 2, was sufficiently concerned to press Staff Grade Psychiatrist 1 to organise a case conference involving the police and other relevant parties, to create a joint management plan.

173. On 16 August 2004 an agency social worker, Social Worker 7, was allocated from the CMHT.

COMMENT

February 2004 when Louisa Ovington apparently agreed that she did not need social services input and Social Worker 5 closed the file to social services, marked the start of a period of extreme turbulence in Louisa Ovington's life, in which the services offered appeared to be more in the nature of 'fire fighting' than resulting from planning and discussion about her needs. Although Louisa Ovington remained subject to CPA/ Section 117 there is no evidence that Consultant 2 acted on the letter written to him by Social Worker 5 informing him that he was now the care coordinator: it appears from the CPA records that Staff Grade Psychiatrist 1 was officially the care coordinator from March 2002 (although Staff Grade Psychiatrist 1 told the panel that he had not joined the trust until 2003). Thus, she was effectively left without a care coordinator until the appointment of Social Worker 7 in August 2004.

174. It seems that over the summer of 2004 mental health services failed to accept their responsibility for the care of Louisa Ovington. Her behaviour was extremely disturbed and Louisa Ovington herself acknowledged that she was "out of control". From the records, it appeared to the panel that Staff Grade Psychiatrist 1 accepted that Louisa Ovington had been diagnosed with a severe personality disorder with a primary diagnosis of alcohol dependency. On the basis of this he and the CRT considered that she 'did not experience mental health problems' and that there was therefore no role at that time for the CRT. Staff Grade Psychiatrist 1 confirmed to the panel that he did not think that Louisa Ovington was suffering from a mental illness and he said that he saw no evidence of depression, psychosis or cognitive impairment. Even if it is accepted that Louisa Ovington was not suffering from a mental illness (such as schizophrenia or bipolar disorder), her mental state was disordered and chaotic at this time and it was causing problems to her and to others.

175. Whilst it would not have been appropriate for the CRT to take on a care coordination role, they did work with patients for up to six weeks at a time. It might have been helpful had they done this with Louisa Ovington.

176. Social Service staff did respond to the requests for help from the public and the domestic violence outreach worker. They finally allocated a Social Worker to Louisa Ovington in August 2004 and Social Worker 7 then became her care coordinator. In the panel's opinion, however, it is regrettable that Louisa Ovington's care was not directly transferred from Social Worker 5 to another worker. It is evident that Louisa Ovington needed consistent support. Team Manager 3 told the panel that he had never had dealings with Louisa Ovington and that the case would simply have been allocated to the next available worker; that he could not explain why her case had remained unallocated from February to August, nor why the care coordination had moved from the CMHT to the consultant, particularly where the client as in this case had, as the panel member put it:

"a reasonable degree of dangerousness, (was a) potential risk in the community, (had) been involved with the criminal justice system, who (was) attached to a CMHT and who (was) concurrently being seen by the crisis resolution service and the drug and alcohol service".

177. He acknowledged that it should not have happened, particularly as only two weeks before the case was closed to social services it was recorded that Louisa Ovington was drinking heavily and suffering from possible psychosis, but he said that there were never enough staff to deal with the number of cases and confirmed that, as other witnesses have said, medical staffing was "a horrendous problem" and that Easington suffered from being on:

"The extremities of whichever health trust that it sat with" (at different times it was part of Hartlepool, County Durham and Darlington and Tees & North East Yorkshire). It was only then when primary care trusts (PCTs) developed and Easington got its own PCT, with the input of Easington PCT that mental health services saw vast investment over a very short period of time".

August 2004 to November 2005

178. On 20 August 2004 Louisa Ovington was detained at Low Newton Prison after a court appearance in connection with several offences. She was remanded for sentencing until 10 September 2004. She was disturbed and was seen by a psychiatrist who prescribed Olanzapine as a sedative.

179. Social Worker 7 noted the need for a clear management plan should Louisa Ovington be bailed into the community. Social Worker 7 contacted a number of professionals about Louisa Ovington including Team Manager 2 of the CRT in case Louisa Ovington needed a safety net at the weekend.

180. A pre-sentence report was prepared. The probation officer concluded that Louisa Ovington presented a high risk of harm to the public and a high risk of reoffending; commented that her behaviour was bizarre on interview and said she could not make recommendations without a psychiatric report. Her assessment (an OASys[64]) suggested a MAPPA referral was indicated. This was not followed up.

181. On 10 September (without the benefit of a psychiatric report) the court sentenced Louisa Ovington to a two year CRO[65]. There was liaison between the remand centre, social services, the CRT and social services emergency duty team. The CRT tried to make contact with Louisa Ovington but failed.

182. The GP asked for advice about medication for Louisa Ovington on 20 September 2004. He had no response and prescribed an antipsychotic for one week.

183. Between September 2004 and November 2004 Louisa Ovington's chaotic and disturbed behaviour continued to cause concern. Various records note the following (but in some cases it was not possible to establish details):

i. On 20 September she made an allegation (with a 999 call) that a neighbour was firesetting (no evidence of this);

ii. On 21 September she was arrested at a hotel for not attending court;

iii. On 22 September she made an "abusive and agitated" call to her GP, who referred the matter to Staff Grade Psychiatrist 1 for urgent advice;

iv. On the same day she made a "hysterical" 999 call claiming that Mr Hilton would not let her out of the house. She was taken under Section 136 MHA[66] to Hartlepool General Hospital. She had apparently self harmed but was assessed as no risk to herself and refused admission. Social Services tried to find her accommodation but were unable to do so. She had to be removed by police;

v. Two days later she was convicted of criminal damage (committed on 17 July 2004);[67]

vi. She found temporary hostel accommodation near Hartlepool but was threatened with eviction as she broke the rules about alcohol and at some point she was in fact evicted;

vii. Despite the efforts of Social Worker 7 and Team Manager 2 she failed to attend an emergency outpatients appointment or a case conference (see later), or indeed any outpatient appointments during this period;

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[64] *Offender Assessment System (a Probation Service risk assessment tool)*
[65] *9th conviction*
[66] *See Chapter 8*
[67] *10th conviction*

viii. When Social Worker 7 finally met her on 10 October 2004 she was "quite high and paranoid" and felt she was being stalked by Mr Hilton. She said that if she saw him she would be driven to attack him. She was apparently taking antipsychotic medication bought off the street;

ix. On 20 October 2004 she was charged with breach of the peace while drunk;[68]

x. On 5 November 2004 she was charged with criminal damage having used a knife to scratch a car.[69] On the same day she was charged with being drunk and disorderly and damage to a police cell;[70]

xi. On 9 November 2004 Louisa Ovington was in custody again, having broken a curfew;

xii. On the same day she was convicted for the offences of 5 November 2004;[71]

xiii. On 20 November 2004 she was charged with being drunk and disorderly and threatening behaviour (threats to stab);[72]

xiv. She was evicted from her (temporary) accommodation at some point;

xv. Louisa Ovington was convicted of the drunk and disorderly offence of 20 November 2004 and received a conditional discharge;[73]

xvi. At some point she was remanded in custody again and remained in custody until 14 January 2005.

Between June 2004 and November 2004 Louisa Ovington had committed 11 sets of offences and in addition had been arrested for being drunk and disorderly or for public order offences (which were not proceeded with). Several of the offences for which she was charged involved violence. In relation to these offences she received eight convictions between June 2004 and January 2005.

184. From 9 September 2004 Louisa Ovington was subject to a two year CRO. She was under the supervision of Durham Probation Service. At various points it was noted that she was supposed to be completing a citizenship programme involving work on anger management and alcohol abuse control. Louisa Ovington was moving around and it was unclear which probation office should remain responsible for her; it appears that Hartlepool took over a 'caretaking' role for a few months and then the responsibility was transferred to them. The records show that Social Worker 7 kept in touch with probation as far as she was able.

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[68] *17th offence*
[69] *18th offence*
[70] *19th offence*
[71] *11th conviction*
[72] *20th offence*
[73] *12th conviction*

185. Following the brief visit to Hartlepool General Hospital on 22 September 2004, (see paragraph 183 (iv)) Louisa Ovington was referred to the CRT, but they were unable to track her down. Team Manager 2 from the CRT was very concerned about Louisa Ovington. He wrote to Social Worker 7 to express his concern that Louisa Ovington was continuing to come into contact with the criminal justice system and that there was 'still a lack of clarity around the mental health service response' adding that ' the need to develop a joint management plan is pressing'.

186. In the meantime, the GP was concerned about Louisa Ovington's presentation and had been trying to get advice about prescribing medication for her from Consultant 13. He (Consultant 13) arranged for her to see Staff Grade Psychiatrist 1 urgently in Outpatients on 30 September 2004 and advised on medication.

187. Team Manager 2 attended the outpatients appointment on 30 September 2004 but Louisa Ovington did not attend. She had missed a probation appointment as well.

188. Team Manager 2 had in August asked Staff Grade Psychiatrist 1 to arrange a case conference. This took place on 5 October 2004. By then it was known that Louisa Ovington was living in homeless accommodation in Hartlepool, but that she would be evicted within ten days as she had broken rules by drinking. A representative attended from the CRT, as well as Social Worker 7, Staff Grade Psychiatrist 1 and Probation Officer 4. The police were not in attendance. Although there were concerns expressed about the impossibility of formulating a management plan for Louisa Ovington, until she "engages with services and has a firm address", Social Worker 7 stressed the need to keep communication open; she also expressed her view that a 'public protection meeting should be called to include the police, given Louisa Ovington's potential risk to herself and others'.

189. An outpatient appointment was arranged on 7 October and it was agreed that if she failed to attend appropriate action would be taken and relevant people would be informed. It was also agreed that there should be a forensic assessment.

190. Louisa Ovington did not attend the outpatient appointment despite Social Worker 7 letting her know it had been put back for two hours to accommodate her; Social Worker 7 did attend. Staff Grade Psychiatrist 1 proposed to discharge Louisa Ovington from services since she had failed to attend two appointments. At the appointment Social Worker 7 again suggested to Staff Grade Psychiatrist 1 that it might be helpful to refer Louisa Ovington to forensic services and that Louisa Ovington might benefit from DBT[74]

[74] *Dialectical behaviour therapy- a specific psychological therapy for the treatment of emotionally unstable personality disorder.*

191. On 7 October 2004 Louisa Ovington's probation officer rang Social Worker 7 and informed her that Louisa Ovington had attended her probation appointment on 6 October and had been abusive. Social Worker 7 raised the issue of a public protection meeting. The probation officer told her that she did not fit probation's criteria for this.

192. On 13 October 2004 Social Worker 7 again raised the matter of a referral to a public protection/risk meeting with a more senior probation officer, after Louisa Ovington, presenting as 'high and paranoid' had said that if she saw Mr Hilton she might be driven to attack him. Again the probation officer said she did not think it was necessary "unless there were presenting behaviours that increased the likelihood of risk" and suggested that a multi agency meeting might be better. Probation records on 14 October 2004 indicate that they did not regard Louisa Ovington as high risk.

193. At a CMHT meeting on 19 October 2004 Social Worker 7 spoke to Staff Grade Psychiatrist 1 who agreed not to discharge Louisa Ovington but to offer her another appointment; in addition consideration was to be given to a referral to the personality disorder unit at St Nicholas' Hospital in Newcastle. A further outpatient appointment was scheduled for 2 November 2004 which Louisa Ovington did not attend; she was discharged from the service after a CMHT meeting on 23 November 2004.

194. By 9 November 2004 Louisa Ovington was in custody again after breaking a curfew imposed on 26 October 2004. She was briefly released then remanded again and remained in custody until 14 January 2005 when she was due in court for the offences of 5 November 2004. Social Worker 7 contacted the court diversion scheme[75] and highlighted the areas of concern - difficulties with engagement, homelessness, breaching of her CRO and impossibility of preparing a management plan.

195. On 14 January 2005 Louisa Ovington was convicted of criminal damage and ordered to pay compensation.[76] She was released from custody. There was no recorded contact with her from the services for 5 days although evidence suggests that attempts were made to track her. Social Worker 7 picked the matter up quickly, contacting the CRT and probation. Louisa Ovington made contact on 19 January 2005 and told Social Worker 7 that she was staying with Mr Hilton. Social Worker 7 tried to get accommodation sorted out for her. There were still problems about who was taking responsibility for her in the probation service. Hartlepool Probation Service wanted to transfer case responsibility back to Peterlee but there seemed to be difficulties about this until Louisa Ovington had a permanent address. This caused some difficulties in coordinating her care. The case was finally passed back to Peterlee in February.

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[75] A Home Office scheme to divert potential offenders with mental illness from the criminal justice system to healthcare

[76] 13th conviction

196. On 20 January 2005 a probation assessment form (OASys) was completed that indicated that Louisa Ovington was low risk and there was no need for a referral to MAPPA.

197. On 4 February 2005 Louisa Ovington received her fourteenth conviction for offences committed the previous August and was given a conditional discharge and compensation order[77].

198. Social Worker 7 went to some lengths to try to get Louisa Ovington housed. At this time probation recorded that she was talking about becoming engaged to be married to Mr Hilton.

199. On 22 March 2005 Louisa Ovington attended an outpatient's appointment with Staff Grade Psychiatrist 1 (accompanied by Social Worker 7). It was the first time in nearly a year that she had seen him. She reported that she had 'been off' alcohol for nearly four months (of which she had been in prison for nearly two) and that this (alcohol) was her 'big problem'. She was to continue on anti psychotic medication and a mood stabiliser.

200. The care coordinator, Social Worker 7, prepared a quite detailed care plan, jointly agreed with Staff Grade Psychiatrist 1 and Louisa Ovington. She was on enhanced CPA. Her stated needs were housing, structured activities, completion of the 24 month CRO (which involved a citizenship programme covering anger management and alcohol abuse awareness overseen by a probation officer). In addition Social Worker 7 completed a Durham County Council social care and health practitioner progress chart.

201. In March 2005 Louisa Ovington moved to permanent supported accommodation. Social Worker 7 liaised with all parties to give full information about her situation. For the next four months Social Worker 7 worked hard to coordinate support for Louisa Ovington including sorting out her benefits and helping her consider further education possibilities. She instigated a referral to an education centre

202. In July Louisa Ovington saw Staff Grade Psychiatrist 1 and reported that she was well; no evidence of mental illness was noted. She had discontinued taking the anti-psychotic medication.

203. In July 2005 Louisa Ovington's CRO was transferred to the Hartlepool service

[77] *14th conviction*

204. However Louisa Ovington's enthusiasm both for her housing and for education waned; she wanted to be nearer to Mr Hilton and on 30 July 2005 after a window was put out at her flat she went to stay with him. In September she moved to her own accommodation near him. Social Worker 7 reported that Louisa Ovington was "desperate to be near" Mr Hilton. The move, away from supported accommodation, caused some problems with Louisa Ovington's benefits which Social Worker 7 was involved in sorting out.

205. In early October 2005 there were signs that Louisa Ovington's mental state was deteriorating:

- She attended A&E at Hartlepool General Hospital after telling her GP that she had taken an overdose of her mood stabilising medication and eight cans of lager. The hospital diagnosed alcohol poisoning and discharged her after giving her advice;

- She caused criminal damage to Mr Hilton's property on 8 October 2005, for which she was arrested and charged; [78]

- She reported that Mr Hilton was drinking again.

206. Her mood was noted by Social Worker 7 to be low and she took immediate steps to assist and support her, involving a representative from 'Mental Health Matters', a mental health charity offering services and support in the region. It was arranged that she would look again at the possibility of a college course, might consider voluntary work and would have some help with structuring her day. A CPA meeting was to be organised for 27 October 2005. Louisa Ovington agreed to contact her GP and was prescribed an anti-depressant.

207. Social Worker 7 visited Louisa Ovington on 26 October 2005 to tell her she was leaving but that she would continue to be supported. A CPA meeting was to take place the following day. The new care coordinator was to be CPN 2. Staff Grade Psychiatrist 1 would attend, Louisa Ovington would be provided with outreach support by a worker (Support Worker 1) and a CPN (CPN 1) would give an overview. Mental Health Matters would support her.

COMMENT

The panel could not trace the record of the meeting. It seems that Social Worker 7 may have left somewhat abruptly because she was an agency social worker.

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[78] *21st offence*

208. During this period Louisa Ovington was reported to be worried about her impending court appearance for the criminal damage committed on 8 October 2005. Social Worker 7 contacted probation at the court to try to ensure there would be a pre-sentence report (PSR) if she were not to receive a conditional discharge. A PSR was prepared by Probation Officer 5 which assessed Louisa Ovington's risk to the public as medium (despite a very high OASys analysis). She supported the imposition of Community Order (CO)[79] with conditions of supervision, to oblige Louisa Ovington to complete a citizenship module and liaise with CMHTs and ESMI.

COMMENT

Care coordination

From March 2004, after discharge by Social Worker 5, Louisa Ovington's behaviour and presentation became more and more turbulent and disturbed. Social Worker 7, a mental health social worker with the CMHT, took over Louisa Ovington's case in August after six months without a CMHT worker. There is evidence thereafter that considerable attempts were made by her to properly coordinate Louisa Ovington's care; she kept in close touch with probation, with the CRT and with the medical services; she made contact with the Cleveland Court diversion team; she made efforts to sort out Louisa Ovington's housing situation and to support her in relation to the consequences of her offending behaviour, as well as in relation to her engagement with the psychiatric services. Additionally there is evidence that she became very aware of the risks Louisa Ovington posed; she proposed referrals to forensic services, to the personality disorder services and to MAPPA. None of these was acted upon.

Crisis Resolution Team

At points during this period, the CRT was also involved and there was evidence that they responded to the requests to be involved, (although there was some confusion about the referral in relation to the incident in June 2004).

CRT 1 told the panel that the service existed to offer intensive time limited support at home to those suffering from severe mental health problems, with the aim of avoiding hospital admission. However, she told the panel that the team tended to see more of the "worried well" and people suffering from "social stresses". She commented that some GPs would say that patients were suicidal, (even if they were not) and that they were not under the influence of drugs and alcohol (even if they were) to ensure that the CRT would take them on. Nonetheless, CRT 1 also told the panel that she thought it was appropriate of Staff Grade Psychiatrist 1 to refer Louisa Ovington to the team when he did, because Louisa Ovington was in crisis at those times. She told the panel that the crisis resolution service had very limited information about the patients with whom they worked, particularly if they were referred them out of normal working

[79] *Community Orders replaced Community Rehabilitation Orders;*

hours. They did not have access to the CMHT notes. In Louisa Ovington's case, she said, they were not made aware, for example, that she had been in hospital for 18 months on a Section 37. She also stated that the crisis resolution service had no access to CPA information or risk assessments. Their own risk assessments tended to be based purely on what limited information was available at the time, but were updated subsequently. She said that the service was not equipped to deal with personality disordered clients and she felt that dealing with someone like Louisa Ovington was not, according their criteria at the time, appropriate.

Team Manager 2, who was in charge of the team, took a broader view of the function of the CRT service. It was evident that he was concerned about the general mental health service response to Louisa Ovington at this time. He also expressed his concern about the lack of an overall agreed care plan, in view of the fact that Louisa Ovington was coming into contact with criminal justice services as well as health services. He told the panel "It felt like we couldn't get a grip of the situation as an overall service. I felt we were just kind of mirroring some of her behaviour in the presentation. Our response was becoming chaotic as well".

He felt that in the light of the number of referrals received in a very short period of time they needed "an over-arching care plan" to ensure that they all had a shared understanding of what her needs were and what their roles were within that. In September 2004 Team Manager 2 urged multi agency action in relation to Louisa Ovington and expressed his concern to Staff Grade Psychiatrist 1, Social Worker 7 and others.

Team Manager 2 told the panel that Staff Grade Psychiatrist 1 responded to phone calls from the crisis resolution service and made himself available for appointments, within two to three days of a request. However, he commented that when you have a doctor working with the crisis resolution service (as they sometimes had) it gives you a "much, much better system".

MAPPA[80]

The issue of whether Louisa Ovington should have been referred to MAPPA is quite confused. The terminology has changed somewhat; at that point in time the words public protection/risk meeting seem to have been used interchangeably with MAPPA and there is no clear idea about what the difference would have been between a 'risk meeting' and a 'multi-agency meeting'. What is clear is that Social Worker 7 was concerned about Louisa Ovington's risk to the public; that over a period of a week or so she raised this matter with probation several times and that probation did not accept that it was necessary to have a public protection/risk meeting - even after Louisa Ovington had said that she may be driven to attack Mr Hilton. Probation

[80] *See Chapter 5 for an explanation of the MAPPA process*

Manager 1 expressed surprise to the panel about the probation officers' response to Social Worker 7's concerns; she suggested that Social Worker 7 could in any event have made the referral herself - however she accepted the panel's view that if Social Worker 7 had specifically raised the issue of MAPPA with probation it would be reasonable for her to accept their opinion.

Forensic

A referral to forensic services was apparently agreed in the meeting dated 5 October 2004 but never proceeded with. There were community forensic services in place at the time, available for the Durham CMHTs to refer to and Louisa Ovington would have fitted their criteria; they could have assessed her and the panel was told by the consultant in charge of that service that they had better staffing levels than the CMHTs and would have worked intensively with her. Staff Grade Psychiatrist 1 did not refer to them; he told the panel he thought that she did not fit the criteria for a forensic referral in October 2004, but that later on she should definitely have been referred and that this should or would have been done by the care coordinator Social Worker 7. The panel is surprised that given the incidence of disturbed behaviour and increasingly frequent contacts with the police from June 2004, Staff Grade Psychiatrist 1 did not take personal responsibility for ensuring the referral after he had discussed the matter with Social Worker 7 in early October 2004.

Custody diversion

Given the amount of contact Louisa Ovington had with the criminal justice system in this period in particular the panel is somewhat surprised that there was so little involvement of 'custody diversion' schemes, which were set up to divert people from the criminal justice system into health care and to work alongside generic CMHTs in respect of offending behaviour. However, in Louisa Ovington's case, it may be that such a scheme would not have been as effective as a forensic referral.

November 2005 to January 2006

209. CPN 2 formulated a care plan with Louisa Ovington, which placed her on enhanced CPA and set out the agreed needs as: regular monitoring of mental health through outpatients and home visits from CPN 2; assistance with housing and finances; assistance with meaningful activities; reduction of aggressive behaviour and completion of citizenship programme with probation, including alcohol awareness and anger management.

210. CPN 2 also completed a risk assessment. This noted some risks, low to medium and particularly associated with alcohol, but did not appear to take account of the complexities and history of Louisa Ovington's relationship with Mr Hilton.

211. On 22 November 2005 at court for the criminal damage Louisa Ovington's existing two year order CRO was replaced by a twelve month CO with conditions[81].

212. Louisa Ovington did not like the new probation officer and probation quite quickly recorded that because of her abusive and aggressive behaviour there were to be no home visits due to potential risk to staff.

COMMENT

The panel was told that where circumstances change consideration should be given to reviewing an existing OASys assessment. The OASys assessment completed for the court hearing on 22 November 2005 had indicated that Louisa Ovington's risk of harm to the public was medium - despite a very high OASys score. A short while later it was noted that probation had decided that Louisa Ovington was too risky to visit at home; no new OASys assessment was done at this time and this information was not shared.

213. CPN 2 visited Louisa Ovington on the 7 December 2005; she had 'fallen out' with Mr Hilton again and she expressed her dislike of the new probation officer. CPN 2 visited again on the 20 December and no problems were noted. Louisa Ovington had seen the social work assistant on the 14 December and commented both to the assistant and to CPN 2 that she was 'fine' about having fallen out with Mr Hilton.

214. On 2 January 2006 police records note that Louisa Ovington reported she had been assaulted by Mr Hilton. No action was taken.

215. On 4 January 2006 Louisa Ovington cancelled a planned visit by the social work assistant as she had flu.

216. On 8 January 2006 Louisa Ovington killed Mr Hilton by a single stab wound to the heart, with a kitchen knife, whilst he lay in bed at her accommodation. They had each been with other people during the day and had both consumed a very large amount of alcohol. There was no evidence that their sexual relationship had started again but according to the trial transcripts they had seen something of each other over the Christmas season. Louisa Ovington said that Mr Hilton was boasting of his conquests and she only intended to hurt his arm. Louisa Ovington pleaded not guilty to a charge of murder and after a trial was convicted of manslaughter and given an indeterminate sentence of imprisonment for public protection.

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[81] *15th conviction*

217. Louisa Ovington was accepted on a Home Office programme attempting to treat dangerous and severe personality disordered offenders while in custody.

COMMENT

During the last few months before the death of Mr Hilton, Louisa Ovington was allocated to a new probation officer and a new care coordinator. She strongly disliked the probation officer and was aggressive to her. Her response to CPN 2 however seemed positive, although subsequently (after the death) she admitted that she had lied to CPN 2 about her drinking.

CPN 2 told the panel that she had "a few apprehensions" when she first started working with Louisa Ovington "because of her history", but Louisa Ovington was never hostile or threatening to her. She knew that Louisa Ovington was chaotic, abused drugs and alcohol to quite a severe extent, had been on a secure unit and had had drug induced psychosis. However, CPN 2 told the panel that she did not think she was given enough information about Louisa Ovington. Despite this however the care plan prepared by CPN 2 was detailed and Louisa Ovington was appropriately placed on enhanced CPA, (although the risk assessment may have suffered from her lack of information).

The panel is surprised that following the decision by probation that no home visit should be made to Louisa Ovington because of her aggressive and abusive behaviour, this information was not, apparently, passed on to the care coordinator or any other agency. CPN 2 (and Support Worker 1) continued to make lone visits to Louisa Ovington at home.

In the last few months of 2005, although Louisa Ovington's behaviour continued to be disturbed, there was nothing that might have indicated to the care coordinator that Mr Hilton's death at the hands of Louisa Ovington was imminent, or more likely.

The panel noted with great concern that throughout their dealings with Louisa Ovington, none of the agencies (other than the police) was recorded as having made contact with Mr Hilton, the person with whom she had the most significant and longstanding adult relationship outside of her family. In view of the turbulence of their relationship, the frequent allegations of domestic violence, each against the other and frequent threats made by Louisa Ovington that she would kill or attack Mr Hilton, the panel is surprised that there are no records of Mr Hilton being involved in any care planning, or being spoken to about the risks she posed to him.

Chapter 2 – Evaluation of the health care and treatment of Louisa Ovington

Introduction

Louisa Ovington's health care and treatment consisted of three strands: medical treatment, psychological interventions and treatment for addictions. The medical treatment was relatively straightforward: she presented with symptoms of psychosis or depression and was treated, whether in hospital or in the community. The other strands were more complex and, it seemed to the panel, were not perhaps accorded the priority they should have had in considering her overall health and care.

Medical treatment

Louisa Ovington had very little contact with mental health services prior to her first admission in 1995. The panel was not provided with any evidence to indicate that she was involved with Child and Adolescent Mental Health Services (CAMHS), which might have been expected given the extreme trauma which she had experienced. The panel understands that social services were involved with her at some points during her youth, but the records were unavailable. It seems that she was helped and supported mainly by family members.

Louisa Ovington's first formal psychiatric assessment took place in 1993 when she was assessed by Consultant 1, a child and adolescent psychiatrist, who concluded that Louisa Ovington was not suffering from any specific mental disorder and, in particular, that she was not suffering from a conduct disorder. On the basis of the information available to Consultant 1 at that time, this appears to have been a not unreasonable conclusion for her to have drawn.

Between December 1995 and March 1997, Louisa Ovington was admitted to Hartlepool General Hospital psychiatric wards three times. She was suffering from psychotic episodes.

The first admission lasted three months and during this time the medical and nursing teams appropriately managed Louisa Ovington, including referring her for an assessment by a child and adolescent psychiatrist, transferring her to a PICU when her behaviour became unmanageable and using the Mental Health Act to detain her when necessary. She was properly assessed during the admission, with appropriate investigations being carried out. Whilst the clinical team concluded that Louisa Ovington was suffering from a drug induced psychosis, it appears that rightly they did not rule out the possibility that she was suffering from a more severe and long lasting illness and that they considered whether she was suffering from a conduct disorder.

She was appropriately medicated.

The second and third admissions were much shorter, the second lasting less than a month and the third just one day. As before, she was appropriately assessed and treated during admission number two. Nonetheless, during the course of this admission Louisa Ovington allegedly became involved in a relationship with a male member of the nursing staff, who was subsequently disciplined and dismissed. This highlighted to the panel the difficulties in caring for Louisa Ovington.

Louisa Ovington's discharge from her second admission to hospital was precipitated by her using illicit substances during a period of leave. Her third admission was ended within a day of her arrival on the ward, after she used illicit drugs on the ward. It is relatively common practice for patients to be immediately discharged from hospital if they bring in, or use, such substances, provided it is safe to do so. Louisa Ovington was appropriately followed up on each occasion that she was discharged, by a community psychiatric nurse and in outpatients. She was also prescribed ongoing treatment with antipsychotic medication.

Louisa Ovington's fourth admission, for ten days in May 1997, was to the Royal Edinburgh Hospital. The Hartlepool services made some effort to ensure that the team in Edinburgh were informed about Louisa Ovington. Again, she was appropriately assessed and treated whilst in hospital. Her diagnosis was, rightly, reviewed – the comment being made that it was "more likely one of schizophrenia than of drug induced psychosis". On her discharge, arrangements were made for her to be reviewed in outpatients, even though Louisa Ovington was not certain whether she would be remaining in the area.

Louisa Ovington returned to the Hartlepool area and was followed up in outpatients. Consultant 6 tried to support her in the community, for example assisting her return to college.

In May 1998 Louisa Ovington committed several offences and was remanded in custody. She was noted to be severely psychologically and behaviourally disturbed. She was assessed appropriately by Consultant 8 who, when she did not respond to the medication he prescribed, correctly arranged for her transfer to hospital, under Section 35 of the Mental Health Act, which allows for assessment in hospital[82].

Louisa Ovington spent the next eighteen months detained in hospital, first at Durham County Hospital, then at St Nicholas' Hospital, then at Kneesworth House.

The panel was unable to clarify why Louisa Ovington was admitted to Durham County Hospital instead of the local forensic unit, St Luke's Hospital in Middlesbrough. It was

[82] *See Chapter 8*

unfortunate, however, that rather than suffering from what would might have been a relatively short lived episode of psychosis, Louisa Ovington's difficulties proved be more long lasting and the role of the PICU became one more of containment, rather than treatment, until she could be transferred to a more appropriate setting. Nonetheless, during this admission Louisa Ovington underwent numerous physical and psychiatric assessments and her psychotic symptoms were appropriately treated with trials of different psychotropic medications.

At Durham County Hospital, Louisa Ovington verbally and physically assaulted staff and other patients on numerous occasions. The attempt by staff to manage this by using behavioural techniques was appropriate, but in the panel's view the police should have been asked much earlier on to charge Louisa Ovington for her offences.

The work carried out at St Nicholas' Hospital confirmed Louisa Ovington's diagnosis of a personality disorder, but again she was felt to be inappropriately placed there for treatment. Consequently, the focus of attention again became that of finding an alternative setting for her. However, the clinical team used the time to collate a very thorough resume of Louisa Ovington's past psychiatric contacts.

Whilst at Kneesworth House Louisa Ovington underwent a thorough medical assessment. The majority of the work however was psychological. The attempt to assess whether she had a mood disorder underpinning her psychosis and aggressive behaviour was appropriate, however, a month medication free was an insufficient time period to determine this.

A CPA meeting was held 12 days after Louisa Ovington's discharge from Kneesworth House. She was allocated a social worker as her key worker. It was agreed that she would be seen by addictions services and CPNs in the future if she so wished and it was deemed appropriate. Given Louisa Ovington's failure to engage with such services whilst an inpatient, the panel felt that this plan was at very least overly optimistic.

During the first four months following her discharge, Louisa Ovington was not in fact seen by any mental health professionals. Thereafter, she was followed up by a series of care coordinators and she was intermittently seen in outpatients by doctors (most of whom were locums from whom she received little continuity of care). She had a brief admission in February 2001 to Darlington Memorial Hospital. Whilst technically this admission lasted five days, she went on leave the day following her admission and failed to return. Consequently, no useful work was carried out during this admission. It appears that a diagnosis of bipolar affective disorder was considered at this time and there were plans to commence her on a mood stabilising medication, but she left the hospital before this was done. She had a further brief admission in May

2004, to Hartlepool General Hospital during which she underwent a detoxification from alcohol. However, she took her own discharge after five days. At the point of discharge she was diagnosed as having a borderline personality disorder and an alcohol dependency syndrome.

Over the years 2000 to 2005 inclusive, it was notable that whenever Louisa Ovington had a change in care coordinator her mental state deteriorated. This was particularly an issue during 2004 when she was left without any clear community support. Her behaviour became extremely disturbed and the CRT had to become involved with her care. Whilst for the majority of this time Louisa Ovington did have a care coordinator, there appears to have been very little input from medical staff, which seems remiss given the complexity of her case and the severity of her mental and behavioural problems.

Despite numerous admissions and assessments, there was never clarity as to Louisa Ovington's diagnosis. Over the years, diagnoses considered included: drug induced psychosis, schizophrenia, bipolar affective disorder, psychopathic disorder and emotionally unstable personality disorder of borderline type. This lack of clarity appears to have impeded Louisa Ovington's access to some services (for example the CRT) and, to some extent, to have resulted in her difficulties not being regarded as the responsibility of any particular service.

Psychological input

Given Louisa Ovington's experiences and genetic loading (it is suggested that her father may have suffered from delusional jealousy, carried a weapon and followed her mother before the murder) it must have been evident to all the professionals involved with her from her earliest years that she was at risk of developing mental health difficulties. The panel has been unable to ascertain exactly what help she was given in the early years following the death of her mother. It seems that she was supported in the main by her family; there is no evidence that she received any psychological input from professionals at that time.

As referred to in Chapter 1 of this report, Louisa Ovington's first contact with psychiatric services was when she saw Consultant 1 at age 15. Consultant 1 commented that Louisa Ovington had been given help in mourning her mother and in understanding the events that led up to her death, but suggested further work on this and also that Louisa Ovington might find it helpful to meet her father at some point. Louisa Ovington saw a counsellor based at Peterlee College, on a private basis but no records are available. By the time that she next came into contact with mental health services (in December 1995) it was her use of drugs and its effect on her mental state that was the main focus of attention.

During Louisa Ovington's first admission it was understandable that apparently no attempt was made to address Louisa Ovington's underlying psychological difficulties, as her paranoid and aggressive presentation would have prevented this. The child and adolescent psychiatrist who assessed her in January 1996 expressed concerns for her future, referring to her possible personality difficulties.

Although there was a plan to refer Louisa Ovington to psychology during her second admission, there was no further reference to this in the records.

Louisa Ovington's third admission to Hartlepool General Hospital (in March 1997) was very brief and was precipitated by her use of drugs. Two months later she was admitted to the Royal Edinburgh Hospital for ten days. During this admission it was noted that the deterioration in her mental state might have been due in part to her having recently had contact with her father who had just been released from prison. Various other possible psychological triggers were also noted. However, there is no reference to her being referred for any specific treatment for her psychological problems – but again this is understandable given that she told the staff that she was not certain that she would be staying in the area.

Over the course of the next year (30 May 1997 to 5 June 1998) Louisa Ovington was followed up in the community by Consultant 6 and CPN 1. The focus of their work appears to have been monitoring of her mental state in relation to her psychotic symptoms and their treatment. There was no evidence of psychological work.

Tony White Unit

Louisa Ovington was admitted to the Tony White Unit on 5 June1998. Although her psychological issues were noted by the clinical team, it was not feasible to address Louisa Ovington's psychological difficulties whilst she was there; her behaviour was too disturbed and the unit was not set up for this sort of work, including anger management training, which Louisa Ovington specifically requested. Consultant 5 commented that she suffered, "to an extent", from a psychopathic personality disorder. (He was concerned about how this could be treated, as he feared that she would not engage. However, without treatment he foresaw her as having a "tragic future").

The clinical team tried to manage Louisa Ovington's verbal and physical outbursts using behavioural techniques, but there was also evidence that the nursing staff were aware of Louisa Ovington's early life history and that they gave her time to ventilate her views about it. They did not, however, discuss this in depth, because, as Sister 1 told the panel, the whole point of Louisa Ovington being at Tony White Unit was to "settle her" and such discussions would have upset her. She did however talk with the nursing staff about her ambivalent feelings about her father (who came to see her whilst she was there).

When it was decided that Louisa Ovington should be transferred from the Tony White Unit, she was assessed by a forensic psychologist and a nurse consultant from the Newcastle forensic adolescent psychiatry service, who concluded that a full assessment for psychopathy would be appropriate.

St Nicholas' Hospital

Louisa Ovington underwent a psychological assessment when she moved to St Nicholas' Hospital, Newcastle. This process consisted of clinical interview, completion of psychometric inventories relating to personality and interpersonal behaviour and an interview with Louisa Ovington's great aunt and uncle to get a corroborative history. She scored high on the borderline personality disorder scale. Her results fell below the cut off score for psychopathic personality disorder, but a number of features of this disorder were noted. Her responses to the aggressiveness scales highlighted an individual with a quick temper prone to explosive, potentially physically aggressive, outbursts.

Louisa Ovington denied her difficulties (for example, when she attended anger management sessions, she stated that they were a waste of time and that she did not have a problem with managing anger) and she refused to discuss some aspects of her life, such as the murder of her mother. The psychologists recommended further work on dealing with stress and problematic emotions and targeted relapse prevention work. This was reiterated by Consultant 10 from Rampton (who was asked to give an opinion regarding further management). He commented that there was "no evidence that anyone had worked meaningfully with her about the significance of what had happened to her developing perceptions and values to do with important aspects of her life to do with trust and relationships". Amongst other recommendations, he suggested exploratory psychotherapy.

The panel was told by Psychologist 1 that whilst at times Louisa Ovington made it quite clear that she wasn't interested in talking in detail with staff, at other times she was more engaging. Some issues remained essentially "off her agenda", including the murder of her mother, but it was the impression of the staff that over time it became easier for her to engage in this process. They felt that Louisa Ovington needed to be treated in a contained and consistent environment where the staff would have the opportunity to build up over a significant period of time, possibly eighteen months, the kind of relationship that might make therapeutic change possible. Unfortunately, however, as the clinical team did not regard their services as appropriate for Louisa Ovington, they arranged for her transfer to Kneesworth House.

Kneesworth House

Louisa Ovington continued to use the defences of denial and avoidance when she moved on to Kneesworth House. As Assistant Psychologist 2 told the panel, "She was highly defensive, which meant any interviewing with her was problematic,, whether you were experienced or inexperienced".

Whilst at Kneesworth House, Louisa Ovington had six assessment psychology sessions with a 'consultant psychologist and integrative psychotherapist', during some of which she allowed some exploration of her background history. However, despite the fact that issues to do with her mother's death and her relationship with her father were noted, it was not thought appropriate to offer her psychotherapy, because she was very guarded and unwilling to explore issues in detail. The consultant passed the case over to an unqualified, "assistant psychologist" who attempted to work on relapse prevention in terms of Louisa Ovington's drug use and on supporting her in monitoring her mental state when her mood stabilising medication was stopped.

COMMENT

The opinion that Louisa Ovington was not ready to engage with psychotherapy concurred with the view of the staff from St Nicholas'. Psychologist 1 had described Louisa Ovington as being at the very early stages of a change process. She had not reached the point where active work could be done on her difficulties. Thus, she would simply have been unable to use psychotherapy. It appears that Louisa Ovington had made no progress in this direction during her time at Kneesworth House. This may simply be a reflection of the extensive amount of time that would have been required for this to happen, but the panel found no evidence in the notes from Kneesworth House of the use of any interventions to try to move her forward in this way.

It seemed inappropriate to the panel for Louisa Ovington's case to be passed over to such an inexperienced member of staff as the assistant psychologist, particularly given how "very walled off" Louisa Ovington was and how challenging she found the sessions to be.

Louisa Ovington completed a self-reported Personality Assessment Inventory (PAI) in what her then consultant psychiatrist subsequently described as an "almost provocative" way, denying for example that she had difficulties in controlling her impulses. The panel was told that the results of the PAI were interpreted by a clinical psychologist. The PAI conclusions noted her "substantially lower than typical interest in and motivation for treatment". The PAI also noted that diagnoses that should be considered included "psychoactive substance abuse" and "antisocial personality disorder". This was apparently the sole psychometric assessment of personality used as there are no other such assessments in the records.

COMMENT

The panel compared the PAI carried out at Kneesworth House with the results of the personality assessments that were carried out at the Tony White Unit and St Nicholas' Hospital. Her responses to the Millon Inventory when at the former were so biased that the results could not be safely interpreted. However, at St Nicholas' Hospital, the responses appeared frank and open and indicated problems with antisocial behaviour and borderline personality. She scored much higher on the behaviour and lifestyle components of the psychopathy checklists than she did on the internal personality and emotional factors. The psychologist at St Nicholas' Hospital told the panel that other information including observation of behaviour needs to be taken into account when drawing conclusions from such inventories.

Louisa Ovington's dramatically improved behaviour combined with the responses to the PAI is likely to have been what lay behind the conclusion at Kneesworth House that Louisa Ovington was not suffering from a psychopathic personality disorder. However, at Kneesworth House she was not in a stressful situation where her emotional control was likely to be challenged.

The final report from the psychology department was dated 20 January 2000. Whilst this was after Louisa Ovington had been discharged from Kneesworth House, it seems fair to accept that the assessment informed Consultant 11's conclusion that Louisa Ovington did not have a treatable personality disorder or mental illness. The report stated that "psychometrics did not indicate that she met the criteria for the diagnosis of a personality disorder". This statement appears to conflict with the conclusion within the PAI that antisocial personality disorder should be considered as a diagnosis.

The panel was unable to meet with the main author of the final report (Psychologist 2) but they did meet with the assistant psychologist who had worked with Louisa Ovington. She told the panel that she now (as a qualified clinical psychologist) does not regard the use of the PAI as very good practice. She said that she felt that the qualified psychologists (who did not work on the same ward) who interpreted the results should have thought more carefully about it. Her feeling about Louisa Ovington was despite the fact that she did not seem to score within the clinical range or high in levels of psychopathology, she was still very disturbed. She said that Louisa Ovington had worrying anti-social traits which "were not picked up enough on", particularly in relation to her previous offending behaviour and that her risk of violence was possibly not examined enough.

Consultant 9 told the panel that he would not use psychometric tests diagnostically; he would see their use being in confirming clinical opinion. In his view, clinical judgment would be of prime importance, not the psychometric test scores

The conclusion drawn by the psychology department was of particular significance given that the lack of a formal diagnosis of antisocial personality disorder was a fundamental part of what led Consultant 11 to discharge her from Kneesworth House.

The psychology department final report stated that Louisa Ovington might benefit from both a community based drug rehabilitation programme and psychodynamic psychotherapy, but noted that she strongly rejected the first and that the second would only be of benefit when she herself was interested and ready.

COMMENT

Given the severity of the impact on Louisa Ovington of her drug use prior to June 1998, her need to complete a drug rehabilitation programme and her unwillingness to do this in the community, the panel was surprised that Louisa Ovington was not further detained in hospital to permit this work to be carried out on an inpatient basis. Likewise, it appears remiss that she was discharged from hospital without having completed any work on the psychological issues that underlay all her difficulties. Consultant 11 commented to the panel about the difficulty of enforcing psychological treatments with an unwilling patient. However, she also told the panel that the knowledge that one will not be discharged from Section without completion of such work can be a motivating factor towards engagement.

Louisa Ovington was only at Kneesworth House for five months. Assistant Psychologist 2 told the panel it would take time to build up trust and breakthrough with someone who was apparently unable to engage in psychotherapy and Louisa Ovington was "particularly defended" against exploring any issues. As Assistant Psychologist 2 said, it would have been long-term work and she really could not say whether Louisa Ovington would have finally been able to engage in that work.

<u>Post Kneesworth House</u>

Louisa Ovington was discharged from Kneesworth House without any specific psychological support having been arranged for her in the community. Whilst Consultant 10's recommendation that she be provided with a long term "mentor" to provide a stable link while she struggled to re-position and re-socialise herself was probably not at the forefront of the clinical team's mind when she was discharged (he having made that comment some eight months earlier when she was at St Nicholas' Hospital) it was prescient. It took four months for anyone to engage with Louisa Ovington following her discharge and almost a year before there was any further thought of referring her for specific psychological help.

COMMENT

The panel noted that the forensic psychology services at Newcastle offered treatment to both inpatients and outpatients at this time. Psychologist 1 confirmed that it would have been potentially appropriate for these services to have been involved with Louisa Ovington on her return to the Newcastle area. However, no referral was made to that team.

In December 2000 Social Worker 4 noted amongst other issues that Louisa Ovington was confused about her feelings regarding her father. He offered to arrange counselling for her, but Louisa Ovington declined this input. Thus, it appears that her tendency to avoid dealing with difficult issues was continuing. In January 2001, however, Louisa Ovington told Social Worker 4 that she had been intending to ask to see a psychologist, but that she wanted to wait and discuss this further at a later date.

Louisa Ovington could have been in receipt of counselling either from a specific psychological therapies service or more generically from community psychiatric nurses. She was admitted to the Lambton Ward, Pierremont Unit at Darlington Memorial Hospital in February 2001, for four days and ten days following this admission Social Worker 4 received the discharge care plan report which indicated that the staff on the Pierremont Unit would be referring her for CPN support. This does not appear to have happened.

In April 2001, Social Worker 4 made further attempts to get psychological support for Louisa Ovington. It appeared to the panel remarkably difficult for him to get someone to refer her, as he kept being advised to discuss the matter with different people. It was unclear why he could not refer her to the psychology department himself. In the end he asked Louisa Ovington's GP to refer her to the Psychological Therapies Team (PTT). However, at the end of April 2001, he learnt that she was to be offered CPN input from the Barnfield Centre.

It appears that by June 2001 Louisa Ovington had still not seen a CPN (there was some argument about whether she fell into the catchment area for the Barnfield Centre) and Social Worker 4 was concerned that she continued to be extremely upset about issues to do with her mother's death. He said that she was very angry with herself and that she needed a great deal of help. He checked whether Louisa Ovington's GP had referred her to the PTT, but was told that the matter had been passed on to Consultant 15. He therefore discussed her with Cruse bereavement counselling service. They said that Louisa Ovington needed to refer herself to them – but once again, Louisa Ovington said that she would do this "when she was ready" and it appears that she never did so.

On 10 July 2001 Louisa Ovington attended a CPA meeting at which Consultant 5 was present and following this Consultant 5 referred her to Psychotherapist 1, consultant psychotherapist at the regional department of psychotherapy. However, the initial assessment form was sent to the wrong address, so was not completed by Louisa Ovington. A new form was sent out in January 2002 and Louisa Ovington was finally seen by Psychotherapist 1, in May 2002. During the intervening period, Louisa Ovington was referred to an anxiety management course.

Following his assessment of Louisa Ovington, Psychotherapist 1 wrote to Consultant 5 noting that there were major gaps in the history that he had gained and that he could only give a provisional view. However, he thought that there was "evidence of some residual personality disturbance". He also noted that "the assessment of patients who are subject to probation orders is never easy, as there are other agendas going on other than the wish for treatment". Given Louisa Ovington's expectations of symptom relief rather than in-depth exploration, he did not think that the sort of intensive therapy he offered would be appropriate. He suggested "basic psychological treatment on a symptomatic level".

Over the course of May 2002 to January 2006, Louisa Ovington was followed up in the community by several different care coordinators. She was not offered formal psychological treatment again. It was suggested to her GP, by a member of staff from the CRT that she might benefit from anger management. Some work on this was intended to be done at a later stage as part of a CRO, but there is no evidence from the records that it was. Social Worker 7 suggested to Staff Grade Psychiatrist 1 in October 2004 that Louisa Ovington would benefit from Dialectic Behaviour Therapy (DBT) given her diagnosis of severe personality disorder. This was in fact at a meeting in which Staff Grade Psychiatrist 1 had apparently expressed the opinion that having defaulted from two appointments, Louisa Ovington should be discharged from services. There is no evidence that he referred Louisa Ovington for DBT and thereafter there is no evidence of further consideration of psychological therapies.

COMMENT

Whilst the Kneesworth psychology department final report could be criticised in some respects, it was remarkably prophetic in its comments about the likelihood of Louisa Ovington engaging in psychotherapeutic work in the community. Her unwillingness to engage with in depth exploration of her difficulties would have made it extremely difficult, if not impossible, to work with her using a psychodynamic approach. However, she might have found dialectic behaviour therapy more acceptable and it is regrettable that this suggestion was not followed through.

Addictions services

The panel was informed that addiction services were mainly provided by three teams: ESMI (Easington Substance Misuse Initiative) which covered the Peterlee area; CAS (Community Addictions Service) which covered the Sedgefield District Council locality and NECA (the North East Council for Addictions). The first two services worked with clients on a practical and medical level to address their addictions, the third was a counselling service. Whilst there were addiction services in the area, the panel was told that they focussed mostly on opiate use and that alcohol services were more "thin on the ground". Thus, alcohol treatment was largely left to the care of general mental health services.

Louisa Ovington was apparently first seen by drug and alcohol services regarding her drug use when she was 15 or 16, although the panel has seen no contemporaneous records of this contact. She was referred to ESMI just prior to her first admission – but the panel again saw no records of this contact, if it did occur.

The issue of Louisa Ovington's substance misuse was not specifically addressed whilst she was at the Tony White Unit or at St Nicholas' Hospital, although its contribution to her difficulties was noted.

When she was at St Nicholas' hospital she was assessed by a psychologist from the Newcastle forensic adolescent service who noted that drug use was an issue, but that although she might respond to relapse-prevention work she had at that time little motivation to change. It was suggested that a motivational interviewing approach regarding drugs might be useful. Psychologist 1 (psychologist at St Nicholas') noted that Louisa Ovington related all her past difficulties to the abuse of illegal drugs. Consultant 10 (Psychiatrist from Rampton who assessed her at St Nicholas') described Louisa Ovington as a complex and quite profoundly disturbed individual. He felt that she required a period of treatment in a controlled setting until that was a satisfactory understanding of her emotional insecurity and instability and until there was adequate support to ensure that she did not take drugs. Otherwise, he felt that the consequences could be serious or indeed grave.

When Louisa Ovington moved on to Kneesworth House, she engaged in a psychology assessment process, but during this it was noted that although she clearly attributed all her difficulties to her substance misuse, she was "blithely convinced" she would have no difficulty avoiding drugs in the future. One to one psychology sessions and a drug and alcohol group were proposed to address Louisa Ovington's lack of relapse prevention strategies regarding illicit substance use. An inexperienced psychologist attempted to work with Louisa Ovington on this, but Louisa Ovington was apparently resistant and guarded and she avoided effectively doing this work. She did, however,

take part in several sessions of a women's substance misuse group. The assistant psychologist was planning to work on drug issues in future sessions after the Christmas break, but Louisa Ovington was discharged before this could take place.

The psychology department final report dated 20 January 2000 noted that Louisa Ovington's primary way of understanding all of her difficulties was "in terms of her drug use" – her coping strategy being to not use drugs again, as she had promised her uncle John before his death that she would give them up. The psychologists noted that external factors that appeared to have played a part in Louisa Ovington's psychotic breakdowns included her drug use, relationship instability, a drug using peer culture and a lack of purpose and direction in her life. However, the overall conclusion appears to have been that Louisa Ovington was "not ready" to engage in a community based drugs rehabilitation programme.

COMMENT

The impact of drugs on Louisa Ovington's mental health was clearly recognised by the staff at all three hospitals. Louisa Ovington was not willing to address this issue but attempts were made to work on it when she was at Kneesworth House. However, it was inappropriate to ask an unqualified, inexperienced, assistant psychologist to do this work with a reluctant, defended and resistant patient. Nonetheless, it does seem that Louisa Ovington did begin to engage with the process. Further work was planned, but this was prevented by her very abrupt discharge from hospital. Given that she was beginning to engage as an inpatient and the psychologists were clear that she was not ready to engage in a community based drugs rehabilitation programme, it appears very unfortunate that she was discharged at this point.

The panel noted that professionals were only concerned about Louisa Ovington's drug use at this time, not alcohol. This was understandable as, although alcohol contributed to the events that led up to Mr Hilton's death Louisa Ovington did not apparently have a problem with alcohol in 1999 / 2000.

At the CPA meeting held on 24 January 2000, following Louisa Ovington's discharge from Kneesworth House, it was agreed that Louisa Ovington would be referred to the community drug and alcohol team "if she required further support". Louisa Ovington did not wish to be referred to the drug and alcohol service at that time.

Within six months, Louisa Ovington was using drugs again: she told Social Worker 4 on 14 June 2000 that she was thinking of coming off drugs. Two weeks later she agreed that he could refer her to the Community Addictions Service, (CAS), this being the addictions service for the Sedgefield locality. She was then using over £30 of heroin a week. Prior to her first appointment with CAS she told Social Worker 4 that

she had "kicked the habit". She failed to keep the first couple of appointments with CAS, but was finally seen in October 2000.

COMMENT

CAS 1 told the panel that CAS would attempt to engage with patients by sending out letters to them offering them further appointments if they failed to attend. However, if the patient failed to attend twice and did not respond to the letters, then they would be discharged. The "door" would be left open for them to re-refer themselves to CAS if they so wished.

CAS 1 set up a community based heroin withdrawal programme for Louisa Ovington. She also referred her to Orbit 20, a community support agency. Whilst she did not meet up with Social Worker 4, she did communicate with him by telephone and when she had concerns regarding Louisa Ovington's mental state she alerted him to this, suggesting for example that it might be helpful for a CPN to be involved. She saw her role as that of a nurse purely treating drug addiction. She told the panel that she assumed that Louisa Ovington was working on her early life experiences with other people, such as her care coordinator, Social Worker 4.

COMMENT

CAS 1 told the panel that CAS did not follow the CPA, or carry out formal risk assessments, at this time. Nonetheless, she appears to have worked reasonably closely with Social Worker 4. She was invited to attend a CPA meeting in January 2001, but she was unable to attend this and the meeting was cancelled. The panel recognises that it can be difficult to arrange CPA meetings involving professionals from different agencies, but such meetings are important particularly when numerous agencies are involved and when professionals are assuming very demarcated roles.

Louisa Ovington was supported by workers from CAS until February 2001. At this point, she had apparently been drug free for two months and urinalysis was negative for opiates. However, excessive alcohol consumption was becoming a problem; at the New Year she had been remanded in custody by the police after "running around with a knife" under the influence of alcohol. Furthermore, she told Social Worker 4 on 24 January 2001 that she was using alcohol as a substitute for drugs. Nonetheless, CAS 1 felt that Louisa Ovington was aware of the risks of excessive use of alcohol and she discharged her from CAS on 7 February 2001.

COMMENT

CAS 1 told the panel that during 2000, Louisa Ovington did not report that alcohol was a problem to her. However, she acknowledged that as the panel had been informed by the expert witness Dr E. Gilvarry, it is quite common for people who have been addicted to drugs to develop problems with alcohol when they cease using drugs.

Professionals working with Louisa Ovington appeared to be aware that Louisa Ovington was, at least intermittently, drinking to excess during 2001 to 2003, but she was not referred back to addictions services until the end of 2003. She admitted to Consultant 14 on 9 August 2001 that she was drinking two bottles of wine per night and that she was losing her temper. He gave her the number so she could contact the addictions services – but it appears that she did not do this. On 14 November 2001, Louisa Ovington told Social Worker 4 that she was drinking "a small amount of alcohol" but he suspected that she was drinking more than she was admitting to. In April 2002 she admitted to the "occasional blow out" at weekends. In March 2003, following the transfer of her care from Social Worker 4 to Social Worker 5, she admitted to drinking excessively and quarrelling a lot with Mr Hilton and in October that year she told Social Worker 5 that her relationship problems with Mr Hilton were being exacerbated by her occasional excessive alcohol consumption. However, she said she did not want help with this. She saw Staff Grade Psychiatrist 1 shortly afterwards, told him she was consuming 30 units of alcohol per week and accepted a referral to the Peterlee locality addictions service: Easington Substance Misuse Initiative (ESMI).

Louisa Ovington attended an appointment with CAS 2 from ESMI in December 2003. During the initial assessment session, CAS 2 noted Louisa Ovington's forensic history: theft, harassment, threatening behaviour and assault occasioning actual bodily harm on a nurse and she recorded in the brief risk assessment the history of aggression. Louisa Ovington admitted to her that she was drinking at least 63 units per week. She said she did not want to achieve abstinence, but she wanted to control her drinking. She attended two further appointments, but thereafter failed to attend despite having booked three of four of them herself. CAS 2 wrote to her in March 2004, to ask if she wanted another appointment. Louisa Ovington did not respond. At around this time, Louisa Ovington attended an appointment with Staff Grade Psychiatrist 1 and admitted that she was still abusing alcohol, consuming 30 units a week just in weekend binges. Staff Grade Psychiatrist 1 wrote to CAS 2 informing her of this.

On 10 May 2004 Louisa Ovington presented to casualty in an aggressive and intoxicated state. She was admitted and underwent an alcohol detoxification process. She self-discharged five days later. During this brief admission, CAS 2 discharged

her, because she had never had a response to the letters she sent Louisa Ovington in March 2004. Louisa Ovington's GP was concerned that Louisa Ovington had been discharged by CAS 2 and wrote to her, asking her to reconsider it. However, by this time CAS 2 had left the service. Following her discharge from hospital, Louisa Ovington attended at a CPA meeting during which she stated that alcohol was her main problem, that she had problems with her temper which she was unable to control and that she got aggressive at times towards her partner. It was agreed at the CPA meeting that she needed education regarding substance misuse, which should be provided by staff from ESMI. This did not happen.

COMMENT

During these three years, Louisa Ovington continued to only briefly acknowledge having any difficulties. However, it is evident that her alcohol consumption was already associated with aggressive behaviour and that it was exacerbating the difficulties in her relationship with Mr Hilton.

Whilst CAS 2 did complete a very brief risk assessment, it appeared to the panel that she was not engaged with the CPA process and she acknowledged to the panel she had no contact at all with Louisa Ovington's care coordinator. She said that her remit working with ESMI was just to look at the drug and alcohol problems. Like CAS 1 she said that staff would have assumed that the issues to do with Louisa Ovington's past would have been dealt with by others. This appears to be an issue either of poor care coordination, in that the different professionals working with Louisa Ovington did not know what each other was doing, or of there being too many separate specialist services (counselling for addictions being done separately with NECA from both ESMI and CAS).

CAS 2 told the panel that the role of ESMI was to try to engage patients within their service and to manage reduction or abstinence programmes. As she said, however, they did not try to "force programmes" onto people, so if patients did not keep appointments it would be assumed that at that point in life that person didn't want to go further forward regarding the programme. However, the "door would be left open for patients to return in the future if they so wished. But in this particular case more assertive attempts at engagement by staff would have been helpful given Louisa Ovington's longstanding reluctance to be involved with services and the previous assessments that had identified the role of drug use in her mental health difficulties.

Louisa Ovington had no further input from specific addiction services after May 2004. However, it seems that there was some reluctance from other mental health services to be involved with her because they considered her primary diagnosis to be that of alcohol dependency. Staff Grade Psychiatrist 1 apparently told CRT 1 from the CRT

that Louisa Ovington had been assessed as having a primary diagnosis of alcohol dependency and not having mental health problems.

Louisa Ovington continued to drink to excess, but, as is set out elsewhere in this report, came more to the attention of the criminal justice system than mental health services. In October 2004 she was made subject to a CRO which included a requirement of completion of an alcohol awareness course. Nonetheless she continued to drink to excess, to the extent that she was remanded in prison in November 2004 having been drunk and disorderly and broken a curfew. It is not clear from the probation records what, if any, work was done with Louisa Ovington in relation to alcohol: the CRO was difficult to manage as Louisa Ovington was moving from area to area (see chapter five for details).

Mental health staff remained aware of the difficulties that Louisa Ovington had with alcohol. In January 2005 her care coordinator noted that "Louisa Ovington is a vulnerable young woman who when she drinks can be quite aggressive." In March 2005 Louisa Ovington acknowledged to Staff Grade Psychiatrist 1 that her "big problem" was alcohol. However, in June 2005 Louisa Ovington and her care coordinator, Social Worker 7, completed a referral form to the Fenwick Centre (a support centre) in which they stated that Louisa Ovington's alcohol abuse problems were historic and not current and that she had no predisposition towards aggression or violence. In November 2005, Social Worker 7 handed over her care coordination role to CPN 2. She carried out a risk assessment in which she noted Louisa Ovington's historic drug and alcohol use and she commented under the section symptoms and signs suggestive of potential risk or relapse: "Alcohol abuse. Louisa Ovington can become aggressive when under the influence of substances and alcohol. Alcohol consumption increases."

On 21 November 2005 CPN 2 visited Louisa Ovington at home and noted that she had been drinking over the previous weekend and that she had fallen out with Mr Hilton at that time. She had further contact with her over the course of the following month, at which times she made no comment in the notes regarding Louisa Ovington's alcohol consumption. Her final meeting with Louisa Ovington prior to Mr Hilton's death was on 20 December 2005 when Louisa Ovington talked about her feelings for Mr Hilton and the breakdown of their relationship. Again, there was no reference to her use of alcohol in the records regarding this meeting.

On the 8 January 2006, when Louisa Ovington killed Mr Hilton, there was evidence that a considerable amount of alcohol had been consumed by both of them.

COMMENT

In the almost two years leading up to Mr Hilton's death, despite continuing problems resulting from Louisa Ovington's alcohol misuse, Louisa Ovington was not involved with specific mental health addiction services. This may have been in part because she was thought to be doing an alcohol awareness course as part of her CRO. It may also have been in part because of her disinclination to address this issue. However, this will not have been assisted by the willingness of staff to minimise the ongoing problems. Staff should have tried to address her motivation for treatment (generic mental health staff should have an awareness of basis motivational interviewing) and should have closely monitored her alcohol consumption particularly in view of it's (in her case) acknowledged association with aggression.

Chapter 3 – Outline of mental illness and personality disorder

There are three main categories of mental disorder: mental illness, personality disorders and learning difficulties. The disorders are defined and diagnosed, on the basis of the existence of specific clusters of symptoms. However, symptoms and signs of ill health are subjective: experienced, described and interpreted according to the bias of the patient and / or the clinician. There are very few symptoms that are pathognomonic of (i.e. relate just to) particular diagnoses: individual symptoms are common to numerous disorders and thus it is the existence of particular clusters and numbers of symptoms that is important. In addition, disorders evolve over time both in terms of their natural history (for example, psychotic symptoms becoming less pronounced in chronic schizophrenia) and in terms of the understanding of the individual and their clinician as to what the person is experiencing. It is, therefore, quite common for a person's diagnostic "label" to change over time.

Diagnosis informs management. The natures of specific mental disorders are well known and the risk factors, life histories, likely responses to treatment and prognoses are therefore reasonably predictable. Mental illnesses, such as post traumatic stress disorder, bipolar affective disorder and schizophrenia are easier to diagnose than personality disorders: in lay terms, persons suffering from such conditions are more clearly "mentally ill" than persons with personality disorders, because personality characteristics are present in all people, whereas symptoms such as hallucinations and delusions are not the norm.

An individual's personality dictates their characteristic lifestyle and mode of relating to themselves and others. These behaviour patterns tend to be deeply ingrained and enduring. A person with a personality disorder shows extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. The behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance. Personality disorders have historically been regarded as innate and untreatable. They cannot be "cured" by treatment with medication. It is only over recent years that specific psychological tests have been created to formalise the diagnosis of the disorders and that effective psychological therapies such as dialectical behaviour therapy and cognitive behaviour therapy have been developed.

Historically, there was a hierarchy of diagnoses within psychiatric practice. Within this system, mental illnesses were regarded as more significant and worthy of investment than personality disorders, in terms of provision of resources for management, treatment and research. The diagnosis of personality disorder was effectively seen as a diagnosis of exclusion: patients with such diagnoses were seen as untreatable and

beyond the remit of general psychiatric services. This contention has been challenged over recent years, particularly since the publication of "Personality disorder – No longer a diagnosis of exclusion" by the Department of Health in 2003. This document provided guidance on the identification, assessment and treatment of personality disorder within general mental health and forensic services and aimed to ensure that people with personality disorder, who experience significant distress or difficulty as a result of this, were acknowledged to be part of the legitimate business of mental health services.

Louisa Ovington first came into contact with mental health services in 1993, when, aged 15 years, she was assessed by Consultant 1. She found no evidence that Louisa Ovington was suffering from a mental illness, such as post traumatic stress disorder which could have been expected given Louisa Ovington's past history. Consultant 1 also considered whether Louisa Ovington had a conduct disorder. Psychiatrists tend not to diagnose children and adolescents as suffering from personality disorders, because the patterns of behaviour that characterise people with personality disorders are "longstanding and deeply entrenched" – which cannot be said to be the case until adulthood. However, the behaviours exhibited by persons diagnosed in adulthood as suffering from antisocial personality disorders usually begin in childhood and these children are often diagnosed as suffering from a conduct disorder. (The corollary is not true: not all children with conduct disorders go on to develop antisocial personality disorders).

Consultant 1's opinion was that Louisa Ovington did not suffer from a conduct disorder. Over the ensuing years, Louisa Ovington's mental health was repeatedly re-evaluated by the different psychiatrists with whom she came into contact. There was considerable debate about whether she was suffering from a mental illness, from a personality disorder, or from both. Between 1995 and 1999, when she was admitted to Hartlepool General Hospital three times and to the Royal Edinburgh Hospital once, the professionals were trying to determine whether or not her psychotic symptoms were due to her misuse of illicit substances or to her suffering from an enduring illness such as schizophrenia. However, during her more protracted admissions to the Tony White Unit at the Durham County Hospital and Cuthbert Ward at St Nicholas' Hospital, Newcastle, the professionals became increasingly convinced that whilst Louisa Ovington might at times suffer from psychotic symptoms (whether induced by an illness or by the use of illicit substances) her fundamental mental disorder was a personality disorder.

Louisa Ovington was transferred to Kneesworth House Hospital for treatment of her personality disorder. However, she underwent a further series of psychological assessments there, the conclusion of which was that the degree of her personality traits was insufficient to define her as suffering from a personality disorder. In addition,

the Kneesworth House team stated that in their opinion Louisa Ovington was not at that time suffering from a mental illness. In consequence, the clinical team that became responsible for her care following her discharge from Kneesworth House was left uncertain as to her diagnosis: despite her evident serious mental health issues, Louisa Ovington had no formal diagnosis of any mental disorder.

Whilst Louisa Ovington was not given a formal label of personality disorder, a review of her life history, both before and after her admission to medium secure hospitals, shows that she fitted the profile of someone with this type of problem. Thus, she presented immense challenges to the services around her. She was in increasing contact with mental health, social services, A&E, GPs and the criminal justice system. She abused drugs and alcohol; she had interpersonal problems that included violence; she experienced symptoms of anxiety and depression and she had brief psychotic episodes.

COMMENT

It is extremely difficult to work with people that present with these types of problems. The Department of Health document of 2003, "Personality disorder – No longer a diagnosis of exclusion" describes the marginalised service that many people with personality disorders received at that time. It talks of them being treated through A&E and through inappropriate admissions to inpatient psychiatric wards. It describes how these people were on the caseloads of community team staff who were likely to prioritise the needs of other clients over them and who might lack the skills to work with them. It stated that many clinicians and mental health practitioners were reluctant to work with people with personality disorder because they believed that they did not have the skills, training or resources to provide an adequate service and because they believed there was nothing that mental health services could offer. Unfortunately, this description of services appears to have been an all too accurate depiction of some of the mental health services in the Hartlepool area that were involved with Louisa Ovington between 2000 and 2005.

Chapter 4 – The Care Programme Approach (CPA)

After consideration of the voluminous documentation available to the panel and after hearing from many witnesses, the panel's view is that the effective operation of the CPA was absolutely fundamental, perhaps the most fundamental factor in the health care and treatment of Louisa Ovington and for that reason has been dealt with in this separate chapter, which describes the legislative requirements of the CPA and how they impacted on the direct care arrangements for Louisa Ovington.

Policy context

In 1990, the Department of Health issued Health Circular (HC (90)23) entitled:

'The Care Programme Approach (CPA) for people with a mental illness referred to the specialised psychiatric services'

The CPA was introduced as a response to concerns regarding the quality of care being provided to those with mental illness who were being cared for under care in the community arrangements and followed on from a number of serious incidents where the care appeared to fall short of the standards required.

It was intended to provide a framework for effective mental health care and applied to all who came into contact with the secondary mental health services.

Its five main elements were:

- Systematic arrangements for assessing the health and social are needs of people accepted into the specialist mental health services;
- Formulation of care plans which identified the health and social are required for the patient from a variety of providers;
- A minimum, medium or complex care approach level, depending on need;
- The appointment of a key worker to coordinate care;
- Regular review and, where required, revision of care plans.

However, there was general recognition throughout England, that the application of CPA was too bureaucratic and that there was a reluctance to engage with the process.

In an attempt to simplify matters and to bring together the key elements of the health led CPA and the social care led 'care management', the NHS Executive and the Social Services Inspectorate issued new guidance in 1999 entitled 'Effective Care Coordination in Mental Health Services - Modernising the Care Programme Approach'.

The 1999 revised 'CPA' saw the introduction of two levels rather than the previous three and these were described as 'Standard' and 'Enhanced'.

A care coordinator would be identified who would pull together all aspects of care and there was to be an emphasis on recognising the needs of carers subsequent to the Carers (Recognition & Services) Act 1995. The guidance clearly illustrates that it is critical that the care coordinator has the *authority* to coordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency or origin.

An emphasis was also placed on risk assessment and management. Risk assessment is an essential and ongoing part of the CPA process. Care plans for severely mentally ill service users should include an urgent follow up within one week of hospital discharge. Care plans for all those requiring enhanced CPA should include a 'what to do in a crisis' and a contingency plan. It goes on to say that where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements including ongoing risk assessment are essential.

In respect of care plans and reviews, the 1999 guidance states:

- Good practice dictates a move towards more integrated operational practice. Integrated records are an example of such practice. The maintenance of shared records will further reduce unnecessary form filling and bureaucracy will improve communication and, most importantly, will contribute to a streamlined care process to the advantage of the service user and provider;

- There is no longer a requirement for a nationally determined review period of six months for care plans. Review and evaluation of the service user's care plan should be ongoing. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer must also be able to ask for reviews at any time. All requests for a review of the care plan must be considered by the care team. If the team decides that a review is not necessary the reasons for this must be recorded. The annual audit of CPA should check that reviews of the care plan have been carried out;

To reduce risk, the plan as a minimum, should include the following information:

1. Who the service user is most responsive to;

2. How to contact that person and;

3. Previous strategies which have been successful in engaging the service user.

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

The guidance goes on to illustrate what is regarded as a 'whole systems approach' to mental health care and states that all mental health service users have a range of needs which no one treatment service or agency can meet. Having a system which allows a service user access to the most relevant response is essential - getting people to the right place for the right intervention at the right time.

This principle is, of course, particularly important in the case of individuals who need the support of a number of agencies and services and there are some who, as well as their mental health problem, will have a learning disability or a drug/alcohol problem. In all these cases a coordinated approach from the relevant agencies is essential to efficient and effective care delivery.

Effective care coordination should facilitate access for individual service users to the full range of community supports that they need in order to promote their recovery and integration. It is particularly important to provide assistance with housing, education, employment and leisure and to establish appropriate links with the criminal justice agencies and the Benefits Agency.

Care Programme Approach in respect of Louisa Ovington

Louisa Ovington was first admitted as an inpatient in December 1995 and subsequently detained under Section 3 of the Mental Health Act. This was the start of a long and challenging journey through the specialist mental health services and during this involvement she was quite correctly subject to CPA. At the time of her first admission there were three levels of CPA: simple, complex and multidisciplinary. (When CPA was first revised in 1999 this was changed to two levels: standard and enhanced and changed again in 2008 to one level, simply known as CPA). At a care planning meeting in February 1996 Louisa Ovington was assigned a CPN as her key worker (who remained in this role during 1996 and 1997) but it is unclear from the records which level of CPA was applied. She was discharged from inpatient care on 13th March 1996 and followed up in the community.

On 12 December 1996 Louisa Ovington was admitted to Hartlepool General Hospital and a 'client centred care plan' was drawn up on admission. She remained an inpatient for four weeks and a care planning meeting was held on 20 December 1996. She was discharged on 10 January 1997 after it was discovered she had been taking illicit drugs and was followed up at outpatient clinics but was subsequently readmitted to Hartlepool General Hospital on 6 March 1997 at the recommendation of her key worker. She was in hospital for one night and she was discharged with community follow up. At this time Louisa Ovington returned to Edinburgh and in her absence a CPA meeting was held on 22 April 1997 attended by her great uncle, key worker and CPA manager. It was at this meeting that her key worker announced she was leaving and would need to be replaced.

From 20 May 1997 Louisa Ovington had a ten day inpatient stay at the Royal Edinburgh Hospital. She had already been discharged from community services in Hartlepool/Durham and the CPA manager wrote to Edinburgh Royal to let them know this and that Louisa Ovington was on 'Full CPA' which appears to be the local description of multidisciplinary CPA, the highest level.

Louisa Ovington returned to the north east in about June 1997 and resided with her great uncle. Outpatient appointments were arranged in Edinburgh which she failed to attend but she did attend outpatient appointments with Consultant 6 from July to October 1997 and during this period she also saw CPN 1 as her key worker. There was little subsequent health or social care involvement, CPN 1 having discharged her, until May 1998, when she was assessed by Consultant 8 following a referral from Low Newton prison. Consultant 8 reviewed her several times and she was admitted to the Tony White Unit in Durham. While she remained there several care planning meetings and reviews were held, including a Section 117 meeting. A mental health social worker, Social Worker 1, had contact with Louisa Ovington throughout this period but her role in terms of the CPA is unclear.

Transfer to a forensic unit in Newcastle (Cuthbert Ward, St Nicholas' Hospital) took place in January 1999 and she remained on 'full CPA'. Several CPA / multidisciplinary team meetings took place during her stay on Cuthbert Ward; numerous care plan reviews were undertaken and she was visited by her social worker/key worker, Social Worker 2, from the community team. Louisa Ovington was transferred on to Kneesworth House in Hertfordshire on 16 August 1999.

Louisa Ovington remained at Kneesworth House until 12 January 2000 and during her time there, meetings were held to devise and review care plans. Although there is some evidence from the Durham records that there was communication between the staff and Social Worker 2 the Kneesworth records contain no social work notes. A CPA/Section 117 meeting was not held until 24 January 2000, twelve days after her

discharge. It was held in Durham and attended in addition by representatives from Kneesworth House. A full discharge summary and final CPA document was sent to Consultant 9 on 31st January 2000. At this time Louisa Ovington's key worker/care coordinator was still Social Worker 2.

The discharge planning process appeared untimely, ill prepared and not consistent with the principles of good practice embedded within the CPA. The evidence suggests that the timing of the discharge was linked only to the expiry of the Section 38 rather than informed clinical practice.

It is noted from the records that Team Manager 1, community team manager in Easington was concerned about Louisa Ovington's offending history, including threats to kill. He felt that good practice meant that a joint multidisciplinary meeting should be held prior to Louisa Ovington's appearance in court on 12 January. (In addition he was concerned that the Code of Practice to the Mental Health Act required such a meeting to consider the after care to be provided under Section 117 of the Act.) He spoke to Newton Aycliffe CID who informed him of Louisa Ovington's previous convictions. He also considered whether public protection procedures should be implemented if Louisa Ovington returned to the area.

The CPA meeting held on 24 January 2000 did result in a care plan being produced setting out contingencies. Reasonably clear guidance was produced for action by the community team but there is no evidence that this was pursued. The key worker was Social Worker 2 who did not visit Louisa Ovington throughout the subsequent three months. On 26 April 2000, she wrote to the community team in Spennymoor, copied to Consultant 12 and the CPA office at Bishop Auckland, attaching the minutes of the CPA/Section 117 meeting held on 24 January. This stated that Louisa Ovington had moved to an unknown address and that Social Worker 2 would be leaving and could not be immediately replaced due to staff shortages. The letter also said that her cousin (with whom Louisa Ovington was living, along with the cousin's partner Mr Hilton) had discovered that Louisa Ovington and Mr Hilton were having an affair and that Louisa Ovington had been asked to leave their home on 17 April 2000.

On 27 April 2000 there was a change of care coordinator, which proved significant for Louisa Ovington's care, when Social Worker 2 handed over to Social Worker 4. He immediately attempted to contact Louisa Ovington and on 13 June undertook a full needs assessment. In a care plan review of 16 June 2000 it was noted that Louisa Ovington required monitoring of her mental health and social work input. Social Worker 4 engaged in this role.

Following a series of missed outpatient appointments Louisa Ovington was discharged by her psychiatrist in June 2000 but followed up by Social Worker 4. A CPA meeting

was held on 5 December 2000 to coordinate her care package. At this time Louisa Ovington was also being seen by the community addictions team. She told her care coordinator that she was unhappy with her housing, confused regarding her feelings about her father and that her relationship with her boyfriend appeared to be deteriorating.

Social Worker 4 arranged a CPA meeting on 8 January 2001 but it did not take place as neither the GP nor the community addictions worker could attend. However, he met with Louisa Ovington the following day and a care plan appropriate for her needs was drawn up.

On 1 February 2001 Louisa Ovington was admitted to Darlington Memorial Hospital following an attempt at cutting her wrists. She was discharged on 5 February and a CPA/Section 117 document was completed on 6 February 2001. Consultant 15 completed a risk assessment document on 8 February 2001 and probation, as part of a pre-sentence report in connection with an offence of possession of an offensive weapon, also completed one on 11 February 2001 which noted a high risk of dangerousness and reoffending.

Social Worker 4 continued to follow her up and noted that she had replaced drugs with alcohol consumption. Louisa Ovington agreed to a request from Social Worker 4 that she be referred to a psychiatrist. (It seems surprising that she had not continued with support from a psychiatrist after discharge from Darlington Memorial Hospital.) On 14 February 2001, Social Worker 4 received the discharge summary from Darlington Memorial Hospital which recommended that Louisa Ovington should be referred to community psychiatric nurses. Social Worker 4 agreed to pursue this. At the beginning of March 2001 Louisa Ovington registered with a new GP.
On 10 April 2001 Social Worker 4 wrote to the GP requesting that Louisa Ovington be referred to psychological services. He responded by referring Louisa Ovington to Consultant 15 instead of psychological services.

During 2001 Louisa Ovington had a great deal of involvement with the criminal justice system, but not apparently with health/social care. Her care coordinator however was concerned about her deteriorating mental health and arranged a CPA meeting in July. He felt that Louisa Ovington needed urgent psychiatric treatment. At this point Social Worker 4 was informed that Consultant 5 would be the psychiatrist with responsibility for Louisa Ovington. On 2 August 2001 her GP received a letter from on behalf of Consultant 15 discharging Louisa Ovington from his care.

During October 2001 there was confusion about the identity of Louisa Ovington's consultant. She was seeing Consultant 5 at Darlington Memorial Hospital, but also apparently Consultant 14 at Peterlee health centre. Louisa Ovington was also referred

at this time to a psychotherapist, Psychotherapist 1 but due to mislaid forms, the appointment did not take place until early 2002.

Louisa Ovington was noted to be under the care of Consultant 13 in January 2002 as Consultant 14 had left the area[83]. A care plan dated 18.February 2002 notes that there had been/would be referrals to the drug and alcohol services 'as and when required', referral to psychotherapy and general monitoring. (Psychotherapist 1 reported in June 2002 that Louisa Ovington would not be suitable for psychotherapy.)

In December 2002 Social Worker 4 felt that Louisa Ovington had been stable for an extended period of time and he should transfer her to the local community mental health team. A CPA meeting was planned for 23 January 2003 but had to be cancelled. The handover of care took place on 27 January 2003 when Social Worker 5 advised Social Worker 4 that she was becoming Louisa Ovington's care coordinator. Social Worker 4 visited Louisa Ovington on 28 January 2003 to inform her.

A joint visit with Social Worker 4 and Social Worker 5 took place on 10 February 2003 to meet Louisa Ovington. Social Worker 5 visited Louisa Ovington on 13 March 2003 and it was agreed that visits would occur six weekly with Louisa Ovington being able to contact her at any time in between should the need arise. There were no major events during the remainder of 2003, although Louisa Ovington continued to drink excessively, was seen by ESMI and suffered spells of depression and premenstrual tension.

On 26 February 2004 Social Worker 5 discharged Louisa Ovington as she was leaving the area. The care coordinator recorded that Louisa Ovington "agreed" that she did not need further input from the "team". The case was closed to social services but was "still open to the CMHT" and care coordination was transferred to Consultant 2, without apparently any consultation with him. There was no evidence of planning or discussions around this handover of care.

COMMENT

As is detailed in the narrative in chapter 1 and elsewhere in this report, 2004 marked a period of increasingly chaotic and turbulent behaviour in Louisa Ovington's life, with extensive police and probation involvement and the intervention from time to time of the CRT. The details are not repeated here. From February 2004 to August 2004 there was no care coordinator allocated from the CMHT- it appears that either Consultant 2 or Staff Grade Psychiatrist 1 took the formal role.

On 10 May 2004 Louisa Ovington was admitted to the University Hospital of Hartlepool following a visit to A&E. Staff Grade Psychiatrist 1, care coordinator at the

[83] *The issue of large number of doctors apparently involved with Louisa Ovington and the problems with the provision of psychiatrists in this area is dealt with at other points in this report.*

time, drew up a CPA document which outlined the need to monitor her mental health and educate her about substance misuse. It also recorded that Easington CRT should be involved. Louisa Ovington remained on the ward until 15 May 2004 during which time she had alcohol detoxication and was interviewed regarding an alleged rape.

Following a particularly tumultuous few months, Team Manager 2, CRT manager, wrote on 9 August 2004, to Staff Grade Psychiatrist 1 asking for a case conference involving the police and all relevant parties so as to create a joint management plan. This did not happen.

On 16 August 2004 Team Manager 3, of the CMHT passed the case to Social Worker 7, who then became Louisa Ovington's care coordinator.

On 22 September 2004 Team Manager 2 wrote to Social Worker 7 to reiterate the need to develop a joint management plan in relation to Louisa Ovington's continued contacts with the criminal justice system and to say he hoped this would be agreed and clearly recorded at the CPA meeting that he understood had been arranged for 5 October 2004. The meeting subsequently took place on 5 October 2004 and it was recognised that there was a major issue with Louisa Ovington's disengagement with services. It was recorded that "it would be impossible to prepare a management plan for Louisa Ovington unless she engages with the services and has a firm address in the Easington District". Social Worker 7, her Care Coordinator stressed that "communication lines must be kept open and consideration needs to be given to whether a public protection meeting should be called, which would include the police, given Louisa Ovington's potential risk to herself and others." It was also agreed at this meeting to refer Louisa Ovington to forensic services but this was never done.

Social Worker 7 discussed Louisa Ovington at the team meeting on 12 October 2004 and as she (Louisa Ovington) had just transferred from Peterlee to Hartlepool Probation Service, Social Worker 7 took the opportunity of raising the issue of a public protection meeting. Probation responded that they did not think a public protection meeting was necessary and recommended a multi-agency meeting instead.

On 2 November 2004 Louisa Ovington failed to attend a meeting with Staff Grade Psychiatrist 1. He requested that the team consider whether she should be discharged from services due to lack of engagement. On 23 November 2004 he wrote to Louisa Ovington's GP stating that he had offered Louisa Ovington three appointments which she failed to keep and it was decided in the community team meeting that she be discharged from their care.

Social Worker 7 completed a progress assessment on 1 January 2005 and noted that Louisa Ovington was a "vulnerable young woman who when she drinks can be quite

aggressive. She cannot control her anger and has been in violent relationships. When stabilised on medication and without alcohol, she can be pleasant and engages well with support staff."

Social Worker 7 prepared a care plan on 22 March 2005 which noted that Louisa Ovington was on 'enhanced' CPA and outlined the current management arrangements. Social Worker 7 also prepared a practitioner progress chart which offered a 'global' view of Louisa Ovington's current position. The remainder of 2005 was relatively uneventful.

The role of care coordinator changed from Social Worker 7 to CPN 2, on 9 November 2005 and Louisa Ovington attended an outpatient appointment with Staff Grade Psychiatrist 1 on 10 November. A care plan was prepared on 20 November 2005 which was jointly signed by Louisa Ovington and CPN 2. The essential components of this plan included:

- Monitoring of mental health through attendance at outpatient appointments and fortnightly visits from CPN 2;
- Assistance with appropriate housing;
- Provision of meaningful day activities (looking at training and voluntary work options);
- Reduction of aggressive behaviour;
- Assistance with financial affairs.

CPN 2 also completed a risk assessment at this stage which outlined many of the issues affecting Louisa Ovington. It was notable however that the relationship with Mr Hilton was not referred to and this may have been due to CPN 2's lack of in depth knowledge of the case at that stage.

No events of note occurred between this time and the 8 January 2006, the day on which Louisa Ovington killed Mr Hilton

Summary

The CPA when applied properly can be an effective process to assist health and social care staff assess, plan, implement, monitor and evaluate care given to those under the care of the secondary mental health services.

The essence of CPA is to ensure care coordination, which put simply, should prevent those with greatest need from falling through the net of available services. This is particularly important where geography is an issue or in major cities where services can often be fragmented across boroughs or districts. When someone who has a mental illness that requires enhanced levels of care chooses to move localities, this can present major problems for service providers and in the case of Louisa Ovington this presented a significant challenge.

The role of care coordinator was created to ensure that a professional with appropriate knowledge and skills maintained oversight of those under their care. This is not to say that the care coordinator must be *involved* in all aspects of care, but that he or she should have an ongoing awareness of *who is doing what to whom where* and that those who are involved in the care are appropriately informed, including of course the service user and their carers. This should be implemented through the establishment of regular CPA meetings where care is planned and reviewed and the distribution of care plans through written or electronic means. Due to the complexities of coordination and the time involved it is expected that those on enhanced CPA will *not* be care coordinated by medical staff, (but this is an option for those on standard CPA whose needs are less).

This role is assisted in each mental health trust by the provision of a CPA department, headed by a manager who should ensure that CPA is properly functioning, staff are appropriately trained, policies and updated guidance are available, regular audit is undertaken and care plans are regularly reviewed.

COMMENT

It is clear from the evidence received by the panel that Louisa Ovington's movements since she first came into contact with the mental health services have presented a challenge to the staff responsible for providing her care. This challenge has been made more difficult as a result of the major organisational changes resulting from national policy guidance and local mergers of mental health services and has placed a greater responsibility on local managers and practitioners to ensure smooth transition and continuity of care.

It is also clear from the evidence that this worked well on occasions but on others it left much to be desired. The movement of Louisa Ovington between localities and teams was not well coordinated and where robust care plans and transfer documentation should have been in place, there was in fact little evidence of this. This was clearly illustrated in the poor discharge planning arrangements when Louisa Ovington was at Kneesworth House and later on, the relatively poor joint working and communication between the CRT and the CMHT. Similarly, it was recognised that Louisa Ovington was a challenge to the specialist teams and her level of

dangerousness was noted. There was however, a general absence of sensible risk management and the application of recognised techniques to ensure engagement. This is particularly evident in the lack of effort made by psychiatrists to engage Louisa Ovington in structured treatment programmes.

There are instances where good work was undertaken, particularly when Louisa Ovington's care was coordinated by Social Worker 4 and then, Social Worker 7. A great deal of effort was made to identify and plan for Louisa Ovington's needs, especially housing and training/employment. Realistic attempts were also made to reduce dependence on illicit substances, but in the time leading up to the offence, it appears that Louisa Ovington was increasing her dependence on alcohol and there was little success in resolving this problem.

Considering that Louisa Ovington was subject to enhanced CPA during the majority of the time she was involved with mental health services, the panel was concerned about the paucity of written evidence of the use of the CPA in the records generally and disappointed that there was no evidence from the CPA office indicating that they had ensured that the programme was properly monitored and regular reviews held and recorded.

These issues are addressed in greater detail elsewhere in the report and appropriate recommendations are outlined in the relevant paragraphs.

Chapter 5 – Involvement with police and probation

Note: there are several references in this report to MAPPA (Multi Agency Public Protection Arrangements). It is a matter of great significance that in the case of Louisa Ovington, MAPPA was never invoked. The following, as an introduction to this chapter, should serve as a necessarily brief outline of the MAPPA process.

MAPPA

The Criminal Justice and Court Services Act 2000 introduced a framework known as Multi-Agency Public Protection Arrangements (MAPPA), under which a duty was placed on the police and probation services (collectively known as 'The Responsible Authority") to work together to protect the public from convicted dangerous, violent and sexual offenders living within the community.

The Criminal Justice Act 2003 extended the duty to the prison service, who then became the Responsible Authority jointly with the police and probation services. In addition to the duty on the Responsible Authority, this Act placed on various agencies including local authority social care services, primary care trusts, other NHS trusts and strategic health authorities a 'Duty to Cooperate' with the Responsible Authority.

The aim of MAPPA is to enable the identification of the relevant offender, to provide a formal setting for the sharing of information, to undertake a rigorous risk assessment and to formulate and put into effect a robust risk management plan.

The means by which these are achieved are, first, by establishing into which of three categories the offender fits, then managing the offender according to certain criteria. Rigorous risk assessment is a crucial part of the process - without accurate, up to date risk assessment the management of that risk cannot be robust or effective.

There are three categories of offenders who may fit the criteria for MAPPA:

1. Registered sex offenders as defined in the Sexual Offences Act 2003;

2. Violent and other sex offenders who have received sentences of imprisonment of more than one year;

3. Other offenders "who are considered by the Responsible Authority to pose a risk of serious harm to the public"[84] who is a category 3 offender is a matter of quite difficult judgement – the Guidance indicates that the person must have a conviction for an offence which shows s/he is capable of causing serious harm to the public and that the Responsible Authority must 'reasonably consider' that

[84] *MAPPA Guidance Probation 2003*

the offender may cause serious harm to the public. The guidance goes on to say that the responsibility for identifying category 3 offenders lies with the agency 'that initially deals with them'.

The Responsible Authority for the locality will have established a unit to run MAPPA for the area and set out referral procedures. (Durham/Darlington's public protection unit, a product of a joint police and probation initiative, was established in 1999).

Management of MAPPA - once accepted and placed in categories 1, 2 or 3, an offender subject to MAPPA is managed at one of three levels. While the assessed level of risk is an important factor, it is the degree of management intervention required which determines the level.

Level one: involves normal agency management. Generally offenders managed at this level will be assessed as presenting a low or medium risk of serious harm to others and it is only suitable where risks can be managed by one agency[85].

Level two: local inter agency risk management, through a process of formal meetings with permanent representatives of crucial agencies which have a role to play in risk management and others as necessary, in a process that is dynamic, i.e., that changes to suit the circumstances of the offender. Most offenders subject to this level are assessed as high or very high risk of harm.[86]

Level three: known as Multi-Agency Public Protection Panels (or MAPPPs). This level is appropriate for the 'critical few' - those offenders who pose the highest risk of causing serious harm, whose management is so problematic that multi-agency co-operation and oversight at a senior level is required with the authority to commit exceptional resources, or who are exceptional as a result of media scrutiny/public interest.[87]

Good risk assessment involves those undertaking it being prepared to actively investigate the offender's circumstances and background, to ensure that they have all relevant information and to take the time to evaluate it thoroughly. MAPPA enables and promotes this, resulting in more effective supervision and better public protection. The guidance[88] recognises that the evaluation of risk is a dynamic, not a static process; therefore if an offender is subject to MAPPA, any changes in risk profile can be managed.

Management of risk can take many different forms, for example regular visits by police, referrals to forensic services for assessment, assistance with housing.

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[85] In 2004/05 about 71% of MAPPA offenders were managed at this level.
[86] In 2004/05 about 25% of MAPPA offenders were managed at this level.
[87] In 2004/05 about 3% of MAPPA offenders were managed at this level.
[88] MAPPA Guidance Probation

The guidance states that the 'strength of MAPPA lies in coordinating how each agency fulfils its responsibilities and thereby makes the coordinated outcome greater than the sum of its parts'[89].

It is very important that victims' needs are represented in MAPPA with the result that additional measures can be put into place to manage the risks posed to known victims.

Police and probation involvement

This investigation has been set up to examine the health care and treatment received by Louisa Ovington. It is no part of the panel's remit to comment on the way in which either the police or probation dealt with her, except in so far as they were, or were not, interacting with mental health services and thus how their actions or inactions may have influenced the quality of health care and treatment she received.

The panel was given access both to police information and probation files and in addition was assisted by Detective Superintendent 1 and Probation Manager 1 who freely agreed to talk to the panel. The panel also had sight of the Domestic Homicide Review conducted by the Durham and Darlington Domestic Homicide Review Board in accordance with the guidance issued under the Domestic Violence, Crime and Victims Act 2004. This report included management reports produced by Durham Constabulary, National Probation Service County Durham, Tees Esk and Wear Valleys NHS Foundation Trust and Durham PCT. The panel was also given copies of the 'timelines' produced for the homicide investigation detailing Louisa Ovington's police involvement over eight years and relevant community (health and social care) information over ten years.

Police

Information about Louisa Ovington's formal involvement with the police and criminal justice system is mainly in the public domain but in any event the panel had access to her list of convictions.

From her first recorded offence in 1996 until Mr Hilton's death in January 2006 Louisa Ovington was charged with a total of thirty offences resulting in sixteen convictions (there were no acquittals - several of the offences were grouped together in terms of the convictions). These included six offences against the person, two sexual offences, three offences involving offensive weapons (knives), eight offences against property and two offences of public order.

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[89] *ibid*

All the courts before which Louisa Ovington appeared in relation to the offences were Magistrates' courts, except for the manslaughter. Magistrates' courts hear cases of crimes committed in their particular district. Louisa Ovington was convicted of offences in Easington (Peterlee) court three times, in South Durham court twice, in Durham court once, in Newcastle upon Tyne court once, in Hartlepool court four times, in Teesside court once, in North Durham court twice and in Sedgefield court once.

The sentencing varied. For a group of seven offences she received a Hospital Order - that is, she was ordered to be detained in a psychiatric hospital. The courts imposed three separate "probation orders" known as CROs/ COs. On two occasions (prior to the killing) she had knives forfeited and destroyed. She was conditionally discharged on eight occasions, (four of which were part of the same group of convictions). She was, variously, fined (small amounts), ordered to pay compensation and detained for one day (the longest custodial sentence she actually received until the conviction for manslaughter).

Including the offences for which she was charged, the police, in information collated for the trial, noted that Louisa Ovington had, in a period of eight years ending in January 2006, a total of seventy-four 'interactions' with Durham Constabulary. She made large numbers of nuisance 999 calls, often when seriously intoxicated, about which she was warned. She made numerous complaints about Mr Hilton and allegations about his behaviour to her, (as well as making unfounded allegations against others) and on five occasions reported that she had attacked or killed Mr Hilton, or threatened to do so. There were complaints from others about the disturbances she caused. In 2004 in particular her behaviour was especially disturbed. At one point the policeman concerned was moved to record that Louisa Ovington and Mr Hilton were two people in a very volatile relationship and the police feared that *"one day one will seriously assault the other."*

On very many of the occasions when the police had contact with Louisa Ovington they noted that she was seriously intoxicated.

The police response

DS1 investigated the homicide; until then he had had no dealings with Louisa Ovington. As part of his investigations he commissioned detailed 'timelines" of Louisa Ovington's involvement with the police from 1998 and of relevant community (health and social care) information from 1996. He chaired the Domestic Homicide Review.

DS1 told the panel bluntly that, in his view and with the benefit of hindsight the killing of Mr Hilton was *the most predictable homicide he had ever dealt with*. This was said with the advantage of having been able to take a detailed and longitudinal view of Louisa Ovington's history of involvement with the criminal justice system, as well as having access to (at least some) of her health records and those of Mr Hilton (which the panel did not have) and of discussions and input from probation and the trust.

During the period post dating Louisa Ovington's discharge from Kneesworth, although the police were well aware of Louisa Ovington's behaviour and the risks she posed and knew that she had involvement with the mental health services and probation, there was no attempt (by the police) to invoke a multi agency response. This would have been available under the aegis of MAPPA. DS1 told the panel that Louisa Ovington should have been dealt with under MAPPA. He said, "(It's absolutely clear, she should have been."

He told the panel that:

- Despite the fact that agencies were taking Louisa Ovington seriously 'there was a problem with information sharing' and this led to inadequate risk assessment. MAPPA involvement would have provided a multi agency response. DS1 said:
  "Police had information (about Louisa Ovington's high risk), health had information, probation had information, but no one had the whole picture".

- MAPPA involvement would have raised awareness, raised concerns and shared responsibility. He told the panel that MAPPA is a very effective multi agency group of people who are experts in their own field in managing dangerous people.

- There were numerous things that MAPPA could have done - for example putting Louisa Ovington onto alcohol programmes, sending a beat officer around regularly, encouraging Louisa Ovington and Mr Hilton to live further apart.

In relation to who should have made the MAPPA referral, the panel was told that 'any agency' could make it. Once the referral was made, the meeting would be convened. However DS1 commented that not all personnel (even in the police force) would understand the process.

Although there were two documented occasions when the police contacted the mental health services, once in relation to the incident on 30 July 2004 when Louisa Ovington had threatened to kill Mr Hilton saying she had a gun, knives and a sword and again three days later when she pulled a knife on a neighbour, there was no regular exchange of information with the other agencies; no formal line of

communication and no officers with responsibility to liaise with Mental health services. Again, the panel was told that this would have been done through the MAPPA process had MAPPA been invoked.

The Mental Health Act provides a mechanism under Section 136 where the police can forcibly remove and take a person to a place of safety. This was done at least once, on 22 September 2004. After the hospital refused to admit Louisa Ovington the police were required to remove her from the building. The panel was told that the police being 'open 24 hours a day' are the agency that that is used where other agencies are unable to deal with people.

The issue of medical confidentiality was problematic. DS1's view was that when a person gives information to a medical professional indicating the possibility of risk to another there should be some forum where that information can be shared or discussed without fear of breach of confidentiality. He told the panel that the doctor should be able to discuss this 'in the round' with other professionals to decide whether the protection of the public should outweigh patient confidentiality. The panel agrees that medical confidentiality can present an obstacle, but notes that MAPPA would have been an appropriate forum for such discussions.

The panel asked DS1 whether in retrospect he felt that the police had regarded Louisa Ovington's behaviour as commonplace for the area and therefore taken them less seriously. He denied this, saying that having looked at her offences they were not commonplace and although some offences committed in the area were alcohol and drug related, Louisa Ovington's behaviour was beyond the norm.

There was considerable evidence of domestic violence in the relationship between Louisa Ovington and Mr Hilton. The police view was that Mr Hilton was quite placid and that he was the victim of far more violence from Louisa Ovington than she was from him. DS1 confirmed that the domestic homicide review had noted: "Due to the high level of contact there is a possibility that some agencies experienced drift and became complacent and accepting of the levels of violence in this relationship." DS1 confirmed that it is possible for the police to become 'case-hardened'.

COMMENT

Louisa Ovington was well known to the police and at times came into contact with them on an almost daily basis. The police were aware that she had involvement with the mental health and social care services, as well as with probation. The domestic homicide review noted that there were ten incidents in which the police were involved that should have triggered referrals to other agencies. There were only in fact two referrals, both in 2004 and both led to further investigation by the mental health

and social care agencies. The panel's view is that the extent and at times, notably in 2004, intensity of Louisa Ovington's involvement with the police, should have alerted the police to the need for information sharing with health, social care and probation, not simply reporting incidents as they occurred, but in a more structured way. It is acknowledged by the police and by probation that MAPPA would have been the right forum for information sharing and could have resulted in a coherent approach to minimising Louisa Ovington's risk.

Although the police was not the only agency that could have referred Louisa Ovington to MAPPA, the panel's view is that the police, who constituted the 'Responsible Authority' along with probation and the prison service, should in any event have done so: this would have enabled those caring for Louisa Ovington both to receive more information about Louisa Ovington's behaviour, which would have informed their own risk assessments and (in the interests of public protection) to share information which they would otherwise regard as confidential, which would have informed the risk assessments of others.

Probation

There were ten occasions in which County Durham Probation Service was involved with Louisa Ovington, namely:

i. In the preparation of a pre-sentence report (PSR) in June 1998;

ii. In the planning for Louisa Ovington's care after discharge from Kneesworth House in January 2000;

iii. In the preparation of a PSR in February 2000;

iv. In the preparation of a PSR in February 2001;

v. In the supervision of an eighteen month CRO imposed on 7 June 2001;

vi. In the preparation of a PSR in June 2004;

vii. In the preparation of a PSR in September 2004;

viii. In the supervision of a two year CRO imposed on 10 September 2004;

ix. In the preparation of a PSR in November 2005;

x. In the supervision of an 18 month CO imposed on 22 November 2005.

Details

First PSR June 1998

In June 1998, in relation to the offences for which Louisa Ovington was made subject to a Hospital Order under Section 37 of the Mental Health Act, a PSR was prepared by Probation Officer 1, which indicated that a community penalty was inappropriate.

Discharge from Kneesworth House, January to February 2000

The probation service had no more dealings with Louisa Ovington until January 2000, when they were involved in discussions after the discharge from Kneesworth House. Although the five month assessment at Kneesworth House had concluded that Louisa Ovington suffered neither from a mental illness nor a personality disorder, Consultant 11 had recommended, in relation to the offences (against the nursing staff at the Tony White Unit) for which Louisa Ovington had been detained under Section 38 of the Mental Health Act, a probation order with a condition of psychiatric treatment and residence.

However Probation Officer 2 in conjunction with Durham Social Services (Team Manager 1) did not agree that a probation order was necessary.

Second PSR February 2000

Probation Officer 2 completed a PSR for court in February 2000, when Louisa Ovington was due back in court for sentencing in relation to the offences. She concluded that Louisa Ovington was at low risk of reconviction although if she did reoffend there would be a high risk to the public. She suggested that the court might, exceptionally, consider a conditional discharge. She pointed out to the court that there would be ongoing contact between the social worker (Social Worker 2, the care coordinator) and Louisa Ovington and family, contact between Louisa Ovington and the 'nominated psychiatrist' in the area in which she lived and contact with the CPN. (All of which had been agreed at the care planning meeting, which took place in January 2000 at which Probation Officer 2 was present. In the event, none of this happened).

The court duly imposed a conditional discharge for two years.

COMMENT

On the information available to Probation Officer 2 it does not seem unreasonable that she believed that a conditional discharge might be appropriate rather than a

CRO with a condition of psychiatric supervision. The conclusions of the Kneesworth assessment were that Louisa Ovington was neither suffering from mental illness nor personality disorder. Despite this, at the meeting in January 2000 a care plan had been drawn up which provided for support from psychiatric as well as health and social care services. It was most unfortunate that the planned services did not materialise until at least May 2000, by which time Louisa Ovington's whereabouts were unknown, her residence with her cousin and Mr Hilton having been abruptly terminated when her cousin discovered that Louisa Ovington and Mr Hilton were having a relationship.

Third PSR February 2001

In February 2001 another PSR was prepared, by Probation Officer 3, in connection with the offence of possession of an offensive weapon on 1 January 2001. It was alleged that Louisa Ovington had been walking down the road with a knife with which she said she was going to kill her cousin (Mr Hilton's ex partner). Probation Officer 3 assessed Louisa Ovington's risk of re-offending and dangerousness as high, with a serious risk of harm to the public. She recommended a probation order, subject to a psychiatric report. Consultant 5 prepared the report, agreed that a probation order with a condition of psychiatric treatment was appropriate and volunteered to supervise the psychiatric treatment element.

First CRO June 2001

Following the recommendation of the third PSR, on 7 June 2001, Louisa Ovington was made subject to an 18 month CRO, with a condition of psychiatric treatment, for the offences of possession of an offensive weapon and breach of conditional discharge. In the probation file, the stated objectives of the order were the reduction of the risk of reoffending and the increase of Louisa Ovington's ability to manage anger.

Probation records at the completion of the order in December 2002 note that Louisa Ovington response to their supervision was 'excellent' and it would seem that she did everything that was expected of her.

Unfortunately, in relation to the condition of psychiatric treatment, there was no clarity about how this would operate or who was to be the supervisor. (Consultant 5 told the panel that whenever he made a recommendation for a condition of psychiatric treatment he would offer to be the supervisor, but that it was "very seldom" that he was given written confirmation of this, or any other details of the order.) The records indicate that in fact eight different psychiatrists were involved in Louisa Ovington's care between January 2000 and December 2002, but she only saw Consultant 5 once during the eighteen months of the order. In October 2001 Consultant 5 was so concerned that she had not attended outpatient appointments that he informed her care coordinator.

There is evidence in the probation records of communication between the care coordinator and probation and of probation being invited to meetings. In December/ January 2001 Probation Officer 4 is recorded as trying to ascertain who the responsible psychiatrist was. Probation was clearly aware that Louisa Ovington was involved with other agencies.

COMMENT

The panel was told by Probation Manager 1 and by Mr J. McCartney that neither legislation nor Government guidance defines who should be responsible for managing a condition of psychiatric supervision when added to a probation order. The view of both of them however was that the probation officer in charge of the case should be the person responsible. In Louisa Ovington's case there was utter confusion about this. The order did not name the supervisor; it was not sent to Consultant 5; and there was no recorded attempt by probation to identify the supervisor and ensure that this vital condition was complied with other than an attempt to find out who Louisa Ovington's consultant was in December 2001. The panel is very surprised at this; if the condition were thought so important, the panel would have expected that there would have been clear lines of accountability and proper procedures for checking that it was being complied with both by Louisa Ovington and by the psychiatric supervisor. The lack of clarity rendered the condition worthless as an 'arm' of the order, almost as though it were an entirely extraneous element and not an essential requirement in rehabilitating Louisa Ovington and managing her risk. In fact she was, from time to time, attending outpatients' appointments but very much according to her own agenda. It is notable however that she attended Probation regularly, perhaps from concern that she would otherwise be 'breached' and end up in custody, of which she was known to be fearful.

<u>Fourth PSR June 2004</u>

On 11 June 2004 Louisa Ovington pleaded guilty to a public order offence committed on 6 June 2004. A PSR was directed by the court, with a view to a possible CRO, but Louisa Ovington failed to attend either of the appointments made by Probation Officer 6. In her report dated 30 June 2004 Probation Officer 6 stated that she had contacted the police domestic violence unit who confirmed that Louisa Ovington had made numerous telephone calls to them in the past six months, which information supported Louisa Ovington's description of her current difficulties. The PO asked for a further adjournment to enable the report to be completed; however, it would appear that the court proceeded without a report and Louisa Ovington was fined £50.

In the risk assessment (completed by another probation officer) attached to the PSR documentation there is no mention of previous offences with weapons, nor, apart from a brief reference to current depression and a previous alleged incident of self harm, to a history of mental health problems.

COMMENT

The probation officer established from the police domestic violence unit that Louisa Ovington had had frequent contact with them and that she had had personal difficulties; there is no evidence however of any attempt to seek information from Louisa Ovington's care coordinator and the OASys assessment makes little or no mention of a history of mental health difficulties; nor does it mention previous offences with weapons. However, Louisa Ovington had not attended for her appointments and it may have been the case that if the court had been prepared to wait, a further report would have had the benefit of more detailed information. The sentencing happened at a time when Louisa Ovington's behaviour was becoming more and more disturbed. It is notable that only a few days after she pleaded guilty to the public order offence on 11 June 2004, the Police recorded that Louisa Ovington and Mr Hilton were two people in a very volatile relationship and the police feared that "one day one will seriously assault the other".

Fifth PSR September 2004.

On 20 August 2004 Louisa Ovington was convicted of four offences which took place over a period of a month, from July to August 2004; having a bladed article in a public place (a four inch kitchen knife); theft; criminal damage and common assault. She was remitted in custody for sentence. The court adjourned the case for a PSR which was dated 6 September 2004 and which concluded that Louisa Ovington was at high risk of reoffending and a high risk to the public. The probation officer felt she was unable to make firm recommendations without a psychiatric report, as she could not be confident about Louisa Ovington's ability to comply with the terms of CRO without such a report and in the light of Louisa Ovington's 'bizarre behaviour' when interviewed. However, the court proceeded without a further psychiatric report and made a CRO on 10 September 2004.

The OASys assessment which informed the report indicated that a referral to MAPPA was appropriate. (This did not happen).

COMMENT

It is interesting that the court decided to proceed without a psychiatric report. It is also notable that the OASys assessment indicated that a MAPPA referral was justified. It did not happen. Probation Manager 1 told the panel that this report would have been prepared by a court based probation officer: when a further assessment was done by the probation officer in charge of the CRO, the level of risk was assessed differently and no MAPPA referral was made. She said that it should have been.

CRO dated 10 September 2004

On 10 September 2004 Louisa Ovington was made subject to a two year CRO managed by County Durham Probation Service. Difficulties arose when Louisa Ovington moved, shortly after the imposition of the CRO, from the County Durham probation area into temporary accommodation in the Hartlepool area. At first, Hartlepool was asked to 'caretake' the case and then the order was formally transferred to Hartlepool on 5 November 2004. On 27 July 2005, as Louisa Ovington had moved back into the County Durham probation area, the order was transferred again. The situation was further confused by the fact that Louisa Ovington attended from time to time at both offices regardless of which service had responsibility for the order. Additionally Louisa Ovington spent some time on remand. Notes on the file indicate probation's own concerns about the management of the order.

The records in relation to this CRO indicate that various officers were expending considerable energy in dealing with Louisa Ovington's housing problems.

As part of the CRO, Louisa Ovington was required to undertake a 'citizenship' programme with modules in anger management and alcohol. There are no details in the probation file about the content of the modules, nor whether they were completed.

There is evidence in the records of ongoing contact between Louisa Ovington's care coordinator and the probation officers who were dealing with Louisa Ovington at any one time.

In relation to Louisa Ovington's risk to the public, the care coordinator, over the period of a week or so in October 2004, was expressing real concern to Probation and several times raised the matter of whether a "public protection meeting" should be held. Probation's view was that Louisa Ovington did not present sufficient risk, despite a report that Louisa Ovington had made threats to kill Mr Hilton.

COMMENT

The management of this CRO seems to have been bedevilled by Louisa Ovington's chaotic lifestyle, making her supervision very difficult indeed. Probation Manager 1 told the panel that probation should have acted to clarify "who was responsible for what" as Louisa Ovington would not have been alone in being a 'very chaotic offender'. It seemed to her that Louisa Ovington was 'calling the shots' and manipulating the system. Current rules prevent 'caretaking 'arrangements and stipulate that there has to be a clearly identified person to manage the order.

One of the problems was that there were two different systems of recording in place in Teesside (Hartlepool) and Durham; this meant that information (for example, in relation to serious domestic incidents) might have been, in Probation Manager 1's words "lost". This itself would have militated against a proper understanding of risk. The panel noted that the care coordinator expressed her concerns about risk to probation more than once and was told that Louisa Ovington either did not fit the criteria for a 'public protection meeting' or that in probation's views there were "no current risk of harm issues", despite the reports that Louisa Ovington had made threats to kill Mr Hilton. Probation Manager 1 expressed surprise to the panel about probation's response; she suggested that the care coordinator could have made a referral to MAPPA herself; however she conceded that if the care coordinator had specifically raised the issue of MAPPA with probation it would have been reasonable for her to accept their view. The panel however noted that probation, with the police (and later the prison service) constituted the MAPPA 'Responsible Authority' (and that the County Durham Probation Service acknowledged the strengths of the MAPPA system in their third annual MAPPA report in 2003/4, at a time when Louisa Ovington was behaving as though she was out of control and was causing great concern to the health and social care agencies).

The terminology in relation to public protection at this time was confused; the terms public protection meeting and risk meeting and MAPPA seem to have been used loosely and interchangeably. (Probation Manager 1 also told the panel that at the time there was confusion about the various MAPPA levels; the terminology is now clearer.) What was clear was that the care coordinator had serious concerns, which had been expressed to the CMHT, Staff Grade Psychiatrist 1, the CRT and probation and that she looked to probation as the persons who had the necessary expertise to make a decision on whether the level of risk was serious enough to warrant a multi-agency response. When they decided it was not, she presumably accepted that view. (It is also of note that the probation officer who prepared the PSR which preceded the CRO had assessed the risk as high and the OASys assessment had indicated that a referral to MAPPA was called for).

The panel's view is that according to the criteria at the time, as set out in the guidance for probation[90] Louisa Ovington would not have fitted MAPPA Categories 1 or 2. However, given the commission of several offences showing that she was capable of causing serious harm to the public, given her general forensic history, her alcohol and drug misuse, her mental health problems, her frequent threats to kill, her frequent use or threat of the use of knives, her chaotic and unstable lifestyle and her out of control behaviour particularly in 2004, she would have been likely to fulfill the criteria for Category 3. She would probably have been managed at level two, which would have enabled all the agencies dealing with her (health, social care, drug and alcohol teams, housing, police and probation), to share their knowledge formally.

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[90] *MAPPA Guidance Probation*

There appears to have been no formal referral made. The panel does not know whether Social Worker 7 was aware of the referral process, but her several attempts to raise this matter representing one of the Duty to Cooperate authorities amounted to a request of the Responsible Authority (probation) to refer her for consideration of putting MAPPA into place and this should undoubtedly have been acted upon.

In relation to anger management and alcohol control, there is no written evidence in the notes for this CRO about whether, or how, the necessary work was completed. This is of particular concern in relation to alcohol use; it was correctly identified as a significant factor in the OASys assessments and in the management plan which is part of OASys in January 2005 there is reference to alcohol misuse being dealt with by 'ongoing monitoring' and a programme entitled 'Addiction VI 2' but nothing more. (It may be that the work was done but because of the structural difficulties in managing this order it was not recorded.)

Sixth PSR dated 7 November 2005

On 7 November 2005 Probation Officer 5 prepared a PSR in relation to an offence of criminal damage and breach of conditional discharge. The report concluded that the likelihood of reconviction was high and the risk of serious harm was medium. The report recommended a CO with a supervision requirement consisting of completion of a compulsory citizenship module, including offence analysis and victim awareness work. Louisa Ovington would also be required to liaise with both CMHT and the ESMI programme in relation to her alcohol use.

Third CO (previously CRO)

At court on 22 November 2005 Louisa Ovington was made subject to a two year CO. The previous CRO was revoked.

The file shows that Louisa Ovington attended regularly and there is evidence that she started to complete the work required of her.

There is also evidence in the notes that the probation officer was aware of the involvement of other agencies and kept in touch with Louisa Ovington's care coordinator.

Shortly after the commencement of the order it is noted that Louisa Ovington was aggressive and abusive towards staff in the office and a decision was made not to visit her at home. There is no record of this being communicated to the care coordinator, however.

COMMENT

As Louisa Ovington was arrested for the homicide of Mr Hilton on8 January and thereafter remained in custody, the CO became dormant until revoked, although probation continued to be involved for some time. There is nothing of note in this short involvement of probation -the records although necessarily brief were clear and showed that the probation officer was aware of the wider issues in relation to health and social care. It is a little surprising that alcohol related work was not part of the planned programme, although the PSR had indicated that Louisa Ovington would be expected to be in touch with ESMI.

Chapter 6 – Risk assessment and management

Formalised risk assessment is a relatively new concept: the panel was told by several clinicians and staff members in relation to the admissions to the Tony White Unit and St Nicholas' Hospital that in 1998 to2000 risk assessment was not formalised but would be conducted on an ongoing, every day basis as part of their clinical/nursing duties.

It is now generally acknowledged within mental health services that risk assessment is an essential component in managing people with mental illness. It is also recognised that there are a variety of instruments available with which to undertake these assessments, the choice of which to use being a matter of local preference.
Each mental health trust has its own clinical governance arrangements which will oversee the risk management measures in clinical areas and these will be subject to regular audit and review. In addition to ensuring that effective policies and procedures are in place, each trust has a responsibility to ensure that processes are in place to monitor risks, whether clinical or organisational and there are structures in place to review incidents and advise on actions which need to be implemented to minimise or remove future risk.

For the first part of Louisa Ovington's journey through mental health services, formal risk assessment was in its infancy. After December 2000, however, the trust area had formalised its risk assessment policies. The following description is taken from the former Tees and North East Yorkshire NHS Trust care coordination policy (December 2000):

- Risk assessment is an essential element of good mental health practice and is not regarded as, or fulfilled simply by, an exercise of completing a "risk assessment" form. It is an ongoing process which team members and other involved agencies must carry out. It is their responsibility to regularly consider risk issues and record these considerations clearly.

- After the initial risk assessment, further assessments will be undertaken as a minimum, prior to leave, prior to discharge from hospital and at every review. Any major life event should trigger a review and further risk assessment.

- The need for positive, supportive and therapeutic risk taking is essential to effective care delivery and a key element of the care coordination process.

- Risk assessment and its management must be based on detailed evidence of a person's psychiatric and social history together with information regarding their current mental state and functioning. This must also involve consideration of the

person's social, family and welfare circumstances and include the views of the carer and any significant others.

- Professionals involved in the risk assessment process will utilise all sources of information available to them and will be responsible for communicating to others involved any relevant information/details that they are in possession of, or that they receive, in a timely manner.

- In certain cases, risk assessment may involve public protection strategies e.g. public protection meetings, child protection.

- The risk assessment and management plan will be recorded using agreed documentation.

There is clear evidence of the existence of recognised risk assessment tools contained within the mental health records. Examples are: Tees and North East Yorkshire NHS Trust risk assessment for Easington Locality and County Durham and Darlington Priority Services NHS Trust risk assessment form. Risk assessment is incorporated into the CPA documentation and the probation service uses an Offender Assessment System 'OASys'.

It is clear from clinical documentation that risk assessments were undertaken on Louisa Ovington and the following examples can be regarded as such although they do not necessarily follow recognised methods. What is interesting are the frequent differences in view between professionals, often during the same chronological periods, as to whether Louisa Ovington was (a) mentally ill, (b) at risk to herself or others:

- 1993 Report by Consultant 1 ("did not think a diagnosis of conduct disorder was appropriate – did not get the impression that Louisa Ovington had had long standing behaviour problems").

- 1998 Assessment by Consultant 8 ("Louisa Ovington had been overactive, destructive of property and volatile in mood").

- 1998 Clinical note by Consultant 5 ("Is this an opportunity to rescue her from a tragic future by means of treatment?").

- 1998 Medical report by Consultant 7 ("desperately needs treatment – must be in medium security").

- 1998 Report by Consultant 5 ("dangerous potential – needs higher security").

- 1999 Letter from Consultant 10, Rampton Hospital ("Louisa Ovington is complex and quite profoundly disturbed – needs period of treatment in controlled setting...adequate support otherwise the consequences could be serious or grave").

- 1999 Letter from Specialist Registrar 1 to court ("Louisa Ovington has severe personality disorder with subsequent dangerous behaviour").

- 2000 Letters from Kneesworth House post discharge - ("no sign of mental illness, no bad behaviour").

- 2001 Risk assessment at Darlington Memorial Hospital signed by Consultant 15 ("no risk of violence or assault against others").

- 2002 Psychotherapist 1 report notes "Louisa Ovington would not be at risk. CPA minimum level".

- 2004 Risk assessment in A&E by CRT ("thinks of suicide daily").

- 2004 Further CRT risk assessment ("risk minimal if abstains from alcohol") and a later assessment which determined she had no intention to kill her partner.

- 2004 Assessed in A&E by psychiatrist ("no risk to self").

- 2004 Assessed at case conference where the care coordinator Social Worker 7 stressed the importance of keeping in touch with her and noted that consideration should be given to a MAPPA meeting given her potential risk to self and others.

- 2005 Risk assessment undertaken by new care coordinator CPN 2 regraded to enhanced CPA.

- In addition there were various risk assessments conducted by probation under their Offender Assessment System (OASys), which show different levels of assessed risk, or on occasion an apparent 'mismatch' between the assessed risk and the action taken or recommended.

COMMENT

The examples referred to above reflect Louisa Ovington's unstable lifestyle with periods of relatively low risk behaviour followed by escalation (generally coinciding with increased substance or alcohol use) particularly during 2004 and 2005 when her care coordinator and the CRT manager, were sufficiently concerned to consider making a request to convene a public protection meeting.

It is apparent that formal risk assessment was undertaken periodically by several agencies but the outcomes are not as informative as one would expect and regrettably there is little evidence that any consistent action was implemented as a result.

There were clearly opportunities for addressing some of the concerns and these were missed. A referral to MAPPA would have enabled a rigorous risk assessment to be completed based on the information which each agency held. But even without the benefit of the MAPPA approach, the agencies failed to work together consistently and effectively to manage Louisa Ovington's risk. The conclusions and recommendations in this report deal with this aspect

Chapter 7 – Provision of mental health services

Introduction

Key features of Louisa Ovington's passage through mental health services were the challenges presented by her regular changes of address, including times where she was of 'no fixed abode'; her own complex interconnected mixture of needs arising from mental disorders, sometimes as a consequence of substance abuse; and behavioural problems leading to her extensive involvement with the criminal justice system. Two other factors were also present which impacted on her care, the modernisation of mental health services and the service reconfigurations linked to organisational mergers.

Louisa Ovington's copious clinical records describe a journey from Edinburgh to Easington and its surrounding areas in the north east and contain detailed information on her experiences in both hospital inpatient and community environments. Her journey also extended to Hertfordshire where she spent several months in a private psychiatric hospital.

The following sections attempt to highlight the numerous agencies and teams with which she came into contact, the policies in place at the relevant periods and the positive or negative effects of them on Louisa Ovington's care.

Service configuration

There were numerous organisations which were responsible at different times for providing care to Louisa Ovington and the key ones are listed below as they were then known:

- County Durham & Darlington NHS Trust
- Durham County & Darlington Priorities Services NHS Trust
- Tees and North East Yorkshire NHS Trust
- Newcastle City Health NHS Trust
- Hartlepool & East Durham NHS Trust
- Hartlepool Community Care NHS Trust
- South Tees Community & Mental Health NHS Trust
- North Tees & Hartlepool NHS Trust

- South West Durham Mental Health NHS Trust
- Edinburgh Healthcare NHS Trust
- Easington Primary Care NHS Trust
- Tees Health Authority
- Partnerships in Care
- County Durham Social Services
- County Durham Probation Services
- Teesside Probation Service

Louisa Ovington was treated at the following hospitals:

- Hartlepool General Hospital, Hartlepool
- The Duggan Keen Unit at Winterton Hospital, Sedgefield
- The Royal Edinburgh Hospital
- The Tony White Unit at the County Hospital Durham
- Cuthbert Ward (forensic unit) St Nicholas Hospital, Newcastle,
- Clopton Ward, Kneesworth House, Hertfordshire
- Darlington Memorial Hospital

In addition, between 1995 and 2006 Louisa Ovington was supported by the following mainstream community teams:

1995 - 2000	Hartlepool Community Mental Health Team
2001 - 2003	Newton Aycliffe Community Mental Health Team
2000 - 2001	Community Addictions Service
2001 - 2002	Hartlepool Mental Health Day Services
2003 - 2004	Easington Substance Misuse Initiative
2003 - 2006	Easington South Community Mental Health Team
2004 - 2005	Crisis Resolution Team
2004 - Brief involvement	Hartlepool Social Services

Although not necessarily an integral part of community teams, an important contribution to Louisa Ovington's care was provided by senior medical staff at a variety of locations in the north east. These were mainly in the form of outpatient clinics and whilst not part of the mental health services, her general practitioner also remained in contact through the mental health staff.

Service modernisation

During the period 2000 to 2006 major developments were taking place to modernise and improve mental health services throughout England and Wales. A significant development was the integration of health and social care services. Whereas previously, social work staff had worked within their own teams managed and resourced through the county wide social care structures, new partnership arrangements were put in place, where both health and social care staff would work together within integrated teams jointly managed by someone from either agency. This was intended to improve communication and continuity of care and in many areas appeared to be working very well.

Concurrently, policy guidance was issued as a result of the national service framework for mental health which required mental health providers to review their community care arrangements and introduce prescribed new services.

Examples of new services which were prescribed nationally included:

- Crisis resolution /home treatment teams which were intended to act as gatekeepers to mental health services by often being regarded as the first point of contact for someone in crisis. They provide assessment to those referred to them and in consultation with other partner agencies, decide on the most effective option for problem resolution. This could be by working with service users intensively at home or working in conjunction with other teams e.g. CMHTs.

- Assertive outreach teams who provide intensive support, particularly at home, to those with severe mental health problems and who have difficulty engaging with treatment programmes.

- Early intervention in psychosis teams are specialised teams who identify and engage those who are at the early stages of psychosis and are often just going through adolescence. It is generally accepted that a probable diagnosis of psychosis should be present in order to access this team and once engaged, their interventions are likely to be intensive.

- Primary care services covers a wide range of responsibilities from supporting GP's to providing new services within practices. An example of this is the appointment of practice counsellors who would see people who do not have severe mental disorder and support them over a defined period of time. There would also be an opportunity to look at clinical records within GP surgeries to identify whether there are people with undetected mental illness who may benefit from treatment.

- Mental health promotion looks at the incidence of mental illness in local communities with a view to reducing and resolving causative factors.

The work involved in developing these new services was significant and required considerable organisational change with the imaginative use of new and existing funding sources.

The changes had a major impact on staff, in terms of how they adjusted to the change from traditional to new ways of working and how each of the new services related to each other and other partners in both primary and secondary care.

The pace of change was rapid and closely 'performance managed'. The introduction of the new services however varied in different localities, depending on resource allocation and the ability to recruit and retain staff.

The setting up of the new teams also affected the way in which traditional mental health care was offered. The crisis resolution and home treatment team changed the way that hospitals used their inpatient beds and as people were being cared for more intensively at home, the requirement for beds diminished and trusts took the opportunity to review the provision. There was also an effect on the way CMHTs and consultant psychiatrists worked as the more specialised services were introduced and it is almost certain that these changes were being worked through during the time that Louisa Ovington was receiving care from the local services.

In addition to the modernisation agenda, there was also major organisational change in respect of trust mergers and the aspirations of mental health service providers to become NHS Foundation Trusts.

The impact of these considerable changes on Louisa Ovington's healthcare and treatment was significant. In the first instance, there was a period when services were grossly underdeveloped and required a major injection of resources. From the evidence received from witnesses and from available records there was a lack of coordinated care due in the main to the general absence of appropriate services and the inability to recruit and retain clinicians.

The new PCT in Easington, together with key partners, introduced planning mechanisms to ensure that service developments were properly identified and funded. This was particularly relevant as the local area had been identified as suffering from significant deprivation.

COMMENT

As an illustration of some of the difficulties faced by the Easington area, Trust Manager 1, who was project manager in the PCT at Easington for mental health and subsequently head of mental health and children's services, told the panel that when he took over in 2000 there were three providers of mental health services in Easington, which was at the outward boundary of all three. He told the panel "Easington was said to have the greatest prevalence of mental health problems outside of inner city London" and that there was a "massive prevalence of mental health problems, running alongside some of the poorest services in terms of quantity and to some extent quality." He added that there was "A complete lack of services … things we take for granted today didn't exist, no crisis services, no services beyond nine to five Monday to Friday, massive vacancies in the consultant field, nurses, social workers."

He commented that no-one wanted to work in Easington, as it was perceived as a difficult patch to work, the physical facilities being poor and the situation complicated by the ' three way' trust providers. Staff did not believe that things could change "It was just a wasteland really for mental health services."

From the time that the PCT was established in 2002, much attention was given to delivering a high quality mental health service to the local community and this process was informed through the publication of the National Service Framework for Mental Health and its policy implementation guidance. As a result of this and the major new funding which was made available by the PCT, a complete reappraisal was undertaken of current services and the need for the introduction of a modern approach to mental health care. It was also recognised that for this to succeed the planning and delivery of new services would have to be undertaken in partnership with other agencies, particularly the social services departments.

Policies and procedures

One outcome of the change process to have a direct effect on clinical care was the need to introduce new guidance on how the teams should operate. Each new service therefore would have its own operational policy describing what it offered, to whom, where, when and by whom. This would include a benefits analysis and set out systems which would be required to monitor effectiveness and efficiency.

The policy changes were driven by the roll out of new services and the joint working arrangements which were being established at a period when mental health services were undergoing possibly the biggest change since the closure of the asylums in the 1970s and 1980s. The policies defined quite clearly how the new teams should operate.

The investigation panel has been able to obtain from several mental health providers copies of their policy and procedure documentation. The ability to gather all the policies which would have been in place during Louisa Ovington's passage through the services was impeded by the frequent organisational changes which had taken place. Many of the original policies could not be retrieved and had been replaced by new ones written for the new trusts.

The following have been provided:

- Newcastle City Health Trust – CPA policy (August 1997).
- Newcastle City Health Trust – Observation policy and guidelines (October 1996).
- Joint policy and procedures for Hartlepool & East Durham NHS Trust and Hartlepool Social Services – CPA (May 1997).
- Hartlepool Community Care NHS Trust – CPA (Undated).
- Tees and North East Yorkshire NHS Trust – Care co-ordination (December 2000).
- Tees, Esk and Wear Valleys NHS Foundation Trust – Cleveland Diversion Team (July 2009).
- Tees and North East Yorkshire NHS Trust & Durham Social Services – Easington CMHT (Undated).
- Easington assertive outreach team (Undated).
- Easington crisis resolution service (Working Draft 1January 2004).
- County Durham and Darlington Public Protection strategy (Undated).

Although it was not possible to track down all the policies the panel was generally satisfied with the explanation that was given regarding the merging of policies as a result of organisational change. (The only one outstanding which the panel would have been interested to look at was that which outlined arrangements for risk management, but no copies were submitted for our consideration).

As mentioned elsewhere in this report, the CPA is central to ensuring that care is effectively provided and coordinated and that it reaches the people in the right place with the right intervention at the right time.

CPA policies appear to have been in place in the relevant areas at the appropriate times. Each area had the services of a CPA manager who was charged with the responsibility of ensuring that CPA was delivered throughout the local mental health services in accordance with Department of Health guidelines.

The changeover from CPA to the newer version 'care coordination' in 1999 seems to have been handled well and has complemented the partnership arrangements which were established to develop integrated services with colleagues in social services.

The panel has heard evidence about the measures put in place to ensure effective 'joint working' which has included appointment of joint managers from both health and social care. This is reflected in the development of policies for the new services linked to the modernisation agenda.

The policies for the CMHT, crisis resolution service and the assertive outreach service were in place at the relevant times and whilst they needed to be introduced in stages across the localities, they appeared to be available if required.

However, the key issue in respect of both service provision and policy implementation is not so much that they were in place, but how they *were implemented in practice.*

The effectiveness of CPA/care coordination has been considered in a separate chapter.

The panel recognises that whilst the referral of Louisa Ovington to the assertive outreach team may have been desirable and may have helped to overcome some of the issues around engagement, the operational policy is clear that the person being referred must be suffering from a *severe and persistent mental disorder* and this had not been established in Louisa Ovington's case.

Perhaps the most significant policy change was the introduction of the CRT where the emphasis was shifting from hospital to home based treatment. The CRT took on the role of 'Gatekeepers' for the mental health service and there was an expectation that they would provide a rapid assessment of crisis and either work with someone for a short care spell or signpost to an appropriate service.

The policies, however, clearly promote joint working and in particular, the CRT policy states:

Assessment will focus on the following areas:

- The presenting problems;
- Comprehensive assessment of risk;
- Clinical signs and symptoms;
- Family and carers needs and views;
- Determine the level of need and appropriateness of ongoing treatment;
- Level of intervention required;
- Risk management with regard to unsafe/inappropriate behaviour;

- Past psychiatric history;
- Social support and needs;
- Willingness to engage and cooperate with services.

(The above objectives are wholly acceptable for a crisis team and, if applied within achievable timeframes, can provide valuable support to the overall treatment programme. CRTs have the opportunity to provide either time limited brief intervention or to assist other teams, for example, CMHTs in providing a broader range of treatment options).

COMMENT

There did not seem to be a clear strategy in place when Louisa Ovington was receiving input from the CRT in addition to the CMHT

The effect on Louisa Ovington's care

The nomadic and sometimes chaotic nature of Louisa Ovington's life, moving across service boundaries, sometimes of 'no fixed abode' or unable to be located, presented a challenge for the teams dealing with her, as did her reluctance to engage with care plans. It is clear from the documentation and from witness testimony that some staff tried to ensure that continuity of care was maintained, while others were less vigilant.

As the services were reconfigured and new teams were established, the opportunities for better engagement with access to a wider range of skills and facilities should have seen a more valuable contribution being made to the needs of Louisa Ovington and her partner. However this was not always apparent and there continued to be regular changes in the teams and key staff who attempted to engage with her. There was also little evidence of effective inter-agency working (see below). Apart from a few relatively short interventions by the recently formed CRT, nothing much appeared to have changed and for long periods Louisa Ovington was virtually left to her own devices.

In Louisa Ovington's case the arrival of integrated working and the availability of rapid response input should have produced 'added value' to her care through a proper assessment of her needs (and possibly those of her partner, Mr Hilton). There remained continuing uncertainty regarding her diagnosis and whether in fact she was suffering from mental illness. There were many indicators of her instability and at times her propensity to cause harm and these issues should quite clearly have been addressed by the range of skills available within the new services. Louisa Ovington was at times less than honest with professionals and would tell them only what she wanted them to know. The professionals were not all agreed on diagnosis, and together with Louisa Ovington's abuse of drugs and alcohol, a clear set of health and social care objectives was difficult to produce.

The panel was informed by Team Manager 2 of the efforts made to encourage joint working, but for a number of reasons this did not seem work well in relation to Louisa Ovington. She was an ideal candidate for comprehensive joint working, particularly given that her presentation was complex, that she was involved with a number of agencies and that she was capable of dangerous behaviour. She merited being continuously on enhanced CPA and her history should have been properly considered through the risk assessment process.

The policies clearly identify the roles of the teams and their aims and objectives and at first sight constitute a commendably thorough approach when read together. In practice, however, little change took place in how the services worked together in dealing with the issues and concerns which were emerging with increasing regularity in the lives of Louisa Ovington and Mr Hilton.

Chapter 8 – Use of the Mental Health Act and compliance with the Code of Practice

At all relevant times in the period during which Louisa Ovington was receiving mental health services, the legislation regulating the detention of mentally disordered people was the Mental Health Act 1983, prior to its amendments in 2007. The Act was supported by the Code of Practice (Government guidance) in force from 1 April 1999. The preamble to the Code states: "The Act does not impose a legal duty to comply with the Code but as it is a statutory document, failure to follow it could be referred to in legal proceedings." It is widely accepted as a baseline of good practice, from which deviation requires justification.

The Act sets out the strict criteria under which persons suffering from various types of mental disorder can be detained and the safeguards in place for such detention. Distinction is made between those persons detained after, or during, involvement with the criminal justice system and those who are detained without such involvement. The following is (as accurately as can be established) a list of the occasions when Louisa Ovington was detained in a psychiatric hospital under the Act:

- On 23 December 1995 Louisa Ovington was admitted to Hartlepool General Hospital informally (i.e. without compulsory detention).

- From 24 January 1996 to13 March 1996 she was detained, while in hospital, under Section 3 of the Act, which provides for detention for treatment for up to six months, if certain conditions are met.

COMMENT

There is nothing to indicate that this was an inappropriate detention. Louisa Ovington was suffering from psychotic episodes and at one point her behaviour became so hard to contain that she was transferred to a psychiatric intensive care unit where she could be better managed. She was only detained for two months, although she was in hospital for longer. There was no evidence that she had recourse to any of the safeguards under the Act - for example Mental Health Review Tribunals[91] or Hospital Managers'[92] review powers - nor that she wished to do so but was prevented from doing. This detention however had highly significant consequences, for a patient detained under Section 3 (and some other sections) of the Act acquires, through the operation of Section 117, a right to free after care services. Section 117 of the Act imposes a duty on local authorities and health authorities to provide after care services once the patient is no longer detained. The right and the corresponding duty, continue indefinitely, unless the authorities deem it no longer necessary (and they have not done so in Louisa Ovington's case). Therefore for all the periods of time

[91] *A review by a judicial body of whether the criteria for detention remain satisfied.*

[92] *A review by specially appointed Mental Health Act managers as to whether the detention should remain in place.*

Louisa Ovington spent living in the community after the lifting of this detention the authorities remained under a specific duty to provide her with care, in addition to their general duties under community care legislation and under the CPA.

It appears from the records that a CPA meeting was held on 21 February 1996 to plan for Louisa Ovington's discharge, although the panel has not seen the record of the meeting itself.

Despite several short admissions to hospital, the Mental Health Act was not used again until June 1998.

On 30 May 1998 Louisa Ovington was remanded to Low Newton Prison, Durham, on charges of theft, threats to kill, possession of a bladed article and criminal damage. Serious concerns were expressed about her mental state and on 5 June 1998 she was transferred to the Tony White Unit at the County Hospital Durham under the care of Consultant 5, under Section 35 of the Act, to enable a report to be prepared on her mental condition and a recommendation as to sentence. Section 35 enables a court to remand a person to hospital, for up to 28 days, for a report to be prepared. The period can be renewed, for 28 days each time, to a maximum of 12 weeks.

COMMENT

This seems to have been an appropriate use of Section 35 and properly implemented. There must have been one renewal as the matter did not come back to court for sentence until 17 July 1998.

Consultant 5 expressed his view that Louisa Ovington was suffering from a mental illness and personality disorder and recommended that the court should make an order under Section 37 of the Act (often known as a 'hospital order') so that she could receive treatment in hospital. Section 37 provides that a court can, on conviction for an imprisonable offence, authorise an admission to and detention in hospital provided certain criteria (as to the existence of mental disorder and appropriateness of the admission) are met. On 17 July 1998 an order was made under Section 37 and Louisa Ovington returned to the Tony White Unit for treatment.

She remained under Section 37 until she was transferred to St Nicholas' Hospital in January 1999.

COMMENT

Again, this seemed to be an appropriate use of Section 37, properly implemented. Section 37 is often accompanied by a 'restriction order' under Section 41- an order made by the court restricting the patient's discharge, transfer, or leave from hospital without the consent of the Home Office. The order can only be made where it is

necessary to protect the public from serious harm. This was not thought appropriate at the time. Section 37 is not a time limited order, but carries safeguards (not available under Section 35), including an ability to apply both to the Hospital Managers and to a Mental Health Review Tribunal for the detention to be reviewed. Additionally the responsible psychiatrist must discharge the patient when the criteria are no longer met. Louisa Ovington did apply to the managers, but her detention was upheld. She also wrote to the Mental Health Act Commission, who at the time had responsibility for monitoring the conditions of detained patients.

While at the Tony White Unit Louisa Ovington's behaviour had been extremely disturbed and she was charged with assault occasioning actual bodily harm on a member of staff. It was apparent that the Tony White Unit was not the right place for her and lengthy discussions took place between Consultant 5 and Consultant 9 at St Nicholas' Hospital. Consultant 9 agreed to take Louisa Ovington into the forensic secure unit at St Nicholas. However his view was that rather than transfer her under Section 37 (a 'Hospital Order'), the court should be asked, when the matter of the Assault Occasioning Actual Bodily Harm came before them, to impose a Section 38 'Interim Hospital Order' under which a person who has been convicted may be detained in hospital to allow further examination and consideration of the need for a hospital order' The order must be renewed by the court every month and can only last for a maximum of 12 months. On 13 January 1999, the Section 37 order was discharged, a Section 38 order imposed by the court and Louisa Ovington was transferred to St Nicholas' Hospital.

COMMENT

Initially this seemed illogical to the panel - normally Section 38 would precede Section 37, not follow it. The provision was apparently included in the Act to enable doctors who may only have had a brief time to examine the offender to have 'the response in hospital evaluated without any irrevocable commitment either side to this manner of dealing with the offender should it prove unsuitable'[93]. The panel asked both Consultant 5 and Consultant 9 why it had been done, as it would have been straightforward to transfer Louisa Ovington under Section 37. Consultant 5 told the panel that he would have preferred Louisa Ovington to continue under Section 37, or ask the court to make a Section 37 order with a Section 41 restriction. Consultant 9 told the panel that he favoured the use of Section 38, as it would, he told the panel, have kept Louisa Ovington in hospital and obliged the court to remain involved. If she had remained detained under Section 37 and the proceedings against her had been discontinued, there was a chance she could have successfully appealed against the Section 37 and been discharged by a Mental Health Review Tribunal. There was no such appeal possible against Section 38. His clear view was that the matter should ultimately be disposed of with a Section 37/41.

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[93] *Home Office Circular No 71/1984*

However reasonable this may have seemed at the time and however worthy the intention, with the benefit of hindsight, the panel could see that it had most unfortunate consequences. By the time Louisa Ovington was transferred to Kneesworth House the Section 38 had only five months to run before it lapsed or was replaced by a different section, which in the event did not happen.

That apart, the Section 38 was correctly implemented and there was no suggestion that the Act and Code of Practice were not complied with.

On 16 August 1999 Louisa Ovington was transferred to Kneesworth House Hospital Hertfordshire, under Section 38 of the Mental Health Act.

She was classified under the Mental Health Act as suffering from mental illness, one of four possible classifications, (which included psychopathic disorder).

COMMENT

The classifications set out, at that time, in the Act were not synonymous with psychiatric diagnoses. They carried differing legal implications. They tended to cause confusion and now no longer apply. In relation to the classification of the disorder as mental illness, this is however perhaps surprising; Consultant 10 considered that Louisa Ovington was suffering from a treatable form of psychopathy and Consultant 9 considered that mental illness was not the primary diagnosis; she was transferred to Kneesworth for ongoing assessment of the treatability of her personality disorder. However Kneesworth concluded that she was suffering from neither.

The Section 38 order was due to expire on 12 January 2000. When the time came, because the hospital made an apparently last minute decision not to ask the court for a hospital order, let alone one with a restriction order attached, Louisa Ovington was discharged into the community very abruptly. There was no planning before discharge as far as the panel can ascertain: certainly there was no care planning meeting until after discharge.

At the point of discharge it appears that Consultant 11 did not appreciate that Louisa Ovington was subject to Section 117. (Her entitlement derived from both the Section 37 under which she had been detained in the Tony White Unit and from her earlier detention under Section 3, in 1996). Consultant 11 did however note that Louisa Ovington should, as a matter of good practice, have a care planning meeting, albeit some time after discharge.

COMMENT

The (then) Code of Practice to the Act clearly required that there should be planning for aftercare before discharge and set out in some detail in chapter 27(of the Code of Practice) how this should be done and who should be involved in the process.

It also states:

> *"...it is clear that a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully without danger to themselves or other people."*[94]

And in relation to the Section 117 provisions:

> *"The aftercare of detained patients should be included in the general arrangements for implementing the CPA, but because of the specific statutory obligation it is important that all patients who are subject to Section 117 are identified and records kept of them'."* [95]

There is no evidence in the records that Louisa Ovington's status as a 'Section 117' patient was recorded.

The notes show that the discharge was virtually unplanned; there is some evidence that the locality social worker was in touch with the hospital prior to discharge but there were no specific social work notes amongst the Kneesworth records (and the hospital confirmed that they would not be located anywhere else). Durham Social Services expressed concern about the abrupt discharge without any aftercare planning. Louisa Ovington had been detained in secure facilities for 18 months. It was, to say the least, surprising that there was no proper planning and the consequences were, in the light of the declaration in Chapter 27.1 of the Code (above) that Louisa Ovington was not equipped, certainly for more than a short period, to cope with life outside the hospital without danger to herself or others. In this respect it cannot be said that the discharge from Kneesworth House was in accordance with the Code of Practice.

On the 22 September 2004 Louisa Ovington made a 'hysterical' 999 call claiming that Mr Hilton would not let her out of the house. She was taken under Section 136 MHA (see 'comment' below) to Hartlepool General Hospital. She had apparently self harmed but was assessed as no risk to herself and refused admission.

COMMENT

The effect of Section 136 is that a police officer may, if a person in a public place appears to be suffering from mental disorder and is in immediate need of care and control, take that person to a 'place of safety' (normally a hospital, but sometimes a police station) to enable the person to be examined by relevant professionals to see whether any arrangements should be made for the persons treatment or care. In this case the section was used appropriately, but there was no further treatment or care deemed necessary.

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[94] *Code of Practice Ch 27.1*

[95] *Code of Practice Ch 27 .3*

Chapter 9 – Conclusions and recommendations

As will be clear from the narrative of significant events in chapter 1 of this report Louisa Ovington's path through her ten years of involvement with the services was far from straightforward; it was crowded with obstacles and was both multi layered and multi stranded. The panel has attempted to produce from the 6500 or so pages of information available to it, (enhanced by the oral evidence given) a reasonably coherent and readable, if lengthy, report. Because of the complexity of Louisa Ovington's needs and the many agencies involved there has been some inevitable repetition in the panel's analysis of the significant aspects of Louisa Ovington's treatment and care set out earlier in this report.

As the panel's work progressed it became clear however, that there were a number of issues which had particular significance in the context of Louisa Ovington's journey through the mental health services and which impacted adversely on the quality of the health care and treatment afforded to her.

These included:

- The circumstances leading to the decision to admit Louisa Ovington to Kneesworth House, the process which resulted in her discharge and her aftercare arrangements.
- The unsatisfactory way in which, with some exceptions, the CPA was applied, throughout the time when she was supposed to be subject both to CPA and Section 117 of the Mental Health Act.
- The effect on patient care of major reorganisations and staffing shortages.
- The failure to give sufficient weight to the impact of drug and alcohol abuse upon Louisa Ovington's general mental health.
- The failure to engage Louisa Ovington with psychological treatments or to refer her to forensic services in the community.
- The failure to invoke public protection arrangements (MAPPA).
- Inadequate collaboration between services, including the failure to share information between the agencies.

Overall, the panel concluded that, if the agencies involved with Louisa Ovington had worked together more effectively, it is possible that Mr Hilton's death would not have occurred.

Given the multiplicity of agencies involved with Louisa Ovington at any one time, the panel found it hard to attribute clear responsibility to specific agencies or individuals: the failures seemed to be more rooted in systemic inadequacies than individual shortcomings; however, there were instances of practice that fell short of acceptable standards of care.

Louisa Ovington's presentation over a period of years reflects, the panel suspects, the reality that faces many mental health agencies. Her difficulties, after she suffered a highly traumatic event as a young child, showed in ways that were neither particularly dramatic nor unique. They were chronic and deep seated and resulted in years of disruptive behaviour, culminating in an event which tragically ended her victim's life, altered his family's life forever and effectively ruined her own. Her problems were not susceptible to a quick, obvious solution. The following conclusions and recommendations seek to deal with specific areas of practice which, were the recommendations to be acted on, would result in better, more coherent and more robust care for patients such as Louisa Ovington.

The panel also acknowledges that because of the number of professionals involved in her care, the following conclusions and recommendations have a degree of overlap.

i. CPA/Care coordination

There is no reason why staff should not now be familiar with the requirements of the CPA. It is clear from the actions/omissions of staff involved with Louisa Ovington that most did not for whatever reason follow the guidance issued in 'Effective Care Co-ordination' and appeared at best to apply the requirements in a 'mechanistic' way. The opportunities afforded through the practical application of the CPA were not maximised in this case.

Particular issues of note were:

a) Role of care co-ordinator – During the five years following her discharge from Kneesworth House, Louisa Ovington had at least six different care coordinators and several consultants were at least nominally involved with her care, though she mainly saw Staff Grade Psychiatrist 1. The quality of the input from the different professionals varied. Social Worker 2, despite her pivotal role as Louisa Ovington's first care coordinator post discharge after 18 months in hospital, never saw Louisa Ovington. Social Worker 4 had extensive useful contact with her. Social Worker 5 failed to ensure that Louisa Ovington had proper follow-up when she left her post. The panel was concerned that Louisa Ovington was effectively left without a care coordinator for six months and considers that Team Manager 3 should have stepped in and allocated a worker to her much sooner

than he did. For those six months, Consultant 2 appears to have been the nominated care coordinator. It was Staff Grade Psychiatrist 1 who was following Louisa Ovington up in outpatients and only he who (in theory) was seeing her regularly. Social Worker 7 worked well with the other agencies involved with Louisa Ovington, attempting to arrange case conferences and MAPPA meetings. CPN 2 was only involved with Louisa Ovington for a couple of months before the homicide occurred.

It is quite clear in the guidance produced by the Department of Health in 1999 that the appointment of a care co-ordinator was a key component in ensuring the success of Effective Care Co-ordination. It is reasonably clear from the records who had this responsibility at any given time apart from one spell in 2004. What is less clear however is how well this responsibility was discharged. There were some attempts made at pulling together interested parties to CPA meetings although these were infrequent and poorly attended. (There was however evidence of good practice in calling CPA meetings at moments of crisis or acute concern, although the nature of these last minute meetings meant that, often, essential professionals could not attend) .With the exception of Social Worker 4 and Social Worker 7, the panel's view is that the Louisa Ovington's care was poorly coordinated. There was little or no overview and the impression was one of 'fire-fighting' when necessary and dealing with issues as they arose. There was no sense of purpose or direction with resolving her psychological problems and very little progress with her social issues. The guidance outlined by the Department of Health in 1999, provided a clear vision of the role of the care co-ordinator and with it the opportunities to plan care and commit resources. There is little evidence of this occurring.

b) CPA levels/Section 117 Mental Health Act – It was unclear at times what level of CPA was in place and it appears from the records that it may have varied between 'standard' and 'enhanced'. The panel was surprised that, given the history of violence, arrests, convictions, behavioural disturbances and abuse of drugs and alcohol which required almost a constant multi-agency involvement, Louisa Ovington was not maintained on enhanced CPA and subject to regular CPA and Section 117 reviews. In the case of Section 117 this was a statutory obligation deriving from her very first stay in hospital and in addition following her detention under Section 37. It should never have been overlooked.

c) Care planning forming the basis of treatment – Key components in ensuring the successful application of the CPA are the systematic recording, reviewing (incorporating the views of all relevant parties) and auditing of care plans. The panel could find little documentary evidence that this consistently occurred. It is clear however that on the occasions when care plans were completed, compliance with CPA objectives was patchy and the policing of this was minimal.

Had detailed, up to date and accessible plans been in place this would have facilitated the continuity of care which was lacking as Louisa Ovington moved between services. The panel fully understands the services' difficulties in gaining Louisa Ovington's agreement to engage with them and notes on occasions her outright resistance to any intervention. The presence of proper care plans together with good inter-agency working would have enabled a more strategic approach with realistic longer term objectives.

d) Maintaining a comprehensive history – There are copious records generated by each of the mental health services with which Louisa Ovington had contact and the panel has been in the privileged position of having access to what is believed to be most of them, as well as to police and probation records. Despite the quantity of information contained in them, there was no comprehensive (or even summary), regularly updated history. It almost appears that each intervention was the first episode in her care with little recognition of what went before. The fact that she spent 18 months of her life, at a relatively young age, detained in secure hospital facilities, did not appear to have registered, either at all or with the significance that it merited.

Additionally there was little evidence of any attempt being made to consider whether her psychological and behavioural problems were showing any sign of improvement or deterioration.

e) Discussion with and assessment of families As has been previously noted in this report little attempt appears to have been made to capture the views of either Louisa Ovington's partner or her family members. In particular, there are no records that Mr Hilton was approached for his opinions or to have his needs assessed as her 'significant other'; this was most concerning given their volatile history.

f) Discharge care planning – The clinical team at Kneesworth House will have known from the first day of Louisa Ovington's admission there that they would have to make a recommendation to the court regarding disposal by 12 January 2000 when the Section 38 finally expired. However, the decision to recommend a probation order with a condition of treatment was only made two days before that court appearance. Until then, it appears that it was planned to recommend that Louisa Ovington be detained under a hospital order. As a consequence of this sudden and late change in plan, there was no time for a care planning meeting to be held with the home team before discharge and there was no discussion with probation, who concluded that they did not need to be involved. The care package that was subsequently set up was not implemented and Louisa Ovington became lost to services at this critical point.

It was of concern to the panel that although Consultant 9 offered to accept continuing responsibility for Louisa Ovington and offered the forensic services at Newcastle as a point of contact for Kneesworth House, the staff at Kneesworth House did not keep him informed about Louisa Ovington's progress. Neither he nor the forensic team were involved in any discharge planning. Furthermore, there was no evidence of any correspondence from Kneesworth House with the funding authority.

There was a Locality care coordinator at the time (Social Worker 2) who did have dealings with Kneesworth House. However she did not seem to regard it as necessary to keep Consultant 9 informed.

g) Transfers – Transfers of care coordination were variably managed. The panel was told by the care coordinators whom they interviewed that they were only given limited information about Louisa Ovington when they began their work with her. From review of the notes, it is apparent that only one care coordinator actually introduced the new care coordinator to Louisa Ovington when they handed over her care. Social Worker 5 concluded that Louisa Ovington did not require a CMHT worker; she discharged Louisa Ovington from the team and it was only a month later that she wrote to Consultant 2 to inform him that he was to be the care coordinator. There is no evidence that he ever met her. Patients often have difficulty in coping with changes in workers and it was notable to the panel that Louisa Ovington's mental state and behaviour significantly deteriorated following each transfer of care.

h) Record keeping – The panel was concerned to note that that despite the integration of mental health social workers into CMHTs to work alongside health professionals, it seemed that the recording systems of health and social services remained distinct: social services using SSIDs[96] and health their own recording system. Thus, a new care coordinator from a different discipline (for example a CPN who took over from a social worker) would not record on the same system. If this is the case, then the continuity of record keeping is broken, there is the potential for information being 'lost' between the systems and thus of other professionals being unaware of what may be highly significant events. The panel also heard that, because the CMHT office was shut outside normal office hours, the CRT was unable to access the CMHT notes, or could only do so with difficulty. It is hard to understand how such an obvious problem had not been anticipated and dealt with, leading as it did to a situation identified elsewhere in this report of services responding to Louisa Ovington as though each presentation were new: having a snapshot of her difficulties rather than a longitudinal view, or at the very least having some documented context in which to deal with her.

[96] *Social Services Information Database*

i) CPA administration – The role of the CPA office was unclear. The panel could find no evidence of a relationship between the care co-ordinators and the CPA administration in this case. There is some evidence that care plans were produced and typed copies appeared in the records, but these were produced some time apart and did not seem to be the result of any guidance from the CPA administration to undertake CPA reviews and produce updated plans (see (c) above). The panel was also concerned that there was no rationale for the way care co-ordinators were allocated and the decision to allocate the care co-ordination responsibility to senior medical staff in Louisa Ovington's case was inappropriate and should have been challenged by CPA administration.

The panel is aware that further modifications have been made to the CPA guidance in 2008. In particular, the new guidance suggests that in reviewing policies and practice mental health trusts should:

– Consider whether the documentation used to record the needs and plans of service users not needing (new) CPA can be simplified;

– Consider the refined definition of (new) CPA to ensure individuals with higher support needs are identified and appropriately supported; and that individuals not needing this level of support are also appropriately cared for;

– Review key groups and consider need for (new) CPA;

– Be clear on the links between need for CPA and eligibility criteria;

– Ensure systems are in place for service users to be appropriately and safely allocated to and from CPA.

- **Recommendation 1. Trusts should ensure that the new CPA guidance is or has been implemented and that this is fully understood by staff and supported with intensive training.**

- **Recommendation 2. Trusts should ensure that all patients subject to CPA have a designated care coordinator who should be responsible for following the patient throughout stays in hospital whether locally or further afield, within the NHS or within the private sector. It should be the responsibility of the treating hospital to ensure that care coordinators are invited to care planning meetings and that they are kept informed about any impending significant changes to the plans. Where the patient has been placed outside the locality, the care coordinators should, in turn, ensure that other relevant professionals in the locality are informed of all developments.**

- **Recommendation 3. Formal care planning meetings, involving current and future care providers, must be held prior to a patient being discharged from hospital and prior to any event that is known to have the potential to result in the patient being discharged (in this case, the expiry of the Section 38 order).**

- **Recommendation 4. If a patient is admitted to an independent hospital outside the local area, progress reports are sent to the care coordinator and the funding authority at least every three months.**

- **Recommendation 5. Care coordinators may leave their posts at short notice. The panel accepts that this and difficulties in replacing staff, may militate against good handovers between care coordinators. However, trusts should ensure that transfers of care are agreed to in writing, that the new care coordinator accepts that he/she is taking on responsibility for the patient and that CPA documentation includes a full and up to date historical summary that can be handed over to the new care coordinator.**

- **Recommendation 6. Trusts should give serious and urgent consideration to implementing a unified computerised record keeping system on which all entries relating to the day to day working with a client are recorded, by all mental health professionals.**

- **Recommendation 7. Trusts should ensure that a thorough needs assessment is carried out for both carers and "significant others" to properly inform risk assessments and care plans.**

ii. Risk assessment

Past behaviour is the best predictor of future behaviour. An accurate and complete history is therefore essential as the foundation for an effective risk assessment and management plan.

There was little evidence of formalised risk assessment within health and social care that was meaningful in the context of Louisa Ovington's repeated threats of violence and abuse including serious threats against Maurice Hilton. Several local models were in use but the impression given was that they were completed on an 'ad hoc' basis with little or no valid contribution to the overall treatment programme.

The only other agency that used formalised risk assessments routinely was the probation service which used its standard, nationwide OASys tool. This could at times have usefully informed health and social care risk assessments, or been used in multi agency working, particularly in relation to MAPPA, but there was no evidence of this.

Some of the risk assessments from all agencies that undertook them failed to accurately reflect historical details and at times it seemed that the assessments might have become an end in themselves, rather than being used to inform a risk management plan. Furthermore, there is a danger with formalised risk assessments that they supplant personal professional judgement.

'Lone worker' policies: While there was no evidence that Louisa Ovington presented a clear danger to professionals visiting her at home, neither was there any evidence of any 'lone worker' policy being in place in the mental health services. However, there may have been informal practices in each office. Only on one occasion (by probation, during the supervision of the brief CO in November 2005[97]) was there any mention that staff might be at risk from Louisa Ovington - and that was not communicated, as far as the panel could establish, to the care coordinator. The panel was told that risk assessment is partly a dynamic process - each new circumstance informs it. Any perceived increase in risk should be reflected in (amongst other things) heightened awareness of staff safety.

- **Recommendation 8. Trusts should ensure that accurate and regularly updated risk assessments, using a reliable tool, are carried out and that the results of these are incorporated into risk management plans. This should be supported by training and regular audit.**

- **Recommendation 9. Trusts should review policies to ensure that there are up to date 'lone worker' or 'home visit' policies in place in each part of the front line services, that staff are aware of such policies and aware of the procedures in place to implement them.**

- **Recommendation 10. Where there are several agencies involved with a patient and one of those agencies (be it health, social care, probation, or police) has implemented or considered implementing a 'lone worker' or 'home visit' policy in relation to that patient, this should be communicated to the other agencies involved, either through the care coordinator, or through public protection arrangements.**

iii. Public protection - MAPPA

The panel concluded that undoubtedly Louisa Ovington should and could, have been made subject to MAPPA. Had this happened, the wealth of information about her, which the agencies possessed but was never put together, would have been shared; a properly informed and rigorous risk assessment carried out (and updated to reflect new events or information), and a robust multi agency risk management plan could have been implemented. This would have placed a responsibility on the professionals involved to manage her risk, which would, as part of a joint approach, have been taken more seriously than it was.

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[97] *Chapter 1 Paragraph 212*

It was evident from the records and from what the panel was told by some witnesses that, in 2004, there was confusion, ignorance and perhaps an underlying lack of confidence, amongst some health and social care professionals about what avenues could legitimately be pursued when issues of public protection were raised. The issue was mentioned several times and although Social Worker 7 raised the matter specifically with probation on at least two occasions, on being rebuffed she did not pursue the matter. Despite the fact that it was perfectly reasonable of her to accept the view of the probation service (since they were part of the Responsible Authority), in her role as a representative of one of the 'duty to cooperate' authorities, she or her manager could have made the referral to the MAPPA agency themselves.

Both the police and probation have acknowledged that they should have referred Louisa Ovington for MAPPA.

MARAC (Multi Agency Risk Assessment Conference) and MAPVA (Multi Agency Protection of Vulnerable Adults) are two further frameworks for public protection, both introduced locally after Louisa Ovington killed Mr Hilton. (The panel does not know and has not investigated, whether Mr Hilton would have been categorised as a vulnerable adult).

- **Recommendation 11. Staff dealing with patients whose behaviour is clearly risky or potentially risky, who have a history of detention in hospital as offenders, or have had dealings with the criminal justice system for violent offences, need to know when and how, it is appropriate to refer to MAPPA. The criteria and MAPPA referral procedures, external and internal to the particular organisation, should be made crystal clear to all mental health professionals, including doctors, working in front line services, should be part of any induction programme and a regular and compulsory part of ongoing training. The training need not be burdensome, lengthy or expensive.**

- **Recommendation 12. Similarly, staff should be made aware of the potential for referral to MARAC and to MAPVA and clear about the criteria and procedures as set out above.**

iv. Organisational structure

It is unfortunate that during her ten year journey through the psychiatric services in the north east, Louisa Ovington was admitted to no fewer than five inpatient units. This excludes her inpatient episodes in Edinburgh and Kneesworth House. The resultant change of psychiatrists and other clinical staff would have done little to bring together her needs into a consistent and meaningful clinical management plan.

It is recognised also that services in the Easington locality were not as well developed into the new millennium as they were elsewhere in the north east. A major investment programme was established through Easington PCT to enable the new services required by the Mental Health National Service Framework to be provided.

While this was a welcome development it did produce a period of turbulence while reorganisation was taking place and this together with Louisa Ovington moving into new localities gave rise to a fragmented approach to her care. In particular, the following issues were noted:

a) Staffing issues – The panel heard in evidence that recruitment and retention were major issues locally. This was more so with senior medical staff than other disciplines and it resulted in a number of temporary psychiatrists being appointed as locums. The number of times Louisa Ovington changed psychiatrists in addition to changes to care co-ordinators and a change of GP is noted elsewhere in this report. This picture was mirrored within other agencies and it is noted that Louisa Ovington was involved with at least seven probation officers during the period under review.

   The consequences of such major disruption to her management are clear.

b) Team changes – while the new developments were welcomed - the arrival of new teams bringing with them new staff and enhanced inter-agency working - the benefits to Louisa Ovington's care were less than clear. There should have been an opportunity for multi-disciplinary working with Louisa Ovington benefiting from a broader range of skills, but the reality was that staff continued to work in an un-disciplinary manner with little cross fertilisation of ideas. The CRT offered much in their operational policy but limited themselves in what they were able in practice to offer Louisa Ovington.

   There is little evidence of staff within the teams utilising the availability of peer review or clinical supervision to audit their clinical input to individual cases.

   What should have been an opportunity for 'joined up working' did not fully materialise.

- **Recommendation 13. The panel recommends that the question of continuity of care is addressed; where possible, care should follow the patient and where a patient moves within a reasonable distance, there should be no undue haste to enforce changes of service provider.**

- **Recommendation 14. Trusts should take the opportunity to review the joint working arrangements within teams, to determine whether**

appropriate opportunities exist for clinical supervision, peer and case review and to instigate procedures if not.

v. Clinical issues

a) Provision of inpatient care

Prior to 1998 Louisa Ovington was appropriately managed in relation to her psychotic illnesses and whilst her emerging personality disorder was not treated it was recognised as an issue. From June 1998 to January 2000, Louisa Ovington was detained in a psychiatric intensive care unit, a forensic medium secure unit and finally a specialist personality disorder ward in an independent sector hospital. She was treated for symptoms of mental illness at each institution, but whilst her personality problems were recognised at all three, at none did she receive adequate treatment for these. This appeared partly to be due to her being placed in units that did not feel equipped to work with her (the Tony White Unit and St Nicholas' Hospital) and in the case of Kneesworth House, because they concluded that she suffered only from personality disorder traits and in any event Louisa Ovington declined to engage in therapeutic work. It appears that there was little attempt to motivate her in this.

- **Recommendation 15. The panel recognises the pressure that may force psychiatrists to rapidly admit a patient to hospital where there is an urgent need for treatment. However the appropriateness of the placement should be kept under close review and trusts should ensure that the responsible psychiatrist is supported in finding an alternative placement when clinical need, or the safety of staff, is an issue. Trusts should also ensure, wherever possible, that choice of hospital is motivated not by expediency but by matching the patient's need to the care that can be offered.**

b) Use of psychometric tests

The psychologists at Kneesworth House concluded that Louisa Ovington was not suffering from personality disorder. This conclusion was based in part upon Louisa Ovington's answers to self-reported questionnaires and it contradicted the clinical opinion of other psychologists who had worked with Louisa Ovington previously. This conclusion underpinned the decision of the consultant not to recommend any further detention.

The panel heard from clinicians from other hospitals that psychometric testing should not be used to diagnose personality disorder, in isolation from clinical judgement.

- **Recommendation 16. Trusts should review clinical practice to ensure, in relation to psychometric tests, that they are only regarded as an adjunct to clinical judgement to inform diagnosis. They should not, on their own, be regarded as diagnostic instruments.**

c) Personality disorder services

When Louisa Ovington was transferred to St Nicholas' Hospital she was thought to be suffering from a personality disorder (possibly psychopathic) and mental illness (possibly schizophrenia or bipolar disorder). By the time she was transferred on to Kneesworth House, there was less evidence that she was suffering from a mental illness but staff were clearer that she was suffering from a personality disorder. However, when she was finally discharged back into the community there was still no clarity as to her diagnosis. The discharge report from Kneesworth House stated that she had a "past history" of mental illness and that she "could not be said to have a personality disorder". Inconsistently, the staff from Kneesworth House stated at Louisa Ovington's post-discharge care planning meeting that they felt she needed a condition of treatment attached to a probation order, but they did not specify whether she needed treatment for illness, personality disorder, or both. This lack of clarity about diagnosis meant that no appropriate treatment plan was formulated. It appears evident to the panel that thereafter Louisa Ovington's mental health difficulties were not taken so seriously and there was at times reluctance from services to be involved with her because she was not regarded as mentally ill.

- **Recommendation 17. The trusts need to be clear where the remit for working with people with personality disorders falls. It needs to be recognised that personality disorders can be as serious as illnesses such as schizophrenia in terms of their negative impact on the individual and the society around them. Appropriate, ideally specialist, services need to be provided for such patients and the professionals working with them need specific training and support.**

d) Use of forensic services

Louisa Ovington was followed up in the community by general adult mental health services; the CMHT, the addictions services and, at times, the CRT. Given her history of violence and her detention in conditions of medium security, following her discharge from Kneesworth House she should at least have been discussed with, if not taken on by, the forensic services, which the panel were told would have been willing and able to work with her.

- **Recommendation 18. Whilst not all patients who have been in medium secure hospitals require ongoing support from forensic services, mechanisms should be put in place to ensure that such patients are discussed with the local forensic services when they are discharged into the community. Ideally, the forensic services should be invited to attend the pre-discharge care planning meeting, but if this is not possible, then the treating community team should subsequently discuss the case with their local forensic team.**

e) Use of addictions services

From at least 1996 onwards, the misuse of drugs and alcohol had a seriously harmful effect on Louisa Ovington's mental health and impacted on the safety of others. She was intoxicated with alcohol when she killed Mr Hilton. In the panel's opinion this issue was inadequately addressed. Some attempts were made to tackle it, both whilst she was in the community and also as an inpatient. She was discharged from Kneesworth before this work could be completed and she did not properly engage subsequently in the community. Little attempt seems to have been made to motivate her to do this. Furthermore, the panel was concerned to note that the staff working with her appeared to simply accept whatever Louisa Ovington told them about her drug and alcohol use. The community addiction services worked independently from the mental health teams. There seemed to be poor integration and information sharing between adult mental health services and addiction services and the addiction services appeared to have seen their role purely as dealing with the immediate problem of Louisa Ovington's drinking and drug use, rather than exploring what lay beneath it, or what its consequences were both in terms of her own health and the safety of others. The panel is concerned that, in cases, such as this, where patients are subject to CPA, addiction services are not part of the CPA process and are not incorporated into the mainstream community mental health services.

- **Recommendation 19. Trusts should endeavour to improve the joint working between the addiction services and the adult mental health services, with sharing of information and collaborative care coordination.**

- **Recommendation 20. Alcohol services often stress that patients need to engage with them on a voluntary basis. However, this does not preclude the need for these services to make every effort to motivate the patients to engage. Staff working with this client group should be trained in such techniques and receive regular supervision.**

f) Use of "talking therapies"

The panel could find no evidence that anyone ever did any significant work with Louisa Ovington regarding her childhood experiences. She appears not to have been offered psychological help during her childhood; she did not engage with psychologists whilst in hospital; she did no formal work on this in the community.

The panel accepts that Louisa Ovington was reluctant to engage in psychological work. Nonetheless, the panel considers that significant opportunities to attempt treatment of Louisa Ovington were missed:

- She could have been referred to CAMHS following the death of her mother.

- She saw a private counsellor when she attended Peterlee College, but no attempts were made to refer her for counselling through the NHS when she began to come into contact with adult mental health services.

- There was little opportunity for her to engage in psychological work when she was admitted to the PICU at the former County Hospital in Durham. When she moved on to Newcastle and then to Kneesworth House, psychologists carried out assessments, but they did not tackle the more difficult task of engaging her in therapeutic treatment.

- A year after her discharge, Social Worker 4 tried to arrange some formal counselling for her. At this point Louisa Ovington was ambivalent about engaging in this work. It took at least six months for an agency to indicate that they would be willing to work with her. By this time, she appeared to have lost any interest that she had had in doing this work and she did not approach the agency herself as they had requested. Social Worker 4 then attempted to have Louisa Ovington referred for psychotherapy – but again it took over six months for her to be seen. It appears that little effort was then made to encourage her to take up the option of doing this work, on the grounds that Louisa Ovington was apparently only looking for symptom relief. Subsequently, she was never referred for any form of therapy, despite various staff discussing the potential value of this for her.

- The panel was told that, at that time, there were no specific services for people with personality disorders and specialist treatments such as dialectical behaviour therapy were unavailable. Whilst it might have been difficult to engage Louisa Ovington in psychodynamic therapy and the process of it might have been very disturbing for her, it was unfortunate that it took so long for her to be referred

and subsequently for the assessment for psychological work to take place, as any motivation she had for doing the work appears to have been lost during the intervening period.

- **Recommendation 21. Trusts should review the provision and availability of "talking therapies", including dialectic behavioural therapy in the trust area and encourage clinicians to actively consider whether the needs of a patient should be addressed by psychotherapy or psychology. This is particularly important where a patient (such as Louisa Ovington) has suffered some form of extreme childhood trauma.**

g) Referral procedures

The panel noted that on a number of occasions there was confusion about how referrals to services should, or could be made.

Examples were:

i. In April 2001, Social Worker 4 was attempting to get psychological support for Louisa Ovington. It appeared to the panel remarkably difficult for him to get someone to refer her, as he kept being advised to discuss the matter with different people. It was unclear why he could not refer her to the psychology department himself. The referral to Psychotherapist 1 was finally done by Consultant 5 in July 2001.[98]

ii. At around the same time, Social Worker 4 was trying to get Louisa Ovington referred to CPN services, which should have been done after her discharge from Darlington Memorial Hospital in February 2001. He seemed to be unable to effect this referral and again, the panel was unclear about why.[99]

iii. In early 2002 there was no clarity at all about who was responsible for overseeing Louisa Ovington's psychiatric care. Social Worker 4 was attempting to find out about her current mental health. After several calls, first to Consultant 14 (who he was informed had left several months earlier) and then to Consultant 13, to no effect, he was told by Consultant 13's secretary that if he wished to access Louisa Ovington's outpatient records, he should ask the GP to get hold of them.

iv. On 10 June 2004 the emergency duty social worker received a referral from Louisa Ovington's landlady about Louisa Ovington's extremely disturbed behaviour. The social worker rang the GP, who told her to contact the CRT, who refused to take a referral from the social worker, as it 'needed to come from a

[98] *Chapter 1 paragraph 126*
[99] *Chapter 1 paragraph 118*

professional who had seen her within the past 24 hours'. The social worker then rang Staff Grade Psychiatrist 1 (the apparent care coordinator at this time) who told her to ring the GP again and ask him to make the referral to either the CRT or the CMHT. [100]

v. On 5 October 2004, a referral to the forensic services was apparently agreed at a meeting between Social Worker 7 (the then care coordinator) and Staff Grade Psychiatrist 1. This was not done. Staff Grade Psychiatrist 1 told the panel that it should have been done by the care coordinator, whereas the panel was later told by Consultant 9 that he would have expected the referral to be made by a doctor.

The panel felt that these examples revealed two things, first a general ignorance amongst mental health professionals and staff about referral /access procedures which, if it remains the case, needs to be addressed urgently and secondly an undue rigidity within some of the services about their own referral criteria. While it may be justifiable to decline to accept a person to the service because the person does not meet the criteria for that service, it is less justifiable to decline to accept a referral from a professional who is requesting that the service assess the patient simply because it is the wrong sort of professional making (or trying to make) the referral.

- **Recommendation 22. Trusts should ensure that all mental health professionals and staff across the various services are clear about who can make referrals to any other branches of the services, including psychiatrists, psychology, forensic, CMHT services, CRT, AOT[101] etc. and what the mechanism for referral is.**

- **Recommendation 23. Trusts should disseminate across the services the criteria established by each branch of the service for acceptance into and exclusion from that service.**

h) Disengagement and discharge from services

'Engagement'- the patient's active and willing involvement with the mental health services is a major component in the successful management of mentally disordered patients in the community. However with a complex individual such as Louisa Ovington, whose mental health issues were not easily defined, presented variably, were complicated by substance abuse and resulted in serious behavioural problems, engagement is not straightforward. The panel was concerned to note that there were several occasions when Louisa Ovington was discharged from services. On some occasions this was as a result of failure to attend appointments, notably in the summer of 2004, by Staff Grade Psychiatrist

[100] *Chapter 1 paragraph 127 and see subsequent comment.*
[101] *Assertive Outreach Team*

1, during a period when serious concerns were being expressed about her. In June 2000 she had been similarly discharged by Consultant 12 after three non attendances at outpatients. The letter she was sent remarked, "When people do not attend and do not let us know that they are not attending, then we can assume that things are going well for them at present and that they no longer need our services". At other times she was discharged because she was felt not to fit the profile of the service. The drug and alcohol services discharged her twice, accepting her statements that she no longer needed their help. The CRT saw no role for themselves in May 2004, since the primary diagnosis was 'alcohol dependence and anger management' issues. Social Worker 5, in early 2004, discharged her, noting that she had 'agreed' with Louisa Ovington that she did not need input further, leaving her without an active care coordinator and with her file closed to social services.

It is easy to sympathise with front line staff in overstretched services dealing with difficult clients who only 'engage' when they feel like it. The panel's view however is that the services were sometimes too ready to believe that because Louisa Ovington was not attending she must therefore be in less need of services; or that the responsibility should lie on her to arrange and attend appointments; or that they should 'empower' Louisa Ovington by accepting her own evaluation of her needs. The panel is also concerned that in some instances services may have elevated their discharge practice to the status of policies, which may then have been too rigidly enforced.

Additionally, patients with personality disorder will, by the nature of the disorder, present additional problems in terms of engagement.

- **Recommendation 24. That the trusts reviews all policies, formal or informal, that prescribe general rules for discharge from services and ensure that they are not applied in a formulaic way. Discharge should be dictated not by non attendance per se, or by self evaluation, or by rigidly applying service criteria, but by clinical need and an up to date assessment of risk. If a patient has repeatedly failed to attend appointments, careful consideration should be given to whether more active steps should be taken to ensure engagement. The care coordinator's opinion should be sought, as he or she is likely to have a broader knowledge of the patient.**

- **Recommendation 25. There should be programmes in place to ensure those working with patients with personality problems are appropriately trained in motivational interviewing and engagement techniques.**

i) Joint working

Louisa Ovington was involved with her GP, mental health services (general adult services, addiction services, the CRT), social services, probation and the police during the years following her discharge from Kneesworth House. She clearly presented complex problems to those working with her. It was apparent to the panel that some of those working with her saw the need to work jointly with all agencies, but this never occurred effectively. There was little evidence of mental health professionals working with her GP, or of her GP being a pivotal figure in her care. There was very limited sharing of information between services, particularly between health/social services and the police/probation.

- **Recommendation 26. Trusts should ensure that appropriate channels of communication are set up between mental health services and all other agencies working with patients. Care programme meetings could be a forum for this. GPs should be invited to attend all such meetings. Where criminal justice professionals are involved with a patient, the CPA meeting should be used as an opportunity for liaison with and sharing of information between all the different agencies. (See below).**

vi. Interface between police, probation and the mental health and social care services

Louisa Ovington's first encounter with the criminal justice system occurred when she was 15. When she was 22 she committed the serious offences which resulted in her spending 18 months detained in hospital. Thereafter her offending continued and gradually increased in frequency, although it did not result in custodial sentences or further detention in hospital. In 2004, Louisa Ovington's behaviour deteriorated dramatically and for a few months she was rarely out of contact with the police. Between 2000 and 2005, the probation service was involved with her in the preparation of six pre-sentence reports and in supervising three community orders.

Louisa Ovington was subject to the CPA (and entitled to Section 117 aftercare services) from 1996 when she was first detained in hospital. Thus, for a period of ten years she was acknowledged to be a person with serious mental health problems. Yet from early 2000 three strands of her life, involvement with mental health services, police and probation, seemed to run on parallel lines. All these agencies had amassed information along the way about her risky tendencies, but they rarely shared the information or effectively worked together. However there were good efforts by two or three mental health professionals and a few isolated instances where the police or probation services were pro-active in making contact with their colleagues in health, or where each was actively seeking (rather than offering) information.

It would seem from the panel's experience in reading and hearing the evidence that there is a degree of scepticism or mistrust between some of these services; for example, criticisms were voiced about the police or Crown Prosecution Service (CPS)[102] being reluctant to prosecute offences committed by patients in hospital, which would be pursued if the offender were in the community; and the police remarked that the issue of medical confidentiality bedevils attempts at information sharing. The panel accepts that this is a difficult issue, but would point out that the principle of confidentiality has to be weighed up against the need for public protection. ***If there were ever a case where information sharing and a joint approach were essential, this was it.***

Observations to the SHA in relation to the police and probation services:

The panel does not believe it would be appropriate, or welcome, to make recommendations for action to either the police or probation service, since, although they have cooperated fully with the investigation, they have had no part in commissioning this report. However, the panel expresses the respectful wish that the SHA should communicate the following suggestions to the police and probation service, which it hopes the two services will regard as helpful and constructive in furthering what must be a shared aim of reducing risk to the public as well as promoting an understanding of mental health issues suffered by offenders:

- **Durham Constabulary should establish and maintain, by whatever means are appropriate, a direct and formalised channel of communication between themselves and the mental health services within the Durham police area. Where the police are aware that an offender has mental health issues they should establish whether the offender is subject to the CPA, establish the identity of the care coordinator and ensure that the offender's interactions with the police are reported to the care coordinator.**

- **The police should wherever possible, attend case conferences when invited and care coordinators should ensure that where there is any suggestion that the client is involved with the police, a police presence, or, if not possible, a brief written update on police involvement, is requested and the police should as far as possible, comply with this request.**

- **The two preceding paragraphs are equally applicable to the probation service where it is involved with a client.**

- **The probation service, which seemed, from the information before the panel, to be more accustomed than the police to (at least) informal communication with the mental health services, should nonetheless review**

[102] *Crown Prosecution Service*

their procedures for formal contact and sharing information. They should ensure that when they are supervising a client with known mental health or drug and alcohol problems, there is a formal system in place for communication with the mental health services, so that information can be shared both ways.

- **No CO with a condition of psychiatric supervision should be made unless the probation service has (after consultation with him/her) identified the supervisor and informed the court of his/her identity. The court service should be invited by the probation service to consider revising its form to include the name and professional details (address and discipline) of the supervisor in the order and the probation service locally should amend its procedures to ensure that the probation officer understands that it is his/her responsibility to manage that condition and establish procedures by which this is done in every case.**

vii. Policies and procedures

Several policies and procedure documents were received which helped the panel to understand the remit and workings of the numerous teams with which Louisa Ovington came into contact. The standard of the content and presentation varied considerably and it was not always possible to ascertain when they were produced, by whom, for which organisation and on what date they should be reviewed. It may be that as a result of the recent trust mergers many documents have eluded the archives and therefore were not retrieved.

- **Recommendation 27. Trusts should ensure that all policies include the production and review dates; the author; the organisation to whom it relates and are archived in a system, preferably electronic, where easy access is available.**

viii. Records

The panel found that most of the health records examined were reasonably comprehensive, some more than others. However there was much more variation in the standard of organisation of the hospital records: those from Edinburgh, Winterton, the Tony White Unit, St Nicholas' Hospital and Kneesworth were well organised and easy to follow, (although Kneesworth had no section covering the hospital social work department's involvement), whereas the records from Hartlepool General Hospital and Darlington Memorial Hospital were not: little logic or method seemed to have been applied to how they were set out and this made it hard to see clearly what had happened during Louisa Ovington's periods as inpatient.

The GPs' records were clearly based on the 'Lloyd George' system and were somewhat sparse, but may have accurately reflected their relatively minor degree of involvement in her mental health care.

The social work records were reasonably comprehensive and easy to follow although her child and adolescent social services records could not be found. Her education records had been destroyed, which was unfortunate.

The records from the CMHT and CRT were also reasonably comprehensive and easy to follow; the addictions services' recording was somewhat sparse, perhaps reflecting Louisa Ovington lack of engagement.

There was a notable lack of CPA documentation throughout the records: this may have reflected either the relative infrequency of CPA planning or meetings, poor recording, or poor storage of documents. The CPA office for the trust area, which should retain all records, had a very limited archive of CPA documentation relating to Louisa Ovington.

As has been remarked on earlier in this report, there was a complete absence in any of the records of any comprehensive and regularly updated summary of Louisa Ovington's history which would have informed clinicians who took over her care.

- **Recommendation 28. Trusts should ensure that all professionals keep up to date, contemporaneous notes that are organised methodically and in such a way that they are readily accessed (by those authorised to do so) and easily understood.**

- **Recommendation 29. A comprehensive, regularly updated chronological history should be maintained which is accessible by all those (authorised to do so) who are dealing with the patient.**

- **Recommendation 30. Where trusts are commissioning services from independent sector providers, trusts should ensure that the practice of those providers complies with those recommendations.**

- **Recommendation 31. The panel is concerned that many of the above conclusions and recommendations echo those made in other investigation reports, therefore consideration should be given to the use of such reports for training purposes. Additionally, the panel hopes that this report is widely disseminated across agencies.**

This investigation was established to examine the health care and treatment afforded to Louisa Ovington. Nonetheless, whatever deficiencies the panel may have identified, it should never be forgotten that it is Louisa Ovington who was actually responsible for Mr Hilton's death.

List of recommendations

The panel recommends that North East Strategic Health Authority requires trusts to adopt the following recommendations:

- **Recommendation 1. Trusts should ensure that new CPA guidance is or has been implemented and that this is fully understood by staff and supported with intensive training.**

- **Recommendation 2. Trusts should ensure that all patients subject to CPA have a designated care coordinator who should be responsible for following the patient throughout stays in hospital whether locally or further afield, within the NHS or within the private sector. It should be the responsibility of the treating hospital to ensure that care coordinators are invited to care planning meetings, and that they are kept informed about any impending significant changes to the plans. Where the patient has been placed outside the locality, the care coordinators should, in turn, ensure that other relevant professionals in the locality are informed of all developments.**

- **Recommendation 3. Formal care planning meetings, involving current and future care providers, must be held prior to a patient being discharged from hospital, and prior to any event that is known to have the potential to result in the patient being discharged (in this case, the expiry of the Section 38 order).**

- **Recommendation 4. If a patient is admitted to an independent hospital outside the local area, progress reports are sent to the care coordinator and the funding authority at least every three months.**

- **Recommendation 5. Care coordinators may leave their posts at short notice. The panel accepts that this, and difficulties in replacing staff, may militate against good handovers between care coordinators. However, trusts should ensure that transfers of care are agreed to in writing, that the new care coordinator accepts that he/she is taking on responsibility for the patient, and that CPA documentation includes a full and up to date historical summary that can be handed over to the new care coordinator.**

- **Recommendation 6. Trusts should give serious and urgent consideration to implementing a unified computerised record keeping system on which all entries relating to the day to day working with a client are recorded, by all mental health professionals.**

- **Recommendation 7. Trusts should ensure that a thorough needs assessment is carried out for both carers and "significant others" to properly inform risk assessments and care plans.**

- **Recommendation 8. Trusts should ensure that accurate and regularly updated risk assessments, using a reliable tool, are carried out, and that the results of these are incorporated into risk management plans. This should be supported by training and regular audit.**

- **Recommendation 9. Trusts should review policies and ensure that there are up to date 'lone worker' or 'home visit' policies in place in each part of the front line services, that staff are aware of such policies, and aware of the procedures in place to implement them.**

- **Recommendation 10. Where there are several agencies involved with a patient and one of those agencies (be it health, social care, probation, or police) has implemented or considered implementing a 'lone worker' or 'home visit' policy in relation to that patient, this should be communicated to the other agencies involved, either through the care coordinator, or through public protection arrangements.**

- **Recommendation 11. Staff dealing with patients whose behaviour is clearly risky or potentially risky, who have a history of detention in hospital as offenders, or have had dealings with the criminal justice system for violent offences, need to know when, and how, it is appropriate to refer to MAPPA. The criteria and MAPPA referral procedures, external and internal to the particular organisation, should be made crystal clear to all mental health professionals, including doctors, working in front line services, should be part of any induction programme and a regular and compulsory part of ongoing training. The training need not be burdensome, lengthy or expensive.**

- **Recommendation 12. Similarly, staff should be made aware of the potential for referral to MARAC, and to MAPVA, and clear about the criteria and procedures as set out above.**

- **Recommendation 13. The panel recommends that the question of continuity of care is addressed; where possible, care should follow the patient, and where a patient moves within a reasonable distance, there should be no undue haste to enforce changes of service provider.**

- **Recommendation 14. Trusts should take the opportunity to review the joint working arrangements within teams, to determine whether appropriate opportunities exist for clinical supervision, peer and case review, and to instigate procedures if not.**

- **Recommendation 15. The panel recognises the pressure that may force psychiatrists to rapidly admit a patient to hospital where there is an urgent need for treatment. However the appropriateness of the placement should be kept under close review, and the trust should ensure that the responsible psychiatrist is supported in finding an alternative placement when clinical need, or the safety of staff, is an issue. The trust should also ensure, wherever possible, that choice of hospital is motivated not by expediency but by matching the patient's need to the care that can be offered.**

- **Recommendation 16. Trusts should review clinical practice to ensure, in relation to psychometric tests, that they are only regarded as an adjunct to clinical judgement to inform diagnosis. They should not, on their own, be regarded as diagnostic instruments.**

- **Recommendation 17. Trusts needs to be clear where the remit for working with people with personality disorders falls. It needs to be recognised that personality disorders can be as serious as illnesses such as schizophrenia in terms of their negative impact on the individual and the society around them. Appropriate, ideally specialist, services need to be provided for such patients, and the professionals working with them need specific training and support.**

- **Recommendation 18. Whilst not all patients who have been in medium secure hospitals require ongoing support from forensic services, mechanisms should be put in place to ensure that such patients are discussed with the local forensic services when they are discharged into the community. Ideally, the forensic services should be invited to attend the pre-discharge care planning meeting, but if this is not possible, then the treating community team should subsequently discuss the case with their local forensic team.**

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- **Recommendation 30. Where trusts are commissioning services from independent sector providers, trusts should ensure that the practice of those providers complies with those recommendations.**

- **Recommendation 31. The panel is concerned that many of the above conclusions and recommendations echo those made in other investigation reports, therefore consideration should be given to the use of such reports for training purposes. Additionally, the panel hopes that this report is widely disseminated across agencies.**

ADDITIONAL OBSERVATIONS TO THE SHA IN RELATION TO THE POLICE AND PROBATION SERVICES

The panel does not believe it would be appropriate, or welcome, to make recommendations for action to either the police or probation service, since, although they have cooperated fully with the investigation, they have had no part in commissioning this report. However, the panel expresses the respectful wish that the SHA should communicate the following suggestions to the police and probation service, which it hopes the two services will regard as helpful and constructive in furthering what must be a shared aim of reducing risk to the public as well as promoting an understanding of mental health issues suffered by offenders:

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- **The two preceding paragraphs are equally applicable to the probation service where it is involved with a client.**

- **The probation service, which seemed, from the information before the panel, to be more accustomed than the police to (at least) informal communication with the mental health services, should nonetheless review their procedures for formal contact and sharing information. They should ensure that when they are supervising a client with known mental health or drug and alcohol problems, there is a formal system in place for communication with the mental health services, so that information can be shared both ways.**

- **No CO with a condition of psychiatric supervision should be made unless the probation service has (after consultation with him/her) identified the supervisor, and informed the court of his/her identity. The court service should be invited by the probation service to consider revising its form to include the name and professional details (address and discipline) of the supervisor in the order, and the probation service locally should amend its procedures to ensure that the Probation Officer understands that it is his/her responsibility to manage that condition, and establish procedures by which this is done in every case.**

List of abbreviations

AOT:	Assertive Outreach Team
CAS:	Community Addictions Service
CMHT:	Community Mental Health Team
CO:	Community Order (Probation)
CPA:	Care Programme Approach
CPN:	Community Psychiatric Nurse
CPS:	Crown Prosecution Service
CRO	Community Rehabilitation order
CRT:	Crisis Resolution Team/Service
CT:	Computerised tomography
DBT:	Dialectical Behaviour Therapy
EEG:	Electro-encephalogram
ESMI:	Easington Substance Misuse Initiative
MAPPA:	Multi-Agency Public Protection Arrangements
MAPVA:	Multi Agency Protection of Vulnerable Adults
MARAC:	Multi Agency Risk Assessment Conference
MDT:	Multidisciplinary Team Meeting
MHA:	Mental Health Act
NECA:	North East Council for Addictions
OASys:	Offender Assessment System (Probation)
OT:	Occupational Therapy
PAI:	Personality Assessment Inventory
PICU:	Psychiatric Intensive Care Unit
PSR:	Pre- sentence Report (Probation)
PTT:	Psychological Therapies Team
RMO:	Responsible Medical Officer
SHA:	Strategic Health Authority
SSIDs:	Social Service Information Database
TEWV:	Tees Esk and Wear Valleys NHS Foundation Trust

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