

**Report of the  
Independent Inquiry  
Into the Care and Treatment of  
Matthew Martin**

**A report commissioned by  
Avon, Gloucestershire and Wiltshire  
Strategic Health Authority**

**Published July 2003**

# **PREFACE**

We were commissioned in July 2000 by Avon Health Authority to undertake this Inquiry.

We now present our report, having followed the terms of reference and the procedure which was issued to all witnesses and their representatives.

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# ACKNOWLEDGEMENTS

Our grateful thanks are due to all of the following

- William Evans for his energy, thoroughness and patience at the task of providing secretarial support to the inquiry. His care and dedication as the public face of the Inquiry has ensured that the procedure has run smoothly, with witnesses and organisations given every assistance.
- Harry Counsell & Company for their quick and accurate transcription services.
- Members of the family of the late Michael Martin and Matthew Martin for their co-operation in an emotionally demanding process.
- All witnesses for giving willingly of their time and memories.
- Steve Mulley for his tolerance as the representative of the commissioning agency
- Ruth Shakespeare for her advice on the continually evolving state of mental health services in prisons
- Roger Pedley for his advice on the ever changing face of local health purchasing and provision
- Elaine Rowland for her valuable advice on report presentation and her precision proof reading

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# Chapter One

## INTRODUCTION

- 1.1 On 25 February 2000 Matthew Martin pleaded guilty at Bristol Crown Court to manslaughter on the grounds of diminished responsibility of his father, Michael Martin. Matthew Martin killed his father at home in Almondsbury, South Gloucestershire, on 6 May 1999.
- 1.2 The Court made a hospital and restriction order under s37/41 Mental Health Act 1983. Matthew Martin remains detained under that section in Fromeside Regional Secure Unit, Bristol.
- 1.3 Matthew Martin had been in receipt of mental health services from what is now Avon and Wiltshire Mental Health Care Partnership NHS Trust some eighteen months prior to the homicide. At the request of the Trust, Dr Newbery, Consultant Psychiatrist, Southmead Hospital, provided a report on 18 May 1999. The Trust did not carry out an internal review.
- 1.4 In circumstances such as these Health Circular HSG(94)27 requires that an independent inquiry be carried out into a patient's care and treatment order to learn lessons for the future. During June and July 2000 the then Avon Health Authority appointed the Independent Inquiry Panel and its secretarial support. Delay followed from Matthew Martin's decision in August 2000 not to authorise release of his confidential documents. Matthew Martin eventually gave his consent in January 2001.
- 1.5 Terms of Reference and Procedure for the Inquiry are included at Appendices A and B.
- 1.6 Information was sought from 87 agencies or individuals and written evidence received from 82. Of those, 29 witnesses gave oral evidence to the Inquiry over a period of 16 days between 3 July 2001 and 1 November 2001 (Appendix C). Where the draft report made any express or implied criticism of a witness an opportunity to provide a written response was given. Without exception, witnesses were courteous, helpful and co-operated fully with the Inquiry. We extend our thanks to all who participated.
- 1.7 Our sympathy goes to the bereaved family of Mr Michael Martin who have suffered and continue to suffer the pain and repercussions of this homicide within the family.

- 1.8 We are satisfied from the evidence that Matthew Martin was mentally ill at the time that he killed. He had been out of contact with local psychiatric services for nearly two years during which time there had been a number of missed opportunities for his referral back to the mental health team. Had Matthew Martin been receiving regular anti-psychotic medication, either in hospital or in the community, we think it likely that the symptoms of his mental illness would have been reduced. However, it is impossible to say whether this would have prevented the killing.
- 1.9 We make a number of recommendations aimed at improving access to mental health services and provision of information to carers. We express particular concern over psychiatric services in prisons and make recommendations concerning the need for improved sharing of information between prisons and local community mental health teams. Matthew Martin's non-compliance with treatment and disengagement from psychiatric care reveals a need for policies targeted towards the provision of planned care for this group of mentally ill people.
- 1.10 Although Matthew Martin's involvement with mental health services was limited to a period of about a year he had contact with numerous other agencies. The report aims to capture the essence of his scattered, often very temporary engagement with a variety of organisations. It was this which characterised his drift away from psychiatric care.

## **Chapter Two**

### **OVERVIEW OF SERVICES**

#### **A summary**

- 2.1 By the time he killed at the age of 25 Matthew Martin had been registered with 14 different GP's. He had been seen by both NHS and private psychiatrists in his childhood and teens. He had been convicted of 39 offences, been the subject of probation and psychiatric reports for court and been in prison 3 times. He had received treatment under s37 MHA 1983, been in psychiatric hospital once, received follow-up care as an out-patient, been seen by police begging on many occasions and stayed in several different bedsits and hostels for the homeless. His lifestyle was that of a traveller. From September 1997 Matthew Martin chose to withdraw completely from psychiatric care. Although he ostensibly lived with his father he slept rough out of choice. He accessed only a small part of a wide network of provision intended to cater for mentally ill and homeless people.
- 2.2 This chapter reviews the services provided and available to Matthew Martin.

#### **General Practitioner Services**

- 2.3 Twenty-one addresses are recorded for Matthew Martin from his childhood until the killing when he was 25 years old. Matthew Martin was registered with fourteen different GP practices in Gloucestershire, Clwyd, Sussex, Bristol, Cornwall and Glastonbury. He had been registered with a GP at Thornbury Health Centre, South Gloucestershire for the year prior to the homicide. Avon Health Authority was at the time responsible for the contracting of that GP service.

#### **NHS Child and Adolescent Mental Health Services**

- 2.4 Matthew Martin received services from the South District Child Guidance Service of Clwyd Health Authority and was seen briefly by a Consultant Child Psychologist, Clwyd.

## **General NHS Services**

- 2.5 As a child Matthew Martin received health services from Clwyd Health Authority. He was seen by a health visitor, District Community Physician and community paediatrician in connection with enuresis and encopresis. As an adult he attended the Accident and Emergency department of Bristol Royal Infirmary (for which Bristol & District Health Authority and later United Bristol Hospitals NHS Trust were then responsible) on 5 occasions after minor injuries following fights or breaking into premises. He also attended at Southmead Hospital (a district general hospital for which Southmead NHS Trust was then responsible) for treatment to a minor injury to his arm and on one occasion expressing concern about a lump on his arm.

## **Private Health Services**

- 2.6 In 1989 Matthew Martin was seen by privately by a consultant psychiatrist in Bristol. In 1992 he was seen by a psychiatrist of the private psychiatric hospital Ticehurst House in East Sussex.

## **NHS Psychiatric Services**

- 2.7 Matthew Martin was actively in receipt of local mental health services for a year between August 1996 and September 1997.
- He was an in-patient on Weston Ward, Southmead Hospital, Bristol from 23 August 1996 until 2 December 1996 subject to s48 followed by s37 MHA 1983.
  - He was assessed on Weston ward at Southmead Hospital on 5 April 1997 but not admitted.
  - He was seen as an out-patient on 5 September 1997.
  - He was admitted informally overnight to Weston Ward from 12 to 13 September 1997.
- 2.8 Southmead Hospital had and still has a purpose-built unit with three wards of 20 beds, each serving a defined geographical area. Weston Ward served the north central area of Bristol. The psychiatric team providing Matthew Martin's care was led by the same consultant throughout.
- 2.9 Matthew Martin received in-patient nursing services from the Trust and was allocated a Community Psychiatric Nurse upon discharge from hospital on 2 December 1996. That service was provided until 24 January 1997.

- 2.10 The Trust's Occupational Therapy service carried out an assessment of Matthew Martin's in-patient needs on 2 October 1996 following referral by his key nurse.
- 2.11 From 1996 there was a community mental health team (CMHT) based at Gloucester House which adjoined the relevant part of Southmead Hospital. The team consisted of two consultant medical teams, two psychologists, an occupational therapist, an art therapist and the day hospital team. Two social workers worked with team but at that time were not fully integrated into the CMHT.
- 2.12 From 1996 onwards Avon Health Authority were the strategic and purchasing authority for health services in both Bristol and South Gloucestershire. Until 31 March 1999 responsibility for service provision in northwest Bristol and parts of South Gloucestershire was with Southmead Health Services NHS Trust. On 1 April 1999, just weeks before the homicide, responsibility for provision of acute mental health services throughout Bristol and South Gloucestershire transferred to Avon & Wilts Mental Health Care NHS Trust.

## **Social Services**

- 2.13 Matthew Martin received no mental health service from any social services department and neither Bristol Social Services Department nor South Gloucestershire Social Services Department had any record of a referral made to them.
- Between 1974 and 1996 any social services involvement would have been the responsibility of Avon County Council.
  - From 1 April 1996 until the killing Bristol City Council, as a unitary authority, provided social services within Bristol. This authority would certainly have been responsible for any social services provision until May 1998 when Matthew Martin moved to his father's home in South Gloucestershire.
  - From May 1998 the position was less clear. Matthew Martin stayed for a few days at a Salvation Army establishment in Bristol which would have entitled him to services from Bristol. However, South Gloucestershire Social Services would have accepted a referral made to them from May 1998 since Matthew Martin lived, or was sleeping rough, within their area for most of this period. The Panel heard that if contact had been made with any social services department it was probable that a discussion between local authorities would have been needed to establish Matthew Martin's place of residence. Dr Newbery, Matthew Martin's RMO would also have considered which psychiatric team, and therefore which CMHT and social services department, should most appropriately take forward Matthew Martin's care and treatment.
  - Bristol Social Services mental health team were located in Southmead Hospital and although not formally part of the Trust CMHT were closely connected with it.

## **Criminal Justice System**

- 2.14 Between 1990 and 1999 Matthew Martin was convicted of 39 offences on 12 occasions. Of these, 1 involved motoring offences, 7 were theft related and 10 concerned failure to surrender to bail. All of the theft-related offences predated Matthew Martin's admission to psychiatric hospital in 1996. The offence resulting in a hospital order under s37 MHA involved burglary, possession of an offensive weapon and ABH.
- 2.15 After his discharge from Southmead Hospital Matthew Martin was convicted of 5 offences, all of which involved either threatening behaviour, possession of offensive weapons or assault. 4 of the offences were connected with begging:
- In July 1997 Matthew Martin was fined by Plymouth Magistrates' Court for begging and having a locking knife in a public place, and was ordered to serve 1 days imprisonment in default.
  - In August 1997 Exeter and East Devon Magistrates' Court fined him for begging and threatening behaviour in Exeter.
  - In November 1997 Matthew Martin was arrested by Avon and Somerset police for threatening behaviour at Glastonbury; bailed, he did not attend court, but was convicted in March 1998 by Mendip Magistrates' Court and fined.
  - In November 1998 Plymouth Magistrates' Court remanded Matthew Martin in custody after he had been arrested by Devon and Cornwall Police in Plymouth having fired an airgun at a passer-by in public. Devon Probation Service provided the court with 2 pre-sentence reports, and a consultant forensic psychiatrist at Exeter prison provided a psychiatric report, after which Plymouth Magistrates' Court sentenced Matthew Martin to 6 months imprisonment, which he served at Exeter prison: he was released in February 1999.
  - In March 1999 Bristol Magistrates' Court convicted Matthew Martin of assault on a bus driver and criminal damage to cars with a spade. He served 1 months imprisonment in Bristol prison, and was released on 24 March 1999.
- 2.16 From 1996 Matthew Martin appeared before courts in the following petty sessional divisions: Bristol, North Avon, Exeter, Mendip and Plymouth. Each of those areas was served by different combinations of statutory agencies. See table below.
- 2.17 Several witnesses remarked that the territorial boundaries of criminal justice services (magistrates' courts, police, probation, Crown Prosecution Service) did not and do not match the boundaries of health or social services authorities.

<b>Place</b>	<b>Magistrates' Court</b>	<b>Police force</b>	<b>Probation service</b>	<b>Local prison</b>	<b>SSD authority</b>	<b>Health authority</b>
Bristol	Bristol	Avon & Somerset	Avon	Bristol	Bristol CC	Avon HA
Almonds-bury	North Avon	Avon & Somerset	Avon	Bristol	S Glos C	Avon HA
Exeter	E Devon	Devon & Cornwall	Devon	Exeter	Devon CC	Devon HA
Glaston-bury	Mendip	Avon & Somerset	Somerset	Bristol	Somerset CC	Somerset HA
Plymouth	Plymouth	Devon & Cornwall	Devon	Exeter	Plymouth CC	Devon HA

## **Court Diversion and Liaison Schemes**

- 2.18 At the relevant times, no court diversion schemes were in force at any of the courts mentioned above, but at Plymouth Magistrates' court a psychiatric nurse attended cells if the police had expressed concerns about a prisoner's mental welfare. No information reached the Probation Officer whether a nurse had seen Matthew Martin.

## **Probation**

- 2.19 In 1996 a report was prepared by Avon Probation Service but it was not available to the Inquiry because that service has destroyed all records relating to Matthew Martin and no-one now working for that service recalls him. A report and addendum report were prepared by Devon Probation Service following Matthew Martin's arrest and remand to HM Prison, Exeter, in November 1998.

## **Prison Healthcare Service**

- 2.20 In date order:

- Matthew Martin was an inmate at HM Prison, Horfield, Bristol from 25 July 1996 to 23 August 1996 during which time he was admitted to the prison healthcare unit and assessed by two independent psychiatrists for the purpose of transfer to Southmead Hospital under s48 MHA.
- From 11 November 1998 to 9 February 1999 Matthew Martin was in HM Prison, Exeter where he was seen by a probation officer and received a psychiatric assessment for a court report from an independent forensic psychiatrist but was not admitted to the healthcare unit.
- From 9 March 1999 to 24 March 1999 Matthew Martin was in HM Prison Horfield, Bristol. He was not admitted to the Prison

Healthcare Unit nor did he receive any psychiatric care, treatment or assessment.

## **Local Authority Housing Services**

- 2.21 Bristol City Council was the housing authority for Bristol from 1974 until the homicide. From 1974 to 1996 it was a district council under the LG Act 1972, and from 1 April 1996 it was a unitary authority under LG Act 1992. From 1974 Bristol City Council operated a homeless service through its district offices though Matthew Martin received no direct housing service from these offices.
- 2.22 For the year prior to the killing Matthew Martin's home address was with his father in Almondsbury, South Gloucestershire. South Gloucestershire Council, a unitary authority, was responsible for housing in that area and had a homelessness unit a few miles north of Almondsbury. Matthew Martin had no contact with South Gloucestershire housing services.

## **Combined Statutory and Voluntary Housing Services**

- 2.23 The Hub Advice Centre in central Bristol provided a service for street homeless people. It was funded by and contained workers from Bristol City Council Housing Department, Shelter, Bristol Cyrenians, the Benefits Agency, Learning Partnership Southwest Ltd, the Employment Service of the Department of Education and Employment, the Advice Centre for Avon, Avon Health Authority and Bristol City Council Social Services Department. The centre opened in 1995 and provided a one-stop multi-agency centre offering advice and help to single people needing housing. It estimated that about 25% of callers were of no fixed abode or sleeping rough with 17% admitting to mental health, drug or alcohol problems. Southmead Hospital nursing staff accessed advice from The Hub on Matthew Martin's behalf during his admission in November 1996.
- 2.24 Bristol Rough Sleepers Initiative was a multi-agency consortium led by Bristol City Council. Participants included voluntary organisations and central government. It conducted street counts and outreach monitoring; and encouraged housing associations, the city housing department and voluntary agencies to develop new housing and support services. Until changes in funding, the Initiative included an outreach team run by the Salvation Army. In 1999 RSI funding was replaced by funding under the then Department for the Environment, Transport and the Regions' Homelessness Action Programme. The Initiative now arranges outreach through English Churches Housing Association; resettlement through Bristol Cyrenians and the Salvation Army; and advice via Bristol Cyrenians at The Hub. It also continues to provide outreach via the Inner City Mental Health Team; resettlement through Second Step Housing Association and Missing Link; and a floating support service via Bristol Drugs Project. Since 1999, a

housing association has provided a floating support service for former rough sleepers who have been re-housed in RSI general needs tenancies.

## **Voluntary Sector Housing Agencies**

2.25 In date order:

- Between 11 March 1996 and 8 April 1996 Matthew Martin stayed at Ron Jones House, Jamaica Street, a hostel in central Bristol managed by the Elim Housing Association. Prior to discharge from hospital in November 1996 he visited Ron Jones House with his father but did not accept accommodation there. Ron Jones House targeted single homeless people but would not take those with high support needs, serious mental health problems, a history of alcohol, drug abuse or arson. Referral was by agency.
- For two days in May 1996 Matthew Martin stayed at the Cork Simon Community in Ireland. This was a hostel run by a voluntary organisation for homeless people with multiple problems.
- In October 1996, whilst an in-patient at Southmead hospital Matthew Martin made an application to Second Step Housing Association although he did not later attend for interview. Second Step was and is an industrial and provident society with an office in Central Bristol, specialising in accommodation for people with or recovering from mental illness.
- From 30 October 1998 to 4 November 1998 Matthew Martin stayed at a Salvation Army hostel in central Bristol for single adult men.
- On 23 April 1999 Matthew Martin sought accommodation at the English Churches Hostel, Jamaica Street, Bristol. This was a hostel providing accommodation and outreach work.

## **Related housing and social services provision not accessed by Matthew Martin or arranged on his behalf**

2.26 Several voluntary sector organisations offering housing or social services provision which might have been able to offer a service to Matthew Martin had no record or recollection of any contact with him. They included:

- Alcohol Advisory Centre, which has a regional as well as local office in central Bristol. It offers advice and information; individual counselling; individual assessment; day care programme; a dry house; needle exchange; young people's project; help with training and jobs.
- Alpha hostel, which provided accommodation for homeless men.
- Avon Council on Alcohol and Drugs, which provided advice and related services.
- Bristol Cyrenians was represented in The Hub advice centre, and one of its workers saw Matthew Martin. In addition, the organisation

independently offered (1) a day centre with crisis services; showers; laundry; food; free clothing; advice and info on finding accommodation, housing rights, benefits; social educational and recreational activities; specialist medical primary physical and mental health care, and a well dog clinic; and (2) a resettlement service for single homeless people and rough sleepers over 16.

- Bristol Methodist Centre, whose day centre offers shower, laundry, clothing, midday meal, tea, coffee; advice on and referrals to night shelters and hostels; weekly visits from a primary healthcare team visits; Narcotics Anonymous; a resettlement worker; and courses in art, writing, and computing. The Centre is for people who are homeless or whose housing is temporary or insecure.
- Crisis Centre, which served people who are homeless with alcohol, drug or mental health problems. It offered a day centre, advice, counselling, referrals, a sharps box, food and games.
- English Churches, in origin a housing association, which offered (1) a hostel for men and women over 18, and (2) outreach work, offering access to accommodation and referrals for specialist help.
- Inner City Mental Health Team, including community psychiatric nurses, social worker and consultant psychiatrist, which ran an outreach service, targetting single homeless rough sleepers over 16 with mental health problems. It offered access and referrals for rough sleepers into NHS psychiatric services.
- Julian Trust, which accepted self-referrals from single homeless people over 18, of whom 90% were men. It ran a night shelter.
- Redwood House hostel, which received men over 18 only.

2.27 Although Matthew Martin lived from time to time in the Glastonbury area of Somerset, none of the agencies who responded to enquiries, including the community mental health team based at Wells and serving Glastonbury, had any record of contact with him.

2.28 The following organisations did not respond to enquiries:

- Alcoholics Anonymous, which operates in Bristol, but only from a Post Office box and telephone.
- Bristol Drugs Project, which provides advice and support; a drop in and needle exchange; counselling, day care, and relapse prevention, a telephone helpline, acupuncture, and support and advice to offenders. It offered a special service for under-18s.
- The Robert Barton Trust at Glastonbury, which offers advice and accommodation to single people with housing, mental health, alcohol and drugs problems.

### ***Discontinuity between services***

*Although Matthew Martin was admitted to psychiatric hospital on only one occasion for any length of time, his history reveals scattered contact with many services and agencies since childhood. Indeed it is this spread of contact which characterised the pattern of Matthew Martin's unfolding mental illness and lifestyle. It emerges as one of the reasons for lack of continuity in his mental health care and treatment. Each of the many organisations saw only a small part of the whole picture. No one organisation had a complete overview.*

*Adding to the sense of discontinuity and disjointedness the Inquiry Panel was struck by the past and present complexity of mental health service provision in Bristol and the surrounding area. A web of interconnecting statutory and voluntary organisations existed that was difficult to penetrate. One witness from within the service network invited us to "let him know when we had worked it all out because he couldn't understand it either". The Trust should produce information which explains mental health services throughout the Bristol area.*

#### **▪ *Recommendation 1***



# Chapter Three

## THE HISTORY

- 3.1 Mental illness did not appear suddenly in Matthew Martin's life. It followed on the heels of an unhappy, disturbed childhood and adolescence. That disturbance grew gradually into a drifting lifestyle which co-existed with Matthew Martin's psychotic illness, sometimes making it difficult to distinguish one from the other. His early history is described here partly because it is relevant to the development of this whole picture and partly because Matthew Martin killed his father who was instrumental in seeking help for his son during much of his life.

### Early History

- 3.2 Matthew Martin was born in Bristol on 30 August 1973. From a very early age his life was characterised by instability. The family had two moves of house and Matthew Martin was separated from his mother at age four months and eight months when she was admitted to hospital firstly for an operation and secondly for a period of five months when she was treated for severe depression.
- 3.3 When Matthew Martin was aged 4, he was drawn to the attention of the Health Visitor by teachers and the school nurse because he was showing "*marked aggression and restless behaviour*". After additional problems of enuresis and encopresis developed his mother described feeling unable to cope with him. He was referred to the Child Welfare Clinic and seen there with his mother. The District Community Physician referred him to a Child Psychologist but although Mrs Martin asked for Child Guidance help Mr Martin expressed strong opposition to this. Subsequently Mrs Martin did not take up the offer of an appointment or home visit. Matthew Martin was also referred to a paediatrician although examination remained incomplete because his mother was unwilling to attend appointments.
- 3.4 Matthew Martin's parents separated in 1980 and the following year when he was 8 years old his mother died in a car crash. Suicide was suspected. Her ashes were scattered at Canford Cemetery, Westbury-on-Trym. In the year before he killed his father this was to become the place at which Matthew Martin often slept, explaining that the stones were "*his family*".
- 3.5 Mr Martin met and later married his second wife, Gillian. Matthew Martin was described as attention seeking at home and disruptive at preparatory school. At the age of 11 he set fire to the garage at home and was asked to leave school because he broke another pupil's jaw. He was moved to a local state school and from there to a small independent school in Bristol, when at the age of 14 he took an

overdose of Ibuprofen. Leaving under threat of expulsion for his behaviour he was transferred back to another local state school.

- 3.6 By the age of 15 Matthew Martin was described as aggressive and hyperactive and his father sought a private psychiatric assessment from the consultant psychiatrist who had previously treated his mother. At that time he was showing what the GP described as “*major behavioural problems, increasing truancy and aggressive behaviour at school*”.
- 3.7 No evidence of psychiatric illness was found and referral to a Consultant in Child and Adolescent Psychiatry was recommended. Referral was never made but the records available do not indicate the reason for this. After involvement of an education welfare officer and warnings from school about his behaviour and truancy Matthew Martin was eventually suspended. Although he was given the opportunity to sit exams he did not do so and left school with no qualifications.

### **From the age of 17**

- 3.8 After he left school Matthew Martin was convicted of a series of offences including driving without a licence or insurance, theft, burglary and obtaining property by deception. For these he received sentences of Probation, Community Service and detention in a Young Offenders’ Institution.
- 3.9 Early in 1992 his father arranged for Matthew Martin, then aged 19, to be assessed for admission to the Adolescent Service and Young People’s Unit of Ticehurst House Hospital, a private psychiatric hospital in East Sussex. The problems which Matthew presented were described as “*persistent delinquent behaviour*”. Matthew was seen but described as “*therapeutically inaccessible*” and not suitable for the inpatient treatment programme. A letter back to the GP ended with the prophetic statement “*the prognosis ..is not good*”.
- 3.10 Soon after this Matthew Martin adopted a travelling lifestyle. He told the Inquiry that this was connected with his love of being alone in the countryside. He made an association with New Age travellers, visited ley-lines, stone circles and Glastonbury, sleeping outdoors and earning some money through carving in stone or wood. During his periodic returns home he was scruffy, talked of hearing voices and laughed inappropriately. Mr Martin supported his son in a number of ways, buying him blankets, warm clothing and train tickets. Matthew Martin had various addresses in Bristol, Cornwall and Glastonbury from which he registered with different GP’s. There appears to have been some use of illicit drugs, including LSD although no suggestion that this was excessive. Girlfriends were evident occasionally including one in Ireland whom Matthew Martin visited on several occasions.

- 3.11 By this time Matthew Martin had appeared before five adult courts, mostly for offences related to theft, but one offence, in 1992, was for having an offensive weapon.

***Use of the private health sector***

*A strong preference for use of the private health sector characterised Mr Martin's early involvement with the care and treatment of his son. This continued into Matthew Martin's adulthood when Mr Martin arranged private accommodation for his son rather than accept hostel accommodation arranged by Southmead Hospital.*

***Psychological treatment in childhood and adolescence***

*The evidence suggests that there was some degree of family dysfunction during Matthew Martin's childhood which was never treated. Whilst psychological treatments are unlikely to have altered the later development of mental illness, they may have promoted greater social engagement thereby facilitating Matthew Martin's access to treatment for mental illness.*

***Difficulty of distinguishing between personality disintegration and lifestyle choice***

*At the outset it appears that Matthew Martin's travelling was probably a chosen lifestyle. Some professionals involved with him as he became ill described the difficulty of distinguishing symptoms of mental ill-health from 'New Age' spiritual beliefs. Personality disintegration brought about by mental disorder was not always easy to separate from his chosen drifting lifestyle.*

**First evidence of mental illness**

- 3.12 Theft-related offending persisted. Matthew Martin was required to attend at an attendance centre but did not do so and was made subject to a Probation Order. On several occasions he attended at A&E with physical injuries arising from fights and subsequent neglect of his injuries. A pre-sentence report by the probation service described gambling and alcohol problems.

- 3.13 In 1995 Mr and Mrs Martin's home was badly damaged by fire. Arson was considered the cause and police expressed their view that Matthew Martin might be responsible, but he was never charged. Traces of firelighters were found under Mr and Mrs Martin's bed, and in other rooms in the house. Mr Martin later said he believed that his son had set fire to the house under the influence of delusions about freeing the house of spirits.
- 3.14 Later records indicate that during 1996 Mr Martin began to feel increasingly worried about his son after he talked of believing he was an Egyptian king in a past life. He lost friends and possessions, heard voices and was paranoid. Mr Martin tried unsuccessfully to persuade Matthew Martin to see a private psychologist.

### **Diagnosis of psychosis in HMP Bristol**

- 3.15 In July 1996 Matthew Martin was arrested on charges of burglary, possession of an offensive weapon and ABH, and detained in custody at HM Prison, Bristol. A psychiatric assessment, for the first time, raised the possibility of schizophrenia. After further examination by psychiatrists from Fromeside Regional Secure Unit Matthew Martin was transferred to Southmead Hospital for psychiatric treatment under s48 of the Mental Health Act.

***Transfer from prison to hospital: good practice***

*Matthew Martin's mental illness was quickly recognised in HMP Bristol and a speedy transfer made to Southmead Hospital. This was good practice.*

### **Southmead Hospital**

- 3.16 Diagnosis on admission to Southmead Hospital in August 1996 was given by consultant psychiatrist Dr Newbery as schizo-affective disorder and that remained her diagnosis. The Inquiry heard from Mrs Martin that her husband, having been told that his son did not suffer from schizophrenia, believed schizo-affective disorder to be a psychosis of lesser severity. She expressed to us her husband's concern that this seemed to minimize Matthew Martin's mental illness.

### **Diagnosis**

*The Inquiry Panel met with Matthew Martin on one occasion but did not attempt a mental state examination of him. Our comments on diagnosis are based upon evidence received by the Inquiry. We consider that diagnoses of schizophrenia and schizo-affective disorder were both reasonable in 1996. Dr Tomison Matthew Martin's current Consultant Psychiatrist confirms a present diagnosis of schizophrenia. Based on the evidence we have received we are confident that the nature of Matthew Martin's illness was discussed fully with Mr Martin.*

*Conduct disorder in Matthew Martin's childhood was unlikely to have been connected with his later development of schizophrenia. However, early behaviour problems may have indicated the presence of a personality disorder. Dr Newbery never regarded this as a primary diagnosis and the Inquiry agrees with this. In any event it is the opinion of the Inquiry that the possible presence of personality disorder did not influence the mental health services' responses to Matthew Martin. Dr Tomison, currently treating him, does not view him as suffering from a formal Personality Disorder.*

*Matthew Martin's travelling lifestyle may have arisen in part from conduct disorder and in part from lifestyle choice. Its persistence may have been connected with negative symptoms of schizophrenia and the damaging effects of personality disintegration brought about by psychotic illness.*

### **Medication and management in hospital**

- 3.17 Matthew Martin showed a general reluctance to comply with medication, was angry and irritable and on one occasion threatened a nurse that he would use a knife. He was warned about the danger of lighting candles in his bedroom. On two occasions he was absent from hospital without leave for up to five days. During these periods medical notes reveal that there were doubts about the ability of Southmead Hospital to contain Matthew Martin and a suggestion that the Home Office be informed. Transfer to Fromeside Regional Secure Unit was briefly considered.

- 3.18 Eventually oral anti-psychotic medication was tolerated. Matthew Martin responded well to this and showed willingness to take it. A depot injection was considered in order potentially to improve compliance but he refused this.

### **Psychiatric reports for court**

- 3.19 Dr Newbery prepared two reports for the court and one for Matthew Martin's solicitors. In her first court report, prepared in early September 1996, she described Matthew Martin's florid paranoid psychosis and his need for intensive care and further assessment. He was still too unwell to appear in court. By the time of her next court report on 24 September 1996 Dr Newbery felt that grounds for a s37 hospital order were tenuous since Matthew Martin was mentally well and not a risk to himself or others. She did however foresee that he would need close monitoring following discharge. Her report on 30 September 1996 to Matthew Martin's solicitors was more cautious, expressing the concern that if Matthew Martin were not detained he would leave hospital, disappear and be unavailable for follow-up. She wanted him to accept depot medication before discharge and also wished to assess his dangerousness. Making reference to the house fire Dr Newbery commented '*we need to gain further details of this incident and discuss this with Matthew in order to understand this and predict his future dangerousness*'. She suggested asking the court to consider s37, a deferred sentence or a probation order with a condition of psychiatric treatment. Dr Arnott's court report in October 1996, recommended s37 MHA, confirming an acute psychotic illness, that treatment was at an early stage and that in-patient treatment was required since Matthew Martin would not comply with out-patient care.
- 3.20 On 8 November 1996 Bristol Magistrates' Court made an order under s37 MHA. Matthew Martin remained at Southmead Hospital.

### **Arranging accommodation prior to hospital discharge**

- 3.21 Early on in the admission Mr Martin had made it very clear that he did not want his son to return to his home, referring to the house fire as the reason for this.
- 3.22 Ward staff assisted Matthew Martin with an application for supported housing through The Hub Advice Centre. They helped him complete an application to Second Step Housing Association, but he did not attend his appointment with them. With the help of nursing staff a place was offered at Ron Jones House, Bristol and on 20 November 1996 he was given leave to stay there under s17 MHA. Within two days Matthew Martin's father had expressed his dissatisfaction with the accommodation and instead obtained a bedsit for his son in Westbury-on-Trym. Matthew Martin moved there on 22 November 1996.

**Assessment of housing need**

*There was no multi-disciplinary assessment of Matthew Martin's housing need. This was unsatisfactory. Chapter 4 discusses this more fully.*

**Improvement in Matthew Martin's mental health**

- 3.23 By the end of November 1996 medical notes recorded that no signs of mental illness were seen. On 23 November 1996 he became subject to consent to treatment procedures under the MHA. These required that the RMO either record on a 'Form 38' that Matthew Martin consented to the medication he was receiving or seek a second opinion from the Mental Health Act Commission. Medical notes indicate that Matthew Martin accepted oral medication but refused depot medication.

**No Form 38**

*A Form 38 should have been completed on or before 23 November 1996. Chlorpromazine continued to be prescribed for Matthew Martin and he continued to accept it.*

**Discharge from hospital and s37**

- 3.24 One formal meeting was held to plan for Matthew Martin's discharge from hospital. At that meeting on 2 December 1996, held to conform to the requirements of CPA, he was discharged both from hospital and from s37. There was no intention that the meeting would fulfil the requirements of s117 MHA 1983 concerning after-care.
- 3.25 The meeting was not fully multi-disciplinary. Dr Newbery told the Inquiry that she did not request the attendance of a social worker because she believed that the social services department were under-resourced and could not routinely provide a service to her team. No occupational therapist or GP attended. Although it was recorded in the medical notes that the GP had been invited the GP notes reveal no record of an invitation. The CPN, Mr Nick Heneker, attended but had only just been allocated the case and had not met Matthew Martin prior to discharge. It was agreed that he would visit Matthew Martin fortnightly. No contingency plans were made should Matthew Martin fail to comply with his medication, move away, fail to accept CPN visits or fail to attend out-patient appointments. Mr Martin was present at the meeting and appears to have been the only person, other than Matthew Martin, to have seen the bedsit. The CPN recalls giving Mr Martin his telephone number, though no agreement was reached that

he would act as a contact point for CPN or psychiatrist in the event that there was a break down in follow-up arrangements.

- 3.26 Matthew Martin's CPA care plan, recorded by the SHO at the meeting, was simple. It gave the name of the care co-ordinator (Dr Newbery) but no date or venue for the next meeting. The level of CPA was not indicated. Matthew Martin's needs were summarised as '*Review of mental health and medication*' and '*Review of mental health*'. His care plan was '*Regular OPAs with Dr Newbery*' and '*Visits by CPN at home every fortnight*'. No date was set for review of the CPA plan.
- 3.27 No formal risk assessment took place and the house fire was not discussed.
- 3.28 In a discharge letter to Matthew Martin's GP his prognosis was described as "*Depends on whether Mr Martin continues to take his medication, which is generally felt to be unlikely*". Further management was given as "*Initially will be visited by a CPN fortnightly at home. Regular outpatient appointments with Dr Newbery. Continue on our reducing dose of Chlorpromazine 400mg bd at discharge.*"

***Weaknesses of the planning for discharge***

*The Inquiry finds that the RMO, SHOs and ward staff were working hard to arrange discharge and follow-up for Matthew Martin. They felt under considerable pressure. But despite undoubted commitment and extensive input there were several weaknesses in the procedure. The CPA meeting took place too late for a proper multi-disciplinary assessment to be undertaken, the care plan was insufficiently detailed and the designated care co-ordinator was too busy for the role.*

*Had the care plan followed Department of Health guidelines covering a risk assessment, plans for dealing with non-compliance and a date for review, there might have been less likelihood of Matthew Martin evading the attention of the psychiatric staff following his discharge from Southmead Hospital. Similarly, had the care plan contained all these details and been circulated as required to psychiatric and social work staff and to Matthew's father, the latter at least might have felt more confident about how best to help his son.*

*Chapter 4 examines CPA and planning for discharge in more detail.*

## **After Discharge**

- 3.29 On 12 December 1996, ten days after his discharge the CPN visited Matthew Martin, who told him that he had been picked up by police on suspicion of attempting to enter a neighbour's house. Mathew Martin remained of the view that he did not need medication. There was no discussion of this visit with Dr Newbery but the CPN planned to make his next visit on 31 December 1996 though in the event he did not do so because Matthew Martin said he would be busy with his family over the holiday period. When Mr Heneker called at the house on a further three occasions during January 1997 there was no reply. He did not know that Matthew Martin had already moved from his bedsit. That was still unknown to him or to Dr Newbery when on 24 January 1997 he wrote to Dr Newbery explaining that he had been unable to contact either Matthew Martin or his father and that he would be discharging Matthew Martin from his caseload. Dr Newbery agreed. Mr Heneker recalled that he had tried to ring Mr Martin on a couple of occasions but had not been successful in making contact. Records indicate that Matthew Martin was discharged from the Trust's CPA database in February 1997.

### ***Untapped potential of CPN follow-up***

*As had been expected Matthew Martin proved difficult to follow-up. He was seen by the CPN only once after discharge and by then he had already come to the attention of the police. Attempts to make further contact with him or his father ceased within a month with the agreement of Dr Newbery. No letter to this effect was written to Mr Martin who continued to have contact with his son and may have known his whereabouts.*

### ***Discharge from CPA***

*Dr Newbery told the Inquiry Panel she did not know that Matthew Martin had been recorded on the computer database as discharged from CPA. She was clear that she did not discharge him from CPA and did not discharge him from her care. She told us that that Matthew Martin was still in need of specialist mental health services and did not satisfy the criteria for discharge from the CPA process. We entirely accept Dr Newbery's evidence on these points.*

## The nine months after hospital discharge

- 3.30 From January 1997 Matthew Martin moved to a bedsit in Bristol, but unfortunately confusion at the hospital over his address complicated the delivery of out-patient appointments. At one point Freemantle Road was thought to be 3 Mantle Road.
- 3.31 In early April 1997 a worried Mr Martin spoke to his GP, who arranged for an emergency assessment of Matthew Martin at Southmead Hospital where he was seen by an SHO. Matthew Martin had been homeless for four days after leaving his flat because it was a *“bad colour and had a bad feeling”*. He was dishevelled, believed that people had been trying to influence him for several months and that he could read other peoples thoughts. GP notes record that Matthew Martin was staying with his father. Mr Martin had the impression that Matthew Martin was not taking his medication. Hospital admission was offered but Matthew Martin refused and was considered *‘not sectionable’*. He agreed to see Dr Newbery as an out-patient and accepted Chlorpromazine.
- 3.32 Notes from that hospital assessment indicate that Matthew Martin had moved to live with his father. Nevertheless, two subsequent letters offering an out-patient appointment were incorrectly addressed to an address in Bristol. Matthew Martin remained unseen and on 22 April 1997 Dr Newbery eventually wrote to Matthew Martin, again at an incorrect address, offering to see him if he made contact with her. On the same day she wrote to Matthew Martin’s father commenting that she would be happy to see Matthew Martin but *“it may be the only way he is likely to come is if you are able to persuade him and bring him along. It may be best therefore to arrange an appointment via yourself. I would be very grateful if you would let me know how he is and whether you feel able to persuade him to come and see us.”*
- 3.33 On three occasions during April, May and June 1997 Matthew Martin was found by the police to be begging in Whiteladies Road, Bristol. On the latter occasion he was convicted of having in his possession a sharp locking pocket knife with a 8cm blade. In August 1997 he was arrested for begging and threatening behaviour in Exeter High Street. That was followed by two further incidents in Exeter and Newton Abbott.
- 3.34 During the course of 1997 Mr Martin underwent heart by-pass surgery and reached the point where he felt that he could no longer support his son. He expressed this concern in a careful, polite and meticulously drafted hand-written letter to Dr Newbery on 2 September 1997. His son was described as deteriorating at an alarming rate, living rough

and lacking the mental ability to survive. Mr Martin expressed frustration at his failed attempts to persuade his son to accept help, giving an account of how Matthew Martin had jumped out of the car during an attempt to take him to Southmead Hospital after he had been aggressive in front of Mr Martin's grandchildren. He asked Dr Newbery how he could refer him for urgent assessment, commenting "*Does he have to commit a crime to get back into the system?*"

- 3.35 Dr Newbery did see Matthew Martin on 5 September 1997, three days after the letter was written. As before Matthew Martin was offered informal admission which he refused, and was not considered 'sectionable'. A further out-patient appointment was made with arrangements for him to attend at the Day Hospital.
- 3.36 A week later on 12 September 1997 Matthew Martin presented himself at Southmead Hospital and requested admission. He was seen by an SHO and admitted informally. He described himself as having lived rough for the previous six months, saying he planned to go to Ireland shortly and wanted a rest before he went. He said he drank 5 litres of cider a week and smoked cannabis occasionally. During a mental state examination he was disinhibited, laughing inappropriately and muttering to himself. The SHO wondered whether he was responding to auditory hallucinations. He was not thought to represent any risk to others. In discussion with the duty psychiatrist it was decided that should Matthew Martin seek to leave hospital he should be compulsorily detained, if necessary under the provisions of s5(2) MHA. This would have permitted his detention for up to 72 hours whilst an application under s2 or s3 was made. However, the following day, when Matthew Martin asked to leave hospital he was assessed by the SHO on call who, after discussion with the consultant on call, felt he was not detainable.
- 3.37 Matthew Martin left with an appointment to see Dr Newbery on 15 September 1997 but did not attend and instead went to Ireland. This was the last contact Matthew Martin had with Southmead Hospital. In a letter to his GP dictated on 24 September 1997 the SHO to Dr Newbery described Matthew Martin as having persecutory beliefs, believing he was being watched, followed and controlled and that he was "*sensitive to the airways*". He had a three month history of thought insertion, irregular thoughts in his head which were not his own. He had had occasional suicidal thoughts in the past. Prognosis was dependent upon whether Matthew Martin continued to take his medication. Further management was described as "*he will be seen by Dr Newbery in clinic where arrangements for further follow-up will be made*".

### ***'Sectionability' and relapse***

*On three occasions in the course of five months Matthew Martin was considered for detention under the MHA by a psychiatrist but considered not to be 'sectionable'. There was no formal application or assessment under the MHA and no ASW at any time saw Matthew Martin. Yet signs of self-neglect suggest a degree of risk to himself that may have sufficed for compulsory admission had they been clearly identified and associated with his mental illness rather than his lifestyle. This complex point is discussed further at Chapter 4.*

### ***Outpatient follow-up***

*Although outpatient appointments were mistakenly sent to the wrong address it became clear that Matthew Martin was reluctant to engage with services. Dr Newbery's decision in April 1997 to ask Matthew Martin to contact her was, we consider, not unreasonable. Mr Martin did indeed get in touch with Dr Newbery but by that time, early in September 1997, he was feeling desperate.*

### ***Incorrectly addressed letters***

*Given Matthew Martin's lack of co-operation with follow-up appointments this may not have had any impact upon the course of events, though under different circumstances it might have proved critical.*

## **Accessing mental health services**

- 3.38 Remaining frustrated with the accessibility of services for his son Mr Martin wrote again to Dr Newbery on 22 September 1997. Matthew Martin was not, he said, taking his Stelazine. He did not believe he could live effectively on his own and he feared for the outcome. Once more Mr Martin described the difficulty of obtaining an urgent assessment. He would make strenuous efforts to persuade his son that he should see Dr Newbery and briefly obtain his co-operation, but before it could be arranged Matthew Martin would have changed his mind. His efforts included speaking to Dr Newbery's secretary, the ward staff and the day centre manager. Reference was made to an occasion when he had taken his son to Southmead Hospital ward but

been turned away. We found no record of this on the ward. Mr Martin concluded by asking *“if there is any way in which some form of urgent attention can be accommodated, to properly assess his (Matthew Martin’s) state and provide the care and help to which he is entitled”*.

- 3.39 On 14 October 1997 Dr Newbery responded sympathetically in writing to Mr Martin’s letter explaining that no sense of urgency had been conveyed to her by her secretary. She described the *“strict channels”* for emergency help, explaining that if someone needed an assessment the same day it needed to go through the GP who would access the emergency services. Out of hours Mr Martin could speak to the emergency duty team for social services but they usually needed to be accessed by the GP. She offered Mr Martin the opportunity to contact her if the situation were urgent and he had the time, although she explained that it was unlikely she would be in a position to see his son the same day.
- 3.40 Dr Newbery informed the inquiry that she was expecting to be contacted again. She considered that Matthew Martin’s case was still open and that it was an *“on-going situation”*. She had thought that at some point an assessment of Matthew Martin under the MHA would become necessary. A letter to Matthew Martin’s GP confirms that planned follow-up was intended.
- 3.41 It appears that Mr Martin wrote a letter in reply to Dr Newbery on 29 October 1997. That letter was shown to the Inquiry by Mrs Gillian Martin. She did not know whether it had been sent but there was no record of it in Matthew Martin’s medical notes and Dr Newbery did not recall having seen it. In it Mr Martin stated *“...the content of your letter gives me little hope that the psychiatric services can indeed do anything constructive to help Matthew and others in his position. I am desperately trying to be unfrontational, believing that solutions can usually be found by reasoned, consultative approaches. In essence your letter gives the message that no professional help can be accessed, unless his GP requests it, or his mental state provokes police intervention”*. He added that Matthew Martin had recently attended his GP suffering, so it appears, from delusional ideas concerning a lump on his arm, and been informed that he had been removed from his surgery list. Without a GP Mr Martin wondered what he should now do if his son returned in a disturbed state. Mr Martin described threatening remarks made to him by Matthew Martin but said that he had never shown violence towards him.

### ***Breakdown in communication between Mr Martin and Dr Newbery***

*In her sensitive and supportive letter Dr Newbery provided the tone of response needed to Mr Martin's concerns. She clearly attempted to provide him with encouragement. But dissuaded rather than encouraged, it seems that Mr Martin did not even send the further letter of frustration he had drafted to Dr Newbery. Sadly, and paradoxically, Dr Newbery's letter seemed to mark the end of Mr Martin's attempts to reinstate care for his son at Southmead Hospital. There was no further communication between Mr Martin and Dr Newbery. Nor did Matthew Martin himself refer to Dr Newbery after September 1997. Most concerning of all, Mr Martin's loss of trust in the mental health services remained unknown to Dr Newbery who believed that she had left channels of communication open. The factual accuracy and adequacy of Dr Newbery's letter in terms of access to services is considered more fully in Chapter 4.*

### ***Misunderstanding over Matthew Martin's registration with his GP***

*Mr Martin's feelings of powerlessness were aggravated by his belief, expressed in an unsent letter to Dr Newbery, that Matthew Martin no longer had a GP, thereby depriving him of his main route back to Dr Newbery. But the Inquiry heard that Matthew Martin had not been removed from his GP's list. Unfortunately, since Dr Newbery did not receive Mr Martin's letter she was unable to correct this misconception or provide further reassurance.*

### ***Confusion over points of access to mental health services***

*It is sad and unsatisfactory that well-intentioned communication between Mr Martin and Dr Newbery should have resulted in such failure to find common ground. It is the Inquiry's view that the problem did not lie with Dr Newbery. Multiple and uncoordinated access points within health and social services produced frustration and misunderstanding. As a result services appeared remote and unresponsive.*

### **Need for single point of access to services**

*Dr Newbery should not have needed to explain at length how to arrange for Matthew Martin to be seen. It should have been simple and understandable with one single point of access.*

- **Recommendation 2**

### **Support for Mr Martin**

*Other homicide inquiries<sup>1</sup> have noted that those closest to the patient will often be the first to detect signs of deterioration. Relatives must know clearly how and to whom to pass that information on. Channels of communication must be left open. Where relatives are relied upon entirely by professionals to instigate referral the relatives will feel exposed to a great deal of pressure. They must feel informed and supported. Local advocacy, user and carer support services existed in 1997 but there was no evidence that Matthew Martin had made contact with them. Our recommendations advise that the Trust and social services work with local advocacy and carer support services to produce a Trust leaflet for users and families. Every effort should be made to reduce the stigma often associated with seeking help for mental illness.<sup>2</sup>*

- **Recommendation 1.**

### **Recording user contact with services**

*Any unexpected user or carer contact with a mental health organisation, whether ward, day centre, medical secretary or other, should be drawn to the attention of the RMO as an indicator of the mental health of the individual, and entered into the patient's medical notes.*

- **Recommendation 4**

## **Loss of contact with mental health services**

3.42 After November 1997 Matthew Martin had no further contact with local mental health services. During the year until November 1998 he lived

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<sup>1</sup> Eg the *Clunis* inquiry

<sup>2</sup> A wealth of information exists on the affect of stigma eg *Stigma* Royal College of Psychiatrists; *Respect MIND*.

at a bedsit in Bristol, stayed for a few days at the Cork Simon Community in Ireland, lived for four months with his father and stayed for five days at a Salvation Army Hostel in Bristol. According to his own account in August 1998, he had slept rough for several months in Canford Cemetery, Bristol where he was *"amongst the stones and his 'real' family"*. Wherever he was ostensibly based it seems that he did not regularly sleep there and he often appeared to be homeless out of choice.

- 3.43 Matthew Martin returned repeatedly to his father. Mrs Martin recalls that Mr Martin became increasingly frightened of his son's *"violent tempers"*, locking his own bedroom door at nights and hiding knives from him. He had '999' programmed into his mobile telephone by his bed. During April 1998 the situation became intolerable for Mrs Martin after Matthew Martin punched her in the face following an argument. She left home and thereafter lived separately from her husband, visiting him at weekends.
- 3.44 It seems that in May 1998 Mr Martin attempted to control the situation by agreeing that Matthew Martin could live with him on the condition that he register with his local GP, Dr Thompson at Thornbury Health Centre. He was duly registered there by his father but then failed to attend an appointment. When he did visit Dr Thompson in August 1998 it was to ask for *"pills to get his head right and mellow him out"*. GP notes record that Matthew Martin denied hallucinations but seemed disturbed at times with a possibility of 'knights move thinking'. It noted that he was *'filthy'*. Stelazine was prescribed.
- 3.45 Matthew Martin's move to the Salvation Army Hostel, Bristol at the end of October 1998 was precipitated, he told staff there, by his father *"throwing him out the day before as he was selling the house"*. Within days Salvation Army staff became alarmed by Matthew Martin's possession of a large knife, his bizarre behaviour and conversation. They concluded that he was *'really high risk'* and contacted Bristol social services asking for an assessment, though there was no social services record of this. Believing, correctly, that Salvation Army staff were trying to get psychiatric help for him Matthew Martin promptly left the hostel. He had been there for only a few days, leaving on 4 November 1998. He appears to have been homeless after that.
- 3.46 During the year November 1997 to November 1998 Matthew Martin appeared before Magistrates' Courts on several occasions. He was convicted by Mendip Magistrates' Court for threatening behaviour, found begging by police in Whiteladies Road, Bristol and again whilst begging, arrested in Plymouth city centre with an air gun and hammer after a member of the public told police that he had fired a pellet at his foot. Matthew Martin was charged with possession of an offensive weapon and causing an affray. He appeared before Plymouth

Magistrates' Court in November 1998 and was remanded in custody to Exeter Prison.

## **HMP Exeter**

- 3.47 On 11 November 1998 Matthew Martin was seen at the Health Care Unit of Exeter Prison for a routine reception health screen. He said that he had been treated in Southmead Hospital for claustrophobia and had been prescribed Stelazine.

## **Probation and psychiatric reports for court**

- 3.48 Within two weeks Ms Judy McVey, Probation Officer saw Matthew Martin and spoke to his father by telephone in order to prepare a report for court. Mr Martin told her that because of Matthew Martin's deteriorating behaviour he was unable to have his son to live with him any more. Her probation report stated "*...for the last two years Matthew Martin has lived a nomadic lifestyle largely on the streets of Bristol..... There would appear to have been a progressive mental illness which has not been adequately treated..... It would be my view that a range of offences are a possibility with this Defendant's personality and the risk of serious public harm at some point is a possibility*". She recommended a psychiatric assessment and on 9 December 1998 the court agreed.
- 3.49 Matthew Martin remained in Exeter Prison on remand where, during two interviews with visiting Consultant Forensic Psychiatrist Dr Gallwey, he was suspicious and hostile but showed no clear signs of schizophrenia. Dr Gallwey thought he might have some current mental health problems which were not possible to assess in one interview, but Matthew Martin would not agree to an assessment in the Prison Healthcare Unit. In his psychiatric report dated 14 December 1998 Dr Gallwey described Matthew Martin as having "*...a long history of psychotic illness interspersed with drug abuse and extreme social dislocation.... The latest offence must represent some risk to the public if he becomes more disturbed*". Dr Gallwey did not however find that there were indications of active disturbance to make recommendations under the MHA. After talking to Dr Newbery on the telephone he recommended that, if there was a Community Disposal by the court, the Probation Officer should take Matthew Martin to see Dr Newbery so his aftercare could be arranged. Matthew Martin said that he would be agreeable to such an arrangement. Dr Gallwey doubted whether Matthew Martin would take medication in the long term. He made no other recommendations to the court.
- 3.50 In her addendum probation report Judy McVey could not recommend a community sentence because of doubts over his ability to comply with reporting instructions and lack of stable address. She expected that

the court would consider a prison sentence but added that prison staff would be able to “...assist with a supportive discharge plan, travel arrangements and a pre-arranged psychiatric appointment, on his return to the community”.

- 3.51 On 8 January 1999 Matthew Martin was convicted of affray and possession of an offensive weapon and sentenced to a total of six months imprisonment. He remained in Exeter Prison to serve the sentence.

***Psychiatric assessment in prison***

*Although Dr Gallwey considered it desirable that Matthew Martin be further psychiatrically assessed in the Prison Healthcare Unit this did not take place. This is considered in more detail at Chapter 5.*

**Release from HMP Exeter**

- 3.52 The Exeter Prison Healthcare Unit did not have sight of the probation report that made reference to a supportive discharge plan. On 8 February 1999 it considered Matthew Martin fit for discharge. An offer was made to contact Dr Newbery for an out-patient appointment but Matthew Martin declined saying he would probably go to see her. He was on no medication. The following day he was released.
- 3.53 The Prison Healthcare Unit had no contact with Southmead Hospital. and were unaware that Matthew Martin was still technically subject to s117 aftercare. Dr Newbery told the Inquiry that she would have seen Matthew Martin in prison if she had been asked. She was not sent either the probation reports or the psychiatric report and was not informed of the sentence imposed by the court or his release date. Following his release Matthew Martin did not attend at Southmead Hospital.

***Absence of supportive discharge plan***

*The probation report outlined to the court an expectation that Matthew Martin would receive a supportive discharge plan upon his release from prison including a pre-arranged out-patient appointment. The reasons this did not take place are considered at Chapter 5. An opportunity to re-engage Matthew Martin in planned psychiatric care was missed.*

### **Confidentiality and communication**

*Information was not shared between probation, the independent psychiatrist, the prison healthcare unit and Southmead Hospital. The Inquiry concludes that an inflexible commitment to confidentiality obstructed essential sharing of information and permitted Matthew Martin to be released into the community without an adequate psychiatric assessment, without a home address, without an out-patient appointment and receiving no medication. This is considered in more detail at Chapter 5.*

### **After release from HMP Exeter**

- 3.54 Matthew Martin was released from Exeter Prison on 9 February 1999. It is unclear where he then lived, although a medical examination following his application for sickness benefit gives his address as his father's home. In February 1999 Matthew Martin's father put his house on the market for sale.
- 3.55 On 9 March 1999 Matthew Martin was arrested at Bristol bus station. He had been refused entry to a bus because he was drunk and had then punched the driver in the face. He had gone on to damage two cars nearby with a gravedigger's spade. After arrest he was remanded in custody to Horfield Prison, Bristol.

### **HMP Bristol**

- 3.56 Matthew Martin remained in prison on remand until his conviction by Bristol Magistrates' Court for common assault and damage to property on 18 March 1999. He was sentenced to one month's imprisonment, remaining at Horfield Prison and being released on 24 March 1999. Prison records concerning Matthew Martin's period at Horfield Prison were missing and therefore unavailable for the Inquiry. There is nothing to indicate that he was seen by the Prison Healthcare Unit or assessed as mentally unwell.

### **No psychiatric assessment**

*Over a period of fifteen days Matthew Martin was arrested, remanded, convicted, sentenced, served a prison sentence and released. At no time was any psychiatric assessment suggested. Nor was a probation report requested. Nor was any court diversionary scheme activated. No connection was made with his previous prison sentence in Horfield. No link was made with Exeter Prison. Nor was there any communication with Exeter Prison Healthcare Unit or Southmead Hospital. This entry into and exit from the criminal justice system was entirely self-contained. Opportunities for Matthew Martin's re-engagement with mental health services were missed.*

### **The final six weeks**

- 3.57 Within five days of his release from prison on 24 March 1999 Matthew Martin visited his GP, Dr Thompson requesting a sick note for three months. He said that he was living at home with his father again and Dr Thompson noted that he seemed well but "*a bit muddled at times*". His mood was "OK" and he had no disturbing thoughts. Medication was not discussed, requested or prescribed. Dr Thompson believed that Matthew Martin was still under the care of Dr Newbery. There was nothing to suggest that Matthew Martin's condition on that day was unusual or in any way different from his presentation during the preceding years. He knew nothing of Mr Martin's anxieties, the assault by Matthew Martin on Mrs Martin, the recent offence or Matthew Martin's prison sentence.
- 3.58 Following the homicide a friend of Mr Martin's recalled that Mr Martin had told him Matthew Martin returned home in March 1999 and was getting "*more weird or ill*". He said he feared his son would hurt him and that although he could not cope with him he could not abandon him. He described having "*exhausted all treatment avenues*". There is no evidence that Mr Martin made any of this known to Southmead Hospital, social services or Matthew Martin's GP Dr Thompson.
- 3.59 The police later received evidence from the person who cleaned Mr Martin's house that he was keeping knives hidden and communicated with his son through notes. These would sometimes ask Matthew Martin to tidy up or "*find yourself a flat*".
- 3.60 On 18 April 1999 Matthew Martin's brother-in-law saw Matthew Martin begging in Gloucester Road, Bristol.

- 3.61 On the morning of 23 April 1999 Matthew Martin called at English Churches Hostel, Jamaica Street, Bristol seeking accommodation. A room was kept for him but he did not reappear. Matthew Martin later said that he had been sleeping rough in St Andrew's Park, returning to his father every three or four days.
- 3.62 Three days before the killing Matthew Martin was seen walking barefoot in Bristol city centre. Then, the day before the killing, he was spotted looking "*his usual unkempt self*" by a friend of Mr Martin's, walking along the A38 near Almondsbury. The same friend telephoned to Mr Martin who said he would like to talk. They agreed to meet at the local pub where Mr Martin told his friend that his son "*was crazed, mumbling to himself*".

### **The killing**

- 3.63 Matthew Martin later said that during the two or three days before the homicide he had been hearing voices telling him to kill his father. He described how, on 5 May 1999, he had stolen an axe from a hardware store and followed his father into the kitchen where he struck him with the axe.

### **The aftermath**

- 3.64 Dr Arden Tomison, Consultant Forensic Psychiatrist, Fromeside Regional Secure Unit, in his court report dated 8 December 1999 described Matthew Martin's state of mind in HMP Bristol after the offence. He was grossly disturbed and presented as a wild, dishevelled, rather gaunt figure whose thinking was so disorganised that it was difficult to obtain a coherent history from him. He laughed inanely and hysterically at all hours of the day and night. His disturbance was said to be consistent with an acute phase of schizophrenia.
- 3.65 On transfer to Fromeside Clinic, with medication, his thinking became more organised and his mood more stable. Dr Tomison's opinion was that Matthew Martin's illness had run a chronic and unremitting course and that he was suffering from a major mental illness at the time of the homicide. For the purpose of sentencing he added that Matthew Martin's illness and its symptoms would have substantially impaired his responsibility for acts and omissions on the day in question.

### **Matthew Martin's mental illness and the homicide**

*The Inquiry Panel accepts the opinion of Dr Tomison that Matthew Martin was suffering from schizophrenia at the time of the killing. He had been out of contact with mental health services and was not compliant with treatment.*

### **Homicide by mentally ill people who are out of contact with services**

*The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 1999<sup>3</sup>, found that*

- *71% of patients convicted of homicide were out of contact with services at the time of the offence, usually following "patient-initiated" discharge*
- *most homicides were not regarded as preventable but in around half mental health teams were able to identify factors which could have made homicide less likely, most often improved patient compliance.*

*We make recommendations aimed at improving mental health services to users who have lost contact with services. We recommend a local policy targetted at the care of this group of patients. We also suggest that the Department of Health consider how new mental health legislation might best be drafted to deal specifically with this problem.*

- **Recommendation 6**

### **Homicide risk to family members**

*The above Confidential Inquiry also found that mentally ill homicides were most likely to kill a family member or spouse<sup>4</sup>. Mr Martin should have been able to express his fears for his own safety to mental health services and expect a helpful response. Mental health services should alert relatives and carers to the risks arising from mental illness.*

- **Recommendation 3**

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<sup>3</sup> Royal College of Psychiatrists, 1999  
<sup>4</sup> op cit, 1999

## Chapter Four

### MENTAL HEALTH SERVICES

- 4.1 Responsibility for provision of a local community mental health service to Matthew Martin was shared between the NHS purchasers, providers and local authority social services. In this they were variously required to act both together and separately. Chapter 4 charts the local care and treatment provided to Matthew Martin and considers the points at which services could have been improved.

#### **Care Programme Approach (CPA): national guidelines**

- 4.2 The principles of the Care Programme Approach (CPA) were at the time contained in a 1990 Health Circular HC(90)23/LASSL(90)11, which came into effect on 1 April 1991. The circular required the then District Health Authorities to implement the CPA for people with a mental illness accepted by the specialist psychiatric services. It asked Social Services Departments to collaborate with Health Authorities in this and to continue to expand social care services to patients being treated in the community. Key features of the CPA were the assessment of both the health care and social care needs of patients, the drawing up of individual care programmes with a written care plan, the appointment of key workers and the holding of regular reviews. From the beginning, Health Authorities and provider units had the lead responsibility for the implementation of the CPA, but it was clearly acknowledged by the Department of Health that joint working and training between social services and health, together with closer integration of the CPA and care management, were vital to the success of the CPA initiative.
- 4.3 Health Circular HC(90)23/LASSL(90)11 was followed in May 1994 by HSG(94)27 which reiterated the principles of the CPA and emphasised the need for risk assessment prior to discharge. The circular also drew attention to patients to whom Section 117 applied and the need in their case to implement the CPA fully in order properly to discharge Section 117 aftercare duties.
- 4.4 In 1999 *Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach*<sup>5</sup> brought about procedures for integration of CPA and Care Management, known as the Integrated Care Programme Approach (ICPA).

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<sup>5</sup> NHS/SSI policy booklet, October 1999

## **Matthew Martin's entitlements under CPA and s117**

- 4.5 As a former prisoner transferred under Section 37 to Southmead Hospital, Matthew Martin was entitled both to aftercare under Section 117 MHA 1983 and to services within the framework of CPA including systematic assessment of his health and social care needs, a care plan, a keyworker and regular review. Health Circular HSG(94)27 spells out the functions of the keyworker whose job included keeping in close contact with the patient, monitoring the delivery of the care plan and taking immediate action if the plan was not implemented. The circular similarly indicates the expected contents of a care plan: the first review date; information relating to past violence or assessed risk of violence; name of the key worker and how to access him or her; and what to do if the patient fails to comply with treatment or other requirements. However, even without the security of arrangements offered by the CPA and Section 117 aftercare, Matthew Martin would have been entitled to an assessment of his needs by a social worker under the NHS and Community Care Act 1990.

## **CPA in the Trust and Social Services**

- 4.6 During the time that Matthew Martin was subject to CPA the local policy and procedure was contained an undated document entitled The Care Programme Approach. Although this was developed by the Trust we were told that it had been agreed with Bristol Social Services. In common with most social services departments Avon Social Services (prior to April 1996) retained separate case management documentation. Guidelines outlined the need for integration with CPA and a 'Mental Health/Social Services Interface Flow Chart' illustrated the operational connection between the two systems,
- 4.7 When unitary local authorities came into existence on 1 April 1996 Bristol Social Services continued to use the case management documentation inherited from Avon Social Services. But the Panel heard that it was unclear to health or social services staff whether any of the old Avon Social Services guidelines on integration with CPA continued to apply. There were no guidelines on joint working from health. It was this structure that was operational during the period from 1996 to 1999 when Matthew Martin was subject to CPA procedures.
- 4.8 The inquiry heard that new joint procedures for ICPA Procedure, Good Practice and Guidance have been applicable in the Avon & Wiltshire Trust since 2001. We are informed that the ICPA process is now consistent throughout the Trust area as required by Social Services Inspectorate inspections and a Commission for Health Improvement review.

***No guidelines on CPA joint working***

*No social services and health jointly agreed guidelines on the operation of CPA existed between 1996 until the homicide in May 1999. Old documentation had not been revised after unitary authorities replaced Avon Social Services. This was unsatisfactory and confusing.*

▪ ***Recommendation 5***

## **Hospital Discharge December 1996**

- 4.9 Whilst we are careful not to accord this moment too much significance it is clear, with hindsight, that this discharge from hospital was a key point in Matthew Martin's history. It turned out to be the only period he spent in local psychiatric care and it provided an opportunity for making a comprehensive plan that would deal with Matthew Martin's expected non-compliance and disengagement from mental health services. There is no question that any staff involved with Matthew Martin could have foreseen the homicide two years later.
- 4.10 A range of services were available. By virtue of s37 Matthew Martin was subject to s117 after-care requirements under the Mental Health Act 1983. He was entitled to a social work assessment under the NHS and Community Care Act 1990. The Care Programme Approach applied to him. CPN, social services, OT and various housing services were available to be accessed. Health Circular HSG(94)27 required a risk assessment upon discharge from hospital and consideration of a plan for non-compliance. The Code of Practice, MHA 1983 published in August 1993, at paragraph 27.7 described the people who should be involved in multidisciplinary meetings to establish a care plan. They included the RMO, ward nurse, social worker, GP, CPN, the patient, relative and someone from housing authorities if accommodation was an issue.

## **CPA meeting and care plan**

- 4.11 Within the Trust CPA documentation applicable to Matthew Martin a three-tiered approach to CPA and the requirements of the CPA system were spelt out. There was a clear intention in the document to monitor the progress of the CPA and an explanatory leaflet was produced for service users although neither Matthew Martin nor Mrs Martin could recall having seen this. No guidance was given as to when CPA planning for discharge should begin. The Inquiry heard that this varied according to the custom of different consultant psychiatrists. It was not

uncommon for the CPA meeting to take place upon discharge of the patient from hospital. There was guidance on discharge from the care planning system, including the need to ensure that everyone involved with the patient's care was in agreement that they should be discharged, preferably by holding a CPA meeting. Matthew Martin's first and only CPA meeting took place on the day he was discharged from hospital and from his Section 37 order, just over three months after his admission. The view taken at the time was that there was no need for a formal CPA meeting in advance of his discharge. The timing of the meeting complied with CPA procedures as they then existed. Present at the meeting were Dr Newbery, CPN Nick Heneker, a ward nurse, Matthew Martin and Matthew Martin's father. Although medical notes indicated that the GP was invited the GP notes did not record any invitation and no GP attended. No social worker was invited.

- 4.12 The CPA Care Plan itself was completed at the meeting by the SHO. It was contained on one page with carbonated copies intended to be provided to the service user and the Care Programme Administrator. The tier of CPA was to be indicated by deletion of options. It provided for the name of the keyworker and the date of the next meeting but not specifically for information about assessed risk, how to access the keyworker or what to do if the patient failed to comply with treatment or other requirements. Completion of the Care Plan was brief. The level of CPA was not indicated nor was a review date given. Matthew Martin's needs were described in very general terms.

***Trust CPA strengths and weaknesses***

*Generally, we conclude that CPA procedure and practice, as it applied to Matthew Martin at that time, was poor and of a standard that did not meet statutory requirements. Trust CPA policy had some strong points. An intention to monitor it, the inclusion of a leaflet for users and copies of the care plan for users were good features, although there was no evidence that CPA had been monitored and no record from the family that the leaflet had been seen. Weaknesses included a failure to take account of Health Circular HSG(94)27 requirements concerning risk assessment or contingency planning for non-compliance and a low expectation concerning advance planning for discharge. Care plan forms, by their design, invited brevity. Neither policy nor training encouraged rigorous completion of documentation. The Care Plan, as completed, conformed to only one of the requirements of Health Circular HSG(94)27; inclusion of the name of the keyworker (now called care co-ordinator).*

*Of the other requirements it failed to include; first review date; information relating to past violence or assessed risk of violence; how to access the care co-ordinator and what to do if the patient fails to comply with treatment or other requirements. Trust policy should have set a standard rather than reflecting established practice of the most pressured mental health teams.*

- **Recommendation 5**

**Care Plans in the Mental Health Bill**

*As presently drafted new mental health legislation will make care plans a statutory requirement prior to compulsory treatment for longer than 28 days. This is an opportunity to ensure that care plans properly address risk assessment and non-compliance with treatment<sup>6</sup>. HSG(94)27 has largely failed to do this over a period of eight years<sup>7</sup> and it is clear that a greater statutory force is needed.*

- **Recommendation 20**

## Social work

- 4.13 No local authority social worker was at any stage involved with the assessment of Matthew Martin's needs. Bristol Social Services had no record of any referral to them concerning Matthew Martin, although we heard from the Salvation Army that they had tried to seek an assessment in October 1998. No social worker was at any stage involved with the assessment of Matthew Martin's housing, practical needs or coping skills. Other than the history taken by an SHO for psychiatric assessment there was no psycho-social assessment of the family nor any discussion between a social worker and Mr Martin concerning his fear of having his son home or his potential to provide a link with psychiatric services after discharge. Nor was any referral made for an assessment for s117 aftercare or under the NHS and Community Care Act 1990. The Inquiry heard that there was no routine social work presence at Dr Newbery's ward rounds or CPA meetings. Bristol Social Services' social workers were located in a building next door but were perceived to be so short staffed that it was unlikely they would be able to help. Dr Newbery had become so

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<sup>6</sup> for further views and information on care planning/campaigning groups ref *Charter for Consensual Treatment* Mental Health Alliance; CPA Association

<sup>7</sup> Evidenced from other homicide inquiries eg *Richard Gray*, Wiltshire Health Authority and Wiltshire Social Services, October 2001

pessimistic that she no longer invited social workers to CPA meetings, even when there were clear statutory obligations involved, unless they were already involved in a case.

**Absence of social work referral**

*This was extremely unsatisfactory. There was no evidence to the Inquiry that the social workers were or so under resourced or desperately busy that they would not have responded to a referral from Weston Ward about Matthew Martin had it been made.*

▪ **Recommendation 7**

## **Planning for non-compliance and disengagement**

- 4.14 Although a CPN was present at the CPA meeting he had not previously met Matthew Martin, having been allocated the case just that morning. We were told that this was usual for a first admission. Visits to Matthew Martin were to be made every two weeks but no contingency plan was made to deal with Matthew Martin's anticipated non-compliance. Nor was there any clear practical plan should Matthew Martin move address or become homeless.

**Development of assertive outreach**

*Compliance might have been improved if there had been an opportunity for the building of a rapport between CPN and Matthew Martin before discharge. Fortnightly CPN visiting was unlikely to be sufficient but we were told that in 1996 this was usual practice. Assertive outreach teams have since developed to provide intensive support for such patients.*

**The need to anticipate homelessness**

*It was expected that Matthew Martin would move fairly quickly from his accommodation. A clear agreement between CPN, hospital and Mr Martin would have helped to keep track of him.*

**Need for policies on non-compliance and disengagement**

*The Trust had no written policies on non-compliance or disengagement. This was not, and is not, unusual. The National Confidential Inquiry into Suicide and Homicide by People with Mental*

*Illness, 1999 found that only a minority of Trusts did do so. Their recommendations concerning disengaged patients include the need for a comprehensive social and clinical care plan, satisfactory housing and assertive outreach in response to loss of contact with patients including those who are homeless. They recommend a written policy on non-compliance which is made known to staff, patients and families.*

- **Recommendations 6 and 20**

## Care co-ordinator

- 4.15 Trust CPA procedure indicated that the care co-ordinator should be community based. We heard that Dr Newbery took on the task because she believed she was the only person in a position to do it.

### ***The role of the care co-ordinator***

*We are of the opinion that it is good practice where a patient is subject to level 2, level 3 or enhanced CPA for the care co-ordinator to be either a CPN or social worker. The care co-ordinator must be able to keep in touch with a discharged patient, ensure that plans are put into effect and report back on progress to the RMO. Neither the CPN at Southmead Hospital nor the hospital social workers formally took on this role and the opportunity for close, co-ordinated work between staff on Matthew Martin's behalf was missed. We were pleased to hear that the Trust is presently examining the issue of care co-ordinators.*

- **Recommendation 5**

## Risk assessment

- 4.16 There was no formal written risk assessment prior to discharge and no assessment of Matthew Martin's dangerousness. This was despite Mr Martin's fear of having his son home and Dr Newbery's view, expressed in her report to Matthew Martin's solicitors, that his future dangerousness needed to be assessed as a result of the suspected arson.

### ***Need for formal risk assessment***

*There should have been an assessment of Matthew Martin's dangerousness to his father. A procedural requirement to undertake a comprehensive written summary of risk would have focussed attention on this unresolved matter. As it was the implications of the house fire for Matthew Martin's future housing, risk and relationship with his father remained unexplored. Health Circular HSG 94(27) issued in 1994 required that Trust policies ensure the existence of procedures for risk assessment upon discharge from hospital. By 1997 they were still not in existence.*

#### **▪ Recommendation 3**

## **Housing**

- 4.17 Arrangements for Matthew Martin's accommodation after discharge were dealt with by the ward staff and SHO. They put a great deal of effort into finding supported accommodation for Matthew Martin which came to nought. Assessment by Second Steps Housing Association did not take place because Matthew Martin did not attend for an interview. A provisional place for Matthew Martin at Ron Jones House was in the end not proceeded with because Mr Martin was unhappy with the accommodation. In any event, it later emerged that there was a background of suspected arson which we were told would have necessitated a further examination of the risks involved. Matthew Martin was eventually found bed-sit accommodation by his father but there was an expectation that he was unlikely to remain there for long. An air of pessimism surrounded his future. He had been resident for only two weeks on s17 leave prior to the CPA meeting, and it seems that he remained there for only a further few weeks before he moved and was lost to the CPN and RMO.
- 4.18 Bristol Social Services, who provided the social work service for Dr Newbery's team, were not asked to assist with Matthew Martin's housing. They expressed surprise at this and were also surprised that they had not been invited to attend Matthew Martin's CPA meeting. They were nevertheless unsure that they would have been able to contribute since housing needs were generally dealt with by referral to The Hub.

- 4.19 Matthew Martin described himself in an application form to Second Steps Housing Association as needing help with a number of daily living tasks but there was no Assessment of Daily Living carried out by the Occupational Therapy service. It is clear that Matthew Martin was sometimes unable to manage his daily life. He lived rough and begged but there was no assessment of his practical coping skills.

### ***Complex housing needs***

*Matthew Martin's housing needs were not simple. They were complex. There was a background of suspected arson, his father would not have him home for that very reason, he was expected to disengage and drift from whatever accommodation he had, and his coping skills were poor. The complexity of Matthew Martin's housing need was not fully recognised. A thorough multi-disciplinary assessment would have saved time and prevented wasted effort.*

### ***The Hub***

*The Inquiry heard that The Hub was largely concerned with the problems of homelessness experienced by people who self-referred. It aimed to provide street access to professional help. It was, and still is, considered to be very successful with this group of homeless people. But Matthew Martin was already within the mental health care system as an in-patient subject to s37 MHA. His needs were complex and he needed a comprehensive multi-disciplinary assessment which The Hub was not in a position to provide.*

### ***Incomplete assessment of housing need***

*We conclude that Matthew Martin's housing needs were not assessed fully or adequately. Social services should have been asked to investigate his father's concerns about having his son live with him. An OT assessment of daily living should have been undertaken. A wide range of accommodation opportunities in the Bristol area (see Chapter 2) remained unexplored. It was unsatisfactory that the task of finding accommodation was left to busy nurses on the ward who could not have been expected to have the necessary expertise but who nevertheless did their best to be helpful.*

▪ **Recommendation 7**

## **S117 aftercare**

- 4.20 Section 117 is a statutory duty on the part of health and social services to provide aftercare for patients who have been detained in hospital under Sections 3, 37, 47 or 48 of the Mental Health Act. Planning for such aftercare is usually in practice subsumed within CPA meetings. In the case of Matthew Martin the Inquiry heard from Dr Newbery that the sole CPA meeting was not a s117 meeting because no social worker attended. No social worker attended because no social worker was invited. No social worker was invited because none were involved with Matthew Martin. Without an invitation to a s117 meeting there was no opportunity for social services to assess a need for involvement. Social services did not know that they were not invited. This was a circular argument.
- 4.21 Evidence to the Inquiry indicated that social workers at Southmead Hospital were chronically understaffed and very busy and that arrangements for joint working between psychiatric and social work staff had consequently petered out. It was not made clear to the Inquiry how, in these pressured circumstances, work was prioritised. Detained under section 37 MHA, Matthew Martin could have expected to be a priority for social work support.

### ***Absence of assessment for S117 aftercare***

*There was a failure to adhere to statutory requirements concerning s117 aftercare. Matthew Martin was not assessed under s117 as to the existence or absence of aftercare needs. Nor at any point was he formally discharged from s117 aftercare. Both assessment and discharge would have required formal agreement between the RMO and the social services department. Whether realistic or not, perceived pressures upon social services staff had produced a practice that did not permit routine fulfilment of s117 requirements.*

▪ **Recommendation 8.**

## **Discharge from s37**

- 4.22 On 2 December 1996 Matthew Martin was discharged not only from hospital but from s37. He had been living in his bedsit whilst subject to s17 leave for 10 days.

### **Potential for greater use of s17 leave**

*Whilst not outside the scope of accepted practice at the time, more use could have been made of s37 combined with s17 leave to monitor and control follow-up. Matthew Martin would have remained subject to the consent to treatment requirements of the MHA and the conditions of his leave could have required that he comply with medication and reside at a particular address. All the psychiatric reports for court had made reference to the difficulties of compliance and continued engagement with services expected after Matthew Martin's discharge from hospital. Indeed, this appears to have been the rationale for the making of the s37 order. Yet the s37 was discharged when his dangerousness had still not been assessed, he had not been persuaded to accept depot medication, his future compliance with oral medication was expected to be poor, he had been in his bedsit for only 10 days and there had not been any opportunity to establish a regular pattern of CPN visiting or attendance at hospital appointments.*

*Since 1999 case law<sup>8</sup> has extended the scope of s17 leave. New proposals in the Mental Health Bill build further on this theme with plans for compulsory treatment in the community. We hope that disengaged patients and their families will gain from this.*

## **Discharge from CPA**

- 4.23 Computer records shown to the Inquiry Panel reveal that Matthew Martin was discharged from the CPA database in February 1997 at the point that he had apparently not responded to CPN visits. It remains unclear how Matthew Martin's name was removed from the register. We accept the evidence of Dr Newbery that she had not been consulted and did not know he had been discharged from CPA.
- 4.24 Trust CPA policy at the time required that everyone involved with a patient's care was in agreement that they should be discharged, by

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<sup>8</sup> *B v Barking, Havering and Brentwood Community Healthcare NHS Trust* [1999]1 FLR 106; *R (on application of Epsom and St Helier NHS Trust) v The MHRT* [2001] EWHC Admin 101

holding a CPA meeting if possible. It required that where a care co-ordinator “loses track” of a service user despite reasonable efforts to trace him/her the reasons and concerns should be recorded. Yet administratively discharge from CPA was a simple process. We heard that it was often carried out by a telephone call to the administrative officer who held the database on computer. Nothing on the computer recorded whether a meeting had been held or who provided the information. No form needed completion for incorporation onto the medical file.

#### **Discharge from CPA**

*The circumstances of Matthew Martin’s discharge from CPA remain a mystery. It is clear that Dr Newbery never intended that he be discharged and did not know about it. Somewhere there was slippage between clinical CPA decision making and computer management of the database. Administrative and IT procedures should facilitate policy not frustrate it. The Trust and social services should review its ICPA policy, tightening procedures for discharge from ICPA, and taking particular account of the need to plan carefully for discharge from ICPA of disengaged, non-compliant patients and ensuring that RMO approval is always obtained.*

#### ▪ **Recommendation 5**

#### **Continued clinical involvement**

*Despite Matthew Martin’s discharge from the CPA database in February 1997 Dr Newbery was very clear in her evidence to the Inquiry Panel that she had not discharged him from her care. She continued to send him out-patient appointments and he was seen at Southmead Hospital on three further occasions during 1997. She also engaged in correspondence with Mr Martin. Her actions were consistent with active CPA involvement.*

#### **Absence of CPA**

*Did the absence of CPA matter? Yes, we think it did. CPA provides a structure, which should act as a safety net and prevent drift. Without it there was no procedural framework for planning Matthew Martin’s future care. No six-monthly multi-disciplinary reviews of the care plan were routinely*

*triggered. No meetings needed to take place and none did take place.*

## **User and carer access to mental health services**

- 4.25 The complexity of the organisation of social services and health following the break-up of Avon in 1996 has been alluded to elsewhere in this report. Few of the witnesses to the Inquiry were able to describe without difficulty the baffling arrangements and relationships consequent upon local government re-organisation, a task made the more difficult as health re-organisation subsequently began to take place and is still to be completed. In her letter of 14 October 1997 to Mr Martin, Dr Newbery describes to him the procedures for accessing help from Southmead Hospital, with the GP as the main route in the event of failing to get through to any of the hospital psychiatrists. It is unfortunate that her advice to Mr Martin about access to help through social services lacks clarity.

### ***Direct approach to social services***

*The bewildering descriptions given by witnesses of relationships between neighbouring authorities and agencies in existence at the time should not obscure the fact that, wherever Matthew was, he or his father could have approached directly the local social services mental health team or the Emergency Duty Team to request help. After May 1998 when Matthew Martin had moved to live with his father that approach could have been made either to Bristol or South Gloucestershire social services. An assessment could have been undertaken by a social work member of either social services team and a judgement made about how best to help, including assessment by an ASW under the MHA for compulsory admission if necessary. The ambiguity of Dr Newbery's advice about approaching social services meant that Mr Martin was left with the impression that he could receive help only by going through his GP.*

## **'Sectionability' under the MHA**

- 4.26 An overview of the nine months after discharge suggests that there was a gradual deterioration in Matthew Martin's mental health and that he was relapsing. He repeatedly failed out-patient appointments, was often non-compliant with medication and showed signs of personal neglect, social isolation and physical deterioration. By September 1997

he was expressing delusional ideas. Yet at no time was it felt by the psychiatrists involved that statutory grounds for detention were met. There was never any involvement of an ASW in the assessments. This section considers whether the decision-making on compulsory admission was appropriate. Could and should Matthew Martin have been detained under the MHA for assessment or treatment during this period?

- 4.27 In addition to the statutory criteria the MHA Code of Practice then and now<sup>9</sup> refers to the factors to be taken into account when assessing under the Act. Several of these are likely to involve the assistance of an ASW. They include ‘- *the needs of the patient’s family or others with whom he or she lives; - the need for others to be protected from the patient; - the burden on those close to the patient of a decision not to admit under the Act*’. Acknowledging the occasional practical difficulties of obtaining all this information, the paragraph concludes ‘*In certain circumstances the urgency of the situation may curtail detailed consideration of all these factors*’.
- 4.28 With or without these factors the psychiatric assessment of Matthew Martin required a decision to be made about his degree of relapse. But that was not easy. Just how much evidence of relapse is needed before detention is justified has been the subject of much debate. For many years it was normal practice to wait for psychotic symptoms to “ripen” before resorting to the powers of the Act. But that changed with the *Falling Shadow* Independent Inquiry report published in 1995<sup>10</sup>. Advocating early intervention it was considered that there was no legal need to await a significant deterioration in mental health before action was taken. Use of powers under the MHA was justified where a patient refused medication which on previous evidence would lead to relapse and consequent risk to himself or others. Did this mean that Matthew Martin should have been detained?
- 4.29 Pointing out that psychiatrists must act on evidence, not hunch or suspicion, the Mental Health Act Commission Discussion Paper ‘*The Threshold for Admission and the Relapsing Patient*’ issued in June 1998<sup>11</sup> considered that where there was no very clear pattern of relapse, waiting to see whether psychotic symptoms emerge may be the only possible approach.

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<sup>9</sup> Code of Practice paragraph 2.6 in current edition; text identical to that in previous edition.

<sup>10</sup> *The Falling Shadow: One Patient’s Mental Health Care: Independent Inquiry into the care and treatment of Andrew Robinson*, 1995

<sup>11</sup> Discussion Paper *The Threshold for Admission and the Relapsing Patient*, Mental Health Act Commission, June 1998

- 4.30 That position has been confirmed by the case of *Ex parte Smith*<sup>12</sup> which accepted that the nature of a person's mental illness can indeed provide the basis for detention even where there is no symptomology at the time. But there needs to be some familiarity with the person's pattern of relapse. Non-compliance with medication can by itself be sufficient but only where relapse is already known to result in swift deterioration and extreme risk to others.

***Assessing non-compliant and disengaged patients under the MHA.***

*Preliminary psychiatric assessments were made under pressure on the ward when Matthew Martin was about to discharge himself or had declined informal admission. No formal assessment for s2 or s3 was made under the MHA. No social worker was at any time involved. If an assessment under the Act had been requested the guidelines for good practice described in the MHA Code of Practice would have applied. With a fuller understanding of Matthew Martin's background relapse may have been sufficiently evident to provide grounds for compulsory admission, particularly by September 1997.*

*However, we have the advantage of hindsight. The admission in 1996 was Matthew Martin's first and there had been no chance to observe the development of a familiar relapse pattern. Neither was it entirely clear whether his drifting lifestyle was attributable to relapse or chosen lifestyle. Moreover, although there was evidence of some risk to others should Matthew Martin relapse (based upon his forensic history, some threatening behaviour in hospital and a possible arson in the past) there was not the highly dangerous behaviour associated with relapse in 'The Falling Shadow'<sup>13</sup>. There can be no certainty that the grounds for compulsory admission would have been met even with the fullest assessment.*

*There is nevertheless, in our view, a message here. We conclude that where patients are non-compliant, disengaged, socially isolated and physically neglectful of themselves particular*

<sup>12</sup> *R v South Thames MHRT ex parte Smith*; TLR 9.12.1998; (1999) COD 148; (1999) 47 BMLR 104

<sup>13</sup> *op cit*, 1995

*attention must be given to obtaining information from all sources. Assessments based upon a snapshot of the moment may not adequately capture the degree of deterioration, risk and relapse which is present. Where possible an ASW should be involved and a formal assessment under the Act carried out including all the factors in the Code of Practice. Trust policies on non-compliant and disengaged patients should give guidance on this.*

▪ **Recommendation 6.**

# Chapter Five

## PRISON AND CRIMINAL JUSTICE SERVICES

- 5.1 Matthew Martin was not an unusual or remarkable individual. His degree of mental disturbance matched that of many others who were, and still are, disengaged from psychiatric services. The criminal justice system bears the burden of dealing with this huge problem, trying to identify those whose mental illness might make them dangerous to others at some future point.
- 5.2 Between December 1996 and May 1999, whilst out of contact with mental health services, Matthew Martin was convicted five times for offences connected with begging. Four of these offences also involved threatening behaviour, possession of offensive weapons and/or assault. He was in prison on two occasions. Each contact with police, courts, probation and prison services offered a missed opportunity for referral to local psychiatric services for re-assessment. Yet on no occasion did this take place. We consider what happened, why and what improvements could be made to these services.

### Prison

- 5.3 The prison population has a very high incidence of mental ill-health. The Office for National Statistics in 1997 found that 9 out of 10 prisoners have at least one of five disorders (neurosis, psychosis, personality disorder, alcohol abuse or drug dependence). Between 12% and 15% of sentenced prisoners have four of the five. Government policy in the last few years has focussed on tackling the problem, hoping that this might reduce crime, re-offending rates and social exclusion.

### Background to prison health care

- 5.4 At the time Matthew Martin was in prison, all health care to inmates was provided by the Home Office. Standards were set<sup>14</sup> with the aim of giving prisoners access to the same quality and range of health care as that provided to the general public by the NHS. The need for a 'seamless service' from community through to release was identified in 'The Future Organisation of Prison Health Care'<sup>15</sup> and a formal

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<sup>14</sup> Prison Service in Prison Rules

<sup>15</sup> Department of Health, Joint Prison Service and NHS Executive Working Group Report, published in March 1999

partnership between the Prison Service and NHS at local and national level was recommended.

## Inspection reports

- 5.5 Usefully, since they were conducted at almost the same time that Matthew Martin was in prison, the HM Chief Inspector of Prisons produced an Inspection report of HMP Bristol on 12 to 21 April 1999<sup>16</sup> and an Inspection Report of HMP Exeter on 17 to 26 May 1999<sup>17</sup>.

## Mental health services in prison

- 5.6 At the time of the homicide mental health services in prison had not been specifically targeted for development nationally. Subsequent Government initiatives concerning mental health in the community have expressly included prisoners.
- 5.7 *The National Service Framework (NSF) for Mental Health*<sup>18</sup> applies to prisons. *The NHS Plan*<sup>19</sup> sets out a vision for mental health services in prison, including the commitment that by 2004 *'All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator'*.
- 5.8 Further emphasising the development of joint NHS and prison partnership *'Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*<sup>20</sup> states

*'the NHS cannot relinquish responsibility for patients at the prison gate..... Prisoners who were on CPA before entry into prison should be able to have their programmes of treatment....continued as far as possible within the prison setting. Care co-ordinators based in the community should endeavour to retain contact with patients who have been sent to prison, and liase with prison based staff working with the patient, in order to provide continuity of care, particularly on release..... It will be important to ensure that there are mechanisms in place to help identify prisoners who are, or should be, on CPA'*.

- 5.9 Information must be shared for this to operate effectively, and the report adds:

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<sup>16</sup> [www.homeoffice.gov.uk/hmipris/inspects/Brist1a](http://www.homeoffice.gov.uk/hmipris/inspects/Brist1a)

<sup>17</sup> [www.homeoffice.gov.uk/hmipris/inspects/exetcpe](http://www.homeoffice.gov.uk/hmipris/inspects/exetcpe)

<sup>18</sup> Department of Health, September 1999

<sup>19</sup> Department of Health, July 2000

<sup>20</sup> Jointly published December 2001 by the Department of Health and the Prison Service

*'Where possible (and generally with the patient's consent) relevant information should be passed to the patient's GP, their care co-ordinator where they were in contact with community mental health services.... A multi-disciplinary team comprising those who have been caring for the individual within the prison and those who will be responsible for his or her care on release should develop individualised care plans. These should involve the patient and where possible his or her family, and with a care co-ordinator identified to help ensure that the plan is followed'.*

- 5.10 Confidentiality is a major concern and, unless properly addressed, has the potential to undermine the successful operation of such a scheme. Prison is not a hospital, civil sections of the MHA do not, as yet, apply and a patient's right to have their medical records kept confidential is not lost or superseded by becoming a prisoner. Improvement in information flow between the NHS, prisons, social services, the probation service, the police and courts is being examined by a Prison Health Policy Unit and Task Force<sup>21</sup>. Changing the Outlook describes this as operating alongside a prison *Mental Health Expert Group* which will oversee the implementation of the in-reach community mental health services into prisons as set out in the NHS Plan.
- 5.11 By the date of publication of this Inquiry report all prisons and their local NHS partners should have completed a detailed review of mental health needs and developed action plans, including a training needs analysis for prison staff and in-reach teams<sup>22</sup>. A number of prisons have already become pilot areas for provision of mental health care by local NHS Trusts.
- 5.12 Further commitment to parity between prison and community mental health services has been contained within the *Draft Mental Health Bill Consultation Document*,<sup>23</sup> where there is also reference to the expectation that patients could be subject to non-resident compulsory treatment orders within prisons. This is a fast developing area. At the time of writing this report the Department of Health has announced the transfer of all health care services within prisons from the Home Office to the Department of Health, by April 2003<sup>24</sup>.

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<sup>21</sup> The *Annual Report* of the Prison Health Policy Unit and Task Force is published on [www.doh.gov.uk/prisonhealth/annualreport.pdf](http://www.doh.gov.uk/prisonhealth/annualreport.pdf) and their *Newsletter* is published quarterly on [www.doh.gov.uk/prisonhealth/newsletters.htm](http://www.doh.gov.uk/prisonhealth/newsletters.htm).

<sup>22</sup> For further information see *Guidance on Developing Health Needs Assessments and Health Improvement Plans* on [www.doh.gov.uk/prisonhealth/needsassessment.pdf](http://www.doh.gov.uk/prisonhealth/needsassessment.pdf) and *Clinical Governance for Prison Health - Getting Started* on [www.doh.gov.uk/prisonhealth/dohclinicalgov.pdf](http://www.doh.gov.uk/prisonhealth/dohclinicalgov.pdf).

<sup>23</sup> paras 3.33 – 3.42

<sup>24</sup> DoH Press Release [www.doh.gov.uk/prisonhealth/index.htm](http://www.doh.gov.uk/prisonhealth/index.htm)

### ***The Inquiry response to government proposals***

*We fully endorse the proposals for change in Changing the Outlook. This Inquiry report reveals a number of very practical areas that will need significant improvement in order to ensure effective continuity of care from community to prison and upon release. They include the development of cross agency information systems, the tracking of individuals between services and improved training to identify mental illness in prisons. Confidentiality and information exchange emerges as in need of urgent consideration by prisons and all relevant agencies and services. National guidance is needed to ensure that Primary Care Trusts and in-reach teams consider these points.*

#### **▪ Recommendation 10**

### ***The future of prison psychiatric services***

*Provision of mental health services by NHS Trusts has the potential to enhance the status of mental health care within prisons. It is more likely to deliver a seamless service, counter the problems of information sharing and develop a quality of provision which matches that in the community. The initiative needs to be properly backed by resources to ensure that it is well staffed and operates effectively.<sup>25 26</sup>*

## **HMP Exeter**

- 5.13 Dr Gallwey was the only visiting psychiatrist regularly employed at HMP Exeter in 1998. He explained that he had no written contract with the prison. He undertook sessional work as requested. That might sometimes involve the preparation of a court report. On other occasions he might be asked for his opinion on the treatment and management of a particular patient. He visited the prison two or three times a week. He explained that if after seeing a patient he felt some action was needed by the prison health care staff he would give detailed instructions regarding treatment and management but delivery of care was the responsibility of the prison health care team. He frequently asked to see patients he had assessed for follow-up review, but new referrals and re-referral of cases he had seen and discharged

<sup>25</sup> Home Office Minister for Prisons press release 6 March 2002

<sup>26</sup> [www.homeoffice.gov.uk/hmpris/ch3](http://www.homeoffice.gov.uk/hmpris/ch3)

from his case load were through the health care staff. He had no responsibility for the organisation and management of psychiatric services at the prison. There was no specialist in mental health with such responsibility. This rested with the Senior Medical Officer.

- 5.14 In 1998 two specialist CPN's were employed by the local Regional Secure Unit at the Butler Clinic, Dawlish providing a liaison service to the prison as part of an agreement with particular health authorities. But we were told that the scheme did not apply to Bristol residents and Matthew Martin did not come within its remit.

***Recent developments in mental health care at HMP Exeter***

*HMP Exeter has now transferred secondary mental health services to the local Mental Health Trust. We have been told that the in-reach service to HM Prison, Exeter is in an embryonic state with further resources needed fully to develop it. There is no longer a visiting psychiatrist and as yet no provision of consultant time. We consider that this remains an unsatisfactory state of affairs. Specialist management responsibility for psychiatric care at the prison is urgently needed. This should extend to all inmates regardless of location within the prison or district of origin.*

▪ ***Recommendation 15***

## **HMP Bristol**

- 5.15 In his April 1999 inspection report of HMP Bristol Sir David Ramsbotham, HM Chief Inspector of Prisons<sup>27</sup>, said

*'HCS (health care standard) 2c requires that the care of mentally disordered in-patients shall be under the direction of a psychiatrically qualified doctor.... This standard was not met at Bristol... A system was in place for a visiting psychiatrist to see in-patients on request and for reviews but this, in our view, fell short of the requirements of the HCS.'*

- 5.16 On 28 February 2001 *HMP Bristol; Health Needs Assessment Interim Report*<sup>28</sup> stated

<sup>27</sup> [www.homeoffice.gov.uk/hmipris/inspects/Brist1a](http://www.homeoffice.gov.uk/hmipris/inspects/Brist1a)

<sup>28</sup> Produced jointly by HM Prison Service and Avon Health Authority

*“There is no input from Avon and Wiltshire Health NHS Trust to support those sufferers with a level of illness who would normally remain in the community. These patients are supported by the staff of the Health Care Centre who feel that they are unable to provide an appropriate service but would welcome a joint initiative”.*

- 5.17 At the time of writing we understand that Avon & Wiltshire Partnership Trust have recruited a senior manager with responsibility for prison inreach and a small mental health team is in place.

***Responsibility for psychiatric services in HMP Bristol***

*There was no specialist psychiatric service at Horfield Prison, Bristol. This was a major weakness. The bodies presently commissioning mental health services in HMP Bristol should ensure that there is provision for a doctor qualified in psychiatry to provide sessions for all inmates regardless of location within the prison or district of origin.*

▪ ***Recommendation 13***

**Prison reception health screening**

- 5.19 Busy local prisons carry out routine health screening of prisoners upon their reception. This is carried out by Prison Medical Officers who often have some GP training. No additional information about a prisoner’s health background is generally available at that point. In keeping with this usual practice, all the information obtained about Matthew Martin’s mental health background was through his own account at reception screening. On none of the occasions he was in prison was mental disorder identified as a problem at that initial screening.
- 5.19 No systems existed at either prison for establishing that a person had been in another prison. We heard that there is no national database for this. Nor, in HMP Bristol in 1999, was there any system in operation that would make a connection with his 1996 admission to the prison health care unit. None of his psychiatric history seems to have been known.

***Information at reception screening***

*There was no means of tracking Matthew Martin’s health record within the HMP Bristol healthcare unit nor was there at either prison any routine system for identification of Matthew Martin’s connection with community mental health services.*

*We conclude that there was insufficient background information available at initial health screening in HMP Bristol or HMP Exeter properly to assess Matthew Martin's mental health needs. Similar criticism, made in a previous Independent Inquiry, was reinforced by the European Court of Human Rights which found, in that case, that the prison authorities were in breach of Article 2<sup>29</sup>.*

### **Identification of mental illness at reception screenings**

*None of the prison reception screenings at HMP's Bristol and Exeter recorded that Matthew Martin was showing any signs of mental disorder. Whilst we cannot, and do not, question any of the particular assessments a high number of prisoners suffer from mental disorder. Prison officers carrying out initial health screenings should receive training in the identification of mental illness. Confirmation of that need appears in the inspection report of HMP Bristol<sup>30</sup> where Sir David Ramsbotham, HM Chief Inspector of Prisons, said 'In view of the very high levels of psychiatric morbidity among prisoners....the proportion of nurses with mental health training appeared low'. Need for such training was also recorded in the Independent Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford.<sup>31</sup>*

### **Follow-up after reception health screening**

*At HMP Exeter it was known that Matthew Martin had been treated in psychiatric hospital, probably for a psychotic illness. This did not trigger any procedures for contact with the hospital.*

### **▪ Recommendations 10, 12, 14 and 17**

## **Mental health assessment and treatment in prison**

5.20 At HMP Bristol in 1996 Matthew Martin was appropriately identified as mentally ill whilst on the 'wing'. He was admitted to the health care unit and later transferred to Southmead Hospital. This was good practice.

<sup>29</sup> *Edwards v UK* ; 46477/99; *Times* 1.4.2002; (2002) *Current Law* May 2002, 477; ECHR

<sup>30</sup> Announced visit May 1999: cf *Nursing in prisons: report of a working group considering development of prison nursing*: HM Prison Service and NHS Executive, October 2000

<sup>31</sup> *supra*

- 5.21 At HMP Exeter in 1998 Matthew Martin was assessed by visiting psychiatrist Dr Gallwey for the purpose of a court report. He recommended that Matthew Martin be further assessed in the prison health care unit but he refused. It was the Prison Governor's right to move Matthew Martin to the health unit against his wishes but we heard that since Matthew Martin "did not hit any of the 'trigger points' " for removal they would not try and force compliance.

***Treatment of mental illness in prison***

*This is a common problem relating to mentally ill prisoners. Where someone with mental illness does not present severe behavioural problems they are unlikely to be transferred to the Health Care Centre. This has been recognised by other Homicide Inquiry reports<sup>32</sup>. In-reach teams should be required to carry out mental health assessments wherever they are necessary, whether in the health care unit or the prison wing.*

- ***Recommendations 13 and 15***

## **Confidentiality**

- 5.22 Dr Davis, Clinical Director of Devon District Cluster of Prisons (Exeter, Channings Wood in Newton Abbott and Dartmoor) described two difficulties facing prisons: getting information in and getting information out. We found many more. On closer examination major problems existed within HMP Exeter over flow of confidential information between the healthcare unit, experts writing reports, visiting psychiatrists, prison wings and Probation.

- 5.13 It is apparent from national guidance on the use of confidential information in prisons<sup>33</sup> that this is not a problem confined to HMP Exeter but a serious issue for all prisons.

## **Getting information in**

- 5.24 In order to obtain confidential medical information from Southmead Hospital it was necessary to obtain Matthew Martin's consent. Confidentiality in the NHS is governed by statute and a number of

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<sup>32</sup> Independent Inquiry into the Care and Treatment of *Kevin Keogh* commissioned by Manchester Health Authority, 2000

<sup>33</sup> *Good medical practice for doctors providing primary care services in prison*: consultation document, 2002; *Guidance on the protection and use of confidential information in prisons and inter-agency information sharing*. Information and Practice Note: Prison Health Policy Unit, April 2002.

Health Circulars and professional guidance<sup>34</sup>. Underlying this guidance is the principle that patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care. If doctors are asked to provide information about a patient they should seek the patient's consent to the disclosure of information wherever possible. In order to establish that this consent is valid the patient must be informed of the reasons for which the information is required. The guidance produced by the Royal College of Psychiatrists<sup>35</sup> indicates that where doctors request hospital case notes from another unit, of a patient they are currently treating, patient consent is not required provided patients are informed of this policy. When notes are required for other purposes, such as the preparation of reports in the course of criminal proceedings *"it is important to tell the patient in what capacity the doctor is acting, who requested the report and the exact purpose for the request"*<sup>36</sup>.

## Getting consent

- 5.25 Matthew Martin was remanded in HMP Exeter for the preparation of a psychiatric report. It was for this purpose that Dr Gallwey was asked by the medical officer to examine him. Matthew Martin gave written consent to the release of confidential medical information held by Southmead Hospital. There was no record of any discussion with Matthew Martin as to the purpose for which the information would be released. Consent was contained in a pro forma letter to Dr Newbery dated 9 December 1998 which read

*"The above named (Matthew Martin) is at present under our Medical Care at HM Prison, Exeter. He states he has received care from you as (Out Patient). In order to continue his care could you please supply details of (his) care and treatment and medical state while under your care."*

- 5.22 The Medical Officer was given as Dr Gallwey. Matthew Martin gave his consent at the bottom of the letter

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<sup>34</sup> Supra and HSC 1999/012 (Caldicott Guardians; HSG(96)18 (*The Protection and Use of Patient Information*); EL(92)60 (NHS Executive, *Handling Confidential Information in Contracting: A Code of Practice*); EL(95)75 (NHS Executive, *Handling Patient Information in Contract Minimum Data Sets*); *Confidentiality* (GMC); Access to Medical Records Acts 1988 and 1990; *Good psychiatric practice: confidentiality*, Royal College of Psychiatrists Council Report CR85; the National Confidentiality and Security Advisory Body, Department of Health

<sup>35</sup> Op cit CR 85

<sup>36</sup> Op cit CR 85

*“I, Matthew Martin, being currently under the care of the Medical Officer at the above Establishment do hereby consent to you disclosing details of any medical information they require”.*

- 5.23 Dr Davis, Clinical Director of Devon District Cluster of Prisons told us that he understood this consent to be limited to that needed for Dr Gallwey’s preparation of the court report. He did not believe that Matthew Martin’s consent extended to the release of information from Southmead Hospital to prison health care staff generally. As a result there was no contact between the health care unit and Dr Newbery. No documentation was received from Southmead. Information sharing took the form of a telephone conversation between Dr Gallwey and Dr Newbery.

***Interpretation of the prison consent form***

*In our opinion the prison consent form permitted disclosure of Matthew Martin’s Southmead Hospital medical records to the prison healthcare service for the purpose of treatment and planning of his care after discharge. Consent was contained in a letter written on prison health care notepaper. It was expressly stated as being for the purpose of Matthew Martin’s continuing care. That was consistent with GMC Guidance on confidentiality<sup>37</sup> which refers to the need for consent to treatment. Dr Gallwey was the named Medical Officer and in this capacity he was employed by the prison health care unit. Nowhere did the consent form contain any reference to the preparation of a report for court. There is no indication that Matthew Martin was informed of the purpose for which consent was sought as recommended by the Royal College of Psychiatrists Guidance on Confidentiality<sup>38</sup>. If it had been intended that consent be limited to preparation of a report it should have been made clear. Had Dr Gallwey been asked to assist with discharge arrangements we have no doubt that the same consent form would have covered communication between Southmead Hospital, Dr Gallwey and prison health care staff. No additional consent would have been needed.*

<sup>37</sup> Confidentiality: Protecting and Providing Information: GMC, September 2000  
<sup>38</sup> op cit

**Consent and planning for Matthew Martin's release**

*Despite the clear scope of consent provided on the form it was the understanding of the Clinical Director that it was limited to receiving confidential information solely for the preparation of a court report. It was unacceptable that this lack of clarity should have prevented the prison healthcare unit from seeking information from Southmead Hospital to assist with discharge arrangements. If further written consent was needed from Matthew Martin it should have been sought.*

▪ **Recommendation 16**

**Good practice**

*There are examples of good practice around the country. Some prisons routinely obtain consent for medical records to be made available to the prison as part of reception screening. This is approved by Changing the Outlook and we endorse that.*

## **Confidentiality of the psychiatric report**

- 5.24 Having been asked only to provide a court report Dr Gallwey was not asked to see Matthew Martin again nor was his report seen by the Exeter Prison health care unit. We were told that where the release of a psychiatric court report was sought there was a procedure. For reasons of confidentiality the consent of the author was always needed and, if the author requested it, also the consent of the court. Dr Gallwey told us that, if asked, he would have agreed to the disclosure of his report to Dr Newbery. He was not asked. He added that he would have assisted with the making of discharge arrangements had he been asked to do so. He was not told that his recommendation that Matthew Martin be taken to see Dr Newbery on release had not been achieved and he was unaware that Matthew Martin had received a custodial sentence. Upon giving evidence to the Panel he expressed surprise that he had not been asked to see Matthew Martin prior to release. He told us that Matthew Martin had given his verbal consent to him for aftercare arrangements to be made and if asked by the health care unit to assist with this Dr Gallwey could and would have done so.

### **Consent and psychiatric reports for court**

*There is an absence of guidance over confidentiality in this area. Although extensive guidance is available to doctors responsible for treating patients as to the release of clinical information to courts and legal advisers no guidance exists for doctors whose sole responsibility is the preparation of expert reports and who may in the course of their work become aware of information regarding risk and clinical need which is unknown to those clinicians responsible for providing care for the individual. Guidance should be provided on this.*

- **Recommendation 17**

#### **Good practice**

*In some parts of the country local agreements between courts and prisons have removed responsibility for provision of Court reports from the Prison Health Service<sup>39</sup>. This simplifies the issue of confidentiality.*

## **Confidentiality of the probation report**

- 5.25 Confidentiality was described as a problem in relation to Probation in Exeter Prison. The probation report had recommended that 'supportive discharge plan' was made for Matthew Martin but that report was never seen by the healthcare unit because they believed they were not permitted to see it. They understood that the probation service withheld their reports for reasons of confidentiality but we were told by probation that that this was not so. The probation report was not seen because it was filed elsewhere in the prison. They could have seen it if they had asked. There was no written procedure on this.

### **The need for a policy**

*The absence of a written policy on disclosure of information was unsatisfactory. Probation, the prison and the Mental Health NHS Trust responsible for provision of psychiatric services in Exeter Prison should together produce a policy that ensures probation reports are available to the prison wing and health care unit where necessary.*

- **Recommendation 19**

<sup>39</sup> eg, we are told, Leeds and Manchester

## Getting information out

- 5.26 In order to prepare any kind of plan for Matthew Martin's release from Exeter Prison it would have been necessary to get information out, to Southmead Hospital and his GP. The Clinical Director of Devon Prisons Cluster described the restrictions imposed by confidentiality. The Official Secrets Act prevents a doctor saying whether a particular person is or is not in prison, there is the principle of medical confidentiality and the job description of the Clinical Director which we were told referred to his "*absolute instruction to maintain confidentiality of medical records*".
- 5.27 There was a note on the Exeter Prison health care unit records that, on the day of his release, Matthew Martin did not wish an appointment to be made for him with Dr Newbery. No other planning was made for his discharge.
- 5.28 Upon release it was common for a patient to be provided with a pro forma which gave information for a GP and inviting the GP's contact with the prison medical service. There is no record that Matthew Martin was issued with such a form. Matthew Martin's GP told the Inquiry that he knew nothing of any period in prison and would have wished for information about this, particularly concerning his reported dangerousness.
- 5.29 We heard that where there was a clear and extreme risk to the public as a result of the nature of an individual's offence, the need to share information overrode confidentiality and MAPP (Multi-agency Public Protection) meetings took place with police and probation. The criterion of extreme risk did not apply to Matthew Martin and there were no grounds to convene a MAPP meeting.
- 5.30 We were told that there might have been a reason to breach confidentiality and inform local psychiatric services if Matthew Martin had shown obvious signs of both mental illness and risk to others. This was consistent with recent Guidance issued by the Prison Health Policy Unit.<sup>40</sup> However, neither was thought to exist. The prison healthcare unit did not know that the Probation Officer, Ms McVey, had identified mental illness and risk to others because they had not seen her report.

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<sup>40</sup> *Guidance on the protection and use of confidential information in prisons and inter-agency information sharing*: Information and Practice Note, Prison Health Policy Unit, April 2002. Disclosure can be justified to protect the patient or someone else, from risk of death or serious harm, or for the prevention of serious crime.

### **Matthew Martin's release from HMP Exeter**

*It was unacceptable that the suggestion of a 'supportive discharge plan' for Matthew Martin's release from prison, put before the court and upon which sentence was based, was not actioned. We identify a number of failures:*

- *The Probation Report should have been seen by the prison medical officers. The stated plan for "supportive discharge", the "progressive mental illness" and "risk of serious public harm" identified by the Probation Officer would together have been sufficient to justify making contact with Dr Newbery and sharing information even in the absence of Matthew Martin's consent<sup>41</sup>.*
- *Before his release Matthew Martin should have had a further psychiatric assessment as suggested by Dr Gallwey in his pre-sentence report. Dr Gallwey expressed surprise that such a reassessment was not made. As a result the extent of Matthew Martin's mental illness was not fully known.*
- *Dr Gallwey should have been asked to assist with the making of aftercare arrangements. He said he had received Matthew Martin's consent for this and would have done it if asked.*
- *Contact could and should have been made with Dr Newbery. Sufficient written consent had already been provided by Matthew Martin.*
- *The written remarks about Matthew Martin's risk to others constituted a sufficient change in his management needs to warrant notification to his GP<sup>42</sup>. He had a GP who should have been informed.*

### **Poor communication between prison and GP's**

*The weaknesses in this area have already been acknowledged in a Prison Health Consultation Document which states "the flow of information*

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<sup>41</sup> See note 39 above.

<sup>42</sup> Good medical practice for doctors providing primary care services in prison. DoH/HMPS consultation document.

*between the prisoner's general practitioner in the community and the prison doctor, and then back again, has traditionally been poor. Doctors working in prisons have a responsibility to change this situation*<sup>43</sup>. We conclude that this can best be achieved by inclusion of GPs in the planning of local policies on confidentiality between prisons and other agencies.

▪ **Recommendations 13 and 15**

**Lack of planning for release and aftercare in HMP Exeter**

*With no specialist mental health service in the prison no-one had managerial responsibility for processing cases or planning aftercare services. This was a major weakness and it seems to have been one of the principal reasons that planning for Matthew Martin's release from prison was almost entirely absent. HM Chief Inspector of Prisons, Sir David Ramsbotham, said in his Inspection Report of July 1999.<sup>44</sup> 'Most of the prisoners released from Exeter had no preparation for release or aftercare....neither had they received any input into their welfare or offending needs during their time in custody. This represents not only a neglect of their individual needs but also a significant lost opportunity for the prevention of further re-offending and the protection of society. Some form of pre-release preparation for prisoners discharged from this prison should be provided.' Matthew Martin's unplanned discharge represented a missed opportunity to re-engage with local psychiatric services. That he was one of many, and perhaps unremarkable at the time, makes this more of a failure rather than less.*

▪ **Recommendations 14 and 17**

**The barrier of confidentiality**

*Confidentiality was repeatedly given as the explanation for failure of communication between prison, visiting psychiatrist, community and probation. Yet on closer examination these apparent hurdles could have been overcome. We could not escape the conclusion that the barriers had more to do with an approach to working which*

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<sup>43</sup> Op cit

<sup>44</sup> [www.homeoffice.gov.uk/hmipris/inspects/exet](http://www.homeoffice.gov.uk/hmipris/inspects/exet)

compartmentalised agencies. Commitment to confidentiality was used to justify a failure to communicate.

### ***The need for clearer guidance on confidentiality in prisons***

Yet confidentiality was also a genuinely confusing subject. We conclude that clear guidelines are needed if there is to be any change in the culture of information sharing within prisons. *Changing the Outlook* records that good practice would be to establish information sharing protocols with local agencies, so that all are clear about what information can be shared with whom and how. To that we would add that the circumstances in which confidentiality can be breached should be transparent and readily understood by all agencies and individuals.

### ***Sharing of information upon release from prison: the future***

Proposals within *Changing the Outlook* for a seamless service between prison and community will rely for their success upon significant sharing of information. A major shift in thinking will be needed to achieve this. The Clinical Director of Devon Prisons Cluster spoke to us of a “psychological wall” between the inside and the outside. The principle that a prisoner has every right to keep his prison sentence secret is strongly held. *Changing the Outlook* acknowledges the complex problems posed by patient confidentiality and the Prison Health Policy Unit is ‘actively pursuing these issues and will be issuing further guidance’.

### ***Confidentiality and Human Rights***

Article 8 of the European Convention on Human Rights provides for an individual’s right to privacy. It also permits legitimate interference with those rights for the protection of others. Of course, that interference must be in proportion to the rights lost. Local and national guidance on confidentiality should aim to encourage a confident exercise of discretion by staff when balancing risks and rights.

### ***Recommendations 10, 13 and 15***

## **Criminal Justice Services**

- 5.31 From first diagnosis of mental illness in 1996 Matthew Martin came into contact with the criminal justice system in Bristol, Almondsbury, Exeter, Glastonbury and Plymouth.

## **Court Diversion and Liaison Schemes**

- 5.32 No diversion or liaison schemes were in place at the relevant time in any of the courts before which Matthew Martin appeared.

- 5.33 At the time of the homicide, there had been some movement towards a diversion or liaison scheme in Avon:

- From 1993 NACRO and the Avon Mentally Disordered Offenders' Working Group developed a pilot monitoring scheme at Trinity Road police station, in central Bristol
- In 1992 a multi-agency Mentally Disordered Offenders' Committee (sic) was established for the Avon & Somerset police area. The initiative was led by the police and probation service. That committee was responsible for two initiatives. Firstly, in April 1992, a "Procedure for section 136 of the MHA 1983 and provision for mentally disordered offenders." That included a statement that "*sometimes the public interest might be met by diverting mentally disordered persons from the criminal justice system...*", gave brief examples, and dealt in more detail with certain diversion options. That document was revised in 1997. Secondly, in August 1999 a handbook for staff working with mentally disordered offenders. Its aims explicitly included "*to divert (as appropriate) mentally disordered people who have committed an offence from the criminal justice system.*" It identified agencies and assigned roles to them, but did not say anything about how mentally disordered offenders might be diverted.
- Between 1995 and 1996, a number of local multi-agency monitoring groups were set up along the lines of that piloted at Trinity Road. Their main focus was on monitoring activity at seven police custody suites. Their role in monitoring what occurred at the court stage was limited by the little information available from the courts. Although they were invited to be members of the various groups, the courts were not consistently or comprehensively represented. The monitoring groups were expected to make recommendations to service development groups, one for each local authority area, on local circumstances, and the Avon Mentally Disordered Offenders Working Group on issues affecting the whole of Avon Health Authority's area.

- Avon Health Authority brokered attempts to establish a protocol for exchange between agencies of confidential information about Mentally Disordered Offenders, but this was not adopted by all concerned.
- In 1996 the Social Services Inspectorate recommended that Bristol Social Services Department “*should pursue in conjunction with other relevant agencies, extending the court diversion scheme*”.
- In September 1998 Avon Health Authority and Bristol Social Services Department commissioned from the University of the West of England research to identify needs for a service to improve access to and take-up of health and welfare services by mentally disordered offenders<sup>45</sup>. This involved examination of all custody cases coming before Bristol Magistrates Court over several months. The researcher’s first interim report drew attention to, among other things, the lack of a clear referral process. The second interim report identified a need for a court-based liaison scheme, and suggested a perceived reluctance on the part of agencies to engage with mentally disordered offenders.
- By late 1999 the reference to diversion no longer appeared in the Avon Mentally Disordered Offenders Working Group terms of reference. It was considered that “*under the provisions in force a significant number of mentally disordered offenders were diverted before the court stage*”. Its recommendations did not include the establishment of diversion schemes, but noted the research being done at Bristol Magistrates’ Court by the University of the West of England. The final report (March 2001) of the UWE research project re-affirmed a need for a court-based liaison scheme, and offered a blueprint for such a service for Bristol.

5.37 From 1998 attendance at and the effectiveness of local Mentally Disordered Offenders Working Groups declined. By 2001, Avon Probation service had ceased to attend.

5.38 The Avon Mentally Disordered Offenders Working Group had no direct input into local strategic planning, its role being largely advisory. It made representation and recommendations to the new specialist Mental Health NHS Trust then being set up to serve Avon. Local groups fed into plans for implementation of the *NHS National Service Framework*. At the time of the Inquiry, primary care trusts were being formed for each of the local authority areas in Avon (two for Bristol), and Avon Health Authority was apprehensive whether a uniform approach to mentally disordered offenders throughout the Avon & Wilts Mental Health Partnership NHS Trust could be developed. A collegiate (sic) commissioning group was expected to consider whether certain

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<sup>45</sup> Ahmad Y, Musa P and Parry S, 2001

services should be commissioned collectively *“for reasons of being specialist, required by a relatively transient population, or involving high costs and low numbers”*. Included in the list was a need to consider *“arrangements for providing court diversion or liaison, prison in-reach / liaison, step-down accommodation, and the pooling of resources between the probation, police and housing services”*.

- 5.39 The Inquiry was told that court diversion schemes now operated in Gloucester, Plymouth, parts of Dorset and Wiltshire.

**Absence of Court Diversion/Liaison Schemes**

*It is to the credit of Avon Health Authority and Bristol SSD that early positive moves were being made, with the help of the University of the West of England, to explore the development of court diversion and court-based liaison schemes in Bristol. It is of concern that the full potential of Mentally Disordered Offenders Working Groups has not been achieved.*

*We strongly endorse the consideration given by Avon Health Authority to commissioning of Mentally Disordered Offenders services collectively across Primary Care Trusts and the involvement of probation, police and housing services in the provision of court diversion and liaison schemes. There appears to be a fund of useful information from pilot schemes and research which should be drawn upon. Multi-agency risk management strategies should be developed and protocols for the sharing of information between organisations providing services for mentally disordered offenders.*

▪ **Recommendation 9**



# Chapter Six

## CONCLUSIONS

- 6.1 We are satisfied that Matthew Martin killed his father whilst suffering from paranoid schizophrenia. It was difficult for clinicians to be sure how much of Matthew Martin's itinerant lifestyle was attributable to choice or gradual personality disintegration due to mental illness, but his withdrawal into begging and sleeping rough was accompanied by a strong sense of increased personal danger felt by his father. Clinicians and other professionals assessing Matthew Martin did not have the full picture of this risk since Mr Martin did not divulge his mounting fears for his safety

### **Missed Opportunities**

- 6.2 We conclude that no one action or omission led irrevocably to the fatal outcome. Rather there were a number of shortcomings in the care and treatment of Matthew Martin, each of them representing a missed opportunity to plan for his anticipated disengagement from services or re-engage him in the psychiatric care and treatment which might have diverted him from that final course.
- 6.3 We are aware that Matthew Martin's history conforms to the stereotype of a mentally ill young man, drifting and apparently homeless, who could be said to have been a 'victim of community care'. His father could be seen as having been 'failed by the system' in that he managed alone and without support whilst afraid of his son. Although these easy phrases can be criticised for their emotive tone, this Inquiry must address the very real fear that there is a failure of service provision for such sufferers of mental illness and their families. Given the intention to expand community care through future mental health legislation, albeit with a new element of compulsion, there must be a confidence that those suffering from mental illness will not 'slip through the net'. These missed opportunities represent that 'safety net'. Each are important to those who, in the future, might tread the same gradually deteriorating path. It should be stressed that had Matthew Martin re-engaged with local mental health services this would have provided an opportunity for psychiatric care and treatment. It would not necessarily have prevented the homicide.
- 6.4 The following summarises the key points at which opportunities were missed. The cumulative effect was to allow an apparently unstoppable drift away from psychiatric services.

### ***December 1996***

- 6.5 Discharge from hospital and s37 MHA provided an opportunity to plan for Matthew Martin's anticipated non-compliance and disengagement from services. But CPA planning was poor, there was no risk assessment or s117 aftercare and CPN services were limited. The efforts made hardworking staff under pressure were inadequate to formulate the intensive care plan needed to support Matthew Martin or provide for a contingency plan in the event that he might withdraw from services.

### ***February 1997***

- 6.6 Discharge from CPA occurred without the knowledge of the RMO, Dr Newbery. Matthew Martin had failed to keep CPN appointments because he had moved address. Precisely how his name then came to be removed from the CPA computer database remains unclear. Absence of CPA had little immediate impact because Dr Newbery remained committed to Matthew Martin's care. But it meant there was no trigger for a six monthly CPA review. Trust procedures for discharge from CPA were not followed. Practice was too loose and imprecise. It should not have been possible to discharge Matthew Martin from CPA so simply. An opportunity to keep the CPA framework of Matthew Martin's care was missed.

### ***April to September 1997***

- 6.7 Matthew Martin was considered for detention under the MHA on three occasions by psychiatrists and found not to be detainable. Yet there was evidence from his father that he was already relapsing, deteriorating physically and mentally. A formal assessment under the MHA with the involvement of an ASW would have provided a fuller picture and may have resulted in compulsory admission. These early opportunities to re-establish in-patient psychiatric care were lost and the opportunity did not arise again.

### ***October 1997***

- 6.8 Dr Newbery's letter to Matthew Martin's father was a sympathetic personal approach intended to describe how to access services but it left Mr Martin feeling angry and frustrated. He needed to know from the Trust what it was reasonable to expect of a relative or carer, how to access advice, what changes of circumstances he should tell the hospital about and who to speak to if he feared for his safety. He needed a simple, single point of access agreed between the Trust, social services and GP. This was a lost opportunity to ensure that Mr Martin remained engaged with mental health services on his son's behalf. No contact was made by the family with any mental health service after this date.

### **November 1997 to March 1999**

- 6.9 Matthew Martin was arrested in November 1997, March 1998, September 1998, November 1998 and March 1999 and convicted of several offences connected with begging and threatening behaviour. No court diversion or liaison schemes brought him to the attention of psychiatric services. Good court liaison schemes aim to pick up mentally disordered offenders. These were opportunities missed.

### **April 1998**

- 6.10 Matthew Martin assaulted Mrs Martin. Had the police, GP or mental health services been involved at this stage any of these could have arranged assessment of Matthew Martin under the MHA 1983.

### **October 1998**

- 6.11 The Salvation Army hostel in Bristol made contact with social services and police after a large knife was found in Matthew Martin's room. His behaviour was bizarre and he was described as a "really high risk". But Matthew Martin left the hostel before he could be seen, apparently deliberately avoiding social services. This was an occasion when Matthew Martin seemed almost to slip through the fingers of services.

### **February 1999**

- 6.12 Matthew Martin was released from HMP Exeter. A psychiatric report described Matthew Martin's psychotic illness and risk to the public. A probation report referred to Matthew Martin's '*progressive mental illness which has not been adequately treated*' stating '*a risk of serious public harm at some point is a possibility*'. The court sentenced on the basis that a supportive discharge plan would be made for his release. That never happened. Refusing an out-patient appointment with Dr Newbery he was released without any information being conveyed to community mental health services. This represented the most significant missed opportunity for reactivating local psychiatric care. The failure to plan effectively for Matthew Martin's release reveals major weaknesses in the mental health service provided by HMP Exeter.

### **Early March 1999**

- 6.13 During March 1999 Matthew Martin was briefly in HMP Bristol where there is no record that he was identified as mentally ill or had any previous psychiatric history. This was an entirely self-contained period of imprisonment. No contact was made with mental health services.

### **Late March 1999**

- 6.14 Matthew Martin visited his GP who did not find him to be actively psychotic. He did not know that Matthew Martin had been in prison and

believed he was still under the care of Dr Newbery. Neither did he know that Mr Martin was fearful of his son and was hiding knives from him. This was Matthew Martin's last contact with health services before the homicide in May 1999.

## **Inquiry recommendations**

6.15 Many of our recommendations concern matters which have occupied the minds of countless other inquiries. Risk assessment, discharge planning, CPA, communication between professionals are all included. But this Inquiry has particular themes which run like a thread throughout. As a result our recommendations can be drawn together under just two broad headings:

- caring for patients who drop out of psychiatric care
- prison mental health services

6.16 The following is a summary only. Detailed recommendations are contained within Chapter 7.

## **Caring for patients who drop out of psychiatric care**

6.17 Some resolution of this problem is vital if there is to be confidence in present and future mental health care. We make recommendations directed locally and nationally.

## ***Need for a local policy on the care of non-compliant and disengaged patients***

6.18 Our single most important recommendation for action by the partnership Trust and local social services is the development of a joint policy to target the care of non-compliant, disengaged patients. That policy should be drawn up with the assistance of local advocacy, user and carer groups. It should deal with the following specific points:

### ***(i) Hospital discharge of non-compliant patients***

All staff involved with Matthew Martin's discharge from Southmead Hospital acted with energy and dedication. But they were disadvantaged by Trust policies that set low standards for discharge planning and did not specifically target non-compliant patients. Our recommendations require

- contingency planning in anticipation of non-compliance
- written risk assessment that addresses the risks associated with non-compliance
- s117 aftercare where statute requires it

- a social assessment where patients are expected to be non compliant.

**(ii) Assessment of non-compliant patients under the MHA**

Where patients are non-compliant, disengaged, socially withdrawn and where negative symptoms predominate, there should be considerable clinical caution about coming to a preliminary view that a patient is not 'sectionable'. Formal assessment under the MHA will enable the involvement of an ASW and a full background to be obtained from all sources, including the family as required by the MHA Code of Practice. We recommend

- guidance to clinicians that where patients are or are likely to become non-compliant with medication full assessment under the Act will usually be appropriate
- training on the threshold for compulsion for all staff involved with assessments under the MHA

**(iii) Provision of information to carers**

Mr Martin felt very unsupported. Of all the evidence to this Inquiry the single most powerful document was an unsent letter written by Mr Martin outlining his frustration at failed attempts to obtain help for his son. We are concerned to ensure that our recommendations improve the accessibility of mental health services and by so doing reduce the stigma associated with seeking help for mental illness. We recommend

- a clear single point of access to mental health services for users, relatives and carers
- information leaflets for carers which spell out what it is reasonable for them to provide or put up with, when to seek help and whom to approach if they fear for their safety
- procedures for consultation with carers before discharge of disengaged, non-compliant patients from CPA

***Need for new legislation which will satisfactorily address the needs of disengaged and non-compliant patients***

6.19 Untreated schizophrenia typically follows a downward path resulting in personality disintegration and withdrawal. 71% of patients convicted of homicide have been out of contact with services at the time of their offence.<sup>46</sup> This must be a concern for those drafting new Mental Health legislation.<sup>47</sup> We recommend that the Department of Health consider

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<sup>46</sup> *Confidential Inquiry*, Royal College of Psychiatrists, 1999

<sup>47</sup> Draft Mental Health Bill

whether, as drafted, the Mental Health Bill adequately deals with non-compliant and disengaged patients. Specifically;

- there is no statutory requirement that care plans include contingency planning for non-compliance and disengagement
- there is no statutory requirement that care plans be drawn up with multi-disciplinary input
- care plans have no statutory force after discharge from compulsion
- there is no statutory provision for aftercare.

6.20 We express the hope that there will be a re-examination of these points to ensure that primary and subsidiary legislation together provide satisfactory safeguards for those who might otherwise drift away from mental health services and pose a risk to themselves or others.

6.21 We welcome the proposal that new legislation will contain a duty to consider whether there is a need share information for risk assessment and a general duty on all agencies to co-operate in the sharing of such information.<sup>48</sup> Commitment in the Bill to consultation with carers should be backed by supportive structures in the community. Proposals for compulsory treatment at home should not rely for their success on vulnerable family members who, although willing, may be unable to seek help. It may be difficult for relatives to take a detached, clinical view. And they may simply be fearful.

## **Prison mental health care**

6.22 Prisons are under enormous pressure. Overcrowding is well-publicised. Yet it is not widely known that 9 out of 10 prison inmates suffer some form of mental health problem.<sup>49</sup> Improvements in their care could reduce offending connected with inadequately treated mental illness. In parallel with this, improvement of police/court liaison schemes could further divert some mentally ill offenders from prison to treatment in the community.

6.23 We were very concerned at failures of communication within Exeter Prison, and between probation, prison and community psychiatric services. Clarity over patient confidentiality is essential.

6.24 Of the most urgent importance is the appointment of on-site mental health professionals to manage the treatment of mentally ill inmates. It is clear from evidence we have heard that extension to all prisons of secondary NHS mental health services provided by NHS Trusts, whilst desirable, cannot be seen as guaranteeing either improved staffing or

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<sup>48</sup> *Mental Health Bill Consultation Document* para 3.30

<sup>49</sup> [www.doh.gov.uk/primhealth/ministerial](http://www.doh.gov.uk/primhealth/ministerial)

funding of services within prisons. Nor does it necessarily impact upon the initial identification of mental illness. We recommend:

- continued developments in line with services described in *Changing the Outlook*,<sup>50</sup>
- appointment of specialist mental health services to provide clinical leadership to psychiatric services at HMP Exeter and HMP Bristol ,
- review by HMP Exeter of its procedures concerning sharing of information and confidentiality of medical information, and
- the issue to prisons of guidance on information sharing and confidentiality by the Prison Health Policy Unit Taskforce.<sup>51</sup>

6.23 Prison mental health care is a rapidly expanding area which has developed even as this report has been written. We consider that our recommendations are timely. They urge progress in the direction already proposed by the Government, but stress the need to resolve a number of practical problems. Funding, management of mental health services throughout the prison, training and information sharing are all crucial. Without attention to these details we consider that the culture of prison mental health services will be difficult to change and the successful growth of new inreach services limited.

## Commentary

6.25 Mental health homicide inquiries typically repeat the same themes. Failure of communication and failure to listen to relatives are almost always featured. That they are repeated here indicates not that such inquiries are unnecessary. Sadly they are needed to expose the continued inability of services to resolve the problem and ensure there is never complacency.

6.26 In conclusion, Matthew Martin received care and treatment from many professionals who individually gave of their best. There were failures in the form of many missed opportunities to co-ordinate Matthew Martin's care and treatment in the community. But that failure was largely of organisational communication. With many and diverse statutory and voluntary agencies there was no over arching mental health policy for disengaged patients, no effective forum for joint planning of services for those who dropped out of psychiatric care and little sharing of information. Services were fragmented and lacked continuity. Matthew Martin's care fell unsatisfactorily between hospital, community mental health services, social services, housing agencies, probation, prison, police, courts and family.

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<sup>50</sup> Department of Health and HM Prison Service, 2001

<sup>51</sup> [www.doh.gov.uk/prisonhealth/newsletters](http://www.doh.gov.uk/prisonhealth/newsletters)

6.27 We have concluded that creating the connections between these agencies is desirable but not achievable without a certain cost. That cost is to an individual's right to confidentiality and to remain free of treatment. Extreme risk of harm can readily justify compulsory treatment or sharing of confidential information without consent. But the theme of this Inquiry has been the more difficult and fine line constantly drawn between two rights and freedoms. Respect for Matthew Martin's chosen lifestyle, his freedom not to be treated and his right to keep information about himself private has repeatedly been balanced against the rights of others to be protected from any risk of harm to them from Matthew Martin. Most organisations erred on the side of non-intervention in Matthew Martin's life. With hindsight that was a mistake. Our recommendations focus on getting the balance right. In particular, organisations involved, however peripherally, with the care and treatment of mentally disordered offenders, need to have a sensible degree of communication and information sharing with each other in order to obtain the very basic information necessary to assess risk in the public interest. With the Human Rights Act has come a greater awareness of the need to weigh up competing rights. Improvement of mental health services in prisons and creation of new mental health legislation provide two immediate opportunities to think clearly about the balancing act between risks and rights.

# Chapter Seven

## RECOMMENDATIONS

### **The Avon and Wiltshire Mental Health Partnership NHS Trust (“the Trust”)**

1. The Trust should produce a leaflet for users and carers area which summarises mental health services. It should be drawn up with the advice of local user, carer and advocacy groups. The leaflet should include information on hospitals, out-patient psychiatric care, ICPA, social services, voluntary sector support for users and carers, housing, homelessness and involvement with the police and courts. It should ensure that access to services, support and advocacy is simply described. It should provide information on the service a user and carer can expect. If the patient concerned is subject to ICPA the care co-ordinator should be named. Families should be given advice on what to do and whom to contact if they feel concerned about their own safety or that of the patient. The leaflet should be dated and regularly updated to reflect organisational change. (see pages 17 and 33)
2. The Trust should ensure that there are clear points of access to mental health teams provided for families who are concerned about a patient’s risk as recommended by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 1999<sup>52</sup>. Information should be available 24 hours a day and there should ideally be a simple, single point of access. (see page 33)
3. The Trust should ensure that in order to comply with HSG(94)27 a policy exists for the formal assessment of patients’ risk upon discharge from hospital, whether or not that is also incorporated into ICPA (see page 48). That Trust risk assessment policy should
  - (i) require that information concerning risk status be communicated between professionals before discharge from hospital
  - (ii) remind professionals that where family members are caring for their mentally ill relatives this may put them at increased personal risk (see page 40)
  - (iii) require that any person considered to be at risk be informed unless there are reasons not to do so (see page 40))

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<sup>52</sup> supra

- (iv) require the keeping of a written record that all the matters concerning risk at (i), (ii) and (iii) have been considered prior to discharge from hospital (see page 48)
  - (v) require formal reassessment of risk at each CPA review and upon discharge from CPA
4. The Trust should put in place procedures which will ensure information about a patient's attendance at any part of the mental health service is shared with other relevant professionals and brought to the attention of the RMO and care co-ordinator. (see page 32)

### **The Trust, Bristol City Council and all other Local and Unitary Authorities in the area covered by the Trust<sup>53</sup>**

5. The Trust, jointly with the above authorities, should review ICPA policy and procedure throughout the area covered by the Trust to ensure that it meets the needs of non-compliant patients and/or those who have or are thought likely to become disengaged from psychiatric care. ICPA policy should be consistent with the Trust policy on non-compliant and disengaged patients (see Recommendation 6). The joint review of ICPA should ensure that:
- (i) It is operationally applicable to all mental health care staff through the use of consistent, comprehensive joint policies, procedures and guidelines.
  - (ii) All policies, procedures and guidelines are routinely reviewed following any reorganisation or boundary change to ensure continuity and clarity. (see page 43)
  - (iii) ICPA is monitored and audited regularly (see page 45)
  - (iv) ICPA documentation is designed to encourage completion in relation to risk assessment and contingency plans(see page 45)
  - (v) All staff who complete ICPA documentation have regular training (see page 45)
  - (vi) ICPA documentation complies with HSG(94)27 in that it incorporates
    - a requirement for risk assessment on discharge from hospital
    - a contingency plan in the event of a patient's non-compliance with treatment. (see page 45)
  - (vii) There is clear guidance that care co-ordinators should be CPN's or social workers so that in addition to the RMO there is a professional whose remit it is to visit the patient and/or carer at home (see page 47)
  - (viii) Procedure for discharge of patients from ICPA must require approval of the RMO. Written reasons should be given and the

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<sup>53</sup> The nature of the Trust partnership differs in each Unitary Authority area. In Bristol the functions will not be legally transferred. The Inquiry is informed that the Trust would lead and undertake most of the work on the recommendations with the City Council overseeing the Trust Performance in this.

decision made only after consultation with relatives and multi-disciplinary discussion. An ICPA discharge meeting should be held unless there are clear reasons not to do so. It should be normal practice to hold an ICPA discharge meeting where non-compliance and disengagement are the reasons proposed for discharging a patient from ICPA. Discharge from ICPA should not be entered on the computer database without a record that the above procedures have been carried out. A summary of the reasons for discharge from ICPA should be clearly available on the patient's medical notes. (see page 52)

6. The Trust, jointly with the above authorities, should formulate a written Trust-wide policy to deal with patients who are non-compliant and who become disengaged from psychiatric care, taking into account the recommendations of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 1999<sup>54</sup>. The policy should refer to the need for assessment under the MHA to include those factors outlined in the MHA Code of Practice. There should be a commitment, backed by funding, to provide training for social work and psychiatric staff involved with assessment under the MHA of non-compliant patients. (see pages 40,47 and 56)
7. The Trust, jointly with the above authorities, should review the provision of social work support to mental health teams throughout the Trust area, ensuring that staffing is adequate to meet the requirements of ICPA, s117, assessment of housing needs, psycho-social assessment as needed and social work support for users and carers. Referral procedures should be jointly agreed and fully understood. (see pages 47 and 50)
8. The Trust, jointly with the above authorities, should ensure that throughout the Trust area procedures exist to fulfil the statutory obligations of s117 MHA 1983 through identification of patients subject to s117, reminders and prompts for action, review and discharge from s117 (see page 50)

**The Strategic Health Authority, Bristol North and Bristol South and West Primary Care Trusts, Bristol City Council, Avon and Somerset Constabulary and Avon Probation Service**

9. A joint commissioning group comprising the above bodies should produce plans for joint commissioning of services for Mentally Disordered Offenders in Bristol. Services should be developed in conjunction with planning for mental health in-reach in HMP Bristol. The function and composition of Mentally Disordered Offenders

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<sup>54</sup> supra

Working Groups should be reviewed to ensure their seniority and effectiveness in making recommendations and reviewing progress. The commissioning group should

- (a) Consider establishing multi-agency risk management meetings to coordinate services' responses to the small number of mentally ill people who present a potential risk to the public<sup>55</sup>.
- (b) Review existing procedures, if any, for the sharing of information between services for mentally disordered offenders. Produce a protocol for information-sharing for local agencies taking into account guidance on confidentiality, when it is issued, from the Prison Health Policy Unit and Task Force. (see page 75)

### **Prison Health Policy Unit/Task Force**

- 10. The Prison Health Policy Unit and/or Task Force should produce practical guidance on information-sharing, confidentiality and consent in order to ensure that continuity of service between prison and community, as proposed in Changing the Outlook, is a realistic and manageable proposition. Guidance should take into account the need for a common clinical governance framework encompassing the prison health service, and that of the local Primary Care Trusts, specialist mental health providers including prison in-reach teams and GPs. (see page 60) Prison Health Policy Unit and/or Task Force guidance should be directed to ensuring that:
  - (a) Information systems are in place to identify during reception health screening those prisoners who have had previous contact with local community psychiatric services and in particular those who are subject to CPA (see page 63)
  - (b) Where a prison inmate is known to community psychiatric services and/or subject to CPA a procedure exists to share information with the patient's consultant psychiatrist and care co-ordinator prior to release and a plan made for discharge (see page 63).
  - (c) Consent for release of community psychiatric records and two-way sharing of information between prison and community is routinely sought at prison reception health screenings. Consent forms should clearly specify to whom disclosure is made and for what purpose, whether for assessment, treatment, preparation of a report or follow-up after discharge/release. The scope of the disclosure should be unambiguous, stating whether it includes the prison wing, prison health care service, visiting psychiatrist, probation, in-reach team, community psychiatric services or GP. Consent forms should comply with the HRA and existing guidance from the GMC and Royal College of Psychiatrists and make clear the circumstances

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<sup>55</sup> recommended by Kevin Keogh Inquiry and implemented in Manchester.

under which information might be shared without a patient's consent. (see page 72)

11. The Prison Health Policy Unit and/or Task Force should stress to Clinical Directors of prisons the importance of establishing multidisciplinary specialist mental health services within prisons. This should be considered urgent and essential to the effective implementation of plans within Changing the Outlook.
12. The Prison Health Policy Unit and/or Task Force should recommend that prisons review the training of those prison medical staff who conduct reception screening. Training should focus particularly on the detection of severe mental illness and the actions to be triggered by recognition of such illness. In-reach services and prisons should consider joint training programmes to examine these issues. (see page 63)

**The Trust, the Prison Service at HMP Bristol, Bristol North and Bristol South and West Primary Care Trusts and Bristol City Council**

13. The above commissioners of mental health services as appropriate should set up a review body to review primary and secondary level mental health services to HMP Bristol. The commissioning bodies should put in place a Service Level Agreement for a multidisciplinary specialist mental health service. This should include (see pages 62, 64, 71 and 72)
  - Sessions within the Prison by a doctor qualified in psychiatry
  - Service provision throughout the prison regardless of an inmate's location within the prison or district of origin
  - The development of a policy on consent, confidentiality and the sharing of information between prison mental health services, psychiatrists providing expert reports, local psychiatric facilities, GP's, probation and the prison wings.
14. The commissioning bodies should ensure that (see pages 63 and 71)
  - HMP Bristol put into place an operational system that will detect at reception health screening whether an inmate has had previous contact with the prison health care centre.
  - Information systems are developed to support prison mental health services, including procedures to establish whether an inmate is known to local psychiatric services outside the prison and/or subject to ICPA.
  - Basic information concerning any inmate found to be known to psychiatric services is shared with all relevant staff.
  - Procedures exist for routine seeking from inmates of their consent to disclosure of confidential information.

- If consent is given (or not needed according to the policy then drafted) confidential information concerning an inmate is shared, as needed, between prison mental health services, local psychiatric facilities, the prison wing and any psychiatrist who has prepared an expert report.
- Information systems exist to identify those inmates in need of support upon release from prison.
- Training in the detection of mental illness at reception screening is provided.

**Exeter Primary Care Trust, the Prison Service at HMP Exeter, Devon County Council and the Devon Mental Health Partnership NHS Trust**

15. The above commissioners of mental health services as appropriate should set up a review body to review primary and secondary level mental health services to HMP Exeter. The commissioning bodies should put in place a Service Level Agreement for a multidisciplinary specialist mental health service. This should include (see pages 61, 64, 71 and 72)
  - Sessions within the Prison by a doctor qualified in psychiatry
  - The appointment of a senior manager with responsibility for prison inreach. The provision of specialist management of psychiatric care within Exeter Prison should be considered urgent.
  - Service provision throughout the prison regardless of an inmate's location within the prison or district of origin
  - The development of a policy on consent, confidentiality and the sharing of information between prison mental health services, psychiatrists providing expert reports, local psychiatric facilities, GP's, probation and the prison wings.
  
16. The above commissioners of services should ensure that HMP Exeter, and from April 2003 the NHS Trust providers of mental health services, urgently review prison consent procedures. These service providers should clarify the legal scope of HMP Exeter's existing consent form as it applies to doctors working in the NHS and privately, for the purpose of providing continuity of care and the preparation of court reports. Consideration should be given to revision of this form and inclusion within any new form of consent to release of information from the prison to GP and psychiatrist in the community for follow-up after release from prison. (see page 67)
  
17. The commissioning bodies should ensure that (see pages 63 and 71)
  - HMP Exeter put into place an operational system that will detect at reception health screening whether an inmate has had previous contact with the prison health care centre.

- Information systems are developed to support prison mental health services, including procedures to establish whether an inmate is known to local psychiatric services outside the prison and/or subject to ICPA.
- Basic information concerning any inmate found to be known to psychiatric services is shared with all relevant staff.
- Procedures exist for routine seeking from inmates of their consent to disclosure of confidential information.
- If consent is given (or not needed according to the policy then drafted) confidential information concerning an inmate is shared , as needed, between prison mental health services, local psychiatric facilities, the prison wing and any psychiatrist who has prepared an expert report.
- Information systems exist to identify those inmates in need of support upon release from prison.
- Training in the detection of mental illness at reception screening is provided.

### **Royal College of Psychiatrists/General Medical Council**

18. The Royal College of Psychiatrists and the General Medical Council should issue guidance on the roles and responsibilities of psychiatrists and doctors who have been instructed by Courts and others to prepare reports as experts when they are not also involved in the treatment of the person about whom the report is prepared. The guidance should indicate the circumstances under which information can become available to the treating clinicians where clinical need and/or risk is identified during the preparation of the reports. (see page 68)

### **Devon Probation Service, HMP Exeter and Devon Mental Health Partnership NHS Trust**

19. The above bodies should jointly develop a policy on disclosure of probation reports to prison health care units and the prison wing. The policy should ensure that reports are brought to the attention of doctors where information within probation reports needs be disclosed in preparation for release (see page 68)

### **Department of Health**

20. The Department of Health should consider whether, as presently drafted, the Mental Health Bill provides for the management of non-compliant patients who would otherwise disengage from mental health services following discharge from compulsory treatment. (4.12) In particular the Department of Health should consider giving statutory force to the inclusion within care plans of contingency planning for non-compliance and disengagement, a requirement that care plans be

drawn up with multi-disciplinary input and the statutory provision of aftercare (see pages 45 and 47).

# Appendices

- A Terms of reference of the Inquiry
- B Procedure adopted by the Inquiry
- C Lists of
  - Witnesses who gave oral evidence
  - Other organisations and witnesses who responded to requests for information
  - Other organisations and individuals approached for information
  - Individuals making representations
- D Bibliography
- E Glossary of acronyms

## **Appendix A**

### **Terms of Reference of the Inquiry**

#### TERMS OF REFERENCE

1. Establish the chronology of events and care received.
2. Establish what responses were made within both General Practice and Hospital settings to the patient and his family when help was sought and to determine the adequacy of these responses.
3. Review the adequacy of the care received between 1996 and 1997 when the patient was known to have been in contact with mental health services.
4. Review the extent of the care (if any) provided between October 1997 and May 1999 or at the time of the incident.
5. Review the suitability of the care received in the light of the patient's history and assessed health and social care needs.
6. Review the extent to which the care corresponded with statutory obligations and relevant guidance from the Department of Health and any other local operational policies. This should include a review of the professional judgments made and what indicators were used to assess risk, what protocols were in place for risk assessment and how they were used in this case.
7. Determine what services were in place between October 1997 and May 1999 for service users who are homeless.
8. Establish appropriate arrangements for the dissemination of the findings of the report, including the availability of the report to the public.
9. Ensure that the implications of the report are considered within an agreed timescale, and that the Chair be asked to return in 6/12 months to conduct a review of progress against an agreed action plan.
10. Establish appropriate communication arrangements agreed with the family.

## **Appendix B**

### **Procedure adopted by the Inquiry**

#### PROCEDURE TO BE ADOPTED BY THE INQUIRY

1. The following describes the procedure which the Inquiry will follow in order to obtain evidence and produce its Report.
2. Following a review of the documentation, the Inquiry will consider which individuals should be invited to give evidence.
3. Each witness of fact identified by the Inquiry will receive a letter which will
  - (a) inform them of the terms of reference and the procedure to be adopted by the Inquiry;
  - (b) invite them to provide a written statement, and outline the issues they are invited to deal with;
  - (c) explain that, after receiving their statement, the Inquiry will decide whether they should also be invited to attend the Inquiry to give oral evidence;
  - (d) inform them that if or when they attend the Inquiry they may bring with them a friend, relative, member of a trade union, lawyer, member of a defence organisation, advocate or anyone else they may wish to accompany them, with the exception of another Inquiry witness;
  - (e) inform them that it is the witness who will be asked questions and be expected to answer;
  - (f) inform them that their evidence will be recorded, and a verbatim transcript sent to them for their signature confirming its accuracy.
4. Witnesses of fact will be asked to affirm that their evidence is true.
5. Any points of potential criticism will be put to a witness of fact, either orally when they give evidence or in writing at a later time, and they will be given a full opportunity to respond before the Report is written.
6. Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances.
7. Anyone else who feels they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider.
8. All sittings of the Inquiry will be held in private.

9. The evidence which is submitted to the Inquiry, whether orally or in writing, will remain confidential to the Inquiry, save as disclosed within the body of the Inquiry's final Report and executive summary.
10. Findings of fact will be made on the basis of evidence received by the Inquiry. Comments which appear within the narrative of the Report, and any recommendations, will be based on those findings.
11. The findings and recommendations of the Inquiry will be contained in a final Report which will be presented to Avon Health Authority, which will make arrangements for publication.

## Appendix C

### **Lists of witnesses, of other individuals and organisations who gave information, and of other individuals and organisations approached by the Inquiry**

#### ***Witnesses who gave oral evidence***

Arnott, Dr M S McM, senior registrar forensic psychiatry, Fromeside, now consultant psychiatrist, Southmead hospital, Bristol

Braidwood, Mr K, Team Manager, Social Services, S Gloucestershire Council, Thornbury, now team manger, mental health team, Staple Hill, S Glos

Brown, Dr RM, HM Prison healthcare centre, Bristol, now medical practitioner, Broadway Lodge, Weston super Mare

Clutterbuck, Ms P, resettlement worker, Floating Support Scheme, Second Step Housing Association, Weston super Mare

Cree, Ms C, Administration Services Manager, Southmead Hospital

Davis, Dr B, SMO, HCC, HM Prison Exeter (not involved at the time)

Gallwey, Dr PLG, consultant forensic psychiatrist, HM Prison Exeter HCU

Giles, Mr J, Assistant Director Adult Community Care, S Gloucestershire Council Social Services Department (not then involved)

Heneker Mr N, then community psychiatric nurse, Southmead hospital, Bristol

Hennell, Mr M, Second Step Housing Association, Bristol

MacPhail Mr J, approved social worker, Emergency Duty Team, Social Services Department, South Gloucestershire Council

Martin, Mr M H M, subject

Martin, Mrs GA, widow of Mr Michael Martin

McIlvaney, Mr I, CPA manager, Avon & Wiltshire Mental Healthcare Partnership NHS Trust (not then involved)

McVey, Ms J, probation officer, Devon probation service, Plymouth, now probation officer, HM Prison Dartmoor

Mitchell, Mrs M, mental health social worker, Salvation Army Hostel, Bristol

Mukwaya, Ms M, manager, Ron Jones House, Bristol, now project manager, Elim Housing Association, Thornbury

Newbery, Dr FE, consultant psychiatrist, Southmead Hospital, Bristol

Painter, Mr A, Area Services Manager, Bristol City Council neighbourhood and housing services department

Phillips, Mrs G, Mental Health Act Administrator, Donal Early House, Southmead Hospital

Rowe, Mr L, senior nurse, Southmead Hospital, Bristol

Stoneman, Ms S, Mental Health Programme Manger, Avon Health Authority and chair, Avon mentally disordered offenders working group (not then involved)

Smith, Ms D, Divisional Director, Social Services Department, Bristol City Council (not then involved)

Spurgeon, Mr D, chair, South Gloucestershire mentally disordered offenders working group

Thompson, Dr MJ, GP, Thornbury Health Centre, S Gloucestershire  
Tomison, Dr A, consultant forensic psychiatrist, Fromeside Clinic, Bristol  
Ward, Dr B, then SHO psychiatrist, Southmead hospital, Bristol, now GP at  
Keynsham  
Whiffin, Mr M, then ward manager, later senior nurse advisor, Southmead  
hospital, now Associate Nurse Director, Avon and Wiltshire Mental  
Health Partnership NHS Trust  
Woods, Ms A, then service manager, mental health, Southmead Hospital,  
now general manager Brain Injury Rehabilitation Unit, Frenchay

***Other individuals and organisations who gave written evidence or  
information to the Inquiry***

Abraham, Dr C, then SHO psychiatrist, Southmead hospital, Bristol  
Ahmad, Y, lecturer in social policy, University of the West of England, Bristol  
Benefits Agency, Bristol  
Berry, Ms J, then senior social worker, Bristol City Council  
Davis, Detective Inspector M, Avon & Somerset Police, Staple Hill, S Glos  
Edwards, Ms A, Managing Director, Second Step Housing Association, Bristol  
Metherall, Ms C, Devon Probation Service (not then involved)  
Joynes, Ms L, Bristol Cyrenians at The Hub Advice Centre, Bristol  
Meller, Dr RC, consultant child and adolescent psychiatrist, Bristol  
Pedley Mr R, chief executive, Avon & W Wilts MHC NHS Trust (not then  
involved)  
Reeves, Dr GE, GP, Southmead/Westbury-on-Trym, Bristol  
Risdale, Mr R, General Manager, The Hub advice centre, Bristol (not then  
involved)  
Rogers, Dr JC, GP, Lake Surgery, Southmead/Westbury-on-Trym, Bristol  
Rowlands, Dr MH, then senior medical officer, HM Prison Bristol, now with  
Gwent Substance Abuse Service, Abergavenny  
Sanders Mr A, then family practitioner administrator, Avon Health Authority  
Speed, Mr D, clerk to the justices, Bristol  
Williams, Dr MP, medical officer, HM Prison Bristol

Alpha Project, Bristol  
Avon Alcohol Advisory Service  
Avon and Somerset Constabulary  
Avon and Somerset Magistrates' Service  
Avon and Wiltshire Mental Health Partnership NHS Trust  
Avon Probation Service  
Bristol City Council Neighbourhood and Housing Services Department  
Bristol City Council Social Services Department  
Bristol City Council Education Department  
Bristol Royal infirmary  
Central Devon Magistrates' Courts  
Cork Simon Community, Cork, Ireland  
Court Service, Bristol (Bristol Crown Court)  
Crown Prosecution Service, Bristol  
Crown Prosecution Service, Exeter  
Cyrenians, Bristol

Devon County Council Social Services Department  
Devon Probation Service  
Elim Housing Association  
English Churches Housing  
HM Prison Service, Bristol and Exeter  
Mental Health Act Commission  
North Bristol NHS Trust  
Plymouth City Council Department for Social and Housing Services  
Plymouth District Magistrates' Court  
Redwood House Hostel,  
Rosebank Community Mental Health Team, Wells, Somerset  
Salvation Army, Bristol  
Second Step Housing association, Weston-super-Mare  
Somerset Drugs Project  
Somerset Probation Service  
Southern Health Board, Cork, Ireland  
South Gloucestershire Council Education Department  
South Gloucestershire Council Housing Department  
South Gloucestershire Council Social Services Department  
Taunton Association for the Homeless  
Turning Point, Wells, Somerset  
University of the West of England, Bristol

***Other individuals and organisations approached by the Inquiry***

Bristol Drugs Project  
Julian Trust, Bristol  
Smith, Dr Jeanette, then psychiatrist, Fromeside Clinic, Bristol  
Rankin, Ms H, former general manager, Southmead Hospital, Bristol  
Street Self-Help Centre, Street, Somerset

***Representations were also received from:***

Yates, Dr DH, retired consultant psychiatrist

## Appendix D

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## Appendix E

### Glossary of Terms

A&E	accident and emergency (department of a hospital)
ASW	approved social worker
CIN	community intervention nursing (team)
CMHT	community mental health team
CPA	Care Programme Approach
CPN	community psychiatric nurse
GMC	The General Medical Council
GP	general medical practitioner
HCS	healthcare standard
HMP	Her Majesty's prison
ICPA	integrated care programme approach
LG	local government
LSD	lysergic acid diethylamide
MAPP	multi-agency public protection (meetings)
MDO	mentally disordered offender
MHA	Mental Health Act
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NSF	The national service framework (for the NHS)
OPA	out-patient appointment
OT	occupational therapy
RMO	responsible medical officer
RSI	Rough Sleepers Initiative
SHO	senior house officer (junior doctor in a hospital)
SS	social services
SSD	social services department (of a local authority)

*Distributed by:*

Avon, Gloucestershire and Wiltshire  
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