Northumberland, Tyne and Wear NHS
Strategic Health Authority

Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Thomas Gallagher

February 2005

Contents

1 EXECUTIVE SUMMARY

1. This inquiry was established under the terms of HSG(94)27, Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community, following Thomas Gallagher's conviction on 3 April 2003 of the murder of his wife Elizabeth Gallagher on 22 September 2002. Thomas Gallagher had been admitted as an informal patient to the acute inpatient psychiatric unit at ward 21 North Tyneside General Hospital between 19 August 2002 and 3 September 2002 and between 9 and 11 September 2002, and had been seen on medical follow-up by the community mental health team on 19 September 2002. Secondary mental health care services within North Tyneside, including ward 21, are the responsibility of Newcastle, North Tyneside and Northumberland Mental Health NHS Trust.

2. On each occasion, although it was not clear whether Thomas Gallagher was suffering from any mental disorder within the terms of the Mental Health Act, the decisions to admit him for assessment represented good care.

3. Although the evidence suggests that different management would probably not have prevented the murder, the panel found that on each admission there were opportunities to intervene which were not acted upon, and areas where lessons could be learned. These include:-

- The implementation of what was the care programme approach (CPA) and is now care co-ordination policy and procedures.
- The development and implementation of a care plan which actively engages patients who are not inclined to participate in the therapeutic process.
- The provision and documentation of medical supervision at the appropriate level of seniority.
- The procedures for carrying out and recording comprehensive risk assessments.

- The procedures for making and documenting decisions to grant leave, and to discharge, from hospital.

4. Since the time of these events the trust has brought about changes which address some of these areas of concern.

Simon Garlick

Dr Isaura Gairin

Tom Welsh

2 INTRODUCTION

1. The basis of the inquiry

We were appointed by the Northumberland, Tyne and Wear Strategic Health Authority (SHA) on the 13 November 2003 to enquire into the health care and treatment of Thomas Gallagher (TG), and to deliver to the SHA our report which should include findings and recommendations. At all relevant times TG was involved with the psychiatric services of the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (the trust).

The inquiry panel consisted of:

Mr Simon Garlick - Solicitor Advocate, Partner of Ben Hoare Bell Solicitors, Sunderland – Chair.
Dr Isaura Gairin - Consultant Forensic Psychiatrist, Regional Centre for Forensic Psychiatry, Wakefield.
Mr Tom Welsh - General Manager/Head of Nursing for Mental Health Services of Craven, Harrogate and Rural District Primary Care NHS Trust.

2. Terms of reference

2.1 The terms of reference of the inquiry were:-

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

- The quality and scope of his health care and treatment with particular reference to the assessment and management of risk.
- The appropriateness of the treatment, care and supervision in relation to: the implementation of the care programme approach, the assessment of risk in terms of harm to himself or others, the standard of record keeping.

- The extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health, and with good practice.

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

2.2 The panel had access to the serious incident management review conducted internally by the trust.

3. Evidence

3.1 The panel met on 13 occasions between 13 November 2003 and 12 October 2004.

3.2 The panel visited TG in prison on 8 January 2004.

3.3 The panel had access to comprehensive documentation, a list of which is set out in the bibliography.

3.4 The panel heard evidence from a number of witnesses including doctors, nurses, social workers, and managers. All those who gave formal oral evidence received transcripts of their evidence and were given the opportunity to amend and approve those transcripts.

3.5 The agencies involved have been given the opportunity to disclose fully all relevant information or documentation and the inquiry panel assumes that all evidence received, whether written or oral, has been based on full and frank disclosure.

3.6 The panel was helped in this inquiry by the open approach which was demonstrated by all of those who gave oral evidence, particularly the doctors, nurses and other staff who came into clinical contact with TG, for whom the

inquisitorial process was naturally difficult. All of the clinicians from whom the panel heard displayed a committed and thoughtful approach to the treatment of mental health patients and, to the extent that the panel identifies shortcomings in the care given to TG, it is to the systems rather than to any individual failings that the panel believes attention should be directed.

3.7 The panel has been conscious throughout that it has had the opportunity to scrutinise in hindsight, and at its own pace, the care provided and the decisions made in relation to an individual patient, and that in reality, the needs and requirements of any single patient had to be balanced by clinicians against the competing demands of other patients, and in the context of demanding clinical practice.

Glossary

Specific clinical terminology is defined in the glossary at Section 11.

3 SUMMARY OF EVENTS

1. TG was born on 17 June 1957 and was aged 45 at the time of these events. He was married to Elizabeth Gallagher (EG) and the couple had two children who were aged seven and four at the time of these events. EG worked as a pharmacist's assistant at a local pharmacy and TG worked irregularly as a self-employed decorator. Other than one isolated episode in which he took an overdose in November 1979 (aged 22), he had not had any contact with mental health services.

2. The relationship between the couple deteriorated in the late 1990s, at which time TG developed a pattern of regular heavy drinking. In about mid-August 2002 EG left the family home taking the children with her and returned to her parents' house. TG continued to have regular contact with the children.

3. On 17 August 2002 TG presented to his general practitioner (GP) who noted that he was very upset about the sudden split with his wife. He was prescribed Diazepam (a tranquilliser).

4. On 19 August 2002 TG took an overdose of 20 Diazepam tablets, 10 Fluoxetine tablets (an antidepressant – apparently obtained from a family member), and approximately eight pints of beer. He had written a suicide note, but after taking the overdose had telephoned his wife at his parents-in-law's house, and told her that he had taken the overdose. She and her parents arranged for TG to be taken to North Tyneside General Hospital by ambulance. He was admitted for observation overnight.

5. The following day, 20 August 2002, he was seen by the deliberate self-harm team at North Tyneside General Hospital who assessed him as being at high risk of further self-harm, and he was therefore admitted to ward 21. Ward 21 is an acute inpatient psychiatric facility. He remained on ward 21 as a voluntary patient until the 3 September 2002, when he was discharged home with a plan for a medical follow up seven days later.

6. On the night of the 8/9 September 2002 TG was arrested following an incident in which he caused damage to the family home when drunk. He was detained by the police and put before the North Tyneside Magistrates' Court later on the 9 September 2002, when he was bound over to keep the peace. Later that day, he presented himself to the accident and emergency department at North Tyneside General Hospital expressing threats of further self-harm and threats of serious harm to his wife.

7. He was assessed by the crisis assessment and treatment service team who considered that the risk of him harming himself or others was sufficiently high that he ought not to return home without further assessment. The team attempted to admit TG to a specialist mental health hostel, but was unable to do so. Accordingly, it arranged for his re-admission to ward 21, for what was intended to be a short admission for further assessment. Notes of medical and nursing assessments carried out on re-admission record his threats of further self-harm, and of harm towards his wife.

8. On 10 September 2002 he was allowed to go on home leave. A clinical review carried out in his absence assessed him as displaying no evidence of any mental illness, and on 11 September 2002 he was discharged, with medical follow up one week later at the community mental health team's community clinic.

9. He attended for a medical follow up at the community clinic on 19 September 2002 when he was discharged to primary care with advice on alcohol consumption.

10. On 22 September 2002, at the family home, TG killed his wife by stabbing her. Subsequently he was charged with and pleaded guilty to murder. He was convicted on the 3 April 2003 receiving a mandatory life sentence.

4 PROVISION AND DELIVERY OF MENTAL HEALTH SERVICES IN NORTH TYNESIDE

The panel consider that it would be helpful to describe briefly the provision and delivery of mental health services in North Tyneside, particularly those services with which TG came in to contact, so that his management may be seen in context.

Provision

1. Primary care

1.1 As is commonplace nationally, primary care within North Tyneside is the provision of care by GPs and other health professionals attached to GP practices, which may be community psychiatric nurses, counsellors or psychologists. GPs are also able to access other statutory or voluntary services such as Relate counselling or drug and alcohol services.

1.2 GPs may refer those with severe or enduring mental health problems, and those who present to primary care in psychiatric crisis, to secondary mental health services including specialist services. Within North Tyneside those in psychiatric crisis would normally be referred initially to the crisis assessment and treatment service (CATS).

2. Secondary mental health services

2.1 The bulk of secondary mental health services, including specialist services within North Tyneside, are provided by the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust which was founded in April 2001. North Tyneside is one of three localities within that trust. The locality director of North Tyneside mental health services is also an assistant director of social services for North Tyneside local authority. This is a joint appointment which reflects the long term aim of integration of health and social care for those

with mental health difficulties, in accordance with government policy and guidance. Within the North Tyneside area therefore, the locality director takes responsibility for all mental health professionals.

2.2 Within North Tyneside secondary mental health services include:

- community mental health teams
- the crisis assessment and treatment service
- deliberate self-harm team
- the assertive outreach team
- drug and alcohol services
- acute inpatient psychiatric facilities

3 Delivery of services

3.1 Primary care

TG was registered with a GP whom he saw on a number of occasions before, between and after his admissions. He did not however access secondary mental health services through his GP since the first admission arose through his having taken an overdose, and the second from self presentation at the accident and emergency department. The panel were told that at this GP's practice at the time of these events there was a three month waiting time for primary care counselling; further it could be difficult to obtain an urgent assessment from the community mental health team (CMHT), although the GP made no request in TG's case.

3.2 Secondary mental health care

As noted above the principal elements of secondary mental health service with which TG came into contact were the deliberate self-harm team, ward 21 acute psychiatric inpatient facility, the Whitley Bay community mental health team and the crisis assessment and treatment service (CATS).

3.2.1 The deliberate self-harm team

The function of the deliberate self-harm team, a trust-wide service, is to carry out psychiatric assessment of patients admitted to hospital as a result of any deliberate self injury and, in consultation with other mental health services, to arrange for appropriate treatment, follow up, support or advice to be given to the patient.

3.2.2 The crisis assessment and treatment service (CATS)

The crisis assessment and treatment service was developed to operate across North Tyneside and Newcastle between 2000 and 2002. The service's (undated) policy document describes its functions and the principles under which it operates. These include:-

3.2.2.1 The team has a gate keeping role for acute psychiatric services. This means that the team will assess patients who are referred for admission to an inpatient psychiatric unit to see whether they can instead be treated within the community, either within the community mental health team or under the short term management of the crisis assessment and treatment service (CATS) itself.

3.2.2.2 The team offers community assessment and treatment for people experiencing acute psychiatric crisis who do not require inpatient treatment.

3.2.2.3 The team provides early discharge planning, that is to say facilitating the early discharge of psychiatric patients from hospital to the community.

3.2.2.4 The team operates under an overriding principle that it will assume short term case management of clients during a psychiatric crisis, until such time as the patient is referred to the community mental health team hospital ward or elsewhere.

3.2.2.5 The team's policy document sets out "intake criteria" which include that "the person appears to have a psychiatric disorder, and is at risk of admission to a psychiatric inpatient facility".

3.2.3 The community mental health teams (CMHT)

3.2.3.1 In North Tyneside the majority of secondary mental health services are provided through community mental health teams. North Tyneside is divided into four areas each of which has its own community mental health team. These are Longbenton, Wallsend, North Shields and Whitley Bay. Community mental health teams are multidisciplinary, comprising typically of one or two consultant psychiatrists, a junior doctor of senior house officer (SHO) grade, community psychiatric nurses (CPNs), occupational therapists, social workers, support workers, community staff nurses, psychologists and managerial and administrative support. The community mental health teams deal with the majority of patients in the community and will see them either at their own bases, or at the patient's home. Most patients managed by the community mental health teams are referred by GPs (GPs) or other professionals on a non-urgent basis, or come to them through the crisis assessment and treatment service who may have been requested by primary care services to carry out an urgent assessment. The community mental health teams may also assume responsibility for patients within their area who are admitted to hospital through the crisis assessment and treatment service or deliberate self-harm team, for example, as a result of an overdose.

3.2.3.2 Each of the consultant psychiatrists working in the community mental health teams has admitting rights to ward 21 and patients remain the responsibility of the community mental health team whilst admitted. The ward does not have a post of lead consultant to take responsibility for the running of the ward or for inpatients. In practical terms, members of each community mental health team including the consultant psychiatrists, senior house officers, social workers, community psychiatric nurses or other team members come in to the

ward to assess, treat, monitor and review inpatients for whom their team is responsible.

3.2.3.3 TG was the responsibility of the Whitley Bay community mental health team. The panel had access to the operational policy for the Whitley Bay community mental health team (CMHT), (October 1999) which sets out its aim as the provision of care to "those people with long term mental health problems, those with complex needs and those at high risk of harm to themselves, harm to others and self neglect". The policy sets out clinical priority groups. It lists services offered by the team which are said to include solution focused counselling, specialist family interventions and therapeutic group work. It sets out the procedures for treatment of patients, and expectations for care programme approach meetings.

3.2.3.4 All of the community mental health teams within North Tyneside are supported by the acute psychiatric inpatient facility at ward 21 of North Tyneside General Hospital. The Longbenton team has an additional inpatient facility at a unit called The Grange.

3.2.4 Ward 21

3.2.4.1 Ward 21 of North Tyneside General Hospital is the principal acute psychiatric inpatient facility within North Tyneside. At the time of these events (August to September 2002), it was a 37 bedded ward divided in to a mixed gender area of 25 beds and a women's wing of 12 beds.

3.2.4.2 As a result of the involvement of the crisis assessment and treatment service (CATS) team in reducing admission, and facilitating early discharge, bed occupancy of ward 21 had, by the time of TG's admissions, fallen to approximately 70-80%. There was a consensus of opinion that while the number of patients on the ward had diminished, their level of dependency had increased. Approximately half of the patients were detained under the Mental Health Act, the balance being informal patients.

3.2.4.3 The ward has no lead consultant psychiatrist. Patients remained the responsibility of the community mental health team (CMHT) which admitted them, or which assumed responsibility for them because of their address. As noted above, consultant psychiatrists from the community mental health teams have the right to admit patients to ward 21 and the teams retained responsibility for their patients whilst they were in hospital. In practice, the consultant psychiatrist of the Whitley Bay community mental health team, and his senior house officer (SHO) spent a considerable amount of their time on the ward, rather than in the community. Other members of the community mental health team would come to the ward, for example for the purposes of a care programme approach review, as and when necessary.

3.2.4.4 The nursing teams, comprising nurses and nursing assistants, were led by a ward manager assisted by team leaders. The nurses were divided into two teams, one covering the Whitley Bay and North Shields areas, and the other the Wallsend and Longbenton areas.

3.2.4.5 Primary nursing had been implemented on the ward. The role of the primary nurse was to take responsibility for the implementation of the care plan for the patient, and he/she was expected to attend care programme approach reviews, and to be involved in other discussions about the patient. The primary nurse was allocated to a newly admitted patient by the ward manager, or team leader. A patient's primary nurse might not be on the ward at the time of the admission, but this system enabled patients to be allocated in proportionate numbers between senior nurses.

3.2.4.6 Nurses on ward 21 operated an assessment and evaluation process called the Tidal Model. This model aimed to involve the patients as much as possible in the process of their assessment, and in the formulation and review of their care plans. Under this model patients were allocated a nurse for each shift. He or she was charged with maintaining contact with the patient, setting goals and evaluating progress against those goals. The allocated nurse would document their contact with and observations of the patient.

3.2.4.7 Nursing and medical records were kept separately in different folders stored in different rooms on the ward. The panel heard that nurses and doctors were able to access each others sets of notes, but that this was not the usual practice, and that for this reason on occasions some notes were copied so that they appeared in both the medical and the nursing records.

3.3 Other relevant services

3.3.1 There are a variety of other services to which those with mental health problems might be referred by primary or secondary mental health services, or in some cases might self-refer. Those relevant to TG's management include:-

- Scrogg Road Hostel, a specialist mental health hostel owned and operated by Newcastle social services department, to which North Tyneside social services and others had access on an individual contract basis.
- Drug and alcohol services which included within the trust area the NHS facility of Plummer Court and the voluntary organisation Turning Point.
- The Sunniside Project established by Mental Health Matters (a specialist charity). The project offers employment and training opportunities to people experiencing mental health problems.
- George Square – the local housing authority's homeless persons unit.

3.3.2 North Tyneside social services department provided an emergency duty team, which was a generic team set up to deal with a range of out-of-hours emergencies. It was this team which was contacted by the crisis assessment and treatment service (CATS) when they were seeking authority to place TG at the Scrogg Road Hostel.

4. The care programme approach (CPA)

4.1 The care programme approach applied to all those who came in to contact with secondary mental health services in North Tyneside.

4.2 The care programme approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. Its four main elements were:-

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services.
- Arrangements for the formulation of care plans which identify the health and social care required for the patient from a variety of providers. Depending upon their level of need, patients are assigned a 'minimum', 'medium' or 'complex' care programme approach level.
- Appointment of a key worker to coordinate care.
- Regular review and, where required, revision of care plans.

4.3 The care programme approach co-existed with the day to day management of care. Following publication of the national service framework for mental health in 1999, the NHS Executive issued new guidance called *Effective Care Co-ordination in Mental Health Services*, which set out to modernise the care programme approach.

4.4 The new guidance plainly sets out the aim of achieving integration between the processes described in the care programme approach and day to day care management of the patient. The new system, known as care co-ordination, became the process for delivering integrated health and social care to all adults in contact with the secondary mental health system.

4.5 Within the trust the completion of the development from care programme approach to care co-ordination did not take place until March 2003. However, for at least the preceding year, the new policy was being introduced. The period during which TG received care from the secondary mental health system in North Tyneside fell within this transitional year. Although TG was formally subject to the care programme approach rather than to the new care co-ordination regime, some of the documentation within his records reflects the fact that at the time the trust was looking forward to the implementation of the care co-ordination system.

4.6 The policy document for the Whitley Bay community mental health team describes how the team complies with the care programme approach (CPA). The team held regular multidisciplinary reviews in relation to each of their patients. For inpatients, those reviews would normally be held on the ward. The panel heard that it was undesirable for several care programme approach inpatient reviews to be held simultaneously, because of the demands on nursing time, so that a system developed of arranging care programme approach meetings for each community mental health team (CMHT) within North Tyneside on set days of the week. In the case of the Whitley Bay community mental health team these meetings usually took place on Tuesday afternoons.

4.7 The Whitley Bay policy document specifically describes the care programme approach process which ought to take place when the community mental health team learns that a patient for whom it is responsible has been admitted on to ward 21. The policy says that a care programme approach admission meeting will be organised by the admitting nurse on the ward, and that all admission meetings should be attended by a social worker from the team. The panel understood the purpose of these admission meetings to be that they provided an opportunity to consider the initial assessment and care plan (which will have been made by medical and nursing staff on admission at the time decisions about medication, observation level etcetera were made), and to try and match resources to the patient's needs, whether within an acute inpatient psychiatric setting or through discharging the patient to community based treatment by the community mental health team to specialist mental health services, or to primary care. Under both care programme approach and effective care co-ordination it is envisaged that the patient, if able to, will participate in the process of planning care. There is an expectation that significant others, such as the patient's close family or carer will, with the patient's consent, be invited to any multidisciplinary meetings or reviews, and will participate in the process of planning and delivering care.

5 FIRST ADMISSION 20 AUGUST 2002 TO 3 SEPTEMBER 2002

NARRATIVE OF TREATMENT

19 August 2002

TG was brought by ambulance to the accident and emergency department of North Tyneside General Hospital with a history of having taken an overdose of Diazepam, Fluoxetine and alcohol. He was admitted overnight to a medical ward for observation and assessment.

20 August 2002

TG was assessed by the deliberate self-harm team who recorded a history of heavy drinking. They found TG to be still suicidal and at high risk of further deliberate self harm. They discussed him with the senior house officer (SHO) who worked under one of the consultant psychiatrists in the Whitley Bay community mental health team, which was responsible for TG because his address was in Whitley Bay. It was agreed that TG should be admitted as an informal patient to ward 21.

On admission to the ward the SHO carried out a detailed assessment. He noted TG's history of having separated from his wife which had led to excessive drinking and poor sleep. His mood was noted to be very low. After taking the overdose he had called his wife who had called an ambulance. TG told the doctor that he still felt suicidal. He was unwilling to talk about his family background. On examination he was visibly agitated, dishevelled, depressed and anxious. He expressed a wish to have his wife back.

The plan was to admit him to the ward informally and to review him. He fell asleep before the physical examination could be carried out. He was put on level 2 observations (observation every 15 minutes).

The records note that his wife (EG) was shocked about her husband's overdose, but relieved that he was being looked after in hospital.

21 August 2002

TG was seen again by the senior house officer (SHO) who carried out a detailed physical examination. It was noted that TG was confused, and had a poor memory of the previous day. The nursing notes record that a care co-ordination meeting (technically this should have been described as an admissions care programme approach meeting) had been booked for 3 September 2002 at 1.30pm, two weeks ahead, and that TG was to be asked if he wished to ask anyone to attend.

He continued on 15 minute observations and was described as having low mood and not interacting with other patients.

22 August 2002

TG's full blood count is noted as normal. There are no other medical entries.

The nursing notes record that his wife visited him on the ward.

The Tidal Model (Barker 2001) assessment was carried out. This records TG as expressing the hope that he and his wife could sort things out and start again. He told nursing staff that he had a tendency "to bottle things up", and a plan was agreed whereby TG could approach staff if he wished to discuss his situation or his feelings. He was however observed to be more settled.

23 August 2002

He was seen by the senior house officer who noted him to be feeling better, and recorded that his wife had been visiting him on the ward, but that she had made it clear to TG that she did not wish to be reconciled to him. TG was

noted to be feeling anxious and having difficulty in sleeping properly, but still expressing the hope that he would be able to sort things out with his wife (EG).

A plan was made to start him on Fluoxetine (an antidepressant) and to give him night sedation. His level of nursing observations was decreased to level 3 (this allows the patient freedom of movement within the ward but with supportive observations).

The daily nursing records contain the same plan to offer TG one-to-one time but note that no time was requested. The notes record a discussion between TG and a nurse about welfare benefits.

In the morning TG was noted to be settled and brighter in mood. In the afternoon he was noted to be unsettled and was prescribed Lorazepam. Subsequently he was said to be in a brighter mood.

24 August 2002

The nursing notes record that TG was to be offered one-to-one time with a member of staff, and subsequently that he had not requested any time or voiced any problems. It is recorded that TG was out with his wife for two hours during the afternoon. He was observed to be settled and bright.

25 August 2002

The daily nursing note records that TG was offered one-to-one time. It is noted that he attempted to telephone his wife during the morning and became very agitated when he could not get through. The records then note that EG had telephoned the ward to tell them that TG had arrived at home. Subsequently TG returned to the ward but then, after notifying staff in the agreed manner, returned home again. Later that day TG was noted to be tearful.

26 August 2002

The daily nursing notes record plan to offer one-to-one time. The notes record that nurse A had had some discussions with TG about his family and also about practical issues such as welfare benefits. The notes record that he spent approximately five hours off the ward at his home. He appeared to be settled and bright all day.

27 – 28 August 2002

On both of these days TG seemed bright and spontaneous in his reactions and for much of each day spent time off the ward.

29 August 2002

TG was medically reviewed by the senior house officer (SHO) who recorded that TG had been seeing his wife regularly since admission, and that he felt that he had adjusted to the fact that he was not going to get back together with her. The senior house officer records him as acknowledging that alcohol was causing problems for him, and agreeing to go to the community based drug and alcohol service for help. A plan was made that TG should have overnight leave during the weekend.

30 August 2002

The plan notes that Thomas should approach staff if he would like any time and that he planned to spend most of the day off the ward. It is recorded that he had gone home for the day to see his children. Subsequently it is noted that he left the ward twice during the afternoon and evening, on the last occasion returning at 11.30 pm, when he appeared to be affected by alcohol.

31 August 2002

The plan that he should have weekend leave is noted. He was noted to be bright and settled.

1 and 2 September 2002

No records.

3 September 2002

There is a record of a clinical review endorsed as a care co-ordination meeting which was attended by TG, the consultant psychiatrist, the senior house officer (SHO), nurse A and some medical students.

The meeting resulted in a decision to discharge TG. He was to be seen on 9 September 2002 for medical follow up. It was also planned that TG should be referred to an occupational therapist within the community mental health team with a view to a referral being arranged to Mental Health Matters, a voluntary agency, which offers training and education opportunities to people with mental health problems.

The plan included that TG remain on his present medication (Fluoxetine) for a period of six months and that he self-refer to Turning Point (a drug and alcohol service) if necessary.

The senior house officer made a contemporaneous medical note of the meeting. He noted that TG said that he was feeling well although lonely; that he was not sure about the accommodation position; that he wanted to stop/decrease alcohol but did not want to be referred to the drug and alcohol service.

The senior house officer also recorded the views of nurse A who had been TG's primary nurse during this admission. He was noted as not having any concerns about TG at present. He said that TG had not been any problem in management. He recorded that no further feelings of self-harm had been expressed and noted on one occasion that TG returned to the ward after having had a few drinks.

The senior house officer (SHO) recorded various decisions of the meeting which included that TG should be discharged that day, and noted that alcohol risks had been discussed with him and that he had been given information about self-referral to Turning Point and to Plummer Court (both facilities for drug and alcohol addiction).

After the meeting a proforma discharge notification letter was completed by the senior house officer and one copy faxed to TG's GP. This recorded the discharge diagnosis as:

i. (a) Depressive episode severe in remission
   (b) Alcohol abuse
ii. No personality diagnosis
iii. Gout
iv. Relationship problems
v. Global Functioning > 95.

The letter notes the continuation of Fluoxetine, and that a medical follow-up was to take place with the senior house officer on 9 September 2002.

6 FIRST ADMISSION 20 AUGUST 2002 TO 3 SEPTEMBER 2002

COMMENTARY

1. Decision to admit to Ward 21

1.1 TG was admitted for observation and assessment on the night of 19 August 2002 and was assessed by the deliberate self-harm team the following day. They found that he had taken a serious overdose of 10 Paroxetine and 20 Diazepam combined with 8-9 pints of beer. TG had written a suicide note and said during the assessment that he thought that the medication would be enough to kill him. He was not pleased to have survived and still felt suicidal. After taking the overdose he had called his wife, and now regretted doing that. He was clearly in despair about the break-up of his marriage and appeared to have few sources of support. The team carried out the Beck suicide score and found him to be of high risk of suicide. They discussed TG's situation with the medical staff on ward 21 following which an informed decision to admit TG to the ward as an informal patient was made.

1.2 The panel concluded that it represented good practice to admit TG to the ward so that an assessment could be made of whether he was suffering from a mental illness.

2. Medical input

2.1 The panel was told that there was no consultant psychiatrist with overall responsibility for inpatients on ward 21. All patients on the ward remained the responsibility of the community mental health team whose consultants would spend some of their time on the ward and some in the community. The community mental health teams also had one or more senior house officers (SHOs) whose duties were also split between the ward and the community although, in the case of the Whitley Bay community mental health team, the senior house officer spent the majority of his time on the ward.

2.2 The panel understand from witnesses who gave oral evidence that the ward may have been particularly busy at the time of TG's admission, with two or more patients exhibiting severely challenging behaviour. Furthermore, the panel were told that of the approximately 31 patients on ward 21 at the time, 11 were the responsibility of TG's consultant psychiatrist.

2.3 The records demonstrate that TG was seen by the senior house officer (SHO) at appropriate intervals.

2.4 Although there is no documented medical record of the consultant psychiatrist in charge of TG having any contact with him, or making any decisions about his care, until the meeting on the 3 September 2002 (which made the decision to discharge TG), the panel was told, and accept, that there will have been informal contacts between both doctors and TG, which are not recorded in the notes.

2.5 At the time of TG's admission the senior house officer had been working on ward 21 for two weeks. Before that he had completed one six month post at another hospital. He was therefore a relatively inexperienced senior house officer.

2.6 Had there been a formal multidisciplinary assessment carried out in relation to TG within approximately one week of his admission, there would have been an earlier opportunity to consider whether TG's admission should continue and, in the event that it did, to make decisions about arrangements for home leave.

3. Nursing care

3.1 The Tidal Model assessment was completed on 22 August 2002. It produced a significant amount of information about the background to TG's crisis, and demonstrated that he had some insight in to the reasons for the breakdown of his marriage, and the impact which his behaviour, including excessive alcohol

consumption, was having on his family. In the course of the assessment TG confessed to a tendency to “bottle things up”.

3.2 It is clear from the daily nursing records, which are of good quality, that the processes of allocating a nurse for TG, of observing and recording his mood and behaviour, and of offering him time to discuss his problems, were carried out with commitment.

3.3 When interviewed by the panel TG, whose memory of events within either admission was poor, conveyed his strong impression that he had been left largely to his own devices. The records reveal little evidence of therapeutic interventions during this admission.

3.4 The initial assessments of TG suggested that he was unlikely to take the initiative to approach staff in order to discuss his problems. It ought to have been clear within a few days of his admission that a more active approach was required to engage TG in discussions about the problems which he had revealed in the initial assessment. However, after that point, there is little evidence of attempts on the part of nursing staff to actively engage TG in discussion about his problems and the reasons for his admission.

3.5 It is clear from the records that TG's wife visited him on the ward on at least three occasions during the early part of his admission. After these first few days, TG was spending much of his time away from the ward in contact with his wife and children. It is clear that TG's perception was that the breakdown of his relationship with his wife was at the centre of his problems. On the first day of his admission to the ward EG's shock about her husband's overdose is noted. However, after that, there is no record of any attempt on the part of the nursing staff to speak to EG about her husband, or about the problems in the relationship. The panel finds that it is probable that TG, who could not remember being asked for permission for staff to approach EG, would readily have consented to this. This omission is all the more surprising given the fact that there were two young children of the marriage, on whom TG's behaviour,

mental health and admission to ward 21 might have been expected to have a severe impact.

3.6 It is clear from the records that, with the exception of one minor episode of agitation, and one instance of him returning to the ward after he had been drinking, TG presented no management problem and, in the context of a ward which was particularly busy, and which contained some very disturbed patients, the panel's impression is that TG was, to use his own expression, 'left largely to his own devices'.

3.7 It is not clear to what extent the Tidal Model may have been responsible for engendering what the panel finds to have been a passive rather than proactive approach to TG's admission. Nursing staff interviewed by the panel valued the positive emphasis which the Tidal Model places on empowering patients to participate in the process of care and care planning. However, they recognised that for some groups of patients (for example, those with complex and profound mental health problems), the model was of limited use. They also accepted that a more focused and directive approach may need to be taken with patients, such as TG, who wish to avoid confronting difficult issues which may have led them into crisis and admission to hospital.

3.8 The records do not demonstrate that the primary nurse or any of the nurses allocated to TG took responsibility to evaluate his key presenting features which were the break up of his relationship bound up with excessive alcohol consumption. Without such an evaluation it was impossible to formulate and develop an effective intervention. The panel conclude that there may have been an over emphasis on the alcohol issue, without there being clarity about the extent to which this was cause or effect of the relationship breakdown, and at the expense of looking at the relationship issue itself.

4. Care programme approach

4.1 On the day after admission to the ward a care programme approach (CPA) admission meeting (called, in anticipation of changes being introduced, a care co-ordination meeting) was diaried. TG was admitted to the ward on a Tuesday. The panel was told by a number of witnesses that the ward aimed to arrange care programme approach admission meetings within a week of admission. However, both medical and nursing staff told the panel that, because of the system of allocating care programme approach/care co-ordination meeting reviews of a particular team to a particular slot of the week (for the Whitley Bay community mental health team Tuesday afternoons), it could sometimes happen that a team's slots were full, and therefore meetings were postponed for a week. In TG's case the Tuesday after his admission was an extra-statutory holiday (following the August bank holiday) and it seems that, because of this, and perhaps because there appeared to have been a relatively large number of patients admitted under the care of the Whitley Bay community mental health team at this time, it was not possible to hold the care programme approach admission meeting on the first Tuesday after TG's admission.

4.2 As a result, the care programme approach admission meeting – the first multidisciplinary meeting – was not until the 3 September 2002, and this resulted in a plan to discharge immediately.

4.3 Although the notes record that, when the care programme approach admission meeting was booked for 3 September 2002, TG was to be asked if he wished to invite anyone to attend the meeting, there is no evidence that this was followed up.

4.4 The Whitley Bay community mental health team operational policy document (October 1999) says that a social worker will attend all admission care programme approach meetings, but this did not happen on 3 September 2002 and the social worker's absence is not noted or explained.

4.5 As an adult in contact with secondary mental health services, TG was subject to care programme approach (CPA) once admitted to hospital and should have been registered on the care programme approach database. However, there is nothing in the records to suggest that TG's care programme approach status was ever considered at this point. Had it been concluded that TG was not suffering from a mental illness, but was in psycho-social crisis in reaction to life events, it would have been correct within the care programme approach to have deregistered TG on discharge without making arrangements for any further review or for the provision of services by the community mental health team. In fact however, the discharge notification form completed by the senior house officer on 3 September 2002 contained a mental health diagnosis, and apparently envisaged that a community mental health team social worker might be involved with TG. It was also resolved at the discharge meeting on the 3 September 2002 that a community mental health team occupational therapist might remain involved to facilitate a referral to Mental Health Matters. In those circumstances TG ought to have been registered under the care programme approach database and assigned a care programme approach level.

5. Leave arrangements

5.1 The granting of leave from the ward to patients was governed by a policy for patient leave of absence produced (under the previous trust arrangements) in December 1998. The policy distinguishes between the granting of leave to patients detained under the Mental Health Act and to informal patients such as TG.

5.2 The policy allows the doctor in charge of the patient’s care to delegate his/her authority to grant leave, stipulating that such a decision should be recorded in the medical records, and be subject to regular review. The policy says that decisions about leave should involve consultation with the patient and, where appropriate, with relatives and carers. Arrangements for leave should be described in a leave care plan.

5.3 There is no evidence that TG had articulated, or been assessed as presenting, any risk to any third party during this admission. The decision to grant increasing amounts of leave following the initial period of assessment was in accordance with the policy, and represented a constructive and therapeutic approach to reintegrating TG in the community. The decision to grant weekend leave was made after medical review by the senior house officer (SHO) on 29 August 2002.

5.4 The panel notes that no risk assessment or review is specifically recorded in the records in relation to any of the decisions to grant leave. There is no record of any consultation with TG's wife (EG), about decisions to grant leave.

6. Discharge arrangements

6.1 The decision to discharge on 3 September 2002 was clearly appropriate in light of the observations of TG's mood and behaviour during admission, the absence of any further suicidal ideation beyond the second day after his admission, and the findings on clinical review on both 29 August and 3 September 2002.

6.2 Neither the record of the care co-ordination meeting held on 3 September 2003 nor the medical note made at the same time contain a mental health diagnosis of TG.

6.3 The discharge diagnosis section of the discharge notification letter completed by the senior house officer (SHO) after the meeting on 3 September records "depressive episode – severe in remission", a diagnosis which the consultant psychiatrist told the panel he did not agree with.

6.4 The panel understood that a copy of the discharge notification letter sent to the community mental health team and kept on their records did not, as a matter of practice, contain either the discharge diagnosis section, or the "additional contents" section which were blanked out on all but the top copy

(which was sent to the patient's GP). As a result it would not have been possible for community mental health team staff to ascertain from the copy of the discharge notification letter within their records what discharge diagnosis had been given to the patient.

7 3 SEPTEMBER 2002 TO 22 SEPTEMBER 2002, INCLUDING SECOND ADMISSION (9 – 11 SEPTEMBER 2002)

NARRATIVE OF TREATMENT

4 September 2002

On the day after his discharge TG attended his GP who recorded that TG felt very agitated. The GP changed his anti-depressant medication and arranged to see him a further week ahead.

8 September 2002

After drinking heavily TG damaged the family home. He was subsequently arrested by the police and detained in the cells overnight.

9 September 2002

TG was brought before the North Tyneside Magistrates for breach of the peace. He was bound over to keep the peace.

Shortly before 2pm TG drove to North Tyneside General Hospital and presented himself to the accident and emergency department. He was seen by a senior house officer (SHO) in accident and emergency. TG said that he felt that his life was not worth living and that he was planning to buy medication to try to end his life. The senior house officer had serious concerns that TG would deliberately harm himself, and referred him to the crisis assessment and treatment service team for assessment.

A crisis assessment and treatment service triage nurse decided that TG should be subject to a full crisis assessment and treatment service assessment. At approximately 4pm a social worker, accompanied by a support worker, carried out this assessment. They noted that TG was disappointed that there had not been reconciliation with his wife when he was

discharged on 3 September 2002; that his drinking had increased and that the damage to the family home had been done after drinking eight or nine pints of beer. The crisis assessment and treatment service (CATS) assessment records:

> *"at interview he continued to assert an intention to overdose, or to attack his wife. He intended to drink should he return home, and in the context of last night's actions there seemed every likelihood of recurrence and decompensation."*

At the time he was assessed he was said to have clear speech, clear thought, clear perceptions and good insight. There is no record that TG showed signs of being under the influence of alcohol.

The social worker considered that whilst TG did not require admission to hospital, it would not be appropriate for him to go home because of the degree of risk to himself and others. He therefore made efforts to find an alternative placement and secured the agreement of the Scrogg Road Hostel to accept TG for the night. The hostel is a specialist mental health hostel run by Newcastle social services, to which the trust could negotiate access on a case by case basis. The social worker told the panel that, although the hostel was prepared to accept TG, he was unable to secure authority for the funding from the North Tyneside social services department.

As a last resort he therefore arranged for TG to be admitted again to ward 21 for a short admission.

During the evening of the 9 September the social worker accompanied TG to the ward and handed over either the original or a copy of the notes which he had made on assessment. There is no evidence that these notes included a standardised risk assessment document such as the FACE risk profile (which the panel were told was being used by the crisis assessment and treatment service at this point). The social worker told the panel in oral evidence that he

had consulted with ward staff because he believed that although there was no clear cut evidence of any mental illness and therefore no strong case to admit TG, there were major risk features.

The social worker told the panel that TG had made two explicit threats: the first that, if he came across his wife with another man in a car park he would run them down: the second, which he repeated, that if she was going with another man he would stab her.

Neither of these two threats is recorded in the crisis assessment and treatment service (CATS) documentation, however the social worker told the panel that he clearly recalls that when he arrived at the ward to hand TG over, he told the ward staff about his level of concern, and told them about both specific threats.

TG was subsequently seen by the senior house officer (SHO) who had been involved with him during the first admission, and nurse A who had been TG's primary nurse during the first admission. They saw TG at about 7 pm.

The senior house officer recorded that TG had threatened to kill himself or his wife. He found him to be tense and sweating profusely, but to have spontaneous speech which was coherent.

He noted that TG had thoughts of "*threatening self-harm and harm towards his wife.*" He concluded "*this seems to be more of a behavioural problem related to alcohol than mood disorder. Short admission seems to be* [sic] *to get over self-harming behaviour".*

Nurse A carried out a nursing assessment at about this time, which recorded the history that "*Thomas then presented at A and E, saying he planned to buy tablets to overdose on them with whisky. Thomas also said he would run down his wife and her male friend if he saw them in the street."* The assessment concluded that TG was at risk of self-harm, suicide and harm to

others. His mental state was said to be lucid and insightful. A nurse's global assessment of suicide risk (under the Tidal Model) was carried out which resulted in a total score of 18, which is high risk.

Following admission, the daily nursing record reported "*Thomas is happy to be on ward 21 and does not feel inclined to self-harm, now he is here."*

10 September 2002

The daily nursing record contains a plan to attempt to complete the Tidal Model assessment and to offer TG one to one time to discuss his present situation.

The evaluation section of the record notes that the nurse was advised by the ward manager "*to use Tidal Model assessment from Thomas' last admission as he was only discharged on 3 September 2002."*

Subsequently it is recorded: "*Thomas left ward after tea for overnight leave. Advised to use time to 'sort his self out.' Due back on ward to see* [SHO] *to be discharged."*

During TG's home leave a clinical review was held by the consultant psychiatrist, the senior house officer, a social worker and a community psychiatric nurse from the community mental health team, and TG's primary nurse.

The clinical review note states that TG had been "*readmitted by CATS on 9 September 2002 despite protests from staff;"* that he was laughing within one hour of being admitted to the ward, and that there was no evidence of a mental health problem. The only plan made was to refer him to the homelessness unit for advice on housing.

The clinical note made by the senior house officer (SHO) contemporaneously with the clinical review states that there was no sign of mood problems observed by staff and that TG appeared to have "*more an adjustment problem with no affective component notable".*

11 September 2002

A discharge checklist was completed.

There are no medical or nursing records.

A proforma discharge notification letter was completed by the senior house officer.

This records a discharge diagnosis of

1. *Adjustment problems regarding separation from wife.*
2. *Alcohol abuse problems.*
3. *No mental illness.*

The discharge medication is said to be only the gout medication.

The discharge notification letter records that TG was advised to see his GP within 14 days. TG was also subject to the statutory seven day medical follow up and was provided with an appointment for the 19 September 2002.

In the additional comments/other support arrangements section of the discharge notification letter the senior house officer wrote "*repeat admission following threatened self-harm. No problems with mood noted or acknowledged. Not to be admitted if presents in similar circumstances."*

On the same day TG went to see his GP who noted the reasons for his second admission to hospital and noted "*definitely more settled. No suicidal ideation*".

12 September 2002

TG attended Turning Point (substance misuse services). This followed a referral made by either the police or the probation service following TG's arrest on 9 September 2002. The level of his drinking was assessed and a decision was made to offer him day care services.

14 September 2002

The prosecution witness statement of RA, a friend of TG, says that TG made threats to stab his wife during the evening. He had been drinking heavily at the time he made these threats.

18 September 2002

Nurse B, who had been TG's primary nurse on the second admission, completed a nursing discharge profile which was sent to the GP. This was a combined report on both the first and second admissions. It recorded under a heading 'interventions…including outcome' that TG had been offered one to one time to discuss current difficulties and to communicate feelings but that there had been "*limited engagement with staff.*"

TG saw his GP who noted him to be improving and continued his medication. The GP told the panel that he could remember that at this attendance TG seemed much better and gave the impression of having *"moved on".*

19 September 2002

According to the prosecution witness statement of RO, TG telephoned him at approximately 1.15 am, clearly drunk and repeated several times his threat to stab his wife.

Later that morning TG attended the Whitley Bay community mental health team for medical follow up with the senior house officer (SHO). He was said to be having no problems with his mood but still to be drinking significant amounts. He expressed regret about drinking and smashing up his house. He was noted to be prescribed Paroxetine and Diazepam by his GP.

He refused referral to the drug and alcohol services and was accordingly discharged to primary care and encouraged re alcohol abstinence. It was noted that housing was still an issue.

The senior house officer has not recorded any discussion with TG about the threats which he had made towards his wife.

According to the prosecution witness statement of RH (an acquaintance of TG), in the afternoon of 19 September 2002 he met with TG whom he found to be very angry. TG repeated on a number of occasions “I am going to get it sorted” and “it’s getting sorted” without making it clear to what he was referring.

The Turning Point documentation suggests that there was contact with TG on 19 September 2002 but no details are available.

21 September 2002

According to the prosecution witness statement of RH, TG became drunk during the evening and told him “I’ve got a knife. I’ll do it”.

22 September 2002

TG went with his wife to the family home at approximately 11.30am following which TG killed his wife by stabbing her. The pathologist subsequently identified more than thirty stab wounds to the body of which ten were deeply penetrating.

23 September 2002

TG was arrested during the afternoon. Whilst in custody he was assessed by a different consultant psychiatrist, who had no prior acquaintance with him, and who certified him fit to be interviewed.

8 3 SEPTEMBER 2002 – 22 SEPTEMBER 2002, INCLUDING SECOND ADMISSION (9 – 11 SEPTEMBER 2002)

COMMENTARY

1. Role of the crisis assessment and treatment service (CATS)

1.1 TG was appropriately referred to the crisis assessment and treatment service by the accident and emergency department senior house officer (SHO) at North Tyneside General Hospital. The crisis assessment and treatment service noted a number of features which they assessed as presenting a serious risk either to TG himself or to a third party. These were:-

- He was asking for help and articulating thoughts of self-harm, and harm towards his wife.
- He had just been released from court after causing substantial damage to his own home.
- He had been drunk at the time he damaged his home, and said that he would drink heavily if he returned home.
- He said that he intended to take a further overdose (having taken a serious overdose some three weeks earlier).
- He made two specific threats of how he was going to harm or kill his wife.
- At the time of assessment he was said to have clear speech, thought and perception, and did not appear to be under the influence of alcohol.

1.2 It is unfortunate that the social worker's efforts to have TG admitted to the Scrogg Road Hostel foundered as a result of what the panel accepts to have been funding difficulties rather than any difficulties arising from TG's presentation. The panel understands that following organisational re-arrangements, such difficulties no longer arise.

1.3 The decision by the crisis assessment and treatment service triage and assessment team to admit TG to ward 21 in the absence of any suitable community placement was, in the panel's view, a pragmatic as well as appropriate one. It is not certain that TG met the crisis assessment and treatment service's intake criteria, as he was displaying no clear evidence of psychiatric disorder, but the level of risk he presented was thoroughly and appropriately recognised.

1.4 The panel recognise the crisis assessment and treatment service's actions in appreciating the level of risk presented by TG, but find it surprising that this was not documented in a standard risk assessment form which ought to have highlighted the specific threats which TG made to stab his wife or to run down her or her partner.

1.5 The panel nevertheless accepts that the degree of risk assessed by the crisis assessment and treatment service was verbally communicated in broad terms to the hospital staff. It is clear from both the medical and nursing notes made on admission, that TG's threats to kill or cause serious harm to his wife were appreciated. Although there is no written evidence in the hospital notes of TG's threat to stab his wife, the nursing records record his threat to run her and her male companion down.

1.6 As the crisis assessment and treatment service had assessed TG as not having a psychiatric disorder requiring admission to hospital, it was reasonable for the plan on admission to be for a short admission, specifically so that a further risk assessment could be carried out on the ward.

1.7 It is not clear whether the crisis assessment and treatment service notes were filed with TG's medical notes, nursing notes or whether copies were placed on each file.

2. Risk assessment on the ward

2.1 The absence of a comprehensive risk assessment is not noted by the ward staff nor did they take steps taken to carry out such an assessment on the ward.

2.2 After the admission the nursing record on 9 September 2002 notes that TG was happy to be on the ward and did not feel inclined to self-harm now he was there. No mention is made of any risk to third parties.

2.3 Although on the following day a nursing plan documents an intention to carry out the Tidal Model assessment, the ward manager took the view that the assessment from the previous admission could be used, given that only one week had elapsed since the end of that admission. In evidence, the panel were told that the decision to use the Tidal Model assessment from the previous admission was taken for the practical reason that, at that time, TG was on leave and was not on the ward to go through the assessment again.

2.4 After the medical and nursing admission notes on the evening of the 9 September 2002, there is no evidence within the clinical records that anyone attempted to explore with TG whether his thoughts of serious harm towards his wife were continuing, or to assess their seriousness. There was therefore no opportunity to consider whether any urgent intervention was required, or whether the staff on the ward should use their discretion to contact TG's wife to warn her of TG's expressed intentions. It may or may not have been appropriate to take such a course but as there was no assessment of the degree of risk, staff were in no position to make any judgment about the issue.

2.5 Witnesses who gave evidence to the panel appear to have assumed that that the threats which TG had made against his wife had been made whilst he was affected by alcohol. Although the senior house officer's (SHO) conclusion was that TG was exhibiting a behavioural problem related to alcohol rather than mood disorder, there is no evidence in any of the records made by the

senior house officer (SHO), the assessing nurse or the crisis assessment and treatment service (CATS) that TG was under the influence of alcohol at the time he made clear and specific threats. The panel concluded that this apparent misconception about the context in which TG made threats, may have led to these threats being underestimated.

2.6 The ward manager advised the allocated nurse on 10 September 2002 that it was acceptable to use the Tidal Model assessment which had been completed at the beginning of the first admission, some three weeks earlier. This did not take in to account the fact that TG was presenting with new features which ought to have prompted clinical staff to undertake a further assessment, including risk assessment.

3. Leave

3.1 Paragraph 1.4 of the trust's policy for patient leave of absence (December 1998) recommends that records to be taken into consideration when considering leave should be filed together and that they should include the initial clinical assessment, the risk assessment, the record of current observation levels and any past and current leave records.

3.2 Paragraph 1.6 stipulates:-

"prior to the patient going on leave the nurse in charge/named nurse should satisfy themselves that earlier assessment remains valid. When there is cause for concern, the nurse in charge/named nurse should discuss their concerns with the responsible medical officer (RMO) or duty doctor. The concerns and outcome of the discussion should be documented in the nursing record."

3.3 It is noted in the nursing records for the afternoon of 10 September 2002 that TG had left the ward for overnight leave and had been advised to use time to *'sort his self out'.* There are no documents recording any clinical review or

assessment of TG before the decision was made to grant leave. The note of the clinical review held on 10 September 2002 in TG's absence does not mention the issue. There is no evidence of any compliance with the policy which stipulates that any decision to grant leave should be supported by a risk assessment as well as a review of current observation status.

3.4 The records contain a security plan dated 9 September 2002 which states *"Tom will tell staff when he leaves ward".* The records contain a blank leave care plan proforma which ought to have been filled in before leave was granted to demonstrate that it had been planned, and that it was supported by a current risk assessment. The proforma reminds clinical staff of the requirement to discuss proposed leave with the patient and "…as appropriate, carers and relatives."

3.5 As noted in the context of TG's first admission, the written protocol for granting leave stipulates that if a doctor in charge of a patient's care delegates his authority to grant leave to another person, this delegation should be recorded in the medical record. There is no such record in these notes.

3.6 The panel took careful oral evidence on the issue of what, if any, risk assessment was carried out before a decision to grant leave was made. Allowing for the passage of time, the panel has nevertheless concluded that no assessment of risk was undertaken before TG was allowed leave to return home, where it ought to have been assumed that he would come in to contact with his wife against whom, less than 24 hours previously, he had made specific threats of serious harm. The context in which leave was granted included TG's history of recent heavy drinking, of damage to the family home, and of his assertion that he would drink heavily if he returned home.

4. Discharge

4.1 TG was admitted to ward 21 with a clear plan that the admission should be short. The nursing notes of 10 September 2002 record that TG had gone

home for leave but was to return to the ward the following morning to be discharged.

4.2 The panel acknowledge that, on the basis of the documented evidence, it was reasonable to conclude that TG was not suffering from a mental illness at the time of the second admission.

4.3 However had a comprehensive risk assessment been undertaken arrangements for TG's discharge may have been different.

4.4 There is no documented record of when, by whom and on what basis the decision to discharge was made. The panel was told that the decision to discharge was not made during the review on 10 September 2002.

5. Medical follow up 19 September 2002

5.1 TG saw his own GP immediately after discharge on 11 September 2002 and then a week later on 18 September 2002. His GP had the clear impression that TG was progressively coming to terms with the change in his circumstances.

5.2 There is no evidence that the senior house officer (SHO) who saw TG on medical follow up on the 19 September 2002 explored any issues relating to TG harming his wife or any other third party. There was no written risk assessment within the records which might have prompted the senior house officer to look at this issue.

5.3 The panel notes that according to statements taken by the police in connection with TG's prosecution, he had made explicit or implicit threats to harm his wife to two separate witnesses both in the early hours and during the afternoon of the 19 September 2002, that is both before and after his medical review. On the other hand, when he had seen his GP on 18 September 2002, he had seemed to the GP to be coming to terms with his situation.

9 SUMMARY OF FINDINGS

FIRST ADMISSION

1. The decision by the deliberate self-harm team, in consultation with medical staff on ward 21, to admit TG to the ward on the 20 August 2002 represented good practice.

2. There is evidence that at the time of TG's first admission the ward was particularly busy, and contained patients whose behaviour was challenging to staff. The records also suggest that the consultant psychiatrist in charge of TG had a disproportionate number of inpatients at the time.

3. The senior house officer's (SHO) assessment of TG was thorough and well documented. However, his experience was limited. It is unsatisfactory that there is no documented medical review of TG by the consultant psychiatrist until the date of his discharge, two weeks after his admission.

4. The discharge notification form completed by the senior house officer at the end of the first admission contained a diagnosis which appears not to be supported by the evidence, and with which the consultant psychiatrist did not agree. The copy of the form filed within community mental health team (CMHT) records does not include the diagnosis or comments sections, which are blanked out.

5. There was a lack of clarity about TG's care programme approach (CPA) status. Contrary to guidance he was not registered for care programme approach purposes on admission. At the time of his discharge from the ward there was no clear record of whether TG was being allocated a care programme approach level.

6. The initial Tidal Model assessment was carried out well by nursing staff and brought out that the principal cause of TG's self harming behaviour was the

breakdown of his relationship with his wife, in the context of excessive alcohol consumption. There was frequent and well documented contact and observation between nursing staff and TG throughout the admission however, there was a lack of focus in trying to get to the bottom of TG's problems.

7. This lack of focus is illustrated by the omission to involve EG in discussions during her visits, or in the care co-ordination meeting, and by the arrangements for that meeting which took place on the day of discharge two weeks after admission, and was not attended by a social worker in accordance with community mental health team (CMHT) policy.

8. In spite of the frequent contact between TG and nursing staff, no-one took responsibility to explore the reasons behind TG's crisis. He was clearly a patient who was not inclined to take the initiative in talking about his problems and therefore a more active engagement was required.

9. The decision to grant TG leave from the ward during this admission appears to have been clinically appropriate and consistent with good discharge planning.

SECOND ADMISSION

10. On 9 September 2002 the crisis assessment and treatment service (CATS) team recognised the serious risk which would have arisen from allowing TG to return home without further assessment, and in the absence of their preferred community placement, appropriately arranged a short admission to ward 21 for the purposes of TG undergoing further risk assessment.

11. The crisis assessment and treatment service did not fill in a FACE risk profile or record at all important specific threats made by TG. However, they communicated to the hospital staff their level of concern about TG’s risk to himself and others. The threats by TG to cause serious harm to his wife are clearly documented in the hospital records.

12. Hospital staff assumed that TG's threats were made whilst he was affected by alcohol, although the evidence suggests that at the time he made threats recorded by the crisis assessment and treatment service (CATS) and the hospital staff, he was sober and coherent. The threats to harm his wife were not taken seriously and, as a result, this short admission was treated by the ward staff as if it were a continuation of the previous admission. This is reflected in the decision to rely on the Tidal Model assessment from the first admission, when TG was in fact presenting with a different set of risks because he was now threatening to harm others in addition to himself. The panel also notes the lack of reference within the discharge notification letter to TG having made threats to any third party.

13. The omission to follow the procedures set out in the policy for patient leave of absence, and in particular to carry out and document a risk review before granting leave, as well as before discharging TG, deprived the staff of any opportunity to assess the seriousness of the risks posed by him. This was a significant omission.

14. The trust's internal review summarised clinicians' views as being that "*explicit risk assessment recording in low risk situations would be purely defensive*". The panel notes that TG's presentation on 9 September 2002 did not suggest it to be a low risk situation. He was making repeated specific threats towards his wife and his suicide score carried out by nursing staff was in fact considerably higher than that recorded at the beginning of his first admission by the deliberate self-harm team.

15. In the panel's view the classification of an event or situation as 'low risk' should always be supported by an initial documented risk assessment.

16. Neither the decision to discharge TG nor any aftercare plan were explicitly documented. There is no evidence that any current risk assessment was undertaken as part of the discharge procedure. Given the risks displayed on admission, the panel would have expected that a medical member of staff of

appropriate seniority would have been involved in the discharge decision, and that the decision would have been clearly documented.

17. At local follow up on the 19 September 2002 (three days before the offence) there is no record of any attempt to explore whether TG's wish to harm his wife remained current. There was no risk assessment document within the records to prompt such a reappraisal.

10 CONCLUSIONS, RECOMMENDATIONS AND OBSERVATIONS

CONCLUSIONS

1. It is important to state that the ultimate responsibility for the death of Elizabeth Gallagher lies with Thomas Gallagher who killed her, and who did not advance any defence of diminished responsibility at his trial.

2. The panel acknowledge that there is little evidence that TG was suffering from mental illness during either admission. On the evidence available there were at no time any grounds to section him under the Mental Health Act.

3. The panel was impressed by the professionalism and commitment displayed by all of the medical, nursing, social services and managerial staff whom the panel interviewed. During what was inevitably a difficult process, their evidence was open and thoughtful. The panel notes that all spoke of being well supported by colleagues as well as by management. The panel noted what appeared to be a constructive and flexible relationship between the medical and nursing staff. All of the witnesses interviewed accepted responsibility for their professional actions.

4. The panel commends the decisions of the deliberate self harm team, ward 21 and the crisis assessment and treatment service (CATS) team to admit TG on each of his two admissions for assessment

5. Whilst it may be considered that an earlier multidisciplinary meeting during TG's first admission could have resulted in earlier discharge, TG did spend two weeks on ward 21. The panel consider that an opportunity to engage him was missed. This appears to have happened due to a combination of factors:

    a) TG was clearly an undemanding patient who did not wish to engage voluntarily with nursing staff.

b) In contrast there were a significant number of highly disturbed patients on the ward at the time.

c) At the time of TG's first admission the consultant psychiatrist in charge of him had responsibility for a disproportionate share of the patients on the ward.

d) The Tidal Model may have allowed TG to pass through the nursing and care planning process without his problems being confronted.

6. TG's second admission was regarded as an (unnecessary) extension of his first admission. The change in his presentation, although initially assessed and noted, was not acted upon. The procedure for carrying out a comprehensive risk assessment and for referring to such an assessment when making decisions about leave and discharge was not followed, nor were these decisions appropriately documented.

7. The panel notes that TG's expressions of hostility towards his wife were not consistent. After the evening of 9 September 2002 he did not volunteer to health professionals any further feelings of hostility. There is no evidence that his threats were related to any underlying mental disorder which would have been amenable to standard psychiatric interventions.

8. It has not always been possible for the panel to determine whether an identified gap in the records reflects an omission to record or a lack of action.

9. Nursing staff told the panel that they were concerned about the amount of documentation associated with the Tidal Model. Medical staff expressed concern about the time required to carry out and review risk assessments. The panel noted that at that time the practice of the medical and nursing staff maintaining separate records created a potential for misunderstanding. For example, it was not clear to the panel whether on the second admission doctors as well as nurses had seen the crisis assessment and treatment service (CATS) documentation.

RECOMMENDATIONS TO THE TRUST IN RESPECT OF ACUTE CARE ADMISSION

1. A care co-ordination admission meeting should be held in accordance with the community mental health team procedure (that is to say attended by a consultant psychiatrist and a social worker from the team) as soon as possible after admission to the ward. In the case of patients not previously known to mental health services the admission meeting should always take place within seven days of admission.

2. The panel has commented on the lack of clarity in the application of the care programme approach/care co-ordination procedure to TG. The panel commends the new care co-ordination documentation which provides a structured approach to care planning. The trust should ensure that all members of staff understand the care co-ordination process, and how it is to be documented.

3. Where a risk assessment has identified significant risk factors (to the patient or to others), procedures should ensure that risk assessments are regularly reviewed. In particular the risk assessment should be reviewed at the point of discharge from hospital, and on post discharge follow up.

4. If a patient is re-admitted, however soon after a previous discharge, a fresh assessment of the patient should take place to identify any change in presenting features. This should include a fresh risk assessment.

5. The panel notes and commends the clear guidelines and procedures produced for granting of leave to both informal and detained patients. Decisions to grant leave must be documented in accordance with these procedures. Training should be provided so that all members of staff understand the decision making process in relation to leave, the factors which need to be taken into consideration in granting leave, and how decisions are

to be documented. Decisions to grant leave should be supported by ongoing risk assessments.

The panel notes that the policy and procedure documentation on care co-ordination introduced in March 2004 emphasises the requirements to update risk profiles and use them as a basis for developing a risk management plan which will include decisions about leave.

6. Decisions to discharge patients from hospital should be informed through a multidisciplinary process, however ultimate responsibility for discharge rests with senior medical staff. Decisions to discharge must be clearly recorded. They must (and must be seen to) be based on up to date risk assessments. The discharge notification procedure should be changed so that the community mental health team and the ward have a copy of the full form, and can see the diagnosis and comments sections.

7. Senior medical involvement with a patient should take place on at least a weekly basis, and should be documented.

8. Arrangements should be put in place to ensure that the inpatient work load of a particular consultant psychiatrist is not excessive (for example, as a result of there being a disproportionate number of inpatients from one team at any one time). The consultants' job plan should be designed to allow for sufficient time for clinical and educational supervision of junior doctors.

9. The panel understands that the trust is creating a post of lead consultant for ward 21, which will provide an administrative lead for medical issues. The lead consultant should, in the panel's view, have a responsibility for ensuring that there is adequate consultant psychiatrist and junior doctor cover for patients within each community mental health team (CMHT), and that the system is sufficiently flexible to allow for cover to be provided in the event that a particular consultant psychiatrist has an excessive workload.

10. The trust should review the way in which the Tidal Model nursing assessment, and the primary and allocated nurse systems operate. The panel believes that the Tidal Model system has many strengths, not least its emphasis on empowerment of the patients, which should be retained. However the process can become mechanistic and clinically ineffective if it does not produce a clear care plan which should involve a more pro-active approach for those patients who are less inclined to engage with staff.

11. The trust should proceed towards the goal of creating integrated medical and nursing records. The panel notes that significant advances have already been made in this direction. The trust should review whether use of the new care co-ordination documentation in tandem with the Tidal Model nursing assessment does not duplicate documentation, and whether the documentation cannot be further rationalised.

12. In accordance with guidance to effective care co-ordination, carers/important others should be involved in the planning and delivery of care. Subject, where appropriate, to the patient giving consent, they should be invited to care co-ordination meetings and reviews. Their involvement should be documented.

    The panel understands that the care co-ordination document being introduced by the trust does require clear records of the involvement of carers/important others, and of their participation in care co-ordination reviews.

OBSERVATIONS TO THE STRATEGIC HEALTH AUTHORITY

1. The panel recognises that there is debate nationally about how health and social services should manage the significant group of people who may not have a psychiatric diagnosis, but may be in acute psychosocial crisis. The panel notes that within North Tyneside discussions about future development of secondary mental health services suggest that, in accordance with national guidance, those services should be concentrating their resources on those with severe and enduring mental illness.

2. Historically the primary care services have dealt with the majority of people requiring assessment and treatment for mental health problems, and with those without a psychiatric diagnosis. However, in the past the primary care service has not been well placed to deal with those who require urgent intervention in order to avert a crisis. Primary care services such as psychology and counselling usually have waiting lists of at least some weeks, if not months.

3. The panel were pleased to see that within North Tyneside's discussions about an integrated mental health service for the locality, there is a recognition of the need for clear arrangements for the assessment, by other parts of the integrated mental health service, of people with urgent problems who are not in psychiatric crisis. The panel notes the proposals to develop primary care mental health workers. The panel considers it important that resources should be available either within the primary care system, the trust or the social services system (or some combination of the three) to offer support to that group of people who are in crisis, but for whom secondary mental health services are not the appropriate resource.

11 GLOSSARY

1. Diazepam – Benzodiazepine type of treatment commonly used to treat anxiety symptoms, insomnia and agitation.
2. Fluoxetine/Paroxetine – Antidepressant drug, commonly used to treat and to prevent relapse of episodes of depression.
3. Deliberate self-harm – Term used in psychiatry to describe behaviours through which people inflict harm upon themselves.
4. The assertive outreach team - Is a team of multidisciplinary professionals dedicated to provide community support and care to a patient affected by a severe and persistent mental illness associated with a significant level of disability.
5. Informal patient/admission – Refers to a voluntary hospital admission as opposed to formal admission, which would refer to admission under the provisions of the Mental Health Act 1983.
6. Level 2 observation – Refers to the level of patient supervision by nursing staff. Nursing observations can be implemented in three levels: level 1 being constant, level 2 when the observation is intermittent but not exceeding 15 minutes, and level 3 when the patient has greater freedom of movement, including being allowed time off ward.
7. Lorazepam – Benzodiazepine type of treatment commonly used to treat anxiety symptoms, insomnia and agitation.
8. Global functioning – Term used to describe the extent to which an individual is capable to engage with general day-to-day activities.
9. Beck suicide score – Score obtained in the implementation of the Beck Suicide Intent Scale, aimed at assessing degree of suicidal intent in a particular case.
10. Suicidal ideation – Equivalent term to refer to thoughts of committing suicide.
11. Decompensation – Term used to describe a deterioration in an individual's psychological well-being.
12. FACE risk profile – Assessment tool utilised in psychiatry to quantify the degree of risk that a patient may present in relation to behaviours that may cause harm to himself/herself, or others.

13. Global assessment of suicide risk – Is a term utilised in the Tidal Model of nursing assessment to quantify the potential risk of suicide in a case in relation to the individual's perception of current problems.
14. Affective component – Term used to describe symptoms that are associated with mood disorders, such a depression or mania.
15. Diminished responsibility – A finding, on a charge of murder, that at the time of the homicide the perpetrator was not fully responsible for his actions on mental health/disorder grounds. The finding has the effect of reducing the conviction from murder to manslaughter.

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